COURSE #96594 — 5 CONTACT HOURS/CREDITS RELEASE DATE: 03/01/24 EXPIRATION DATE: 02/28/27

Conducting Culturally Sensitive Psychosocial Research

HOW TO RECEIVE CREDIT

- Read the enclosed course.
- Complete the questions at the end of the course.
- Return your completed Evaluation to NetCE by mail or fax, or complete online at www.NetCE.com. (If you are a behavioral health professional or Florida nurse, please return the included Answer Sheet/Evaluation.) Your postmark or facsimile date will be used as your completion date.
- Receive your Certificate(s) of Completion by mail, fax, or email.

Faculty

Alice Yick Flanagan, PhD, MSW, received her Master's in Social Work from Columbia University, School of Social Work. She has clinical experience in mental health in correctional settings, psychiatric hospitals, and community health centers. In 1997, she received her PhD from UCLA, School of Public Policy and Social Research. Dr. Yick Flanagan completed a year-long post-doctoral fellowship at Hunter College, School of Social Work in 1999. In that year she taught the course Research Methods and Violence Against Women to Masters degree students, as well as conducting qualitative research studies on death and dying in Chinese American families.

Previously acting as a faculty member at Capella University and Northcentral University, Dr. Yick Flanagan is currently a contributing faculty member at Walden University, School of Social Work, and a dissertation chair at Grand Canyon University, College of Doctoral Studies, working with Industrial Organizational Psychology doctoral students. She also serves as a consultant/subject matter expert for the New York City Board of Education and publishing companies for online curriculum development, developing practice MCAT questions in the area of psychology and sociology. Her research focus is on the area of culture and mental health in ethnic minority communities.

Faculty Disclosure

Contributing faculty, Alice Yick Flanagan, PhD, MSW, has disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

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Division Planners/Director Disclosure

The division planners and director have disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

Audience

This course is designed for nurses, social workers, therapists, mental health counselors, and other allied health professionals who work in a clinical practice setting and who are currently conducting psychosocial research with ethnic minorities.

Accreditations & Approvals

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A complete Works Cited list begins on page 34.

As a licensed professional, you are responsible for reviewing the scope of practice, including activities that are defined in law as beyond the boundaries of practice for an LMSW and LCSW. A licensee who practices beyond the authorized scope of practice could be charged with unprofessional conduct under the Education Law and Regents Rules.

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AACN Synergy CERP Category B.

Social workers completing this intermediate-to-advanced course receive 5 Clinical continuing education credits.

NetCE designates this continuing education activity for 3 NBCC clock hours.

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In addition to states that accept ANCC, NetCE is approved as a provider of continuing education in nursing by: Alabama, Provider #ABNP0353 (valid through 07/29/2025); Arkansas, Provider #50-2405; California, BRN Provider #CEP9784; California, LVN Provider #V10662; California, PT Provider #V10842; District of Columbia, Provider #50-2405; Florida, Provider #50-2405; Georgia, Provider #50-2405; Kentucky, Provider #7-0054 (valid through 12/31/2025); South Carolina, Provider #50-2405; West Virginia, RN and APRN Provider #50-2405.

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Special Approvals

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About the Sponsor

The purpose of NetCE is to provide challenging curricula to assist healthcare professionals to raise their levels of expertise while fulfilling their continuing education requirements, thereby improving the quality of healthcare.

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Disclosure Statement

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Course Objective

The purpose of this course is to provide skills and competencies to equip healthcare professionals conducting or analyzing psychosocial research, to ensure that it is culturally sensitive and relevant throughout all stages of the research process.

Learning Objectives

Upon completion of this course, you should be able to:

1. Outline the reasons healthcare professionals should have a working knowledge of research designs and concepts.
2. Identify the tenets of basic and applied research.
3. Discuss the parallels between research and clinical practice.
4. Review different sources of knowledge, characteristics of empirical knowledge, and various research traditions.
5. List concerns and support for conducting culturally sensitive psychosocial research.
6. Define dimensions of culturally sensitive research.
7. Discuss the advantages and disadvantages of various research and sampling designs and their application in research with ethnic minority participants.
8. Discuss instrument- or measurement-related issues when conducting research with ethnic minority participants, including different translation methods.
9. Discuss data collection, recruitment issues, and barriers to participation when conducting research with ethnic minority participants.
10. Outline the appropriate data analysis and dissemination of research findings when conducting culturally sensitive research.

INTRODUCTION

Frequently, the term "research" invokes images of laboratory experiments, scientists, or an individual collecting data or information on an esoteric topic. In reality, all clinical practitioners engage in psychosocial research to some extent. Research involves the empirical and systematic examination of primary data, collected by an individual or group firsthand in order to understand a particular social phenomenon [1]. The term "psychosocial research" refers to the empirical examination of psychological, social, and cultural forces operating in a particular situation [1].

Researchers and practitioners often see their roles and values as being distinct and dichotomized. While it is true researchers and practitioners have their own sets of skills and specialized knowledge, the reality is that practitioners, including nurses, social workers, counselors, psychologists, and mental health workers, observe and interact with a variety of social problems and generally have questions about: the magnitude of the problem; the psychosocial ramifications for individuals, families, communities, neighborhoods, and society; its relationship to other factors; and effective interventions [3]. Psychosocial research provides the vehicle to answer these questions. Yet, tension between researchers and practitioners has been enduring and does not appear to be diminishing. Practice seems to be disengaged from the body of research obtained, and researchers often do not go back to practitioners to help frame questions that could be of practical value to the field [3].

In addition, the cultural and organizational norms from which researchers and practitioners operate are different. Research-practice partnerships can reduce this tension, but this requires open communication to ensure that the research study is asking questions relevant to practitioners' needs and that the diverse strengths of all participants are recognized [89; 90].

Conducting empirical research can offer the opportunity for practitioners to sharpen and refine their clinical skills. One of the characteristics of scientific research is that it is based on systematic observations, and practitioners employ observation techniques to understand phenomena [2]. Empirical research also employs observation as a data collection method; however, it is structured and systematic, with the goal of replication [2].

Practitioners should also be familiar with psychosocial research concepts and skills. Practitioners use an array of interventions when working with individuals and/or families, and many funding agencies and organizations are requesting scientific evaluations of interventions and programs to determine how effective they are. Often, anecdotal data are not sufficient, as these funding agencies desire empirical data demonstrating effectiveness.

Finally, even if practitioners do not conduct psychosocial research, they are consumers of research. Practitioners should be equipped with the skills to critique research literature and to understand the methodologic limitations of studies in order to understand if the findings were interpreted accurately, as this impacts how practitioners shape their practices and deliver services.

Not only should practitioners be familiar with how to conduct psychosocial research, they should also be acquainted with culturally sensitive research methods. As the United States grows more multicultural, this has become a greater issue. It is estimated that by 2060 non-Hispanic White Americans will no longer be the "majority group," dropping from 199 million in 2020 to 179 million in 2060 [123]. Furthermore, between 2016 and 2060, the foreign-born population is expected to grow from 14% to 17% of the population [123]. If these projections are met, the proportion of U.S. population will be greater than the historic high of 15% in 1890 [123].

Consequently, practitioners will inevitably work with clients and families from culturally diverse contexts. Therefore, culturally competent and sensitive research will be needed. Other terms that may appear include diversity, equity, and inclusion. Typically, it is assumed that concepts are monolithic and can easily be applied from one culture to another with the same meaning [4]. Such an assumption can lead to misinterpretation of data, which can ultimately pathologize certain groups because the benchmark is from a Eurocentric perspective. This has been further complicated by the use of the term culture to refer to other subgroups (e.g., youth culture, workplace culture) [155]. While these terms encompass more than simply the concepts of race, ethnicity, and culture, this course will focus on conducting research with racial/ethnic minority and cultural groups.

REVIEW OF RESEARCH CONCEPTS AND RESEARCH PHILOSOPHIES

BASIC AND APPLIED RESEARCH

Basic research has been defined as social research that is used for the primary purpose of advancing knowledge without the consideration of the economic or social benefits, practical ramifications to practice, or transferring the information to key individuals in sectors who can apply the findings [1; 91]. It is a bottom-up strategy of collecting information to advance knowledge [156].

Traditionally, a significant amount of financial and time investments have been made in basic research, resting on three assumptions [5]:

- Basic research will lead to solutions for existing social problems.
- Findings from basic research will trickle down to various segments of society.
- The market will employ the most promising solutions.

These goals of basic research have been called into question, particularly during a time when greater fiscal accountability is required.

Applied research refers to using social research methods to learn about a particular issue (i.e., violence, depression) with specific practical outcomes in mind, with the assumption that specific groups or society as a whole will benefit from the research findings [1; 136]. This has been referred to as "the science of the concrete," in which the goal is to study everyday practices to ensure that multiple perspectives are captured and not privileging any one voice [124]. The goal of applied research is the immediate application of research activities and outcomes into practice and disseminating research findings to professionals in order to implement the information [5; 91; 136; 156; 185]. Applied research, unlike basic research, is often conducted in real-life situations, in which it is not possible to control the settings or conditions under which the study is conducted [6]. There have been discussions of whether this dichotomy is artificial. Some have argued for a middle category of "use-inspired research," in which the goal is to maximize knowledge and application [91]. The term "implementation science" has also been used, which emphasizes application of the intervention or policy [185]. As with all dichotomies, it is presented in absolutes. For example, it is assumed that basic research is guided by theory while applied research does not. The reality is that applied questions can only be asked and answered within a theoretical context [92].

PARALLELS BETWEEN RESEARCH AND CLINICAL PRACTICE

The methods and concepts that psychosocial researchers apply and that practitioners use in clinical practice are similar. The research process entails a series of steps comparable to phases in clinical practice [1]:

- Identify the problem
- Formulate a strategy
- Implement a plan
- Analyze
- Draw conclusions

Identifying the Problem

In research, a specific topic to be studied is identified. This topic is very specific, observable, and measurable. From this topic, specific research questions are generated, for which answers will be sought. Similarly, in clinical practice, an assessment of each client is conducted to identify the specific problem to be worked on. The identified problem should be concrete and behaviorally oriented in order to best help the client identify the problem. After the problem is identified, assessments in the research and practice arenas are similar. In research, prior literature and the body of knowledge are assessed to understand what methodologies have been used and what has previously been learned in order to build on the existing knowledge foundation [3]. Similarly, in practice, the practitioner assesses the client's strengths, resources, and barriers in order to understand how he or she might respond to the current situation. The researcher should engage the practitioner and those working in the community to identify shared concerns or problems [124].

Formulating a Strategy

In research, a design will be identified, facilitated by the specific research topic and the research questions generated. The research design is a detailed plan about how the data will be collected. Research designs fall into three categories: quantitative, qualitative, and mixed method (containing both quantitative and qualitative elements). In a similar vein, practitioners in clinical practice develop a strategy for intervention. The intervention is guided by the problem identified. For example, if the problem identified by the client is smoking, the practitioner may elect to use a behavioral intervention plan to reduce smoking. The behavioral model outlines the theoretical framework that maps out the intervention(s) for the identified problem.

Implementation of the Plan

The researcher will implement the research plan in a systematic manner so that all phases of the research study are clearly laid out, allowing other researchers to replicate the study. Surveys or questionnaires are often used to measure the concept that is the focus of the study. In clinical practice, practitioners implement an intervention with the client that may consist of a series of systematic steps. The feasibility of the study plan should also be evaluated. This will involve evaluating financial, time, and ethical implications.

Analysis

After the data are collected, it is analyzed so that the research questions identified in the first step can be answered. Statistical analysis may be used if the data are quantitative, or data analysis may be used to extrapolate themes for a qualitative study. In clinical practice, the practitioner should evaluate whether the goals of the intervention plan were achieved. For example, to what extent did the client's behavior change? What were the benefits and costs of the intervention to the client? These questions should be evaluated or analyzed. In both instances, critical reflection is key to accurately interpreting the data [124].

Conclusions

After the data are analyzed, the researcher should interpret the findings. What do the findings mean in light of previous research? What practical ramifications do the findings have for clinical practice, service delivery, policy, and future research? Similarly, the practitioner in clinical practice engages in a termination phase with the client at the conclusion of the clinical work, which involves working with the client to assess how the intervention progressed, what goals were or were not achieved, and future plans. Furthermore, researchers and practitioners in all phases take into account the role of ethics and values. The ethics of beneficence, respect for persons, and justice are followed to ensure that adequate protections are in place for human participants, while practitioners operate within their agencies' mission, policies, and code of ethics. The protection of clients is guided by laws, codes of ethics, and regulations [3].

As illustrated, there are many interconnections between research and practice. Research informs practice and certainly clinical practice contributes to research endeavors. Unfortunately, researchers and practitioners have dichotomized the activities in each arena when they actually complement each other.

SOURCES OF KNOWLEDGE

What is knowledge? What knowledge base(s) does a particular professional field draw from? What are the different sources of knowledge that guide decision making in clinical practice? What is known, and beyond this, how do clinicians know what they know? These might sound like philosophical and rhetorical questions, but in reality, exploration of these questions raises critical awareness and understanding of one's professional discipline, which will ultimately shape how practice and research are conducted [7].

Understanding the nature and sources of knowledge is known as epistemology [7]. It has been proposed that there are four sources of knowledge [8; 9; 10; 11; 12; 13; 93; 125]:

- **Ethical knowledge**: Practitioners often make decisions when an ethical or moral situation is confronted. These decisions are guided by an ethical awareness of what is right or wrong as dictated in a code of ethics outlined in one's professional discipline.
- **Aesthetic knowledge**: This type of knowledge is linked with the art of clinical practice. It entails the practitioner's perceptions, understanding, empathy, values, and daily experiences. A response stemming from aesthetic knowledge is influenced in part by whom the practitioner is and the practitioner's clinical interaction with the client.
- **Personal (experiential) knowledge**: This type of knowledge is based on practitioners' experiences, both from their own participation with a situation and from their interpersonal relationships with others. It is believed to be highly pragmatic by practitioners, because the individual has had direct interaction with the problem or situation. Personal knowledge also stems from practitioners' intuition or gut instincts. Intuition is traditionally dismissed in the sciences because it involves a rapid understanding of something without conscious use of reasoning. However, this type of knowledge plays an important role in the reflective process.
- **Empirical knowledge**: This type of knowledge is derived from empirical research, which involves a systematic investigation and observation of a phenomenon. One goal of empirical research is to develop a scientific body of knowledge from which a professional discipline may draw. Another goal is to begin to identify causal relationships and to link interventions to outcomes in a systematic manner. This course focuses on empirical knowledge, particularly culturally sensitive research methods used to acquire empirical knowledge on psychosocial topics.

The goal of this section is not to elevate one type of knowledge over another; it is important to weave the four types of knowledge in an integrated manner. Decision making in clinical practice, drawing from all four sources of knowledge, can decrease distortions and biases that might result if only one primary source of knowledge is used [14]. Multiple sources of knowledge serve as a platform for practitioners to check the accuracy of their decisions [14].

CHARACTERISTICS OF EMPIRICAL KNOWLEDGE

Because this course focuses on conducting psychosocial research with ethnic minorities, it is important to review the characteristics of empirical research. Characteristics that are unique to empirical knowledge that set it apart from the other types of knowledge have been identified [15; 186]:

- **Empirical** knowledge is derived from scientific methods based on direct observation of the world.
- Empirical knowledge aims for **objectivity**. Although it is not possible to be completely objective, researchers implement mechanisms to reduce the impact of their biases, worldviews, assumptions, and subjectivities in the research process.
- Empirical knowledge is **provisional**; in other words, the research findings are never conclusive. They are accepted tentatively, leaving open the possibility for future studies to either confirm or refute the findings.
- Empirical knowledge is **public**, as the information is made available for review and critique.
- Empirical knowledge is characterized by **systematization** and **replication**. Research follows a set of rules and procedures to ensure that other researchers can conduct studies in the same manner.

Empirical knowledge may be further characterized as descriptive, causal, procedural, and relational [94]:

- Empirical knowledge is **descriptive** because the knowledge obtained can describe a phenomenon.
- Empirical knowledge is **causal**, as it can produce information that infers cause and effect.
- Empirical knowledge is **procedural** in that there is inherently an operational activity.
- Empirical knowledge is **relational**, because the knowledge obtained can delineate relationships between concepts.

APPROACHES TO EMPIRICAL KNOWLEDGE BUILDING

As briefly noted, there are three classifications of research designs. These may also be considered three approaches to obtaining empirical knowledge [2; 15; 95; 96; 187; 188]:

- **Quantitative approach**: This approach employs deductive logic to obtain knowledge and arrive at conclusions. According to this approach, there is one single objective truth or reality that can be measured or quantified. In other words, the focus is on breaking social phenomenon down into quantifiable or measurable terms. The researcher identifies hypotheses with embedded variables. It is assumed that these variables or concepts can be observed and measured. The researcher may then carefully collect data in a controlled situation to either accept or reject the hypotheses set forth. It is guided by a research tradition called logical positivism.
- **Qualitative approach**: This method uses inductive logic to gather data and focuses on understanding social phenomenon from the reality of the people who live it. Concepts that are examined are broadly identified, as it is assumed that they cannot be easily measured or quantified. Qualitative researchers argue that there is no single objective reality; instead, reality is considered subjective. As such, social phenomena are context bound and value-laden. It is guided by a research tradition called interpretivism.
- **Mixed methods approach**: This method, as the term implies, employs features of both quantitative and qualitative methods. Some argue that mixed methods can yield a richer understanding of a particular social phenomenon, as the use of multiple methods may allow for more details to be elicited.

REVIEW OF RESEARCH TRADITIONS (EPISTEMOLOGICAL PARADIGMS)

All research methods are guided by a research tradition or an epistemological paradigm. As noted, epistemology is the study of the roots of knowledge. An epistemological paradigm, or research tradition, offers a set of assumptions about how researchers view the problems to be studied, how to go about collecting data, and how to analyze and interpret the data [16; 17]. Researchers are guided by a specific epistemological framework that informs their knowledge limitations, and the research methods allow researchers to discover what they believe can be known [18]. Consequently, every researcher has a unique epistemological perspective when using a specific research approach (i.e., quantitative, qualitative, mixed methods). Not taking into account one's epistemologic framework may introduce biases when collecting and analyzing data [126].

In this course, four research traditions will be reviewed: logical positivism, interpretivism, critical theory, and feminist theory.

Logical Positivism

Logical positivism, or positivism, emerged from the Enlightenment era in the 18th century when philosophers were moved away from knowledge derived from faith, metaphysics, or religion [2; 16; 157]. At the beginning of the 20th century, this paradigm was viewed as the leading scientific approach and was equated with truth seeking [157]. Philosophers argued that knowledge should be built on direct and systematic observations of the world. Logical positivism is based on the belief that research of social phenomena should be measurable, objective, and discernible through the senses [2; 16; 19; 158]. This theory argues that there is one true objective reality that can be identified, measured, observed, and quantified [17; 157; 189]. In other words, psychosocial concepts that might be of interest to researchers (e.g., depression, family violence, family caregiving, acculturation) are realities that can be apprehended and measured. Researchers who are guided by logical positivism use deductive, linear methods to accumulate data to test hypotheses. Hypotheses are logical statements about the direction of one's anticipated findings. For example, one might hypothesize that there is a positive correlation between age and depression. In this epistemologic paradigm, the term "etic approach" is often used. This approach assumes that the researcher can be objective and can observe differences and similarities from group to group. Hypotheses can be made and tested and the findings generalized across cultures [126; 189].

This research method is categorized under the heading of quantitative research designs, whereby rigorous instruments are used to measure the concepts or variables and the researcher attempts to control the research environment. Examples of quantitative methods include experimental designs, quasi-experimental designs, and surveys. The data collected are then subjected to statistical analysis in order to either accept or reject the hypotheses [2; 158]. Many disciplines, including the "hard" sciences, rely on logical positivism in their research.

Interpretivism

By the 20th century, scholars and philosophers began to question whether it made sense to use logical positivistic research traditions to understand human phenomena and the complex facets of social reality [19; 20]. It was maintained that there was no objective social reality that could be easily measured, as logical positivists contended. This paved the way for a research tradition that positioned itself opposite to logical positivism. Interpretivists argue that social phenomena and human interactions can only be understood when the researcher taps into participants' lives, voices, and social realities. The meanings they ascribe to events, behaviors, and situations and specific context are crucial. Thus, there are multiple realities that cannot easily be measured, as reality is fluid [2; 157; 189]. Interpretivists emphasize the experiences of those individuals who live out the phenomenon day-to-day and how they construct and reconstruct meanings of these experiences and interactions [17; 158]. In cross-cultural research, researchers take an "emic" approach, characterized by a belief that there are culturally specific elements that cannot be easily measured [126].

Interpretivists employ qualitative research methods, such as phenomenological interviews, that are open-ended and unstructured to allow researchers to freely discuss and explore a particular topic without any predetermined definitions of that concept. Examples of specific qualitative methods include grounded theory, phenomenology, ethnography, and focus groups [1; 2]. Interpretivistic researchers use a very reflexive, descriptive, and subjective methodology [97; 187].

Unfortunately, the debate between logical positivism and interpretivism (or quantitative and qualitative research) is contentious and continues to divide scholars and researchers. The reality is that both traditions have unique strengths, dimensions, and goals that may be used in complement to one another [21].

Critical Theory

Critical theory emerged after World War I in reaction to logical positivism [22]. It was argued that there are three different types of knowledge: empirical/analytical knowledge, historical/hermeneutical knowledge, and emancipatory knowledge [22; 23]. Empirical/analytical knowledge relies on knowledge derived from technical rules by which concepts can be measured and the environment controlled. Historical/hermeneutical knowledge focuses on understanding individuals' subjective experiences. Emancipatory knowledge focuses on illuminating oppressions experienced by individuals that emanate from societal institutions; once individuals realize that they are oppressed and marginalized, they will be called into social action to liberate themselves [2; 22; 158]. Individuals can only realize their oppression when they can rationally evaluate the constraints of their marginalization by participation in the scientific process [98]. Therefore, scientific knowledge can liberate and create social change [127]. Emancipatory knowledge is at the heart of critical theory.

Critical theory argues that there are multiple social realities and that it is not easy to observe and measure social phenomenon. Critical theorists take this one step further and maintain that individuals' social realities are influenced by oppression, subjugation, marginalization, and other factors that maintain the societal status quo [2]. These factors include gender, socioeconomic status, sexual orientation, religion, and disability status [17]. Critical theorists assert that these dimensions contribute to hierarchal power relations and that all individuals construct their experiences based upon power relations within a social and historical context [17]. Researchers who are influenced by this perspective will consider how historical, social, and cultural context influence the topic by identifying who has the power and how this power has affected the topic being studied and the researcher's biases [127].

Critical theorists assert that science and research are political, because the formulation of what to study is politically, economically, and socially charged. Topics that relate to marginalization and oppression are taken for granted, and for the most part, researchers avoid investigating such issues. These theorists believe that if researchers take on a stance involving critical theory people will be liberated from the oppressive and hierarchical structures [98].

Critical theorists rely on qualitative methods to study social problems; however, they also argue that traditional science maintains hegemonic ideology and does not produce knowledge that is beneficial to marginalized populations [2]. Critical theory has its origins in promoting social justice and, therefore, asserts that science should ultimately bring about social action to eradicate injustices [24]. The goal of science, then, is to emancipate oppressed groups [17]. Participatory action research (PAR) is a methodology aligned with critical theory and will be discussed in greater depth later in this course.

Feminist Theory

Feminist theory can be placed under the broader critical theory category [159]. There are many different strains of feminist theory, and this section is not meant to be a comprehensive or exhaustive discussion of feminist theories [159]. One unifying theme that runs through all the variations of feminist theory is that "feminism speaks with one voice in characterizing the world it experiences as a patriarchal world and the culture it inherits as a masculinist culture" [25].

Feminist theorists argue that women need sciences that target women [26]. In other words, these theorists challenge androcentric theories and argue for the need for knowledge about topics relevant to women that would explain the relationship between gender and social, cultural, and political structures in society [27]. Feminist researchers assert that there is frequently too much emphasis on sex differences in research. When differences are found, these tend to be attributed to women's differences from men, who serve as the benchmarks [99].

Feminist methodologies in knowledge acquisition can be characterized by: valuing women and their ideas, experiences, social realities, and needs; recognizing the structural and ideological conditions that discriminate against women; and desiring to bring about social change [28; 190]. Researchers further elaborate on the methodological conditions that characterize feminist research [29; 100; 128]:

- Research should be based on women's experiences and the validity of women's perceptions as truth.
- Artificial dichotomies and sharp boundaries are suspect in research involving women and other humans and should be carefully scrutinized.
- The contexts and relationships of phenomena, such as history and concurrent events, should consistently be considered in designing, conducting, and interpreting research.
- Research should address questions that women want answered.
- The researcher's point of view should be described and treated as part of the data.
- Research should be nonhierarchical; participants and researchers should be partners.
- Researchers' interpretations of observations should be validated by and shared with the participants so that they benefit from research in which they have taken part.
- The researcher's self-awareness and self-reflection about themselves and reactions of others help in the acquisition of knowledge.
- Gender is not the only social force that affects the lives of women. Other social factors (e.g., race, ethnicity, class, religion, sexual orientation, disability) intersect to make women's voices invisible.

Postmodernism

Postmodernism emerged in the middle of the 20th century as a response to the modernism of the Enlightenment era, which promoted human rationality and empirical knowledge [129; 130]. Postmodernism is characterized by relativism and multiple ways of knowing [130]. In other words, postmodernists believe that there is no single objective truth or a neutral scientific knowledge base [129; 160]. Phenomena are unstable concepts [191]. Instead, social realities are constructed by individuals differently, influenced by the local context [131]. Language and its meaning are subjective and ever-changing [160]. Therefore, for the postmodernist researcher, because it is impossible to know what to do in advance, there are no set pre-existing methodologies to use [191]. Holtz asserts that research methods can help the postmodernist researcher to understand the "plurality of culturally embedded psychological realities and the ways in which such realities can change understand certain traditions" [192]. Overall, postmodernist researchers employ qualitative methods.

REASONS FOR CONDUCTING CULTURALLY SENSITIVE AND RELEVANT PSYCHOSOCIAL RESEARCH

Historically, research theories and the empirical literature have focused on homogeneity [132]. As such, collecting research data that allows for comparisons of racial and ethnic groups is a controversial issue [30]. Concern exists regarding the possibility of reinforcing stereotypes and prejudices by using benchmarks that are based on White, European standards and triggering social division when focusing on racial and ethnic differences [30; 133]. Yet, by ignoring these important variables, the understanding of how these social categories influence social inequities is masked, and this can have adverse health, mental health, and social outcomes.

The American Sociological Association (ASA) has identified several reasons for conducting research that examines race and ethnicity [30]. First, race and ethnicity influence the distribution of resources, leading to health, social service, and mental health disparities [161]. Second, race and ethnicity have been powerful forces in mobilizing social movements and political action. Third, race and ethnicity influence social interactions that can lead to a cycle of adverse and disparate outcomes. Similarly, race and ethnicity affect health and mental health outcomes. For example, African Americans have higher death rates and higher levels of hypertension compared to White Americans [30]. Although genetics may account for these disparate outcomes, other social processes (i.e., coping, help-seeking patterns, access to services) might influence the outcomes. In other words, explanations take into account the external social environment and how this might affect behavior and outcomes [134]. For example, by examining race, researchers then examine the role of institutional racism in health treatment disparities. Institutional racism affects differential availability and access to services in the healthcare system [101]. Fourth, ethnocentrism should be avoided, which would require a recognition of other viewpoints and voices so as to not perpetuate the established power relationships in traditional research [102]. Finally, employment and segregation continue to be affected by race and ethnicity, as well as gender/sex and ability [30]. Intersectionality is another key factor to take into account in culturally sensitive research [133]. Proponents of incorporating race and ethnicity into research also note that there can be tremendous within-group differences within a racial group [135].

Despite the clear need, scholarship in different disciplines has not adequately represented racial and ethnic minority groups. For example, a meta-analysis of vocational research published between 2005 and 2015 found that only 4.3% focused on racial and ethnic minority groups [162]. In a content-analysis study involving 634 articles from major social work journals, only 16.5% focused on race/ethnicity [163]. A similar study found the rate to be as low as 7.28% [164]. Despite the amount of attention given to racial disparities during the COVID-19 pandemic, there still appears to be a lack of reporting on race and ethnicity in COVID-19-related research. An analysis on the reporting of race in COVID-19 studies in three top medical journals during the first wave of the pandemic found that 62.5% of the articles that met the inclusion criteria did not report race [193].

Today, many researchers and scholars recognize the importance of taking culture into account in explaining behavior. A strict universalist stance (i.e., the view that culture is not important) is generally not adopted [194]. However, much of the research literature on ethnic minorities is still based on Eurocentric theoretical frameworks rather than on culturally specific paradigms [31]. Eurocentric paradigms are monocultural and androcentric. When applied to racial and ethnic groups, these paradigms do not capture the groups' experiences with the majority culture. It is vital that questions be raised that tap into racial and ethnic minority groups' experiences.

Some experts encourage researchers who conduct research with different cultural groups to take it one step further and ask why the study is being conducted [103]. If a study is being conducted in order to examine differences or compare different racial groups, it will likely perpetuate the deficiency model. Unfortunately, minimal training prepares researchers to conduct culturally sensitive and relevant research. In many cases, the community under study ends up feeling disrespected and research results may be more harmful than beneficial for them [195].

It is for these reasons that the ASA advocates scientific inquiry that examines the causes and consequences stemming from these social categories [30]. According to the ASA, "studying race as a social phenomenon makes for better science and more informed policy debate. As the United States becomes more diverse, the need for public agencies to continue to collect data on racial categories will become even more important" [30]. If the ASA's premise that race and ethnicity are vital social forces that impact individuals' lives is accepted as true, then the next question is: how do researchers go about studying the impact of race and ethnicity on various social phenomena in a manner that is culturally sensitive and appropriate?

CULTURALLY SENSITIVE RESEARCH PROCESSES

Culturally sensitive research approaches recognize ethnicity and culture as central to the research process [32]. Culturally sensitive research has been defined as "that which incorporates into its design and implementation the historical context and cultural experiences, norms, values, beliefs, and behaviors of a distinct ethnic or cultural group" [104]. Some researchers use the term "cultural integrity," which refers to respecting research participants' cultural norms and values and aligning research as such [165]. Taking into account how cultural identities intersect and influence behavior, the research process should reflect cultural sensitivity and inclusivity [195]. The result is that aspects of a group's culture and historical and contemporary experiences are acknowledged, and the group's social realities are not viewed from a deficit perspective [32]. In culturally sensitive research, researchers are connected to the community, which allows them to elucidate the social experiences and thoughts of the participants, acknowledging that there are multiple realities, perhaps different from the established theoretical knowledge base [33]. The culturally sensitive researcher, working with the community being studied, with cultural informants, and with other gatekeepers, develops the study and interprets the data to advance theories that are relevant to the specific cultural group [194].

The following dimensions have been suggested as part of the framework of what constitutes culturally sensitive research [32; 137; 138; 139; 165]:

- **Culturally congruent research methods**: The use of qualitative research methods to "investigate and capture holistic contextualized pictures of the social, political, economic, educational factors" is advocated. However, this does not necessarily mean that it is not possible to draw on quantitative research methods to study cultural groups and their experiences, and quantitative methods are not dismissed altogether. Another research method that may be suitable is Participatory Action Research (PAR), also known as community-based participatory research. This method has its epistemologic base in critical theory and actively involves the people affected by the social problem.
- **Culturally specific knowledge**: Knowledge pertaining to the group's unique historical and cultural experiences is used. The researcher also acknowledges his/her insider and outsider perspectives related to the research process. For example, researchers will be outsiders to a certain extent even if they are from the same ethnic minority or cultural group. As researchers, they will hold the power to define the "problem." Researchers may be given the opportunity to obtain insider perspective by studying and becoming

more familiar with the cultural group's norms, beliefs, and values. The outsider/insider perspective should be continually balanced. One way to enter into a group is to interview community leaders and providers in order to enhance understanding of the sociopolitical context and the issues that the community faces. Therefore, context is of paramount importance.

- **Cultural resistance to theoretical dominance**: The research process acknowledges the vital role of a group's experiences with discrimination, prejudice, marginalization, and oppression and attempts to further uncover, understand, and respond to these processes.
- **Culturally sensitive data interpretations**: The analysis, interpretation, presentation, and dissemination of data reflect the cultural group's social realities. The group's knowledge base should be considered as legitimate as the dominant culture's.
- **Culturally informed theory and practice**: Theories advanced from the research reflect the group's experiences and can direct the formulation of interventions, policies, and service delivery that are also culturally relevant. Researchers have an obligation to work with the nonacademic community in a collaborative manner to promote change that is beneficial for the cultural group and the community.

It is incumbent upon researchers who wish to conduct culturally sensitive research to incorporate the following concepts throughout the research process: an understanding of their own values and biases; an understanding of the cultural values, beliefs, and norms of the group under study; an incorporation of skills for a variety of tasks involved in collaborating and working with the community under study; an ability to identify their personal and institutional values about research as well as the community's values about research; and the maintenance of respect for the culture under examination as well as the integrity of the research process [34]. Attempts should be made to understand the institutional norms affecting mainstream research. For example, how do values promoting individualism and the non-duality of the mind and body influence how researchers in the United States conduct research and how might this conflict with the values from other cultural groups [140]?

Conducting culturally sensitive psychosocial research does not consist of a finite set of rules that guarantees culturally sensitive research [35]. Instead, it is a continual, organic process whereby the researcher constantly attempts to mesh the research process with the cultural group's values, norms, and characteristics [35]:

> Research is made culturally sensitive through a continuing and open-ended series of substantive and methodological insertions and adaptations...The insertions and adaptations span the entire research process...Research, therefore, is made culturally sensitive through an incessant, basic, and active preoccupation with the culture of the group being studied throughout the process of research.

POSITIONALITY

There has been increased attention about the need for researchers to reflect and be transparent about their positionality. Positionality refers to the disclosure of the researcher's sex/gender, racial/ethnic, religion, gender orientation, and other self-identifications and how these social categorizations may affect the research process. Reflecting on their own background and experiences with privilege, marginalization, and oppression, researchers should deeply explore how these issues shape the formulation of the research questions and how data are collected and analyzed [196; 197]. This is not an one-time reflection, but a sustained work of continual self-reflection of the dynamics of the researcher's multiple social positions and their influence on power and privilege in relation to research participants and the community [198; 199]. Positionality mapping may be beneficial in starting the process of transparency and reflection [198].

CULTURALLY RELEVANT RESEARCH QUESTIONS AND THEORIES

The research process begins with asking culturally relevant research questions—questions that improve the quality of participants' lives and align with the norms and values of the group being studied [165]. It is important to focus on specific characteristics, experiences, or attributes that are relevant to the group (e.g., racial socialization, immigration, acculturation, enculturation, prejudice, bias) [166]. While simply comparing results to a White sample may be easier, it can inadvertently convey a deficit, give the impression of White supremacy, or suggest that one group is more well-adjusted or the norm [166; 194]. Employing a strengths-based approach is recommended to avoid reinforcing negative stereotypes. For example, instead of examining the attrition and school drop-out patterns of African American youth, a strengths-based approach would to examine patterns of academic achievement in this group [166; 194].

Use of appropriate theoretical frameworks should also be considered. Theoretical frameworks can generally be organized into three categories to help guide culturally sensitive research studies: generalizability, group differences, and multicultural perspective. A generalizeability approach assumes that the construct being studied is universal. Social learning theory is an example of this type of framework. Group differences approaches are more appropriate when the goal of the study is to understand how and why two groups differ. A multicultural approach focuses one group and specific attributes unique to that group [167].

Intersectionality theory should also be considered when conducting cross-cultural research. Crenshaw first coined intersectionality to mean that an individual's social identity often overlaps with other social categorizations, such as race, gender, class, age, ability, and socioeconomic status, all of which are connected to privilege and marginalization [188]. Intersectionality theory acknowledges the complexity of lived experiences, and multiple social categorizations are personified by an individual [195]. The convergence of these multiple forces inevitably shapes behaviors and experiences [200]. Intersectionality should be accounted for when formulating the research questions; designing the recruitment of research participants; collecting, analyzing, and interpreting data; and recommending practical implications and solutions [195]. Researchers often neglect to fully incorporate social context, power, and social justice despite purportedly indicating that their studies are grounded in intersectionality [200].

CULTURALLY SENSITIVE RESEARCH DESIGNS

In the previous sections, various research traditions and how they guide the different classifications of research design were reviewed. As noted, research designs can be viewed as the overall plan by which empirical knowledge is acquired.

Quantitative research designs, guided by logical positivistic paradigms, assume there is one defined, objective reality that can be measured. Therefore, it is debatable whether these traditional research designs are optimum for conducting research with ethnic minority groups. If there is one universal reality, then should one assume that the monocultural and Eurocentric conceptualizations of a phenomenon apply to ethnic minority groups? Instead of accepting this theory, some assert that qualitative research designs guided by interpretivism may be more amenable when working with ethnic minority groups [36]. In this scenario, starting with the lived experience of research participants, researchers would not force a schema on the conceptualization of a problem. Furthermore, some assert that qualitative research fosters relationships between researchers and participants. This is particularly crucial in research with cultural groups and racial/ethnic minorities that are more relationship-centered [104]. Qualitative designs may also be more amenable to high context cultures, given that they tend to rely on oral traditions [105]. Finally, reflexivity, an inherent part of qualitative research, can identify the insidious ways in which Eurocentricism can enter into the research process [106].

Quantitative and qualitative designs are often viewed as mutually exclusive categories rather than principles that may complement each other [21]. Mixed method research designs fill this role, using the strengths of both quantitative and qualitative research designs to capture cultural nuances. Two studies involving African Americans and Chinese participants that used a mixed method design are discussed here. In these cases mixed method designs harnessed the strengths of both quantitative and qualitative methods. The cases illustrate the particular amenability of mixed designs to exploring the cultural nuances of a social phenomenon.

Researchers conducted both closed-ended surveys and ethnographic interviewing of African American and White children and their parents [37]. The researchers maintained that a mixed method design provides a layered understanding of the problem. The quantitative and qualitative analyses revealed interesting data about how society perceives and labels attention deficit hyperactivity disorder (ADHD) symptoms in ethnic minority children. African American girls with ADHD were more likely to be described as "bad," "stubborn," and "uncontrollable," while White girls were described as "reactive." African American boys were labeled as "endangered." Ultimately, these role perceptions influenced the types of interventions used. African American girls were given behavior modification interventions including spanking and disciplining, and African American boys were given more restrictions and behavioral modifications. In both cases, the ADHD symptoms were not viewed as indications of an illness but as behavioral problems. White girls received less professional help than their male counterparts because their symptoms were perceived as due to stressful events; boys' symptoms were believed to be related to genetics, which led more quickly to professional help. If the authors had used only one design method, these rich, multilayered explanations would not have been extrapolated.

Using a mixed method design as well, researchers explored factors contributing to the tendency for Chinese women to underuse cervical cancer screenings [38]. Qualitative methods, using focus groups with both screened and unscreened women, revealed that discomfort, modesty, and embarrassment impeded participants seeking cancer screening. In the quantitative research component, physicians were surveyed. This survey added to the data by identifying an additional cultural element, fatalism, which influences Chinese women's screening behaviors.

Participatory action research, or PAR, is premised on critical theory and feminist theories, and PAR researchers employ either quantitative, qualitative, or mixed-methods. PAR advocates that marginalized communities should take charge in developing the study, with the goal of instigating social change in their communities [201]. With this approach, the researcher does not enter the process as the expert; rather, the community and the research participants are the experts [201]. The community is engaged and participates actively in all stages of the research process. The research team collaborates with the community and stakeholders to identify a meaningful problem that they want to solve. Existing strengths, resources, and assets of the community are harnessed, with an emphasis on co-learning between the community and the research team [202]. Co-planning and communication with the community help to mitigate the fear and mistrust many communities have with researchers. Community engagement and buy-in are crucial in order to create long-lasting, feasible, and sustainable solutions [201; 202]. Consequently, knowledge is co-created and shared by not only the researcher but by the researched. Ultimately, this process shifts the power dynamics in research projects [199].

CULTURALLY SENSITIVE SAMPLING DESIGNS

Sampling refers to the process of recruiting research participants. Ideally, probability sampling designs will be employed because they rely on a random process, which means every individual in the population of interest has an equal probability of being selected [2]. Probability sampling is highly desired because it produces a research sample that is more likely to represent the population of interest [2]. In addition to the expense, however, there are challenges with using probability sampling designs when trying to recruit ethnic minorities. Ethnic minorities, particularly immigrants who are not familiar with social science research methods, may be fearful and mistrustful of strangers contacting them without any warning [39; 40]. A review of the factors affecting ethnic minorities' participation in studies will be provided later in this course.

POPULATION DEFINED

One of the challenges of conducting culturally sensitive psychosocial research is defining the population to be studied. For example, a researcher may be interested in studying Hispanic families. The term "Hispanic" refers to a large and heterogeneous group who share some threads of similar cultural characteristics, values, and belief systems. However, to categorize all individuals from Latin America as Hispanic minimizes the tremendous diversity of individuals born into one of the several nations that make up Spanish-speaking Latin America [40]. A research participant who is Mexican American may reflect various demographic, social, political, and educational differences compared to a Cuban American participant [40]. To classify Chinese from Taiwan or from Cambodia or Chinese Americans from the United States all into one group labeled "Chinese" would undercut the political history affecting each of these Chinese subgroups. Chinese individuals from Cambodia, for example, who were targeted by the Khmer Rouge between 1975 and 1979 and experienced torture, political persecution, and harsh treatment because of their ethnicity, have starkly different social realities than those of third-generation Chinese Americans born in the United States [41]. Similarly, when studying Muslims, it is vital to remember that this is a diverse group, with differences in religious beliefs/traditions, national origin (e.g., Pakistan, Bangladesh), and ways of self-identifying [107]. A classification like "non-White" may be viewed as derogatory as it is not a racial/ethnic category. It is analogous to using "non-male" as an identifier of sex [166].

Many times, researchers employ demographic variables or self-identified racial and ethnic categories to capture the concept of culture [40; 42]. For example, research participants might be asked to designate an ethnic category or might be asked where they were born. These demographic variables are then used to define culture. The simple demographic variable of birthplace does not necessarily capture the subjective nature of culture, which is comprised of beliefs, norms, and values, nor does it fully capture the dynamic and fluid nature of culture [43; 44]. Even asking seemingly basic demographic questions (e.g., marital status) may require cultural nuances. For example, some cultures have a tradition of long engagement periods, and these individuals may not feel comfortable marking "single" or "married" for their marital status [107]. In other words, demographic variables may serve as proxies for culture, but they do not have inherent psychological, cultural, and/or social meanings [194].

Researchers often define ethnicity based on research participants' self-classification. The rationale for using self-identification classifications warrants merit. It can be argued that individuals know best what their cultural values and preferences are and how these influence the construction of their identity. Yet, how other groups ascribe meaning and identity also plays a role in the construction of ethnic identity [44]. Researchers describe a focus group study where the eligibility criterion was "self-identify as Chinese" [41]. One focus group participant maintained that she was Taiwanese, although she was ethnically Chinese. However, she did not want to be affiliated with the political ideologies of mainland China. Hence, her perceived ethnic and cultural identity was Taiwanese.

Best practices when assessing participants' racial/ethnic categorization include [166]:

- Allow for self-selection/definition from a multiple response options.
- Provide participants to select from multiple race/ethnic categories.
- Ask about country of origin.
- Avoid general categories (e.g., Hispanic, Asian) and oversimplified specific groups (e.g., Cuban, Salvadoran, Chinese).
- Keep abreast of the literature and other studies that have studied groups of interest and new terminologies (e.g., Latinx, BIPOC).

At first glance, defining the population of interest does not appear complicated. However, one of the dimensions of culturally sensitive sampling requires an understanding of how cultural cognitive scripts and the tremendous within-group differences influence the definition of racial, ethnic, and cultural categories. Unfortunately, it is not simple to capture the dynamic nature of these scripts and their effect on identity.

RECRUITING AND ACCESSING RESEARCH PARTICIPANTS

There are many different sampling strategies that may be used to recruit ethnic minorities for participation in psychosocial research. As discussed, probability sampling designs pose challenges. Consequently, nonprobability sampling designs are used more frequently. Unlike probability or random sampling, nonprobability sampling designs are not concerned with obtaining a sample that represents the larger population of interest [2]. Convenience or purposive sampling, a type of nonprobability sampling design, is used to recruit participants who fit a predefined criterion, using multiple recruitment methods, such as disseminating information about the research study through flyers, advertisements, and word of mouth. Potential participants would then be screened to determine if they meet the eligibility criteria. Studies using convenience sampling include [45; 46; 47; 48; 141; 169; 203]:

- Researchers use bilingual interviewers who visit ethnic grocery stores, churches, English classes, and other places where Asian Americans congregated
- Researchers recruit students from psychology classes
- Researcher speaks on two radio shows for women
- Researcher recruits Chinese elders from *tai chi* classes and cultural events
- Researcher recruits Chinese participants from a Buddhist temple and a community health event
- Researchers visit ethnic fairs
- Researchers recruit African American men from barbershops

Other researchers describe recruiting African Americans through Black churches' rosters for survey studies on diet, hypertension, and blood pressure [49; 108]. Media outlets that target a specific group or are presented in the target audience's native language can also be helpful [108].

In addition to being creative with recruitment methods, alliances with community leaders are vital to success. In one study, researchers recruited Latinas using convenience sampling, offering financial incentives, childcare, and transportation, but they struggled with successfully recruiting for more than one year [109]. However, after the researchers formed an alliance with a well-respected pastor, who endorsed the study, and moved the data collection to the church, participants were much more likely to participate. One motivating factor was the women's interest in sharing financial incentives with the church. Research indicates that going into the community to develop relationships and establish trust/credibility is one of the most effective strategies for recruitment of African American research participants [168].

Personal referrals, including potential participants' close friends or family members or trusted individuals from the community, can be very useful [141; 203]. In a longitudinal study with Latino immigrant families, researchers and interviewers recruited from school and holiday events. Before attending these events, however, the researchers asked mothers who lived in the community to accompany them. These women allowed the researcher to more easily enter into the group and be trusted by potential participants [142].

One major limitation of convenience sampling is that the research participants recruited do not necessarily represent the population of interest; they may be more educated and/or from higher socioeconomic brackets. Snowball sampling is another form of nonprobability sampling whereby potential contacts are obtained through referrals from one or a few participants, and then referrals from those participants, and so forth, generating a "snowball" effect [2; 196]. Several challenges are inherent with this strategy. Some people may be hesitant to provide names and contact information for friends, family members, or acquaintances. Others may only have a name without specific contact information. This causes researchers to have to track down the information and create a system to keep track of the names obtained [50]. Additionally, participants will often give names from their own social network. Consequently, the individuals referred will be more similar to the initial set of participants, limiting the range of diversity of the sample [51]. Nevertheless, Rankin and Bhopal maintain that snowball sampling is an effective strategy, particularly when interviewers who ask for referrals are known and are familiar with the nuances of the community [50].

Another type of nonprobability sampling method is selection by ethnic surnames. The underlying assumption in using ethnic surnames as an identifier is that the ethnic group under study has surnames that are unique from other groups and are representative [52]. Himmelfarb, Loar, and Mott, for example, identified 35 Jewish surnames and used a random sampling of persons with these distinct Jewish surnames [53]. They found there were no major differences between samples obtained based on these surnames and sampling from lists obtained from Jewish organizations. Similarly, Shin and Yu compared the proportion of persons with the surname Kim in eight groups from different regional, occupational, and socioeconomic backgrounds [54]. They approximated that the surname Kim reflected more than one-fifth (22%) of the Korean population. Consequently, using Kim as the identifier was a viable method for selecting potential Korean American participants. In another example, Chinese elderly were identified using Chinese surnames from 1990 Medicare enrollment files and then compared to their demographic profiles from 1990 U.S. Census data [52]. The demographic profiles from these two datasets were comparable, supporting the use of ethnic surnames as a viable sampling technique. However, several caveats should be acknowledged when ethnic surnames are used for sampling purposes. A particular ethnic surname is not always exclusively representative of that ethnic group, and not all ethnic minority households may have a unique surname [55]. Finally, this technique does not identify those ethnic minority women who marry outside their ethnic group [52].

A probability sampling strategy called time-space sampling has been employed to identify hidden or difficult to access populations. Time-space sampling was developed by the Centers for Disease Control and Prevention (CDC) and has been used primarily for research with gay and lesbian groups. However, the concept can be extrapolated for research with ethnic minorities. Time-space sampling involves recruiting participants from the target study population during times and places where they congregate rather than where they live [56]. It involves three steps [56]:

1. Identifying venues where the group congregates and randomly selecting from all the identified venues
2. Randomly selecting days or time periods associated with the venue
3. Visiting the selected venues during these time frames and systematically approaching and recruiting participants

There is no one preferred culturally sensitive sampling strategy that will ensure enhanced research participation and retention of ethnic minority research participants. Often, ethnic minorities are particularly wary of researchers asking for private personal information that is perceived to potentially place the group or community at risk [40]. Consequently, it is crucial for researchers to continually reflect how they can establish collaborative and trusting relationships with gatekeepers, community leaders, and research participants.

One interesting and collaborative exercise to promote engagement and collaboration is to conduct a transect walk. This involves the research team, community leaders, residents, gatekeepers, and other trusted individuals walking together through a defined path in the community. During this walk, the parties discuss the steps necessary to involve all interested parties and to ensure the research is culturally relevant and sensitive [126].

CULTURALLY SENSITIVE INSTRUMENTS AND MEASUREMENT

In research, measurement refers to capturing the attributes or dimensions of the concepts or variables under examination. One of the main challenges when conducting culturally sensitive psychosocial research is ensuring that the concepts being studied are not based on Eurocentric definitions. The meanings of social phenomenon are not universal, meaning everyone does not define, perceive, or ascribe the same meanings and attributes to a particular concept. Rather, culture, race, and ethnicity influence meanings and attributions. Researchers should guarantee the measurements or instruments utilized adequately capture the substantive meanings, including the cultural nuances from one group to another. Researchers cannot merely assume that one instrument that may have worked well for White, middle-class adults will have the same meaning for other groups, and vice versa [42]. The context of social class, intersectionality, immigration, and other experiences relevant to racial and ethnic minority research participants should be captured in measures [162]. When examining an instrument, it is necessary to consider whether the instrument is equivalent in terms of concepts, linguistics, operations, and the scale/response format.

CONCEPTUAL OR CONSTRUCT EQUIVALENCE

Concepts or constructs that are examined in a research study may not always be relevant for each cultural group. For example, the concept of "ethnic identity" for ethnic minorities who have been residing in the United States for many generations may not necessarily be as relevant or important as it is for recent immigrants [42]. Sense of self as a construct is also culturally scripted. Some groups, such as Hispanics and Asians, are collectivistically oriented; thus, their sense of self revolves around the group. Groups from Western industrialized countries generally perceive their positions as more individualistic [57]. This is often reflected in language. In Chinese culture, the concept of "self-esteem" is not equivalent to Western definitions. The closest (but not equivalent) concept is self-respect [170].

When asking about marital status as a demographic question, it is now commonplace to include a response allowing for cohabitation or a permanent relationship with a partner outside of marriage. However, in some cultures, there is no simple term to capture this concept [143].

In addition, future-oriented questions may be religiously dissonant to some research participants. In one study, Turkish and Moroccan participants were asked whether they believed their health would worsen, a question that confused and distressed them [110]. The authors speculated that the distress was in response to religious beliefs about fate; the participants did not believe they could comment about the future, as fate had already predetermined events. Conceptual or construct equivalence of an instrument is not easy to establish. Searching the literature is recommended to determine what has been written about similar topics and its relation to the target culture [58]. Consulting with experts about the topic and the culture of interest and conducting focus groups with individuals who are representative of the target culture may be helpful.

SCALE EQUIVALENCE OR RESPONSE FORMATS

Scale equivalence refers to the extent to which the response choices have similar meanings across cultural groups [42; 59]. The Likert scale is a common response format. Likert scales are a scaling method that measures the level of agreement or disagreement. Research participants might be asked to select from a 5-point Likert scale, in which 1 represents "Strongly Agree," and 5 means "Strongly Disagree." The issue of scale equivalence is whether these response options might be culturally influenced.

Researchers found that when an odd number of response options are used, Asian and Asian American research respondents are more likely to select the neutral response category [60]. For this ethnic group, selecting a neutral response conveys modesty; conversely, selecting an extreme response on a Likert scale would mean that one was boisterous [61]. This is culturally consistent with values in Asian groups emphasizing harmony and conflict-free relationships [60]. However, the converse has been found to be true for Hispanics. Hispanics correlated those who select a middle of the road or neutral response as either hiding something or responding insincerely [61]. One study found that Hispanics were more likely to select the extreme scaled responses compared to their non-Hispanic counterparts [61]. This is known as an extreme response style. It is the tendency for some research participants to select the extreme endpoints of a scale when responding to a question [62].

Acquiescence bias is another form of response style, whereby research respondents agree with the question(s) regardless of the content [62]. Some researchers speculate that cultural values emphasizing harmony influence this response pattern, and they posit that a cultural script in Hispanic culture known as *simpatia*, which emphasizes harmonious, cooperative, and positive social relations, has a role in acquiescence bias in this population [40]. In one study, Latino research participants who were less acculturated or had stronger Latino cultural orientations displayed higher levels of acquiescence bias [204]. In addition, when the interview was conducted in Spanish, this influenced acquiescence, even after controlling for acculturation and other participant characteristics. Other studies have found that certain racial/ethnic groups are more likely to choose the option "yes" in yes/no questions [166].

Religious beliefs may also influence how participants respond to usually closed-ended questions. In a study of Turkish and Moroccan participants answering questions about health and well-being, the individuals responded *Al-ḥamdu lillāh*, or "thanks be to God," instead of "yes" [110].

Courtesy bias is a similar term that refers to East Asian populations who tend to exhibit acquiescence bias [62]. A study of more than 20,000 employee surveys representing 19 different countries from Europe, Asia, Australia, North America, and South America examined the extent of extreme response styles and acquiescence bias in respondents from these different countries [62]. The findings indicate that countries that were more individualistic-oriented were less likely to provide acquiescent responses, with respondents expressing stronger opinions. Male-centered cultures also tend to emphasize assertiveness and, consequently, extreme responses. This study contributes to a body of knowledge related to the role of culture in data collection.

OPERATIONAL EQUIVALENCE

Operational equivalence refers to whether the procedures, ways of administering the instrument, instructions, and formatting of the instrument are logical for other cultures [144]. Many instruments, for example, have a time reference for the participant to consider (i.e., in the last week). However, not all cultural groups will share the same concept of chronology as the group for which the instrument was originally developed and targeted [58]. Researchers should also consider whether the mode of administration is culturally consistent with the norms of the cultural group. For example, some cultures may find it culturally offensive to have a young interviewer ask elder research participants personal questions [41; 58].

LINGUISTIC OR SEMANTIC EQUIVALENCE

Linguistic equivalence refers to the extent to which the content and grammar of question items have the same meaning when used for individuals in different cultural groups [42; 58]. For example, the term "mental" can be misinterpreted as offensive by other cultures. In the Pakistani language, the term "mental" is negative, referring to a lunatic or a person who must be hospitalized [63]. The Khmer term for mental illness is *ckuot*, which also means crazy [41]. When the meanings used in an instrument are altered and ultimately interpreted as offensive or humorous in another cultural context, the reflective meaning changes [58].

In some cases, terms that exist in one culture do not exist in another. For example, the term "self-esteem" as defined in Western culture does not exist in Chinese language or culture [57]. The sense of self in Chinese culture is not individually rooted but oriented in relationships to others, and children are socialized to minimize their own roles in their accomplishments and to consider modesty, humility, and the feeling of others [57; 170]. So, the concept of self-esteem is not easily translated.

Level of education and social class should also be taken into account when assessing an instrument's linguistic equivalence. For example, in Puerto Rico, the word "hair" is translated into Spanish as *cabello*. However, if the study involves Puerto Rican children this may not be the most recognizable term. The average Puerto Rican utilizes the term *pelo*; *cabello* is a more formal term among elder Puerto Ricans [111].

DYNAMIC EQUIVALENCE

Dynamic equivalence refers to the translated instrument having a similar or equivalent effect compared to the original instrument [111]. In order to achieve dynamic equivalence, an instrument's items usually cannot be directly translated. For example, the term "no smoking" can be translated to *défence de fumer* in French; however, *défence de fumer* literally means "interdiction to smoke" [111]. The reader would likely eventually determine that this means smoking is prohibited, but the effect is not necessarily the same.

TRANSLATING INSTRUMENTS/MEASURES

When conducting research with ethnic minority populations, it is frequently necessary to translate instruments into the target language. This can be particularly challenging if the target and source languages are different in terms of semantics and syntax (e.g., Chinese and English). The complexity is augmented by the fact that the cultural norms may be at different ends of the continuum (collectivistic vs. individualistic) [170]. There are three primary reasons for translating an instrument: it is more cost-effective than developing a new instrument, it increases the validity and reliability of the data, and it enhances the comparability of data across groups [145]. The specific translation procedures should be carefully selected in order to promote conceptual and linguistic equivalence of the instruments used across groups. Researchers should be familiar with the merits and limitations of the three common translation techniques [40; 64; 65].

Direct Translation (Asymmetrical, Unicentered, or Forward Translation)

This method involves a one-way translation of the instrument by a bilingual translator and emphasizes a literal translation. As a result, the instrument may look unnatural or stilted in the new language. Or when literally translated, it is simply confusing. For example, the term "and/or" is frequently used in English, but it does not translate well and is frequently confusing for Spanish speakers [145]. Cultural idioms are likewise difficult and require knowledge of both cultures. Additionally, the translated instrument is solely dependent upon the translator's skill and knowledge. This translation method is commonly used when there is only one accessible translator, and it is one of the most time-efficient and cost-effective methods available [66; 145]. When direct translating procedures are used, it is highly recommended that the translated version be tested on a sample of respondents from the target language. The main dilemma of this translation method is that any differences or similarities found in the subject matter under examination may be due to the cultural group rather than errors in translation [67]. This type of translation is most suitable for instruments with strong established validity and reliability in their original source language; however, it does not take into account minimizing cultural biases or examining for construct equivalence [103].

Back-Translation (Double Translation)

In this process, two translators are involved. The first individual translates the question items into the target language. The second individual independently takes the newly translated instrument and translates the material back to the original language [66]. The test instructions should be translated in a similar manner. The two versions are then compared, and discrepancies are noted, discussed, and negotiated by the two translators. The goal is to achieve a conceptually equivalent translation. A better translation can be produced by hiring four translators to conduct two iterations of the back-translation process.

Maneesriwongul and Dixon recommend that back-translation be combined with the bilingual technique [67]. This involves testing both the source version and the targeted language version with bilingual research respondents [66]. When comparing the results of the two versions, discrepancies can be noted. However, the main challenge is to find enough bilingual research respondents. Furthermore, bilingual translators have unique knowledge of the languages that are not present for the majority of the target population.

Another recommendation to reduce discrepancies is to form a committee of translators to independently translate and capture subtle meanings. Ideally, the committee would consist of experts the language, research methods, and the topic of the study [171; 172]. Having a committee allows for discussion of discrepancies and consensus, with the goal of having one final version in the end [166; 171; 173].

Symmetrical Translation

In symmetrical translation, both the source and the target languages are open to revision until both are comparable and culturally relevant. Decentering is a process used in symmetrical translation when the target language is unnatural and/or very different from the source. Decentering typically involves multiple translators working in collaboration and placing equal value on the source and target languages.

Researchers strive for conceptual translations, allowing translators greater flexibility in the choice of wording [66]. The following are some practical steps to consider when embarking on the process of translating questionnaires or instruments [68; 171]:

- **Contact the original author of the instrument or questionnaire**. Because translating instruments and procedures is a complex task, researchers should determine if the instrument has been translated. If an instrument has been translated, researchers should review the content to see if the translated instrument reflects subtle cultural differences. Perhaps the translated version was originally translated for a highly educated group, and now the study sample is the same cultural group but from a lower socioeconomic bracket and educational level.
- **Create a translation team**. Determine how many translators will be involved and who they will be. The number of translators needed is somewhat related to the type of translation technique used. For example, if the researcher opts to use direct translation, then only one translator will be involved. Choosing a translator who is bilingual and a native speaker is recommended. Depending upon the instrument being translated, translators with clinical experience may be beneficial. A clinician would be proficient in determining whether certain items have clinical significance.

- **Standardize guidelines and procedures**. If multiple persons or teams are involved in the translating process, then every member should be familiar with the protocol of the research study, the target population, and the basic procedures regarding good question development. Each member should independently translate the instrument and then convene with the other members to compare the translated versions. A dialogue and negotiation regarding disagreements over terms or phrases is part of the process. This may involve talking to the original author and discussing with individuals outside the group (i.e., colleagues) who might be able to bring a fresh perspective. Documentation of the procedures and findings during the translating process is crucial.

The demographic characteristics of the translators (i.e., acculturation level, socioeconomic status, educational background) have the potential to impact the dynamics of the relationship among the translators on the translation team [66]. For example, one translator might defer to another translator due to higher perceived professional or personal status in the community or merely because the second translator is an elder [41]. Researchers should be finely attuned to the subtle cultural nuances and continually debrief members of the research team.

It is important for a variety of reviewers to test the many different iterations of the translated instrument. One reviewer, for example, might want to compare the original text to the translated text, focusing on the source text, while another reviewer can focus on the dynamic equivalence [111]. Finally, after an instrument has been translated, it is advisable to pilot or pretest the version in the field [40; 68]. This can be done by pretesting on a small sample of participants from the targeted study group using a survey design or by conducting focus groups [112]. If using a focus group, participants can review the question items and discuss ambiguities and poorly translated items. In addition, focus groups can be used after the pilot study. If the data from the translated instrument do not make sense, focus group participants can assist in interpreting the data and reviewing the translated instrument.

Cognitive interviewing using the "think-aloud" method has also been recommended [173]. This method involves pilot-testing the translated version with research respondents. These respondents answer survey questions that assess comprehension, confidence, and recall. Furthermore, a set of pre-developed items are established to allow respondents to think aloud about how they derived their responses. This strategy can help the interviewer evaluate comprehension of the translated question items as well as any issues translators may have struggled with.

Many of the same concepts described for instrument translation apply to translation of interview transcripts. It has been recommended that audio files first be transcribed verbatim and then translated, after which the two versions are compared [138].

Overall, there are some basic protocols for improving the translation quality [145]:

- Use simple sentences.
- Employ active voice.
- Avoid slang, jargon, and colloquialisms.
- Take into account the target group's literacy level.

Finally, it is vital to pilot or field test translated instruments in order to identify any unanticipated issues or problems [145; 171].

The research team may want to discuss the merits and limitations of hiring professional translators from outside the community or lay translators from the community. Hiring translators who are outside the community could help increase objectivity; they are more likely to focus on the authenticity and neutral form of the language, in part because they have a more disembodied experience from the local context of the community [203; 205].

However, community translators are more likely to emphasize the role of context and colloquial forms of the language because they have a higher degree of being personally and relationally invested in the community [205]. There is no one right answer; however, there is consensus that good translations of instruments and study procedures require time, resources, and money.

CULTURALLY SENSITIVE DATA COLLECTION AND RECRUITMENT PROCEDURES

ESTABLISHING CREDIBILITY WITH PARTICIPANTS

As noted, ethnic minority communities may be mistrustful of researchers entering and potentially exploiting research participants. Historically, there have been cases of researchers breaching social and cultural etiquettes, not involving the community and their leaders in the research process, and abandoning the study group once the data are collected. Furthermore, when interpreted without a full historical and cultural context, data can pathologize communities and their members. It is for these reasons that many ethnic minority communities tend to be reluctant to participate in research.

Given this context, it is important for researchers and sponsoring organizations to develop relationships with communities and their leaders and to establish legitimacy and credibility. This involves the community's views regarding the level of authority and trustworthiness of the researcher and the sponsoring agency of the study. Researchers have identified two types of credibility: ascribed credibility and achieved credibility [69].

Ascribed credibility refers to a perceived attribute connoting position and authority. These attributes or characteristics might include age, gender, credentials, or race [41]. For example, in Asian culture there is an emphasis on hierarchal relationships. The age and gender of an interviewer might affect perceived credibility. In other situations, research participants may ask interviewers personal questions about their age, marital status, and education in order to assess the interviewer's ascribed credibility. Researchers should carefully train interviewers how to respond to personal questions and limit the amount of information they disclose [41].

Another way of obtaining ascribed credibility is by highlighting the role of the sponsoring organization or institution of the study. In some cases, studies may be imbued with a certain amount of ascribed credibility due to the affiliated institutions [41]. In one example, studies were sponsored by two well-known universities and a local school district. Because of the amount of respect attached to education and participants' own aspirations to have their children and relatives attend those universities, it was believed that a certain amount of ascribed credibility and legitimacy were obtained. In both cases, letters on the sponsoring university and school district letterhead were sent out introducing the study. In other studies with the different Asian American groups, they indicated that having an endorsement of the study from a respected individual from the community or a family member would facilitate research participation [113].

Achieved credibility is based on a researcher's ability to gain the trust of research participants [69]. How well interviewers are able to make participants feel comfortable, the level of professionalism conveyed by the different members of the research team, and the ability of the research team to involve community leaders and cultural experts all assist in lending legitimacy to research studies. For example, in the African-Caribbean community, researchers are often scrutinized to determine how sensitive and/or respectful they are of cultural norms, and it is in this way that credibility is achieved [106].

Researchers should be cognizant of the study group's communication style and incorporate this preference in the research process [146]. For example, in groups partial to oral communication making face-to-face contact or phone calls may be more effective than written communications (e.g., e-mail, letters, flyers). It has been observed that the Chinese language is not direct [203]. In Chinese conversation, "beating around the bush" is a sign of politeness, especially when interacting with those perceived to be in authority or in respected positions or with strangers. Therefore, it is important to know when to continue to question with gentle probes [203].

Giving is another way to obtain achieved credibility [70; 141]. Giving, by providing incentives for research participation, produces a perceived equitable exchange between the researcher and the research participant [71]. Incentives can be either monetary or nonmonetary in nature. When conducting research with ethnic minority groups, it is crucial to take into account social context and cultural beliefs about incentives and how these beliefs may influence decisions to participate [114]. In one study in the Khmer community, community informants advised the researchers that monetary incentives may not be culturally appropriate because participants may not be comfortable in accepting checks [41]. Many of the Khmer locals worked only for cash. In this case, grocery coupons were offered, which was more culturally sensitive. Community stakeholders and other trusted community members and experts should be consulted [174; 175].

USE OF LINGUISTICALLY AND ETHNICALLY MATCHED INTERVIEWERS

Whether interviewers and participants should be matched based on race or ethnicity (racial/ethnic concordance) in order to help increase response rates is another issue that has been raised. Becerra and Zambrana argue that response rates can be enhanced by using same-race or same-ethnicity interviewers [36]. The premise of this perspective is that two individuals from the same group are more likely to share similar cultural values and therefore are more likely to develop rapport and communicate more easily [72]. There is a body of knowledge in the counseling field, particularly in counseling Asian American and immigrant clients, that ethnic matching decreases likelihood of early termination. The ethnic responsiveness hypothesis argues that there are beneficial outcomes when matching clients and counselors along ethnicity, language, and gender [73]. In one review of barriers and facilitators to racial and ethnic minorities' participation in research studies, researchers found that cultural congruence between the researcher/interviewer and the participant was key to promoting participation [113]. African American research participants liked having a "personal touch," and Filipino participants were more comfortable if they knew members of the research staff. In another study, African American participants preferred to have a racially congruent interviewer when the study involved racial content [126; 147].

However, not all studies have found significant positive outcomes when matching interviewers and research participants [74]. In a study of infertility in the South Asian community, it was assumed that South Asian female research members would be more likely to connect with South Asian women with infertility issues because of their "insider status" [115]. However, in this case, the White female research members had easier access to participants because their "Whiteness" was ascribed to their being "experts" [115]. In another study, researchers tested whether ethnically matched interviewers and research participants influenced refusal rates [72]. Their findings did not lend support to the premise that ethnically matched pairs of interviewers and research participants affected refusal rates. In this study, the mental health diagnosis of the participant played a more influential role. A 2020 study found that attrition was higher among African American and Hispanic participants in racially/ethnically concordant dyads compared with discordant dyads [176]. The authors speculated that perhaps racially/ethnically matched researchers defied stereotypical assumptions of what participants believed scientists should look like [176]. Ultimately, it is vital to remember that shared ethnicity between the researcher/interviewer and participant does not necessarily guarantee trust and entry into the community [174]. Consultation with community leaders and cultural experts in determining the best approach within a particular community may be advisable.

It is recommended that interviewers should be fluent in both the dominant language and the language of the participant, and that research participants should be given a choice in deciding the language they prefer to have the interview conducted in. Interviewers may be required to switch between English and the respondent's native language depending upon the situation. This was the case in a study with Latino research participants in which participants asked to have the interview conducted in English but then switched to Spanish midway [204]. In another study, some participants expressed concerns with language barriers and started with Mandarin but then switched to English during the interview [203]. Therefore, interviewers should have both language versions available to make sure that the questions are asked in the same way to each participant and that on-the-spot translations are not being done.

A study of Asian Indian women in the United Kingdom demonstrated the extreme complexities involved when various languages must be accounted for when attempting to ensure an inclusive sample [75]. In this case, different interpreters fluent in a total of 45 languages had to be hired. Interpreters and interviewers were paired during the recruitment stage; however, it was difficult to determine which languages were needed. The authors describe how, after knocking at the doors of households, interpreters and interviewers would gesture in an attempt to communicate; family members were brought to the door to help; and in some cases, relatives were telephoned to help translate over the telephone. In conducting research studies with ethnic minorities, academic research training held by researchers may be thrown to the wayside when there is a commitment to conducting culturally relevant research that encompasses an inclusive sample [76].

TRAINING AND SUPERVISING INTERVIEWERS

The hiring of individuals to conduct the interviews is extremely crucial, as they are often the first point of contact to represent the research study. How potential participants are approached influences whether they decide to participate in a study [116]. Training for interviewers and recruiters should include sensitivity, flexibility, and adaptability [116]. Not only should the potential participant be approached with respect, but potential participants and their family members should be approached in a manner that minimizes power differentials [116]. In certain cultures, the research participant may seek permission or approval from family members before agreeing to be involved. Recruiters should always ask potential participants if they are comfortable in the setting [116].

Hiring interviewers who are ethnically matched to the target population or who can speak the same language as the research sample is ideal but will not solve all problems. Some have found that participants are less inhibited to talk with an interviewer who is racially/ethnically matched [166]. A study with low-income African Americans with mental health problems relied upon hiring interviewers who had clinical experience in working with this population [72]. Research studies focusing on sensitive topics, such as rape, may indicate a need for clinical interviewers who are female and have experience in dealing with trauma. Similarly, in a study about cervical cancer screening with South Asian women, researchers found that even having a male staff member accompany a female interviewer was perceived as embarrassing to the participants [148]. However, a study examining ethnic minorities' attitudes toward computer technology is more benign and may not necessarily require interviewers who have a clinical background.

Some recommend that intensive and consistent training and/or supervision sessions be provided to interviewers throughout the research process [72; 177]. They also encourage reviewing specific topics with interviewers, such as: how to approach research participants; how to explain concepts about informed consent, confidentiality, and voluntary participation; the nature of the study; and the type of survey or interview instrument(s). When contacting participants and their families, research staff should remember that research participation may not be individuals' first priority, and the research should conform to the needs of the participant, being as flexible as possible, rather than the other way around [142; 177]. For example, in many cultures, women's priorities revolve around their families and children, and data collection will take into considerations the needs of the entire family and family/childcare activities [148].

Training protocols should also be developed to establish how interviewers should respond to domestic violence, child abuse, elder abuse, and instances in which participants indicate they may hurt themselves or someone else. Although informed consent forms might emphasize the confidentiality of participants' responses, the limits of confidentiality should be defined, as should interviewers' roles and responsibilities in reporting cases of abuse. In some cases, interviewers, particularly if they are from the same community as the research participants, may perceive contacting legal authorities as a sign of betrayal to the community [41]. However, it is important to note that each state has laws that mandate the reporting of child abuse and neglect for specific professionals [77].

Monitoring interviewers and providing regular supervision is another important component of the ongoing training [41]. Having consistent and continual oversight and team meetings is essential to ensuring cultural sensitivity, research fidelity, and study coordination [177]. This should involve continually assessing and processing successes/failures and experiences of interviewers, research assistants, and other members of the research team [178]. In addition, the various feelings that are engendered when interviewing respondents should be monitored, particularly sensitive research topics such as trauma, violence, bereavement, or chronic illness. Attention should be paid to interviewers' potential to experience vicarious or secondary traumatic stress.

Safety protocols should be discussed and reviewed, with an emphasis placed on minimizing risks to the interviewer. Interviewers should feel supported by the researchers if they feel they cannot conduct an interview at night in neighborhoods with high crime and violence or if apartments do not appear safe. Specific guidelines and protocols should be established and followed for all interviewers and researchers who work in the field should carry their cell phones, fully charged [149]. This can include ensuring access to cell phones, alerting others as to plans and whereabouts, and scheduled check-ins and follow-up.

Questionnaires completed by interviewers should be reviewed and edited regularly. When question items are not asked, interviewers can be asked to contact respondents. However, this should not be the case when a participant refuses to answer a question. In such cases, the interviewer should clearly indicate that the participant refused to answer a question item. Missing data can be reduced in this way, and retraining of the interviewers can be conducted as necessary.

The interviewers' recruitment of respondents for the study should be monitored. When it is difficult to recruit respondents, interviewers may feel frustrated, resulting in a high attrition rate.

DATA CHECKING AND ANALYSIS

Best practices for culturally sensitive data checking and analysis include but are not limited to [155; 166; 179; 206]:

- Check for missing data as a first step.
- Avoid aggregating different subgroups together into one category because sample sizes for the subgroups are too small.
- Compare the demographics of the study sample with the group in the overall population. For example, assess whether variables such as socioeconomic status, income, educational level, age, gender/sexual identify, and marital status for the study sample are similar to or different from this population in general?
- Take into account historical, sociopolitical, economic, immigration, and religious contexts to avoid perpetuating stereotypes.

BARRIERS TO ETHNIC MINORITY RESEARCH PARTICIPATION

Institutional racism has significantly contributed to the pervasive mistrust among ethnic minority communities about research. For African Americans, their mistrust towards researchers stems from the historical legacy of slavery and how the science of mental health was employed to explain racial inferiority [72]. Ultimately, these rationalizations were used to support the institution of slavery [72]. It was not uncommon for researchers to falsify data to misrepresent African Americans, which ultimately perpetuated negative images of African Americans (e.g., the portrayal of the welfare mother, grandmother-headed households, absent fathers) [113]. This history has contributed to negative feelings between the African American community and the academic research community [72; 207; 208].

African Americans' wariness of research can also be linked back to the Tuskegee Study, conducted from 1932 to 1972 by the U.S. Public Health Service. The Tuskegee Study examined the course of syphilis in approximately 400 African American men with the disease [78]. By 1945, penicillin had become the accepted course of treatment for syphilis; however, in order to continue to follow the course of the disease, the researchers did not inform the research participants of this advancement [79]. These men went untreated for another 40 years, resulting in more than 100 deaths [79].

The Tuskegee Study continues to perpetuate fear that ethnic minorities who are recruited for research, particularly clinical trials, are merely experiment subjects [80]. Distrust of researchers continues to be the top barrier to research participation among African Americans [168; 208]. In a focus group study with African Americans examining perceptions towards medical research, researchers found that participants saw the value of clinical research; however, they did not want to participate in research because they feared their race was being used as inhuman subjects. Many also feel that the research is only of benefit to White communities [207]. They were also concerned about the risks associated with medical research, fearing that researchers would not always be completely truthful when conveying the risks and benefits [81]. Interestingly, when asked about the Tuskegee Study, all participants were familiar with the study; however, many conveyed inaccurate information. When the moderator attempted to provide correct historical information regarding the study, this information was challenged as inaccurate and deceptive [81]. This speaks to how indelibly embedded the Tuskegee Study has become in African American consciousness. It will likely taint research for many years to come. Even today, African Americans report lower levels of trust of healthcare providers in general compared to their White counterparts. These varying levels of trust may result in disparities in health care and preventive services [150].

Similarly, other cross-cultural studies indicate that people in general do not trust physicians and the healthcare system. This general apprehension appears to extend to medical research. A group of researchers conducted focus groups with Japanese lay persons and interviews with physicians about medical research [82]. Their findings showed that Japanese lay individuals were concerned with use of experimental elements such as placebos and randomization. The findings also highlighted the role of Japanese cultural norms emphasizing harmony in affecting the notion of voluntary participation in the informed consent process, leading Japanese patients to feel uncomfortable refusing their physicians and research. Ultimately, this may adversely color their views regarding medical research. Physicians express concern about how the media has negatively shaped public attitudes toward research, and they stress the need for more awareness and education to be disseminated. A greater collaborative effort between research communities and the public is needed to combat these perceptions.

Fear of government officials can also impede research participation. Some ethnic minority immigrants have relatives who are either undocumented residents or perhaps are themselves undocumented residents. Many view the consent form as a way of extrapolating additional private information [174]. Therefore, they may be fearful that researchers could report the data back to the government, leading to deportation [41; 113]. Immigrants originating from countries where political persecution is common may be fearful of any inquiries and potential ramifications, particularly research perceived to be sponsored by the government [83].

One interesting finding from a systematic review of barriers to racial and ethnic minorities' participation in research studies was that fear of discrimination from health insurance companies was a motivating factor [113]. For example, African American and Latino participants revealed that they were concerned that participation in health studies and clinical trials could result in their health statuses being disclosed to health insurance companies. In a systematic review of barriers related to the participation of South Asians in health-related studies, the theme of trust emerged. South Asian participants report being fearful of their health statuses being disclosed, their immigration status being jeopardized, and a general distrust of the government [151].

Finally, it is important to remember that research is generally a Western concept. Recent immigrants may not be familiar with the research process, in which personal and sensitive questions may be asked. In some cultural groups, the acquisition of knowledge is closely guarded and supervised by community leaders and other gatekeepers [34]. This is very different in Western industrialized countries, in which knowledge acquisition is viewed as a right.

In 2006, researchers completed a study that inquired whether ethnic minorities' negative attitudes and perceptions towards research impede research participation or whether these groups are given fewer opportunities to participate [84]. The researchers systematically identified 20 health studies that reported consent rates by ethnicity and race, collectively representing 700,000 individuals who consented to participate in a diverse range of health studies. They found that although the consent rates did not differ significantly by ethnicity or race, White Americans were more frequently offered the opportunity to participate compared to their ethnic minority counterparts in some studies. The authors concluded that there is a need for researchers to provide greater access to ethnic minorities rather than targeting education and awareness to ethnic minorities.

Logistical barriers can also impede research participation. This can include finding time constraints, transportation barriers, financial stress, and family conflict [177; 209]. Furthermore, research participants often feel that their time was wasted if they never receive information about the final findings. This is particularly an issue in medical research, in which test results or information about the medical condition may be personally beneficial [209].

CULTURALLY SENSITIVE DISSEMINATION OF RESEARCH FINDINGS

One of the major factors eliciting distrust among ethnic minority communities toward researchers is their experience of feeling as though their communities are being used as laboratories [85; 86]. The term "tourist-researchers" or "helicopter researchers" has been used to describe researchers who obtain data without taking the cultural context into account and without giving back to the community [152; 166]. They prioritize academic output over giving back to the community [207].

This is augmented by the power dynamics inherent in the researcher/researched relationship [87; 88]. Researchers often define the "problem," and after the data are collected, they tend to leave the communities and analyze the data without any consultation with community experts, leaders, or residents. As a result, researchers are perceived as "outsiders," representing mainstream power structures [87; 88]. It is suggested that the researcher/researched relationship is also embedded with overtones of one party "looking over" or "looking after" another party, where the researcher is seen as having an authoritative role [76]. Historically, as outsiders, researchers have interpreted the data in a manner that pathologizes the community. They often analyze and interpret the data without taking into account the community's historical and sociocultural contexts. This is a form of marginalization, whereby a group is viewed and labeled as distinct from the norm [153]. Therefore, culturally sensitive researchers should ensure that findings are relayed back to the community in such a way that it leads to a dialogue about how the data can be employed to shape and support needed social programs and policies. This is a way of giving back to the community, and it serves to build a foundation of credibility and trust for researchers to conduct future studies in the communities [41]. Often, results of research are published in academic journals and may be difficult for communities to access and/or understand. Researchers should therefore identify nonacademic outlets for distribution of research results (e.g., radio, ethnic newspapers, social media, blogs) [166].

Some experts recommend employing the use of a cultural reader—an individual who is familiar with the group's cultural norms, values, and history—to read and review any reports and results before they are published [104]. This helps to avoid perpetuating any errors, stereotypes, and mistaken assumptions about a group. Although most groups want researchers to relay the findings back to the community, there may be subtle intergroup differences [113]. In one example, African American research participants indicated they wanted the findings reported back to the individual level (i.e., to the participants), but Pacific Islanders and Native Hawaiians were more concerned with reporting back findings to the community and families [113]. The key is to ask.

ETHICS AND CULTURALLY SENSITIVE RESEARCH

The Belmont Report identifies three main principles to guide ethical research: respect for persons, beneficence, and justice. According to the Belmont Report, "respect for persons incorporates at least two ethical convictions: first, that individuals should be treated as autonomous agents, and second, that persons with diminished autonomy are entitled to protection" [117]. In regard to research participation, the autonomous individual has the right to make decisions of whether he or she wants to participate. At the heart of informed consent is the belief that information should be communicated in an understandable manner. This also gives research participants a sense of control, increasing their sense of autonomy [208]. Vulnerability and how it affects autonomy should be considered. If research participants are undocumented immigrants, for example, they may be fearful that if they do not consent, they risk being deported [152].

The notion of "self" is at the heart of Western ideologies of individualism, as exemplified by consent forms, documents that provide information to the research participant so he/she can make an informed decision about whether to participate. In the United States, the individual signs the consent form to signifying that he/she understands the information provided. However, researchers in some cultures may equate participation in an interview as consent, expressing confusion in the need for a signed consent form [210]. However, in other cultures, community consent and decision making are advocated [117]. For example, in research that involves Native American tribal groups, the community leader, elders, grandparents, and/or other relatives provide the consent, not the individual [117]. In patriarchal or androcentric cultures, the male head of a family (e.g., husband, father) may be the one to give consent for a female research participant [180]. Whether or not this is appropriate for the research being conducted should be assessed.

A signature is required on most Western informed consent forms to represent understanding and agreement on the part of the individual involved. However, this might be viewed as violation in social etiquette in some cases. In some cultures (for example, Egypt), signatures are usually associated with major life events and legal matters. Therefore, requiring a signature outside these circumstances would imply a lack of trust, particularly when verbal consent has been given [118]. Other groups simply believe that verbal consent is adequate [119; 120]. In a study with Muslim women, the researchers recorded the women's verbal consent and literate family members reviewed the consent form [154]. In some cases, traditional written consent forms may need to be replaced by oral, video, audio recording, or pictorial methods [180]. Thumbprints may also be permissible in lieu of signature. The following ethical questions addressing informed consent should be addressed when conducting cross-cultural research [206]:

- Do Western researchers still obtain consent in cultures in which obtaining consent is not necessary or even frowned upon?
- How do the participants understand the concept of consent?
- Who is authorized to give consent?
- How should consent be obtained?

The concepts of privacy and confidentiality are also affected by culture. In Western culture, home life is considered a private space. However, this is not the case in some cultures. In one study involving interviews of adolescents and their parents in Saudi Arabia, neighbors and relatives would visit unannounced throughout the interview [181]. Asking the visitors to leave was a breach of etiquette and social conduct.

The second principle of the Belmont report is beneficence, or to do good. When working with participants from other cultural groups, it is important to evaluate if the study ultimately benefits the group being studied. In other words, do the findings result in stigmatization of the study population [121]? Researchers should examine what the notions of well-being and hierarchy of needs signify with different cultural groups [121]. The risks and benefits should be weighed, and the risks must be acceptable to the group.

The final principle is justice, or the equitable distribution of the risks and benefits of the research. Researchers should consider if a study targets marginalized groups because it is convenient or if they believe they use can undue influence to increase research participation.

INTERPROFESSIONAL RESEARCH COLLABORATIONS

When researchers from more than one discipline work together this is referred to as interprofessional research collaboration [182]. Given that social problems are complex and multilayered, collaboration can be helpful [182; 183]. Furthermore, collaborating with researchers from other disciplines allows for a diverse array of methodologies to help answer research questions.

Core concepts of interprofessional research collaboration include [183]:

- Interdependency
- Sharing power and resources
- Shared goals, decision making, labor, values, and philosophy
- Openness
- Honesty
- Authenticity

Benefits of collaboration include [182]:

- Opportunities for out-of-the-box thinking
- Greater access to network of other researchers
- Enhanced resources
- Greater productivity
- Cross-fertilization of knowledge from other fields
- Shared costs
- Shared skills, expertise, and knowledge

Conducting research with racial and ethnic minority groups can be challenging, and collaboration may provide new lenses to help ensure that all aspects of the research process are culturally sensitive. Promotion of interprofessional research collaboration should include [184]:

- Ensuring the research and the research questions are meaningful for the community
- Demonstrating cultural humility among team members, community members, and cultural brokers
- Holding regular team meetings to facilitate communicate, clarify roles and tasks, and discuss and process any issues that arise
- Communicating continuously to promote collegiality
- Remaining flexible and willing to alter procedures

CONCLUSION

As Salois and Holkup state, “the best intentions of research scientists may go awry when trying to operate within a cultural ethos that is vastly different from the world of academia” [122]. Ultimately, researchers should spend considerable time in the cultural community of interest in order to develop relationships, rapport, and trust with local community leaders, frontline professionals working in the community, and community residents in order to ensure that they invest and “own” the research [72]. Because frontline helping professionals have firsthand knowledge and hands-on expertise in working with the community, they can develop working hypotheses but be unable to test the concepts due to time and fiscal constraints. However, researchers from academic institutions have more funding opportunities but less clinical knowledge and access to hard-to-reach populations. Therefore, collaborative partnerships should be fostered [72]. Several questions should be continually used to foster a negotiation process and dialog between the research team and the community to encourage collaboration [76]:

- What are the expectations from the ethnic minority community and its research participants?
- What are the researchers' roles, and how can the research fulfill the researchers' obligations to the community?
- How can the research be conducted in a manner that respects the community?
- How can the knowledge acquired from the research be used in a meaningful and culturally sensitive manner?
- To whom is the research accountable?
- How can the research contribute meaningfully to the activities of the community?

Implicit Bias in Health Care

The role of implicit biases on healthcare outcomes has become a concern, as there is some evidence that implicit biases contribute to health disparities, professionals' attitudes toward and interactions with patients, quality of care, diagnoses, and treatment decisions. This may produce differences in help-seeking, diagnoses, and ultimately treatments and interventions. Implicit biases may also unwittingly produce professional behaviors, attitudes, and interactions that reduce patients' trust and comfort with their provider, leading to earlier termination of visits and/or reduced adherence and follow-up. Disadvantaged groups are marginalized in the healthcare system and vulnerable on multiple levels; health professionals' implicit biases can further exacerbate these existing disadvantages.

Interventions or strategies designed to reduce implicit bias may be categorized as change-based or control-based. Change-based interventions focus on reducing or changing cognitive associations underlying implicit biases. These interventions might include challenging stereotypes. Conversely, control-based interventions involve reducing the effects of the implicit bias on the individual's behaviors. These strategies include increasing awareness of biased thoughts and responses. The two types of interventions are not mutually exclusive and may be used synergistically.

Works Cited

1. Monette DR, Sullivan TJ, DeJong CR, Hilton TP. *Applied Social Research: A Tool for the Human Services*. 9th ed. Belmont, CA: Brooks/Cole; 2013.
2. Neuman WL. *Social Research Methods: Qualitative and Quantitative Approaches*. 7th ed. Los Angeles, CA: SAGE Publications; 2009.
3. Drisko J. Split or synthesis: the odd relationship between clinical practice and research in social work and in social work education. *Clinical Social Work Journal*. 2014;42(2):182-192.
4. Papadopoulos I, Lees S. Developing culturally competent researchers. *J Adv Nurs*. 2002;37(3):258-264.
5. Gruman JC. Basic vs. applied research: finding a balance. *Chron Higher Educ*. 2003;49(29):B20.
6. Lutzker JR, Tymchuk AJ, Bigelow KM. Applied research in child maltreatment: practicalities and pitfalls. *Child Serv Soc Policy Res Pract*. 2001;4(3):141-156.
7. Berragan L. Nursing practice draws upon several different ways of knowing. *J Clin Nurs*. 1998;7(3):209-217.
8. Carper BA. Fundamental patterns of knowing in nursing. *ANS Adv Nurs Sci*. 1978;1(1):12-23.
9. Johns C. Framing learning through reflection within Carper's fundamental ways of knowing in nursing. *J Adv Nurs*. 1995;22(2):226-234.
10. Eisengart SP, Faiver CM. Intuition in mental health counseling. *J Ment Health Couns*. 1996;18(1):41-52.
11. Schon DA. *The Reflective Practitioner: How Professionals Think in Action*. New York, NY: Basic Books; 1983.
12. Basford L, Slevin O. *Theory and Practice of Nursing: An Integrated Approach to Caring Practice*. 2nd ed. London: Campion Press Ltd; 2003.
13. Munhall PL. *Nursing Research: A Qualitative Perspective*. 5th ed. Sudbury, MA: Jones and Bartlett Learning; 2012.
14. Clark AJ. Empathy: implications of three ways of knowing in counseling. *J Hum Couns Educ Dev*. 2004;43(2):141-151.
15. Yegidis BL, Weinbach RW, Myers LL. *Research Methods for Social Workers*. 8th ed. Philadelphia, PA: Pearson; 2017.
16. Crossan F. Research philosophy: towards an understanding. *Nurse Res*. 2003;11(1):46-55.
17. Ponterotto JG. Qualitative research in counseling psychology: a primer on research paradigms and philosophy of science. *J Couns Psychol*. 2005;52(2):126-136.
18. Proctor S. Linking philosophy and method in the research process: the case for realism. *Nurse Res*. 1998;5(4):73-90.
19. Cody WK. *Philosophical and Theoretical Perspectives for Advanced Nursing Practice*. 5th ed. Sudbury, MA: Jones and Bartlett Publishers; 2011.
20. Onwuegbuzie AJ. Why can't we all get along? Towards a framework for unifying research paradigms. *Education*. 2002;122(3):518-531.
21. Borland KW. Qualitative and quantitative research: a complementary balance. *N Dir Instit Res*. 2001;112:5-13.
22. Boulos P, Rajacich D. Critical theory as a philosophical base for nursing science. *Guidance Couns*. 2003;19(1):37-44.
23. Roy C, Jones DA. *Nursing Knowledge Development and Clinical Practice*. New York, NY: Springer Publishing Company; 2007.
24. Sorrell JH. The pleasure of dissent: a critical theory of psychotherapy as an emancipatory practice. *Am J Psychother*. 2006;60(2):131-145.
25. Crotty M. *The Foundations of Social Research: Meaning and Perspective in the Research Process*. Thousand Oaks, CA: Sage Publications; 2003.
26. Harding SH. *Whose Science? Whose Knowledge? Thinking from Women's Lives*. Ithaca, NY: Cornell University Press; 1991.
27. Stanley L (ed). *Feminist Praxis: Research, Theory and Epistemology in Feminist Sociology*. New York, NY: Routledge; 2014.
28. Ackerly B, True J. *Doing Feminist Research in Political and Social Science*. New York, NY: Palgrave MacMillan; 2010.
29. Campbell JC, Bunting S. Voices and paradigms: perspectives on critical and feminist theory in nursing. *ANS Adv Nurs Sci*. 1991;13(3):1-15.
30. American Sociological Association. The Importance of Collecting and Doing Social Scientific Research on Race. Available at https://www.asanet.org/sites/default/files/savvy/images/press/docs/pdf/asa_race_statement.pdf. Last accessed February 15, 2024.
31. Padilla AM. Hispanic Psychology: A 25-Year Retrospective Look. Available at https://scholarworks.gvsu.edu/cgi/viewcontent.cgi?referer=&httpsredir=1&article=1025&context=orpc. Last accessed February 15, 2024.
32. Tillman LC. Culturally sensitive research approaches: an African-American perspective. *Educ Res*. 2002;31(9):3-12.
33. Dillard CB. The substance of things hoped for, the evidence of things not seen: examining an endarkened feminist epistemology in educational research and leadership. *Int J Qualitative Stud Educ*. 2000;13(6):661-681.
34. Palafox NA, Buenconsejo-Lum L, Riklon S, Waitzfelder B. Improving health outcomes in diverse populations: competency in cross-cultural research with indigenous Pacific islander populations. *Ethn Health*. 2002;7(4):279-285.
35. Rogler LH. The meaning of culturally sensitive research in mental health. *Am J Psychiatry*. 1989;146(3):296-303.
36. Becerra RM, Zambrana RE. Methodological approaches to research on Hispanics. *Soc Work Res Abstr*. 1985;21(2):42-49.
37. Bussing R, Koro-Ljungberg ME, Gary F, Mason DM, Garvan CW. Exploring help-seeking for ADHD symptoms: a mixed methods approach. *Harv Rev Psychiatry*. 2005;13(2):85-101.
38. Holroyd E, Twinn S, Adab P. Issues and innovations in nursing practice: socio-cultural influences on Chinese women's attendance for cervical screening. *J Adv Nurs*. 2004;46(1):42-52.

39. National Research Council. *Understanding Violence Against Women*. Washington, DC: National Academy Press; 1996.
40. Marin G, Marin VB. *Research with Hispanic Populations*. Newbury Park, CA: Sage Publications; 1991.
41. Yick AG, Berthold SM. Conducting research on violence in Asian American communities: methodological issues. *Violence Vict*. 2005;20(6):661-677.
42. Hughes D, Seidman E, Williams N. Cultural phenomena and the research enterprise: toward a culturally anchored methodology. *Am J Community Psychol*. 1993;21(6):687-703.
43. Mertens DM. *Research and Evaluation in Education and Psychology: Integrating Diversity with Quantitative, Qualitative, and Mixed Methods*. 4th ed. Thousand Oaks, CA: SAGE Publications; 2015.
44. Suyemoto KL. Redefining "Asian American" identity: reflections on differentiating ethnic and racial identities for Asian American individuals and communities. In: Zhan L (ed). *Asian Americans: Vulnerable Populations, Model Interventions, and Clarifying Agendas*. Boston, MA: Jones and Bartlett; 2002: 195-231.
45. Lee MY, Law PFM. Perception of sexual violence against women in Asian American communities. *J Ethnic Cult Diversity Soc Work*. 2001;10(2):3-25.
46. Kennedy MA, Gorzalka BB. Asian and non-Asian attitudes toward rape, sexual harassment, and sexuality. *Sex Roles*. 2002;46(7/8):227-238.
47. Bui HN. Help-seeking behavior among abused immigrant women: a case of Vietnamese American women. *Violence Against Women*. 2003;9(2):207-239.
48. Yoshioka MR, DiNoia J, Ullah, K. Attitudes toward marital violence: an examination of four Asian communities. *Violence Against Women*. 2001;7(8):900-926.
49. Carter-Edwards L, Fisher JT, Vaughn BJ, Svetkey LP. Church rosters: is this a viable mechanism for effectively recruiting African Americans for a community-based survey? *Ethn Health*. 2002;7(1):41-55.
50. Rankin J, Bhopal R. Understanding of heart disease and diabetes in a South Asian community: cross-sectional study testing the "snowball" sample method. *Public Health*. 2001;115(4):253-260.
51. Warner JP, Wright L, Blanchardx M, King M. The psychological health and quality of life of older lesbians and gay men: a snowball sampling pilot survey. *Int J Geriatr Psychiatry*. 2003;18(8):754-755.
52. Rosenwaike I. Surname analysis as a means of estimating minority elderly: an application using Asian surnames. *Res Aging*. 1994;16(2):212-227.
53. Himmelfarb HS, Loar RM, Mott SH. Sampling by ethnic surnames: the case of American Jews. *Public Opin Q*. 1983;47(2):247-260.
54. Shin EH, Yu EY. Use of surnames in ethnic research: the case of Kims in the Korean-American population. *Demography*. 1984;21(3):347-360.
55. Sasao T. Using surname-based telephone survey methodology in Asian-American communities: practical issues and caveats. *J Community Psychol*. 1994;22(4):283-295.
56. Stueve A, O'Donnell LN, Duran R, San Doval A, Blome J. Time-space sampling in minority communities: results with young Latino men who have sex with men. *Am J Public Health*. 2001;91(6):922-926.
57. Wang Y, Ollendick TH. A cross-cultural and developmental analysis of self-esteem in Chinese and Western children. *Clin Child Fam Psychol Rev*. 2001;4(3):253-271.
58. Herdman M, Fox-Rushby J, Badia X. A model of equivalence in the cultural adaptation of HRQoL instruments: the universalistic approach. *Qual Life Res*. 1998;7(4):323-335.
59. Streiner DL, Norman GR, Cairney J. *Health Measurement Scales: A Practical Guide to Their Development and Use*. 5th ed. Oxford: Oxford University Press; 2015.
60. Si SX, Cullen JB. Response categories and potential cultural bias: effects of an explicit middle point in cross-cultural surveys. *Int J Organ Analysis*. 1998;6(3):218-231.
61. Hui CH, Triandis HC. Effects of culture and response format on extreme response style. *J Cross Cult Psychol*. 1989;20(3):296-309.
62. Johnson T, Kulesa P, Lic I, Cho YI, Shavitt S. The relation between culture and response styles: evidence from 19 countries. *J Cross Cult Psychol*. 2005;36(2):264-277.
63. Wheeler EL. Mental illness and social stigma: experiences in a Pakistani community in the UK. *Gender Dev*. 1998;6(1):37-43.
64. Santos HP Jr, Black AM, Sandelowski M. Timing of transition in cross-language qualitative research. *Qual Health Res*. 2015;25(2):134-144.
65. Epstein J, Santo RM, Guillemin F. A review of guidelines for cross-cultural adaptation of questionnaires could not bring out a consensus. *J Clin Epidemiol*. 2015;68(4):435-441.
66. Waltz D, Strickland OL, Lenz E. *Measurement in Nursing and Health Research*. 5th ed. New York, NY: Springer Publishing Company, LLC; 2016.
67. Maneesriwongul W, Dixon JK. Instrument translation process: a methods review. *J Adv Nurs*. 2004;48(2):175-186.
68. Van Widenfelt BM, Treffers PDA, De Beurs E, Siebelink BM, Koudijs E. Translation and cross-cultural adaptation of assessment instruments used in psychological research with children and families. *Clin Child Fam Psychol Rev*. 2005;8(2):135-147.

69. Paniagua FA, Yamada AM. *Handbook of Multicultural Mental Health: Assessment and Treatment of Diverse Populations*. 2nd ed. San Diego, CA: Academic Press; 2013.
70. Jackson AP, Ivanoff A. Reduction of low response rates in interview surveys of poor African-American families. *J Soc Serv Res*. 1998;25(1):41-60.
71. Ibrahim S, Sidani S. Strategies to recruit minority persons: a systematic review. *J Immigr Minor Health*. 2014;16(5):882-888.
72. Thompson EE, Neighbors HW, Munday C, Jackson JS. Recruitment and retention of African American patients for clinical research: an exploration of response rates in an urban psychiatric hospital. *J Consult Clin Psychol.* 1996;64(5):861-867.
73. Alegría M, Roter DL, Valentine A, et al. Patient-clinician ethnic concordance and communication in mental health intake visits. *Patient Educ Couns*. 2013;93(2):188-196.
74. Mier N, Medina AA, Bocanegra-Alonso A, Castillo-Ruiz O, Acosta-Gonzalez RI, Ramirez JA. Finding respondents from minority groups. *J Res Pract*. 2006;2(2):D2.
75. Oakley A, Wiggins M, Turner H, Rajan L, Barker M. Including culturally diverse samples in health research: a case study of an urban trial of social support. *Ethn Health*. 2003;8(1):29-39.
76. Fitzgerald T. Cross-cultural research principles and partnerships: experiences from New Zealand and Australia. *Manage Educ*. 2005;19(1):17-20.
77. U.S. Department of Health and Human Services, Child Welfare Information Gateway. Mandatory Reporters of Child Abuse and Neglect. Available at https://www.childwelfare.gov/pubPDFs/manda.pdf. Last accessed February 15, 2024.
78. Centers for Disease Control and Prevention. U.S. Public Health Service Syphilis Study in Tuskegee. Available at https://www.cdc.gov/Tuskegee. Last accessed February 15, 2024.
79. Reverby SM. Listening to narratives from the Tuskegee syphilis study. *Lancet*. 2011;377(9778):1646-1647.
80. Alvidrez J, Arean PA. Psychosocial treatment research with ethnic minority populations: ethical considerations in conducting clinical trials. *Ethics Behav*. 2002;12(1):103-116.
81. Corbie-Smith G, Thomas SB, Williams MV, Moody-Ayers S. Attitudes and beliefs of African Americans toward participation in medical research. *J Gen Intern Med*. 1999;14(9):537-546.
82. Asai A, Ohnishi M, Nishigaki E, Sekimoto M, Fukuhara S, Fukui T. Focus group interviews examining attitudes towards medical research among the Japanese: a qualitative study. *Bioethics*. 2004;18(5):448-470.
83. Torres JM, Wallace SP. Migration circumstances, psychological distress, and self-rated physical health for Latino immigrants in the United States. *Am J Pub Health*. 2013;103(9):1619-1627.
84. Wendler D, Kington R, Madans J, Van Wye G, Christ-Schmidt H. Minority participation in health research—facts and fiction. *PLoS Medicine*. 2006;3(2):153-154.
85. Moreno-John G, Gachie A, Fleming CM, et al. Ethnic minority older adults participating in clinical research: developing trust. *J Aging Health*. 2004;16(5 suppl):93S-123S.
86. Corbie-Smith G, Ford CL. Distrust and poor self-reported health. Canaries in the coal mine? *J Gen Intern Med*. 2006;21(4):395-397.
87. Fontes LA. Ethics in family violence research: cross-cultural issues. *Fam Relat*. 1998;47(1):53-61.
88. Hosokawa F. *Building Trust: Doing Research to Understand Ethnic Communities*. Lanham, MD: Lexington Books; 2010.
89. Palinkas LA, He AS, Choy-Brown M. Operationalizing social work science through research-practice partnerships: lessons from implementation science. *Res Soc Work Pract*. 2017;27(2):181-188.
90. Cheung M, Ma AK, Thyer BA, Webb AE. Research-practice integration in real practice settings: issues and suggestions. *Res Soc Work Pract*. 2015;25(4):523-530.
91. Tijssen RJW. Discarding the “basic science/applied science” dichotomy: a knowledge utilization triangle classification system of research journals. *Journal of the American Society for Information Science & Technology*. 2010;61(9):1842-1852.
92. Ceci SJ. My journey from basic to applied to basic research: applied research benefits from theoretical training. *Applied Cognitive Psychology*. 2011;25(4):673-674.
93. Boardman FK. Knowledge is power? The role of experiential knowledge in genetically “risky” reproductive decisions. *Sociology of Health & Illness*. 2014;36(1):137-150.
94. Chen Y. Development of a method for ontology-based empirical knowledge representation and reasoning. *Decision Support Systems*. 2010;50(1):1-20.
95. Yilmaz K. Comparison of quantitative and qualitative research traditions: epistemological, theoretical, and methodological differences. *European Journal of Education*. 2013;48(2):311-325.
96. Campbell R, Gregory KA, Patterson D, Bybee D. Integrating qualitative and quantitative methods: an example of mixed methods research in community psychology. In: Lenard J, Glenwich D (eds). *Methodological Approaches to Community-Based Research: Theory and Application*. Washington, DC: American Psychological Association; 2012: 51-68.
97. Hay C. Interpreting interpretivism interpreting interpretations: the new hermeneutics of public administration. *Public Administration*. 2011;89(1):167-182.
98. Swartz MK. Critical theory as a framework for academic nursing practice. *Journal of Nursing Education*. 2014;53(5):271-297.

99. Eagly AH, Riger S. Feminism and psychology: critiques of methods and epistemology. *American Psychologist*. 2014;69(7):685-702.

100. Beckman LJ. Training in feminist research methodology: doing research on the margins. *Women and Therapy*. 2014;37(1-2):164-177.

101. Shavers VL, Klein WMP, Fagan P. Research on race/ethnicity and health care discrimination: where we are and where we need to go. *American Journal of Public Health*. 2012;102(5):930-932.

102. Agyeman J. Under-participation and ethnocentrism in environmental education research: developing culturally sensitive research approaches. *Canadian Journal of Environmental Education*. 2013;8(1):80-94.

103. Erkut S. Developing multiple language versions of instruments for intercultural research. *Child Development Perspectives*. 2010;4(1):19-24.

104. Burnette CE, Sanders S, Butcher HK, Rand JT. A toolkit for ethical and culturally sensitive research: an application with indigenous communities. *Ethics & Social Welfare*. 2014;8(4):364-382.

105. Thomas A. Focus groups in qualitative research: culturally sensitive methodology for the Arabian Gulf? *International Journal of Research & Method in Education*. 2008;31(1):77-88.

106. Higginbottom GMA, Serrant-Green L. Developing culturally sensitive skills in health and social care with a focus on conducting research with African Caribbean communities in England. *Qualitative Report*. 2005;10(4):662-686.

107. Amer MM, Bagasra A. Psychological research with Muslim Americans in the age of Islamophobia: trends, challenges, and recommendations. *American Psychologist*. 2013;68(3):134-144.

108. Hoppit T, Shah S, Bradburn P, et al. Reaching the "hard to reach:" strategies to recruit black and minority ethnic service users with rare long-term neurological conditions. *International Journal of Social Research Methodology*. 2012;15(6):485-495.

109. Mechanic M, Pole N. Methodological considerations in conducting ethnocultrally sensitive research on intimate partner abuse and its multidimensional consequences. *Sex Roles*. 2013;69(3/4):205-225.

110. Hoopman R, Terwee CB, Muller MJ, et al. Methodological challenges in quality of life research among Turkish and Moroccan ethnic minority cancer patients: translation, recruitment and ethical issues. *Ethnicity & Health*. 2009;14(3):237-253.

111. Arffman I. Problems and issues in translating international educational achievement tests. *Educational Measurement: Issues and Practice*. 2013;32(2):2-14.

112. Sousa VD, Rojjanasrirat W. Translation, adaptation and validation of instruments or scales for use in cross-cultural health care research: a clear and user-friendly guideline. *Journal of Evaluation in Clinical Practice*. 2011;17(2):268-274.

113. George S, Duran N, Norris K. A systematic review of barriers and facilitators to minority research participation among African Americans, Latinos, Asian Americans, and Pacific Islanders Americans. *Journal of Public Health*. 2014;104(2):e16-e31.

114. White J, Yuan N, Cook S, Abbey A. Ethnic minority women's experiences with intimate partner violence: using community-based participatory research to ask the right questions. *Sex Roles*. 2013;69(3/4):226-236.

115. Culley L, Hudson N, Rapport F. Using focus groups with minority ethnic communities: researching infertility in British South Asian communities. *Qualitative Health Research*. 2007;17(1):102-112.

116. Gyure ME, Quillin JM, Rodríguez VM, et al. Practical considerations for implementing research recruitment etiquette. *IRB: Ethics & Human Research*. 2014;36(6):7-12.

117. Ruiz-Casares M. Research ethics in global mental health: advancing culturally responsive mental health research. *Transcultural Psychiatry*. 2014;51(6):790-805.

118. Rashad AM, MacVane PF, Haith-Cooper M. Obtaining informed consent in an Egyptian research study. *Nursing Ethics*. 2004;11(4):394-399.

119. Lloyd CE, Johnson MR, Mughal S, et al. Securing recruitment and obtaining informed consent in minority ethnic groups in the UK. *BMC Health Services Research*. 2008;8:68.

120. Vallely A, Lees S, Shagi C, et al. How informed is consent in vulnerable populations? Experience using a continuous consent process during the MDP301 vaginal microbicide trial in Mwanza, Tanzania. *BMC Medical Ethics*. 2010;11:1-12.

121. DuBois JM. *Ethics in Mental Health Research: Principles, Guidance, and Cases*. New York, NY: Oxford University Press; 2008.

122. Salois EM, Holkup PA. Research as spiritual covenant. *Western Journal of Nursing Research*. 2006;28(5):505-563.

123. U.S. Census Bureau. Demographic Turning Points for the United States: Population Projections for 2020 to 2060. Available at https://www.census.gov/content/dam/Census/library/publications/2020/demo/p25-1144.pdf. Last accessed February 15, 2024.

124. Austin MJ, Isokuortti N. A framework for teaching practice-based research with a focus on service users. *J Teach Soc Work*. 2016;36(1):11-32.

125. Williams I, Glasby J. Making "what works" work: the use of knowledge in UK health and social care decision-making. *Policy Soc*. 2010;29(2):95-102.

126. Rajack-Talley TA, Best L, Smith SE, et al. Epistemological inclusiveness in researching the African American community. *Int J Soc Res Methodol*. 2017;20(4):411-423.

127. Salas LM, Sen S, Segal EA. Critical theory: pathway from dichotomous to integrated social work practice. *Fam Soc*. 2010;91(1):91-96.

128. Gray M, Agllias K, Schubert L, Boddy J. Doctoral research from a feminist perspective: acknowledging, advancing and aligning women's experience. *Qual Soc Work*. 2015;14(6):758-775.

129. Caputo R, Epstein W, Stoesz D, Thyer B. Postmodernism: a dead end in social work epistemology. *J Soc Work Educ*. 2015;51(4):638-647.

130. Hodge DR, Derezotes DS. Postmodernism and spirituality: some pedagogical implications for teaching content on spirituality. *J Soc Work Educ*. 2008;44(1):103-123.

131. Hansen JT. The relevance of postmodernism to counselors and counseling practice. *J Ment Health Couns*. 2015;37(4):355-363.

132. Patel SG, Tabb K, Sue S. Diversity, multiculturalism, and inclusion. In: Bond MA, Serrano-García I, Keys CB, Shinn M (eds). *APA Handbook of Community Psychology: Theoretical Foundations, Core Concepts, and Emerging Challenges*. Washington, D.C.: American Psychological Association; 2017: 253-273.

133. Rao MA, Donaldson SI. Expanding opportunities for diversity in positive psychology: an examination of gender, race, and ethnicity. *Can Psychol*. 2015;56(3):271-282.

134. Henshaw EJ. Exploring cultural competency in clinical research through historical reports. Symposium conducted at the meeting of the American Psychological Association; Toronto, Canada; August 6-9, 2015.

135. Nguyen KH, Pasick RJ, Stewart SL, Kerlikowske K, Karliner LS. Disparities in abnormal mammogram follow-up time for Asian women compared with non-Hispanic white women and between Asian ethnic groups. *Cancer*. 2017;123(18):3468-3475.

136. Trafimow D, Osman M. Barriers to converting applied social psychology to bettering the human condition. *Basic & Applied Social Psychology*. 2022;44(1):1-11.

137. Mwachofi AK. Building trust and collaboration with rural minorities: experiences with minority farmers in the Mississippi Delta. *J Health Dispar Res Pract*. 2012;5(2):62-80.

138. Casado BL, Negi NJ, Hong M. Culturally competent social work research: methodological considerations for research with language minorities. *Soc Work*. 2012;57(1):1-10.

139. Harley D, Hunn V, Elliott W, Canfield J. Photovoice as a culturally competent research methodology for African Americans. *Journal of Pan African Studies*. 2015;7(9):31-40.

140. Walters KL, Simoni JM, Evans-Campbell T, et al. Mentoring the mentors of underrepresented racial/ethnic minorities who are conducting HIV research: beyond cultural competency. *AIDS Behav*. 2016;20(Suppl 2):S288-S293.

141. Li W, Tsoh JY. Recruiting and retaining Chinese elders in a longitudinal study. *J Transcult Nurs*. 2017;28(1):63-69.

142. Díaz Y, Denner J, Ortiz E. Critical methods in longitudinal research with Latino immigrant families. *Hisp J Behav Sci*. 2017;39(2):150-168.

143. Im E, Kim S, Chee W, et al. Practical issues in multi-lingual research. *Int J Nurs Stud*. 2016;54:141-149.

144. Regnault A, Herdman M. Using quantitative methods within the Universalist model framework to explore the cross-cultural equivalence of patient-reported outcome instruments. *Qual Life Res*. 2015;24(1):115-124.

145. Ali MM. Are we asking the same questions in different contexts: translation techniques in cross-culture studies in science education? *Journal of Turkish Science Education*. 2016;13(1):31-44.

146. Stennis KB, Purnell K, Perkins E, Fischle H. Lessons learned: conducting culturally competent research and providing interventions with Black churches. *Social Work and Christianity*. 2015;42(3):332-349.

147. Zhang N, Davis RE, Caldwell CH, et al. Ethnic identity, questionnaire content, and the dilemma of race matching in surveys of African Americans by African American interviewers. *Field Methods.* 2013;25(2):142-161.

148. Chan DNS, So WKW. Strategies for recruiting South Asian women to cancer screening research and the lessons learned. *J Adv Nurs*. 2016;72(11):2937-2946.

149. Pashea JJ, Kochel TR. Face-to-face Surveys in high crime areas: balancing respondent cooperation and interviewer safety. *Journal of Criminal Justice Education*. 2016;27(1):95-120.

150. Freimuth VS, Jamison AM, An J, Hancock GR, Quinn SC. Determinants of trust in the flu vaccine for African Americans and Whites. *Soc Sci Med*. 2017;193:70-79.

151. Quay TA, Frimer L, Janssen PA, Lamers Y. Barriers and facilitators to recruitment of South Asians to health research: a scoping review. *BMJ Open*. 2017;7(5):e014889.

152. McLaughlin R, Alfaro-Velcamp T. The vulnerability of immigrants in research: enhancing protocol development and ethics review. *J Acad Ethics*. 2015;13(1):27-43.

153. Nielsen M, Haun D, Kärtner J, Legare CH. The persistent sampling bias in developmental psychology: a call to action. *J Exp Child Psychol*. 2017;162:31-38.

154. Salma J, Ogilvie L, Keating N, Hunter KF. A bicultural researcher's reflections on ethical research practices with Muslim immigrant women: merging boundaries and challenging binaries. *ANS Adv Nurs Sci*. 2017;40(2):109-121.

155. Fischer R, Poortinga YH. Addressing methodological challenges in culture-comparative research. *Journal of Cross-Cultural Psychology*. 2018;49(5):691-712.

156. Reinerman-Jones L, Lackey S. Basic versus applied research: the final episode! Next season: transfer! *Theoretical Issues in Ergonomics Science*. 2011;12(5):395-396.

157. Kankam PK. The use of paradigms in information research. *Library & Information Science Research*. 2019;41(2):8592.

158. Kekeya J. The commonalities and differences between research paradigms. *Contemporary PNG Studies*. 2019;31:26-36.

159. Sharma M. Applying feminist theory to medical education. *Lancet*. 2019;393(10171):570-578.

160. Rosa WE. Healthcare decision-making of African-American patients: comparing positivist and postmodern approaches to care. *Nursing Science Quarterly*. 2019;32(2):140-147.

161. Sabatello M. Cultivating inclusivity in precision medicine research: disability, diversity, and cultural competence. *Journal of Community Genetics*. 2019;10(3):363-373.

162. Flores LY, Martinez LD, McGillen GG, Milord J. Something old and something new: future directions in vocational research with people of color in the United States. *Journal of Career Assessment*. 2019;27(2):187-208.

163. Woo B, Figuereo V, Rosales R, Wang K, Sabur K. Where is race and ethnicity in social work? A content analysis. *Social Work Research*. 2018;42(3):180-186.

164. Corley NA, Young SM. Is social work still racist? A content analysis of recent literature. *Social Work*. 2018;63(4):317-326.

165. Pelzang R, Hutchinson AM. Establishing cultural integrity in qualitative research: reflections from a cross-cultural study. *International Journal of Qualitative Methods*. 2018;17(1):1-9.

166. Burlew AK, Peteet BJ, McCuistian C, Miller-Roenigk BD. Best practices for researching diverse groups. *American Journal of Orthopsychiatry*. 2019;89(3):354-368.

167. Hall GCN, Yip T, Zárate MA. On becoming multicultural in a monocultural research world: a conceptual approach to studying ethnocultural diversity. *American Psychologist*. 2019;71:40-51.

168. Otado J, Kwagyan J, Edwards D, Ukaegbu A, Rockcliffe F, Osafo N. Culturally competent strategies for recruitment and retention of African American populations into clinical trials. *Clinical Translation of Science*. 2015;8(5):460-466.

169. Randolph S, Coakley T, Shears J. Recruiting and engaging African-American men in health research. *Nurse Researcher*. 2018;26(1):8-12.

170. Tan TX, Yi Z, Kim E, Li Z, Cheng K. Linguistic equivalence, construct validity, but lack measurement invariance: an illustration of challenges in cross-cultural research on adolescent adjustment. *Cross-Cultural Research*. 2020;54(4):323-345.

171. Behr D, Sha M. Introduction: translation of questionnaires in cross-national and cross-cultural research. *Translation and Interpreting*. 2019;10(2):1-4.

172. Sharma A, Pachori H, Das B, Unni D. Methodological rigour in translating instruments: an overlooked yet essential aspect in cross-cultural research. *Asian Journal of Psychiatry*. 2020;52.

173. Mizuno M, Sugimoto K, Mayers T, Ferrans C. Ensuring cultural and cognitive integrity in instrument translation: quality of life index for Japanese cancer patients. *Asia-Pacific Journal of Oncology Nursing*. 2019;6(1):64-71.

174. Katigbak C, Foley M, Robert L, Hutchinson MK. Experiences and lessons learned in using community-based participatory research to recruit Asian American immigrant research participants. *Journal of Nursing Scholarship*. 2016;48(2):210-218.

175. Leong FTL, Lyons B. Ethical challenges for cross-cultural research conducted by psychologists from the United States. *Ethics and Behavior*. 2010;20(3-4):250-264.

176. Mindlis I, Livert D, Federman AD, Wisnivesky JP, Revenson TA. Racial/ethnic concordance between patients and researchers as a predictor of study attrition. *Social Sciences and Medicine*. 2020;255.

177. Taani MH, Zabler B, Fendrich M, Schiffman R. Lessons learned for recruitment and retention of low-income African Americans. *Contemporary Clinical Trials Communications*. 2020;17.

178. Ozano K, Khatri R. Reflexivity, positionality and power in cross-cultural participatory action research with research assistants in rural Cambodia. *Educational Action Research*. 2018;26(2):190-204.

179. Rosemberg MA, Boutain DM, Mohammed SA. Transnationalism: a framework for advancing nursing research with contemporary immigrants. *Advances in Nursing Science*. 2014;39(1):E19-E28.

180. Halkoaho A, Pietilä AM, Ebbesen M, Karki S, Kangasniemi M. Cultural aspects related to informed consent in health research: a systematic review. *Nursing Ethics*. 2016;23(6):698-712.

181. Honan E, Hamid MO, Alhamdan B. Ethical issues in cross-cultural research. *International Journal of Research & Method in Education*. 2013;36(4):386-399.

182. Green BN, Johnson CD. Interprofessional collaboration in research, education, and clinical practice: working together for a better future. *Journal of Chiropractic Education*. 2015;29(1):1-10.

183. Gee BM, Devine N, Aubuchon-Endsley NL, Brumley M, Ramsdell-Hudock HL, Swann HE. The reciprocity team: development of an interprofessional research collaboration. *Journal of Allied Health*. 2017;46(2):e43-e49.

184. Delman J, Progovac AM, Flomenhoft T, Delman D, Chambers V, Le Cook B. Barriers and facilitators to community-based participatory mental health care research for racial and ethnic minorities. *Health Affairs*. 2019;38(3):391-398.

185. Ellaway RH, Hecker KG. What role does basic research have in an applied field? *Advances in Health Sciences Education: Theory And Practice*. 2022;27(2):289-292.

186. Lykins T. Empirical Knowledge: What It Is, Features, and Types, Meanings. Available at https://fischerinstitute.com/empirical-knowledge-what-it-is-features-and-types-meanings/#Empirical_knowledge_Characteristics. Last accessed February 15, 2024.

187. Al-Ababneh MM. Linking ontology, epistemology and research methodology. *Science & Philosophy*. 2020;8(1):75-91.

188. Mofitt U, Katsiaficas D, Ghavami N, Minor I, Padilla D, Rogers LO. Intersectionality and identity: a systematic review and qualitative analysis of U.S. research in psychological science. *Identity*. 2023;23(4):288-313.

189. Junjie M, Yingxin M. The discussions of positivism and interpretivism. *Global Academic Journal of Humanities and Social Sciences*. 2022;4(1):10-14.

190. Sikka T. Barriers to access: a feminist analysis of medically assisted dying and the experience of marginalized groups. *Omega*. 2021;84(1):4-27.

191. Stewart GT, St. Pierre E, Devine N, Kirloskar-Steinbach M. The end of the dream: postmodernism and qualitative research. *Qualitative Inquiry*. 2021;27(8/9):1051-1058.

192. Holtz P. Does postmodernism really entail a disregard for the truth? Similarities and differences in postmodern and critical rationalist conceptualizations of truth, progress, and empirical research methods. *Frontiers in Psychology*. 2020;11.

193. Raghav K, Anand S, Gothwal A, et al. Underreporting of race/ethnicity in COVID-19 research. *International Journal of Infectious Diseases*. 2021;108:419-421.

194. Mena JS, Cook NE, Quina K. Multicultural considerations in the psychology research methods course. In: Mena JA, Quina K (eds). *Integrating Multiculturalism and Intersectionality into the Psychology Curriculum: Strategies for Instructors*. Washington, DC: American Psychological Association; 2019: 260-280.

195. Sharma J, McDonald CP, Bledsoe KG, et al. Intersectionality in research: call for inclusive, decolonized, and culturally sensitive research designs in counselor education. *Counseling Outcome Research and Evaluation*. 2021;12(2):63-72.

196. Colón-Aguirre M, Bright K. Incorporating diversity, equity, and inclusion (DEI) into research. *Journal of Education for Library and Information Science*. 2022;63(3):237-244.

197. Massoud MF. The price of positionality: assessing the benefits and burdens of self-identification in research methods. *Journal of Law & Society*. 2022;49:S64-S86.

198. La Scala S, Mullins JL, First RB, Michalska JA. Equity, diversity, and inclusion in developmental neuroscience: practical lessons from community-based participatory research. *Frontiers in Integrative Neuroscience*. 2023;16.

199. Mfoafo-M'Carthy M, Grischow J. Hierarchy and inequality in research: navigating the challenges of research in Ghana. *Qualitative Research*. 2022;22(5):729-742.

200. Chan CD, Henesy RK, Erby AN. Toward praxis, promise, and futures of intersectionality in multimethod counseling research. *Counseling Outcome Research and Evaluation*. 2019;10(1):12-18.

201. Harb CA, Taylor MJ. The utility of community-based participatory research: Increasing research engagement among minoritized ethnoracial groups. *Psychiatric Rehabilitation Journal*. 2023; [Epub ahead of print].

202. O'Brien J, Fossey E, Palmer VJ. A scoping review of the use of co-design methods with culturally and linguistically diverse communities to improve or adapt mental health services. *Health & Social Care in the Community*. 2021;29(1):1-17.

203. Chen L, Tse HW, Wu D, Young M-E. Cross-cultural researchers' positionality in immigrant health research: reflections on conducting research on Chinese immigrants' experiences in the United States. *International Journal of Qualitative Methods*. 2021;20.

204. Davis RE, Johnson TP, Lee S, Werner C. Why do Latino survey respondents acquiesce? Respondent and interviewer characteristics as determinants of cultural patterns of acquiescence among Latino survey respondents. *Cross-Cultural Research*. 2019;53(1):87-115.

205. de Wet A, Dowling T, Swartz L, et al. Complexities in the process of translating research documents in cross-cultural settings. *Global Public Health*. 2020;15(6):818-827.

206. Matsumoto D, van de Vijver FJR. Cross-cultural research methods. In: Cooper H, Coutanche MN, McMullen LM, Panter AT, Rindskopf D, Sher KJ (eds). *APA Handbook of Research Methods in Psychology: Foundations, Planning, Measures, and Psychometrics*. Vol. 1, 2nd ed. Washington, DC: American Psychological Association; 2023: 97-113.

207. Henderson C, Scott T, Schinder B, et al. Shifting the paradigm from participant mistrust to researcher and institutional trustworthiness: a qualitative study of researchers' perspectives on building trustworthiness with Black communities. *Community Health Equity Research & Policy*. 2024;44(2):127-136.

208. Wright KO, Deal B-E, Harrison TR, Malova E, Jia X, Morgan SE. Examining uncertainty management in the clinical trial experiences of African American and Black Caribbean participants and the coordinators who recruit them. *Qualitative Research in Health*. 2023;3:100231.

209. Eliacin J, Polsinelli AJ, Epperson F, et al. Barriers and facilitators to participating in Alzheimer's disease biomarker research in black and white older adults. *Alzheimers Dement (N Y)*. 2023;9(2):1-15.

210. Dai Y. "Chameleonization" in the folds of culture: a comparative analysis of cross-cultural qualitative fieldwork. *International Journal of Qualitative Methods*. 2023;22:1-14.