REPORT DOCUMENTATION PAGE

Form Approved
OMB No. 0704-0188

The public reporting burden for this collection of information is estimated to average 1 hour per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to Department of Defense, Washington Headquarters Services, Directorate for Information Operations and Reports (0704-0188), 1215 Jefferson Davis Highway, Suite 1204, Arlington, VA 22202-4302. Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number.
PLEASE DO NOT RETURN YOUR FORM TO THE ABOVE ADDRESS.

1. REPORT DATE *(DD-MM-YYYY)*
10-04-2021

2. REPORT TYPE
Master of Military Studies (MMS) thesis

3. DATES COVERED *(From - To)*
AY 2020-2021

4. TITLE AND SUBTITLE
Reflective Structured Dialogue:
An Approach to Interpersonal Communication

5a. CONTRACT NUMBER
N/A

5b. GRANT NUMBER
N/A

5c. PROGRAM ELEMENT NUMBER
N/A

6. AUTHOR(S)
Wilson, Meoshia A. (Chaplain, Major), USAF

5d. PROJECT NUMBER
N/A

5e. TASK NUMBER
N/A

5f. WORK UNIT NUMBER
N/A

7. PERFORMING ORGANIZATION NAME(S) AND ADDRESS(ES)
USMC Command and Staff College Marine Corps University
2076 South Street
Quantico, VA 22134-5068

8. PERFORMING ORGANIZATION REPORT NUMBER
N/A

9. SPONSORING/MONITORING AGENCY NAME(S) AND ADDRESS(ES)
N/A

10. SPONSOR/MONITOR'S ACRONYM(S)

11. SPONSOR/MONITOR'S REPORT NUMBER(S)
N/A

12. DISTRIBUTION/AVAILABILITY STATEMENT
Approved for public release, distribution unlimited.

13. SUPPLEMENTARY NOTES

14. ABSTRACT
Contentious conversations on racial disparities and inequities are prevalent in the military and society. Service members are not equipped to discuss race in a way that is constructive and yields valuable outcomes. This paper promotes Reflective Structured Dialogue (RSD) as a communication method that reduces polarization, cultivates understanding, changes people's perceptions with opposing views, and leads to trusting relationships. A case study reveals best practices that can be expected from squadron-level RSD sessions facilitated by the Chaplain Corps. In addition to the above, outcomes could be systemic barriers dismantled, a fair military justice system; and inclusivity, equality, and equity for all.

15. SUBJECT TERMS
Communication Method, Reflective Structured Dialogue; Understanding; Conflict; Contentious Conversations; Community; Facilitate Discussion

16. SECURITY CLASSIFICATION OF:			17. LIMITATION OF ABSTRACT	18. NUMBER OF PAGES	19a. NAME OF RESPONSIBLE PERSON
a. REPORT	b. ABSTRACT	c. THIS PAGE			USMC Command and Staff College
Unclass	Unclass	Unclass	UU	33	19b. TELEPHONE NUMBER *(Include area code)* (703) 784-3330 (Admin Office)

Standard Form 298 (Rev. 8/98)
Prescribed by ANSI Std. Z39.18

United States Marine Corps
Command and Staff College
Marine Corps University
2076 South Street
Marine Corps Combat Development Command
Quantico, Virginia 22134-5068

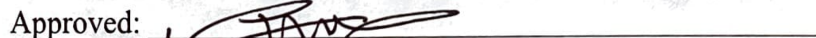
MASTER OF MILITARY STUDIES

Reflective Structured Dialogue:
An Approach to Interpersonal Communication

SUBMITTED IN PARTIAL FULFILLMENT
OF THE REQUIRMENTS FOR THE DEGREE OF
MASTER OF MILITARY STUDIES

Chaplain, Major Meoshia A. Wilson, United States Air Force

AY 2020-21

Mentor and Oral Defense Committee Member: Dr. Claire Metelits

Approved: ______________________
Date: 1 April 2021

Oral Defense Committee Member: Dr. Lauren Mackenzie

Approved: ______________________
Date: 01 Apr 21

Executive Summary

Title: Reflective Structured Dialogue: An Approach to Interpersonal Communication

Author: Chaplain, Major Meoshia A. Wilson, United States Air Force

Thesis: Reflective Structured Dialogue is a method the Air Force Chaplain Corps can use to facilitate contentious conversations in constructive ways, cultivate understanding among people of opposing views, and yield valuable outcomes.

Discussion: This paper will examine the importance of military members having difficult conversations and the need for a proven method to facilitate those conversations. Among the difficult conversations society has today, racial inequities are a major focus. As the military, particularly the Air Force (AF), reflects society, it is paramount that the Chaplain Corps has the necessary tools to facilitate conversations. Reflective Structured Dialogue (RSD) is a method that focuses on understanding other perspectives, having healthy perceptions of those different than ourselves, and on building a trusting relationship. Trusting relationships equates to unit cohesion, and healthy perceptions of others lead to good order and discipline. When inequities and disparities arise, people who trust each other are more likely to have a candid discussion that leads to inclusion, equality, and equity. Although race is the topic of this paper, an exemplary Brazil LGBT case study is used to provide insight on how and why RSD transforms opponents into community members who value one another. The Chaplain Corps personnel specialize in bringing communities together, so the Corps can use RSD to facilitate these conversations among unit members.

Conclusion: There is sufficient evidence that RSD is a tool that contributes to constructive conversations, but it is not the solution. RSD can result in a rich dialogue on existing racial inequities and disparities within the AF and Chaplain Corps. Training would aid discussions within the Corps in preparation for facilitating unit-level conversations. The AFCCC could update the schoolhouse curriculum, as lessons learned are gathered, to ensure that building trusting relationships remains a vital skill of future personnel. The fruit of those trusting relationships will be inclusion, equality, and equity demonstrated throughout all ranks, career fields, AF culture, and the military justice system.

DISCLAIMER

THE OPINIONS AND CONCLUSIONS EXPRESSED HEREIN ARE THOSE OF THE INDIVIDUAL STUDENT AUTHOR AND DO NOT NECESSARILY REPRESENT THE VIEWS OF EITHER THE MARINE CORPS COMMAND AND STAFF COLLEGE OR ANY OTHER GOVERNMENTAL AGENCY. REFERENCES TO THIS STUDY SHOULD INCLUDE THE FOREGOING STATEMENT.

QUOTATION FROM, ABSTRACTION FROM, OR REPRODUCTION OF ALL OR ANY PART OF THIS DOCUMENT IS PERMITTED PROVIDED PROPER ACKNOWLEDGEMENT IS MADE.

Preface

I was compelled to write about an effective method for people to use when having difficult conversations because it is transferrable to every aspect of our lives. Trying to persuade someone or invalidate his or her opinion is commonplace. What is not so common is the discipline of being present with people, having a genuine interest in the experiences that shape their beliefs, and finding value in people even when we disagree. It is important to me as a wife, minister, and leader to welcome or initiate tough talks and encourage others to do the same.

As our nation grapples with the impacts of COVID-19, inclement weather, and deaths of innocent Black people, we must be able to have discussions that identify problems and systems that perpetuate those problems. We also need to discuss the hearts of the people who manage those systems. It is complicated however, I am committed to using my sphere of influence to have constructive conversations that lead to equality for all of humanity, healthy and safe communities, and intercultural partnerships. That is part of the legacy I want to leave on the earth but I want to shift the Air Force Chaplain Corps' culture for now. We get paid to instill and fortify spirituality that assists Airmen in mission accomplishment. I believe we should be leading the way in having difficult conversations and transforming unequal systems.

I owe much gratitude to God for the passion He has given me for people, advocacy, and service. I am also grateful for my husband, Lawrence, who has prayed for and encouraged me, while being patient with me, throughout this journey. I owe a huge thank you to my mentor, Dr. Claire Metelits, for also being patient with me, redirecting me, and providing guidance to help me stay on track. Dr. Lauren Mackenzie introduced me to my topic, along with additional communication theories during my elective course, and I cannot thank her enough. My final thank you is for Stase Wells who helped me navigate this process and improve as a writer.

Table of Contents

DISCLAIMER 2

PREFACE 3

INTRODUCTION 5

DIALOGUE CHALLENGES 6

REFLECTIVE STRUCTURED DIALOGUE 7

LITERATURE REVIEW 9

CASE STUDY 13

- Background 13
- Discuss Vulnerabilities 14
- Disrupt Negative Interaction Cycles 16
- Suggest Ways to Build Rapport 18
- Share What was Learned 20

AIR FORCE CHAPLAIN CORPS RECOMMENDATION 22

- Problem 22
- Current Curriculum 23
- Recommendation 24

CONCLUSION 27

ENDNOTES 30

BIBLIOGRAPHY 32

Introduction

Reports on racial inequities in the military justice system within the United States Air Force (USAF) were disclosed in 2020. According to the Air Force Times, “despite the Air Force’s internal findings in 2016 that it has a ‘consistent’ and ‘persistent’ racial disparity in prosecutions of Black service members, it appears the Air Force has done nothing in the last four years to solve the problem.”[1] Furthermore, The Racial Equality Assessment Team (TREAT) out brief identified racial disparities and unconscious bias within the Chaplain Corps (AF/HC) in 2020. Given how divisive discussions on racial inequities can be, there is a need for additional tools to address the challenges surrounding difficult conversations. One method that has been useful in a host of contexts is Reflective Structured Dialogue (RSD). Since it originated in 1989, RSD has provided diverse tools for preventing cycles of old conversations that are unhelpful, and inviting new ideas and ways of understanding others.[2] RSD is a method the Air Force Chaplain Corps can use to facilitate contentious conversations in constructive ways, cultivate understanding among people of opposing views, and yield valuable outcomes. This paper will outline some of the challenges inherent to constructive dialogue and analyze the principles of RSD and its utility by examining an exemplary case study of medical professionals and lesbian, gay, bisexual, and transgender (LGBT) service users.[3] Although this paper's focus is race, in the absence of peer-reviewed RSD case studies on race, I evaluate what made RSD so effective in the LGBT case and how those best practices can be extended to the AF/HC. The first section of this paper addresses key differences between a dialogue and a debate and details the components that make RSD unique. The following section summarizes RSD literature from varying contexts, followed by an analysis and outcomes of the LGBT case study. The final section draws parallels from the case study to the AF/HC and recommends RSD as a vehicle to curb racial inequities.

Dialogue Challenges

Before reviewing the literature on the use and efficacy of RSD two terms need to be defined. There is a difference between dialogue and debate. Becker, et al describe dialogue as "an exchange of perspectives, experiences, and beliefs in which people speak and listen openly and respectfully."[4] When in dialogue, individuals approach conversations with the intent of embracing diversity of thought, culture, experience, and religious beliefs all while engaged in a conflict. Conflict has less to do with right and wrong and more to do with fundamental differences and is evidence of differences in how people communicate, how emotions are experienced and expressed, of dissimilar values, and the different structure or external framework that encompasses the conflict.[5] To win an argument a person will engage in debate, "speak from a position of certainty, defending his or her own beliefs, challenging and attacking the other side, and attempting to persuade others to his or her point of view."[6] One whose goal is to use the conflict as an "opportunity to be in an extended conversation with the other in which new understanding – not agreement, validation, or consensus – could be constructed" will engage in dialogue.[7]

Structure enables healthy dialogue. A lack of structure can contribute to people being stuck in repetitive discussion patterns. Contentious conversations can unfold in a hostile manner, and if not skillfully managed, escalated emotions, disrespectful name calling, and dismissed viewpoints will result.[8] There is a growing body of scholarly work devoted to the importance of having and managing difficult conversations.[9] One way to manage divisive discussions is through a mediator or negotiator if the intent is to reach a compromise among the parties involved. Another way to handle division is through a facilitator whose intent is to keep participants on track with the purpose for which they are in dialogue, and remind them of the

respectful communication agreement to which they committed.[10] Such a facilitator brings structure and helps regulate appropriate communication to position people to listen to the opposing opinion with an intent to understand. Conversing to understand others is a new discussion pattern that replaces the old one and changes enemies into people in community.

Reflective Structured Dialogue

Although Reflective Structured Dialogue (RSD) has influenced communities for thirty-two years, it is not widely known. Therefore, it is worth outlining to show RSD's purpose and capabilities. RSD is a method to reduce political polarization. RSD highlights problem patterns among multiple generations, identifying issues of triangulation among undifferentiated people, and coaching the "strongest, most differentiated members on the belief that changing any part of the system will change the whole system."[11] Considering the strong beliefs people tend to have about these topics, polarity can be unproductive and damaging. Polarization is displayed in four common communication behaviors: generalizing statements, dismissive remarks, assumptions, and misjudging. RSD uses specific tools that can reduce polarization.

Incorporating the RSD toolbox magnifies the voice of every individual in the dialogue and cultivates understanding among participants. Before an RSD session, all participants consent to an established communication agreement that outlines the ground rules for speaking, listening, and asking questions. When participants adhere to the agreement, sessions become safe, and safety fosters curiosity among the individuals, which expands their understanding of the other person. The primary tools used to foster curiosity are reflection and questioning. The safety of an RSD session enables AF/HC members to be vulnerable while speaking to be understood and listening to understand each other.

The RSD process is meant to break destructive patterns of dialogue and to teach new, constructive communication patterns. Inherently, the structure, reflection, and timed responses prime participants to be fully present and succinctly share their personal experiences. The goal is for participants to discard stereotypes and assumptions, ask clarifying questions, and see each other anew. Participants in RSD sessions do not need to change their positions. Rather, RSD helps people reflect on each person's connection to an issue, helping them to discard stereotypes as they begin thinking differently about those they may at one point have vilified. As participants tell their stories, they reveal their values and beliefs, which fosters mutual respect. The temptation to rebut and persuade was removed because dialogue, not debate, structure was in place.

The most frequent outcome of RSD is a changed perception of people with opposing views because of issues of "introspection" and "extrospection."[12] Introspection is the judging of oneself based on "thoughts, feelings, and intentions;" while extrospection is the judging of others based on their actual words or actions.[13] In the absence of RSD, people are inclined to use different standards to judge each other, which accompanies a particular perception. Participants may not change their position on the topic, but how they perceive and talk about people of the opposing view is altered. An altered viewpoint is only possible for people who pursue *perspective-getting* versus *perspective-taking* when met with different opinions. Perspective-getting is when someone hears an opposing idea, becomes curious, and asks questions to better understand the idea. Adam Grant contends that curiosity demonstrates a person's willingness to *Think Again* about a contrary idea instead of clinging to their first thought or original perception of the person or idea.[14] When people think again, they commit to sustained dialogue that helps all parties see each other more clearly.[15]

RSD has consistent outcomes to include bridge-building, reducing polarization, and healing strained relationships and communities.[16] Since RSD boundaries have been instrumental in many other contexts, it seems promising that RSD could strengthen the military community.[17] The military chain of command presents a culture that can inhibit honest expression and disclosure. Service members who fear reprisal may be reticent to speak about their lived or witnessed experiences. The RSD format could empower fearful service members to speak during the round of questions that all participants may answer.

RSD is not without its critics, however. While a strength of the method is its structured character, it has been critiqued as being too limiting for those who prefer freedom of dialogue without time restrictions.[18] Another critique is that RSD falls short in deliverables. Some participants want an action plan following dialogue, which is not an RSD objective; however, facilitators can adapt the sessions to fit the needs of groups who agree to work toward devising a plan. For AF/HC, a top-down plan has been implemented. It is the bottom-up and lateral relationships that warrant dialogue that can lead to individual perception changes.

Literature Review

RSD has been identified as a dialogue intervention for communities that have difficulty transcending polarization. Scholars have analyzed this intervention and largely agree on its efficacy. What follows is a review of the literature to include the inception of RSD, what makes it successful, and its applicability across topics.

Inception of RSD

In the early 1990s, family therapist Laura Chasin and her colleagues found parallels between their clients' destructive patterns of interacting and communicating and the political polarization among community members on certain topics. Thus, RSD is rooted in family

systems theory which contends that if one person changes their behavior the rest of the family will eventually adjust, with or without a ruckus. Applying this theory to RSD, Chasin et al. changed the dialogue's structure to ensure all RSD participants would engage in respectful dialogue, not debate, during sessions. For structure to enable a respectful discussion was major because people of opposing views began listening and empathizing with each other for the first time. Additionally, Chasin was instrumental in continuous refinements of the RSD model in hopes of relieving facilitators of the burden of creating their own model. The model became a written RSD guide that not only explained the theory and provided a manual for facilitators to employ, but it also presented alternatives that made RSD adaptable to the facilitator's context.[19] Having a product that needed few amendments, if any, made RSD less intimidating to non-therapists who chose to facilitate dialogue.

Why RSD Works

Some researchers deem RSD successful because of its positive impact on communication between participants. DeTemple and Sourrouf study the negative communication styles that bring people to mediation and the need for RSD. According to them, as connections increase between RSD participants, communication improves, which disrupts negative communication cycles. The negative cycle is filled with assumptions, forming rebuttals instead of listening, preparing to tell someone why they are wrong, and winning a debate.[20] The RSD format is appropriate for managing this contentious environment because it removes shouting, and other aggressive behavior and promotes listening and learning.[21] Lodging a verbal attack in response to someone of a dissenting opinion is reflexive, so it is of great significance that RSD can disarm people and prime them to set stereotypes aside and become a student.[22] Such a remarkable change not only benefits the individual in the session, but it gives them a new skill to employ

everywhere they go. Morey contends that participants of an RSD session on the amended definition of marriage testified to being “better listeners, better engagers, and better parents.”[23] Part of what makes RSD useful is the removal of power dynamics, which equalizes participants’ positions and postures them to listen, learn, understand, and grow curious about other people. While remaining on different sides of an issue, people who respect and trust each other do so because of better communication.

Application Across Topics

Several scholars have studied the use of RSD to discuss gun control, religion, immigration rights, environmental conservation, race, and healthcare. As scholars report, RSD participants repeatedly attest to a change in their perception of people with opposing views. Toolan records that participants from an RSD session on abortion that none of their positions about the issue changed, but they discarded “stereotypes and inflammatory language” such as baby-killer or religious fanatic.[24] This was possible because they began to think differently about the people they had once vilified as they reflected on each person’s connection to the issue. As participants told their stories, they revealed some of the values and beliefs which fostered mutual respect. Morey adds that a religious group divided on defining marriage used the unstructured questions of the RSD session to ask clarifying questions of each other. This allowed them to test their assumptions, no longer view the other person as a caricature and begin validating the other person as a human being with experiences and values that have shaped their opinions.[25] DeTemple and Sarrouf maintain that changed perceptions emerge when participants give themselves permission to be uncertain about what they once declared as truth concerning someone they did not know.[26]

Each of the sources above attribute perception changes to the structure that is imposed during dialogue on different topics. Abortion was the first topic that RSD addressed to amplify each participant's concerns and help them think differently about each other. DeTemple regularly employed RSD with her collegiate-level religious studies pupils to teach them the value of suspending judgment while listening to someone attach meaning to their opinions. Morey captured an RSD session where the Minnesota Council of Churches discussed the definition of marriage to determine whether it would change its state constitution. The same article mentioned an educational institution who used RSD to discuss budgeting issues. Chasin et al. record an RSD session among key stakeholders to determine the "future of the northern forests of New York, Vermont, New Hampshire, and Maine."[27] Chasin et al. also note an RSD session among nongovernmental organizations (NGO), in preparation for a United Nations conference, to discuss issues pertaining to the population, environment, and women's health.[28] An apparent strength of RSD is its applicability to multiple groups and a variety of topics.

Many industries benefit from using RSD including education, religion, NGOs, social and political activists, and healthcare. Morey polled participants from his RSD session and contends that 96% of them noted that RSD could be useful in other settings.[29] However, few scholars study how the military can use this method. RSD provides a format that could assist personnel in having constructive conversations that aid good order and discipline. Since the AF/HC has the privilege of providing spiritual care and advising leaders on all things moral, spiritual, religious, and ethical, it is a natural fit for chaplains and religious affairs Airmen to benefit from being RSD participants.[30] The RSD approach is a tool to reduce polarization, cultivate understanding, improve communications, and change perceptions.

The following case study illustrates the conciliatory strides made in a healthcare community using RSD. While the purpose of this paper is to highlight RSD's appropriateness for the AF/HC community in addressing racial inequities and disparities, there is no scholarly literature on RSD and race. The LGBT case study demonstrates similarities to cases of racism. Both demographic factors have caused people (i.e., LGBT, Black) to be historically mistreated. RSD strengths exhibited through the case study will be applied to race in the military to strive toward abolishing generations of racism.

Case Study

Good rapport between health professionals and service users is not automatic. Factors such as non-normative sexual orientation can complicate rapport building. A 2016 study on Health care provision LGBT service users illustrates the discomfort that can exist between providers and LGBT patients. The discourse between health providers and patients was strained, as demonstrated below. The purpose of bringing in RSD was to help both health care workers and their patients construct a relationship that normalized rapport building, triage, and treatment.

Background

The philosophical principles that guide the Brazilian Health System, also known as *Sistema de Saúde* Unico (SUS), include universal access to care, comprehensive and customized care that meets the needs of all population groups.[31] To ensure equity for LGBT service users, SUS partially implemented the National Policy for Integral Health of the LGBT community in 2011. The local LGBT movement continued to push for full implementation and education.[32] The Ministry of Health employed an online course for health professionals in 2015 to refresh them on the policy because of the persistent lack of equity, especially for transvestites. Specifically, health providers made assumptions about LGBT service users' names, respective

gender identities, roommate preferences while in patient, and methods for contracting a sexually transmitted illness. The majority of users demonstrated assumptions about providers being omniscient experts and projected a disrespectful attitude toward them. Providers feel disrespected and embarrassed when transvestite users draw attention to themselves by speaking loudly and in a condescending tone.[33] Users feel disrespected when heterosexual norms are applied to them and when they are prevented from using their preferred restroom.[34] Thus, the Committee of Ethics in Research involving Human Beings initiated the 2016 study to assess and address continued challenges using an uncommon approach. RSD was the method used to address the health care experience for professionals and LGBT service users, hereafter referred to as providers and patients.

Discuss Vulnerabilities

Honest dialogue between providers and patients is vital for a quality health care experience. In keeping with RSD recommendations, the researchers selected a small and diverse group of people. The three providers consisted of a general doctor, a primary care nurse, and a nurse who represented health care in a hospital, emergency department, and an outpatient clinic. The four LGBT patients were even more diverse in age, marital status, socioeconomic status, and sexual orientation—including transvestites and transgender participants. Both of the facilitators were psychologists; the woman was heterosexual and the man was homosexual. Collectively, the diversity of the facilitators and participants appears to have added to the richness of the discussion and provided multiple perspectives. Giving one's honest perspective and sharing life experiences with strangers requires safety, which the facilitators had to establish.[35]

The facilitators made good use of the individual RSD interviews to establish safety and learn each participant's health care experience that informed the user's views. The interview was

advantageous to the participants because they learned the ground rules, which likely encouraged them to be unapologetic in telling their stories during the session. The specific rules were to speak from their own experience, avoid judging people's opinions, listen without interrupting, adhere to the speaking timelines, and refrain from attempting to persuade or rebut.[36] Having honest conversations in a constructive manner is risky, especially when there are power differentials and no previously established relationship. A desire for equitable treatment is motivation to agree to disclose what one holds close and trust that everyone who signed the consent form will comply with the ground rules.

During the session, the first question gave each participant time to state the main challenges that were encountered as a patient or provider. The safety, ground rules, timelines, and moments of reflection were instrumental in the patients and providers sharing their fears and concerns as they reported their main challenges in turn. A primary fear for providers was making a comment that could be insulting or offensive; for patients, their fear was discrimination, social prejudice, and being treated as if they were bad people for not being heterosexual.[37] Providers admitted that they assumed heterosexuality when treating patients, which caused some users to be uncomfortable and embarrassed for having to correct the provider.[38] Patients confessed that they expected providers to be trained as medical professionals who were also trained in how to communicate with and serve a sexually diverse community.[39] Herein lies a huge gap. Providers are not trained to serve a sexually diverse population; instead, they are trained on a biomedical model of care, which will be covered in the next section. Such a model is insufficient, and RSD helped the participants extract this challenge and barrier for them to think through together.

Disrupt Negative Interaction Cycles

The next question highlighted a key component of RSD, disrupting negative cycles, when participants were invited to ask questions regarding the challenges everyone shared with the group. RSD disrupted at least four cycles during this session: the sole use of the biomedical model, disrespect between patients and providers, assumptions about each other, and power distance norms. First, the biomedical model is one that only accounts for the biological factors of a patient, which means it excludes the relationship between the body, mind, "environment or belief systems, economic, social, or cultural conditions" that describe the patient.[40] Thus, when the dialogue exposed such a limiting approach to health care, it led the participants to ask questions from a place of curiosity. Within the RSD framework, curiosity is invaluable because it positions participants to close divides, learn more, make meaning from what they learn, and gain a clearer understanding of others. The question and answer portion of this session was evidence that the participants disrupted the negative interaction cycle and developed a new way of collaboratively exploring the uniqueness of every patient.

Second, the historical disrespect that existed between patients and providers dissolved as participants listened to each other. The dialogue identified disrespect in three areas: patient treatment, provider treatment, and self-respect.[41] The significance of this discovery is that all participants were able to hear specific examples of how they perpetuated disrespect, so there was no room for blame. Providers disrespected patients by treating them differently than they treated heterosexual patients; there was distance and inadequate care that providers resented giving.[42] Patients disrespected providers by being boisterous and speaking in a condescending tone since they assumed providers were experts.[43] It is likely that the interplay between loud patients and embarrassed providers created distance that led to inadequate care from people who were

supposed to be experts. The dialogue successfully painted a picture of this interplay that helped participants see what they could do differently in the future, which promotes self and other-respect.

Third, the dialogue uncovered three assumptions that were misjudgments, which adversely affected the health care experience for patients and providers. Providers assumed the sexual identity of patients was reckless and that every sexually transmitted disease (STD) was contracted due to inappropriate sex, while patients assumed providers asked few questions because of their expertise.[44] When participants shared their assumptions, it demonstrated their ambiguities or uncertainties, which is what RSD targets. Brilliantly, patients were able to see and hear that the experts were not experts in everything and providers were enlightened on how diverse the LGBT community is and that some patients contract STDs even when they practice safe sex or monogamy. Being enlightened is a hallmark of RSD, and this dialogue was an exceptional display of discarding assumptions, owning uncertainties, asking questions, developing compassion, and charting a new path.

Fourth, power distance norms were inverted in this dialogue, and it positively influenced the discussion among the participants. Power distance is the degree to which a society values equal or unequal distribution of power.[45] Small power distance societies appreciate equality and collaboration while large power distance societies hold fast to hierarchies and give authoritative feedback.[46] In the case study, patients imposed a large power distance dynamic when they expected providers to be experts; however, the RSD format introduced the participants to a small power distance dynamic to ensure they learned about and from each other. Changing this dynamic was vital because it postured the participants to collectively think through health care practices and processes, to be outlined in the next section, that would yield better service for

patients and put less pressure on providers.[47] The clarity that participants reported receiving was an indication that small power distance was necessary and should be a new norm between patients and providers.

Suggest Ways to Build Rapport

The final question on improving health care for LGBT patients yielded practical rapport-building and triage questions. An improvement plan is not a primary goal of RSD; however, the resource discussion appears fitting and indispensable to the participants and the future of health care provided to LGBT patients in Brazil. Thus, the first resource focused on names. A recurring challenge for transvestite and transgender patients was their chart and photo identification showed their given name but they wanted providers to call them by their preferred names. A discrepancy between traditional gender names on paper and how a patient is dressed likely generated confusion and awkwardness. It is also possible that some providers held certain opposing beliefs that presented an additional barrier to care. To minimize all barriers, a participant recommended providers acknowledge the patient's written name and ask the patient what he or she would like to be called.[48] The suggestion was simple yet liberating for providers because it equipped them with an approach that demonstrated their desire to treat the patient with respect.

The second resource revolved around assessing the patient's sexual habits. Sex is a private matter, so it is understandable that providers would be reticent to ask questions about patients' sexual behavior. To introduce sex during the resource discussion proved beneficial because it offered providers another question to ask patients: "how often do you have sex?"[49] The participant who recommended the question contends that details, such as the gender of patients' sexual partner(s), are unnecessary. The validity of such a position is debatable;

however, there are additional open-ended questions that could yield information that is paramount to patient health.

The study did not offer other questions to assist providers in understanding the patient's sexual conduct, but providers could ask patients to share any concerns they have about their sexual health and life and give the patient a moment to reflect before responding. Although some patients may not have concerns, others may feel comfortable disclosing habits or situations that are detrimental to their wellbeing. A broader question would be to ask the patient what brings him or her to seek medical advice because their concern may be unrelated to sex.[50] Despite the reason for seeking care, patients should feel cared for by their providers and trust that providers will make recommendations and referrals to facilitate quality patient care. The key to this kind of candid discussion begins with establishing rapport that is genuine and asking questions that lead to an accurate assessment that informs the treatment plan, which the RSD session modeled for both patients and providers.

The third resource aimed to make trans patients feel included during a hospital stay. Every patient wants to be as comfortable as possible while receiving health care. Considering the common mistreatment of the LGBT population in Brazil, patients should not be subjected to the same isolation in a hospital.[51] The dialogue was central to providers learning how to give patients the decision-making power to choose where they would like to be housed. For providers to ask patients which ward would be most comfortable would be the right thing to do, although risky. A heterosexual patient could respond negatively to the entrance of a trans roommate; however, Moscheta et al. determined that part of future relationship-building required more exposure to the LGBT community.[52]

Increased exposure is novel because it forces people to share space, have their assumptions challenged, muster the courage to ask questions from a place of genuine curiosity, and develop empathy in the face of difference. Again, this is the essence of RSD, so the resource discussion confirmed that the participants took another step toward the SUS goal of "radical social inclusion, sensitivity to diversity and specificities, as well as a commitment to confront social inequalities."[53] The next step would be informing the masses on these resources.

Share What was Learned

The primary gap in this study was its omission of a plan to widely disseminate the practical resources, questions, and methods for building rapport and treating LGBT patients with respect. While traditional RSD does not pursue action plans, it does give participants an opportunity to discuss where they should go from here. Since the Committee of Ethics in Research involving Human Beings initiated the study with the purpose of identifying barriers to full implementation to the National Health Policy, it seems consistent that SUS would devise a method to communicate discoveries and potential solutions. There was an important finding in the study when they discarded sole use of the biomedical model of health care. They embraced a concept that no longer exalted the provider as the "one who knows about the other" and gave the provider an opportunity to "know with the other."[54] Moscheta et al. call it *dual responsibility* because collaboration between patients and providers is what would reveal a holistic picture of the patient that precedes a diagnosis and treatment plan. Dual responsibility is the health care practice and patient approach that needs to be publicized and sustained.

To publicize dual responsibility, the recommendation is to expand the conversation beyond the RSD participants, ensure all major hospitals have a LGBT patient advocate, and mandate full implementation of the National Health Policy. Seven participants had a

transformative discussion that proved successful and should empower similar conversations among different groups of providers and patients. If all major hospitals hired a patient advocate who focused solely on the *radical social inclusion* of LGBT patients, these advocates could serve as facilitators of RSD sessions. To hear the concerns of patients and providers would equip advocates with a clear picture of each person's needs.

Advocates could develop a needs assessment tool to employ in their hospital, in conjunction with patient exit interviews, to gauge the patient's experience. The needs of patients and providers being met would demonstrate a shift in the practices and culture of the medical community. A shift in one community could positively impact how LGBT people are treated in other communities within Brazil. Advocates could partner with SUS to establish local, in-person training sessions to mandate the policy and reprimand those who are in violation. The training could promote relationship-building, present sample questions to ask patients, advertise the advocate's contact information, and produce a referral list for patients who need specialty care.

Trained providers who partner with patient advocates have the potential to make the LGBT patient experience one that is respectful, collaborative, and normative. Normalized health care cannot be stressed enough. LGBT people are human beings first and foremost, and they want to receive equal treatment, equal opportunities, and an equal voice in all things pertaining to their healthcare. In spite of the discrimination the Brazil LGBT community has endured and the fact that recommended changes may encounter resistance, these changes could make a monumental difference one dialogue, one provider, and one patient at a time. If incremental change is possible for the Brazil LGBT community, there is hope for the same in the US military. Advocacy for racial equality for all service members is being promoted by the Secretary of Defense, the Air Force Office of Diversity and Inclusion, and The Racial Equality Assessment

Team within the AF/HC. The emphasis on eradicating extremism, amending policies that perpetuate disparities, and removing barriers to equality, demonstrate senior leader's commitment to overhaul the military as an organization. Service members will likely need training to develop new, inclusive norms after having honest, facilitated conversations that will reveal the overt and covert threads that have sustained racism in the military.

As the above case demonstrates, RSD can create authentic and safe spaces for participants to be candid about their experiences and their desires for the future. RSD allows individuals to think through the problems, explore each other's needs, and brainstorm solutions that would be in everyone's best interest. By asking questions, participants enhance their understanding of one another. The RSD is a promising resource for the Air Force Chaplain Corps as they work with groups on issues of racism and diversity.

Air Force Chaplain Corps (AF/HC)

Problem

Based on the identified racial inequities and disparities in the AF and AF/HC, chaplains and religious affairs Airmen may not be equipped to have constructive conversations about race with each other. If unable to have an internal discussion it is unlikely that AF/HC can facilitate a similar discussion among Airmen. It is important to establish a culture that disrupts negative interaction cycles, listens to understand, speaks to be understood, exchanges assumptions for asking questions, and builds trusting relationships that promote equal treatment and opportunity for every Airman. As demonstrated in the previous section, RSD aids multidisciplinary groups in this endeavor.

Current AFCCC Curriculum

There are two parts of the Air Force Chaplain Corps (AFCCC) curriculum that are most relevant to facilitating constructive conversations yet still fall short of what RSD can offer. The Leadership, Mediation, and Negotiation course that is taught to different echelons of AF/HC members. The course provides useful skills that assist AF/HC members in identifying people's interests, sharing power, building options toward a desired change, and persuading people toward that change. Although there are times when persuasion is the skill that AF/HC members use to inspire, cast vision, preach and teach, garner volunteers, and compete for funding, persuasion exalts a particular view at the expense of other views. The kind of conversation that Airmen need to have is one that summons all voices, views, and experiences. Thus, the course does not seem adequate.

Second, the AFCCC uses Augmented Reality and Artificial Intelligence (AR/AI) to teach students different methods for counseling and crisis intervention, performance feedback sessions, and commander advisement. An Avatar is the chosen AR and plays the role of a counselee while AI is used to interpret the counselor's facial expression and body language. The interpretation is fed to the Avatar who then incorporates those inputs into its response and actions. Diversity and inclusion is accounted for since the Avatar can be customized by gender, ethnicity, and age. The advantage of this technology is that the Avatar models verbalizing what the counselor communicated non-verbally. It is a lesson in observing how attentive or inattentive one is as a counselor when engaging a counselee. However, the limiting factor is that AI does not know the story or life experience that informs the counselor's non-verbals and cannot draw meaning from what it does not know. AR/AI is not a complete solution, but it can be used to train AF/HC members on facilitating an RSD session.

Recommendation

The creators of RSD recently published a dialogue guide to facilitate constructive conversations about race among diverse groups. The guide offers three different formats to accommodate a mixed-race group, an all-white group, and an all-BIPOC (Black people, Indigenous people, and other people of color) group.[55] AR/AI could be used with each group to teach AF/HC members how to facilitate an RSD session, after being an RSD participant led by a human trainer.

Training by a human being would begin with the AFCCC having a consultation with Essential Partners (EP). A consultation would give the AFCCC a chance to describe the racial climate in the AF and AF/HC and the need for conversations that foster trust. EP could explain the available RSD training options and the outcomes that AFCCC can expect. Specific attention could be given to intentionally creating a new norm of speaking up without fear of reprisal. The next step would be soliciting three different groups of AF/HC volunteers. It is crucial that participants are volunteers and not voluntold because attitudes will likely impact what information is shared, what kind of experience they have, and what value comes of the RSD session. Staying true to the RSD model of volunteers is a limitation because there will likely be people who need to have their assumptions challenged, but they will not volunteer. The people with racist ideologies who refuse to volunteer potentially remain service members who perpetuate the very culture that this recommendation aims to uproot. Thus, this is truly a leadership issue and commanders will need to buy-in to employing RSD in their units, and incorporate RSD race conversations as a follow-up to recent extremism stand-down discussions.

To ensure lessons from the mixed-race, all-white, and BIPOC sessions can be analyzed for specific problem areas and trends, each participant could join two sessions: mixed race and

either all-white or BIPOC. It could be enlightening for participants to compare their two dialogue experiences and provide feedback on the differences, similarities, and personal takeaways. In anticipation of participants gaining a better understanding of others, they may also be able to brainstorm cultural, hierarchical, historical, and religious dynamics that perpetuate old, negative cycles.

Once AFCCC compiles negative cycles, problem areas, and trends, the staff members could devise connection and structured questions that become RSD scenarios with the Avatar serving as the facilitator who teaches the AF/HC students how to facilitate a session. An example of connection questions would be "Think about a time when you had the chance to talk with someone about race or racial bias, but chose not to do so. What made that conversation feel challenging? What made you pause and how does that relate to how you're approaching the conversation today?"[56] Potential structured questions include "What life experience has most significantly taught you about encounters across racial and ethnic differences? How were you impacted by that experience? What does it mean to you to be talking about that experience here?"[57] Responses to these questions bring in personal stories that may match the facial expressions and body language that the Avatar will interpret. Close coordination with EP could help refine this idea and process.

Provided the AR/AI interplay with students to conduct RSD scenarios disrupts negative cycles, fosters understanding, and builds trusting relationships, the students could practice facilitating with additional questions that further the race dialogue. As dialogue continues, the AFCCC staff can determine what specific changes and adjustments to make to the curriculum.[58] From there, the staff can also establish the best course of action to equip AF/HC members to facilitate RSD sessions with their local AF/HC teams across the AF. Feedback from the teams

will lead to process improvements and hopefully AF/HC teams who have a deeper understanding of each other and trust one another. In the words of Patrick Lencioni, "Trust lies at the heart of a functioning, cohesive team. Without it, teamwork is all but impossible."[59]

If successful within the AF/HC, the AFCCC staff can assist wing chaplains to devise a plan for AF/HC members to facilitate RSD sessions with their local units. Unit commanders would communicate a strong message to their subordinates if they participated in the sessions. Some may be tempted to have commanders only sessions but that would be counter to the new cycles, deeper understanding, and trust that needs to be established. To have the ability to penetrate the hearts of Airmen in a way that could ignite a new, positive cycle in their work center where their voices are heard and they have a fair chance at competing for every opportunity of interest would be evidence that AF/HC can provide spiritual care in ways that contribute to unit cohesion and amplify motivation and mission effectiveness.

RSD is a method the Air Force Chaplain Corps can use to facilitate contentious conversations in constructive ways, cultivate understanding among people of opposing views, and yield valuable outcomes. Some practical outcomes would be identifying systemic barriers, uncovering exclusivity where inclusivity should reign, and banning covert and overt racist traditions. Other outcomes for the military justice system would be commanders and legal advisors who intentionally refrain from issuing harsher punishment to Black Airmen and give them a fair chance at progressive discipline. Relational outcomes include changed perceptions, trusting relationships, dignity and respect being demonstrated to and among all Airmen, and brothers and sisters-in-arms who commit to building a community that closes the say-do gap on inclusion, equality, and equity. The manifestation of the outcomes above would be valuable and evidence of a new cycle, which constitutes success.

As a warfighting organization, with persistent threats on land, sea, air, cyber, and space, there is no room for barriers to having the advantage, being a ready force, and innovating to defeat every enemy. Innovation is a force multiplier that is a byproduct of including people from a wide-range of backgrounds, culture, intellect, skills, and expertise. But before getting to the mission, the people who do the mission need to talk; honest answers need to be given and received. Flawed assumptions and hateful beliefs need to be challenged. The insurrection at the US Capitol on January 6, 2021 is an indication of how some US citizens feel and the lengths they will go to have their grievances heard and decisions overturned. US citizens comprise the military Services and to support and defend the Constitution of the United States, with integrity, means a purification process of sorts is in order; and RSD is the recommended medium.

Conclusion

RSD has shaped skilled conversationalists and enabled them to have honest, constructive conversations, and it can aid AF/HC in doing the same. Its ground rules, removal of power dynamics, moments of reflection, and timed responses consistently create the safety that sets the stage for a candid discussion. Throughout the health care session between providers and LGBT patients, the safety that RSD created was a testament to what happens when old, negative communication cycles get disrupted; new cycles were formed as people listened curiously, gained understanding, and felt connected. RSD enabled the participants to discuss their vulnerabilities, disrupt negative interaction cycles, and suggest ways of building rapport; however, it neglected to show how to share rapport building with all health professionals and LGBT service users.

Sharing information is important and is one of three limitations of this study. The primary audience of this study is the AF/HC and AF. It does not incorporate other branches of service,

which could likely benefit from what RSD can offer and the lessons the AF will glean from RSD sessions. The second limitation is the absence of an action plan for making systemic changes after conducting respectful conversations. The third limitation is the lack of scholarly literature concerning RSD's impact on racial disparities.

Future directions regarding RSD research could include partnering with the Research and Development (RAND) corporation to study RSD's effectiveness on race with small groups throughout the DoD. Such a partnership could reveal trends across the Services that reflect a need for changed policies and a refined culture. Researchers may also consider tracking actual changes, the expediency of those changes, and the results each change yields.

There are changes that the AF/HC needs to make, and it is highly likely that RSD can ignite those changes through constructive conversations that yield valuable outcomes. The integration of AR/AI could bolster those conversations and outcomes. Discussions on issues of race could reveal systemic barriers, exclusivity where inclusivity should reign, traditions of subtle racism, inappropriate remarks; and give people an opportunity to take personal responsibility for their comments and actions that keep Black people and other minorities at a disadvantage. When service members have forthright dialogue, commanders and legal advisors may be more inclined to refrain from issuing and recommending harsher punishment for Black Airmen. Perhaps Black Airmen will get a fair chance at progressive punishment and being treated as if they are innocent until proven guilty. An RSD session among service members could be invaluable and the catalyst for bottom-up and lateral change that begins with a constructive conversation.

There is sufficient evidence that the ground rules, metaphorical removal of rank, reflection, and timed responses could result in a rich dialogue on existing racial inequities and

disparities. Talking about such long-standing issues could lead to a concerted effort toward inclusion and equality becoming the new norm in all AF units because of a clear understanding that pursuing a changed culture is everybody's responsibility. As people embrace their role in the change process, the AF history books will evolve to show consistent top-down changes and advancement from the ground-up as perceptions change, trust gets built, and dignity and respect are given freely to every Airman. This is an integral part of how the Air Force can follow the Chief of Staff's directive to "accelerate change or lose," and the AF/HC has a unique opportunity to do some internal work that could lead to AF-wide transformation: empowered Airmen who can solve any problem that threatens US national security, including racial disparities.[60]

Endnotes:

[1] Air Force Times, accessed December 13, 2020 https://www.airforcetimes.com/news/your-air-force/2020/05/27/air-force-punished-black-airmen-more-report-says-and-covered-it-up/
[2] Richard Chasin et al., "From Diatribe to Dialogue on Divisive Public Issues: Approaches Drawn from Family Therapy," Mediation Quarterly 13, no. 4 (June 1996): 331–336, https://doi.org/10.1002/crq.3900130408.
[3] Murilo S. Moscheta, Laura V. Souza, and Manoel A. Santos, "Health Care Provision in Brazil: A Dialogue between Health Professionals and Lesbian, Gay, Bisexual and Transgender Service Users," Journal of Health Psychology 21, no. 3 (March 2016): 369, https://doi.org/10.1177/1359105316628749.
[4] Carol Becker PhD, Laura Chasin MSW, Richard Chasin MD, Margaret Herzig & Sallyann Roth MSW (1995) From Stuck Debate to New Conversation on Controversial Issues, Journal of Feminist Family Therapy, 7:1-2, 146, DOI: 10.1300/J086v07n01_14.
[5] Suzanne McCorkle and Melanie Reese, Personal Conflict Management: Theory and Practice, 2nd edition (New York: Routledge, Taylor & Francis Group, 2018), 47-48.
[6] Sally A. Freeman, Stephen W. Littlejohn, and W. Barnett Pearce, "Communication and Moral Conflict," Western Journal of Communication 56, no. 4 (December 1992): 311–329, https://doi.org/10.1080/10570319209374421.
[7] Sheila McNamee, "Transformative Dialogue: Coordinating Conflicting Moralities" (speech, Gary Lindberg Lecture, Durham, NH, May 8, 2008), 5.
https://mypages.unh.edu/sites/default/files/sheilamcnamee/files/transformative_dialogue-_coordinating_conflicting_moralities.pdf
[8] David S. Toolan, "Of Many Things," America Magazine (The Jesuit Review, May 7, 2001), accessed February 19, 2021, https://www.americamagazine.org/issue/331/many-things/many-things.
[9] Douglas Stone, Bruce Patton, and Sheila Heen, *Difficult Conversations: How to Discuss What Matters Most; [Updated with Answers to the 10 Most Frequently Asked Questions about Difficult Conversations]*, 2. ed., 10. anniversary ed., now updated with a new chapter, Penguin Book Psychology/Business (New York: Penguin Books, 2010); Donald Ellis, "Talking to the Enemy: Difficult Conversations and Ethnopolitical Conflict," 2020, https://doi.org/10.34891/1FTN-G083; Celeste Headlee, *We Need to Talk: How to Have Conversations That Matter* (New York: Harper Wave, An Imprint of Harper Collins Publishers, 2017); "Constructive Disagreement Resource List," accessed March 24, 2021, https://heterodoxacademy.org/library/on-constructive-disagreement-video-playlist/
[10] Maggie Herzig and Laura Chasin, "Fostering Dialogue Across Divides: A Nuts and Bolts Guide from Essential Partners" (Essential Partners, 2018), 111, https://whatisessential.org/fostering-dialogue-across-divides-download.
[11] James Robert Bitter, Theory and Practice of Family Therapy and Counseling, Second edition (Belmont, CA: Brooks/Cole, 2014), 12.
[12] Emily Pronin, "How We See Ourselves and How We See Others," Science 320, no. 5880 (May 30, 2008): 1177, https://doi.org/10.1126/science.1154199.
[13] Pronin, How We See Ourselves and How We See Others, 1177.
[14] Adam M. Grant, *Think Again: The Power of Knowing What You Don't Know* (New York, New York: Viking, 2021); Adam Grant, *"The Easiest Person to Fool,"* Hidden Brain, podcast audio, March 24, 2021, https://hiddenbrain.org/podcast/the-easiest-person-to-fool/.
[15] Grant, *"The Easiest Person to Fool."*
[16] Katherine Gower, Cornelius Llewellyn, Raye Rawls, and Brandy B. Walker. "Reflective Structured Dialogue: A Qualitative Thematic Analysis." Conflict Resolution Quarterly 37, no. 3 (2020): 209. doi:http://dx.doi.org.lomc.idm.oclc.org/10.1002/crq.21271.
[17] Jerad Morey. "Not Changing Minds but Softening Hearts." Creative Nursing 19, no. 4 (2013): 212. https://search-proquest-com.lomc.idm.oclc.org/scholarly-journals/not-changing-minds-softening-hearts/docview/1499115251/se-2?accountid=14746
[18] Gower et al., "Reflective Structured Dialogue," 220.
[19] Becker et al., From Stuck Debate to New Conversation on Controversial Issues, 148-149.
[20] Jill DeTemple and John Sarrouf, "Disruption, Dialogue, and Swerve: Reflective Structured Dialogue in Religious Studies Classrooms," Teaching Theology & Religion 20, no. 3 (July 2017): 285, https://doi.org/10.1111/teth.12398.
[21] Gower et al., "Reflective Structured Dialogue," 214.
[22] Toolan, "Of Many Things."
[23] Morey, "Not Changing Minds but Softening Hearts," 212-213.
[24] Toolan, "Of Many Things."
[25] Morey, "Not Changing Minds but Softening Hearts," 212-213.

[26] DeTemple and Sarrouf, "Disruption, Dialogue, and Swerve," 288.
[27] Chasin et al., "From Diatribe to Dialogue on Divisive Public Issues," 327-328.
[28] Chasin et al., "From Diatribe to Dialogue on Divisive Public Issues," 328.
[29] Morey, "Not Changing Minds but Softening Hearts," 212.
[30] Air Force Instruction, Chaplain: Planning and Organizing, 52-101, July 15, 2019, 5, afi52-101.pdf.
[31] Moscheta et al., "Health Care Provision in Brazil," 369
[32] Moscheta et al., "Health Care Provision in Brazil," 371.
[33] Moscheta et al., "Health Care Provision in Brazil," 376.
[34] Moscheta et al., "Health Care Provision in Brazil," 375.
[35] Robert Stains, "Cultivating Courageous Communities through the Practice and Power of Dialogue," Mitchell Hamline Law Review 42, no. 5 (2016): 1528-1529, http://open.mitchellhamline.edu/mhlr/vol42/iss5/5; DeTemple et al., "Disruption, Dialogue, and Swerve," 285.
[36] Moscheta et al., "Health Care Provision in Brazil," 371.
[37] Moscheta et al., "Health Care Provision in Brazil," 372-373.
[38] Moscheta et al., "Health Care Provision in Brazil," 370.
[39] Moscheta et al., "Health Care Provision in Brazil," 373.
[40] Vij Mali Nidhi, "A Comparative Assessment of Maternal Health and Maternal Health Policies in India and the U.S.: Need to Transition from a Biomedical Model to a Biopsychosocial Model for Maternal Health Policies," Journal of Health and Human Services Administration 40, no. 4 (2018): 464-465.
[41] Moscheta et al., "Health Care Provision in Brazil," 373-376.
[42] Moscheta et al., "Health Care Provision in Brazil," 372.
[43] Moscheta et al., "Health Care Provision in Brazil," 376.
[44] Moscheta et al., "Health Care Provision in Brazil," 376.
[45]Geert Hofstede, Culture's Consequences : Comparing Values, Behaviors, Institutions, and Organizations Across Nations, 2nd ed., (Thousand Oaks, Calif: Sage Publications, 2001), 79.
[46] Ting-Toomey, "Intercultural Conflict Competence, 105-106.
[47] Moscheta et al., "Health Care Provision in Brazil," 374.
[48] Moscheta et al., "Health Care Provision in Brazil," 373.
[49] Moscheta et al., "Health Care Provision in Brazil," 372.
[50] Moscheta et al., "Health Care Provision in Brazil," 374.
[51] Moscheta et al., "Health Care Provision in Brazil," 375.
[52] Moscheta et al., "Health Care Provision in Brazil," 375.
[53] Moscheta et al., "Health Care Provision in Brazil," 377.
[54] Moscheta et al., "Health Care Provision in Brazil," 373.
[55] Essential Partners, "Race in America: A Dialogue Guide from Essential Partners" (Essential Partners, 2020), 4-7.
[56] Essential Partners, "Race in America," 9.
[57] Essential Partners, "Race in America," 10.
[58] There are other organizations that provide one-page recommendations for conducting difficult conversations, which might be useful for instructors and/or curriculum developers: https://heterodoxnew.wpengine.com/wp-content/uploads/2020/03/The-HxA-Way-Poster.pdf.
[59] Patrick Lencioni, The Five Dysfunctions of a Team: A Leadership Fable, 1st ed (San Francisco: Jossey-Bass, 2002), 195.
[60] "Accelerate Change or Lose," August 2020, 3-6, CSAF-22-Strategic-Approach-Accelerate-Change-or-Lose-31-Aug-2020.pdf (airforcemag.com)

Bibliography

Becker, Carol, Laura Chasin, Richard Chasin, Margaret Herzig, and Sallyann Roth. "From Stuck Debate to New Conversation on Controversial Issues: A Report from the Public Conversations Project." Journal of Feminist Family Therapy 7, no. 1–2 (November 21, 1995): 143–63. https://doi.org/10.1300/J086v07n01_14.

Bitter, James Robert. Theory and Practice of Family Therapy and Counseling. Second edition. Belmont, CA: Brooks/Cole, 2014.

Chasin, Richard, Margaret Herzig, Sallyann Roth, Laura Chasin, Carol Becker, and Robert R. Stains. "From Diatribe to Dialogue on Divisive Public Issues: Approaches Drawn from Family Therapy." Mediation Quarterly 13, no. 4 (June 1996): 323–44. https://doi.org/10.1002/crq.3900130408.

DeTemple, Jill, and John Sarrouf. "Disruption, Dialogue, and Swerve: Reflective Structured Dialogue in Religious Studies Classrooms." Teaching Theology & Religion 20, no. 3 (July 2017): 283–92. https://doi.org/10.1111/teth.12398.

Ellis, Donald. "Talking to the Enemy: Difficult Conversations and Ethnopolitical Conflict," 2020. https://doi.org/10.34891/1FTN-G083.

Freeman, Sally A., Stephen W. Littlejohn, and W. Barnett Pearce. "Communication and Moral Conflict." Western Journal of Communication 56, no. 4 (December 1992): 311–29. https://doi.org/10.1080/10570319209374421.

Gower, Katherine, Llewellyn Cornelius, Raye Rawls, and Brandy B. Walker. "Reflective Structured Dialogue: A Qualitative Thematic Analysis." Conflict Resolution Quarterly 37, no. 3 (March 2020): 207–21. https://doi.org/10.1002/crq.21271.

Grant, Adam M. *Think Again: The Power of Knowing What You Don't Know*. New York, New York: Viking, 2021.

Hofstede, Geert. *Culture's Consequences: Comparing Values, Behaviors, Institutions, and Organizations across Nations*. 2nd ed., Thousand Oaks, Calif: Sage Publications, 2001.

Lencioni, Patrick. The Five Dysfunctions of a Team: A Leadership Fable. 1st ed. San Francisco: Jossey-Bass, 2002.

McCorkle, Suzanne, and Melanie Reese. Personal Conflict Management: Theory and Practice. 2nd edition. New York: Routledge, Taylor & Francis Group, 2018.

Morey, Jerad. "Not Changing Minds but Softening Hearts." *Creative Nursing* 19, no. 4 (2013). https://search-proquest-com.lomc.idm.oclc.org/scholarly-journals/not-changing-minds-softening-hearts/docview/1499115251/se-2?accountid=14746.

Moscheta, Murilo S, Laura V Souza, and Manoel A Santos. "Health Care Provision in Brazil: A Dialogue between Health Professionals and Lesbian, Gay, Bisexual and Transgender Service Users." Journal of Health Psychology 21, no. 3 (March 2016): 369–78. https://doi.org/10.1177/1359105316628749.

Nidhi, Vij Mali. "A Comparative Assessment of Maternal Health and Maternal Health Policies in India and the U.S.: Need to Transition from a Biomedical Model to a Biopsychosocial Model for Maternal Health Policies." Journal of Health and Human Services Administration 40, no. 4 (2018): 462-498.

Pronin, E. "How We See Ourselves and How We See Others." Science 320, no. 5880 (May 30, 2008): 1177–80. https://doi.org/10.1126/science.1154199.

Stains, Robert. "Cultivating Courageous Communities through the Practice and Power of Dialogue." Mitchell Hamline Law Review 42, no. 5 (January 1, 2016). https://open.mitchellhamline.edu/mhlr/vol42/iss5/5.

Stone, Douglas, Bruce Patton, and Sheila Heen. *Difficult Conversations: How to Discuss What Matters Most; [Updated with Answers to the 10 Most Frequently Asked Questions about Difficult Conversations]*. 2. ed., 10. anniversary ed., now Updated with a new chapter. Penguin Book Psychology/Business. New York: Penguin Books, 2010.

Ting-Toomey, Stella. "Intercultural Conflict Competence as a Facet of Intercultural Competence Development: Multiple Conceptual Approaches." In The Sage Handbook of Intercultural Competence. Edited by Deardorff, Darla K. Thousand Oaks, CA: Sage Publications, 2009.