Why is yogurt good for you? Because it has live cultures

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Introduction

Learning about and understanding any culture different from our own can be a daunting task. Cultural sensitivity and competence are a necessity for clinicians and researchers given the increasingly diverse clientele served by speech-language pathologists (SLPs), audiologists, and speech-language and hearing scientists. So where does one begin when attempting to understand and becoming aware of the many cultural variables that can influence a clinical interaction? Through this article, we hope to answer this question by providing a framework for understanding cultural diversity and the dire need for cultural competence in our professions.

The goal of this article is to stimulate discussion and reflection among ASHA's special interest division members about diversity-related issues within the topical focus of each division. For instance, members of Division 10 on Higher Education might discuss recruitment and retention of minority students in speech-language pathology and audiology, instructional strategies to facilitate success for nontraditional learners, and access to postsecondary education for students with disabilities. Similarly, members of Division 12 on Augmentative and Alternative Communication (AAC) might write about differences in clients' perceptions of and attitudes towards using an AAC device.

Background – MIB and K&S document

Within ASHA, the Multicultural Issues Board (MIB) has a three-pronged role: it acts as an advisor, an advocate, and an overseer for the Association's membership on issues of concern for diverse populations. MIB's mission is to ensure that systems are in place that include a consideration of the cultural, linguistic, and professional needs of certified members of ASHA, as well as the needs of students, consumers of speech, language, and hearing services, and the general public. The MIB is charged with reviewing and recommending policies and actions for ASHA members that pertain to diverse populations. As we know, historically, individuals from diverse populations who evidence communication delays or disorders and swallowing disorders may have been underserved. These individuals can be identified by their age, gender or gender identification, language, religion, race or ethnicity, national origin, disability, sexual orientation, and socioeconomic status. Increasing the availability and quality of services for persons in multicultural communities is an essential component of the MIB's charge. Facilitating enhanced knowledge and skills about providing services to diverse populations by ASHA members, is another major focus of the MIB. Finally, the MIB promotes research and education that is relevant to the communication needs, differences, delays, and disorders of persons within multicultural communities.

Recently, the MIB authored a knowledge and skills document for speech-language pathologists and audiologists on the provision of culturally and linguistically appropriate services (ASHA, 2004). Included in this document is a detailed explanation of issues and areas of expertise that comprise cultural and language competency. The knowledge and skills needed by clinicians to

serve members of diverse groups are identified and can be used to create an educational plan to fill gaps in one's own knowledge and skill base. Current terminology also is listed and defined in this document, available on the ASHA website at: **http://www.asha.org/NR/rdonlyres/BA28BD9C-26BA-46E7-9A47-5A7BDA2A4713/0/v4KScultlinguistic2004.pdf**

Our Cultures

Given this background, let us begin our discussion with one definition of the term 'culture'. Bates and Plog (1990) define culture as "a system of shared beliefs, values, customs, behaviors, and artifacts that members of a group use to cope with their world and one another, and that are transmitted from one generation to another through learning". It is clear from this definition that culture has many parameters – some overt and some covert.

Appreciating culture and its multiple parameters is crucial for understanding typical and atypical communication, and for providing culturally sensitive counseling, assessment, and intervention services. Because any culture is complex and multi-faceted, it is important to begin by becoming aware of the key parameters that characterize a culture. Richard Brislin, a pre-eminent cultural anthropologist describes eight such distinctive parameters of a culture (Brislin, 1994). These parameters are:

1. the collectivist-individualist dimension (the degree to which a group or an individual is considered the key unit of society)
2. views of time and space (event-time versus clock-time orientation, use of personal space)
3. language and communication styles
4. roles (for example, gender roles, role of elders, etc)
5. importance of work
6. class and status
7. rituals and superstitions and
8. beliefs and values.

Several cultural identities influence a client's perceptions and behavior in a clinical interaction. Some of these identities are: age, gender, race or ethnicity, occupation, sexual orientation, presence of a disability, literacy and education, socio-economic status, geographical region, and religious or spiritual beliefs. Once we have become aware of and knowledgeable about the composite parameters of a culture, we need to realize that differences exist between individuals from different cultures, and among individuals from the same culture. It is this within- and between-group variability that results in every individual being distinct in some way. Thus, we can debunk the notion that only individuals from a different race or ethnicity are "culturally diverse". In fact, every client and every clinician is culturally diverse in some way or another.

Cultural Competence

Having discussed some key elements that make cultures diverse, let us examine the notion of cultural competence and what it entails. Most importantly, cultural competence is best considered a developmental process because it requires a commitment to life-long learning and continuous enhancement of our **knowledge**, **skills**, and **attitudes**. **Knowledge** refers to the information or content that we need to know in order to become culturally competent. **Skills** refer to what we should be able to do with our knowledge and how we should apply it in our practice of

the professions. Finally, **attitudes** refer to focusing on the kind of professionals we wish to be and the values we wish to embrace as we strive for cultural competence.

In the focus on knowledge, skills, and attitudes, cultural competence does not differ from clinical competence. As conscientious and ethical clinicians, we stay abreast of the latest developments in our chosen areas of expertise. We pursue professional training, continuing education, and opportunities to collaborate with experts to enhance our knowledge and skills. We also cherish certain values such as ethical practice and respect for all clients. Becoming culturally competent requires the very same consistent commitment to excellence. For instance, we would not be able to competently administer the Boston Diagnostic Aphasia Examination (BDAE) to a client without reading the manual and scoring guidelines, studying the forms, observing a colleague administer the test, and practicing to administer the test. Similarly, we will not be able to conduct an ethnographic interview or assess a client's level of acculturation without the requisite knowledge and skills and due diligence in learning these specific techniques.

As professions, we need to broaden our scope of competent and ethical clinical practice to encompass culturally sensitive interactions in the clinic, classroom, and workplace. In a recently authored statement, ASHA's Board of Ethics (ASHA, 2004), made a coherent and compelling case for cultural competence being directly related to principles mandated by our professional Code of Ethics. For instance, Principle of Ethics I, Rule C urges us to be non-discriminatory with respect to culturally and linguistically diverse (CLD) persons, in the delivery of professional services, or in the conduct of research or scholarly activity. Similarly, Rules A and B of this same principle stress the emphasis on competent service delivery and effective use of referrals and resources to provide the highest quality of services. Other ethical principles and their implications for cultural competence also are discussed in this statement.

Stages of Cultural Competence – A Framework

It may be useful to think of culturally competent practice in three overlapping stages of ***Awareness, Application***, and ***Advocacy***[1] (University of Arizona: National Faculty Center, 2004). Initially, in the *Awareness* stage, clinicians must invest time in understanding culture and its multiple parameters followed by first identifying their own culture and reflecting on their own beliefs, values, and stereotypes. Once clinicians are aware of perceptions, values, and other elements of their own cultures, they are better positioned to seek similar information about their clients' cultures and perceptions. After this *Awareness s*tage has begun and clinicians possess the knowledge about their own cultures - and those different from their own, they can begin to apply this knowledge. This can be achieved by infusing this knowledge into their interviewing, assessment, counseling, and treatment approaches.

1- The National Faculty Center (NFC) at the University of Arizona is supported by a congressional award managed by the Department of Education. The mission of the NFC is to teach college faculty to better facilitate the success of diverse students by promoting learner-centered education. NFC activities are structured at multiple levels in a framework of Awareness, Application, and Advocacy, developed by a leadership team that includes the first author. This framework has been adapted, with permission, for use in the context of this article.

The *Application* stage emphasizes translating knowledge about cultural and linguistic diversity into appropriate skills and practices that impact service delivery to diverse clients. For

instance, consider that an SLP attends a cultural competence seminar and learns of the difference between a high-context and a low-context culture (Hall, 1969). The Native American culture is a good example of a high-context culture, where situational nuances are very important in all interactions. Communication with persons from these cultures may include silence and nonverbal communication as critical elements used to convey messages. In contrast, many European cultures are low-context cultures. In these cultures, explicit spoken and written communication is given utmost importance.

Given this difference between high- and low-context cultures, a clinician can infer that a client from a low-context culture may be comfortable completing a detailed case history form at home prior to ever meeting a clinician. On the other hand, a client from a high-context culture would more likely prefer to first meet the clinician and initiate a relationship before providing detailed personal information. Further, clients from high-context cultures might provide more detailed information if a clinician uses ethnographic interviewing techniques (Westby, Burda, & Mehta, 2003). Similarly, rules for verbal and nonverbal communication vary significantly across cultures. So, for example, clinicians cannot make assumptions about the appropriateness of addressing a client by his/her first name, should be cautious when joking during therapy, and would want to think twice before identifying a client's lack of eye contact during conversation as evidence of impaired pragmatics. Caution also is warranted when making assumptions about a child's parents or family situation. For instance, an Asian-American child might have Caucasian parents, or his/her parents might be a gay or lesbian couple.

After applying the knowledge gained in the *Awareness* stage to become culturally sensitive practitioners in the *Application* stage, we are poised to enter the *Advocacy* stage. At this point, we have the knowledge and skills to collectively champion culturally competent practice of the professions. This extends to our role as clinicians, clinical supervisors, instructors, researchers, and mentors. For instance, cultural competence pertains to aspects such as: 1) recruiting participants for a research study that are representative of the local demographics, 2) developing clinical supervision guidelines for diverse student clinicians, and 3) supporting initiatives to prepare graduate students to better serve diverse clients by providing coursework and clinical training opportunities. The *Advocacy* stage involves complementing our knowledge and skills about diversity with an attitude of actively promoting diversity. To become advocates, we must make a strategic shift and take action to create systemic change. This requires facilitating the success of local and national diversity-focused initiatives through sustained participation, disseminating information, and conducting outreach activities to other stakeholders within our institutions.

Fine-tuning the Framework

We are now ready to take our discussion a step further beyond the knowledge and skills required to be culturally competent practitioners. In addition to acquiring knowledge and skills, a commitment to cultural competence requires us to make attitudinal shifts. Tervalon and Murray-Garcia (1998) refer to one aspect of this attitudinal shift as "cultural humility". Cultural humility embodies such principles as a life-long commitment to reflection, self-evaluation and self-critique while admitting limits to one's knowledge and being teachable. This dimension of cultural humility involves respectful, client-centered practice in which health care providers remain flexible in

assessing and treating clients, share the decision-making with clients, and consistently advocate for the patient.

When working with CLD clients, it is likely that despite our expertise in a content area, we may not have successful outcomes, unless we present our recommendations in a culturally and linguistically appropriate manner. For example, depending on how a client perceives illness, disorders, and disability, he/she might have different beliefs about what causes a disorder or constitutes appropriate treatment (Kleinman, 1988) and therefore, not seek out certain types of services. Often, as experts in our areas of practice, we neglect that our CLD clients also are experts in their cultural beliefs and perspectives and that we have valuable opportunities to learn about them, from them.

Cultural humility targets a one-on-one, open dialog with the client, keeping his/her best interests as the focus of service provision. According to Linda Hunt (2001), "following the principle of cultural humility, a culturally competent provider should be open and flexible enough to be able to identify the presence and importance of differences between her orientation and that of each patient, and to explore compromises that would be acceptable to both." What cultural humility seems to boil down to is the "golden rule" that is expressed in a variety of cultures around the world. It is that one treats others as one would wish to be treated under the same circumstances. Therefore, it would seem that in its simplest form, this concept of humility has a place not only inside the clinic, classroom, and workplace but in all our interactions.

In 1991 a movie was released entitled "The Doctor". The plot revolves around a successful, egocentric surgeon who is eventually diagnosed with laryngeal cancer. The doctor, now patient, gets a taste of his own medicine as he is admitted for treatment in his own hospital. The experience is less than optimum or pleasant. As a result, the doctor gains insight and respect for his patients that he had never before experienced. Changed by this walking-in-the-moccasins-of-another experience, the doctor vows that none of his residents will be insensitive and unaware of the needs of their patients. As the movie ends, the doctor is supervising other 'would-be doctors' in an exercise where they are role playing as patients to better understand their patients' perspectives.

Conclusions

In summary, we are a remarkably diverse nation as indicated by the latest census (U.S. Bureau of Census, 2000). Projected demographic trends indicate that this heterogeneity will continue to grow, however, the currently estimated numbers of bilingual/bicultural professionals (in training and practice) lag behind considerably. These trends call for us, as a discipline, to embrace the opportunities and the challenges of providing competent, culturally sensitive services to an increasingly CLD clientele. Ultimately, in our pluralistic society, cultural competence in clinical practice is no longer just an 'interesting topic' but an absolute imperative that cannot be ignored.

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