CLD Corner—Hand Me My Glasses: Learning to Identify Our Biases

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There continues to be a focus in our field on becoming more culturally competent clinicians. Federal and state legislation, codes of ethics, and diversity initiatives challenge us to learn about accents and dialectal differences, learn how to assess and treat bilingual or multilingual clients, and respect our client's backgrounds. While the client is a very large part of the evidence-based practice triangle, so is the clinician. Understanding our own backgrounds and perspectives helps us to be more cognizant and aware of our daily interactions with other colleagues and clients. In this article, I hope to provide an avenue for clinicians to reflect on their personal experiences and how these might impact interpersonal communication and clinical service delivery.

Defining Diversity

Lustig & Koester (2013) define culture as “a learned set of shared interpretations about beliefs, values, norms, and social practices, which affect the behaviors of a relatively large group of people.” Mannix and Neale (2005) have compiled a list of multiple dimensions in which interprofessional teams can be diverse. These include: social identity (gender, ethnicity, religious identity, sexual orientation); knowledge and skills (education, experience, knowledge); values and beliefs (family of origin, generation, personal experiences); personality (temperament, interaction styles); organizational and community (status in an organization, income/resources); andsocial networks (friends, family, colleagues). Culture and dimensions of diversity can be sources of mismatches between clinicians, colleagues, and clients. However, we aren’t always cognizant of these mismatches.

Implicit Bias

I teach a graduate course in collaboration as related to serving bilingual and multicultural populations. As part of this course, I invite my students to participate in some introspection before they learn tools and strategies to help build their cultural competence. Before we focus on how our clients are different from us or even how our colleagues are similar/different to each other, we look inward. What are the lenses through which we see the world? When we first meet an individual, what are our initial impressions of them? What implicit biases do we carry?

Implicit or unconscious bias refers to “perceptions and reactions outside of our conscious control” (Weiss, Tillin & Morgan, 2018). When we see someone for the first time, our mind automatically makes assumptions about them, whether surface-level characteristics such as gender, race, age, profession, physical appearance, temperament, or socioeconomic status, or deep-level dimensions of diversity, such as preferences, values, and personality traits (Harrison, Price, Gavin, & Florey, 2002).

Implicit bias can be a source of tension between client and provider as well as members of interprofessional teams. In terms of service delivery, unconscious assumptions about what our clients value or their backgrounds can impact assessment decisions, treatment recommendations and buy-in, or adherence to a recommended course of treatment. In terms of collaboration with other professionals, implicit bias can cause disagreements and misunderstandings.

Beyond Language, Ethnicity, or Race

Notice Lustic and Koester’s definition of culture does not explicitly state language, ethnicity, or race. While these three are powerful influences as to who we are and are strong components of what we perceive as culture, it is important to remember that members of different ethnic, linguistic, and/or racial groups are not homogeneous. Each individual is unique, and the collection of their

experiences has shaped them into who they are today. This is why it is even more important to be mindful of our unconscious biases. Just because a person looks, talks, or acts a certain way, this should not cause us to make decisions about who they are and what “culture” they represent.

There are several continua of values that may distinguish key beliefs and impact intercultural communication beyond traditional linguistic, ethnic, or racial group characteristics. Here are a few of the continua that I think are relevant to our profession.

Ambiguity tolerance: This refers to how much ambiguity is accepted. On one end, high-ambiguity tolerant individuals are comfortable with ambiguous on unknown situations and encourage different perspectives. Low-ambiguity tolerant individuals go to great lengths to avoid uncertainty, experience anxiety when faced with unknowns, and adhere to concrete and specific rules for communication.

Context: On one end are those who prefer high context, in which meaning is implied by physical setting or something internalized by individuals, and on the other end are individuals who rely on low context, in which information is expected to be explicit and precise.

Orientation: Individuals from individualistic orientations are focused on individual goals. They value autonomy, uniqueness, self-realization, and self-expression. They take care of immediate family members and themselves and have a high focus on independence and privacy. On the other end is the collectivist orientation, in which the emphasis is on interdependence and benefit of a group as a whole. An individual’s responsibility extends beyond the nuclear family, and there is a high value placed on social unit membership.

One of the best examples I have seen of this was an exercise based on Miller & Harwood’s study of feeding practices in mothers from different cultures (2002; Rothstein-Fisch, 2003; Zepeda, Gonzalez-Mena, Rothstein-Fisch, & Trumbull, 2012). During one exercise, they show pictures of two different children eating, one in a high chair eating food from a bowl using its hands and the other child being spoon-fed by its mother. Then they ask audience members to reflect on why each child’s mother would think she was doing a good job. You can guess that the responses were varied. The authors report that respondents likely identifying with more individualistic backgrounds thought the mother allowing the child to self-feed was fostering important independence skills allowing the child to explore food and develop motor and sensory skills. Respondents likely identifying with collectivist cultures thought the mother spoon-feeding the child was communicating care, establishing a bond with the child, ensuring proper nutrition, and that the child was learning manners or obedience (Rothstein-Fisch, 2003; Zepeda, Gonzalez-Mena, Rothstein-Fisch, & Trumbull, 2012). Are any of these wrong? No, of course not. But this exercise made me aware of my own implicit biases and preferences for how I fed my own children (and how others in my social and professional circles would agree or disagree) as well as what recommendations I was likely to make to one of my client’s families.

We can agree that our experiences, education, and personal choices shape our cultural perspectives and our perception of the world. It is important to note that we as clinicians or our clients could be on one end or another or anywhere in between in terms of any of these continua. I have found myself in many situations in which mismatches in one (or all three) of these domains have caused misunderstandings or relational strains both in personal and professional environments. Taking a step back to analyze the “why” behind conflict has helped me realize that taking someone else’s perspective helps reduce conflict and promote more compassion and understanding. Being aware of our “culture” and background and how we have (or haven’t) internalized them impacts our view of others (Friend & Cook, 2017; Tuleja, 2014). It is the lens through which we see our fellow SLPs, colleagues, and the clients we serve. Being aware of these potential differences is one of the first steps we can take to help mitigate our unconscious bias.

Below are several resources you can explore.

Self-assessment:

- Take the Implicit Associations Test (Project Implicit)
- Take ASHA's Personal Reflection on Cultural Competence

Self-reflection:

Take a moment and reflect on your own experiences:

- What are some ways in which your upbringing has shaped you into who you are today?
- How have your experiences shaped your values?
- Do they impact your communication style?
- Are there values you hold that are chosen rather than learned?
- Are there times when you have identified with one "cultural group" even if it's incongruent with your social, ethnic, racial, linguistic, or religious background?
- Can you belong to multiple cultural groups at one time?
- How do these experiences shape how you view or interact with colleagues?
- How does your cultural/socio-economic background impact your interactions and recommendations to clients?

Education:

- Look at Your Blind Spots- Arora, 2017
- Build an Inclusive Speech Room - Le Baron, 2015
- ASHA's Resources on Cultural Diversity:
    - Cultural Competence
    - Examples of Cultural Dimensions

Summary

Individually, we bring a rich wealth of experiences that have shaped us into the people and clinicians we are today. Some of those may be in direct alignment with others we interact with, and others may be in conflict. It is important to not discount the experiences you have had but to be aware that every individual around you may not share your background, even if on the surface it may look like they do. Being conscious of this may help us remember to take a step back, ask lots of questions, and be open to learning from others. Our colleagues will thank us for being more accepting of differences in experience, personalities, and communication styles. Our clients will thank us for being open and valuing their personal and family choices in ways that will enhance their overall quality of life as we help them maximize their skills in communication.

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The CLD Corner was created in an effort to provide information and respond to questions on cultural and linguistic diversity (CLD). Questions are answered by members of the TSHA Committee on Cultural and Linguistic Diversity. Members for the 2019-2020 year include ***Andrea Hughes****, MS, CCC-SLP (co-chair);* ***Irmgard R. Payne****, MS, CCC-SLP (co-chair);* ***Adanna Burrell****, MS, CCC-SLP;* ***Mary Bauman-Forkner****, MS, CCC-SLP;* ***Isabel Garcia-Fullana****, MA, CCC-SLP;* ***Daniel Ibarra****, MS, CCC-SLP;* ***Amy Leal Truong****, MS, CCC-SLP;* ***Mirza J. Lugo-Neris****, PhD, CCC-SLP;* ***Maria Resendiz****, PhD, CCC-SLP;* ***Diana Vega Torres****, BS, (graduate student member); and* ***Chaya Woolcock****, MS, CCC-SLP. Please submit your questions to TSHACLD@gmail.com and look for responses from the CLD Committee on TSHA's website and in the* Communicologist*.*