CLD corner

Addressing Cultural and Linguistic Diversity in Clinical Practice:

What Do You Know About Cultural Competence?

By: TSHA Cultural and Linguistic Diversity Committee Members

The CLD Corner was created in an effort to provide information and respond to questions on cultural and linguistic diversity. Questions are answered by members of the Texas Speech-Language-Hearing Association (TSHA) Committee on Cultural and Linguistic Diversity (CLD). Members for the 2012-2013 year include **Lisa Carver**, MA, CCC-SLP (co-chair); **Ivan Mejia**, MA, CCC-SLP (co-chair); **Scott Prath**, MA, CCC-SLP; **Christina Wiggins**, MS, CCC-SLP; **Brittney Goodman**, MS, CCC-SLP; **Kristin Knifton**, MA, CCC-SLP/A; **Sarah Panjwani**, MS, CFY-SLP; **Mary Bauman**, MS, CCC-SLP; **Phuong Palafox**, MS, CCC-SLP; **Marisol Contreras**, BA; and **Alisa Baron**, BA.

Submit your questions to Ivan Meija at ivanmejia@bilingualspeech.org, and look for responses from the CLD Committee on TSHA's website and in the *Communicologist.*

The CLD Committee is now offering half- and full-day trainings for school districts, education service centers, university programs, and other agencies on Assessment and Intervention with CLD Populations. For information, contact Ivan Meija at ivanmejia@bilingualspeech.org.

Over the past two years, the Texas Speech-Language-Hearing Association (TSHA) Cultural and Linguistic Diversity (CLD) Task Force (now called the TSHA CLD Committee) has presented articles that have focused on the various features of specific languages during assessment and treatment. We have received a lot of positive feedback from our readers about how useful these articles have been, and the committee is delighted to present a new series that we hope will be equally relevant and practical for you to use in your daily practice.

In 2007, the U.S. Department of Labor, Bureau of Labor Statistics (2007), indicated that general opportunities for speech-language pathologists (SLPs) are expected to grow. However, there is also a shortage of SLPs to provide the needed services (Mc Neilly, 2006). There is also a paucity of qualified SLPs who speak a language other than English (U.S. Department of Labor, Bureau of Labor Statistics, 2007). For instance, as of 2002, the American Speech-Language-Hearing Association (ASHA) reported that only slightly more than two percent of certified speech-language pathologists were of Hispanic origin.

According to a recent ASHA survey of speech-language pathologists and audiologists, 1,145 SLPs and audiologists defined themselves as bilingual service providers (10.9 percent of the total). This contrasts with 34.8 percent of households in Texas identifying as bilingual. When asked specifically about the Spanish language, 981 SLPs and audiologists stated that they provide services in the Spanish language (9.4 percent), compared with 29.6 percent of Texas households speaking Spanish in the home (ASHA, 2012).

Data from the 2000 U.S. Census indicated that 31.2 percent of the Texas population of peo-

ple over the age of five spoke a language other than English and that 13.9 percent reported that they spoke English "less than very well." These figures grew to 33.9 percent by 2007, with 25.7 percent speaking English either "not well" or "not at all" (Shin and Bruno, 2003).

Texas is home to at least 145 languages, and the most common languages spoken in Texas were listed as English, Spanish, Vietnamese, German, and Chinese (U.S. English Foundation, 2012). Although American Sign Language (ASL) is not considered a separate language for the purposes of the U.S. census, recent estimates place the language, which has its own distinct vocabulary, grammar, and culture, as being about the fourth most commonly used language in the U.S. (Mitchell, 2004).

Due to the increasing diversity of the U.S. population and the ever-changing landscape of demographics in Texas, service providers are increasingly more likely to encounter individuals from unfamiliar backgrounds and with experiences much different from their own. As a result, service providers may inadvertently offend clients while providing services that dismiss cultural boundaries or norms. These inadvertent offenses may occur because of a paucity of knowledge and limited or no previous experiences with individuals from a particular cultural background. Some factors that shape these cultural differences include pre-existing health conditions, access to healthcare, general cultural practices, attitudes towards disability and healthcare, beliefs about health and wellness, and stereotypic beliefs of disability, poverty, and education.

As mentioned above, another factor that contributes to the complexity of providing services to clients from different backgrounds is the issue of the service provider's own cultural proficiency or cultural competence. Cross, Bazron, Dennis, and Isaacs (1989) as cited by Sutton (2000) define cultural competence as "a set of congruent behaviors, attitudes, and policies that come together as a system, agency, or those professionals use to work effectively in cross-cultural situations. The word 'culture' is used because it implies the integrated pattern of human thoughts, communications, actions, customs, beliefs, values, and institutions of a racial, ethnic, religious, or social group. The word competence is used because it implies having a capacity to function effectively.

"Understanding patients' diverse cultures — their values, traditions, history, and institutions — is not simply political correctness. It is integral to eliminating healthcare disparities and providing high-quality patient care. In a society as culturally diverse as the United States, physicians and others in healthcare delivery need sensitivity toward diverse patient populations and work to understand culturally influenced health behaviors." (Sutton, 2000)

Individual practitioners have many tools at their disposal to help them develop their cultural competency. Tools include appreciation of others' cultures, self-assessment, sensitivity to others' changing levels of comfort in changing situations, sharing your newly learned or existing methods of addressing cultural differences with others in your organization, and changing your service delivery to meet the changes of your changing patient population. As written by Sutton (2000), "There is a vast difference between a group that merely preaches diversity and a group that lives it."

One of the integral steps to making a positive change toward assessing, diagnosing, and providing therapy to culturally diverse populations is self-assessment. ASHA (2012) and others (Goode, 2012) provide tools for you to assess your cultural proficiency. Rust and colleagues (2006) proposed "A CRASH Course in Cultural Competence." In their discussion, which also includes a self-assessment tool, they define their CRASH acronym as follows:

Culture: The importance of shared values, perceptions, and connections in the experience of health, healthcare, and the interaction between patient and professional.

Respect: Understanding that demonstrations of respect are more important than gestures of affection or shallow intimacy. Finding ways to learn how to demonstrate respect in various cultural contexts.

Assess: Understanding that there are tremendous within-group differences, ask about cultural identity, health preferences, beliefs, and understanding of health conditions. Assess language competency, acculturation-level, and health literacy to meet the individual's needs.

Affirm: Recognizing each individual as the world's expert on his or her own experience. Being ready to listen and to affirm that experience. Reframing cultural differences by identifying the positive values behind behaviors we perceive as different.

Sensitivity: Developing an awareness of specific issues within each culture that might cause offence or lead to a breakdown in trust and communication between patient and professional.

Self-Awareness: Becoming aware of our own cultural norms, values, and hot-button issues that lead us to misjudge or miscommunicate with others.

Humility: Recognizing that none of us ever fully attains cultural competence, but instead making a commitment to a lifetime of learning, of peeling back layers of the onion of our own perceptions and biases, being quick to apologize and accept responsibility for cultural missteps, and embracing the adventure of learning from others' firsthand accounts of their own experience.

(Griffer, 2009)

Collectivism Vs. Individualism

Another parameter for assessing one's cultural competence involves understanding the relationship between individuals within a group. Comprehension of relationships between individual and group dynamics is generally referred to as individualism versus collectivism. Individualism prioritizes the self as the primary factor when interacting within a group and in the decision-making process. Collectivism generally concentrates on group identity, with the individual's wants and needs absorbed by the whole group. Individualism and collectivism is embedded in cultural identity. For example, the United States and most western European countries promote individualistic values. However, many other cultures, including those from Asia, Latin America, and many from the Middle East, override the goals of the individual for those that are primarily beneficial to the group.

Why is this important to speech-language pathologists? ASHA and the Council for Exceptional Children states that there are three clinical considerations when implementing services (ASHA *Leader*, 2003):

- Professional evidenced-based practices
- Professional skills and wisdom
- Family and cultural values

As residents living in an individualistic-dominant country, service providers need to take into account the beliefs of clients and their families living a collectivistic lifestyle. For example, a speech-language pathologist may go into the home to work with a child with language impairment. In reality, the SLP may be working with the child but also including and enlisting the help of his four siblings and parents during the session in order to gain the best participation and progress for the child receiving therapy. Therefore, within the lesson plan, a consideration for involvement of family members is important to the values of the clients and assists with more successful therapy sessions. Moreover, after continual dialogue with the mother, the SLP may gain knowledge that the implementation of recommended communication strategies to assist the child may not be as important to the family as other more immediate problems, and therefore frequent modeling of these techniques to family members during sessions may be needed to increase carryover. It is the responsibility of the SLP to initiate communication with the parents to determine familial needs. The information exchange will guide the SLP to be sensitive to individualized differences and continue to provide high-quality services in a non-judgmental way.

Announcement!

Recently, the CLD Committee received information about Carla Aguilar, a researcher at the University of Alabama who has put together a survey to gather information about how SLPs complete communication evaluations for children who speak more than one language. If you are interested in participating in her survey, please contact Ms. Aguilar via email at cjaguilar@crimson.ua.edu.

This article has aimed to introduce and review some components that are critical to the development of healthcare providers' cultural competency. In future articles, we will attempt to provide details regarding some of the factors that should be considered by speech-language pathologists, audiologists, and others when working with those from culturally and/or linguistically different backgrounds. Topics will include poverty, implications of limited access to healthcare, health beliefs and practices, patient advocacy, and patient and caregiver empowerment. In addition, as part of our discussions, we will provide resources for service providers, patients, and their caregivers. ★

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