Addressing Cultural and Linguistic Diversity in Clinical Practice:

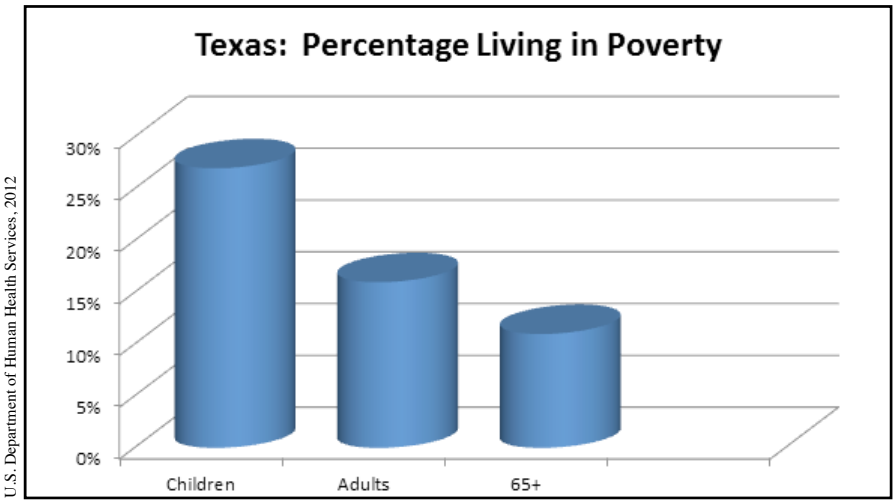
What Do You Know About the Culture of Poverty?

By: TSHA Cultural and Linguistic Diversity Committee Members

The members of the Texas Speech-Language-Hearing Association (TSHA) Cultural and Linguistic Diversity (CLD) Committee are **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.

The CLD Committee has presented articles that have focused on various ethnic and linguistic backgrounds. *Webster's Dictionary* defines cultures as "the customary beliefs, social forms, and material traits of a racial, religious, or social group" (Culture, 2012).We would like to focus on another important cultural group: clients from the culture of poverty. This article aims to provide a better understanding of poverty and practical strategies to use during clinical practice when working with clients from low socioeconomic status (SES) backgrounds.

What is poverty? Federal guidelines classify a family of four as living in poverty if the family's annual income is less than $23,050 (United States Census Bureau, 2012).The percentages of Texans living in poverty are reported by age in Table 1.



U.S. Department of Human Health Services, 2012

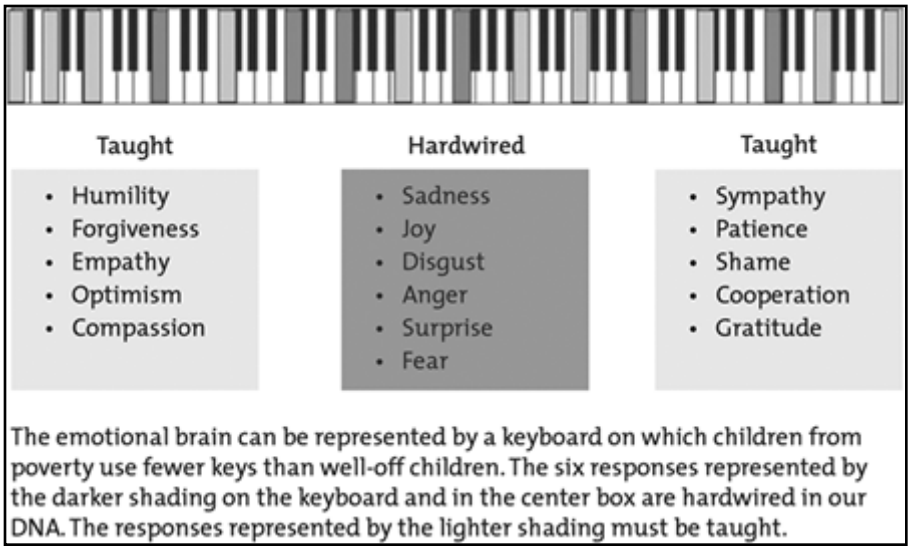
Prior to reading the following information, we want to acknowledge that not all members living in poverty demonstrate the following outcomes. However, in order to best serve our clients from low-SES environments, service providers should understand the potential effects of living in poverty.

Brain and Emotional Development

How does living in poverty affect a person? As service providers, we need to first understand the physiological and emotional implications of an individual growing up in poverty. There are differences in brain development between children from middle-income and low-income families. Cognitive functions affected by poverty include working memory, impulse regulation, and language skills (Noble, Norman, & Farah, 2005). These aforementioned skills affect all tasks of typical daily functioning. These cognitive lags are present through all stages of development, from infancy to adolescence to adulthood (Sameroff, 1998). Fortunately, the brain is an ever-changing, pliable organ that continually responds to input. Later in

this article we will provide strategies for positive cerebral development.

Stress is a part of our everyday lives. We all experience occasional stress that in the long run positively supports our immune system and our ability to cope and persevere. However, exposure to chronic stressors or high levels of persistent stress can be devastating to an individual's well-being. This type of exposure can impact one's physical, cognitive, social, and psychological well-being. Research has shown that individuals exposed to constant negative experiences are not able to achieve healthy growth. When meeting a family's physiological needs overwhelms caretakers, it is challenging for those caretakers to engage in a manner that is fruitful for a child's emotional and academic development. As a result, children living in poverty may not have optimal environments for meaningful learning opportunities (Yang, et al, 2003).



The emotional brain can be represented by a keyboard on which children from poverty use fewer keys than well-off children. The six responses represented by the darker shading on the keyboard and in the center box are hardwired in our DNA. The responses represented by the lighter shading must be taught.

Jensen, 2009)Services, 2012)

When discussing experiences that impact daily living, we must also understand how emotional development takes place. While feelings of sadness, joy, disgust, anger, surprise, and fear are inherent, other emotions must be explicitly taught. Compassion, which is a desire to alleviate another's distress (Merriam-Webster Online, 2012), is conveyed through actions. One can give money to a homeless man on the street or hug a companion when he or she is upset. The skills needed to show compassion must be modeled and demonstrated (Jensen, 2009). As service providers, we need to understand that certain behaviors are a direct result of active, deliberate teaching.

Lack of Experience and Exposure

Now that we have a better understanding of how poverty affects an individual's body and brain, we will address how lack of experience and exposure may impact daily functioning.

The adverse effects of poverty on language, reading, and school performance have been well-documented. What does it mean to live in an environment with language-rich exposure? Children from poverty who succeeded as readers experienced exposure to rich vocabulary, extended discourse, and cognitively and linguistically stimulating home and school environments (Dickinson & Tabors, 1991). Children exposed to fewer language-rich experiences (e.g., vocabulary, dialogue) hear only the most commonly occurring words (Wiezman, 2001). A study by Montgomery (2009) determined that successful readers in first grade have a receptive vocabulary of approximately 20,000 words. Poor first-grade readers, on the other hand, possess a receptive vocabulary of fewer than 5,000 words. Prior to kindergarten, a child in poverty averages a total of 25 home hours spent in reading experiences as opposed to children exposed to language-rich experiences who average 1,000 hours of reading at home (Whitehurst, 1997). In essence, language exposure is greatly limited for children living in poverty. Qualitatively, there are also differences in language use for professional families, working-class families, and families living in poverty.

Research has shown that children from low-SES environments watch more television and have less exposure to books and literacy opportunities compared to children from middle-income families (Kumanyika & Grier, 2006). This puts children from low-SES backgrounds at an educational or academic disadvantage.

Outcomes and Behavior

So what does this information mean to speech-language pathologists (SLPs)? When providing therapy or conducting assessments, it is imperative to understand the implications of working with children who live in poverty. It is also important to understand our personal views when working with clients. Some feel that poverty is a preventable outcome that can be improved by individual accountability. Others may feel that poverty is a result of various societal causes throughout history. Regardless, the caseloads for speech-language pathologists working with clients from low-SES backgrounds have increased, and there is a need for information on how to best conduct assessments and provide therapy to those clients (Roseberry-McKibben, 2001).

Early Language Experiences: Qualitative Differences

	Words heard per hour	Affirmatives per hour	Prohibitions per hour
Professional family child	2,153	32	5
Working class child	1,251	12	7
Welfare child	616	5	11

-Hart & Risley (1995)

With regard to assessment, we must understand the limitations of standardized assessment tools. More than likely, tests will be able to identify an area of deficit; however, tests are not able to determine the child's ability to learn. As an example, Suzy may receive poor scores on a language measure that, interpreted on face value, indicates evidence of a receptive and expressive language disorder. However, with additional information from her teachers and family, the speech-language pathologist discovers that Suzy has not had exposure to vocabulary related to following directions (e.g., prepositions, transitional words) and had limited experiences with literacy.

One effective assessment tool to differentiate between lack of exposure and a true language disorder would be dynamic assessment (Dynamic Assessment, 2012), which is a highly interactive method of assessment that takes into consideration the client's learning potential. When exposed to active learning strategies, are clients able to retain the information? If so, the client does not demonstrate a true language disorder. Instead, lack of exposure (due to culturally and linguistically diverse backgrounds or low-SES environments) contributed to the client's pool of knowledge. In other words, when clients are able to learn specific skills in a short amount of time with explicit teaching, they do not demonstrate a language impairment. So Joe may receive a score on a standardized language measure that would qualify him as an individual with a receptive and expressive language disorder; however, when given the opportunity to learn the vocabulary to follow directions, he was able to demonstrate the skill, which shows that Joe does not have a language impairment. Instead, he needed exposure to the skill set, which demonstrates how dynamic assessment is a method for differentiating between a true disorder and lack of exposure.

Emotional and social instability is commonly faced by low-SES children (Jensen, 2009). Young children require healthy learning and exploration for optimal brain development. Some teachers believe that behavioral deficits are due to a lack of manners or respect, but it is important to understand that these students have a narrower repertoire than we would expect.

Jensen (2009) created a CHAMPS Operating System that is good to keep in mind when working with children in poverty:

• Champion's Mindset – the successful attitude of "I can change, and I can learn new behaviors"

• Hopeful Effort — the drive and the emotional long-term effort to achieve

• Attentional Skills – the ability to stay focused for detailed, lasting learning as well as to resist impulsive shifts

• Memory – short-term and working visual and verbal capacity

• Processing – manipulate and manage sensory (visual, auditory, and tactile) input

• Sequencing – the use of strategy and organizational skills in ordering both tasks and items

Announcement!

Recently, the CLD Committee received information about Carla Aguilar, a researcher at the University of Alabama who has developed 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.

As service providers, we understand that poverty is a complex topic. As such, it is our professional responsibility to provide efficacious therapy and thorough, unbiased assessments to determine the presence of speech and language disorders. Behaviors demonstrated by children from low-SES environments often may be misinterpreted as non-compliance, limited social skill, or a lack of empathy. One's lack of knowledge also may be misinterpreted as a lifelong trait. Based on what is known about the effects of poverty, we now understand that there are potential avenues for change that allow us to understand that these effects are not necessarily permanent. In the section below, the reader will find effective strategies to implement when working with clients from poverty.

Strategies

1. Good Practice in Therapy

• Respect students in good and bad situations.

• Include students in the decision-making process.

• Use direct teaching processes.

• Be very specific in the steps and procedures needed to do something.

• Use mental models, which help translate between the sensory world and the abstract constructs.

• Avoid demeaning sarcasm. Children are very literal, and their ability to perceive and process figurative language develops over time. First, the child needs to recognize the statement as a discrepancy from the facts, and then they need to identify the speaker's communicative purpose. Kids detect sarcasm around the age of six but do not understand the humor until age 11 (Demorest, Silberstein, Gardner, & Winner, 1983).

• Model the process of organizational thinking. For example, say "First, we need to do this so that we have time for these next three activities."

• Discipline in a positive way, not by exerting power but by explaining your reasoning for why something needs to occur. For example, instead of saying "Finish these three cards now!," you may want to say, "If you finish this activity, we can play one of the games you like."

2. Social Skills

• Teach basic meet-and-greet skills, such as face your listener, maintain eye contact, smile, and shake hands.

• Include turn-taking skills when working in a group.

• Be inclusive. Use words like "our" and not a me-and-you model that reinforces a power hierarchy.

• Thank and praise students for even the smallest accomplishments and efforts every time you see them.

• Many SLPs give students toys or objects as rewards, but it may be prudent to give colorful pencils, erasers, crayons, rulers, and even small books and notebooks to enhance their academic experience.

• Apathetic or rude behaviors may reflect a sense of hopelessness or despair. Children may have limited control over their stressors, and they typically do not know how long those stressors will last.

• Incorporate role-playing, hands-on activities, physical activities, or games into your therapy.

• Include responsibilities and the importance of restitution when in the therapy room. A child can wipe off the white board every time they come in as a means of learning responsibility. If he or she says something inappropriate to you or another child, make sure that he or she does something positive as restitution to make up for the misbehavior.

3. Making Therapy Positive

• Create a positive environment, make therapy relevant, and share goals and objectives with the student so they know where they are and where you are trying to go.

• Focus on high-interest activities and embed therapy within those activities.

• Teach content in chunks

• Help the student see the patterns within learning.

• Use conceptual/graphic organizers.

• Use visual symbols to express ideas and concepts and to convey meaning.

• Depict the relationships between facts, terms, and ideas within a task.

• Use memory aids, checklists, journals, and calendars.

• Have students teach a process or sequence to each other.

4. Problem-Solving Skills

• Work on problem-solving skills in therapy.

• Identify the problem, brainstorm solutions, decide which solution is best, implement the best solution, and follow up.

• Provide additional language stimulation activities.

• Children may not be exposed to technology at home, therefore, try and incorporate technology into your therapy.

• Perhaps using an iPad app game in therapy will help reinforce an objective you covered as well as incorporate technology.

5. Increase Parental Involvement

• Include the parents in the development and learning of their child at school.

• Educate parents on how the school can benefit their child's life in other ways.

• Caretakers should be provided with information about the necessity of language stimulation and some ways to incorporate more language into their daily routines.

• Help low-SES families by providing information about free local medical and dental services as well as information about nearby locations where food and shelter are available at minimal to no cost (ASHA Leader, 2001).

• In families in which the caretakers are illiterate, wordless books can be sent home so adults and children can discuss them together. Encourage parents to have children participate in book-reading routines (O'Hanlon & Roseberry-McKibbin, 2004).

• Encourage parents to observe in the classroom and in treatment sessions, and encourage their participation. This will help them acquire ideas about how to work effectively with children at home to promote learning and increase language stimulation.

• Encourage use of public libraries. Provide hours of operation and the address of the local library to parents.

• Since parents may be working and may not have a lot of time to spend with their children, children can be paired up with a peer tutor. The peer tutor can help with homework, reading, and other activities.

We hope the information contained in this article has helped provide useful insight for service providers who work with clients who live in poverty. Future articles will address the implications of limited access to healthcare, health beliefs and practices, patient advocacy, and caregiver empowerment. ★

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