

# **A Guide to Cultural Competence in the Curriculum**

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## ***Speech-Language Pathology***

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**UB** University at Buffalo  
The State University of New York



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# A GUIDE TO CULTURAL COMPETENCE IN THE CURRICULUM: Speech-Language Pathology

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## Preface

### **Purpose of this Guide**

This curriculum guide has been prepared by the Center for International Rehabilitation Research Information and Exchange (CIRRIE) under a grant from the National Institute for Disability and Rehabilitation Research. Its purpose is to provide a resource that will assist faculty in speech-language pathology programs to integrate cultural competency education throughout their curriculum.

CIRRIE's current work with pre-service university training, complements previous CIRRIE publications designed primarily for in-service training, most notably a 12-volume monograph series, *The Rehabilitation Service Provider's Guide to the Cultures of the Foreign Born* (CIRRIE, 2001-2003), and *Culture and Disability: Providing Culturally Competent Services*, a book that summarized the series (Stone, 2005). Because of CIRRIE's funding mandate from the National Institute for Disability and Rehabilitation Research, its focus in the area of cultural competency is on the cultures of persons who have come to the US from other countries. Consequently, the primary focus of this guide is on the cultures of recent immigrant groups, rather than US-born persons. Cultural competency education should certainly address issues related to US-born minorities and Dr. Lubinski addresses her activities to both recent immigrants and US-born persons from a variety of cultural backgrounds.

### **Philosophy and Approach**

This Guide is a curriculum guide. Its objective is to provide a resource to faculty who wish to include or strengthen cultural competency education in their program and courses. Certain limitations are inherent in all curriculum guides. While there are certain common elements or competencies in most professional programs, there are also variations among different institutions in how these are organized into specific courses. Moreover, even courses that have similar objectives may use different titles. We have attempted to provide material that could be included in most speech-language pathology programs, regardless of their specific curriculum structure. Its purpose is to enhance existing curricula by making available to instructors resources, case studies, and activities. This material can be adapted by the instructor as needed, in courses that are specific to cultural competence, or infused into other courses in the curriculum.

At the university level the CIRRIE approach to cultural competency education includes four main principles.

#### *1. Integration of cultural competency into existing courses, rather than creation of new courses*

Although the academic credentialing standards for programs in the rehabilitation professions now require cultural competence, the curricula of most programs are already overloaded. This makes it difficult to add new courses and as a consequence, content involving cultural competence usually becomes incorporated into existing courses retrospectively and in small doses. More importantly, a separate course on cultural competence can make the topic appear to students as isolated from the "real" set of professional skills that they are required to master.

Students may consider it an interesting topic but one of little practical importance. Moreover, by separating cultural competence from courses that develop practice skills, it becomes abstract and difficult to relate to practice.

Another reason for integrating cultural competence into existing courses is that students have an opportunity to see its implications and apply its principles in a variety of contexts. They also see that it is not just a special interest of one faculty member but an integral part of many aspects of their future practice that is supported and embraced by all faculty. When it reappears in their coursework each semester, their knowledge, attitudes, and skills in this area develop and deepen. The CIRRIE curriculum development effort has identified specific types of courses in the speech-language pathology curriculum where cultural competence may be most relevant, and we have identified or developed activities and materials that are appropriate across the curriculum.

## *2. Development of cultural competence education that is profession-specific, rather than generic*

CIRRIE's prior experience with providing cultural competency workshops for in-service training strongly suggests that an off-the-shelf generic approach is less effective than training that is specific to the profession in which the competence is to be applied. Generic training must be understandable by all rehabilitation professions, so examples, terminology, and concepts that are specific to one profession must be avoided. As a result, cultural competence becomes more abstract. With profession-specific training, students are better able to see the relevance and applicability to their profession, not as something outside its mainstream. Consequently, CIRRIE's approach is to work with faculty from each profession to analyze their curriculum and incorporate cultural competence into it in ways that seem most relevant to that profession.

## *3. Multi-disciplinary case studies*

Although CIRRIE's general approach is profession-specific, we have found that studies developed in one program can sometimes be adapted for use in other programs. For example, a case scenario developed for a course in speech therapy may be useful in courses in occupational therapy, physical therapy, or rehabilitation counseling. The general facts of the case may be presented to students from each program, but many of the problems, questions and assignments related to the case may be different for each of the professions. The use of common case studies provides an opportunity to analyze cultural factors from a multi-disciplinary perspective, which is often the type of setting in which rehabilitation is practiced.

## *4. Making materials available to instructors*

Most instructors realize the need for the infusion of culture into their curricula, but they may be reticent to incorporate culture into their courses if the burden of creating new materials is added to their normal course preparation. CIRRIE has approached this dilemma through specific strategies to allow instructors easy access to cultural content. Hence this guide was written. These materials are also available online at <http://cirrie.buffalo.edu/curriculum/>. The website was created to organize cultural materials into inter-disciplinary and discipline-specific assignments, case studies, lectures, reference materials, and classroom activities. This information will be expanded and revised based on feedback from users in universities nation-wide.

## **How to Use this Guide**

Curriculum committees and other faculty groups may wish to consult this guide to examine the ways that cultural competency can be infused across a curriculum and identify ways in which this approach may be adapted to the specific context of their program.

Individual course instructors can identify the sections of this guide that relate most closely to the courses they teach. They can then see how others have included cultural competency in such courses. The resources that are suggested in the guide may be seen as a menu from which instructors can select those that fit their course and their teaching style.

Prior to the main portion of this guide that pertains specifically to speech-language pathology, we have included a section that presents suggestions and resources that are generic in nature and could be used in any of the rehabilitation professions.

We hope that this guide will be useful to those who are committed to strengthening this aspect of our professional programs in rehabilitation. We also understand that many institutions have created or identified resources that are not found in this guide. We welcome your comments and suggestions to increase the usefulness of future versions of this guide.

*John Stone PhD,  
Director, Center for International Rehabilitation Research Information and Exchange  
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## About the Authors

**Rosemary Lubinski, Ed.D.**, is Professor of Speech-Language Pathology in the Department of Communicative Disorders and Sciences at the University of Buffalo. She received her graduate training in speech-language pathology from Columbia University. Dr. Lubinski, a Fellow of the American Speech-Language-Hearing Association, is the author of five texts including *Professional Issues in Speech-Language Pathology and Audiology* in its 3<sup>rd</sup> edition, *Dementia and Communication*, and *Communication Technologies for the Elderly, Vision, Hearing and Speech*. Dr. Lubinski has also published over 100 peer reviewed articles and chapters, has given numerous national and international presentations, received research funding from various agencies, and served on a number of national review panels. Dr. Lubinski's work focuses on communication problems of the elderly, the communication environment, and neurological impairments. She also teaches a seminar in Communication and Multiculturalism.

**Mary Matteliano, MS, OTR/L**, has over 20 years of rehabilitation experience in the area of adult physical disabilities. She has been a clinical assistant professor in the Department of Rehabilitation Science at the University at Buffalo since 1999. In addition, she is the project director for "Cultural Competence in the Curriculum" for four rehabilitation programs. This is a NIDDR funded project through the Center for International Rehabilitation Research Information and Exchange (CIRRIE). Ms. Matteliano has also participated in and co-directed the study abroad program, Health in Brazil, in 2004 and again in 2006. She is currently pursuing her PhD in Sociology; her research explores the provision of culturally competent health care services to those who are from underserved groups.

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# **Part I: Transdisciplinary Instruction for Cultural Competence**

*Mary A Matteliano, MS, OTR/L, Project Director of Culture in the Curriculum, CIRRIE*

## **Introduction**

Rehabilitation services for persons with disabilities are provided in a variety of settings including medical facilities, schools, and the community. The recipients of these services are referred to as patients, students, clients, and consumers, depending on the setting. Henceforth, for the purpose of this guide, we will refer to the recipients of services as clients and students. In all settings, the team approach is valued, and the client or student benefits when each discipline is able to focus on its area of expertise in a collaborative manner. It is not unusual for clients or students to receive therapy from a variety of professionals during their course of treatment. In fact, a client or student may receive some combination of occupational therapy, physical therapy, rehabilitation counseling, and speech-language therapy simultaneously. Additionally, rehabilitation professionals frequently request consultations from other professionals and ask for another discipline's involvement in a case. As a result of these frequent interactions among rehabilitation professionals, a team approach develops in which each provider recognizes and often supplements the unique role of other professionals. Likewise, rehabilitation professionals learn from each other in these settings and are provided with opportunities to appreciate their commonalities. Therefore, it seems fitting that CIRRIE create not only guides that are discipline specific, but also transdisciplinary, containing foundational information for use in all four programs. By providing general content, the expressed needs for cultural competence education can be transferred across rehabilitation programs and serve to unify this intent. With this in mind, the transdisciplinary section of this guide was written to provide an introduction to cultural competence instruction for occupational therapy, physical therapy, rehabilitation counseling, and speech-language therapy programs.

Rehabilitation disciplines use various frameworks and models of service provision that are specific to their practice. A conceptual framework that shows utility for all rehabilitation programs is the International Classification of Functioning, Disability and Health (ICF) (World Health Organization [WHO], 2001). The ICF can be used by rehabilitation professionals to organize and identify relevant domains for assessment, treatment, and evaluation of outcomes (Reed et al., 2005; Rentsch et al., 2003). It also provides a common language for health care providers, thereby enhancing communication among disciplines (Rentsch et al., 2003). By examining the ICF and its classification system, we can further understand the areas of concern that impact the provision of culturally competent rehabilitation services. The ICF guides rehabilitation specialists in the assessment process by providing a framework that addresses client or student needs beyond the impairment level, thus establishing their capacity to perform within the natural environment (American Occupational Therapy Association, 2002). Contextual considerations, the external or internal influences on the client or student, impact the rehabilitation process and must be addressed. For example, external contextual influences may include the individual's immediate environment as well as cultural and societal influences. Internal influences are more personal in nature and include the individual's gender, race, ethnicity, and educational level, among others (WHO, 2001). It is useful for us to use the ICF as

a framework that addresses individuals' performance capacity within the context of their personal and external environment. By understanding this, rehabilitation professionals will improve their ability to address the influence of culture on client or student performance. In the next section we will examine a model that will be used to specifically guide the infusion of cultural competence into the curriculum for rehabilitation programs.

Although there are several models to choose from that can be used to guide curriculum planning, we have chosen the *Campinha-Bacote* model as a guide for teaching cultural competency to students who are enrolled in rehabilitation programs (Campinha-Bacote, 2002). According to this model, achieving cultural competence is a developmental process, not a onetime event. The *Campinha-Bacote* model (2002) consists of five constructs: (1) cultural awareness, (2) cultural knowledge, (3) cultural skill, (4) cultural encounters, and (5) cultural desire. These constructs are intertwined; cultural desire is the foundation of this process and provides the energy that is needed to persevere on this journey (Campinha-Bacote, 2002). Cultural awareness, the ability to understand one's own culture and perspective as well as stereotypes and misconceptions regarding other cultures, is a first step (Campinha-Bacote, 2002; Hunt & Swiggum, 2007). The development of cultural knowledge can be introduced and explored throughout the curriculum, both in courses that are general as well as courses that teach specific therapeutic skills. Cultural skills, the ability to evaluate a client or student and develop a treatment plan, build on the foundations of cultural awareness and knowledge. Courses that emphasize clinical and educational skills can be used to help students develop a skill set that will address the unique needs of the individual. Cultural encounters can be dispersed throughout the curriculum, with the emphasis on the application of practice skills, as the student advances in the program.

## **Implementation of the Campinha-Bacote Model into Curriculum Design**

The next section of the guide is organized into five objectives that reflect the Campinha-Bacote model for achieving cultural competency. The objectives are further divided into specific goals along with suggestions, activities, and resources to achieve the stated objective.

### **Objective 1: Students will Improve their Cultural Awareness**

- 1a. Students will demonstrate the ability to examine and explore one's own culture (including family background and professional program).*
- 1b. Students will identify stereotypes, biases, and belief and value systems that are representative of the dominant culture in the United States.*
- 1c. Students will demonstrate an understanding of how one's own biases and belief system may subtly influence the provision of rehabilitation or educational services and lead to cultural imposition.*

In our experience, we have found that courses that emphasize communication and therapeutic interaction offer opportunities for exploration and understanding of one's own culture. These courses are usually taught to students prior to acceptance into a professional program or during the first year. These introductory courses will sensitize students by providing information that promotes cultural awareness and knowledge, although a comprehensive program should

emphasize a continuum of cultural competence that is threaded throughout the curriculum (Campinha-Bacote, 2002; Kripaiani, Bussey-Jones, Katz, & Genao, 2006). Assignments that are specific to cultural awareness may include a class exercise in which students write about their own ethnicity/racial background. This leads to a class discussion about cultural awareness, stereotyping, and variations among cultures. Several exercises may be used within and outside of the classroom to assist students in improving their cultural awareness. They may be worked on independently or in small groups. Examples of classroom activities that may be adapted depending on the program are included in Appendix A.

Students may benefit from taking the “Implicit Association Tests” online and discussing the results in class. Project Implicit is a collaborative research effort among researchers from Harvard University, University of Virginia, and the University of Washington. There are several exercises offered on this website, and the general purpose is to elicit thoughts and feelings that are outside of our conscious control. Those who participate in these exercises are provided with a safe and secure virtual environment in which to explore their feelings, attitudes, and preferences toward ethnic groups, race, and religion. The outcome of this exercise is for students to understand that they may have an unconscious preference for a specific race, skin tone, religious group, or ethnic group. Students are provided with the opportunity to understand innate and unconscious attitudes that might influence their decision making ability in a rehabilitation setting. Refer to Appendix B for the Project Implicit (2007) website.

The Village of 100 activity takes about 10 minutes to complete and will also lead into some good classroom discussion (Meadows, 2005). Students must imagine that if the Earth’s population was shrunk to 100 persons what the representation of certain racial/ethnic groups would be like in areas that include religious representation, sexual orientation, literacy, wealth, education, and living conditions. Many students are not aware of the privilege they have experienced by living in the US and are enlightened once they examine the rates of poverty and general deprivation that are experienced by the global community. Again see Appendix B for the Village of 100 website.

Many readers may already be familiar with the body ritual among the Nacirema vignette, but we have found that it continues to facilitate self-reflection among students (American Anthropological Association, 1956). Nacirema is American spelled backwards, and this narrative describes the daily rituals of American life from an outsider’s perspective. Many of our commonly accepted practices seem very strange when seen through an outsider’s lens. The purpose of this exercise is to help students understand that although the customs and rituals of persons from other cultures may seem strange, our customs and rituals may also appear odd. Bondar, Martin and Miracle (2002) have concluded that an ethnographic approach, such as the one used in the Nacirema vignette, helps students to gain a different perspective on their culture. Appendix B details information on the Nacirema website.

Self-assessment questionnaires and surveys encourage student self-reflection and lead to group discussions and the development of cultural awareness, cultural sensitivity, and appreciation for diversity (Spence-Cagle, 2006). Several activities that enhance student self-awareness include the *Self-test Questionnaire: Assessing Transcultural Communication Goals*, the *Cultural Values Questionnaire* (Luckman, 2000) and the *Multicultural Sensitivity Scale*

(MSS) (Jibaia, Sebastian, Kingery, & Holcomb, 2000) (Appendix C). The *Self-test Questionnaire, Assessing Transcultural Communication Goals*, was developed to help students understand their knowledge and comfort level with various individuals and groups that reside in the US. Some examples of groups that are represented on this self-test are: Native Americans, Mexican Americans, prostitutes, the elderly, and persons with cancer. The objective of the self-test is to facilitate discussion and develop insight among students on their preferences and knowledge about persons who are different from themselves.

The *Cultural Values Questionnaire* asks students to rate their agreement with a series of statements. Some of the statements demonstrate values that reflect mainstream society in the US including timeliness, stoicism, individuality, while other statements reflect values that might be preferred by societies that value interdependence over independence. This exercise can be used to facilitate discussion among students on values that may be preferred by the rehabilitation provider. Students can develop strategies that tailor rehabilitation programs for persons whose values are different from the provider or the institutions that provide services.

The *Multicultural Sensitivity Scale* consists of 21 statements, and students rate their agreement with the statements on a scale of one to six. The statements ask students to rate their comfort level and willingness to accept various cultures that are different from their own. This scale can be taken on an individual basis and then used to enhance classroom discussion on students' ability to accept, interact, and feel comfortable with clients or students who are from diverse backgrounds.

## **Objective 2: Improve Student Knowledge of Diverse Cultures and Practices**

- 2a. Students will understand various health, education, and disability belief systems and practices.*
- 2b. Students will familiarize themselves with disability prevalence and risk factors among different racial/ethnic groups.*
- 2c. Students will understand and identify racial and ethnic disparities in rehabilitation and educational services in the United States.*
- 2d. Students will recognize and understand various cultural worldviews and disability beliefs and explanatory models.*
- 2e. Students will identify instances when religious or traditional views may influence the client's participation in rehabilitation and educational regimens.*

After general and self-awareness exercises, students can progress to the development of knowledge about other cultures. Encounters in non-traditional settings offer opportunities for students to try out new skills with clients from diverse cultures with guidance and feedback from their instructors (Luckman, 2000; Parnell & Paulanka, 2003). Students may increase their knowledge about different cultures by visiting ethnically diverse neighborhoods, exploring ethnic supermarkets and restaurants, attending religious services that are different from their own religious backgrounds, and observing programs in ethnically and racially diverse neighborhood

community centers (Jeffreys, 2006; Luckman, 2000; Hunt & Swiggum, 2007). These introductory observational opportunities should be set-up as non-threatening encounters that lead to self-reflection through written assignments and group discussions (Hunt & Swiggum, 2007). A by-product of this self-reflective process is the development of an appreciation for ethnic diversity, religious practices, food preferences, family values, health beliefs, and neighborhood community programs (Griswold, Zayas, Kernan, & Wagner, 2007). Furthermore, encounters in ethnically and racially diverse settings allow students to develop confidence when encountering clients from diverse backgrounds (Hunt & Swiggum, 2007). However, both the instructor and students must keep in mind that one or two visits to a “different” neighborhood merely introduces students to the most obvious aspects of a cultural community. Only living and interacting with members of a community on a daily or long term basis truly opens students to a culture.

The acquisition of knowledge about specific cultures can be approached in several ways. Students can access the Center for International Rehabilitation Research Information and Exchange (CIRRIE) on-line monograph series (CIRRIE, 2003). The monographs focus on the top eleven countries of origin of the foreign-born population in the US, according to the US Census Bureau: Mexico, China, Philippines, India, Vietnam, Dominican Republic, Korea, El Salvador, Jamaica, Haiti, and Cuba. There is an additional monograph on the Muslim perspective. Assignments can be provided using a case study format with the monograph series as a resource.

Prior to clinical encounters, the use of case studies is also helpful in developing clinical decision making, self-reflection, and examining ethical dilemmas (Spence-Cagle, 2006). The case study format has been used to help students process, problem-solve, and apply strategies that will enhance their knowledge of culturally competent service (Lattanzi & Purnell, 2006). Therefore, case studies encourage the examination of the professional’s explanatory model and clients’ explanation of their illness experience. Explanatory models are the perceptions and beliefs that rehabilitation providers, clients, students, and their families construct about illness and disability (Kleinman, 1988; McElroy & Jezewski, 2000). They are cognitive and emotional responses based on cultural experiences (Kleinman, 1988). Therefore, explanatory models are not always transparently logical, and if the rehabilitation provider’s communication skills are based on their own perspective, the client or student may experience discrimination. In addition, through the case study format, students can be encouraged to develop *culture-brokering* skills that further expand their appreciation of various belief systems (Kleinman, 1988; Jezewski & Sotnick, 2005). Examples of case studies and case scenario assignments, that are applicable across disciplines, are found in Appendix D.

We refer to the *culture-brokering* model in this guide because it has been shown to be useful in training rehabilitation personnel in identifying and devising solutions for culturally related problems. The *culture brokering* model was adapted by CIRRIE for rehabilitation systems, and a training workshop was designed based on the model (Jezewski & Sotnick, 2005). The model has three stages: (1) problem identification, (2) intervention strategies, and (3) outcomes. *Problem identification* includes a perception of a conflict or breakdown in communication. *Intervention strategies* include establishing trust and rapport and maintaining connections. Stage three is *evaluating outcomes*, both successful or unsuccessful. Success is achieved if connections are

established between consumers and the rehabilitation system, as well as across systems. What makes this brokering model a *culture-brokering* model is a fourth component, *Intervening Conditions*. These are culturally based factors that must be considered at all three stages: analyzing the problem, devising appropriate strategies, and evaluating outcomes. The intervening conditions include a variety of factors including type of disability, communication, age of the client or student, cultural sensitivity, time, cultural background, power or powerlessness, economics, bureaucracy, politics, network, and stigma. The model is not a set of rules or steps to follow. Rather, it is a conceptual framework that can guide the service provider in analyzing problems and devising culturally appropriate solutions. For a more detailed description of this *culture-brokering* model, including its applications to case studies, see Jezewski and Sotnick (2005).

When implementing the *culture-brokering* model, students must understand that health and education seeking behaviors are shaped by the individual's cultural context, and most cultural groups are heterogeneous (Rorie, Pain & Barger, 1996; Menjívar, 2006). Caution within training programs should be exercised. Knowledge of various cultures and their practices, if not considered within the context of individuals and their unique circumstances, can result in destructive stereotyping. Stereotypes that are associated with particular cultures may affect the provision of rehabilitation services in adverse ways. Therefore, although knowledge of cultures is important, students must refrain from stereotyping and be aware constantly of the heterogeneity of persons within cultural groups (Campinha-Bacote, 2002; Juckett, 2005). There are many reasons for intra-cultural variations including the individual's level of education, socioeconomic status, reasons for immigration, and regional and local differences within the country of origin. In addition, the process of immigration is complex. Immigration may be voluntary, or it may be a decision based on persecution or economic hardship. This affects the immigrant's ability to improve social status and assimilate into a new culture. Assimilation is also affected by the human, cultural, social, and economic capital that accompanies the immigrant into the destination country (Alba & Nee, 2003).

### **Objective 3: Improve the Student's Skill in the Assessment of Clients from Diverse Cultures and Practices**

- 3a. The student will learn to determine client and student needs within the context of their culture.*
- 3b. The student will become familiar with and demonstrate the use of assessments that respect and explore client and student culture and the impact it has on their disability.*
- 3c. The student will identify culturally biased assessments and demonstrate the ability to modify or adapt the assessment to fit client and student needs.*
- 3d. The student will utilize the client's family and/or extended family in the assessment process, if designated by the client or student.*

*3e. The student will demonstrate the ability to use a professional interpreter in the evaluation process.*

Students' ability to develop cultural skill depends on the first two constructs that were explored, awareness and knowledge. Skill development overlaps with practice and cultural encounters. Students in rehabilitation professions must understand how to use the interview process to formulate relevant treatment options for their client. Students must then be provided with clinical encounters that allow for the development of skill when working with clients or students from diverse cultures (Campinha-Bacote, 2002). Neighborhood community centers, schools, and adult day care facilities are several examples of potential sites that may offer diversity and contribute to students' fieldwork experiences (Griswold et al., 2007; Hunt & Swiggum, 2007). Through observations and clinical encounters, students develop and expand on their interviewing techniques, including the use of interpreters, the ability to become flexible with traditional assessment procedures, and an appreciation for the client's narrative (Hunt & Swiggum, 2007). The personal narrative, listening to clients or students tell their story, is best learned through clinical encounters (Griswold et al., 2007; Kripaiani et al., 2006). Students must learn when to leave aside traditional assessment procedures and encourage interviewees to describe their illness experience in their own words (Griswold et al., 2007; Kleinman, 1997). The person's view of disability does not necessarily surface when using standardized assessments that are popular among professionals (Ayonrinde, 2003; Becker, Beyene, Newsom, & Rodgers, 1998). Another approach is to adapt current assessment/ evaluation methods and identify culturally relevant assessments within each rehabilitation field.

To understand the participant's perception of disability, interviewers can use a semi-structured format that incorporates the ethnographic principles of open ended questions (Babbie, 2004). Changes and adaptations can be made to the interview questions, according to the interviewee's responses. This format may facilitate the emergence of the interviewee's personal story. Students may also use a modified version of Kleinman's eight questions and incorporate this into their interview schedule. The questions may help providers understand clients by asking for a description of what their disability means to them (Kleinman, Eisenberg & Good, 1978). Caution should be used when incorporating these questions into the interview schedule since some individuals may not choose to discuss their disability experience in this manner. See Appendix E for Kleinman's eight questions.

There are many factors that should be considered by rehabilitation providers in culturally diverse settings, and a number of these should be elaborated on and examined in depth in the academic setting. Examples are:

- Cultures vary on their expectation of formality in clinical situations. For example, Asian Americans may be more formal, especially elders (Liu, 2005; Wells & Black, 2000). Thus, clinical encounters should reflect this style of interaction.
- Some cultural groups communicate in ways that are different from the direct style of communication favored by Americans. For example, some cultures communicate in a less direct manner and rely on the context and subtleties in style to get their message across (Jezewski & Sotnik, 2005).

- Many Latin and Middle Eastern cultures do not value time in the same way as Americans. They may prioritize personal commitments over time commitments in business encounters or in adherence to clinical appointments (Sotnik & Jezewski, 2005).
- Some cultures, for example those of the Middle East, expect long greetings and inquiries about family members and their states of health. They may also expect offerings of food and drink (Ahmad, Alsharif, & Royeen, 2006).
- The assistance of an interpreter should be used to facilitate communication; however, family members should not be used in this role, if possible. The dual role of family member and interpreter may cause conflict, and valuable information may be omitted (Dyck, 1992). Clinicians must become familiar with techniques on how to use an interpreter and seek interpreters who are well-trained and artful in the subtle negotiation process between client and provider (Ayonrinde, 2003).
- In some cultures, such as the Hmong, a husband or oldest son will make decisions for all members of the clan. The individual's wishes are deferred to a designated member in the clan (Leonard & Plotnikoff, 2000). Thus, it is important to ascertain who is the primary decision maker in the family and enlist his or her help in the diagnostic and rehabilitation process.
- All clients have a history prior to their disability. Providers must balance clients' history, present condition, and potential for the future. This process is best accomplished through the dual contributions of provider and client (Fleming, 1991).
- Certain occupations and daily activities may be defined in ways that are not familiar to the provider. For example, some cultures prioritize certain daily activities (e.g. hygiene, dressing, and eating) whereas others do not (Zemke & Clark, 1996).
- Assessment tools that evaluate individual differences and preferences, including the personal narrative, should be included in the rehabilitation process (Clark, 1993).

**Objective 4: Improve the Student's Ability to Develop Treatment Plans for Clients and Students from Diverse Cultures**

- 4a. Students will apply previously learned knowledge and skills to develop culturally competent treatment plans in medical, educational, and neighborhood community settings.*
- 4b. Students will utilize the "Culture Brokering Model" to recognize and identify conflict that is a result of cultural beliefs and values.*
- 4c. Students will demonstrate the ability to use strategies that result in better rehabilitation and educational services for clients and students.*

*4d. Students will demonstrate advocacy skills for those groups that are underrepresented in the rehabilitation and educational systems and will negotiate and network among providers to assist clients and students in achieving adequate services.*

Cultural encounters allow students to apply classroom knowledge and techniques into real world settings. Students gain knowledge about different cultural backgrounds and achieve skill by learning verbal and non-verbal communication techniques. Effective learning is developed through experiences that help students become self-aware and appreciate cultural differences, thus developing acceptance and advocacy (Jeffreys, 2006). Just as students in health related curricula must fulfill fieldwork requirements to ensure that they are competent practitioners, they should also be provided with opportunities to demonstrate competence with culturally specific interactions. Provision of opportunities to gain exposure to various cultural and ethnic groups can be dispersed throughout the curriculum, at many different levels (Kripaiani et al., 2006). The progression may start with encounters that are mostly observational and progress to interactions that require formulating a plan of action, a treatment plan, or a community-based intervention. Our students have performed service work and implemented programs at refugee centers, neighborhood youth programs, international institutions, and community after school programs. As students progress through the curriculum, their cultural encounters will reflect their acquisition of cultural competence skills (Campinha-Bacote, 2002; Griswold et al., 2007; Hunt & Swiggum, 2007).

Contextual considerations that include the individual's process of immigration and assimilation should be incorporated into the assessment process. Several situations that are a result of immigration may impede rehabilitation. Therefore, students should pay attention to such factors as the disruption of family support systems and social networks, post-traumatic disorders experienced by asylum seekers and refugees, and the withholding of information that characterizes undocumented immigrants' worry about deportation (Ayonrinde, 2003). The *Culture-brokering* model (Jezewski & Sotnik, 2005) can be used to demonstrate to students that treatment planning is a process of negotiation. This problem solving model will help students recognize and identify problems related to cultural preferences or beliefs, facilitate conflict resolution through the process of negotiation and mediation, and better prepare them to advocate and network on the client's behalf.

**Objective 5: Students will Develop the Desire for Cultural Competency and Understand that It is a Life-Long Process**

*5a. Students will develop and demonstrate the ability to empathize and care for clients and students from diverse racial/ethnic groups.*

*5b. Students will demonstrate flexibility, responsiveness with others, and the willingness to learn from others.*

*5c. Students will exhibit "cultural humility," the ability to regard clients and students as cultural informants.*

By using the *Campinha-Bacote* model, it is hoped that students will develop the final construct of this model, Cultural Desire. “It has been said that people don’t care how much you know, until they first know how much you care” (Campinha-Bacote, 2002, p. 182-183). Cultural desire is a result of successful cultural encounters. Successful cultural encounters are the result of good preparation and the support and guidance offered to the student throughout the process. The student should understand that this is a life-long pursuit for the professional who has a true desire to practice in a culturally responsive manner.

Griswold et al. (2007) discuss the development of empathy and cultural humility among medical students who have participated in refugee clinics. During an encounter with an elderly Vietnamese woman, a medical student tossed his checklist aside as the patient began to cry and tell him about the loss of her family members. The student discusses a transformation in his approach: “...I was going through the checklist...as she started to cry it shook me...I stopped the interview...as the empathy kicked in, the checklist started to fall out of my head” (Griswold et al., 2007, p.59). Students may find interviews particularly challenging with persons who have suffered grave personal loss or who have been victims of torture. They may at first meet failure because they are unable to show openness and flexibility during the initial assessment. Since these encounters may be difficult, they will need to be provided with opportunities to debrief and discuss their cases with instructors and other students. Opportunities for self-reflection regarding their feelings, as well as the needs of their clients, should be encouraged by their instructors (Griswold et al., 2007). Self efficacy, the belief that one can achieve competence in areas of practice, motivates students to overcome obstacles and embrace the learning experience (Jeffreys, 2006). It is our goal that the outgrowth of these exercises will provide students with positive cultural experiences that improve their confidence, engage their interest, develop their ability to empathize, and result in the desire to provide culturally responsive rehabilitation services across settings.

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## Appendix A: Cultural Competence Classroom Activities

Many of these activities involve encouraging students to meet and interact with individuals from diverse backgrounds. While the experience is important, it is the opportunity to reflect upon the interactions and perceptions that will heighten cultural awareness. Reflection can be encouraged through journal writing, class discussion and debates, and role playing.

### Activities

- a. **Who Am I?** Students begin the process of cultural awareness by exploring their own backgrounds. **Student Assignment:** Investigate your own cultural background. Try going back three generations. Make a genealogical map of your ancestors including their country of origin, family, language(s) spoken, religion, education, occupation, and beliefs regarding health/disease, disability, and education. Be prepared to discuss how you obtained your biographies, from whom, and the information that was omitted or obscure. Other areas that define the culture may be included such as family roles and rules, family support networks, music, food preferences and eating styles, entertainment, clothing, child rearing practices. Think about and be prepared to discuss how cultural influences have been maintained, changed, or have disappeared across generations.
- b. **Story Teller.** Ask students to interview someone in their own family who is an especially good story teller about family life. **Student Assignment:** Interview an individual in your family who has a repertoire of family stories. Record the story(ies) he or she tells about your family's history. What is the story about, and what does it reveal about your cultural, ethnic, linguistic, religious, and racial background? What did you learn from this interview that you did or did not know about your history? Ideally, this story telling activity should be audio/video taped so that it can be presented to the class.
- c. **Pix Share.** Visual history helps students understand their cultural background. Ask students to share pictures of their family and the area in which they have lived most of their life. **Student Assignment:** Find family pictures across generations, if possible. Discuss how these pictures reveal your cultural, ethnic, linguistic, religious, racial background, and living environments. What did you learn from these pictures that you did not know about your family? To whom did you go for the pictures and information about their content? Discuss how the pictures are similar or different across class members.
- d. **Family Differences.** Have students discuss how their own views on cultural issues such as family, religion, health, education, and disability differ from that of their parents or grandparents. **Student Assignment:** What are your family's views on family, religion, health, education, and disability? Compare your views on these topics with that of your parents and grandparents. Also discuss family perceptions of disability especially if there is a family member who has a disability. What rehabilitation services did the family and individual access and to what success? How does your the family view disability and rehabilitation services?

e. **I See My Community.** Ask students to make a video tape of what they think best represents their individual cultural background in their home community. **Student Assignment:** Prepare a video and audio presentation that illustrates what you think is important about your community. Topics might include description of your physical and social neighborhood, education and health care options, transportation, language(s) spoken, icons that represent the community, arts, schools, and assets and problems. Compare and contrast the presentations across students.

f. **New Arrival.** Have students interview someone who has recently immigrated to the US from another country. If the individual does not speak or has limited ability in English, students should use an interpreter. Keep in mind that these are sensitive topics and not all recent immigrants may want to discuss them. Only students who are especially sensitive and grounded in cultural issues should do this assignment. **Student Assignment:** Interview a recent immigrant to the US on topics related to why the individual came to the US, the process and problems in coming, similarities and differences between the old and new communities in which the individual lives, and views on healthcare, education, and disability. Another important topic is the meaning and structure of family in the culture. If the immigrant does not speak English, you may need to work with an interpreter. Class discussion should also focus on several issues including (a) how the interviewer felt working with an interpreter, (b) problems in doing the interview, and (c) belief systems that emerged regarding health, education, and disability. This interview might be repeated with someone who immigrated 10+ years ago to determine how time in the US influenced perceptions of health, education, and disability.

g. **Exchange.** Discuss the experiences students have had to open them to other cultures; e.g. travel, having an exchange student in their home or high school, and living or working with students from other countries. **Student Assignment:** Through what experiences have you opened yourself to other cultures? Describe these. What did you personally gain from traveling throughout the US or other countries or interacting with an exchange student? What issues did you face when you spent time in another country and culture? How did these issues change over time? How do you maintain contact with persons you met from another country? Compare your perceptions from before the cultural exchange, during, and now. How have your perceptions changed?

h. **Getting to Know You.** Encourage students to “get to know” someone from a different culture during the semester and keep a journal about the experience. Remember that visiting another community for a shopping experience will not fulfill the goal of this assignment. **Student Assignment:** Ask a fellow student from another culture if you might spend some time with him or her at home. Immerse yourself in another culture by participating in family and community activities, shopping in the community, and attending church, celebration, or other activities that represent the culture. You might also tutor or mentor a student from a diverse background and discuss this experience. What did you learn about the culture? What experiences were most revealing to you? How do you think you were perceived as a visitor to the community? What will you do to maintain contact with the individuals you met for this assignment?

i. **Cultural Conflict.** Another topic for discussion is cultural conflict. Ask students what cultural conflicts occur in their community and why. **Student Assignment:** What can be done to diminish or erase cultural conflicts? Discuss how media such as television, radio, and other

entertainment venues reflect general American culture and how this is interpreted in various cultures in the US as well as around the world.

j. **Community Visits.** Have students visit a school and a hospital that are comprised primarily of those from diverse backgrounds. **Student Assignment:** Visit a school, hospital, or other agency that delivers rehabilitation services to children and/or adults who are from diverse backgrounds. Discuss how the facility reflects various cultural backgrounds – e.g. staff, language, type and style of delivery of services or classes, inclusion of family, programming, architecture and design, etc. What differences in quality of health care and educational services are apparent?

k. **Continuing Education Possibilities.** Rehabilitation students need to realize that cultural competence is a “profession-long” process. **Student Assignment:** How can rehabilitation specialists increase or improve their cultural competency once they have completed their professional degrees? What types of continuing education programs are available through local, state, or national professional organizations? What other venues are available for continuing education regarding multicultural issues?

l. **Multicultural Preparation.** Caseloads in all types of rehabilitation settings reflect an increase in clients from diverse backgrounds **Student Assignment:** Interview a variety of rehabilitation professionals who work with multicultural populations on their caseloads regarding their academic and clinical preparation for this type of client. How well prepared were they and what have they done post graduation to improve their cultural competency? What suggestions on cultural diversity do they have for clinicians entering today’s profession?

## **Appendix B: Website Resources**

Center for International Rehabilitation Research and Information Exchange (CIRRIE) website:  
<http://cirrie.buffalo.edu/monographs/index.html>

The Project Implicit (2007) website:  
<https://implicit.harvard.edu/implicit/demo/selectatest.jsp>

State of the Village Report website:  
[http://www.sustainer.org/dhm\\_archive/index.php?display\\_article=vn338villageed](http://www.sustainer.org/dhm_archive/index.php?display_article=vn338villageed)

Nacirema website:  
[http://en.wikisource.org/wiki/Body\\_Ritual\\_among\\_the\\_Nacirema](http://en.wikisource.org/wiki/Body_Ritual_among_the_Nacirema)

## Appendix C: Self -Tests and Questionnaires

The reader may refer to the CIRRIE Cultural Competence Website <http://cirrie.buffalo.edu/curriculum/activities/index.html> for information on the following questionnaires and resources:

- *Self-test Questionnaire: Assessing your Transcultural Communication Goals and Basic Knowledge*  
Reprinted with permission from: Randall-David , E., (1989). *Strategies for working with culturally diverse communities and clients*. Association for the Care of Children's Health (ACCH), Bethesda MD.
- *Cultural Values Questionnaire*  
Thiederman, S. B. (1986). Ethnocentrism: A barrier to effective health care. *Nurse Practitioner*, 11(8), 52-59.
- *Muticultural Sensitivity Scale*  
Reprinted with permission from: Jibaja, M. L., Sebastian, R., Kingery, P., & Holcomb, J. D. (2000). The multicultural sensitivity of physician assistant students. *Journal of Allied Health*, 29(2), 79-85.
- Classroom Activities: *Cultural Visit, Observation Visit, and Participant Observation Visit*. Adapted with permission from: Luckman, J. (2000). *Transcultural communication in healthcare*. Albany: Delmar Thompson Learning.

## Appendix D: Case Studies

The following case studies are designed for students and readers across disciplines. One is specific to one or two professions (Study 1), some are designed for all disciplines (Study 2 and 4), and one is specific to speech-language pathology (Study 3). The case studies also differ in their design; some providing more detailed backgrounds (Study 2 and 3), others more study questions and cultural information (Study 2 and 4). Pseudonyms are used in all cases.

### Case Study #1 for PT and OT: Middle Eastern Low Back Pain Patient

#### *Background*

Farideh Daei (*pseudonym*) is a 25 year old woman from Iran. Her physician has recommended a consult for physical therapy for low back pain. During the initial evaluation, Mr. Daei, her husband, answered all the questions directed to Farideh. When asked to rate her pain on a scale of one to ten, the husband answered, "I really don't think her pain is that bad, you can give her a three." The wife compliantly allowed her husband to answer all questions. The PT attempted a physical assessment of the back but had to limit her examination due to Farideh's reluctance to disrobe. The PT was upset after the initial evaluation and was not sure how to go about helping her client's back pain because she was unable to conduct a standard evaluation.

The physical therapist recommended a home assessment by an occupational therapist because Farideh has two children that she picks up and carries, a 2 year old and a 5 month old baby. The OT scheduled a visit to observe Farideh carry out her daily routine and made some suggestions for modifying her child care activities to protect her back. When the OT arrived at the house, she was surprised to find Mr. Daei home. He did not allow the OT any time alone with his wife and answered all questions. The OT found the situation disconcerting since she had to go through a third party in order to understand her client's daily routine. She did not feel she was able to truly assess her client's situation although she was able to show Farideh how to wrap the baby in a sling close to her body when carrying the infant. Farideh and Mr. Daei seemed agreeable to this modification.

#### *Student Reading*

Ahmad, O. S., Alsharif, N. Z., & Royeen, M. (2006). Arab Americans. In M. Royeen & J. L. Crabtree (Eds.), *Culture in rehabilitation* (pp. 181-202). Upper Saddle River, NJ: Pearson Education Inc.

Hasnain, R., Shaikh, L., & Shanawani, H. (2008) Disability and Islam: An introduction for rehabilitation and healthcare providers. *Monograph series for the Center for International Rehabilitation Research Information and Exchange (CIRRIE)*, Buffalo, NY: CIRRIE.

#### *Discussion Questions*

1. What can both therapists do to gain Mr. and Mrs. Daei's trust?

2. Do you feel angry at Mr. Daei for not allowing his wife to participate in the evaluation procedure? Why?
3. What are some other examples of how gender can have a strong influence on communication between the client and clinician?

## **Case Study #2 for SLP, OT, and PT: Hispanic TBI Client**

### *Background*

Hernando Gonzales (*pseudonym*), age 63, incurred a traumatic brain injury (TBI) to the left and right frontal lobes and the left temporal lobe and a broken right shoulder and leg during a car accident on March 15<sup>th</sup> of this year. Mr. Gonzales was born and resides in Mexico and was visiting his sister, Maria, for a two month vacation when the accident occurred. This was his first visit to Buffalo, NY, though he has visited Miami, Florida, and San Antonio, Texas, several times in the past 20 years. Mr. Gonzales has been a widower for 6 months and has four adult children who reside in Mexico. Mr. Gonzales completed 9<sup>th</sup> grade in Mexico and works as a security guard at an industrial site. He speaks fluent Spanish and reads and writes Spanish at about a 6<sup>th</sup> grade level. Although he has taken English immersion classes for several years and his auditory comprehension of English is good, his spoken English is limited. Reading and writing English are basic and inconsistent. He is an ardent soccer fan, enjoys Mariachi music, and attends church on a regular basis.

According to his sister, Mr. Gonzales has a history of hypertension, prostate cancer, and osteoarthritis. He had a partial knee replacement to the right knee three years ago. He wears corrective lenses that were broken during the car accident, and during the optometric evaluation to replace his lenses, early stage bilateral cataracts were noted. Three years ago Mr. Gonzales was diagnosed with a mild bilateral sensori-neural hearing loss during an employment hearing evaluation but refused amplification.

Following the TBI, Mr. Gonzales made good physical recovery. He received intensive occupational and physical therapy for four weeks in a medical rehabilitation unit. Therapies focused on gaining independence in activities of daily living (ADLs). Although Mr. Gonzales made marked improvement in ADLs, he continued to need prompting and reinforcement to initiate and complete activities such as dressing, grooming, and bathing. He still has some difficulties with walking and balance. Cognitive-communicative therapy was also implemented and stressed word retrieval strategies, sentence production related to ADLs, auditory comprehension and verbal expression, and executive skills such as planning, problem solving, and self-evaluation. All therapy stressed the use of English language. Each therapist commented that Mr. Gonzales had difficulty following simple commands given in English and preferred to communicate in Spanish even though only the speech-language pathologist was somewhat fluent in Spanish. He switched between Spanish and English during most informal conversations.

Mr. Gonzales enjoyed inpatient therapies but seemed to want to socialize with other patients and clinicians more than do therapy. Other patients did not understand his overtures spoken in Spanish. Mr. Gonzales became increasingly distracted and uncooperative when tasks involved speaking or understanding English. The female clinicians also noted that Mr. Gonzales infrequently made direct eye contact with them during therapy activities. They were also concerned about some of what they considered inappropriate comments about female patients

and therapists. Continued home-care based PT, OT, and SLP therapies were recommended at time of discharge. Mr. Gonzales stated that he would like to return to his job on a part-time basis when he returns home in several months.

Mr. Gonzales's sister, Maria Lopez (*pseudonym*) age 70, is a widow and resides in an apartment with her adult daughter Rose, age 36, who works as an accountant for a national hotel chain. Rose travels frequently for her employment and relies on friends and neighbors from their church to help her mother. Mrs. Lopez speaks only limited English and prefers to communicate in Spanish. Her daughter says that her mother actually understands English relatively well but is "insecure" about her spoken English skills with those outside the home. Mrs. Lopez indicated through her daughter that she does not want her brother sent to a nursing home and will provide care for him on an extended basis. Mrs. Lopez visited her brother almost daily while he was in medical rehabilitation, often bringing him herbal drinks, sweets, and prayer cards. Therapists noted that Mr. Gonzales became more passive when his sister visited, and he expected her to meet his needs. Thus, Mr. Gonzales will reside with his sister for the next three to four months to receive home care therapy before returning to Mexico. His adult children will visit intermittently to help with care but will be available on an irregular basis. Only two speak English fluently.

You are the speech-language pathologist, physical therapist, or occupational therapist assigned to do home care with this patient. You do not speak Spanish fluently but know some social Spanish. Consider the following questions as you prepare to work with this client in his sister's home.

### *Questions to Consider*

1. In reviewing the background information, what cultural, physical, cognitive, communication, and environmental factors would you need to take into consideration in working with this client in a home care situation?
2. How might cultural differences be confused with or compounded by other physical, cognitive, communicative, or environmental characteristics in this case? Why is it important to differentiate cultural differences from those related to the client's other characteristics?
3. What adjustments might you make in both your assessment and intervention based on this client's cultural and linguistic background and his traumatic brain injury?
4. How would you enlist the help of this client's family, particularly his sister, to facilitate therapy? What problems might you have in working with them to enhance therapy effectiveness?

### *Resources for Working with Hispanic Clients*

American Speech-Language-Hearing Association. (1985). Clinical management of communicatively handicapped minority language populations. *ASHA*, 27, 29-32.

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### **Case Study #3 for SLP: Korean Child with Asperger's Syndrome**

#### *Background*

David Lee (*pseudonym*), age five years ten months, was diagnosed recently with Asperger's syndrome. His parents, Lisa and Adam Lee, followed the recommendation of their pediatrician, Dr. Su, to have David evaluated by the Child Study Team at Children's Hospital four months

after his fifth birthday. Dr. Su was concerned about David's lack of interactive communication skills and his preoccupation with cars. The Lees believed that David's lack of age appropriate socialization was due to being an only child who was cared for by Mr. Lee's mother on a daily basis. Mrs. Soon Young Lee (*pseudonym*), a widow, immigrated to the US from Korea three years ago to help care for her grandson while her son and daughter-in-law completed their doctoral and post doctoral programs in chemical engineering at a local university. Adam Lee, the eldest child and only son in his family, was born in Korea and came to the US for his undergraduate education at age 19 where he met and married Lisa seven years ago. Adam has no interest in returning to Korea to live and is presently negotiating a research and development position for a chemical company in the US. Lisa was born in the US shortly after her parents emigrated from Korea. Lisa is not fluent in Korean. Lisa's parents now reside in California and visit several times per year but cannot provide daily help to Adam and Lisa. Both parents are 30 years old, and Mrs. Lee is pregnant with their second child. The Lees are practicing Christians, and Mr. Lee's mother is a Buddhist.

David received a complete neurological, cognitive, and communicative evaluation at Children's Hospital several months ago. Results indicated that David verbally interacted only when spoken to and that he had difficulty with turn taking and coherence in conversations. Although David used complete sentences and a sophisticated vocabulary about his favorite topic of cars, his speech lacked inflection and sounded "robot-like." David responded to his name inconsistently, and showed little interest in play activities offered to him by either the clinicians or parents. His use of nonverbal communication, such as gaze and gestures, was also inappropriate for a child his age. The Lees stated that they believed that David's communication style in Korean is similar to what he exhibited on the day of the evaluation. David demonstrated some repetitive routines such as stacking and restacking papers and books. David has a special interest in cars and can identify cars by maker and year with precision. He brought several books on cars with him to the Child Study Team evaluation and focused on them even when his parents tried to engage him in conversation. The Lees also commented that David had advanced ability in mathematics and performed at a 5<sup>th</sup> grade level. David is expected to enroll in kindergarten this fall where he can receive speech-language therapy on a daily basis if the parents agree to the recommendations provided at by the Child Study Team. He has not attended preschool and has little socialization opportunities with peers other than when he attends church activities.

The Lees are concerned about their son's lack of interaction skills and the recent diagnosis of Asperger's syndrome. They are also concerned because Adam's mother, who provides most of David's daily care, denies that there is any type of problem. Mrs. Soon Young Lee, a former middle school mathematics teacher in Seoul, speaks Korean to her grandson and believes that he is a gifted child, not one with a communication difficulty. She encourages David's interest in both mathematics and cars and praises his precociousness to family in Korea. She told her son and daughter-in-law that they should be glad that their child is "quiet and smart; he does not talk back to adults, and that is good." She admonished them for "even thinking" that there was something wrong with their first son. Adam also indicated that there is friction with his mother because of his conversion to Christianity and what she considers his "disrespect" for her as the elder in the family.

The Lees are dependent on Mrs. Soon Young Lee for financial aid, help in the home, and child care. Mrs. Soon Young Lee has recently lent her son money for a down payment on a home. They are also concerned that Mrs. Soon Young Lee's criticism of and unwillingness to participate in therapy programs for their son will be detrimental. She has indicated that David should be placed in a school for gifted children and not labeled with Asperger's syndrome or receive any therapies. Mr. Lee states that he wants to do the best by his son, but that his mother's influence in his home is great and that to disregard her wishes will cause greater tension within the family. Mrs. Soon Young Lee has no plans to return to Korea in the near future as she will provide child care for the new baby and David.

### *Discussion Questions*

1. What problems might a multi-generational and multi-cultural family such as this have in understanding Asperger's syndrome?
2. Why do you think the grandmother is so averse to her grandson being labeled with Asperger's syndrome and receiving therapy? How much of her perception is cultural? Related to her personality?
3. Suppose you were the clinician working with this child in kindergarten in a public school, how important would it be to work with the grandmother regarding the nature of and treatment for Asperger's syndrome? What are the advantages and disadvantages of enlisting her help or providing information to her?
4. What referral(s) might be useful in this case? To whom would you refer, and how would you convince the Lees to follow through on the referral?
5. What other issues other than cultural differences toward disability emerge in this case?
6. What resources can you find on Korean culture that might help you to understand the grandmother's perspectives on Asperger's syndrome? Compile a reference list.

### **Case Study #4 for OT, PT, SLP and RC: Hispanic Physical and Communication Disability**

The following case scenario is an example of a culture bound syndrome that is a health belief among some Hispanics. Answer the questions that follow, relying on the *culture-brokering* model and Kleinman's eight questions to assist you with your approach.

#### *Background*

Carlos Garcia (*pseudonym*), a 50 year old Mexican man, is the foreman of a construction crew. He was experiencing chest pain one day at work but did not tell anyone until the pain became so unbearable that he collapsed. An ambulance was called, and Mr. Garcia was taken to the local county hospital. Although he speaks some English, he was not able to provide his medical history due to his severe pain. Mrs. Garcia, who speaks very little English, arrived at the hospital extremely distraught. The Garcias do not have medical insurance and usually rely on the local *curandero* for health advice.

Mr. Garcia was stabilized, and he eventually underwent an angioplasty of the Left Anterior Descending coronary artery with the insertion of a stent. Although the procedure was successful, Mr. Garcia suffered a minor stroke while on the operating table. He presents with mild to moderate slurring of his speech (dysarthria) and a clumsy hand. Upon discharge from the hospital, his physician recommended cardiac rehabilitation, occupational therapy, and speech therapy, but since Mr. Garcia does not have health insurance, he refused. While Mr. Garcia was recovering at home, his wife would not allow him to do anything around the house, even his normal household chores. His wife was clearly close to exhaustion herself since she also cares for her two small grandchildren.

Mr. Garcia has been very depressed. He is worried about working again and if he will be able to continue to earn a living. He is also very scared about having another heart attack. Mr. Garcia is having trouble sleeping, has nightmares, and is losing weight. Mr. Garcia complains, "I no longer feel like a man."

Mrs. Garcia is taking her husband to a local *curandero*, who is treating him for *susto*, "soul loss." She is using various herbal remedies and a change in diet, which relies on the hot and cold model. Because heart conditions are considered hot illnesses, the *cuandero* is recommending whole milk and coconut.

Upon his follow-up visit, the physician assistant, who speaks Spanish, referred Mr. Garcia to the clinic's insurance facilitator. He was qualified for a health maintenance Medicaid insurance program. He will be attending a cardiac rehabilitation program that is run by a physical therapist. Occupational and speech-language therapists will see him in the home setting, and a referral has been generated for rehabilitation counseling to evaluate his potential to return to work.

### *Questions for Students*

1. How would you approach this case and what are your primary concerns?

Students should be concerned first and foremost for Mr. Garcia's health. This can only be accomplished if students understand Mr. Garcia's explanatory model for what has happened. This model may be different from the health care provider, and communication may involve a process of negotiation and strategies to overcome conflict and advocate for Mr. Garcia's well being. The provider must realize that Mr. Garcia is mourning the strength he once had and his role as the provider of his family. Through education and monitored involvement in activity, Mr. Garcia may gain confidence and realize that he is not as fragile as he thought and that he can once again regain his role as the breadwinner of the household. His resumption of work may depend on work modifications and the practice of energy conservation techniques. Contact with his employer may be helpful if Mr. Garcia is willing to adjust his work load as needed.

2. Who are the major players, and what would you do to gain their trust?

Students should realize that Mrs. Garcia and the *curandero* play an important role in Mr. Garcia's health and should be included in the treatment negotiations. Treatments can be discussed with the *curandero*, and suggestions and adaptations to the regime may be negotiated. For instance, skim milk or 1 percent can replace whole milk, and defatted coconut milk is available. Mrs.

Garcia's role as caregiver should also be considered. She may be concerned that her husband will die, and that fear motivates her to assume his chores around the house. Work simulations with careful monitoring might help Mr. Garcia to gain confidence and help his wife to realize that he is not an invalid. Her role should not be diminished but redirected to facilitate the therapy goals.

### *Assigned Readings*

CIRRIE Monograph Series: <http://cirrie.buffalo.edu/monographs/>

Jezewski, M.A., & Sotnik, P. (2005). Disability service providers as culture brokers, In J. H. Stone (Ed.), *Culture and disability: Providing culturally competent services*. Thousand Oaks, CA: Sage Publications.

Santana–Martin, S., & Santana, F. O. (2005). An introduction to Mexican culture for service providers. In J. H. Stone (Ed.), *Culture and disability: Providing culturally competent services*. Thousand Oaks, CA: Sage Publications.

Thompson, T., & Blasquex, E. (2006). The smorgasbord of the Hispanic cultures. In M. Royeen & J. L. Crabtree (Ed.), *Culture in rehabilitation: From competency to proficiency*. Upper Saddle River, NJ: Pearson Education Inc.

### *Learn More about the Client*

As you are reading background information on Mexican and Hispanic cultures, pay attention to several outstanding themes that will affect delivery of services to persons from this particular background. Under each heading, write several examples of the Hispanic view regarding the topics. Note contrasts and similarities between the dominant white culture in the US and Hispanic beliefs and values. Note: Realize that Hispanic culture is heterogeneous and that the examples in the readings are general and they are subject to individual variations and community influences. An individual's level of acculturation is affected by a variety of factors including but not limited to education, migration patterns, family influence, and socioeconomic status.

### Concepts of Disability and Illness

Persons from Mexico and other Hispanic cultures may not differentiate between physical and mental illness. The balance between a person and his or her environment is considered important to one's health. Health is a balance of one's emotional well being, spirituality, physical health, and God's will. Genetic problems or developmental disabilities may be viewed with shame and guilt, blamed on the parents, and looked upon as some type of divine retribution. Mental disability carries more stigma than physical illness. The family and community also feel a joint responsibility for the person with a disability, and institutionalization is rare.

### Independence versus Interdependence

Nurturing those who have disabilities is considered an important role. Conflicts may result if rehabilitation personnel are working toward independence, but the family does not want to give up the role of caregivers. Independence may not be valued; relationships and roles may be based on interdependence. Evaluation tools that measure the level of caregiver assistance may not truly reflect rehabilitation potential or the ability to assume a role in the family and society. For example, the Functional Independence Measure (FIM™) is a measurement of Independence in

Activities of Daily Living. Scores are based on the amount of assistance that is needed from the caregiver.

### Machismo and Marianismo

Machismo is sometimes seen as having a negative connotation. It can also be positive in that a man protects and provides for his family and defends them. In Hispanic families, the man assumes the responsibility for providing for his household. Role conflicts may emerge when families are separated because of job opportunities in the US or when there is a disability or illness. When Hispanic women assume the breadwinner role, there may be conflict with traditional values within the home. Traditionally, boys are given greater freedom than girls, and men are expected to be strong.

A woman's role may be viewed according to the concept of marianismo. Marianismo is based on the Catholic interpretation of the Virgin Mary, who is both virgin and mother. Women are considered spiritually superior to men and capable of enduring suffering.

### Personalismo

Personalismo refers to the Hispanic custom of making small talk before getting down to business. Showing an interest in the other person is considered polite before approaching matters at hand. This may result in misunderstandings and poor communication of vital information in busy hospitals, clinics, and agency settings where a person is expected to provide important medical or personal information upon request. Hispanic persons may also inquire about the service provider's personal life. This reflects a desire to understand something about the person who is providing the care. Health care providers who do not understand this may avoid answering questions about themselves. In the US, provision of personal information about oneself to a client is considered unprofessional.

### *Alternative Health*

#### Curanderos and Espiritualistas

*Curanderos* are traditional Mexican healers; *Yerbalistas* are herbalists; and *Espiritualistas* are spiritualists. One may first procure the services of a traditional healer before utilizing Western Medicine. Physicians and health care providers have been known to work with *Curanderos* and spiritual healers and negotiate positive results for the client.

#### Beliefs Regarding Hot and Cold Remedies

The hot-cold model refers to a Hispanic belief that diseases and disorders can be classified into hot or cold groups. A hot condition must be treated with a cold food or medicine, and a cold condition must be treated with a hot food or medicine.

The following conditions are considered hot illnesses: skin ailments, pregnancy, ulcers, and heart problems. Some cold foods are milk, bananas, coconuts, and beer. Cold ailments may include those that are invisible or that result in immobility such as painful conditions, arthritis, menstrual problems, and colds. Hot foods are evaporated milk, chocolate, onions, and liquors. Penicillin is considered a hot medicine. An example of a conflict that might arise because of this hot-cold

belief is when a physician advises a cardiac patient to avoid high cholesterol foods such as whole milk or coconuts.

### Health Risks for Hispanics

- Diabetes is two times more prevalent among Hispanics
- Hypertension is common
- Obesity
- Cervical cancer is double among Hispanic women
- Higher mortality rates from cancer

### *Questions for Students about Hispanic Cultures*

1. Identify the variety of cultures that fall under the umbrella of "Hispanic." Note the variation in their migration practices. Discuss the problems that have accompanied various Hispanic groups in the US.

Students should discuss the various waves of Hispanic immigration from Castro's Cuba (first wave and recent), refugees from El Salvador, Guatemala and Nicaragua, and Mexican immigrants, both legal and illegal. They should be aware of the problems that are encountered due to language, poor socioeconomic status, access to health care, and the problems that are unique to illegal immigrants.

2. Compare concepts of work and activities of daily living among Mexican or Hispanic persons to the values generally purported by the US. How does this affect those who are disabled?

Those who are disabled, including members of society who are not able to work or earn money, may still be valued and serve other purposes in the community. Visiting, planning community events, helping others, and talking with others are valued roles within a community.

3. The commodity based society in the US differs drastically from the matriarchal society. Explain the differences and the impact this has on disabled persons.

The student should note that in a matriarchal society the roles of the mother, for example caring for others, are valued. In contrast, a patriarchal society values earning money. An elderly person, or one who is disabled, may still feel valued in a matriarchal society and fulfill a role. For example, cooking for others is valued and fulfills a role. In a commodity based system, if one does not earn money, their "work" may not be valued.

4. Discuss the barriers that Hispanic immigrants face when they are disabled or ill (structural and cultural barriers). What health risks affect Hispanic immigrants, and why are these risks more common among this group?

Students should be aware of the structural and cultural barriers that play a role in access to health care. Structural barriers include language, transportation, insurance, and the ability to pay for medical services. Cultural barriers may include mistrust of the medical system, the practice of seeking native healers first, and different explanatory models regarding illness, and disability.

Some of the health risks, such as diabetes, have an evolutionary and genetic component. It is thought that high blood sugar was an evolutionary survival adaptation among native persons. Many of the risks may be due to lack of preventative care secondary to lack of resources and insurance.

### *Activities to Improve Knowledge about Hispanic Cultures*

- Visit a market in a Hispanic neighborhood. Ask the store personnel about different foods that are unfamiliar to you and how to prepare them.
- Visit a *Botanica*, a market where natural remedies and herbs are sold. Discuss healing rituals and practices with the store personnel.
- Visit a *cuandero* or folk healer and learn about the different healing modalities that are used.

## **Appendix E: Kleinman's Eight Questions to Assess the Patient's Perspectives (Kleinman, 1978)**

Note: Rehabilitation professionals provide services to clients who not only have experienced illness, but long and short term disabilities that may be a result of developmental disorders, illness, or an accident. The following questions were modified in order to include those who are experiencing a disability.

1. What do you think caused your problem (disability)? Remember that in some cultures it is inappropriate to question why something occurred.
2. Why do you think your problem (disability) started when it did?
3. What do you think your sickness (disability) does to you? How does it work?
4. How severe is your sickness (disability)? Will it have a short or long course?
5. What kind of treatment do you think you should receive?
6. What are the most important results you hope to obtain from this treatment?
7. What are the chief problems your sickness (disability) has caused you?
8. What do you fear most about your sickness (disability)?

## **Part II: Cultural Competence in the Speech-Language Pathology Curriculum**

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### **Overview**

The statement “You never know who will come through your door” has never been more true for speech-language pathologists working with adults or children in educational, medical, and private practice settings. Our clients are more likely than ever to come from a variety of ethnic, racial, religious, linguistic, economic, and other diverse backgrounds. Some may be recent immigrants, others may have resided in the US for years or generations. Through learning about our clients’ cultural background, we learn to appreciate the influence of the differences and commonalities that bind us together.

In 2005, approximately 25 percent of the US population consisted of individuals whose racial background was African American, American Indian, Asian, Hispanic, or Pacific Islanders, (US Census Bureau, 2007). The majority of these individuals are of Hispanic or Latino heritage and speak Spanish as their primary language. The percentage of racial/ethnic minorities is likely to increase to over 30 percent of the population by the year 2015. At least 8 percent of the total public school K-12 enrollment consists of students who are not sufficiently proficient in English to participate in English only classrooms (Macias, 2007). While many of these students are concentrated in states such as California, Texas, New York, Hawaii, New Mexico, and Illinois, even suburban and rural communities across the country find ethnic, linguistic, racial, and religious diversity in their general and school populations.

Some of these individuals may need assistance in learning English as a second language, and some may exhibit speech, language, hearing, or swallowing disorders along with or separate from any first language differences. Kayser (2007) states that children of African American and Hispanic background are over represented in school clinical populations in comparison to their general demographics. African American students comprise nearly 21 percent of school speech-language special services, and Hispanic students represent about 15 percent.

In addition, the aging of the general population will be evident among those from diverse backgrounds. For example, it is expected that while there will be an 81 percent increase in those over 65 years of age in the next 30 years, there will be a 328 percent increase among Hispanics and a 285 percent increase among Asians residing in the US (US Census Bureau, 2007). All will bring their unique backgrounds to the clinical context.

In contrast, while the demographics of the US are becoming more diverse, the demographics of speech-language pathologists remain relatively uniform. ASHA (2002) reports that about seven percent of its membership of speech-language pathologists and audiologists are from

racial/ethnic minority backgrounds, and fewer than six percent report themselves as bilingual or multilingual (ASHA 2002). The fact that at least 311 different languages are spoken in the US (NVTC, 2007) underscores the need for more bilingual clinical service providers.

Thus, there are two professional priorities. First, there is a concerted need to attract more cultural diversity into the profession. Second, speech-language pathologists must acquire increased cultural competence if they are to serve their pediatric and adult or elderly client populations appropriately and sensitively across clinical delivery settings.

Speech-language pathologists have long been aware of this need for enhanced knowledge, skills, and attitudes regarding cultural, ethnic, and linguistic differences. Cheng (2005) encourages professionals to cultivate our “cultural intelligence” (CQ) that encompasses interrelated cognitive, physical, and emotional domains. Others propose that cultural competence “requires a consistent commitment to excellence” and is developed and refined over a series of stages including awareness, application, and advocacy (Mahendra et al., 2005, p. 5).

In particular, the American Speech-Language-Hearing Association (ASHA), the largest national professional association for speech-language pathologists and audiologists, has taken a leading role in defining this need and articulating ways for achieving improved cultural competency at both the preprofessional (undergraduate and graduate training) and professional levels. ASHA has a membership exceeding 130,000 and provides a national forum to discuss and disseminate information regarding the need for and how to achieve improved cultural competence by its membership.

This commitment to cultural competence is demonstrated in (a) the ASHA Code of Ethics, (b) the Council for Academic Accreditation standards for achieving the Certificate of Clinical Competence, (c) numerous documents including the ASHA Scope of Practice in Speech Language Pathology, the ASHA Preferred Practice Patterns, and several publications notably those prepared with the assistance of ASHA’s Multicultural Issues Board, (d) in the establishment of Special Interest Division 14: Communication Disorders and Sciences in Culturally and Linguistically Diverse (CLD) Populations and its publication *Perspectives*, and (e) in numerous professional presentations at national conferences. The resource section at the end of this section lists recent ASHA documents that focus on service delivery to culturally and linguistically diverse populations with communication disorders.

The ASHA Code of Ethics (ASHA, 2003) specifically states that speech-language pathologists shall not discriminate in their delivery of services and must only provide services that are within their scope of competence (Principle I Rule C and Principle II Rule B). By implication, speech-language pathologists must thus be culturally competent when they provide diagnostic and intervention services to clients and their families from any cultural or linguistic background.

This commitment to cultural competence is also reflected in the standards that applicants for the ASHA Certificate of Clinical Competence in Speech-Language Pathology must meet in their graduate training. Several standards clearly articulate the need for cultural competence. For example, Standard III-C states that applicants must demonstrate knowledge of the nature of speech, language, hearing, and swallowing disorders with respect to cultural correlates. Standard

III-D further addresses the need to possess knowledge about prevention, assessment, and intervention, again taking into account cultural correlates of the disorders. Cultural issues affecting the delivery of speech-language pathology services are also assumed in meeting Standard III-G whereby applicants must demonstrate knowledge of contemporary professional issues. And finally, Standard IV-F states explicitly that applicants must have clinical experience with client/patient populations across the life span and from culturally/linguistically diverse backgrounds. These standards are similar to those proposed by the US Department of Health and Human Services (2001) entitled *National Standards for Culturally and Linguistically Appropriate Services in Health Care*.

ASHA's Multicultural Issues Board (2004) published an official statement regarding the knowledge and skills needed by speech-language pathologists to provide culturally and linguistically appropriate services. This document provides detailed and explicit definition of what constitutes the knowledge and skills needed to provide culturally and linguistically appropriate services. The knowledge and skills include those related to:

1. cultural competence
2. language competencies of the clinician
3. language
4. articulation and phonology
5. resonance, voice, and fluency
6. swallowing

### **Implementation of Cultural Competence in the Undergraduate and Graduate Curriculum**

Prior to any discussion of the implementation of cultural competence in a speech-language pathology curriculum, it should be emphasized that there is a vital need to sensitize and train faculty on this topic. Faculty themselves need to be culturally competent and to know how to infuse it into their academic and clinical curriculum. Battle (2008) states, "(Multicultural) issues are quite complex and could lead to furthering the unintentional development and/or reinforcement of stereotypes and biases if each of the issues is not handled with care. If faculty members are not prepared to handle the issues, the first order is to have them confront their own limitations and seek ways to become culturally competent themselves."

#### **Undergraduate Curriculum**

Coursework at the undergraduate level is likely to consist of liberal arts courses that may expand students' knowledge of other cultures and increase their ability to speak a second language. Students are encouraged to take courses in psychology, linguistics, sociology, anthropology, education, and health behavior that may include sections on diversity. Undergraduate departmental coursework usually focuses on the scientific and social bases underlying communication and its disorders, and these courses are ideal places for infusing information about cultural and linguistic diversity. For example, in an undergraduate phonetics course, regional dialects and foreign accents may be discussed. Clinical observation courses are ideal places to include work with clients from diverse backgrounds. Some undergraduate students are able to study abroad during their junior or senior year, and this provides an excellent avenue to

increase their awareness of other cultures and gain fluency in a second language. In addition, undergraduates often seek volunteer experiences and should be encouraged to spend some of their volunteer hours in placements that serve diverse populations in their home or college communities.

### **Graduate Curriculum**

Graduate level academic and clinical faculty are faced with how to include cultural competence in both traditional coursework and clinical training. Some programs may choose to delegate this topic to one or two required courses; others may infuse cultural topics across the required and elective curriculum; and yet others may do some combination of approaches such as infusion in parts of the curriculum and provision of elective course work in or outside the department. In infused coursework, cultural issues are embedded in teaching and discussion across the semester. For example, the instructor of a Diagnostic Methods course may discuss differences in how to interview parents of children for whom English is a first versus a second language. The topic may also be raised in a Language Disorders in Children or an Adult Aphasia/Neurogenics class. In general, there may be less depth to such discussion because of time constraints, but infusion across coursework highlights the importance of cultural knowledge and competence as essential. Infusion requires that faculty members are both committed to and competent in presentation and discussion of information on multicultural issues and strategies.

Specific coursework focuses on multicultural issues in more depth. Such courses are usually electives or advanced seminars. By their very nature, electives are not taken by all students, and thus, those who do not opt for such coursework are dependent on learning about multicultural issues in infused required courses. Specific coursework may be theoretical, applied, or some combination of both types of information. Specific coursework has the advantage of providing students with in-depth discussion of issues related to cultural diversity and communication disorders. In such courses, students have time to explore issues related to cultural competence, diagnostics, intervention, and other service delivery topics.

In both infused and specific coursework, instructors may need to access a variety of teaching strategies and resources. Typical methods include (a) assigning a cultural/linguistic group to each student as part of a semester assignment, (b) including clients from diverse backgrounds as case discussions or as clinical presentations, (c) guest speakers from diverse backgrounds (clients or clinicians), (d) readings on diversity and specific communication disorders, and (e) audio visual presentations on diversity. Co-teaching courses with faculty from other health related professions and other disciplines such as English as a Second Language also expands coursework content. The remainder of this publication provides a variety of teaching approaches and resources.

ASHA gives Speech-Language Pathology programs latitude in how cultural competence is addressed, but the fact is that students must be able to demonstrate cultural competence through some combination of coursework and clinical practicum. Table 1 shows sample coursework where multicultural topics may typically be found in many programs across the country. Typical topics covered in these courses are presented in Table 2.

Table 1. Sample titles of infused and specific coursework related to multicultural competence in Communicative Disorders and Sciences (CDS)

*Infused Coursework*

Phonetics  
Language Development  
Language Disorders in Children  
Phonological Disorders  
Clinical Methods  
Diagnostic Methods  
Professional Issues in CDS  
Intro to or Overview of CDS  
SLP in the Schools  
Medical SLP  
Research Methods  
Voice Disorders  
Craniofacial Anomalies  
Fluency Disorders  
Hearing Disorders  
Dysphagia  
Motor Speech Disorders  
Augmentative/Assistive Communication  
Aural Rehabilitation

*Specific Coursework*

Cultural/Multicultural Issues in CDS  
Multicultural Aspects of Disability  
Bi or Multilingual Issues  
CDS Language Disorders in Adults  
Cultural and Linguistic Diversity  
Cultural Issues in Communication  
Bilingualism Seminar  
Communication Disorders in Multicultural Populations  
Learning, Literacy, and Culture  
Language Disorders in Bilingual Children  
Assessment and Intervention in Bilingual Children

Table 2. Typical coursework topics regarding cultural diversity

Understanding one's own culture and identity development  
Cultural competence, conflict, and humility  
Terminology and theories of culture and diversity  
Demographics of diversity  
Multicultural aspects of disabilities  
Communication strategies for various cultures  
Multicultural issues in communicative disorders and clinical practice  
Discussion of various cultures e.g. Hispanic, Asian, etc.  
First and second language learning in diverse populations  
Bilingualism, biliteracy, and bilingual education  
ASHA Position Statements on cultural and linguistic diversity  
Clinical skills needed to serve multicultural clients  
Ethnographic methodology  
Differentiating disorders versus differences  
Assessment tools and procedures across disorders, age groups, and settings  
Service delivery strategies across disorders, age groups, and settings  
Counseling issues related to diverse populations  
Evidence based practice as applied to diverse populations  
Working with interpreters and translators  
Ethical, legal, and financial issues and service delivery to diverse clientele  
Working with families and other caregivers  
Specific discussion of various cultures – e.g. Hispanic, Asian, etc.  
Resources and websites on multicultural issues

In addition, graduate students must have opportunities to develop clinical skills with multicultural populations in their practicum or externships. Again, this will vary within programs and the diversity of populations available to them for clinical training purposes. Many programs specifically provide opportunities to work with multicultural populations through preschools and schools in urban areas that enroll large numbers of children from culturally and linguistically diverse backgrounds. These include, but are not limited to Head Start screening and intervention programs, clinical service to Native American Reservations, and clinical placements in schools, centers, or hospitals with diverse populations.

ASHA has published a variety of resources on including cultural diversity in academic curriculum. For example, there are model syllabi for courses on cultural diversity, communication disorders in multicultural populations, speech and language in a cross-cultural society, accent dialect modification, and others. These syllabi outline course objectives, recommended texts and readings, and week by week outlines of lecture topics. ASHA also publishes Policy Documents related to multicultural issues, web site resources, and audio visual resources. All of these materials are listed in the bibliography and can be found at the ASHA website. This document provides numerous specific student/reader assignments that can be incorporated in the above syllabi, infused within courses, or completed as part of continuing education.

## Continuing Education and Cultural Competence

Both ASHA and most state licensure boards require that practicing speech-language pathologists participate in continuing education to maintain their certificate of clinical competence or state license. ASHA, state and local professional organizations, and college or university programs offer practicing clinicians myriad continuing education programs available on the topic of cultural competence. Practicing clinicians know how diverse their clientele have become and have specific questions they want addressed in their continuing education. For example, a clinician working in a school district that has had an increase in children from Southeast Asia, will want to know more about those cultures. Similarly, a clinician doing home care with elders who emigrated recently from Central America, will want to know more about the family life and culture of this population. Clinicians can find continuing education programs that provide foundational or general information about culture, racial and linguistic diversity, as well as related topics, such as bilingualism, teaching English as a Second Language, accent modification, nonbiased assessment, and so forth.

Continuing education focused on cultural issues can be found in many venues including the national convention of the American Speech-Language-Hearing Association held each November; programs specifically offered by ASHA Special Division 14: Communication Disorders and Sciences in Cultural and Linguistic Diverse Populations at this convention and also at various times during the year; and programs offered by state and local professional associations. Reading professional peer reviewed publications in national journals and new texts on multicultural issues is also a learning option.

There is also an increasing awareness of multicultural issues by the publishers of texts and diagnostic and clinical materials. In particular, more diagnostic and clinical materials have become available for individuals who speak Spanish. For example, LinguiSystems has assessment and intervention materials that are in both English and Spanish. Clinicians should check to determine if tests are translations or normed on individuals who speak other languages. Harcourt/Psych Corporation developed the *Diagnostic Evaluation of Language Variation* to be used with all children and helps to distinguish between dialect, difference, and disorder.

Continuing education might also entail emersion in another culture. For example, some clinicians might travel to another country to study provision of speech-language services and to live within the community. The University at Buffalo has an active exchange program with college health care programs in Brazil. Teams of students and practitioners from both countries visit each other and sample various clinical sites in each country. Some clinicians might also apply to an exchange program such as the Fulbright Program that supports travel and study in a wide variety of nations including those in third world countries.

Other clinicians might choose to learn a second language that is common in their clinical population. Some communities have an International Institute that provides language learning classes or referral to other educational or community settings where languages can be learned. Most colleges also offer language courses and often summer or semester opportunities to polish a second language in another country.

Discussion groups on the Internet also serve as a forum for discussion of cultural and clinical issues. Worrall and Hickson (2007) state that speech-language pathologists across the world approach clinical work from “distinct theoretical frameworks and with diverse practical techniques and work in very different policy environments” (p. 125). They encourage clinicians to establish international alliances through the Internet, collaborative research, and experiencing clinical practice in other nations.

Participation in the International Association of Logopedics and Phoniatics (IALP), the largest international organization within the profession, provides an ideal venue for interaction with other clinicians, researchers, and faculty from all five continents. The journal *Folia et Logopedica* also provides articles from international researchers. ASHA has a new International Issues Board, and there may be a new Special Interest Division devoted to this topic.

Finally, clinicians might invite a visiting clinician from another country to observe in their clinical communities. All of these are creative ways to increase linguistic and cultural competence for practicing clinicians.

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## Resources

**American Speech-Language-Hearing Association Office of Multicultural Affairs and Resources** has numerous fact sheets, faculty resources, practice issues and readings and related materials. You will find information on fact sheets, federal legislation, service delivery (e.g. accent modification, bilingualism, dynamic assessment, etc.), resources for cultural competence curricular infusion, web site resources, and audio visual resources. These resources are available at <http://asha.org/about/Leadership-projects/multicultural>

**American Speech-Language-Hearing Association Division 14, Communication Disorders and Sciences in Cultural and Linguistic Diverse (CLD) Populations.** Publishes *Perspectives* several times per year and sponsors national and convention programs on cultural diversity. Retrieved on May 19, 2008, from <http://asha.org/default.htm>

**Fulbright Exchange** Information Retrieved on May 19, 2008, from <http://fulbright.state.gov/>

## Teaching Materials

The purpose of this section is to provide academic instructors and other speech-language pathologists with a broad framework of where multicultural issues might be discussed in infused or specific coursework. The ten knowledge areas and skills are a combination of those proposed by ASHA's Multicultural Board (MIB) (2004) plus others that provide a rich grounding in professional issues. These are divided into three main areas: (1) *understanding culture* emphasizes basic cultural concepts and self-exploration; (2) *clinical service delivery* discusses general principles of assessment, intervention, service delivery, and counseling as well as specific speech and language areas that might be affected by diversity; and (3) *professional*

*issues* focuses on advocacy, ethics, research, and supervision. Each section begins with a definition of a specific knowledge or skill, then presents a menu of student activities, possible evaluation options, and resources. See Table 3 for an outline of the knowledge and skills discussed in this guide.

Faculty or readers are free to choose and adapt the activities that best meet their learning goals and the resources available to them in their college or communities. Some activities might be more feasible for short term projects, others for long term. Activities can be adapted to individual or small group oral discussions or presentations or written paper assignments. It is suggested that students be given an array of assignments from which to choose so that the assignment best fits their interests and ability to access information or experiences. Finally, faculty should discuss the purpose of each assignment so that students understand the rationale and learning goals.

It is important to reinforce throughout the following activities a sense of trust and a safe environment where students are free to disclose their true perceptions of their own and other cultures. Students should always have the option of not expressing their ideas and be encouraged to respect differing ideas. Again, discussion should be guided by faculty who are prepared to avoid discussions that result in stereotypes and to handle sensitive topics.

Many of these activities involve encouraging students to meet and interact with individuals from diverse backgrounds. While the experience is important, it is the opportunity to reflect upon the interactions and perceptions that will heighten cultural awareness. Reflection can be encouraged through journal writing, class discussion and debates, and role playing.

Table 3. Framework of multicultural knowledge and skills presented in this guide.

<i>Understanding Culture Foundations</i>	<i>Clinical Service Delivery</i>	<i>Professional Issues</i>
Cultural Competence	Service Delivery Issues	Advocacy
Language Competency of Clinicians	Language Articulation/Phonology Resonance, Voice, Fluency	Ethics Research Supervision

## **Activities to Develop Understanding of Cultural Foundations**

### **Cultural Competence**

#### *Definition*

ASHA (2004) defines cultural competence as “Sensitivity to cultural and linguistic differences that affect the identification, assessment, treatment and management of communication disorders/differences in persons” (p. 2). Cultural competence must be integrated into service provision so that clinicians can be appropriately respectful of and responsive to cultural and linguistic needs of clients (US Department of Health and Human Services, Office of Minority Health, 2001). Such competence will help clinicians to work effectively in clinical contexts with individuals and colleagues from a variety of cultural and linguistic backgrounds. Cultural competence begins with understanding one’s own culture and belief systems, moves to

understanding and respecting the diversity of others' cultural backgrounds, and eventually leads to appropriate assessment and intervention that is culturally appropriate. Faculty and students need to realize that gaining cultural competence is a life long process and not an end in itself.

### *Activities*

The activities below can be used in conjunction with those presented in Appendix A in this monograph.

a. **Clinician Interview.** If possible, have students meet clinicians from diverse backgrounds. **Student assignment:** Interview at least one clinician from a diverse background. How did this individual become familiar with speech-language pathology and enter the profession? What difficulties (if any) does this individual have in working with clients from various backgrounds? How might the profession of speech-language pathology attract more potential professionals from diverse backgrounds?

b. **In Home Observation.** If possible, have students accompany a clinician during a home visit to a client from multicultural backgrounds. Again, students who choose this assignment should have a good grasp of cultural competence before going into a home. **Student assignment:** Prior to the visit, decide what information you would like to have about the client's background and how you would learn more about this background. Then observe a family of child or adult with a communication disorder from a multicultural background. Consider the following issues for your written or oral presentation: family composition, who serves as caregivers, what is the perception of the communication disability, how does the family view health and disability, and how do they perceive help from a speech-language pathologist? What information does the family want to know about the disorder and intervention? How do they communicate their concerns to the speech-language pathologist? What strategies did the speech-language pathologist use to meet the cultural needs of the client and family?

b. **Age and Gender Effects.** Cultures have various value systems for how elders and men and women are portrayed in public versus private life. **Student assignment:** How does the age or gender of a client and clinician affect the delivery of clinical services in a variety of cultures? For example, what cultures and religions would object to a clinician touching a client of the opposite gender during an oral facial or swallowing evaluation? What would you do if you had a client who objected to you touching him or her during an evaluation? How does your cultural background affect your delivery of services to clients of the opposite gender? Finally, how do you feel about working with clients who are transgender?

c. **ASHA Cultural Competency Checklist.** Cultural self awareness can be developed through completion of ASHA's *Cultural Competency Checklist* (2007). **Student assignment:** First complete the *ASHA Cultural Competency Checklist for Service Delivery, Policy and Procedures and Personal Reflection* yourself. Then ask three speech-language pathologists who work with clients from multicultural backgrounds and three who work with clients from traditional backgrounds to complete this checklist. Compare and contrast your perceptions versus those of the clinicians.

d. **International Views 1.** This may be used as a companion assignment with the two following ones. To better understand communication disability and the presence or absence of rehabilitation services in other countries, students should have foundational work in the political-social environment of various countries from developed ones such as the US to those where there is no rehabilitation. **Student assignment:** Choose a developed versus an underdeveloped country and describe their current political-social environments. How does the development of a country affect its perception of education, health care, disability, and rehabilitation? What programs are offered through ASHA, the World Health Organization, and other agencies that foster improved speech-language and hearing services in developing nations?

e. **International Views 2.** Encourage any students from other countries to share information about professional training in their home country. Remember that some students may feel uncomfortable being singled out to discuss their backgrounds and should never be criticized for their reluctance to discuss their backgrounds. **Student assignment:** Discuss speech-language pathology educational training in other countries. What countries have educational programs, and what is the nature of academic and clinical training? How does training compare with that offered in the US? What would be the advantages or disadvantages of spending time in another country and providing clinical services there? What international exchange opportunities are available through programs such as the Fulbright Program for speech-language pathologists? How can the Internet be used to facilitate international exchange?

f. **International Views 3.** For those instructors who do not have international students available in their classes, it is still important that students have an understanding of speech-language pathology in other countries. **Student assignment:** Choose a country or set of countries in a region of the world and investigate the practice of speech-language pathology in that country. What is the nature of academic and clinical training in that country? Discuss the settings where clinical services are offered and how services are paid for. Investigate the educational and health beliefs of that country and how they might affect the delivery of clinical speech-language pathology services.

g. **Attend a Lecture.** Review your college/university calendar of events and find lectures on political, social, health, or educational issues that affect the diversity of our clinical populations. **Student assignment:** Write a brief report that includes title of presentation, presenter and biography, summary of the lecture, and implications for clinical service delivery.

h. **Create a Conference.** You have been asked by your local or state professional association to put together a two day conference on Multicultural Issues in Speech-Language Pathology. **Student assignment:** Prepare a program proposal that includes the titles of the lectures/presentations, a biography of the presenters, and a rationale for why each section of the program will improve the cultural competence of practicing speech-language pathologists in school and medical settings. Write the learning outcomes for the program.

i. **Journal Journey.** One of the most insightful tasks for students to do as they explore and learn more about cultural competence is to ask them to write a weekly journal. In general, this should not be graded, but the instructor can comment on the reflections. **Student assignment:** Write at least one journal entry each week that reflects on the process of learning more about cultural

competence. You might discuss your reactions to class discussion, readings, and assignments, new people you are meeting, your own thoughts about your own culture, and anything else that helps you to understand the process of becoming more culturally competent.

### *Evaluation*

Several types of assessment might be done with these activities and others described in this publication. The rubric presented in #2 below can be applied or adapted to most of the assignments in this publication.

1. **Self Assessment:** Students should be encouraged to self assess their cultural competence during each semester of their graduate training. For example, students should be able to answer the question, “What do you know now that you did not know previously about \_\_\_\_\_?” Students might also be given feedback on how their journals and willingness to participate in class discussion demonstrate how their perceptions have changed over the course of a semester. ASHA (2007) provides several general *Cultural Competency Checklists* that might be used to assess speech-language pathologists’ perceptions of service delivery, policy and procedures, and personal reflection. ASHA also has available interactive based tools for cultural competence awareness and caseload comparisons. In addition, The *Quality and Culture Quiz* (Manager’s Electronic Resource Center, 2007) is a quick self-administered tool to assess application of cultural competency in medical settings. Rather than give a grade on such an assignment, the professor might comment on the change in perceptiveness revealed in journal writing or class discussion, again keeping in mind that some students may be reluctant to reveal their perceptions.

2. **Rubric.** Written papers and oral presentations might be evaluated using the following criteria and sample rubric. These can be applied to other sections of this resource. All papers and presentations should be evaluated on the student’s ability to respond to the question along the following 3/4 criteria from Superior to Needs Improvement

Content and Depth of Information

Clinical Application

Use of Appropriate Resources

\*Uses Standard American English Writing/Speaking Style

\*Professors should decide if this criterion is appropriate for their students.

A sample rubric is given below.

	<b>Superior</b>	<b>Good</b>	<b>Needs Improvement</b>
<b>Content</b>	Expresses in depth knowledge of multicultural issues. Exceeds expectations in presentation of facts. Presents perceptions clearly and convincingly.	Content is accurate but does not go beyond expectations. Perceptions are credible.	Content is limited. Information is not well-based or presented in a logical manner.
<b>Clinical Application</b>	Highly creative and appropriate clinical suggestions. Applies cultural knowledge to solve diagnostic and intervention clinical issues with accuracy.	Clinical suggestions are standard and reflect sensitivity to cultural issues.	Clinical suggestions are not well-based, do not reflect sensitivity to cultural issues and are limited in number.
<b>Resources</b>	Uses plentiful, high quality and current research based references to support content. Uses appropriate in-text and list reference style with few errors.	Uses a limited number good quality research based references. Uses appropriate in-text and reference list reference style with more than a few a few errors but not excessive.	Uses few references, most of which are of questionable quality. Reference style in-text and reference list contains numerous errors.
<b>Style</b>	Uses standard American English writing style with three or fewer errors. Visual aids are appropriate, captivating and extend oral presentation. Paper or presentation is professional quality overall. Speaking style is clear.	Uses standard American English written style with more than a few errors but not excessive. Paper or presentation is adequate but not exemplary. Speaking style is clear.	Writing contains numerous errors not consistent with college or professional level expectations. Speaking style is not clear to average listener.

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Race, Ethnicity and Culture in Health. Retrieved on June 2, 2008, from <http://amsa.org/minority/>

The Provider's Guide to Quality and Culture. Retrieved on May 19, 2008, from <http://erc.msh.org/mainpage.cfm?file=1.0.htm&module=provider&language=English>

#### *Videos*

*Communicating Effectively Through an Interpreter*. (1998). Available from Cross Cultural Healthy Care Program at PacMed Clinics Seattle, Washinton/. Phone 206-621-4161.

*Cultural Diversity: A Model*. National Center for Neurogenic Communication Disorders University of Arizona, Tucson, AZ.

## **Language Competencies of the Clinician**

### *Definition*

Clinicians may come to the clinical context with some degree of language proficiency in the language spoken by the client or family. This may range from native or near-native proficiency to little or no proficiency in the language or dialect spoken. Language proficiency creates a bond with the client and better promotes clinical interaction. Knowledge and skills to fulfill this

competency also include understanding the nature of a client's language or dialect and developing collaborative relationship with translators and interpreters.

### *Activities*

a. **Become a Second Language Learner.** It is never too late to learn a second language. **Student assignment:** Begin the process of learning a new language by taking a language learning course, living with a native speaker, or traveling to and residing in an area or country where that language is used. For those who have limited language skills in a second language, e.g. from high school or college courses, join a weekly language discussion group at a local college or cultural center where you can refine your skills. Some colleges, school districts, and medical centers offer intensive language learning courses; e.g. Spanish for Medical Personnel. Enroll in one of these courses. Reflect on the process of learning a second language in your class journal.

b. **Phrase Book of Common Phrases.** Clients who speak a language other than English are likely to appreciate a clinician who tries to use their language during social interactions. This is in no way a substitute for using an interpreter for more in depth areas of an evaluation or intervention. **Student assignment:** Have native speakers of a second language help you prepare a manual of common phrases that might be helpful in interacting with a client who does not speak English. Sections of the manual might include: introductions and common social starter phrases, phrases related to education or health care, phrases that might be used in a socially appropriate interview with this client, and words related to the disorder the client may present. Write out the phrases phonetically to facilitate pronunciation. Practice these with the native speaker.

c. **Nonverbal Cues.** Nonverbal communication augments and may clarify verbal comments. **Student assignment:** Watch a video of an interview with a client who is learning English as a Second Language and a clinician. Discuss what you learned from the nonverbal communication of each speaker. What do you know about the client and his/her perception of the communication problem from both verbal and nonverbal information? Try turning off the audio and only observing the nonverbal communication of both speakers. What do you know from the nonverbal communication alone? What are the similarities and differences in nonverbal communication demonstrated by each speaker?

d. **Interpreter Skills.** Interpreters are those who translate one language or dialect into a second one orally (Battle, 2002). Interpreters can be valuable in clinical interactions where the client and clinician do not speak the same language. **Student assignment:** Watch a video of an interview with a clinician, interpreter, and client. Evaluate the role of the interpreter in doing the interview. What skills did the interpreter bring to the session other than linguistic? What were the advantages and disadvantages of using an interpreter?

e. **Working with an Interpreter.** Working effectively with an interpreter takes training, skill, and time. **Student assignment:** Give a presentation using an interpreter to a local group that speaks another language, e.g. a group of Spanish speaking parents in a preschool program. How will you prepare to work with the interpreter? Plan the physical logistics of the presentation. Carry out the presentation and then evaluate your own and the interpreter's performance. Ask the

interpreter about his or her experience in working with you and what you could do better during such a session.

f. **Como esta?** Role playing helps students to actively engage in what they are learning and to empathize with their clients. **Student assignment:** Role play being a client who does not understand the questions posed by a clinician who is using a language other than English during an interview. Discuss how you felt being asked questions that you did not understand. How did the clinician try to meet your needs? How would you get your message across to someone who did not understand you? What is the role of nonverbal communication in this situation?

### *Evaluation*

See the section on Cultural Competence for a sample rubric for evaluation of oral and written assignments.

### *Resources*

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## **Activities to Promote Clinical Service Delivery**

### **Service Delivery Issues**

Diagnostics, Intervention, Inservice Programming, and Counseling in Educational, Medical, and Private Practice Settings

### *Definition*

This competency focuses on understanding how cultural diversity affects service delivery of diagnostics, intervention, inservice programming, and counseling. Clinicians must understand how critical it is to consider cultural diversity when providing services across cultural backgrounds, disorders, and clinical settings.

### *Activities*

a. **Regional Demographics.** Students should have some idea of where clients from diverse backgrounds receive clinical services. **Student assignment:** Describe the cultural demographics in your region in general and then in various clinical settings. For example, determine the education and income levels of various racial/ethnic groups in your community. Who are the most recent immigrant groups? Describe the number of health care providers, the number of families that qualify for Medicaid, reduced and free lunch, and the number of persons not receiving adequate health care. Then analyze how these groups access speech-language pathology services in a major hospitals and public schools in your area. How available are clinical services to those from racial/ethnic backgrounds and those residing in poverty? What is the source of payment for clinical services to these individuals in medical or private practice settings?

b. **Financial Considerations.** This is a good companion assignment to the one above. **Student assignment:** Survey local service delivery programs to determine what is done if clients from any background do not have financial resources for payment. What options are available to support needed services in your community for those from a limited financial background? Compare the financial support for communication services for those residing in the US and Canada or other countries with universal health care. How do recent immigrants access rehabilitation in your community? What do they do if they do not have or do not want to access rehabilitation services? What do they do to compensate?

c. **Preparing for Evaluations.** This is a good assignment to prepare for diagnostics. **Student assignment:** You have a pediatric or an adult client with limited English and/or from a multicultural background scheduled for a speech-language evaluation. What are the similarities and differences in preparing for this evaluation versus one for any other evaluation? What would you do to prepare for this evaluation? How would your decision making differ in this context versus a typical evaluation? Make a list of resources you might use to prepare for this type of diagnostic. You might prepare a Multicultural Resource Binder that collates information and resources on this topic for future reference.

d. **Prediagnostic Questionnaire Critique.** This is a good companion assignment to the one above. **Student assignment:** Review the prediagnostic questionnaire your clinic sends out to diagnostic clients prior to an evaluation. Read each question as if you were a client with either limited English or from a different culture. How would you evaluate each question or area of questions from the client's point of view? For example, how might someone from a background where birth and health information is considered private react to such questions? How could the questionnaire be adapted to meet the needs of multicultural and linguistically diverse clients?

e. **Translate Questionnaires and Informational Handouts.** With increasing linguistic diversity of our clientele, there is need for written materials in a variety of languages. **Student assignment:** If you have students who can read and write fluently in another language, have them translate frequently used prediagnostic questionnaires and informational handouts. Be sure to have these reviewed by another person fluent in the language.

f. **Family Interpreter.** Family friends often act as interpreters in evaluations but pose specific challenges. **Student assignment:** When a limited English speaking client arrives for a speech-language evaluation, he brings a friend or family member to act as an interpreter. How would you handle this situation? What are the advantages and disadvantages of having a close associate act as an interpreter? How does this situation affect the client's privacy? What would you do if you suspected that the interpreter was not objective in the translations?

g. **Authentic Assessment.** Authentic assessments are those that reflect the process of speaking, reading, and writing in the real world including the home and school. This has become an especially valuable tool in the assessment of speech, language, and literacy abilities. **Student assignment:** What types of formal and informal authentic assessments might be used to assess literacy and also oral or comprehension skills? Develop a kit of resources and techniques of how you might use authentic assessments. Be sure to include a bibliography.

h. **Ethnographic Interview.** An ethnographic interview is an alternative means of obtaining information about clients and their families, their views of and strategies to deal with the communication problem, and their perspectives on rehabilitation. It may also involve going into the client's home and doing a naturalistic interview and observation. **Student assignment:** For whom and under what conditions would you do an ethnographic interview? What are the goals of such an interview? What problems might you have in doing this type of interview? Try out an ethnographic interview and write your results. How does the information gleaned from this technique differ from a traditional interview? Create a portfolio of useful resources on this topic.

i. **Time and Space on My Mind.** Time and space are important issues in American culture. **Student assignment:** How do time and the use of space differ across cultures? How should you take time and space into consideration in your service delivery of diagnostics, intervention, and counseling? How do you feel when clients are late or take time by chatting or asking questions that you feel are unnecessary or redundant? How would you manage time in this situation? Describe how various cultures use space particularly during communicative interaction.

j. **Don't Assume.** Length of time in the US may influence how clients access and receive clinical services. **Student assignment:** How should you take length of time in the US into consideration when you do diagnostics, intervention, or counseling? What mistakes might a clinician make on the basis of length of residency in the US? Consider the following example: Suppose you were about to do a diagnostic for a recently arrived engineer from India and a Vietnamese refugee who arrived 30 years ago. What would you like to know about each client that is reflective of his time in the US? How would time in the US affect receptivity to diagnostics and therapy?

k. **Oral Facial Exam.** You will do oral facial evaluations on clients from other cultures. Some may not use typical North American oral hygiene procedures. **Student assignment:** How would

you approach a client from a different background when doing an oral facial examination? What procedures would you use? How would you explain to the client your use of universal precautions such as washing hands before and after the oral facial examination and the use of gloves? What would you say or do about oral hygiene?

**l. Derogatory Remarks.** Professionals may hear others make negative remarks or stereotyped comments about students or clients from diverse backgrounds. **Student assignment:** You are working with an elementary school student who is an English Language Learner and is from a multicultural background. When discussing the student with his teacher, the teacher makes some derogatory remarks about the child's limited English and background. What would you do in this case considering that you need the teacher's cooperation?

**m. Educational Inservice on ESL.** Educating others about the communication characteristics and needs of those from other cultures and with limited English is very important. If you have an English as a Second Language teacher (ESL) in your class, this can be a collaborative project. **Student assignment:** Plan a one hour inservice program for classroom teachers on learning English as a Second Language. Contrast language differences, language learning, and language disorders. Be sure to include your goals, why this is a needed inservice, the differing roles of the SLP and ESL teacher with students with limited English, and suggestions for the teacher. Also include several role playing activities to illustrate your suggestions. Prepare a handout that teachers can use for further information including strategies and/or sources of information in learning English as a Second Language.

**n. Medical Setting Inservice on Diversity.** You work in a long term care setting where there is a majority resident population and a minority staff. You have noticed two things occurring: (1) some staff ignore residents and address them at times by their ethnic group; (2) some residents address the staff using derogatory terms. **Student assignment:** Plan an inservice program for staff on communicating with residents from a cultural perspective. Be sure to include several role playing activities to illustrate your suggestions. How would you (or should you) address the issue of residents' possible inappropriate cultural comments?

**o. Making Referrals for Psychological Services.** Psychological services may be an important adjunct to speech-language pathology services. Such services may be unfamiliar to some clients from a variety of diverse backgrounds. **Student assignment:** After doing a speech-language evaluation, you feel that a referral to a psychologist or other counselor is important for this client. The client and parent are either unfamiliar with counseling or from a culture that does not encourage discussion of personal information with relative strangers. Would you make such a referral in this case? And if so, how would you convince the client and parent that counseling is important in the total remediation plan? What follow-up might be needed in such a case?

**p. Environmental Critique.** Encourage students to look at the physical environments where clinical services are delivered. **Student assignment:** Visit a speech-language pathologist who works in a setting with a large number of multicultural clients. What is visible in the environment that reflects a multicultural emphasis? Should there be more or fewer visual cues to reflect multiculturalism? Why or why not? Ask the speech-language pathologist what he or she uses as resources to meet the needs of these clients. What publishing companies feature

multicultural clinical products? Where might you find client reading materials/books in a variety of languages? Compile these into a resource for future reference.

q. **Challenges.** Providing clinical services to multicultural clients, particularly in urban settings, is challenging. These include misdiagnosis and lack of funding and appropriate programming.

**Student assignment:** What do you see as the challenges facing clinicians who serve those from diverse backgrounds in schools and medical settings? Review the past 3-5 years of the *ASHA Leader*. What multicultural issues regarding communication disorders emerge as important? How is the American Speech-Language-Hearing Association trying to solve these issues? What can you do personally to meet these challenges?

r. **IDEA.** The 2006 IDEA regulations support services to culturally and linguistically diverse student populations. **Student assignment.** Review the IDEA 2006 legislation for its implications for multicultural students and delivery of speech-language pathology services. What do the regulations say about assessment, evaluation, and IEP planning for such students? How is limited English proficiency taken into account in assessment and placement? What is meant by “disproportionality” with regard to student identification and placement? How can SLPs develop best practices to fulfill the goals of IDEA?

#### *Resources*

American Speech-Language-Hearing Association. (2006). Assessing Culturally and Linguistically Diverse Populations. Retrieved on May 6, 2008, from [http://www.asha.org/about/leadership-projects/multicultural/readings/assess\\_cldiverse.htm](http://www.asha.org/about/leadership-projects/multicultural/readings/assess_cldiverse.htm)

American Speech-Language-Hearing Association. (2005). Intervention with Multicultural Populations. Retrieved on May 6, 2008, from <http://www.asha.org/about/leadership-projects/multicultural/readings>

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- Sue, D., & Sue, D. (1990). *Counseling the culturally different* (2nd Ed.). New York: John Wiley and Sons.
- Westby, C., Burda, A., & Mehta, Z. (2003). Asking the right questions in the right ways: Strategies for ethnographic interviewing. *ASHA Leader*, 8, 4-5, 16-17.
- Zhang, C., & Bennett, T. (2001). Multicultural views of disability: Implications for early intervention professionals. *Infant Toddler Intervention*, 11, 143-154.

### *Evaluation*

1. Use Huer's (2005) *Protocol for Culturally Inclusive Assessment by SLPs* to do a self assessment regarding your multicultural competencies for clinical service.
2. See the section on Cultural Competence for a sample rubric for evaluation of oral and written assignments.

### **Language**

#### *Definition*

This competency focuses on understanding the language system used by the client. The clinician must recognize the sociolinguistic and cultural influences on language development, as well as the use and patterns of a client's primary language. Other skills include identifying normal

processes involved in clients learning their first language and now a second language, interviewing clients and family members regarding language learning of first or second languages, and use of interpreters in doing language evaluations. Clinicians must know the ethical and preferred professional guidelines and practice patterns regarding language assessment and intervention and appropriate and alternate approaches to language assessment. Finally, clinicians must know best practices for treatment/management of language disorders for individuals for whom English is a Second Language.

### *Activities*

a. **Preschool Observations. Student assignment:** Observe young children (ages 0-5 years) from diverse backgrounds in day care and preschool programs in the community. Choose a program that serves low income and another that serves middle class children. Record and transcribe the communicative interaction and then analyze for various language development areas such as semantics, phonology, morphology, and pragmatics. What is the impact of economic/sociological factors on language development?

b. **Test Critique.** While there is some emphasis on creating culturally and linguistically appropriate tools, clinicians still need to be vigilant regarding test bias. **Student assignment.** Create a one page critique of standardized language development and disorders tests that includes information on the appropriateness of the test for clients from a variety of cultural, linguistic, and socioeconomic backgrounds. Include such areas as test populations, validity and reliability, and test modifiability. This can serve as the basis for class discussion on cultural bias in standardized tests.

c. **Screening Tool.** Use this activity as the basis for class discussion on the difficulties in creating tests for various multicultural backgrounds and why more tests are not available. Also discuss the use of family or professional interpreters.

**Student assignment:** Create a brief screening tool for some area of language development (e.g. phonology, semantics, etc.) and administer it to children of one or more racial, ethnic, or linguistic backgrounds. If the test is in a second language, try having an interpreter administer the test. Interview the interpreter as to how he/she perceived the tool and its effectiveness in identifying the client's communication needs.

d. **Test Administration. Student assignment:** Administer a standardized test for a special multicultural population (e.g. the Clinical Evaluation of Language Fundamentals-4 (Spanish Edition) (Semel, Wiig, & Secord, 2006). Compare this version of the test with the English version. Do a dynamic assessment whereby you actively interact with the child and coach performance. Compare the different types of information gleaned from both evaluation methods.

e. **Bilingual Interview.** Before this assignment is given, be sure that students understand the difference between English Language Learner and simultaneous bilingual. **Student assignment:** Interview the parents of bilingual children regarding how their children learned both languages. The interview might also focus on why the parents chose bilingualism for their children and their perceptions of the advantages and disadvantages of simultaneously learning and using two languages.

f. **Follow the Children.** Encourage students to observe children learning English. **Student assignment:** For one semester shadow one or more children in a preschool/daycare program who are learning English as a Second Language (ESL). What areas of English language development emerged most quickly and easily? How do the English speaking children interact with the ESL peers? How does teacher communication compare for the ESL versus the English speaking children?

g. **Aphasia Assessment.** You are likely to provide aphasia rehabilitation intervention to older populations who come from diverse cultural and linguistic backgrounds. **Student assignment:** What do you need to consider when doing an interview with this client? What questions might you ask about language use and preferences? What other questions might you ask that explore the influence of culture on the client's present difficulty and therapy planning? How would you include the family in both the interview and the evaluation itself?

h. **Bilingual Aphasia. Student assignment:** Review the literature on bilingual aphasia. Write a "State of the Art" paper on the nature of bilingual aphasia and intervention for these individuals. How would you define "Best Practice" for bilingual aphasics?

i. **English Only?** One of the controversial issues facing speech-language pathologists and educators is the value of teaching students who are English Language Learners in their native language or immersing them in English only classes. **Student assignment:** Have a debate on the issue of teaching in English versus native language. Divide the class into teams to research the positive versus the negative views on this topic. Be sure to address the following issues in the debate: 1. impact of both approaches on developing literacy skills in English and academic achievement; 2. what is the value of bilingual education for students and their families; 3. what are the advantages and disadvantages of speech-language pathologists in providing clinical services to English Language Learner students; 4. under what circumstances should we provide services to English Language Learner students?

j. **SAE Controversy.** Differences in reading test scores of students who use African American English (AAE) and their peers who use Standard American English (SAE) has long been long noted (Connor & Craig, 2006). There also appears to be a complex relationship between oral language skills and literacy development. **Student assignment:** Discuss the issue of teaching SAE to students who use AAE as their first language. First define what is meant by AAE and list its major phonological, morphosyntactic, semantic, prosodic, and narrative characteristics with an example for each: e.g. the use of invariant "be" with example "The man be home at noon." Is there a role for the speech-language pathologist in helping children who use AAE to develop their standard English literacy skills? Be sure to review the position of the American Speech-Language-Hearing Association on African American English.

k. **Diagnostic Manual.** Clinicians need to be able to access bilingual diagnostic materials easily. **Student assignment:** Create a manual of test resources that specialize in bilingual assessments. List the test name, authors, publishers, city, date. Give a brief description of the intended test takers. Review the psychometric information available on the test and critique its validity and reliability.

**1. Community Resources.** Clinicians should be able to access community resources that help them to serve clients from diverse backgrounds. **Student assignment:** Develop a manual of community resources for persons and programs that will help you understand a culture. For example, if your community has a number of individuals from Central America, what community, cultural, religious, or other benevolent resources might support speech-language services? Be sure to list name, contact person, phone and email, services offered, and any other information that will help you to serve clients better.

#### *Evaluation*

See the section on Cultural Competence for rubric to evaluate written and oral presentations.

#### *Resources*

- American Speech-Language-Hearing Association. (2006). Bilingual Language Learners. Retrieved on May 6, 2008, from <http://asha.org/about/leadership-projects/multicultural/issues>
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- Langdon, H. (2002). *Interpreters and translators in communication disorders: A practitioner's handbook*. Eau Claire, WI: Thinking Publications.

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- Roberts, P. (2005). Bilingual aphasia: *A brief introduction*. *Perspectives in neurophysiology and neurogenic speech and language disorders*, 2, 3-8.
- Roseberry-McKibbin, C. (1995). *Multicultural students with special language needs: Practical strategies for assessment and intervention*. Oceanside, CA: Academic Communication Associates.
- Semel, E., Wiig, E., & Secord, W. (2006). *CELF Clinical evaluation of language fundamentals*. 4th Ed., Spanish. San Antonio: Psychological Corporation.
- Taylor, O., & Leonard, L. (1998). *Language acquisition across North America: Cross-cultural and cross-linguistic perspectives*. San Diego: Singular Publishing .
- Wallace, G. (Ed.), (1997). *Multicultural neurogenics*. San Antonio, TX: Communication Skill Builders.

## **Articulation and Phonology**

### *Definition*

Clinicians must be able to provide appropriate assessment and intervention for individuals from diverse backgrounds who have articulation and phonological disorders. This will involve a knowledge and skill base regarding the phonemic structure of the client's first language so that disorders can be differentiated from dialectal differences and accents. This will also facilitate assessment and intervention practices for articulation/phonological disorders in the client's language(s). Critical to this area is differentiation of articulation differences from disorders.

### *Activities*

a. **Transcription.** Phonetic transcription is an important skill to maximize. **Student assignment:** Collect and transcribe a language sample from children between the ages of 2 and 5 whose primary language is not English. Do a phonological analysis of the samples. If possible, also obtain a sample of the child speaking English. How does sound development of this child compare to typical English speaking children of the same age? If possible, follow both children over a period of time and compare how their phonology changes.

b. **Phonological Tests.** Test review is critical to good assessment. **Student assignment:** Identify phonological tests that are appropriate for speakers learning English. How do standardized articulation/phonology tests address the issue of difference versus disorder? Evaluate the psychometric properties of these tests and the standardization procedures used.

c. **EI Interview. Student assignment:** Interview a clinician who works with children from multicultural backgrounds in prekindergarten day care or early intervention programs. Focus on the decision making the clinician uses to distinguish phonological differences versus disorders in this population, assessment tools used, and intervention techniques.

d. **Neurological Case Study. Student assignment:** Create a case study of an adult who was born in another country with a motor speech disorder secondary to stroke or a progressive neurological disorder. Focus on assessment and intervention techniques and how you would communicate effectively with the client and family. What problems might you encounter in working with such cases, and what are possible strategies to overcome these difficulties?

e. **Phonology Distinctions. Student assignment:** Compare the phonology of those who speak a specific Asian language, African American English, Spanish, any other language of their choice, and Standard American English. What is distinctive about the phonology of each language? Make a chart that compares the phonology of each language.

f. **Position Paper Critique.** ASHA has many resources on multicultural issues that students should read. **Student assignment:** Read ASHA's position paper on social dialects. How can this position paper be used to guide clinical services to those whose phonology differs from standard American English?

g. **Literacy Suggestions.** A close relationship between spoken and written English exists. Teachers look for ways to promote literacy from preschool through high school. **Student assignment:** What suggestions might a Speech-Language Pathologist working in the public schools give to classroom teachers regarding phonology and literacy development particularly for those who are English Language Learners? How can the SLP become a vital member of the literacy learning team in educational settings from preschool through high school?

#### *Evaluation*

See the section on Cultural Competence for rubric to evaluate written and oral presentations.

#### *Resources*

American Speech-Language-Hearing Association. (2005). Accents and Dialects. Retrieved on May 6, 2008, from <http://www.asha.org/about/leadership-projects/multicultural/issues>

American Speech-Language-Hearing Association. (1983). Position paper: Social dialects and implications of the position on social dialects. ASHA, 27, 29-32.

Kayser, H. (1998). *Assessment and intervention resource for Hispanic children.* (pp. 124-5). San Diego: Singular Publishing Group.

Myers-Jenning, C. (2000). Phonological disorders in culturally diverse population: Intervention issues and strategies. In T. Coleman (Ed.), *Clinical management of communication disorders in culturally diverse children*. Boston: Allyn and Bacon.

### *Journals*

Bilingual Research Journal  
Journal of Multilingual and Multicultural Development  
Multicultural Perspectives  
Second Language Acquisition Journal  
Teachers of English to Speakers of Other Languages

## **Resonance, Voice, and Fluency**

### *Definition*

Clinicians must have knowledge and skills that reflect their understanding of typical patterns of resonance, voice, and fluency within their clients' communities. This is in addition to knowledge and application of current preferred practice patterns for assessment and treatment of these speech production areas.

### *Activities*

a. **How Loud?** Nonverbal aspects of communication are culture bound. This includes how loud we speak. **Student assignment:** In mainstream American culture, what does a loud versus a soft voice suggest to listeners? How is intensity used and interpreted by other cultures? Do the same analysis for other vocal characteristics such as breathiness, inflection, and pitch? How should a voice therapist keep these differences in mind when working with clients from diverse backgrounds?

b. **Speech Production Diagnostic. Student assignment:** Video tape a resonance, voice, or fluency diagnostic for someone from a diverse background, particularly some one who is an English Language Learner. What differences might be related to the client's background? What speech production aspects do not reveal a cultural or Second Language influence?

c. **Perceptual and Objective Analyses.** This is a good companion assignment for the one above. **Student assignment:** Collect standardized speech samples from speakers of a variety of linguistic backgrounds. For example, get a 5 minute narrative on a topic appropriate for age, gender, and background. Do both a perceptual analysis of their vocal characteristics and an objective analysis of such features as fundamental frequency, intensity, duration, and pitch. What do the perceptual and objective analyses say about these vocal characteristics?

d. **Smoking Around the World.** While smoking has declined in the US, it is prevalent in many other countries. Vocal pathology may be linked to smoking. **Student assignment:** Access the prevalence of smoking around the world on the Internet. How does this prevalence relate to vocal pathology in those countries? How would you convince a recent immigrant who is a heavy smoker to quit smoking because of its impact on his voice?

e. **Stuttering and Diversity. Student assignment:** Suppose during a pre-kindergarten screening you identified a child who recently emigrated from another country as having a possible stuttering problem. What background information would you like to have before you do a complete communication evaluation? How do you think cultural differences might influence this evaluation? What would you do in preparation for a parental conference? How would you integrate the client's cultural background into both intervention with the child and counseling for the parents? Review information from the International Fluency Society.

f. **Resonance Issues.** Cleft palate and cranio facial anomalies may affect individuals from any background. **Student assignment:** Investigate the incidence and prevalence of cleft palate and/or cranio facial anomalies among racial and ethnic groups in the US. How do these statistics compare with other countries? How do various cultures accept problems such as cleft palate and cranio facial anomalies? What would you need to consider when presenting information about these problems to parents or clients from various cultural backgrounds.

### *Evaluation*

See the section on Cultural Competence for rubric to evaluate written and oral presentations.

### *Resources*

Agin, R. (2000). Clinical management of voice disorders in culturally diverse children: Background and definition. In T. Coleman (Ed.), *Clinical management of communication disorders in culturally diverse children* (pp. 197-226). Boston: Allyn and Bacon

Agin, R. (2000). Clinical management of voice disorders in culturally diverse children. Therapy and intervention. In T. Coleman (Ed.), *Clinical management of communication disorders in culturally diverse children* (pp. 227-250). Boston: Allyn and Bacon.

Hatyashi, M., & Fields, Y. (2001). Multicultural issues in the treatment of voice disorders. *Newsletter of the ASHA Special Interest Division 14: Communication Disorders and Sciences in Culturally and Linguistically Diverse Populations*. 7, 1-3.

Robinson, T., & Crowe, T. (2001). Fluency disorders. In Battle, D. (Ed.), *Communication disorders in multicultural populations* (pp. 267-298). Boston: Butterworth Heinemann.

Robinson, T., & Crowe, T. (2000). Multicultural issues and speech fluency. In T. Coleman (Ed.), *Clinical management of communication disorders in culturally diverse children* (pp. 251-269). Boston: Allyn and Bacon.

Tellis, G. (2002). Multicultural aspects of stuttering. *Perspectives on Communication Disorders and Sciences in Culturally and Linguistically Diverse Populations*, 8, 8-11.

## **Swallowing**

### *Definition*

The identification and treatment of swallowing disorders must follow both current preferred practice patterns and also the clients' community patterns for swallowing, feeding, and dietary

preferences. Clinicians need to be familiar with food, eating, and dining preferences of various cultures and ethnic groups to provide culturally appropriate swallowing services.

### *Activities*

a. **Dietary Habits.** New immigrants and individuals from a variety of cultural backgrounds are likely to have distinctive dietary habits that affect provision of swallowing services. **Student assignment:** Choose a particular racial/ethnic group to investigate its food and eating preferences. For example, identify what foods are especially popular or should be avoided. Also study meal time preparation and eating patterns of the group at home and in special settings. This project might be completed through an interview and/or a literature search. It is also a good companion assignment to the following.

b. **Dietician Discussion. Student assignment:** Discuss ethnic food preferences for various cultural and ethnic groups with a registered dietician who works in a nursing home or hospital. How does the setting accommodate to the food and eating preferences of various multicultural groups?

c. **Dysphagia and Diversity. Student assignment:** Consider meal time practices across several racial and ethnic groups. Discuss how a clinician should take differences in food

d. **Religion, Food and Dysphagia.** Food preferences may have a strong religious relationship. **Student assignment:** Discuss the role of religion and food preferences for various groups in your community. Apply this knowledge base to providing clinically and culturally competent care to patients with dysphagia. For example, how would you provide dysphagia therapy to a devout Muslim patient during Ramadan when individuals do not eat between sunup and sundown? How does the religion meet the needs of such patients preparation and meal time into consideration when making dietary suggestions to promote safe and nutritious swallowing. How should a clinician communicate safe swallowing strategies to clients and family members who do not speak English? What other religious restrictions impact delivery of dysphagia services in various clinical settings?

e. **Babies, Swallowing, and Diversity.** Studying family feeding and meal time practices across racial/ethnic groups and income levels is important. This information may have implications for providing swallowing therapy for young children and also in fostering language and literacy. **Student assignment:** Suppose you work in a Children's Hospital with newborn infants and babies who have swallowing difficulties. How do cultural differences in feeding influence your delivery of feeding and swallowing programming? How would you adapt your services to meet these needs? What questions might you ask parents during an interview regarding infant feeding practices in their culture? Prepare a comparison of general American feeding practices of infants and babies versus another culture such as one of the Hispanic cultures. You should consider (at a minimum) such issues as advisory role of family, adding foods to formulas, overfeeding, and use of cow's milk.

### *Evaluation*

See the section on Cultural Competence for rubric to evaluate written and oral presentations.

### *Resources*

Dikeman, K., & Riquelme, L. (2002). Food for thought: Ethnocultural concerns in dysphagia management. *Perspectives on Swallowing and Swallowing Disorders ASHA Division 13, 1*, 31-35.

Religion and Dietary Practices. (2007). Retrieved on May 6, 2008, from <http://www.faqs.org/nutrition/Pre-Sma/Religion-and-Dietary-Practices.html>

Requelme, L. (2004). Cultural competence in dysphagia. *The ASHA Leader*, 22.

Tonkovich, J. Multicultural issues in the management of neurogenic communication and swallowing disorders. In D. Battle (Ed.), *Communication disorders in multicultural populations* (pp. 233-266). Boston: Butterworth Heinemann.

### *Websites*

American Diabetic Association. Diversity resource list. Retrieved on May 19, 2008, from [http://eatright.org/cps/rde/xchg/ada/hs.xsl/CADE\\_3207\\_ENU\\_HTML.htm](http://eatright.org/cps/rde/xchg/ada/hs.xsl/CADE_3207_ENU_HTML.htm)

Cultural and historical aspects of food. Retrieved on May 19, 2008, from <http://food.oregonstate.edu/kelsey/kelsey.html>

Ethnicgrocer. Retrieved on May 19, 2008, from <http://www.ethnicgrocer.com/default.aspx>

Food, Nutrition and Culture. Retrieved on May 19, 2008, from <http://culturedmed.sunyit.edu/bib/food/index.html>

## **Activities to Promote an Understanding of Professional Issues and Cultural Diversity**

### **Advocacy**

#### *Definition*

Advocacy involves accepting responsibility to influence others to do certain things (Kummer, 2007). Speech-language pathologists may need to advocate for clients from multicultural backgrounds to improve clinical service availability and access. Such clients may be at a disadvantage to advocate for themselves because of their communication disorder as well as cultural, language, and economic differences. Advocacy may occur in local communities as well as at state and national levels. Hallowell and Henri (2007) state that advocacy occurs through consumer education and mobilization, education and marketing to third party payers and referral services, financial support, influencing legislation, and educating preprofessional and professionals regarding their roles in advocacy programs.

#### *Activities*

a. **Legislative Action.** Clinicians have a responsibility to understand and, if possible, to influence state and national education and health care legislation. **Student assignment:** Review ASHA's or your state professional association's legislative action programs. How do professional

associations consider the issue of racial/ethnic or low income background in their legislative programming? What needs are or should be addressed so that individuals from diverse backgrounds can benefit from access to speech-language services across service settings?

**b. Health Care Insurance Needs.** Funding for services is a critical issue for all clients including those from diverse backgrounds. **Student assignment:** Find national data that discuss how many individuals from racial/ethnic and low income backgrounds have or do not have health care insurance. How well can these individuals access health care insurance? What types of health care programs are available from national or state government agencies to cover speech-language services in medical and educational settings for such persons?

**c. Presentation to State Legislators.** Students must understand their role in public advocacy for clients from diverse backgrounds. **Student assignment:** You have been asked by your state association to give a 15 minute presentation to state legislators on the topic of speech-language needs among racial/ethnic and low income populations in your state. What would be the goals of your presentation? Prepare the presentation. Be sure to illustrate any disparities in access to services that you can document. Also list 5 questions that these legislators are likely to ask you and provide a compelling response.

**d. Underserved Needs.** Each community is likely to have individuals who may benefit from services but for one or more reasons do not access them fully. **Student assignment:** Consider who is an underserved population for communication disorders in your general community. How does multiculturalism correlate with being in this population? What advocacy programs might improve access to service for these underserved populations, and how can speech-language pathologists contribute?

**e. Mobilizing Clients.** Educating and mobilizing clients themselves are important tactics to improve access to speech-language services across clinical venues. **Student assignment:** Design an educational program for parents, family members, or clients themselves from one particular racial/ethnic or low income group in your community that may not fully access clinical services. In addition to designing the program, answer the following questions: What are the goals of the program? What information is important to convey? What problems (and solutions) might you have in conducting the educational program? What resources are available from your local, state and national professional associations to help you?

**f. Bill of Rights.** Many hospitals have Patients' Bill of Rights outlining how patients should be treated in the facility. **Student assignment:** Create a Patients' Bill of Rights that applies to those from multicultural backgrounds and, in particular, those who do not speak English. Ask some patients and professionals to review your document and provide feedback on its utility.

**g. Community Advocacy Groups.** Each community is likely to have groups that advocate for particular multicultural groups. Students should know what resources these groups might provide the multicultural clients with whom they work. **Student assignment:** Pick a multicultural group in your community, e.g. Hispanic, and identify the community groups that advocate for them. Make a visit to the group or to their website to determine their purposes, actions, and outcomes. How can this advocacy group help the communication needs of your clients?

### *Resources*

Hallowell, B., & Henri, B. (2007). Strategically promoting access to speech-language pathology and audiology services. In R. Lubinski, L. A. C. Golper & C. Frattali (Eds.), *Professional issues in speech-language pathology and audiology* (pp.387-408). Clifton Park, NY: Thomson Learning.

Kummer, A. (2007). Leadership and communication skills. In R. Lubinski, L. A. C. Golper & C. Frattali (Eds.), *Professional issues in speech-language pathology and audiology* (pp. 439-460). Clifton Park, NY: Thomson Learning.

### *Evaluation*

See the section on Cultural Competence for rubric to evaluate written and oral presentations.

## **Ethics**

### *Definition*

Ethics are standards of conduct that guide our professional behavior and promote high and consistent standards of practice (Miller, 2007). Ethical practice should be evident in clinical services and applied to all populations including those from multicultural backgrounds. Changing demographics may influence how ethical standards are applied in clinical contexts.

### *Activities*

a. **Is it Ethical?** Encourage students to review ASHA's Code of Ethics. **Student assignment:** What principles and rules apply to serving clients from multicultural backgrounds in the ASHA Code of Ethics? Discuss how speech-language pathologists may violate each principle when working with those from diverse backgrounds? Why might speech-language pathologists take liberties with ethical practice when working with clients from diverse backgrounds?

b. **Improving Ethics.** This is a good companion assignment to the one above. **Student assignment:** After reviewing the ASHA Code of Ethics, do you perceive that any of the principles or rules need clarification, revision, or additions so that clients from multicultural backgrounds can be served in an ethical and competent manner?

c. **Discrimination. Student assignment:** ASHA Code of Ethics Principle I forbids speech-language pathologists to discriminate in their delivery of professional services on the basis of race, ethnicity, age, religion, national origin, sexual orientation, and disability. What can be done at the college and professional levels to ensure that clinicians do not discriminate in their service delivery?

d. **State Licensure Law Review.** Students should read their state's licensure laws regarding service delivery to clients from diverse backgrounds. **Student assignment.** Read your state's licensure laws regarding speech-language pathology. What sections of the law related to service delivery to clients from diverse backgrounds? How might clinicians abuse this law and why?

### *Resources*

Miller, T. (2007). Professional ethics. In R. Lubinski, L. A. C. Golper & C. Frattali (Eds.), *Professional issues in speech-language pathology and audiology* (pp. 89-99). Clifton Park, NY: Thomson Learning.

### *Evaluation*

See the section on Cultural Competence for rubric to evaluate written and oral presentations.

## **Research**

### *Definition*

Research in speech-language pathology advances our scientific understanding of how and why we communicate, the characteristics and consequences of having a communication problem, and strategies for and the effectiveness of intervention. In addition to basic science research, today's researchers focus on providing evidence of what produces communication change and how these changes manifest themselves in the person's everyday life. Practicing clinicians also want to know how research reflects the cultural diversity of the clients with whom they work.

### *Activities*

a. **Research Funding.** Research often is dependent on funding from national sources such as the National Institutes of Health. **Student assignment:** Review various sources of national funding for research in speech-language pathology (e.g. NIH, NIMH). How is cultural diversity taken into account in priorities for research funding and in assessment of grant applications? What recently funded studies have focused on issues related to multiculturalism and communication disorders? How do such studies affect speech-language development, disorders, and intervention?

b. **Private Funding Sources.** This is a good companion assignment to the one above. **Student assignment:** What private sector funding sources are available to support research initiatives that focus on speech-language pathology and diversity or multiculturalism? What studies have been funded in the past five years on this topic?

c. **Journal Review.** Multicultural issues have become important in our profession, but has this been evident in our research? **Student assignment:** Review the past 5-10 years of published research in major journals in the profession of speech-language pathology in a particular area of interest (e.g. language disorders in children, phonology, etc). What multicultural issues have been researched and published? How would you evaluate the effectiveness of major journals in addressing multiculturalism as a feature in their published research? Choose sample articles and review the subject pool and how they are described. What are the problems with research involving persons from various racial/ethnic and linguistic backgrounds? What guidance might you give editorial boards of journals regarding the need to consider multiculturalism in the research they publish?

d. **Convention Programs.** This is a good companion assignment to the one above. **Student assignment:** Review the ASHA Convention Programs of the past five years to determine what programs have focused on multicultural issues and communication disorders. What is the nature

of these presentations? Who might be considered leaders in the area of multicultural issues and communication disorders? What training programs across the country have faculty and programs that foster a clear interest in this topic?

e. **EBP.** Evidence based practice (EBP) has been a leading issue in the profession of speech-language pathology. **Student assignment:** What studies can you find that focus on evidence based practice as it applies to various multicultural issues? Apply the Oxford Centre for Evidence Based Medicine Levels of Evidence to the research on multicultural topics and speech-language pathology:

A- Recommendations are based on one or more randomized controlled trials

B- recommendations are supported by one or more well designed retrospective, prospective or outcome studies

C- recommendations are supported by case series reports of outcome studies without a control of comparison group

D- recommendations are supported by expert opinion without explicit appraisal (Golper & Brown, 2007).

f. **Research Proposal.** Some students may be excited and willing to design and implement their own research projects. **Student assignment:** Write a research proposal on some aspect of speech-language development, disorders, or intervention that focuses on individuals from one or more racial/ethnic, or linguistic backgrounds Include a Review of the Literature, Research Questions, and Methodology. Have other students critique your proposal for its appropriateness for assessing multicultural populations.

### *Evaluation*

See the section on Cultural Competence for rubric to evaluate written and oral presentations.

### *Resources*

Golper, L.A. C., & Brown, K. (2007). Applying evidence to clinical practice. In R. Lubinski, L. A. C. Golper & C. Frattali (Eds.), *Professional issues in speech-language pathology and audiology* (pp. 560-576). Clifton Park, NY: Thomson Learning.

## **Supervision**

### *Definition*

Clinical supervision is a dynamic process between a supervisor and a supervisee. Its goal is to develop the clinical skills of the supervisee and to optimize service to clients. This definition is based on Anderson's (1988) philosophy of supervision. The supervisee may be a student in training or a professional. One of the goals of supervision is to grow the clinical skills of students with clients from various cultural backgrounds. The Council for Clinical Certification requires that students applying for certification have clinical experiences with such clients. It is expected that clinical competence involves cultural competence. In addition, the cultural background of both the supervisor and the supervisee influences how they will interact during the supervisory process. Finally, you may be asked to supervise speech assistants or aides and translators, some of whom may be from multicultural backgrounds.

### *Activities*

a. **Clinical Assignments.** Students should have clinical experience with clients from a variety of racial/ethnic, linguistic, and economic backgrounds. **Student assignment:** Identify the types of clients your college clinic serves. Also, what externship placements will give you experience in working with adults or children from diverse backgrounds? How do your clinical supervisors prepare you to work with these clients? What can you do to prepare for clinical practice with multicultural clients?

b. **Workplace Conflict.** **Student assignment:** You have been hired as the supervisor of a fifteen member clinical staff at a large community communication disorders center. After several weeks on the job, you realize that there are conflicts between several of the staff from racial/ethnic or linguistic backgrounds and other clinicians. Four of the clinicians are from diverse backgrounds – three are women of color, one wears a head scarf and long sleeves, and three have distinct foreign accents. You notice that some of the other clinicians ostracize these clinicians during clinic meetings, minimize interaction with them during team conferences, and do not invite them to social activities after work. You also notice that the clinicians from diverse backgrounds rarely interact with the other clinicians but do talk informally with the clerical staff. As the new supervisor of this team, what would you do? Devise a plan of action for improving the cultural harmony of this clinic.

c. **Externship Difficulties.** **Student assignment:** You work as a clinician in a community hospital that serves both in and out patient adults primarily with neurological disorders. You have taken students from a local university for several years for their fourth semester full time externship. This semester you were assigned a student whose first language is Korean. She came to the US three years ago to do make up work in speech-language pathology and her graduate degree. The college supervisor stated that “Mary” is a top notch academic student but has difficulties with speaking English. She continues to work with a peer clinician to develop her English speaking skills. When the student arrives you are concerned that her English is difficult to understand. While she is well prepared for the sessions, she speaks very quietly and her English articulation, syntax, and grammar are difficult to understand. Patients repeatedly say “Huh?” or “What?” and one patient used a derogatory comment regarding Mary’s ethnicity. What would you do if you were this supervisor? Should the university training program insist that its students participating in practicum all speak Standard American English? If so, to what level of competence? How should student speaking ability be taken into account in admissions and in clinical training? What is the ASHA policy on this issue?

d. **Interpreter Aide.** **Student Assignment** You work in a school district that serves a large Hispanic population of students, many of whom do not speak English when they first come to school. You have been assigned an Interpreter Aide who will work closely with you and Spanish only speaking students who have communication disorders not differences. How would you train this aide to work with you? What issues would be particularly important for the aide to understand about her role as an interpreter in this context? How would you know that the aide was interpreting reliably between the languages? What problems might you have in this context? Provide possible solutions for each.

*Evaluation*

See the section on Cultural Competence for rubric to evaluate written and oral presentations.

*Resources*

Certo, S. C. (1994). *Supervision: Quality and diversity through leadership*. Boston, Massachusetts: Austen Press.

Karsten, M. F. (1994). *Management and gender*. Westport, CT: Quorum Books.

Society for Human Resources Management. Retrieved on May 6, 2008 from:

<http://www.shrm.org/>