

Cultural Competence in Healthcare Social Work

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INTRODUCTION

With the increasing diversity in the United States populations, social workers and other service providers have been challenged to develop culturally competent skills that meet the “social, cultural and linguistic needs of patients” (Georgetown University Health Policy Institute, 2004). **Culture**, as defined by the National Association of Social Workers (2000) describes “the integrated pattern of human behavior that includes thoughts, communications, actions, customs, beliefs, values, and institutions of a racial, ethnic, religious, or social group” (p. 61). These patterns are passed on through generations. Although culture has historically emphasized race and ethnicity, increasingly broader conceptualizations include class, gender, religious and spiritual orientation, sexual orientations, age, and physical and mental abilities (National Association of Social Workers [NASW], 2006). Recognizing cultural and ethnic differences in healthcare should encompass three general domains: practice approaches, access to services, and healthcare disparities across populations.

In the process of defining cultural competence, we examine the impact of culture on our emotions, behaviors, and values and recognize the particular relevance of culture as it impacts health, healthcare use, and effective intervention. The focus is primarily on practice approaches in the delivery of culturally competent social work services in healthcare settings, although healthcare disparities and access will be briefly addressed. Spiritual and religious orientations are similarly acknowledged for their influence and impact on patient interaction.

DEFINING CULTURAL COMPETENCE

Cultural competence is “the process by which individuals and systems respond respectfully and effectively to people of all cultures, languages, classes, races, ethnic backgrounds, religions and other diversity factors in a manner that recognizes, affirms, and values the

worth of individuals, families and communities and protects and preserves the dignity of each” (NASW, 2001, 2006). **Linguistic competence** is an essential feature of culturally sensitive services and refers to providing readily available, culturally appropriate oral and written language services to individuals with limited English proficiency (Agency for Healthcare Research and Quality, 2003). Linguistic competence is a particularly important aspect of cultural competence in healthcare. Social workers play a key role in ensuring that patient education materials are translated to meet the needs of the service population and in ensuring that translation services and resources are available to the institution and patient (Farrar & Kirkpatrick, 2010).

Health literacy is defined as “the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions” (Nielsen-Bohlman, Panzer, & Kindig, 2004, p. 32). We take an expansive view of health literacy and understand it to be directly influenced by the client system’s culture—that is, their worldview, beliefs about health and illness, and traditional healing practices. Further, this perspective on health literacy is expanded to include the interactional dynamics of the patient–provider relationship. That is to say, the medical care is at least as influenced and directed by the health literacy (worldview, beliefs, and values about health) of the physician, team, and healthcare system as it is by that of the patient (Neuman, Matto, Hutchison & Singleton, 2005).

Cultural competence is not static and requires frequent relearning and unlearning about diversity. Practitioners must acknowledge the implications of their own “cultural lens” and continuously reflect on their own assumptions, biases, and stereotypes. This requires practitioners to adopt an attitude of open-mindedness and respect for all patients, including those who differ from them socially or culturally; to utilize interventions that recognize that effective clinical relationships may be constructed differently across cultures; and to understand the impact of healthcare disparities and inequalities that contribute to unequal access and treatment. Although definitions of cultural competence continue to evolve, Niemeier, Burnett, and Whitaker (2003) observed that the common elements of cultural competence include

- the adjustment or recognition of one’s own culture in order to understand the culture of the patient;
- appreciation and respect for cultural differences and similarities within, among, and between groups; and
- the development of a set of attitudes, behaviors, skills, and policies that help providers to work effectively in cross-cultural situations.

Cultural humility as proposed by Tervalon and Murray-Garcia (1998) describes a life-long commitment to self-evaluation and self-critique in exploring cultural biases. It acknowledges the power differential between providers and patients in order to develop non-paternalistic partnerships for care. Ideally, we should maintain an awareness of and sensitivity to the cultural groups with whom we are working. However, although culture is shared among members of the group, each individual constructs his or her own meaning and interpretation. Using a non-judgmental attitude, being open-minded, and reflecting a

sincere curiosity about the cultural experiences and beliefs of patients are crucial when working with individuals from different cultures. We acknowledge our limited understanding about the patient's culture and validate the patient as an expert in his or her own life and culture. We can then respectfully ask the patient to introduce us to his or her culture so that we might arrive at a shared understanding of his or her health condition, its meaning, and its treatment (Anderson, 1997; White, 1995).

Culture provides a framework in which individuals understand the causes, treatment, and meaning of disease, illness, and disability. In the United States, our science and technology-oriented culture promotes understanding disease as a function of bacteria, virus, or genetic mutation. Correspondingly, treatment is technology-based, including medication, surgery, radiation, and so on. In comparison, other cultures often perceive disease as a function of evil spirits or an imbalance in the body. Kleinman, Eisenberg, and Good (1978) stressed the importance of negotiating these kinds of discrepancies between patient and physician explanations of illness. The authors developed eight culturally sensitive assessment questions that are now familiar from many discussions of cross-cultural medicine:

1. What do you call the problem?
2. What do you think caused the problem?
3. Why do you think it started when it did?
4. What do you think the sickness does? How does it work?
5. How severe is the sickness? Will it be a short course or a long course?
6. What kind of treatment do you think the patient should receive and what are the most important results you hope are received from this treatment?
7. What are the chief problems the sickness has caused?
8. What do you fear most from the sickness?

Congress (1994; 2005) adopted the genogram and eco-map used in social work practice to create a **culturagram**, which identifies common themes, practices, and events in culturally diverse groups. Congress acknowledged that developing cultural competence in each of the many cultures, religious groups, and ethnicities represented in a diverse community can be daunting. It is important to note that approaching individuals and families with a generic or simplified understanding of their culture and background can lead to stereotyping and making assumptions. Illustrating the point, a refugee from the Sudan who has fled the trauma of civil war is very different from an individual from West Africa who immigrated to attend college. Use of a culturagram is valuable in assessing culturally diverse family systems. Ten areas are significant in forming culturally appropriate assessments:

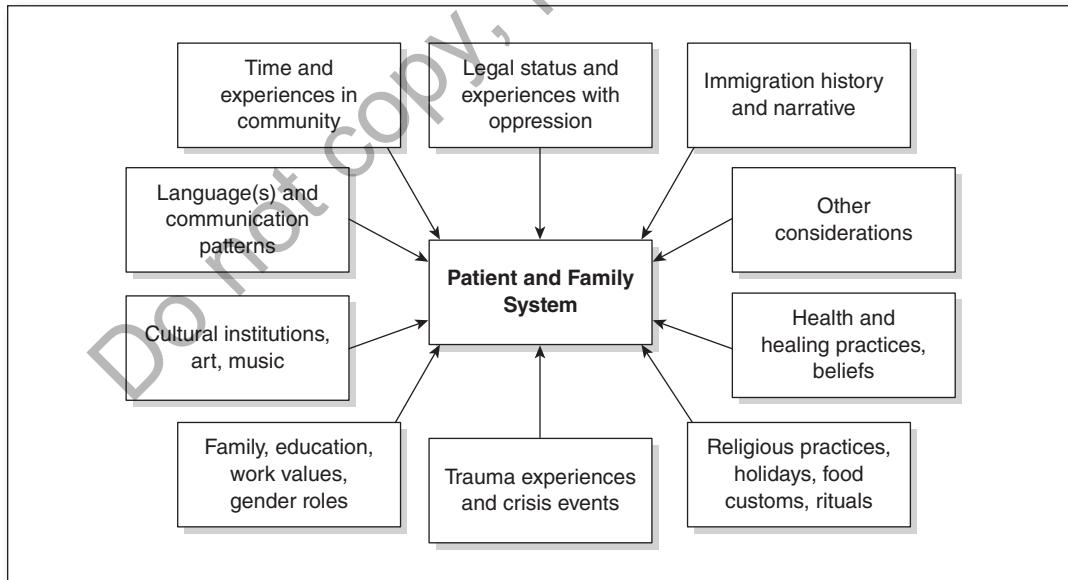
- Reasons for relocation
- Legal status
- Time in community

- Language spoken at home and in the community
- Health beliefs
- Crisis events
- Holidays and special events
- Contract with cultural and religious institutions (including religious beliefs, practices, and customs)
- Values about education and work
- Values about family—structure, power, myths, rules (including roles and gender norms)

Figure 15.1 updates Congress's original culturagram. For example, we include a recognition of the impact of trauma, the importance of immigration narrative (which is often a story that is passed down through generations), rituals, and gender roles, which are often culturally determined.

It is important to contemplate the factors that shape an individual's **worldview**, or, in the original German, *Weltanschauung*. A person's worldview is "the overall perspective from which one sees and interprets the world" (Altman & Rogoff, 1987, p. 8). A person's

Figure 15.1 Culturagram



Source: Adapted from Congress (1994, 2005).

worldview incorporates that person's fundamental beliefs about whether or not the world is safe and predictable, whether people are inherently good or evil, and whether we can control our destiny. People who are refugees from wars or political persecution, for example, are likely to have developed a worldview in which they regard the world as unsafe and unfair. As a consequence, they may have difficulty trusting people in authority, such as physicians and other healthcare providers. Of particular relevance, beliefs about science, medicine, and the causes and treatments of disease are included in a person's worldview.

The African American experience of racism and discrimination in this country extends into healthcare, with African Americans continuing to struggle for equal access to care and equal standards of care. The Tuskegee syphilis experiment, which began in 1932 and continued until 1972, was one of the most horrific examples of inappropriate and immoral healthcare provided to African Americans. These types of experiences have contributed to shaping the worldviews of many African Americans such that the largely white medical establishment is frequently approached with a degree of suspicion.

Understanding an individual's worldview is fundamental to understanding that individual and optimizing treatment (Galanti, 2008; Leininger, 1991; 1996). Failing to appreciate the influence of past experiences, religious beliefs and customs, and health can have profound consequences. The use of native plants, for example, can cause adverse drug reactions, and customs of fasting can complicate diabetes care. In some Asian countries, the practice of "cupping" or "coining" is done to draw out evil spirits. This practice can leave red welts, which could potentially be used as the basis for a referral to protective services. Social work can serve an important role in promoting greater awareness of individual and cultural understandings of, and preferences for, health and healthcare as well as how these conditions interact with typical healthcare practices in the United States. Social work functions in a bridging role between patients and healthcare providers to facilitate a mutual understanding of each other's culture, customs, health beliefs, and practices (Neuman et al., 2005). With such shared awareness, healthcare interventions can be designed with the knowledgeable participation of all parties.

SPECIFIC CONSIDERATIONS IN CULTURALLY COMPETENT HEALTHCARE

The degree to which traditional cultural norms are expressed depends on the extent of assimilation and acculturation. **Assimilation** is the process by which individuals of two or more cultures who have come into contact with each other lose their unique cultural identities and become fused into a single homogeneous cultural unit different from any of the original component cultural units. This is a two-way process in which both the minority and dominant group are modified. It is an evolving process that includes both individual and group identities and, as such, can cause challenges. **Acculturation** describes the process whereby the traits of a new culture are adopted and incorporated into an existing culture. In this process, two or more cultures in contact with one another each become modified, but without much evidence of their fusing into a single homogenous culture (see www.sociologyguide.com).

Both acculturation and assimilation are affected by factors such as the length of one's residency in a country, the degree of social isolation or integration, and the extent to which English is a second language. Health outcomes and health status have been found to be poorer where acculturation and assimilation are limited, as in the case of Mexican immigrants who continue to primarily rely on Spanish as their dominant language (DuBard & Gizlice, 2008). Of note, in many cultures there is heightened acceptance for expression of physical pain or distress rather than emotion. This contributes to **somatization**, or the experience of emotional conflict and anxiety in the body (Galanti, 2008).

Two general approaches exist in developing cultural competency in healthcare. The first, involving a review of commonly encountered ethnic, cultural, and religious groups, runs the risk of potentially stereotyping or overgeneralizing certain cultural traits to patients. In comparison, Galanti (2008) developed a second approach, which considers common dimensions of experiences that may vary according to culture. Social workers taking a position of cultural humility and engaging with patients and families in an exploration of culture, ethnicity, and religion are more likely to reach an understanding of how best to meet identified needs (Anderson & Goolishian, 1992; Anderson, 1997).

Our text interjects information on specific cultural groups to illustrate the themes of this section. While case examples and references to specific cultures are provided, caution must be exercised that every individual and family be regarded as unique. The therapeutic approach of being initially unaware, curious, and culturally humble is recommended; social workers should not make *assumptions* nor rely on *stereotypes* based on assumptions or over-simplifications (Jenks, 2011). The following themes (adapted from Galanti, 2008) commonly vary by culture:

- Family structure, roles, and gender
- Communication patterns and time orientation
- Pain
- Religion and spirituality
- Customs around daily living and life stage events
- Beliefs and practices about physical and mental health and illness

Family Structure, Roles, and Gender

The provision of healthcare services necessitates effective communication with the patient, with the family, and, when the patient is incapacitated, with designated family spokespersons. This has the prospect of becoming complicated depending on the way kinship is structured. In many cultures, family identity and affiliation is determined unilaterally through the father's line or, in the instance of the Jewish culture, by the mother's lineage. Generally speaking, contemporary American society is marked with bilateral identification drawn from both parental lines. *Family structure* describes how a family is organized, how power and authority are distributed, and how roles and tasks are determined.

Gender roles are typically an important consideration in working with people from other cultures. In many patriarchal cultures (such as Muslim cultures), the individual with

the most authority is the oldest male. Direct conversations with female family members can be interpreted as inappropriate and even insulting. Female patients may defer to their husbands in decision making and may even refuse to sign surgical consents and other forms. In some strict Muslim, patriarchal cultures in which the modesty of women is highly valued and protected, assigning same-sex caregivers may be helpful. Generally, it is important to include the female patients in discussions but to accept the cultural expectations of the family.

The term *Latino* is used to designate people in the United States whose origins can be traced back to the Spanish-speaking countries of Latin America as well as the Caribbean, Mexico, Central America, and South America. The term *Hispanic* was created by the federal government as a classification system for those individuals who speak Spanish. Latino is considered to be a more encompassing term and is what we have chosen to use for this text. Both terms are used to describe individuals from a wide array of countries, and there is great variation in language and cultural traditions between the groups (Flores & Vega, 1998). Latinos highly value the extended family and use the term *familismo* to describe this intense sense of belonging and pride in the family. Although it may be difficult to establish trust with Latino families, there is also a high degree of respect for authority and status (*respeto*). Patients may be hesitant to ask questions and may indicate agreement with a treatment plan in order to avoid disagreeing and being disrespectful to the physician. Reciprocal demonstration of respect by healthcare providers is expected, particularly by Latino males.

Latino families tend to be hierarchical and patriarchal. The older generation is respected and revered, with the oldest male typically holding the greatest power in the family. Males in Latino culture are expected to be the head of the household, to be good providers, and to uphold the integrity of the family (*machismo*). Women are socialized to and take great pride in being dedicated, nurturing, and loving spouses. There is a strong value placed on motherhood and having children. This is characterized by the term *marianismo*. In addition, people of Hispanic origin may expect *personalismo*, or a warm, personal regard with people with whom they are interacting. Taking time to inquire about children and elders in the family can demonstrate concern and personalismo.

Other family systems that tend to be patriarchal are those of Asian and Middle Eastern families. In Middle Eastern families, the family spokesperson is likely to be the oldest and most educated male. Husbands may defer to fathers and uncles. When a female patient is being assessed, the husband may answer for her. Sexual segregation may be expected, and women may not be involved in decision making. Asian cultures vary by country and by degrees of education and assimilation. In general, they are patriarchal and revere elders. Both Asian and Middle Eastern families have high-context communications styles (as described below), although Asians tend to be more reserved and indirect, whereas Middle Eastern individuals frequently are more expressive.

Communication and Time Orientation

The anthropologist Hall (1976) identified two general styles of intercultural communication patterns that vary by culture: **high-context** and **low-context communication**. These styles are delineated by how much individuals from the culture rely on other cues besides

words to understand the message being conveyed. Hall believed we receive many more verbal, non-verbal, and contextual cues in an encounter than we can consciously acknowledge or have been taught to be aware of by our culture.

In low-context cultures (as in the United States and particularly within the medical profession), communication is largely determined by the words selected as well as by voice inflection and tone. Communication tends to be precise, logical, linear, and factual; there is a literal interpretation of what is spoken. The broader aspects of low-context cultures are that they tend to be individualistic, to be action-oriented, and to seek quick solutions to problems. Feelings and intuition are not emphasized. The purpose of communication, especially around healthcare issues, is to reach a decision. The culture of medicine places considerable value on low-context communication (Neuman et al., 2005).

In contrast, high-context cultures rely on social and behavioral cues beyond verbal language to interpret messages. These cues can involve sitting arrangements, gestures, posture, and other subtle forms of communication that may or may not be recognized by individuals from low-context cultures. High-context cultures such as those of many Middle Eastern, Asian, and Hispanic cultures are not individualistic but rather value the collective and group. As they are relational, time is needed to develop the trust and relationship essential to providing care. Individuals in these groups value harmony and want to avoid conflict or any signs of disrespect. They may agree in order to be polite, without truly agreeing or even understanding any requests made of them. Communication emphasizes process and will not be directive and action-oriented. As discussions may include many family members, it can prove challenging for healthcare providers seeking to identify *the* family spokesperson. Communication may be reserved and polite, as in Asian cultures, or demonstrative, as in Italian culture. Recognizing whether one is dealing with a high- or low-context culture is an important starting point for engaging with patients and families from different cultures.

In general, providers are wise to avoid the use of colloquialisms and idioms that may be easily misinterpreted by those from another culture. An example could be made of a patient visiting the United States who is anxious to return home and asks his physician when he will be discharged from the hospital. His light-hearted physician jokes that the patient is going to have to stay another week. Seeing the patient's distressed look, the physician replies he "was just pulling the patient's leg." Not understanding the phrase, the patient becomes entirely confused as the physician was not in fact, pulling his leg. For reasons like this, the use of slang terms, especially referencing anatomy, should be avoided. Even specific words can be misconstrued, and they can have different meanings in the same language. Consider that when a patient is informed of "positive" test results, he or she might assume that he or she is receiving good news, when the term "positive" results in fact might be indicative of an abnormality, such as a malignancy.

The formality of communication will also vary by culture. Older African Americans often use a more formal tone when dealing with healthcare providers and typically should not be addressed by their first names unless given permission to do so. Importantly, naming varies by culture. In some Middle Eastern cultures, the first name is followed by the individual's father's name and then by the individual's grandfather's name. It is correct to address this individual as Mr. and then his first name (Galanti, 2008).

Non-verbal communication patterns also vary by culture. Americans value prolonged eye contact and interpret this as indicative of honest and forthright communication. However, in Native American and Asian cultures, it is generally disrespectful to look directly at someone. In Middle Eastern cultures, direct eye contact between the sexes is considered inappropriate. Similarly, touching a patient during conversation is not usually condoned in the Asian culture, and public displays of affection are considered in poor taste. In comparison, Hispanic patients and families may feel comfortable hugging and kissing a nurse or social worker as part of an enthusiastic greeting. Gestures, however, can prove problematic, such as the hand gesture for “OK,” which has a sexual connotation in many cultures. The “universal” thumbs up gesture, is not universal at all, and in fact in Great Britain constitutes an insult.

Time orientation is yet another experience that varies by culture. In the United States, we monitor time by a clock and a calendar. In contrast, Hispanic cultures are more likely to organize time around daily activities and routines. For example, Maria had an appointment to be seen in a health clinic. She arrived an hour late because she needed to take her young son to preschool. She lingered at the preschool, enjoying and participating in the children’s activities. On arriving at the clinic, she was upset to learn that her appointment would need to be rescheduled. She understood that she had an appointment in the morning but did not think an hour delay would matter that much. She also expected the clinic staff to understand that spending time with her child was more important than being on time for an appointment. Native Americans value listening over talking and believe that things will happen when they are ready to happen. In their culture, time is relatively flexible and generally is not structured to the clock. Other cultures, such as that in India, regard the calendar by seasons rather than months. While healthcare workers are unlikely to change cultural differences in time orientation, compromises can be usually be reached when flexibility is granted while explaining the need to be on time.

Experience of Pain

The subjective experience of pain is difficult to assess, and the outward expression of pain varies across individuals and cultures. In general, highly expressive Hispanic, Italian, and Jewish cultures tend to be less reserved and more open in acknowledging pain and discomfort and asking for assistance. In comparison, Asian culture values stoicism and correspondingly discourages demonstrations of pain. Although there may be some cultural tendencies, individual responses to pain vary. As Galanti (2008) noted, failing to appreciate individual and cultural differences in pain behavior can have tragic results. An elderly Asian gentleman was admitted to the emergency room for sepsis, which caused cardiac problems from which the patient nearly died. He had just seen his physician, where he had complained of “jageun,” or small pain while urinating. The physician prescribed medication and scheduled a recheck appointment for three months. The patient appeared satisfied at that time. The physician was unaware that on the previous day, the patient had been found by his wife crying in the bathroom. She later stated that the patient’s discomfort appeared to be severe and had been occurring for three weeks. The patient was culturally conditioned to avoid talking about himself with much detail and to accept a certain amount of pain. The patient was particularly uncomfortable discussing the details of an intimate body function with someone of “high” respect.

Cultural perspectives on the use of pain medications are important as they can affect treatment compliance and clinical outcomes. This can be particularly relevant when analgesics are prescribed to prevent the onset of severe pain, such as post-surgical pain. Individuals harboring suspicions of the healthcare and pharmaceutical system may avoid what they perceive as “unnecessary” pills and resort to medication only when pain becomes severe.

Religion and Spirituality

Religion and spirituality are fundamental elements in the lives of many people and can impact their health and use of healthcare. The term *religion* refers to a formal identification and typically some, or at least minimal, participation with an organized religious group, whereas *spirituality* is used to describe an individual's constellation of attitudes and beliefs about the human spirit, or soul, and its place and relationship to a higher power and the universe. According to Tanyi (2002)

Spirituality is an inherent component of being human, and is subjective, intangible, and multidimensional. Spirituality and religion are often used interchangeably, but the two concepts are different. Spirituality involves humans' search for meaning in life, while religion involves an organized entity with rituals and practices about a higher power or God. Spirituality may be related to religion for certain individuals, but for others, such as an atheist, it may not be. (p. 500)

Although the findings are somewhat inconsistent, there is some evidence to suggest that spirituality can have an effect on mortality, success in coping with chronic illness, and recovery. Research by Yates, Chalmer, James, Follansbee, and McKegney (1981) found that cancer patients who are spiritual have a better quality of life and better outlook than those without such beliefs. Other studies have found that spirituality can enable people to enjoy life, even when experiencing severe pain, and that many find prayer to be helpful in controlling pain (Brady, Peterman, Fitchett, Mo, & Cella, 1999). Spirituality is important in helping people contend with illness and the prospect of facing death. In one study of 108 women with advanced gynecological cancer, 75% said that religion and spirituality played an important role in helping them cope with their disease and 49% said they had become more religious since being diagnosed (Roberts, Brown, Elkins, & Larson, 1997). Heart transplant patients who identify themselves as spiritual and who participate in religious activities complied better with follow-up treatment and had a higher return of physical function, less anxiety, and fewer health worries than other patients (Harris et al., 1995). Some studies have suggested that individuals who are religious may live longer, and researchers have speculated that decreased levels of stress hormones may be involved (Koenig et al., 1997; Strawbridge, Cohen, Shema, & Kaplan, 1997). Exploring the intersection of religion, spirituality, and health is an essential dimension of a comprehensive biopsychosocial-spiritual assessment and can be introduced with simple open-ended questions such as “Has this illness affected your faith or spirituality in any way?”

Acknowledging and supporting prayer activities is important to many hospitalized patients. Although some families may seek the comfort of a chapel, others may not want to leave the patient and prefer to pray at bedside. In some cultures, prayer may be expressive and enthusiastic whereas in others it will be quiet and private. Sensitivity

should be accorded and accommodations made wherever possible. Social workers fulfill a valuable function by offering to connect patients and families with pastoral services in the hospital and/or with the family's religious leader. In the absence of pastoral care services or a patient preference, typically networks of volunteers exist in communities to engage in offering spiritual support to patients.

A major underpinning of one's religion or spirituality is the patient's belief as to whom or what exactly has the power to cause and cure disease. In a number of U.S. religions, including Pentecostalism and Christian Science, only God has this power. American Baptists similarly believe this but may view physicians as being empowered by God and/or Jesus. Many of the Jewish faith believe that only God has the power to heal, but Jewish culture also places a high value on science, technology, and education. Many members of the Jewish faith believe that physicians are the "hand of God" and therefore are typically accepting of modern American medicine. Depending on culture or faith, illness can be seen as punishment for sins or, as it is for the Hmong, the result of evil spirits. In one specific instance, a woman with breast cancer was asked about whether her faith and spirituality were helpful to her in coping with the disease. Breaking down in tears, she shared that she believed the cancer was a punishment from God for an affair she had had 35 years earlier. Tearfully, she said that the man involved had loved her body and, in particular, her breasts.

Other cultural considerations include traditions about blood and body integrity. In some cultures, notably, conservative and Orthodox Judaism, the human body must be buried whole following death, and neither autopsy nor organ transplant can be considered. Although Jehovah Witnesses will accept contemporary medical care, including surgery, a religious prescription prevents the use of blood products and transfusions. In some traditional Asian cultures, the drawing of blood can be problematic as this is associated with "soul loss" and the belief that the soul can become detached from the body and left to wander. Caesarean sectioning may be refused by the Hmong and other traditional Asians cultures because of the belief that the soul is attached to all of the body, and cutting the body cuts the soul from it. A similar belief held by Native Americans makes it taboo to cut a child's hair, which is seen as a sign of a health.

Customs of Daily Living and Life Stage Events

Every one of us has preferences and customs that are part of our routines. Some of these preferences, such as diet and personal hygiene, are culturally influenced. Fasting during Ramadan and Yom Kippur are required in most Muslim and Jewish traditions. This can cause complications for patients who are already nutritionally compromised. Other groups, such as Seventh Day Adventists, Buddhists, and Hindus, are forbidden to eat meat. The eating of pork is taboo in many cultures. Many Jewish individuals keep kosher, with restrictions on mixing meat and dairy products. Filipinos eat rice with every meal and perceive that something is missing if it is not served. Rice consumption is considered essential to their well-being and health (Galanti, 2008).

Insensitivity to the temperature and serving of hot and cold items to patients can prove problematic. In some cultures from tropical and hot climates, only cold foods are eaten during the summer months. Among Mexicans, disease may be viewed as the product of an imbalance between the "hot" and "cold" elements of the body. From that perspective, consumption of food that is too hot or cold contributes to the imbalance. Patient preferences

will also drive behavior, and innumerable examples exist of patients who ate poorly in the hospital until family members were permitted to bring in foods that were part of the patient's cultural traditions or habit.

Customs of bathing and personal hygiene vary, and many cultures, even Western cultures, do not share the American preoccupation with daily showering or bathing. In many African cultures, fresh water is not easily available and a full bath is considered a waste of a precious resource. A layer of dirt can sometimes be seen as either a source of protection or means to hide from evil spirits. In some countries, hospitalized patients may be bathed weekly or less. Toileting customs also vary, with water cleansing preferred over the use of toilet paper in some countries. The custom in some traditional Asian cultures is for both men and women to squat over the toilet—even if this means standing directly on the seat (Galanti, 2008).

All cultures have practices and customs associated with major life stage events, such as birth, coming of age, marriage, and death. Pregnancy taboos and customs have been studied since the late 1800s by early anthropologists. Because pregnancy and birth is a particularly dangerous time for the mother and baby in many parts of the world, it gives rise to numerous customs and taboos. Galanti (2008) noted one common belief shared among Asians, Latinos, African Americans, and many Anglo Americans is proscription against a pregnant woman raising her arms above her head. The fear is that this gesture will wrap the umbilical cord around the baby. In many cultures, special customs surround miscarriages, with full burials and services expected for very early term miscarriages.

Prenatal care is highly valued and is expected by Anglo American women in the United States, where pregnancy is viewed as a medical condition that should be managed with a physician. African American women and those from other cultures may view pregnancy as a natural state that does not warrant medical intervention. Among African Americans, mothers, aunts, and other women provide support, consultation, and advice to the pregnant woman.

Culture may affect how the pains experienced with child birth are expressed. Asian and Filipino cultures that value stoicism have a tendency to be reserved, whereas the African American culture, which is highly expressive, contributes to women being more demonstrative in communicating their labor pains. Who is expected and allowed in birthing rooms varies. It is an increasing custom for Anglo American fathers to not only be present, but to videotape the happy event. Other cultures would find this practice incomprehensible. In Orthodox Judaism and other cultures, pregnancy is seen as an unclean state and husbands may not wish to be involved in any part of the birth process. This is also true of Muslim cultures and may present a difficulty if healthcare staffs have relied on the husband to translate. In Mexican cultures, presence in the labor room is seen as women's work, whereas the job of the male is to be strong for the family outside of the delivery room. Members of many cultures, including Muslims, Southeast Asians, and Africans, bury the placenta after child-birth. In Ann Fadiman's book *"The Spirit Catches You and You Fall Down,"* (1997) about the Hmong culture, the placenta is regarded as the "jacket" of the soul. It is buried in a place that will lead the soul to the place of its ancestors when it departs from the individual. In Vietnamese culture, the umbilical cord is dried for a good luck charm.

Many Latino cultures, including Mexican, perceive it as very inappropriate to talk about bad things in the future, such as an impending death. This perception arises from a strong belief in fate and in tempting fate, called *fatalisimo*. One implication of this belief is that individuals from these cultures are less likely to complete advance directives. Kagawa-Singer and

Blackhall (2001) found that 65% of Korean Americans and 52% of Hispanic Americans prefer not to be informed of a terminal prognosis. In China and other Asian countries, it is customary for the physician to inform the family but not the patient of a terminal prognosis. This presents legal challenges in the American medical system as it contradicts the values of informed consent and right to self-determination. Galanti (2008) recommended that health-care personnel be aware of whether state law permits patients (even competent ones) to assign their medical decision-making authority to their preferred decision-maker. She suggested encouraging patients to sign such forms in advance, thereby providing documentation designed to serve the desire of the patient as well as protecting the hospital and staff.

The intent of hospice care is to provide sensitive, minimally intrusive attention to physical and emotional needs that patients and families have toward the end of life. Consenting to hospice care in some cultures, however, can be viewed as “giving up” or denying the power of God to heal and cure, and making decisions regarding the withdrawal of life supports or implementation of “do not resuscitate (DNR)” orders can have cultural influences as well. In many cultures and religions (Buddhism, Catholicism, Orthodox Judaism, Korean), life is considered sacred in all forms and the withdrawal of life supports can be viewed as a violation of this sacred belief. African Americans are more likely than their Caucasian counterparts to want life support measures continued. For some, this is a product of the experience of racism and discrimination; for others, it is rooted in their religious beliefs. In contrast, Galanti (2008) describes the Chinese valuing of the family over the individual, such that withdrawal of life supports may be permitted if circumstances have transcended into a burden to the family.

Given the nature of healthcare practice, social workers must be aware of the customs, values, and beliefs that surround the end of life, death, mourning, and burial. Compassionate understanding can help to ensure that the wishes of the culture and family, with respect to the body, are honored by the healthcare team. Autopsies and organ donations can be taboo practices. In some cultures, it is unacceptable to leave the body of the deceased individual. In American culture, it is important for many families to be present at the bedside at the moment of death. Talking to the patient and assuring the individual that the remaining family members will be all right after the individual's departure is thought to free the individual from languishing at the end of life. In some cultures, a candle is lit or shoes are placed nearby to guide the departing individual on his or her journey.

Embalming and interment customs vary, and many cultures, including among those of the Jewish faith, have prohibitions about who can handle the body. Although cremation is an increasing practice in the United States, generally Jews and Muslims oppose this practice, as the body must be interred whole. The Catholic position on this practice is mixed, historically believing that a whole body is necessary for resurrection, but cremation is common for Hindus and Buddhists. As a number of cultures (e.g., Mexican, Muslim) regard it as unlucky to discuss funeral wishes in advance, it is not unlikely that all arrangements will need to be made once the patient has died. In American culture, laying out of the embalmed body is common and an open casket is not usual. In contrast, for those practicing Judaism, the body is not embalmed and is buried as quickly as possible. Following a memorial service or mass, Irish Americans commonly hold a wake, which might take on the appearance of a celebration to outsiders. For the Chinese, much of the funeral and burial rites will be determined by the individual's status or place in the family. Younger sons may have smaller, less ostentatious funerals as it is considered inappropriate for elders to

demonstrate too much respect to those who are younger. Many cultures will remove or cover mirrors in the house, and the wearing or prohibition of certain colors is observed. In American culture, the customary color of mourning is black; the Chinese do not wear the color red, as it is seen as the color of happiness.

In Mexican, Puerto Rican, some Muslim, and African American cultures, there is a tendency for visible and noticeable demonstrations of grief, which can include wailing or “keening.” Anglo American culture values a more reserved, even private expression of grief, as do Asian cultures. It is taboo for the Hmong to appear distressed at the passing of a loved one as there is joy in reincarnation. In China and other Asian countries, although stoicism and reserve are valued in mourning, elaborate customary rituals honoring the dead must be performed exactly as prescribed. The purpose of these rituals and all other funerary rites is not only to honor the deceased but also to assist family members to cope with the loss of a loved one. Jews commonly sit *shiva*, during which the grieving family is not left unattended for a period of 7 days. In the United States, the period of mourning may last for at least a year (permitting the passing of all four seasons and associated holidays). During this time, a reserved decorum is expected with dating and remarriage is strongly discouraged. The Chinese period of formal mourning is 100 days.

Cultures around the world believe that the spirits of the dead are present in this world and interact with us on a regular basis. The Chinese believe that the spirit will visit the home within 7 days, and a red plaque is placed outside the door so the spirit does not get lost. Mexicans and other Latin Americans maintain a strong belief in the presence of spirits, and, similar to the Catholic tradition of All Saints Day, the Day of the Dead (El Dia de los Muertos) is celebrated as a holiday on November 2. Families may attend the ceremony, leave food and presents for the deceased, and construct altars in the home in hopes of inviting the dead to visit. The Shonas of Zimbabwe maintain a strong belief in the presence of spirits, feeling that the spirits interact regularly with the community and serve as protectors to the family. Sensitivity to cultural beliefs and practices is crucial, and social workers can help other healthcare team members who might be concerned when individuals from other cultures report believing they were visited by a deceased loved one.

Beliefs and Practices: Physical/Mental Health and Illness

Mental health and mental illness are relatively new concepts in our history. For much of history, mental illness was thought to be caused by evil spirits, the “evil eye,” and curses, or by an imbalance in body humors. In much of the world, it still is. The range of “normal” behavior varies by cultures as well. For example, in an Anglo American funeral, excessive wailing and fainting would cause concern for the individual’s mental health. At African American funerals, this would be customary. There may be a stigma associated with seeking professional help or even in talking about emotional and mental health concerns (Jang, Chiriboga, Herrera, Tyson, & Schonfield, 2011). Individuals may seek solace from family members, the extended family, elders, or the church. When support is sought, it very important to not “pathologize” the presenting problem; talking about stress and nerves may be entirely adequate for counseling. In many Asian cultures, the stigma against mental illness is so strong that individuals commonly somatize their pain into physical illnesses, thereby authenticating the need for supportive counseling by the physician (Nicolaidis et al., 2011; Saechao et al., 2001).

All cultures have their traditions of healing. In the United States, the dominant form is a medical, scientific model, although beliefs about the healing power of God are common. Folk-healing traditions include coining and cupping to draw out evil spirits; sweat lodges and other practices to break a fever or to exude negative energy; exile and quarantine; fasting; medicinal use of plants, foods, tonics, and teas; the use of psychoactive substances; exorcism; acupuncture; use of traditional healers, called *shamans* in many cultures; the sacrifice of animals; prayer; and the performance of healing ceremonies. In Fadiman's book *The Spirit Catches You and You Fall Down*, (1997) progress is made in the care of a severely epileptic Hmong child when the traditional healing practices are understood and accepted and an alliance is formed between the healthcare providers, the family, and the shaman.

The use of plants and dietary supplements can be cause for concern. Forty percent of Americans take some form of dietary supplement. One quarter of Asians and about 10% of African Americans use herbal remedies and supplements as an important part of their self-care. These can interact with prescription drugs in a number of disadvantageous ways. In some instances, the supplement and a prescribed drug may be chemically similar and the combination may result in too strong of a dose. Particular foods can also interact with medicines. To illustrate, individuals taking blood thinners are often advised to avoid cranberry juice and to limit their intake of green, leafy vegetables. Exploring traditional healing practices and customary supplements, foods, and herbs should be incorporated into comprehensive psychosocial-spiritual assessments and shared with physicians for evaluation (American Council on Science and Health, 2000; Arcury, Grzywacz, & Bell, 2007).

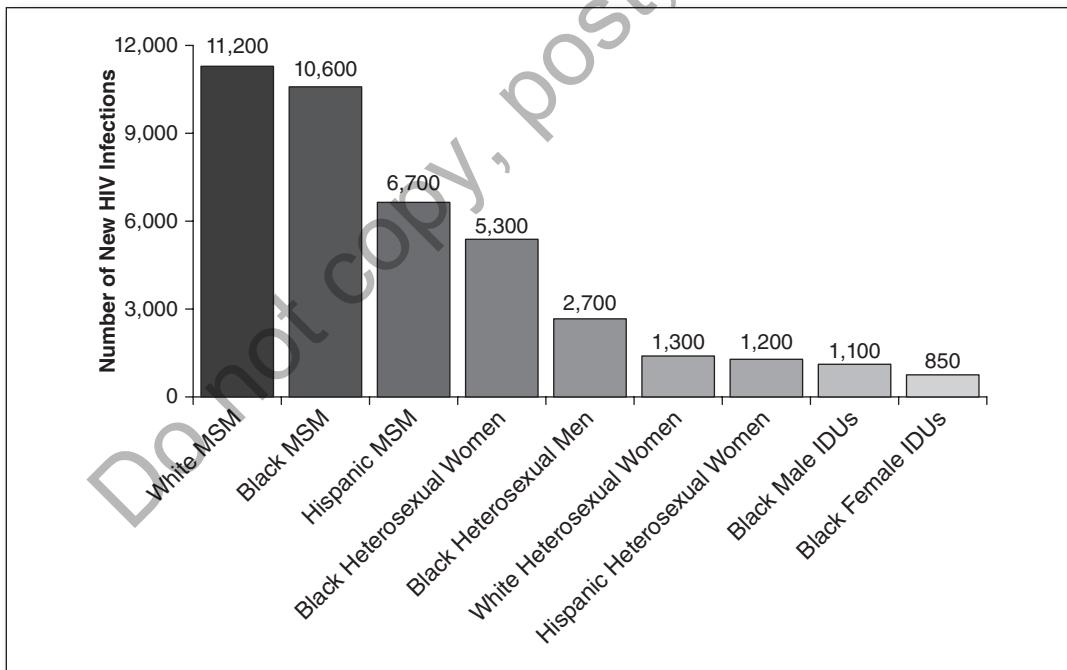
The Gay, Lesbian, and Transgendered Population

Although much progress has been made in recognizing and accepting gay, lesbian, bisexual, and transgendered (GLBT) individuals in many aspects of the "mainstream" U.S. culture, significant barriers persist in access to care and adequacy of care for this population. As Krehely (2009) noted, particularly high levels of healthcare disparities and poor outcomes can be found when GLBT status occurs in conjunction with minority or ethnic status. When compared with their heterosexual counterparts, GLBT individuals are less likely to have health insurance and are more likely to delay care, to fail to fill prescriptions, or to get care in an emergency room. They are also less likely to rate their health as excellent and experience higher rates of certain cancers, psychosocial distress, and suicide attempts. These disparities are attributed in part to the presence of persistent stigma, lack of healthcare insurance or plans that address the specific healthcare needs of the GLBT, inadequate data and research on GLBT health, and the lack of specially trained providers (Krehely, 2009). In addition, according to SAMHSA (2001), nearly one-third of this population may have problems with substance abuse and are less likely to seek treatment than their counterparts. Finally, although accurate estimates of the incidence of interpersonal violence in this population are difficult to attain, Friedman, Marshal, Stall, Cheong, and Wright (2008) found that same-sex couples report interpersonal violence as their most serious health concern after HIV/AIDS.

As much of the healthcare related research in the GLBT population has historically focused on sexually transmitted diseases and HIV/AIDS, a pressing need exists for comprehensive and inclusive studies that address the full scope of psychosocial stressors, stigma, and obstacles to health encountered by this population. Although overall incidence rates

have stabilized for most groups in the years between 2008 and 2010, the estimated rates for males having sex with males (MSM) has increased 12%. Furthermore, the age of incidence decreased and now these diseases disproportionately affect people between the ages of 24 and 35. African Americans, particularly young African American males, are most at risk (Centers for Disease Control and Prevention [CDC], 2013). Cultural and religious stigmas in the African American community regarding males having sex with males are factors that inhibit safe-sex practices, early diagnosis, and treatment. Barriers to healthcare, including access, lack of insurance, and a shortage of primary care providers, are also factors. Because early identification and treatment with antiretroviral therapy have been shown to slow the progression of HIV to the disease AIDS and reduces transmission from one person to another, social workers must become educated and comfortable addressing this issue with at-risk clients. In practice, social workers should encourage individuals to be tested and referred to the appropriate specialists and clinics for care (CDC, 2013). *Figure 15.2* reveals the 2010 incidence rate of new HIV infections and how MSMs are disproportionately affected. Once a patient has been diagnosed, in addition to providing emotional support, social workers can assist the patient in obtaining and maintaining the required drug regimen.

Figure 15.2 Estimated New HIV Infections—2010



Note: MSM = males having sex with males; IDUs = intravenous drug users

Source: Estimated New HIV Infections (2010). Centers for Disease Control and Prevention, 2013.

The limited failure to recognize gay marriage and support the rights of same-sex couples places a significant burden on American's 2.5 million GLBT elders, who are twice as likely to live alone and four times less likely to have children to assist in their care (Krehely, 2009). Even when the couple is recognized and supported by the healthcare team, persistent legal barriers can prevent disclosing medical information and block medical decision making of the same-sex partner of a patient, thereby preventing his or her full engagement in the care of his or her loved one. Along with offering supportive and inclusive care that encourages patients to disclose their gender/sexual orientation and identify issues of concern, social workers involved with this population can intervene by

- encouraging healthcare team members to recognize and address their own feelings and attitudes about working with GLBT individuals;
- contributing to training that enhances the competency/sensitivity of care,
- becoming familiar with and identifying the particular healthcare challenges and problems faced by GLBT patients,
- providing an opportunity for patients to explore and heal from the stigma and negative experiences associated with homophobia and heterosexism,
- assuring the inclusion of GLBT patients in appropriate medical studies and the protection of their rights as human subjects in those studies,
- helping patients assert their rights to competent care, and
- advocating for the inclusion of GLBT partners in medical decision-making processes (SAMHSA, 2001).

CULTURALLY COMPETENT HEALTHCARE ORGANIZATIONS

Culturally competent practice is enhanced when there is an organization commitment to providing culturally competent care. In fact, the literature on culturally competent social work practice states that the efforts of the individual practitioner will not have much impact *unless* expectations for culturally competent practice is woven into the fabric of the healthcare (Bankhead & Erlich, 2005). According to Nybell and Sims (2004), cultural competence in social service organizations requires that staffing management and leadership is congruent with the diversity of the client population served. This necessitates reviewing policies and practices related to recruiting, hiring, training, and retaining a diverse work force as well as assessing the organization within the context of the community it serves. Further, programs and services must be evaluated to determine the extent to which resources are allocated fairly and appropriately so that all groups are served. Agency-wide cultural competence training initiatives should be implemented, specifically targeting the needs and demographic makeup of the

community served. At the level of interaction between professionals and clients, written materials must be translated and resources made available for translation if necessary (Ludwig-Beymer, 2008).

The following guidelines are suggested for culturally competent organizations (Green, 1999; Hutchison, 2003; Lum, 2003; Mor Barak, 2000):

- Diversity should be reflected in all levels of the organization from clients to the board of directors.
- The organization should conduct and support ongoing training and communication about diversity issues and multicultural communication.
- Staff should be actively engaged in learning about the community, its norms, values, and formal as well as informal resources. Particular attention should be paid to preferences for care giving and care receiving.
- Staff should engage in active outreach, attending local functions, giving presentations at community organizations and so on, particularly when a targeted population is suspicious of Western bioscience.
- Staff should maintain working relationships with other organizations that serve the targeted population, such as ethnic agencies (NASW, 2006).

Cross, Bazron, Dennis, and Isaacs. (1983) conceptualized the cultural competence of organizations as falling along a continuum. Beginning with the least level of competence, organizations may be *culturally destructive*, with extreme insensitivity to patients' cultural identities, health practices, and beliefs. *Cultural incapacity* is reflected when organizations have failed to develop any capacity to respond to patients of different cultures. Organizations that believe that good practices in and of themselves are culturally appropriate are seen as *culturally blind*. Organizations that recognize and attempt to rectify weaknesses in serving those from different cultures are regarded as *culturally pre-competent*. A **culturally competent organization** accepts and respects differences between cultural groups, continually assesses their policies and practices regarding cultural sensitivity, has an ongoing commitment to expand cultural knowledge and resources, and promotes cultural competence in hiring and developing staff.

Social workers have much to contribute to organization-wide efforts that enhance cultural competence. Our knowledge of the community, its resources, and formal and informal leaders can be a distinct asset in creating supportive networks of concerned individuals with cultural expertise for guiding the process. Our macropractice skills can lead and facilitate the change effort and ensure appropriate responsiveness to the community at large. Finally, we have the capacity to work at mezzo and micro levels with groups, families, and individuals to ensure that cultural beliefs about health and illness are understood and reflected in care. The following checklist (*Table 15.1*) is adapted from work by Goode (2006) and the National Center for Cultural Competence. Originally designed for

assessing agencies working with children, the checklist has been adapted by others for assessing the cultural sensitivity of healthcare organizations and social service agencies serving a variety of client age groups.

Table 15.1 Checklist for Culturally Competent Organizations

PROMOTING CULTURAL DIVERSITY AND CULTURAL COMPETENCY

This checklist is intended to heighten the awareness and sensitivity of personnel to the importance of cultural diversity and cultural competence in human service and health settings. It provides concrete examples of the kinds of values and practices that foster such an environment.

Directions: Please select A, B, or C for each item listed below.

A = Things I do frequently

B = Things I do occasionally

C = Things I do rarely or never

PHYSICAL ENVIRONMENT, MATERIALS & RESOURCES

____ 1. Pictures, posters and other materials are displayed that reflect the cultures and ethnic backgrounds of patients and families served by the program or agency.

____ 2. Magazines, brochures, and other printed materials in reception areas are of interest to, and reflect the different cultures of patients and families served by the program or agency.

____ 3. When using videos, films, CDs, DVDs, or other media resources for mental health prevention, treatment or other interventions we insure that they reflect the cultures of patients and families by the program or agency.

____ 4. When using food during an assessment, we insure that meals provided include foods consistent with the cultural and ethnic backgrounds of patients and families served by the program or agency.

____ 5. We insure that toys and other play accessories in reception areas and those used during assessment are representative and inclusive of the various cultural and ethnic groups of the community we serve.

COMMUNICATION STYLES

____ 6. For children and youth who speak languages or dialects other than English, staff attempt to learn and use key words in their language so that they are better able to communicate with them during assessment, treatment or other interventions.

(Continued)

(Continued)

____ 7. Staff attempt to understand any cultural or familial colloquialisms used by patients and families that may impact on assessment, treatment or other interventions.

____ 8. The organization has appropriate visual aids available to use with patients and families who have limited English proficiency.

____ 9. Bilingual or multilingual staff are identified and trained/certified as interpreters for assessment, treatment, and other interventions for patients/families w/limited English Proficiency.

____ 10. Bilingual staff or multilingual trained/certified interpreters are available and used during assessments, treatment sessions, meetings, and for other events for patients and families who require this level of assistance.

11. Staff have been trained to keep in mind that:

____ a) limitations in English proficiency are in no way a reflection of an individual's level of intellectual functioning.

____ b) limited ability to speak English has no bearing on an individual's ability to communicate effectively in their language of origin.

____ c) patients may or may not be literate in their language of origin and/or English.

____ 12. Patient education materials and other written communications are translated into the patient's and family's language of origin.

____ 13. Staff understand that it may be necessary to use alternatives to written communications for some patients and families, as word of mouth may be a preferred method of receiving information.

14. Staff understand the principles and practices of linguistic competency and:

____ a) apply them within their programs and services.

____ b) advocate on behalf of patients and families when appropriate.

____ 15. Staff understand the implications of health/mental health literacy within the context of the patient/family's culture or origin.

VALUES AND ATTITUDES

____ 16. Staff use alternative formats and varied approaches to communicate and share information with patients and families who experience illness and/or disability.

____ 17. Staff avoid imposing values that may conflict or be inconsistent with those of cultures or ethnic groups other than their own.

____ 18. Staff discourage others from using racial and ethnic slurs and other derogatory terms by helping them understand that certain words can hurt others.

____ 19. Books, movies, and other media resources used by the agency have been screened for negative cultural, ethnic, or racial stereotypes.

- ____ 20. Staff intervene in an appropriate manner when they observe other staff engaging in behaviors that show cultural insensitivity, bias or prejudice.
- ____ 21. Staff understand and accept that family is defined differently by different cultures (e.g. extended family members, fictive kin, godparents).
- ____ 22. Staff recognize and accept that individuals from culturally diverse backgrounds may desire varying degrees of acculturation into the dominant or mainstream culture.
- ____ 23. Staff accept and respect that gender roles in families may vary significantly among different cultures.
- ____ 24. Staff understand that age and life cycle factors are experienced differently by different cultures and must be considered in interactions with individuals and families (e.g., high value placed on the decisions of elders or the role of the eldest male in families).
- ____ 25. Generally speaking, staff accept and are able to respect the preferences and practices of patients and families from various cultures and to interact non-judgmentally.
- ____ 26. Staff recognize that the meaning, value, and types of health prevention, intervention, and treatment vary greatly among cultures.
- ____ 27. Staff recognize and understand that beliefs and concepts of emotional well-being vary significantly from culture to culture.
- ____ 28. Staff understand that beliefs about physical and mental illness and disability are culturally based and accept that responses to these conditions and related treatment/interventions are heavily influenced by culture.
- ____ 29. Staff understand the impact of stigma associated with physical and mental illness and help-seeking varies between culturally diverse communities.
- ____ 30. Staff understand that religion, spirituality, and other beliefs may influence how families respond to mental or physical illnesses, disease, disability, and death.
- ____ 31. Staff recognize and accept that folk and religious beliefs may influence a family's reaction and approach to an individual with an illness or disability.
- ____ 32. Staff understand and respect that customs and beliefs about food, its value, preparation, and use are different from culture to culture and that this may be an important consideration in healthcare treatment.
- ____ 33. Before meeting with patients and families from other cultures, staff seek information on acceptable behavior, courtesies, customs, and expectations that are unique to that culture.
- ____ 34. The organization and its staff have developed relationships from other agencies, key community informants, and leaders who are also engaged in serving the diverse members of the community.

(Continued)

(Continued)

_____ 35. The organization and program's mission statement, goals, policies, and procedures have been reviewed to ensure that they incorporate principles and practices that promote cultural diversity and cultural and linguistic competence.

_____ 36. The organization regularly assesses the community and population served to identify demographic trends and population changes that necessitate the development or modification of services in response.

_____ 37. The organization has made a commitment to recruiting, hiring, training and retaining a diverse workforce.

_____ 38. The organization has development and implemented an agency wide cultural competence training initiative.

_____ 39. The organization provides regular opportunities for the staff to meet and discuss issues related to cultural competence and serving the needs of the various cultural groups served.

_____ 40. The organization provides support and opportunities for further staff development, training, research, and knowledge development and dissemination around issues of cultural competence in healthcare.

There is no answer key with correct responses. However, if you frequently responded "C," your organization may not necessarily demonstrate values and engage in practices that promote a culturally diverse and culturally competent service healthcare delivery system.

Source: Adapted from Goode (2006).

SUMMARY

Culture as reflected in the thoughts, communications, actions, customs, beliefs, values, and institutions of a racial, ethnic, religious, or social group has a pervasive impact on individual health and use of healthcare services. This chapter has examined these impacts and the importance of developing sensitivity to the cultural nuances of patients and families seeking healthcare. Religious and spiritual orientations have significant roles affecting an individual's persona, including how the individual envisions his or her health condition, the acceptability of treatment, and the manner in which he or she interacts with the healthcare team. Attention to gay, lesbian, bisexual, and transgendered (GLBT) individuals includes the impacts of historic discrimination to this group and the manner in which care is sought out and received.

Individual practitioners and healthcare organizations alike are accountable to maintain a level of cultural competency that reflects their awareness and appreciation for the uniqueness of the individual. Social work in particular has a responsibility to be proactive in assisting the healthcare team to understand patient and family member beliefs and values about one's health condition and the treatment of presenting problems. Respect and

accommodation to patient needs and preferences will enhance the likelihood of positive interventions and outcomes. Sensitivity and compassion based on such respect is fundamental to healthcare social work practice.

KEY TERMS AND CONCEPTS

- Culture
- Cultural competence
- Linguistic competence
- Health literacy
- Cultural humility
- Culturagram
- Worldview
- Assimilation
- Acculturation
- Somatization
- High-context communication
- Low-context communication
- Culturally competent organizations

QUESTIONS FOR DISCUSSION

1. How does cultural humility and the clinical position of “not-knowing” assist us in working with people from different cultures? Are there limitations to this approach? What would be an alternative?
2. Gender roles, power, and authority in families vary by cultural traditions. How might you work with a woman from the Middle East who will not talk with you directly and insists that you speak with her husband?
3. What cultural groups are strongly represented in your community? What do you know about them? How much interaction do you have with them? How well prepared would you feel to work with them in a healthcare setting? What steps could you take to develop some familiarity with other cultures in your community?

EXERCISES

1. Create a list of ten open-ended questions that you could use as part of a biopsychosocial assessment to explore a patient's culture.
2. Go to the website for the Provider's Guide to Quality and Culture (<http://erc.msh.org/mainpage.cfm?file=1.0.htm&module=provider&language=English>) and select one of the cultural groups that are described there. Prepare a brief presentation on the cultural beliefs and practices and present it to your class.
3. Create a culturagram for your family of origin and its culture of origin. If you need to, interview someone to learn about how your family came to America and other religious, cultural, and health beliefs and practices.

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