SUMMER 2007

CURRICULA ENHANCEMENT MODULE

National Center for Cultural Competence

Georgetown University Child Development Center
University Center for Excellence in Developmental Disabilities

Cultural Awareness

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SECTION A.
OVERVIEW & PURPOSE OF MODULE SERIES

Responding to the Vision

MCHB Mission Statement

To provide national leadership, in partnership with key stakeholders, to improve the physical and mental health, safety and well-being of the maternal and child health (MCH) population which includes all of the nation's women, infants, children, adolescents, and their families, including fathers and children with special health care needs. (MCHB, 2003)

The vision of the Health Resources and Services Administration's Maternal and Child Health Bureau (MCHB) is for a future America in which "… there is equal access for all to quality health care in a supportive, culturally competent environment, which is family-centered and community-based; and health disparities by racial, ethnic, geographic area and economic status have been eliminated." The MCHB revised its mission statement and carefully crafted a 5-year strategic plan in pursuit of its vision. The plan includes goals, key strategies, performance measures, and annual priorities.

MCHB Strategic Plan for 2003-2007

Key Strategy	Performance Measure
Develop and promote health services and systems of care designed to eliminate disparities and barriers across the MCH population.	The degree to which MCHB-supported programs have incorporated cultural competence elements into their policies, guidelines, contracts, and training.
Key Strategy	**Performance Measure**
Train an MCH workforce that is culturally competent and reflects an increasingly diverse population.	The degree to which MCHB long-term training grantees include cultural competency in their curricula and training. (http://www.mchb.hrsa.gov/about/stratplan03-07.htm)

The Division of Research, Training and Education (DRTE) plays a central role in supporting both the vision and mission of MCHB through its funded programs. These programs promote interdisciplinary leadership training and new knowledge development to ensure capacity within this nation's current and future MCH workforce. The DRTE has strategic goals and objectives that focus on enhancing cultural competence in student and faculty recruitment and retention, in professional development and continuing education, in evidence-based knowledge and practice, and in cultivation of leadership within the field of public health, particularly in maternal and child health.

Supported through a grant from the DRTE, the National Center for Cultural Competence (NCCC) is assisting the MCHB in realizing its vision and achieving stated goals, with a particular focus on the essential role of cultural and linguistic competency in health care. The NCCC created resources to respond to Goal 3 of the MCHB Strategic Plan that addresses the elimination of health barriers and disparities.

Enhancing Capacity in MCH Training Programs

The NCCC conducted interviews with DRTE grantees to discover interests and needs related to cultural and linguistic competence. Grantees expressed a critical need for instructional materials, curricula, model programs, and multimedia products to augment current training methodologies. In response, the NCCC developed a curricula enhancement module series to increase the capacity of DRTE-funded programs to incorporate principles and practices of cultural and linguistic competence into all aspects of their leadership training. This series includes preservice, inservice, continuing education, and other training activities. In consultation with the DRTE, the NCCC assembled an interdisciplinary work group to identify and reach consensus on core content areas for the module series. The work group membership represented academicians, selected DRTE grantees, health providers, leaders in health care policy and practice, and experts in cultural and linguistic competence.

The module series centers on four core content areas selected by the work group and deemed vital to culturally and linguistically competent health care policy and practice:

Cultural Awareness
Cultural Self-Assessment
The Process of Inquiry -- Communicating in a Multicultural Environment
Public Health in a Multicultural Environment

This curricula enhancement module series is designed to:

- Assist faculty in incorporating five key content areas into existing curricula that are important to cultural and linguistic competence in public health;
- Provide a set of defined areas of knowledge, skills, and awareness related to each core content area;
- Offer relevant materials, articles, publications, and other multimedia resources for each core content area; and
- Provide faculty with instructional and self-discovery strategies.

The NCCC acknowledges the work group for its expertise and wise counsel in supporting this project.

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SECTION B.
CULTURAL & LINGUISTIC COMPETENCE: RATIONALE, CONCEPTUAL FRAMEWORKS, AND VALUES

1. Purpose
This section of the module is to provide faculty with a basic foundation in the philosophy, values, and conceptual frameworks of cultural and linguistic competence.

2. Rationale for cultural and linguistic competence in health care
The NCCC identified several compelling reasons why health care systems should focus on cultural and linguistic competence, adapted as follows from its Policy Brief series for this curricula enhancement module series:

- To understand and respond effectively to diverse belief systems related to health and well-being;
- To respond to current and projected demographic changes in the United States;
- To eliminate long-standing disparities in the health and mental health status of diverse racial, ethnic, and cultural groups; and
- To improve the quality and accessibility of health care services.

Creating and sustaining cultural and linguistic competence will require leadership in every aspect of health care including, but not limited to, health care training and education, public health policy, state public health agencies, research, health care financing, practice and service delivery, workforce development, community engagement, and advocacy. The DRTE is committed to developing such leadership within its training programs.

(See Policy Brief series on NCCC's Web site at http://www.georgetown.edu/research/gucdc/nccc/products.html)

3. Rationale for infusing content related to cultural and linguistic competence into health care training and programs
There are numerous reasons to infuse content related to cultural and linguistic competence into health care training and programs. Though not intended to be all-inclusive, the following list reflects contextual realities and provides reasons that are substantiated in the research literature in this area:

- To address historical issues in health care, such as those issues relating to racism, discrimination, access to care, and significant disparities in health outcomes;
- To address the fact that the formal education of many faculty and staff has not prepared them to incorporate cultural and linguistic competence into teaching and research methodologies;
- To ensure that students develop prerequisite areas of awareness, knowledge, and skills in cultural and linguistic competence;
- To facilitate workforce diversity, both for its reflection of the population served and for its inherent strengths;
- To prepare the future workforce to lead, teach, develop, and administer public health policy and to practice in a multicultural environment;
- To respond to legislative, regulatory, and accreditation mandates; and
- To serve the institution's and professional's best interests by providing a competitive edge in (1) recruiting and retaining faculty and students and (2) obtaining grant funding for teaching, service, research, and other initiatives.

4. Suggested strategies for incorporating cultural and linguistic competence into MCH training programs
To incorporate successfully cultural and linguistic competence into all aspects of MCH training programs, the following strategies are suggested:

- **Create a structure.** Convene a work group with the sole purpose of determining how core concepts relating to cultural and linguistic competency can be integrated into all aspects of the MCH training program. This group will serve as the primary body for conceptualizing, planning, and framing the way in which this integration takes place. The work group membership should be diverse and should include such key stakeholders as faculty, staff, students, and community partners.

- **Clarify values and philosophy.** Each MCH training program will need to establish its own philosophy and values of cultural and linguistic competence. This approach is essential for creating a shared vision among faculty and staff to guide all efforts in this area.

- **Develop a logic model for cultural and linguistic competence.** There are numerous concepts and definitions for cultural and linguistic competence. (See Conceptual Frameworks/Models, Guiding Values and Principles developed by the NCCC at http://gucchd.georgetown.edu/nccc/framework.html). Reach consensus on a definition or framework for cultural competence and linguistic competence within the context of the MCH training program and/or department. The term *logic model* refers to a visual schematic that summarizes the relationship between the resources, activities, and outcomes of a culturally and linguistically competent system of care (Santiago, 2003). For more information, see the *Kellogg Foundation Logic Model Development Guide*, available directly from http://www.wkkf.org/Pubs/Tools/Evaluation/Pub3669.pdf. See also a PowerPoint presentation providing an introduction to the use of logic models (Dr. Rachele Espiritu's "Developing a Logic Model").

- **Adapt or create curricula.** The logic model and framework should be used to guide the adaptation or creation of curricula that infuse content on principles, values, and practices of cultural and linguistic competence that have been determined by the work group.

- **Determine faculty and staff development needs and interests.** Conduct an initial assessment of faculty and staff to determine what they perceive as their training or professional development needs and interests related to cultural and linguistic competence. The assessment should query faculty and staff on the preferred methods, approaches, and formats for increasing awareness and acquiring new skills and areas of knowledge. Such an assessment should be repeated periodically as the group acquires knowledge and skills. Ensure that resources are budgeted to support this effort.

- **Conduct faculty and staff development.** Knowledge of cultural and linguistic competence will vary among faculty and staff. Assessment results should be used to inform strategies for faculty and staff development. Plan and conduct ongoing faculty and staff development activities based on individual needs and preferences. Careful consideration should be given to the fact that faculty and staff will have different levels of comfort with this content area. Appropriate supports should be provided and may include: (1) provide opportunities for faculty and staff to meet informally to share opinions and engage in discussions; (2) create a book club that is dedicated to exploring themes and issues of culture, race, and ethnicity that are often difficult or controversial to discuss solely on an interpersonal level; (3) convene facilitated sessions to address major issues or concerns; and (4) offer mediation and conflict resolution as warranted by specific circumstances.

- **Create a refuge for sharing and learning.** It is critical to provide a safe, non-judgmental forum to explore honestly cultural considerations—their own and those of the constituency groups they serve. Creating such a structure provides a much-needed venue to support faculty, staff, and students in their journey toward cultural and linguistic competence.

- **Conduct an evaluation.** Develop an evaluation strategy that measures at a minimum:(1) the extent to which faculty and staff have increased the incorporation of cultural and linguistic competence into all aspects of the MCH training program; (2) the extent to which students have increased awareness, knowledge, and skills in cultural and linguistic competence; (3) student perspectives on the effectiveness of the faculty and training program in incorporating principles and practices of cultural and linguistic competence; and (4) the extent to which key consumers benefit from the culturally and linguistically competent approaches employed by the MCH training program.

5. Conceptual frameworks, definitions, and guiding values and principles

There is no one definition of either cultural competence or linguistic competence. Definitions of cultural and linguistic competence vary considerably. Such definitions have evolved from diverse perspectives, interests, and needs and are incorporated into state legislation, federal statutes and programs, non-governmental organizations, and academic settings. See the "Resource Section" of this module for additional definitions of cultural and linguistic competence as well as other terms.

Definition and conceptual framework of cultural competence

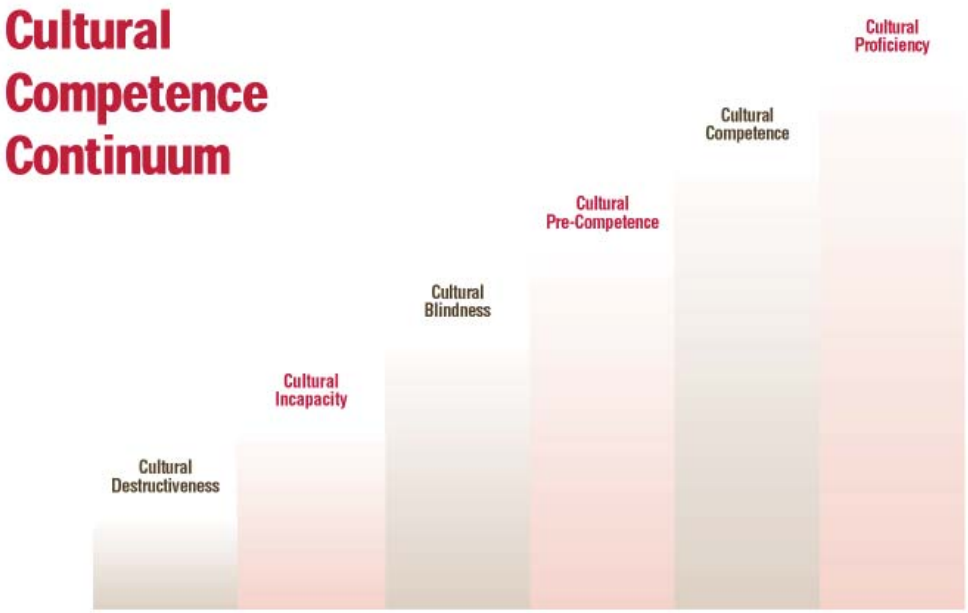
The NCCC embraces a conceptual framework and model for achieving cultural competence based on the work of Cross, Bazron, Dennis, and Isaacs (1989). The NCCC uses this framework and model as a foundation for all of its activities. Cultural competence requires that organizations:

- have defined values and principles, and demonstrate a congruent set of behaviors, attitudes, policies, and structures that enable them to work effectively cross-culturally;

- have the capacity to (1) value diversity; (2) conduct self-assessment; (3) manage the dynamics of difference; (4) acquire and institutionalize cultural knowledge; and (5) adapt to diversity and the cultural contexts of the communities they serve; and

- incorporate the above in all aspects of policy making, administration, practice, and service delivery and involve systematically consumers, key stakeholders, and communities.

Cultural competence is a developmental process that evolves over an extended period. Both individuals and organizations are at various levels of awareness, knowledge, and skills along the cultural competence continuum (adapted from Cross et al., 1989).



For information on characteristics of organizations along the entire continuum, please see Selected Characteristics along the Cultural Competence Continuum (adapted by Tawara Goode, 2004).

Definition of linguistic competence

Definitions of linguistic competence vary considerably. Such definitions have evolved from diverse perspectives, interests, and needs and are incorporated into state legislation, federal statutes and programs, private-sector organizations, and academic settings. The following definition, developed by Goode and Jones (2003), of the NCCC, provides a foundation for determining linguistic competence in health care, mental health, and other human service delivery systems. It encompasses a broad spectrum of constituency groups that could require language assistance oe other supports from an organization or agency, or provider.

Linguistic competence – the capacity of an organization and its personnel to communicate effectively and convey information in a manner that is easily understood by diverse audiences including persons of limited English proficiency, those who have low literacy skills or are not literate, and individuals with disabilities. Linguistic competency requires organizational and provider capacity to respond effectively to the health literacy needs of populations served. The organization must have policy, structures, practices, procedures, and dedicated resources to support this capacity. This may include, but is not limited to, the use of:

- ✓ bilingual/bicultural or multilingual/multicultural staff;
- ✓ cultural brokers;
- ✓ foreign language interpretation services including distance technologies;
- ✓ sign language interpretation services;
- ✓ multilingual telecommunication systems;
- ✓ TTY;
- ✓ assistive technology devices;
- ✓ computer-assisted real-time translation (CART) or viable real-time transcriptions (VRT);
- ✓ print materials in easy-to-read, low-literacy picture and symbol formats;
- ✓ materials in alternative formats (e.g., audiotape, Braille, and enlarged print);
- ✓ varied approaches to share information with individuals who experience cognitive disabilities;
- ✓ materials developed and tested for specific cultural, ethnic, and linguistic groups;

✓ translation services including those of:
- legally binding documents (e.g., consent forms, confidentiality and patient rights statements, release of information, and applications)
- signage
- health education materials
- public awareness materials and campaigns; and

✓ ethnic media in languages other than English (e.g., television, radio, Internet, newspapers, and periodicals).

The organization must have policy, structures, practices, procedures, and dedicated resources to support this capacity.

Cultural and linguistic competence are inextricably linked. There are federal statutes and guidelines governing language access for individuals with limited English proficiency and those with disabilities. For more information, see Policy Brief 2 at http://gucchd.georgetown.edu/nccc/documents/Policy_Brief_2_2003.pdf; National Health Law Program Web site at http://www.nhelp.org/race.shtml#ling; the Office of Civil Rights Web site concerning persons with limited English proficiency at http://www.hhs.gov/ocr/lep/; and for information from the Department of Justice on the Americans with Disabilities Act, see http://www.usdoj.gov/crt/ada/adahom1.htm.

Selected characteristics of organizations striving to achieve cultural competence and cultural proficiency

The following list is designed to highlight selected characteristics that organizations may demonstrate along the cultural competence continuum. These characteristics have been adapted and expanded from the original work of Cross et al. (1989) in several ways: (1) to include principles and practices of linguistic competence, (2) to incorporate mental health as an integral and inseparable aspect of health care, (3) to include salient items that address organizational policy from the NCCC's Policy Brief series, and (4) to reflect evidence-based and promising practices that have emerged in the field of cultural and linguistic competence.

Cultural Competence	Cultural Proficiency
• Create a mission statement for your organization that articulates principles, rationale, and values for cultural and linguistic competence in all aspects of the organization.	• Continue to add to the knowledge base within the field of cultural and linguistic competence by conducting research and developing new treatments, interventions, and approaches for health and mental care in policy, education, and the delivery of care.
• Implement specific policies and procedures that integrate cultural and linguistic competence into each core function of the organization.	• Develop organizational philosophy and practices that integrate health and mental health care.
• Identify, use, and/or adapt evidence-based and promising practices that are culturally and linguistically competent.	• Employ faculty and/or staff, consultants, and consumers with expertise in cultural and linguistic competence in health and mental health care practice, education, and research.
• Develop structures and strategies to ensure consumer and community participation in the planning, delivery, and evaluation of the organization's core function.	• Publish and disseminate promising and evidence-based health and mental health care practices, interventions, training, and education models.
• Implement policies and procedures to recruit, hire, and maintain a diverse and culturally and linguistically competent workforce.	• Support and mentor other organizations as they progress along the cultural competence continuum.
• Provide fiscal support, professional development, and incentives for the improvement of cultural and linguistic competence at the board, program, and faculty and/or staff levels.	• Develop and disseminate health and mental health promotion materials that are adapted to the cultural and linguistic contexts of populations served.
• Dedicate resources for both individual and organizational self-assessment of cultural and linguistic competence.	• Actively pursue resource development to continually enhance and expand the organization's capacities in cultural and linguistic competence.
• Develop the capacity to collect and analyze data using variables that have meaningful impact on culturally and linguistically diverse groups.	• Advocate with, and on behalf of, populations who are traditionally unserved and underserved.
• Practice principles of community engagement that result in the reciprocal transfer of knowledge and skills between all collaborators, partners, and key stakeholders.	• Establish and maintain partnerships with diverse constituency groups, which span the boundaries of the traditional health and mental health care arenas, to eliminate racial and ethnic disparities in health and mental health.

Guiding Values and Principles

Careful consideration should be given to discovering and reaching consensus on the values and principles of cultural and linguistic competence that are chosen as a foundation for health care training programs. The following values and principles are those that guide the NCCC's philosophy and all aspects of its work.

Organizational

- ✦ Systems and organizations must sanction, and in some cases mandate, the incorporation of cultural knowledge into policy making, infrastructure, and practice.*
- ✦ Cultural competence embraces the principles of equal access and non-discriminatory practices in service delivery.*

Practice, Services, and Supports

- ✦ Culturally competent organizations have a service delivery model that recognizes mental health as an integral and inseparable aspect of primary care. For more information, see the Surgeon General's report on Mental Health at http://www.surgeongeneral.gov/library/mentalhealth/home.html and the President's New Freedom Initiative Final Report at http://www.mentalhealthcommission.gov/.
- ✦ Cultural competence is achieved by identifying and understanding the needs and help-seeking behaviors of individuals and families.*
- ✦ Culturally competent organizations design and implement services that are tailored or matched to the unique needs of individuals, children, families, organizations, and communities served.*
- ✦ Culturally competent practice in service delivery systems is driven by client-preferred choices, not by culturally blind or culturally free interventions.*

Community Engagement

- ✦ Cultural competence extends the concept of self-determination to the community.*
- ✦ Cultural competence involves working in conjunction with natural, informal support and helping networks within culturally diverse communities (e.g., neighborhood, civic, and advocacy associations; local/neighborhood merchants and alliance groups; ethnic, social, and religious organizations; and spiritual leaders and healers).*
- ✦ Communities determine their own needs.
- ✦ Community members are full partners in decision making.
- ✦ Communities should benefit economically from collaboration.
- ✦ Community engagement should result in the reciprocal transfer of knowledge and skills between all collaborators and partners. (Taylor & Brown, 1997)

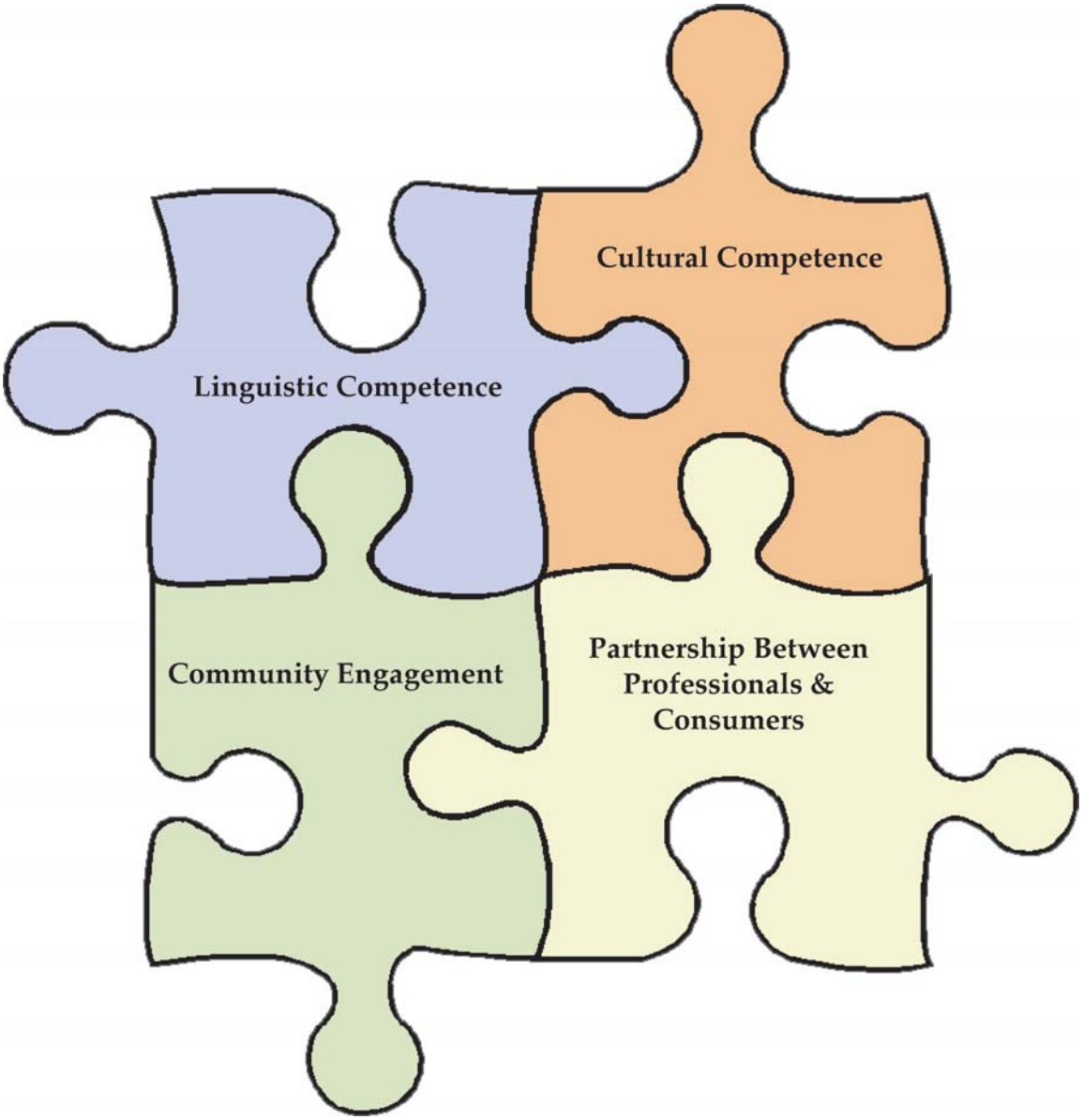
Family and Consumers

✦ Family is defined differently by different cultures.

✦ Family as defined by each culture is usually the primary system of support and preferred intervention.

✦ Family/consumers are the ultimate decision makers for services and supports for their children or themselves (Goode, 2002).

*Adapted from Cross et al., 1989



SECTION C.
CULTURAL AWARENESS

Introduction and Rationale

Cultural awareness is a major element of cultural competence as defined by the National Center for Cultural Competence (NCCC). It is the first and foundational element because without it, it is virtually impossible to acquire the attitudes, skills, and knowledge that are essential to cultural competence.

Defining Cultural Awareness

There are varying definitions of cultural awareness. The following two are offered to underpin the principles and concepts espoused in this module. The NCCC defines "cultural awareness" as being cognizant, observant, and conscious of similarities and differences among and between cultural groups (Goode, 2001, revised 2006). According to Winkelman (2005), awareness of cultural differences and their impact on behavior is the beginning of intercultural effectiveness. He states that "cultural self-awareness includes recognition of one's own cultural influences upon values, beliefs, and judgments, as well as the influences derived from the professional's work culture" (p. 9). (For more definitions, see Teaching Tools: Key Definitions.)

✧ Cultural awareness can help faculty to:

- Acknowledge how culture shapes their own perceptions;
- Be more responsive to culturally diverse students and colleagues;
- Be more sensitive and accessible as a mentor or supervisor;
- Be alert to cultural differences and similarities that will present opportunities and challenges to working in a multicultural environment; and
- Influence the next generation of public health professionals to be culturally aware as a pre-requisite toward achieving cultural and linguistic competence.

✧ Cultural awareness includes being conscious of organizational culture and its implications for policy, practice, teaching, research, and community engagement.

Cultural awareness includes:

- Having a firm grasp of what culture is and what it is not;
- Having insight into intracultural variation;
- Understanding how people acquire their cultures and culture's important role in personal identities, life ways, and mental and physical health of individuals and communities;
- Being conscious of one's own culturally shaped values, beliefs, perceptions, and biases;
- Observing one's reactions to people whose cultures differ from one's own and reflecting upon these responses; and
- Seeking and participating in meaningful interactions with people of differing cultural backgrounds.

Why is it important that health and mental health professionals and the persons who instruct them develop cultural awareness?

There are two very important reasons. First, we can acquire a much deeper self-knowledge when we are able to understand the basis for our own beliefs, actions, and responses toward others. Second, and even more important, we live in a world in which there are myriad different cultures that inform the beliefs and behavior of others. Cultural awareness is the first step in becoming proficient in working well with people from a variety of cultures.

By understanding the cultural genesis of our own and others' beliefs and behaviors, and by remaining open to the idea that other people's cultures guide them in the same way that ours guides us, we as health and mental health professionals, policy makers, and educators will have a better chance of interacting positively with, and appropriately serving, people of varying cultural backgrounds. Such understandings are particularly important for health and mental health professionals and administrators because cultural perspectives and beliefs profoundly affect all aspects of people's behavior with regard to health and well-being.

Cultural awareness is a critical feature of effective health and mental health policy, planning, resource allocation, and service delivery across the entire spectrum of care, including health promotion and prevention. This is so because cultural perspectives inform people's identification and interpretation of symptoms and define the diseases, illnesses, and disabilities they recognize. Culture also shapes their ideas of appropriate treatment. Salient and meaningful interventions cannot be created without an understanding of how the interventions will be interpreted and understood through the cultural framework of different individuals and populations.

Culture creates people's expectations of health and mental health care providers and guides their enactment of sick role behavior. Further, familial and caretaker behaviors are defined by culture. Culture gives meaning to pain, suffering, and death. Without an understanding of culture's impact on concepts surrounding physical and mental health and illness, as well as interpersonal relations, a health or mental health care professional may have difficulty planning efficient and effective care for, and providing such care to, individuals from cultures other than his or her own. Without an awareness of the possibility that cultural issues may be at work, providers may be puzzled at patient resistance, lack of adherence, or seeming disinterest in health and mental health promotion, services, and supports.

Health and mental health organizations, whether public or private, need to be able to serve culturally diverse consumer populations. If management is unaware of the specific cultures in the organization's catchment area, and is unable to assess the specific service needs and preferences of those populations, the services will be underutilized and the organization may fail to get market share.

Moreover, the U.S. health care workforce has become increasingly culturally diverse in the last two decades. This diversity is due to the increase in immigration of a vast number of health care personnel from other countries and the large number of persons who remain in this country after they have received training in many of the health care fields. Because people's attitudes toward work and proper relationships with fellow employees and management also differ cross-culturally, cultural perspectives may impact workplace dynamics in unanticipated and challenging ways. A culturally aware manager or administrator will be alert to these possibilities.

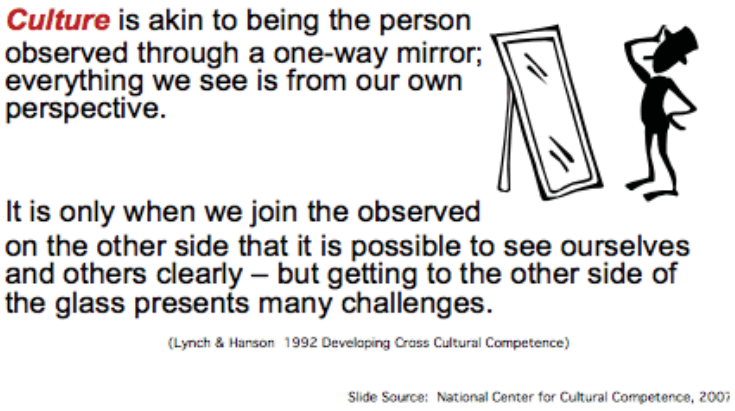
Perhaps deeper self-knowledge and awareness of diverse cultural perspectives would not be necessary if we lived our lives in one small place interacting with the same small group of people for all of our lives as did some of our ancestors. But that is not the world in which most of us now live. We live in a shrinking world in which people from varying cultures interact on a daily basis, one in which the larger nations are composed of people from very different backgrounds. Cultural awareness thus is a professional mindset essential for successful interaction in the multicultural health and mental health care environments. Let us then take a closer look at culture.

Key Content Areas

I. What is Culture

First, what is culture, anyway, and how do we humans acquire our cultures? A good working definition is the following: Culture is the learned and shared knowledge that specific groups use to generate their behavior and interpret their experience of the world. It comprises beliefs about reality, how people should interact with each other, what they "know" about the world, and how they should respond to the social and material environments in which they find themselves. It is reflected in their religions, morals, customs, technologies, and survival strategies. It affects how they work, parent, love, marry, and understand health, mental health, wellness, illness, disability, and death.

Much of culture resides only in people's heads; thus, it is invisible and sometimes hard to detect. One way to understand culture is to think of it as the "software" of the mind. Essentially, individuals are "programmed" by their cultural group to interpret and evaluate behaviors, ideas, relationships, and other people in specific ways that are unique to their group. Another excellent analogy for understanding the cultural process is to see culture as the "lens" through which people in a specific group view the world.



Notice that these analogies imply that culture exercises a kind of invisible control over members of a cultural group. Psychologists call this "internalizing" our cultural norms and concepts. We all do this very naturally. However, this process often has the effect of rendering our own culture invisible to us, though we can readily identify cultures that differ from ours.

Despite the invisibility of "software" or a "lens," a culture is clearly reflected outwardly in such things as how people behave, what they eat, how they dress, the tools they use, and the values and ideas they express. Nevertheless, it takes considerable introspection and self-analysis for individuals to discover how deeply and strongly their culture influences their own thoughts and behaviors. Doing this reflective work is a crucial part of becoming culturally aware.

Table 1. Some Good Definitions of Culture

Definition/Framework	Author
"Culture is a set of meanings, behavioral norms, and values used by members of a particular society, as they construct their unique view of the world."	Alarcon, Foulks, & Vakkur (1998)
"Culture is conceived as a set of denotative (what is or beliefs), connotative (what should be, or attitudes, norms and values), and pragmatic (how things are done or procedural roles) knowledge, shared by a group of individuals who have a common history and who participate in a social structure."	Basabe, Paez, Valencia, González, Rimé, & Diener (2002)
"The term culture refers to social reality. It can be defined as a complex collection of components that a group of people share to help them adapt to their social and physical world."	Yamamoto, Silva, Ferrari, & Nukariya (1997)
"Culture is a shared pattern of belief, feeling, and knowledge that ultimately guide everyone's conduct and definition of reality."	Griffith & González (1994)
"Culture is a shared organization of ideas that includes the intellectual, moral and aesthetic standards prevalent in a community and the meanings of communicative actions."	LeVine (1984)
"Culture is a person's/group's beliefs, their interactions with the world, and how they are affected by the environment in which they exist."	Lotrecchiano (2005)
"Culture is an integrated pattern of human behavior which includes but is not limited to—thought, communication, languages, beliefs, values, practices, customs, courtesies, rituals, manners of interacting, roles, relationships, and expected behaviors of an ethnic group or social groups whose members are uniquely identifiable by that pattern of human behavior."	National Center for Cultural Competence (2001)
"Culture is a system of collectively held values, beliefs, and practices of a group which guides decisions and actions in patterned and recurrent ways. It encompasses the organization of thinking, feeling, believing, valuing and behaving collectively that differentiates one group from another. Values and beliefs often function on an unconscious level."	Sockalingam (2004)

Because human beings in different parts of the world and in very different environments developed distinctively different cultures, they "see" and respond to the world in widely varying ways. Social scientists often call a group of people who share a culture an ethnic group. According to Byrd and Clayton, writing in Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare (Institute of Medicine, 2003), an ethnic group is a group socially distinguished or set apart by others or by itself, primarily on the basis of cultural or national-origin characteristics. Most medical anthropologists and sociologists tend to emphasize the cultural and social aspects of groups and often use the terms "ethnic group" and "cultural group" interchangeably. However, both terms tend to be used somewhat loosely. For example, the term "culture of poverty" was used for many years to identify norms and behaviors common to groups of people forced to live in poverty wherever in the world they happened to live.

Most cultural groups tend to believe that how they see the world is correct, and how they believe and behave is what is most natural to human beings, that is, "human nature." However, in learning about culture, we need to understand that to have culture is human nature, but no specific culture is human nature! When people insist on their own culture as the only correct way to understand the world, they are said to be demonstrating ethnocentrism. It is easy to fall into this fallacious way of thinking. We all do it from time to time; however, the culturally aware person is far less likely to unthinkingly fall into this cognitive trap.

Intracultural Variation

Cultures generally always contain subcultures. These subcultures revolve around such things as gender, age, class, race, religion, occupation, or sexual orientation and identity. Additionally, some subcultures are formed on the basis of a specific disability, such as deafness. The point here is to understand that a subculture shares much of the overarching culture of the larger group within which it occurs, but also has characteristics that are unique and identifiable both to itself and the larger culture. These subcultures are an important source of variation within a culture.

For example, women in a culture are often guided by beliefs and rules for behavior that apply only to the women in that culture. These might include dress, occupations, and maternal, caregiver, and healer roles.

Such subcultures often include a sizeable number of people, so we often hear references to "the culture of medicine," "institutional culture," "organizational culture," "youth culture" or "gay culture." The culture of medicine, for example, is made up of individuals from the larger culture who share specific understandings about science, biomedicine, policies, and ethics related to provider/patient relationships and how health and mental health care services are appropriately delivered. A specific organization, such a as a hospital, college, or health management organization, may also have its own practices, norms, and understandings that the people within it have uniquely developed over time. These create an organizational culture that is often apparent to people both within and outside the organization. Not surprisingly, persons from outside an occupational or organizational culture, when forced to interact with it, may find its policies and procedures puzzling or problematic.

The Culture of Medicine. Socialization into professional cultures occurs through professional training, education, and occupational group norms. The culture of medicine impacts the health system along a wide range of variables, including but not limited to, the selection of students (McGaghie, 2002); what is included or excluded from curricula, the value placed on biology, technology, communication, quality of life, and other variables; and the roles of health providers and patients, ways of talking about and examining individuals, etc. In a recent article for the New England Journal of Medicine, Fox (2005), critiques the lack of awareness of the culture of biomedicine, "far from a neutral background against which other cultures may be measured" (p. 1316). Despite reporting on the diversity of the students in medical education, health educators "do not usually analyze the effects of the composition of the student body and faculty on the value system of the medical school, its cultural ambience and the implicit and explicit attitudinal messages that the educational process transmits" (p. 1317). The culture of medicine extends beyond the university and into hospitals, clinics, and interactions between patients, students, residents, nurses, doctors, and so on. The School of Medicine at the University of California, Los Angeles, developed free streaming videos online with vignettes on the culture of medicine at http://www.medsch.ucla.edu/public/culturevideo/

When we speak of "baby boomer culture," we are referring to a subgroup or cohort defined by its place in historical time. There are other names given to generational cohorts, such as "The Greatest Generation," or "Generation X." These names relate specifically to the age of the persons within the cohort, as well as to distinctive subcultural characteristics that seem to set it apart from other generations.

Other subcultures center on regional/geographic differences. In the U.S., we recognize these differences by such terms as "Midwesterner," "Southerner," and "Yankee." These designations signify that there are commonly recognized subcultural differences in norms, customs, and world view that accrue to place of birth or upbringing. Significant variation within a cultural group is often related to regional differences. For example, an African American from a southern state may differ considerably in language expression, customs, and beliefs from one who grew up in California or New York State.

One particular contributor to intra-ethnic variation is the process of acculturation. A Mayan immigrant from Mexico to the U.S. most likely will retain core cultural values from his native cultural upbringing. These will be modified and added to over time depending upon the amount and quality of contacts with the larger U.S. society. His son or daughter will most likely retain some of the parental values and ideations, but will also acquire cultural concepts prevalent in mainstream U.S. society. His grandchildren, raised by U.S.-born parents and schooled entirely in the U.S., may assimilate into the larger society by marrying a non-Mayan and adopting a non-Mayan lifestyle. The process of losing and gaining cultural traits that comprises acculturation and assimilation is uneven and unpredictable depending upon both individual and historical factors. Core cultural values are retained much longer than those that may be considered superficial.

The use of hyphenated designations, such as Mexican-Americans, Polish-Americans, and African-Americans, acknowledges both the enduringness of ethnic culture and a shared national culture. These designations also call attention to the existence of bicultural or multicultural individuals who integrate characteristics of two or more cultures in their way of life.

Social class is also an important source of variation within a cultural group because it is associated with subcultural differences based on education, occupation, and income. Class differentiation in behavior, norms, values, and habits is recognized both by social scientists and the general public. Researchers utilize mechanisms such as Social Economic Status (SES), which are amalgams of education, income, and occupation, to differentiate upper-, middle-, and lower-class levels; the general public uses terms like "Joe-six-pack" or "high society." Unlike most other subcultures within a culture, social class mediates access to resources and power. It may interact with and cross-cut other subcultural groups, such as those based on ethnicity, gender, and age.

Obviously, a single individual may be a male, a nurse, a baby boomer, an Asian- American, a middle-class Southerner and a Catholic (gender, occupational, age, class, regional, racial, and religious subcultures) while still being a member of a larger cultural group. Moreover, an individual may move more fluidly through some subcultural groups than others. Age, for example, cannot be changed, but people sometimes move from one religious, occupational, or class subculture to another.

Another complication to this picture of culture and subcultures is that seemingly similar subcultures across ethnic groups may be very different in content. While gender subcultures exist in all cultural groups, they exhibit different characteristics across groups: The roles and expectations of women and men in Arabic cultures, for example, are quite different from the norms for the genders in many European cultures. A culturally aware person will not expect gender subcultures to be the same across ethnic groups and will not make assumptions based on the characteristics of subcultures within a single cultural group. Avoiding such easy assumptions when policy making, planning, or delivering health and mental health services to several different ethnic or cultural groups is critical.

The interaction of subcultures, and the dynamism that occurs when a culture interacts with its total social and material environment, means that individuals and groups within a single culture vary in terms of their acceptance and enactment of core cultural values, customs, beliefs, and norms. In small, relatively homogeneous ethnic groups, this type of variation is not great; in complex societies in which there is much interaction among many cultural groups and subcultural groups, consistent immigration of a variety of groups, easy travel across regions, and much outside influence, intracultural variation tends to be much greater.

Not surprisingly, with all this complexity, cultures are dynamic. They change and adapt over time through a variety of influences: contact with other cultures, the invention of new technologies, war, and environmental change, just to name a few. Some aspects of a culture change slowly, as with religious beliefs or social roles; other aspects of

culture change more rapidly, such as adoption of new foods or technologies. Perspectives of health, mental health, disease, disability, and well-being, if they are linked to a culture's religious or spiritual beliefs, which they often are, may be resistant to change. However, with the advent of new health care technologies and procedures that are seen to be effective, even long-held beliefs often can be modified.

> *A culturally aware person is mindful of these dynamic aspects of culture and is cautious not to easily generalize or stereotype individuals based on an over- simplified evaluation of their cultural backgrounds. Cultural awareness includes an understanding of the potential interaction among subcultural identities within each individual person and the implications of that interaction for health and mental health care.*

II. How Do Human Beings Acquire Culture?

We humans are in the process of acquiring our culture, consciously and unconsciously, throughout our lives, though most of our basic cultural understandings are acquired early on from our parents and other intimates, schools, and religious teachings. By the time a child is 5 years old, many of the foundational aspects of culture have been internalized. By the teen years, these foundations have been thoroughly elaborated upon through the process of socialization.

It is important to remember that culture is learned through language and modeling others; it is not genetically transmitted. Culture is encoded in the structure, vocabulary, and semantics of language. Persons acquainted with more than one language are aware that there are concepts, norms, and emotions that are available in one language/culture that are not available in the other, and this is a reminder of the inextricable link between language and culture.

Much of culture is acquired out of consciousness, through exposure to the speech, judgments, and actions of others. Because we learn all of our lives, we are constantly learning our cultures. We may even pick up and incorporate parts and pieces of a culture different from our own through that process known as acculturation if we have the opportunity to live in a different cultural environment or associate frequently with persons from another culture. The unconscious operation of cultural learnings in our minds is both beneficial and problematic. It is beneficial in the sense that much of the time we automatically know how to behave appropriately in many situations, and we have values by which to rapidly evaluate the actions and ideas of others. On the other hand, the internalization of our cultural values ill prepares us for interaction with, and evaluation of, people from other cultures.

III. What Culture Is *Not*

Cultural groups are not ***necessarily*** national origin groups, because most sizeable nations include more than one ethnic/cultural group, as in Mexico or China where there are numerous indigenous or immigrant groups characterized by significantly different cultures. The U.S., for example, incorporates many different cultural and subcultural groups, both native born and immigrant. However, depending on historical and geographical factors, a nation may shift from homogeneous to heterogeneous in ethnic composition and vice versa. A culturally aware individual, again, is alert to the possibility of numerous ethnic cultures within an overarching national identity and to shifts in the ethnic composition of a nation over time. Such shifts need to be considered, in, for example, the provision of language services in health and mental health care facilities.

Further, cultural groups are not the same as racial groups, though culture and race are both aspects of human diversity. Race is a social construct used by scientists and the general public to identify groups of people by physiological characteristics such as skin color, hair texture, facial features, bone structure, and the like. As pointed out by Byrd and Clayton in Unequal Treatment (p. 474), "Scientists who study race consider it a socially determined category based on shared physical characteristics … most commonly dividing the human family into three to five major "racial groups." Very recently, population geneticists studying the genetic constitution of populations around the world have been able to link genetic heritage with the ancient geographic distribution of populations that correspond closely with commonly used racial designations. They have also been able to link disease resistance and susceptibility as well as response to pharmaceuticals to these different heritage groups. However, it is clear

that virtually none of these population geneticists still believe in "pure" races, because many groups overlap the racial classification systems that have been used. In any event, the diversity represented by race is not at all the same as that represented by culture.

Most races are made up of many cultural and ethnic groups: Bantus and Zulus, for example, are cultural groups that belong to the Black race, and Hmong, Mien, and Zhuang are all cultural groups that belong to the Asian race. Clearly, these groups are culturally very different from each other because culture and ethnicity refer to the concepts inside people's heads, not to their physical characteristics. Moreover, a cultural group may be made up of persons from several races as with Puerto Ricans who can be of African, American Indian, White, or mixed racial descent.

Because race is a socially defined construct used to categorize people by their physical characteristics, it is not surprising that different cultures have very different perspectives with respect to racial identifiers and to relations between people of different races. Physical variations, most often in appearance, acquire distinct meanings and are linked to class or caste in various ways, depending upon the specific culture. Someone classified as "Black" in the U.S., for instance, might be considered "White" in Brazil and "Colored" in South Africa. These meanings structure social relations, oftentimes resulting in stratification and discrimination over time. Further, when a racial group is excluded or isolated from other groups within a culture, and the isolation continues over several generations, the group may develop a distinctive group identity that becomes a subculture within the larger culture. In this way, culture may become linked with race though the two are conceptually different.

> *A culturally aware individual will be knowledgeable about the interaction between culture and race, and be sensitive to the effect of his/her own culture on racial ideology, bias, and race relations. Most important, a culturally aware health care policy maker, manager, educator, or provider should be alert to how his/her own culture, be it organizational, occupational, or national, construes, interacts with, and structures its relations with different racial or cultural groups.*

IV. Culture and Race in the Epidemiology of Disease

Both culture and race can affect the health and mental health of individuals but in quite different ways that are critical for health care policy makers, planners, and providers of services to discern. To illustrate: Most Japanese men and women, like many Asians, metabolize alcohol differently from Whites or Blacks, a circumstance that is genetically based. Among many Japanese, consumption of even a very small amount of alcohol causes a visible phenomenon called facial flushing, a pronounced redness or blush. This is a *biological* effect linked to race. However, strong *cultural* norms encourage Japanese men to socialize together, drinking heavily while ignoring the flushing effect. On the other hand, Japanese *cultural norms* which proscribe heavy drinking among women cause them to report being embarrassed if flushing occurs and to refrain from drinking heavily. In working with Japanese alcoholics or abusers, culturally aware treatment providers will be cognizant of the interaction between culture and inherited traits.

Similarly, members of the Papago cultural group within the American Indian racial group have an inherited propensity to Type 2 diabetes. This propensity is exacerbated and expressed if a Papago's diet is high in saturated fats and she/he has a sedentary life style. Diet and life style are culturally shaped; the inherited susceptibility to diabetes is not. In planning health care for members of this cultural group, culturally informed policy makers and treatment providers would take into consideration the complex etiology of the disease within this population.

Very recently, in response to the finding that many Black people metabolize medications differently from White people, a medication, BiDil, has been formulated for Black people with heart failure. Culturally aware health care providers including pharmacists will understand that a Black patient's need for this specific medication is based on biology. The development and marketing of a drug for a specific racial group has not been without controversy. Please refer to the following for more information about BiDil: June 23, 2005 news release from the Food and Drug Administration at http://www.fda.gov/bbs/topics/NEWS/2005/NEW01190.html; articles by Carmody & Anderson, 2007; and Temple & Stockbridge, 2007.

The term *cultural epidemiology* refers to a culture's effect on the incidence and prevalence of diseases and disorders within an ethnic or cultural group. It additionally refers to the way a culture affects the onset, symptom recognition, course, and outcome of disease processes among members of the group. For example, a cultural group's acceptance or rejection of condom use or circumcision will affect the incidence of HIV within the group. A culturally shaped explanatory model for respiratory problems or infant diarrhea will affect the timing of health care seeking and receptiveness to various treatment modalities. Another example, as it relates to mental health, is that the symptoms of depression vary across cultures. Group members' responses to persons who experience depression and other forms of mental illness are culturally influenced.

It would be impossible for health and mental health professionals[1] to understand the workings of culture on the health and well-being of all people in all cultures. Rather, cultural awareness involves the recognition that people of different cultures understand and respond to health and mental health issues quite differently, and that these differences do in fact cause variation in the epidemiology of disease. The education of culturally aware health and mental he Both culture and race can affect the health and mental health of individuals but in quite different ways that are critical for health care policy makers, planners, and providers of services to discern. To illustrate: Most Japanese men and women, like many Asians, metabolize alcohol differently from Whites or Blacks, a circumstance that is genetically based. Among many Japanese, consumption of even a very small amount of alcohol causes a visible phenomenon called facial flushing, a pronounced redness or blush. This is a biological effect linked to race. However, strong cultural norms encourage Japanese men to socialize together, drinking heavily while ignoring the flushing effect. On the other hand, Japanese cultural norms which proscribe heavy drinking among women cause them to report being embarrassed if flushing occurs and to refrain from drinking heavily. In working with Japanese alcoholics or abusers, culturally aware treatment providers will be cognizant of the interaction between culture and inherited traits.

V. Culture and Personal Identity

Usually each of us draws a major part of our sense of self from the cultural group in which we grew up and were socialized. As we are able to demonstrate that we have integrated the cultural lessons of our group and behave and think accordingly, we are accepted and integrated into the group. Being accepted, identified with, and supported by a cultural group is essential to our sense of security. Research has demonstrated that social support and a sense of belonging have positive effects on mental and physical health while social isolation has negative effects. The link between health/mental health, and cultural integration remains strong throughout our lifetimes.

Just as cultures are not static, neither are our personal identities, which are derived from cultural conceptualizations. A woman may be a wife, a mother, a divorcee, or a grandmother at different times in her life. She may be a factory worker, a refugee, or an immigrant. Each of these statuses carries with it a set of cultural norms and expectations. Additionally, if a woman moves from one culture to another, she may adopt some of her new culture's ideas about the role of wife while still keeping some of her old culture's ideas. As individuals move through life, their personal histories interact with their cultures in a dynamic complexity.

Because much of cultural learning takes place out of consciousness, we are not always aware of the manner in which culture shapes our personal identities or that we all have a cultural identity that is an integral aspect of our individuality. However, if we develop cultural awareness, we begin to see how aspects of our culture have shaped our beliefs and behaviors. Individual characteristics such as gender, age cohort, and race, as well as physical and intellectual abilities and disabilities, interact with cultural and subcultural factors such as class, education, religion, and occupation to produce our unique identities.

A growing phenomenon in today's complex societies is individuals who self-identify as bicultural or multicultural. One example of a bicultural individual would be a person who understands and is able to interact effectively and easily in two cultures, oftentimes a heritage culture and the culture into which he or his family has immigrated. A bicultural person may speak more than one language fluently. Individuals who self-identify as multicultural typically

[1] The term *health and mental health professionals* includes, but is not limited to: provider of health or mental health services, health or mental health educators, policy makers, researchers, faculty, and administrators.

acknowledge multiple cultural and/or ethnic heritages and may be multilingual. Such individuals can be particularly effective in health care settings because they can function as *cultural brokers* within these organizations.

Cross, Bazron, Dennis, and Isaacs (1989) describe another example of biculturalism in which members of racial and ethnic groups, who are not recent immigrants to the U.S., view themselves as bicultural and needing to navigate between the "majority culture" and the "minority culture." The biculturalism of these individuals may be overlooked by the health and mental health care system because of assumptions about their complete assimilation.

Many bicultural persons are able to move fluidly from one culture to another, but for some, the differences in cultures present problems of marginality or relational difficulties. Some individuals may be marginalized in the sense that they have lost the security and support of their native cultures and have not been able to integrate into another culture. Such individuals are often at risk for poor mental and physical health. This issue of cultural marginalization is especially critical when considering the health needs of refugees, many of whom may have left their cultural homeland unwillingly or under duress.

> *A culturally aware health care professional will be alert to potential problems of cultural insecurity and marginalization in these populations. Such circumstances also present unique mental health issues that require the attention of culturally knowledgeable professionals.*

VI. Cultural Identity and Cultural Clustering in Communities and Organizations: Implications for the Health and Mental Health Professional

Traditionally and continuing into the present, immigrants and refugees have tended to settle in geographically distinct sections of urban areas. Such practices are completely understandable given the support and identity functions of people's cultures. Enclaves provide immigrants and refugees the comfort of being near people who share their values, norms of behavior, and language. Such cultural concentrations have been given such names as "Chinatown," "Little Italy," or "Little Saigon." Often one or several of such cultural enclaves can be found within the catchment area of a clinic, hospital, or health plan. Rather than viewing these communities as made up of persons who resist acculturation to the language and culture of the larger society, they can be seen as protective of individuals in the cultural group, buffering the effects of the "culture shock" that comes with entering a new society. These communities are health sustaining, because they function to prevent the debilitating effects of marginalization.

> *A culturally aware health and mental health care professional, seeking to give effective and appropriate care to all patients and clients, will see these communities as important resources and aids to cross-cultural understanding.*

Not all cultural communities are formed willingly, however. Some communities in the U.S. have been formed by various types of coercion. Discriminatory housing policies and poverty have created barrios, ghettos, and slums. Moreover, indigenous peoples were forced onto reservations.

> *Cultural awareness requires that policy makers and planners as well as service providers understand the historical basis for cultural group clustering in their catchment areas, whether it is the result of choice, coercion, or a combination of both. Such understandings are necessary if health and mental health care organizations are to engage effectively in cooperative planning with the cultural groups who they hope will be satisfied consumers of care.*

Most ethnic enclaves of any size will have healers and religious or spiritual leaders who understand the views and values of their cultural group. These persons can be important collaborative resources. They can help others to understand the values around health and mental health care within the cultural group. They can be called upon

to educate health care professionals about the group's needs, preferences, and expectations about appropriate health and mental health care. Additionally, they can clarify the meanings behind what may appear to be puzzling behavior or ideas on the part of ethnic group members. Seeing a health or mental health care professional or organization reach out to important leaders in their culture may enhance ethnic group members' trust because it underscores willingness to learn and signifies respect and acceptance.

> *A culturally aware health or mental health professional should take the opportunity to locate, engage, and learn from cultural group leaders in their locale. As part of their education, health and mental health professionals from all disciplines should develop values, attitudes, knowledge, and skills necessary for culturally aware community outreach and engagement. They should be given ample opportunities to learn skills related to cross-cultural collaboration and mediation through internships and preceptorships within cultural communities. Lastly, they should also be encouraged in their intellectual and social curiosity.*

Cultural group clustering happens at the organizational as well as the community level and for the same reasons: individuals identifying and receiving support from the group with whom they feel most comfortable. This interaction is visible when individuals cluster together in staff meetings, in employee lounges, at lunchtime, and in other places that allow voluntary seating or gathering. Culturally aware managers, administrators, and human resources personnel will be cognizant of the positive effects of these identity groupings on morale among cultural group members while at the same time being aware of and managing potential negative effects of on-the-job cultural clustering. On-the-job cultural clusters can foster efficiency and cooperation among the group members; conversely impermeable and persistent clusters can undermine teamwork with colleagues who are not members of the cultural groups. Such clustering oftentimes gives rise to stereotyping, and in-group, out-group behavior, and exacerbates the natural ethnocentric tendencies common to all of us. Managers and supervisors who oversee a multicultural workforce should be given the opportunity to: (1) learn about the work-related values, practices, and norms of the cultural groups they supervise; (2) develop skills in hiring, forming, and supervising multicultural teams; and (3) participate in ongoing professional development and continuing education in cultural and linguistic competence.

VII. Cultural Awareness and Professional Effectiveness

Because so much of our cultural identity is developed out of awareness, becoming truly aware of the powerful and significant effects of culture on our personalities is not easy. To do so requires that we develop habits of introspection, self-awareness, curiosity, openness, and observation. Cultural awareness impacts our own personal functioning. Through exposure to other cultures, self-observation, and reflection, we can come to know ourselves as cultural beings—observing our personal variations in behavior and attitude in different situations—and have a greater ability to learn and change over time.

Of great importance, cultural awareness can positively impact our interactions with others: If we are *aware* cultural beings, we are conscious that we experience other cultural beings through our own cultural lens/filters. We can be aware of the powerful effect of our ethnocentrism and culture-based biases on our value judgments about, and responsiveness to, people from cultures different from our own. These understandings are necessary prerequisites for achieving professional effectiveness and cultural competence.

SECTION D.
TEACHING TOOLS, STRATEGIES, & RESOURCES

Section D offers strategies, tools, and resources to become more culturally aware and to help trainees become more culturally aware. It identifies areas of awareness, knowledge, and skills in cultural awareness and offers case studies, self-discovery exercises, and resources to incorporate cultural awareness into existing training curricula.

Areas of Awareness, Knowledge, and Skills

The NCCC selected the following areas of awareness, knowledge, and skills to highlight in this curricula enhancement module. This list is not exhaustive. Faculty are encouraged to adapt and enhance the following characteristics based on the needs, interests, and areas of focus within their respective disciplines and training programs.

Awareness of

- ✧ Models of culture;
- ✧ One's self as a cultural being;
- ✧ One's biases and stereotypes;
- ✧ The fact that culture impacts health and mental health:
  - Beliefs and practices
  - Treatment and care delivery
  - Access and utilization of care
  - Status and outcome
  - Outcomes, including racial, ethnic, and geographic disparities;
- ✧ The need for ongoing self-reflection and learning;
- ✧ The impact of organizational and professional culture on practices and policies; and
- ✧ Health and mental health inequities in current systems.

Knowledge of

- ✧ Techniques for self-reflection; and
- ✧ Group-specific as well as cross-cutting knowledge in applying cultural awareness to practices and policies.

Skills in

- ✧ Integrating cultural awareness into curricula and teaching activities;
- ✧ Modeling cultural awareness across all aspects—teaching, research, and practicum;
- ✧ Communicating and interacting in a multicultural environment;
- ✧ Observing others and reflecting on one's own thoughts and behaviors.
- ✧ Interactions with peers and other health and mental health professionals;
- ✧ Managing the dynamics of difference across cultural groups;
- ✧ Providing supervision to diverse students in multicultural environments.

Case 1: Faculty Dynamics Associated with Advancing Cultural and Linguistic Competence

You are faculty of an interdisciplinary training program in maternal and child health. Your program was successful in a grant application to MCHB that requires the integration of content on cultural competence into leadership curricula. Only two program faculty were involved in conceptualizing and writing the grant, and there were no internal review processes for other faculty and staff to provide input. Since the grant award was announced there has been tension among program faculty about the mandates, and a considerable degree of dissension among program faculty. Detractors state that: (1) the grant represents another federal mandate based on scant evidence about the efficacy of cultural competence; (2) the curriculum is already full and there is no place for additional content without taking something else away; (3) cultural competence is only applicable to clinical care and lacks relevance for population-based studies; and (4) there is a lack of awareness, knowledge and skills in this content area among faculty. Proponents feel that the grant provides the impetus and much needed resources to finally begin to address cultural competence in a meaningful manner across the entire program and it is simply the right thing to do.

As a faculty member proponent of this program, what strategies would you use to address this dilemma?

Area of Guidance for Faculty

> *"Students, research workers, and professionals in the behavioral sciences—like members of the clergy and educators—are no more immune by virtue of their values and training to the diseases and superstitions of American racism than the average man" K. Clark, from E. Mazel, 1998.*

From the NCCC's experiences, issues of culture and language typically evoke powerful emotions and responses which sometimes underlie rational arguments against integrating cultural and linguistic competence. As a faculty member proponent, you must anticipate resistance and be prepared to respond to it in a variety of ways.

The NCCC has found the following strategies to be helpful in addressing these challenges.

Attend to adaptive challenges. According to Heifitz (2002) "Adaptive challenges require people to learn new ways, change behavior, achieve new understandings, see the world through new filters…" http://www.growth-strategies.com/subpages/articles/073.html. When applied to this case study, it is important to be able to address the adaptive challenges that some faculty may be experiencing.

Use the developmental nature of cultural competence to your advantage. Faculty are used to seeing themselves as experts in specific content areas which may not be the case with cultural and linguistic competence. You can use the cultural competence framework to your advantage in this situation. Share that cultural competence is a developmental process and that no one is expected to acquire instant expertise. Rather, a culturally competent department or program establishes structures to support faculty and students learning over time.

Offer a safe refuge for authentic discussions. You may encounter an adaptive challenge where there is clear bias. People are often reticent to discuss issues associated with stereotyping, bias, prejudice and other 'ISMs'. Race, ethnicity, culture, class sexual orientation and identity, and religious affiliations/beliefs often evoke such deep emotions that people cannot even engage in or have a civil discussion. There are few opportunities and forums to share perspectives in a safe and authentic manner. Identifying approaches to confront attitudinal barriers in an open, honest, and supportive manner, and charting a course for change remain among the most difficult, yet necessary paths to advance and sustain cultural and linguistic competence The NCCC recommends that training programs adopt such practices to begin the hard work of confronting the undercurrents and engendering an environment of trust and respect.

> *"Our truncated public discussion of race suppresses the best of who and what we are as a people because they fail to confront the complexity of the issue in a candid and critical manner." (Cornell West, 1993)*
>
> *Ella Mazel "And don't call me racist !"*

Consider a broad range of strategies.

- Provide information on evidence about cultural and linguistic competence and their relationship to health and mental health disparities and inequities.
- Involve faculty, staff, and students in a process to define and reach consensus on what cultural competence and linguistic competence mean within the context of the MCH program and develop a logic model.
- Identify champions or credible voices (both internal and external) to the program and university to share perspectives with faculty who remain hesitant.
- Form an internal structure to explore how to infuse content on cultural and linguistic competence into the curriculum and training program (consider including students, community stakeholders, other interested faculty).
    - Identify other departments and faculty that have expertise in this area to serve as mentors and coaches.
    - Identify other MCH interdisciplinary training programs that taken journey including their challenges and successes.
    - Develop a plan to measure change over time including:
        - Faculty buy in and acceptance
        - Faculty awareness, knowledge and skills
        - Student satisfaction with learning experiences and curricula
        - Student knowledge and skill acquisition
        - Other ideas.

Recommended Readings & Resources for this case study

Leadership Without Easy Answers (1998) Heifetz, R. A. Bellknap Press

Eliminating racial and ethnic disparities in health care: what is the role of academic medicine? J.R. Betancourt (2006). Academic Medicine Sep;81(9):788-92.

Cultural competence in health care and its implications for pharmacy. Part 1. Overview of key concepts in multicultural health care. (2007). American College of Clinical Pharmacy, M.B. O'Connell, E.J. Korner, N.M. Rickles, J.J. Sias. Pharmacotherapy Jul 27(7) 1062-79.

The Role and Relationship of Cultural Competence and Patient-Centeredness in Health Care Quality. M.C. Beach, S. Saha, and L.A. Cooper.

Improving Quality and Achieving Equity: The Role of Cultural Competence in Reducing Racial and Ethnic Disparities in Health Care. J.R. Betancourt

The Evidence Base for Cultural and Linguistic Competency in Health Care. T. D. Goode, M. C. Dunne, and S. M. Bronheim.

Cultural Competency and Quality of Care: Obtaining the Patient's Perspective. Q. Ngo-Metzger, J. Telfair, D.H. Sorkin, et al.

Taking Cultural Competency from Theory to Action. E. Wu and M. Martinez.

Cultural competence and medical education: many names, many perspectives, one goal. (2006) J. Betancourt, Academic Medicine. Jun, 81(6), 499-501.

Community-based approaches to strengthen cultural competency in nursing education and practice. (2007). N.L. Anderson, E.R. Calvillo and M.N. Fongwa. Journal of Transcultural Nursing. Jan;18(1 Suppl):49S-59S; discussion 60S-67S.

A framework for cultural competence in advanced practice psychiatric and mental health education. (2006). J.S. Mahoney, E. Carlson and J.C. Engebretson. Perspect Psychiatr Care, 42(4) 227-37.

Teaching culturally appropriate care: a review of educational models and methods. (2006) C. Hobgood, S. Sawning, J. Bowen and K. Savage. Acad Emerg Med Dec 13(12) 1288-95.

Numerous programs offered at universities address cultural and linguistic competence, see for example the University of California – San Francisco.

Case 2: Addressing Challenges to Cultural and Linguistic Competence in Field Placements and Practicum Settings

Faculty have noted a growing trend in the past three years that students are increasingly reporting incidents in their practicum settings in which they witness bias, stereotyping, and discrimination resulting in questionable quality of care or other disparities in care. Students routinely report clear violations of Title VI in which patients and their families are denied language access services. Students state that they are reluctant to speak up because it may negatively impact their practicum experience, yet there are ethical and moral considerations that often place them in untenable situations.

Faculty and staff have discussed these issues and have not reached agreement on how best to support the students and maintain the number of clinical practicum placements that are needed for the interdisciplinary program.

The dean convened a team to develop strategies and a plan of action to address these issues. As a team member, how would you approach this problem in collaboration with your colleagues?

Areas of Guidance for Faculty

First it is important to determine what you and your colleagues can do at the individual level and what needs to occur at the department or institutional level in addressing this dilemma. The following are suggested strategies that can be part of the plan of action.

Individual faculty level

- ❑ Prepare students for experiences that they may encounter in a variety of settings:
  - power differentials in the hierarchy of medicine or other health and mental health professions
  - failure to provide interpretation and translation services
  - stereotyping, bias, and discrimination
  - racial and ethnic concordance or discordance between provider and patients/consumers
  - differential treatment based on sexual orientation and identity

- ❑ Determine which experiences are unethical, discriminatory, of poor or questionable quality of care, and merit reporting to leadership in practicum settings. Ensure that faculty and students are informed and are fully aware of procedures to follow in the event that they encounter such experiences.

- ❑ Create a structure to engage students both individually and in small groups to share their experiences. Offer guidance and encourage peer support.

- ❑ Include in curricula content on cross-cultural communication and how to address bias, stereotyping, discrimination and other "ISMs".

- ❑ Encourage students to keep a log to document issues and concerns and not to rely solely on memory.
- ❑ Collaborate with students to publish the training program's insights and lessons learned in addressing issues of bias, discrimination and other "ISMS" in health and mental care systems.

Departmental or Institutional level

- ❑ Create a structure for faculty to discuss issues across practicum settings.
- ❑ Execute interagency agreements or memoranda of understanding, between the University/Training Program and the practicum setting, that include clear procedures to address the previously described issues and problems
- ❑ Determine thresholds for incidents and methods of communication of concerns to key contacts in practicum/placement settings.
- ❑ Develop clear guidelines for incident reporting, that are sanctioned by the University or Department, for students to follow.
- ❑ Conduct regular review processes on the appropriateness of placement settings.
- ❑ Discontinue collaboration if the liabilities outweigh the benefits.
- ❑ Establish a structure that involves community stakeholders to identify new and alternative placement settings.

Recommended Reading and other Resources

101 Tools for Tolerance at http://www.tolerance.org/101_tools/index.html

Village of 100, 3rd edition, 2006, available from
http://www.trainingabc.com/xcart/catalog/product_17531_Village_of_100__Third_Edition.html

Toward Culturally Competent Care: a Toolbox for Teaching Communication Strategies. S. Mutha, C. Allen and M. Welch. See http://futurehealth.ucsf.edu/cnetwork/resources/curricula/diversity.html

Research, curricula, and resources related to lesbian, gay, bisexual, and transgender health in US schools of public health. (2007). H.L. Corliss, M.D. Shankle and M.B. Moyer. American Journal of Public Health Jun 97(6), 1023-7.

Racial and ethnic differences in patient perceptions of bias and cultural competence in health care. (2004). R.L. Johnson, S. Saha, J.J. Arbelaez, M.C. Beach and L.A. Cooper. J Gen Intern Med Feb 19(2) 101-10.

Medical student, physician, and public perceptions of health care disparities. (2004). E. Wilson, K. Grumbach, J. Huebner, J. Agrawal and A.B. Bindman. Fam Med Nov-Dec 36(10), 715-21.

Disparities in Patient Experiences, Health Care Processes, and Outcomes: The Role of Patient-Provider Racial, Ethnic, and Language Concordance (2004). L.A. Cooper and N.R. Powe, The Commonwealth Fund. See http://www.commonwealthfund.org/usr_doc/Cooper_disparities_in_patient_experiences_753.pdf?section=4039

Self-Discovery Exercises

Creating Your Own Cultural Genogram

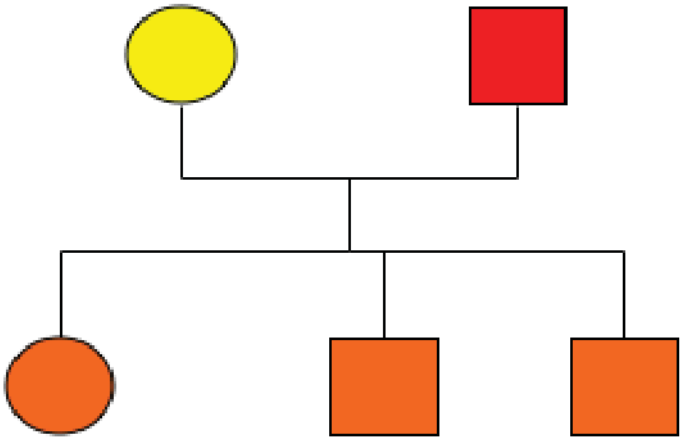
Jean Gilbert, PhD
adapted with permission from Hardy & Laszloffy, (1995)

The U.S. is full of people from many different countries and cultures. This exercise encourages participants to take a look at the culture or cultures that have influenced them. This exercise was developed in 1995 by Hardy and Laszloffy to increase people's awareness of how they have been influenced by culture. Looking at how culture has influenced you can help you be more sensitive to the way culture has shaped others. After you complete your own personal genogram and the questions relating to it, we'll take the opportunity to compare notes in a group discussion. However, you need only share what you feel comfortable sharing!

Instructions:
What you will need in order to complete this exercise: graph paper and colored pencils. When you have finished the exercise, you may want to share it with your family. They may be able to help you add to it if you like. In any case, it will make for a lively and informative family discussion!

Although many genograms go back for several generations, the one you will complete today will just go back to your grandparents, that is, your mother's and father's mother and father and will include your parents' generation (and aunts and uncles) and your own generation with all your brothers and sisters and their spouses. Clearly, you have a lot more relatives than just this three-generation genogram, but this is all we have time for today!

Here is how it is done: Women are represented by circles; men are represented by squares. A marriage is represented by a line connecting a square and a circle. Children resulting from a marriage are shown as circles and squares on a line descending from the marriage line.



The wife in the diagram above came from Mexico (yellow) and married a Mexican American man (red), and they had three children born in the U.S. (orange). How would you draw it if the man had married two different women, the one shown from Mexico, the other an Anglo American married later? (He would have a white circle connected to him as well, and their blue children would be half siblings to the orange kids.)

We see only two generations in this diagram, and this is a *nuclear family*; if we could see three generations, it would be an extended family. You will be drawing a three-generation *extended family*, using only your grandparents, your parents' generation, and your own generation (maybe you'd better put in your own kids before you take it home, though!).

1. From what countries and cultures do persons in your genogram come?

   You may have descended from just one group or several. You may want to use different colors or symbols to identify each influence in your family tree; thus, if your grandfather was Italian and Irish, you may color his "square" with two colors or symbols, half green and half yellow or a blend of two colors.

2. As you build your genogram, consider the following questions and jot down a few notes:

   a. Were any of the persons shown first generation Americans? That is, did they come here from another country? Put an "FG" in their circle or square. How many first generation persons are there in your genogram? How many countries did they come from? Do you know how old they were when they came and why they came?

   b. Did the migrants come from rural or urban backgrounds? Put a small "r" or a "u" next to the "FG."

   c. How do the persons in your genogram self-identify, that is, do they see themselves as belonging to any specific ethnic, racial or national group?

   d. Do race, skin color, and educational background have any significance in this extended family? Explain a bit about your answer.

   e. Are there intercultural/ethnic marriages in this extended family? If so, how were these marriages accepted in the family?

   f. What range of education is represented in this extended family group?
   From _____ to _____ ?

   g. Who was/is the most influential person in this genogram? Why?

   h. Have there been cultural conflicts among people in the genogram? If so, what kinds of things cause these conflicts? How are/were they resolved?

   i. What important generational differences in terms of women's and men's roles exist among the relatives in your genogram? Do you see these as cultural differences?

   j. What illnesses have caused difficulties in this extended family?

   k. What do members of the family do when someone is ill? Are there caregiver persons in the family? What kinds of treatments are used, traditional and modern?

   l. How are older members of this extended family treated differently from younger members, if at all?

   m. What languages are spoken in this extended family group? How many and who are dominant in a language other than English? How many and who speak only English? What part has language played in the relationships among people in your family?

Thinking over all of the questions discussed above, what cultural values do you see as having shaped your family and its members? How have they shaped you? Is there any national or ethnic culture that has had especially strong influence on you and your family? How is this shown in your lives? Spend a few minutes writing out your response to this question.

The Name Game

Training Objectives:

- To understand how cultures are reflected in names and naming practices.
- To increase cultural awareness of self and others.

Materials:
Paper and pencils are helpful but not essential. Chart padding is also helpful during report-out.

Directions:
Have participants divide into groups of three or four and share with each other information about their names and naming practices in their families by discussing these issues:

1. How they were named and the history behind their first and last names. For example: Were they named after someone? Is this a common practice in their families? Is their first name reflective of a particular ethnic or linguistic heritage? Is their first name spelled or pronounced differently in various cultural groups?

2. Does their last name reflect a particular ethnic or linguistic heritage? Was their family surname changed in any way upon coming to the U.S.? Does anyone have a name that is frequently mispronounced? If so, how does this make them feel?

3. What names have they given their children? Did they have special reasons for naming their children what they did? Do their children's names reflect any ethnic or linguistic heritage? Did they deliberately anglicize their children's names?

4. Did discussing their names and naming practices reveal anything about their cultural heritage? If so, what aspects of culture were reflected in names and naming?

Have one person from each group report to the whole group about cultural learnings gleaned from this discussion of names.

Notes to Facilitator:
Cultural practices affect us from the very moment we enter life. In some cultures, great significance is placed on the name given to a newborn, while in other cultures, value is placed on the uniqueness or popularity of the name. One practice is no better than the other; they are simply different.

Teaching Tools

As stated throughout this module, *cultural awareness is an important part of cultural competence*. Some strategies to promote cultural awareness include using the eco-map, the cultural genogram (see Self-Discovery Exercises), the self-assessment checklist series (see Resources for this module) and forms of self-observation through video, journal, peer role play, and feedback. Cultural awareness can also be exercised in an organizational setting using book clubs, videos and discussion, and facilitated training.

There are numerous methods of practicing cultural awareness, including "natural" ways such as culture shock (see Teaching Tools: Cultural Awareness and Culture Shock); consciously practicing awareness, including participation in self-discovery exercises; seeking out interactions and information, including discussion groups, and so forth; and actively learning/experiencing other cultures, including language, a powerful tool intimately linked with culture.

First step—culture shock. According to Storti (2001), the first step of cultural awareness, realizing that we expect others to be like us, is the most difficult, because these expectations, thoughts, feelings, and attitudes are subconscious. "It so happens, however, that we have readily at hand a fool-proof mechanism for raising this particular instinct to the level of conscious awareness: it is none other than that frustration, surprise, or anger that

arises in us at the time a cultural incident occurs" (p. 76). One recommended method of learning from cultural incidents is to schedule at a time each day to recall these encounters and reflect on them, alone or with others. With practice, greater awareness may become available during a cross-cultural incident.

Consciously practicing openness. Participating in self-awareness discovery exercises, observing and reflecting on the behaviors of self and others.

Seeking out interactions and information. Another way of actively promoting cultural awareness is to ask. This step includes, but is not limited to: (1) working with a cultural broker, (2) using a culturally competent process of inquiry, and (3) conducting focus groups.

Active learning and experience of other cultures. This step includes, but is not limited to: (1) formal cultural or cross-cultural training; (2) reading translated literature, biographies, and so forth; (3) learning the language; and (4) participating in cultural immersion programs.

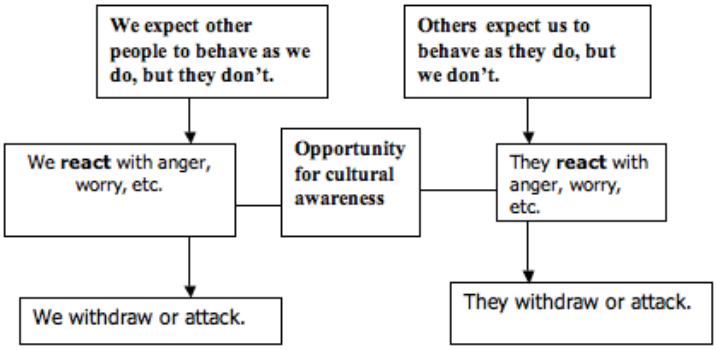
Storti emphasizes the importance of reinforcement and repetition in becoming effective in specific cross-cultural situations. Ethnocentricity is like a default position that must be resisted, and this resistance has to be ongoing.

Teaching Tools: Cultural Awareness and Culture Shock

Cultural awareness is promoted by the process of encountering difference. When one perceives that another person does not behave according to one's own deeply held cultural expectations, this collision is an opportunity to consider these expectations more fully in light of this encounter and to assess how they are culturally bound.

Although the term "culture shock" usually applies to experiences with people raised in different countries, shocks of much smaller scale can occur as people encounter different families, schools, and work or home environments. It is also common for people to perceive themselves as normal and others as different or deviating. This perception is related to ethnocentricism, a tendency that seems to be common to every culture—viewing one's own group as superior as well as the norm. The following figure, adapted with permission from Storti (2001), offers a depiction of what happens when people behave contrary to our expectations, or we behave contrary to theirs.

Figure 1.



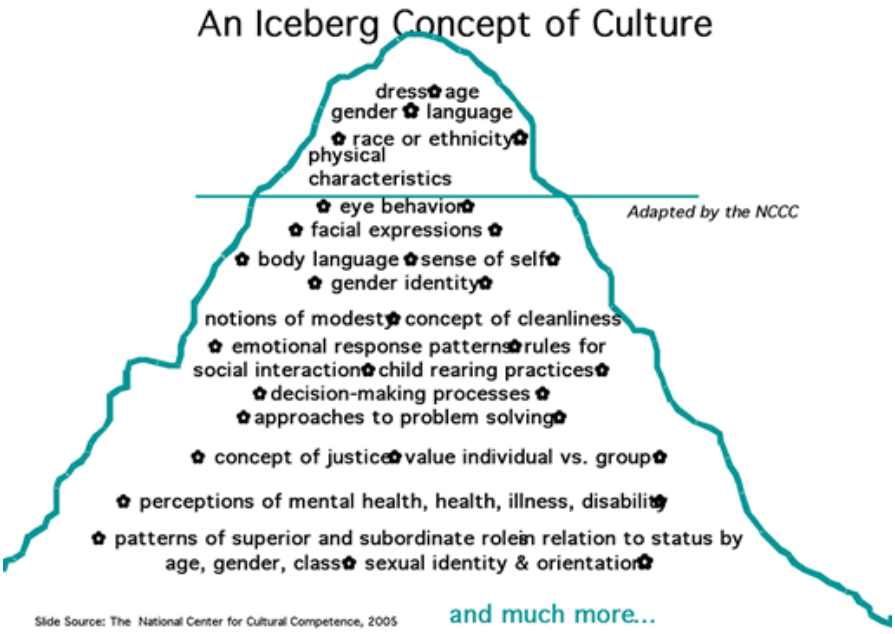
The process of cultural awareness is ongoing. Even the knowledge that members of other cultural groups behave differently may not impact our behavior. "What the conscious intellect tells us … is no match for what a lifetime of cultural conditioning has taught us. For the notion of cultural differences to take deep and lasting root in our psyche, it must be constantly reinforced over a sustained period until it is internalized. Until that time, it's entirely possible—indeed, it's inevitable—that we can cheerfully subscribe to the view that foreigners are different and still be stunned the first time we see a Hindu drink cow urine"
(Storti, 2001, p. 69).

Storti adds that because culture is related so strongly to values, cross-cultural challenges to belief systems can be perceived as threats, and the response is often deeply emotional. Thus, cultural awareness requires understanding, reflection, and supports in order to deal with the strong opinions and emotions that cross-cultural conflict can provoke.

Teaching Tools: The Iceberg Model

The image of an iceberg was used by Sigmund Freud to illustrate the hidden force of the subconscious mind. This image has become widely used in the public domain as a helpful illustration and/or exercise to gain knowledge about, and understand the aspects of, culture that are not easily discerned, invisible, and/or at the subconscious level, but all nevertheless influential aspects of culture. For example, the Peace Corps uses an iceberg exercise as part of its training curriculum, Culture Counts (see Exercises).

The iceberg model offers a picture to understand how cultural awareness may help health and mental health professionals be alert both to the "invisible," below-the-surface cultural factors that influence health and well-being, as well as the tendency to respond and react to the visible factors alone.



Definitions for This Module

Ethnicity: Ethnic quality or affiliation. The Institute of Medicine (IOM), in a 1999 report edited by Haynes, M.A. and Smedley, B.D., defines ethnicity as how one sees oneself and how one is "seen by others as part of a group on the basis of presumed ancestry and sharing a common destiny…" Common threads that may tie one to an ethnic group include skin color, religion, language, customs, ancestry, and occupational or regional features. In addition, persons belonging to the same ethnic group share a unique history different from that of other ethnic groups. Usually, a combination of these features identifies an ethnic group. For example, physical appearance alone does not consistently identify one as belonging to a particular ethnic group.

Race: There is an array of different beliefs about the definition of race and what race means within social, political and biological contexts. The following definitions are representative of these perspectives:

- a tribe, people or nation belonging to the same stock; a division of humankind possessing traits that are transmissible by descent and sufficient to characterize it as a distinctive human type;
- is a social construct used to separate the world's peoples. There is only one race, the human race, comprised of individuals with characteristics that are more or less similar to others;
- Evidence from the Human Genome project indicates that the genetic code for all human beings is 99.9% identical; there are more differences within groups (or races) than across groups.
- The IOM (Haynes & Smedley, eds., 1999) states that in all instances race is a social and cultural construct. Specifically a "construct of human variability based on perceived differences in biology, physical appearance, and behavior". The IOM states that the traditional conception of race rests on the false premise that natural distinctions grounded in significant biological and behavioral differences can be drawn between groups.

Acculturation. Cultural modification of an individual, group, or people by adapting to or borrowing traits from another culture; a merging of cultures as a result of prolonged contact. It should be noted that individuals from culturally diverse groups may desire varying degrees of acculturation into the dominant culture.

Assimilation: to assume the cultural traditions of a given people or group.

Cultural group. A cultural group is defined simply as a collection of individuals who share a core set of beliefs, patterns of behavior, and values. The groups may be large or small, but they are identified by their ways of thinking and behaving. All cultural groups are marked by intragroup variation. Many factors of diversity impact culture, including, but not limited to: ethnicity, country of origin, language, gender, race, physical appearance, age, religion, sexual identity, disability, education, and social class or status.

Cultural identity. Usually, individuals draw a major part of their sense of themselves from the cultural groups in which they grew up and were socialized. This sense of themselves shapes their cultural identity. Again, factors of diversity influence an individual's total identity at any given time, factors that are more or less permanent, such as gender, race, age cohort, physical ability/characteristics, and sexual orientation; or are fluid factors, such as educational background, religion, occupation, marital or parental status, geographic location, socioeconomic class, or military and refugee experience. People in a cultural group who form bonds with each other around some of these diverse factors may form a subculture.

Just as cultures are not static, neither are personal identities that are derived from cultural conceptualizations. A woman may be single, a wife, or a divorcee at different times in her life. Additionally, if a woman moves from one culture to another, she may adopt some of her new culture's ideas about the role of a wife while still keeping some of her old culture's ideas.

The cultural framework or lens. One way of conceptualizing the effect of culture is seeing it as a lens through which cultural group members view the world—like a pair of glasses, it influences how one sees reality. Through this lens or framework, culture helps people sort and decide what stimuli are attended to and how; and what stimuli are not attended to and, most important, confers conscious and subconscious value, positive or negative, on events, behaviors, communication, and so on. Individuals acquire this lens through the process of socialization, which begins in infancy and continues throughout life.

Invisible racism. "Students, research workers, and professionals in the behavioral sciences—like members of the clergy and educators—are no more immune by virtue of their values and training to the diseases and superstitions of American racism than the average man" (Kenneth B. Clark, 1971, excerpt from Mazel's 1998 book, "And don't call me a racist!"). "The very absence of visible signs of discrimination creates an atmosphere of racial neutrality and encourages Whites to believe that racism is a thing of the past" (Derrick Bell, 1992, excerpt from Mazel's 1998 book, "And don't call me a racist!").

Micro inequities. Micro inequities are "apparently small events which are often ephemeral and hard to prove, events which are covert, often unintentional, and frequently unrecognized by the perpetrator. Micro inequities occur whenever people are perceived to be 'different'…[and] work both by excluding the person of difference and by making that person less self-confident and less productive." "These mechanisms of prejudice against persons of difference are usually small in nature, but not trivial in effect. They are especially powerful taken together." (Rowe, 1990, p. 2).

The following terms are from the work of Jose J. Soto, JD, (2004):

Prejudice: negative attitudes, thoughts, and beliefs toward an entire category of people formed beforehand and without full knowledge or complete examination of the facts.

Racism: any program or practice of racial discrimination, segregation, persecution, and domination based on race; the notion/attitude that one's own ethnic stock is superior.

Individual racism: personal attitudes, beliefs, and behaviors designed to convince oneself of the superiority of one's race/ethnicity over those of other races/ethnicities.

Institutional: social, economic, educational, and political forces or policies that operate to foster discriminatory outcomes or give preferences to members of one group over others.

Cultural racism: beliefs, feelings, and behaviors of the members of a cultural group that assert the superiority of their group's accomplishments, achievements, and creativity over those of other groups based on race.

Examples of activities that have had negative impacts on persons of color:

- Exclusion from unions, organizations, and social clubs;
- Seniority systems ("last hired, first fired");
- Income differentials;
- Role casting in media based on stereotypes;
- Pricing in real estate sales/rentals;
- Neglect in maintenance/repair of rental properties;
- Inferior municipal services (trash, policing, streets);
- Gerrymandering ..fixing the boundaries;
- Admissions based on test scores..tests biased;
- Differential education based on preconceived potential or ability;
- One-sided curriculum.

Resources for the Cultural Awareness Module

Self-Assessment checklist series

- Promoting Cultural & Linguistic Competency Self- Assessment Checklist for Personnel Providing Services and Supports In Early Intervention and Early Childhood Settings, at http://www11.georgetown.edu/research/gucchd/nccc/documents/Checklist.EIEC.doc.pdf

- Promoting Cultural and Linguistic Competency Self-Assessment Checklist for Personnel Providing Primary Health Care Services, at http://www11.georgetown.edu/research/gucchd/nccc/documents/Checklist%20PHC.pdf

- Promoting Cultural Diversity and Cultural Competency Self-Assessment Checklist for Personnel Providing Services and Supports to Children with Disabilities & Special Health Needs and their Families, at http://www11.georgetown.edu/research/gucchd/nccc/documents/Checklist.CSHN.doc.pdf

- Promoting Cultural Diversity and Cultural Competency: Self-Assessment Checklist for Personnel Providing Behavioral Health Services and Supports to Children, Youth and Their Families at http://www11.georgetown.edu/research/gucchd/nccc/documents/ChecklistBehavioral-Health.pdf

- Promoting Cultural Diversity and Cultural Competency Self-Assessment Checklist For Personnel Providing Services and Supports to Individuals and Families Affected by Sudden Infant Death Syndrome and Other Infant Death (SIDS/ID), at http://www11.georgetown.edu/research/gucchd/nccc/documents/Checklist.SIDS-ID.pdf

The Cultural Competence Health Practitioner Instrument, at http://gucchd.georgetown.edu/nccc/pa.html

Exercise 2: Attitudes Toward Families and Culture, from the System of Care Primer Hands-On, Skill Building in Strategy for System of Care Leaders

Ten Things You Can Do to fight Prejudice and Racism, American Psychological Association, at http://www.apa.org/pi/oema/racism/q17.html

Ideas for Taking Action, from The Spokane Task Force on Race Relations, 2002, http://www.wsu.edu/PHRC/ideas.html

Project Implicit: an Internet-based exercise on hidden bias, https://implicit.harvard.edu/implicit/

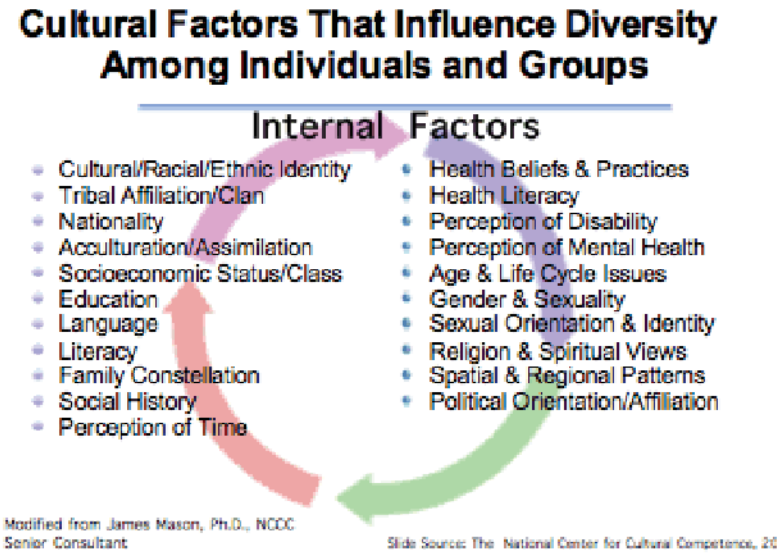
Developing cross-cultural competence: A guide for working with children and their families. 3rd edition. (2004). E. W. Lynch & M. J. Hanson, Baltimore, MD: Paul H. Brookes.

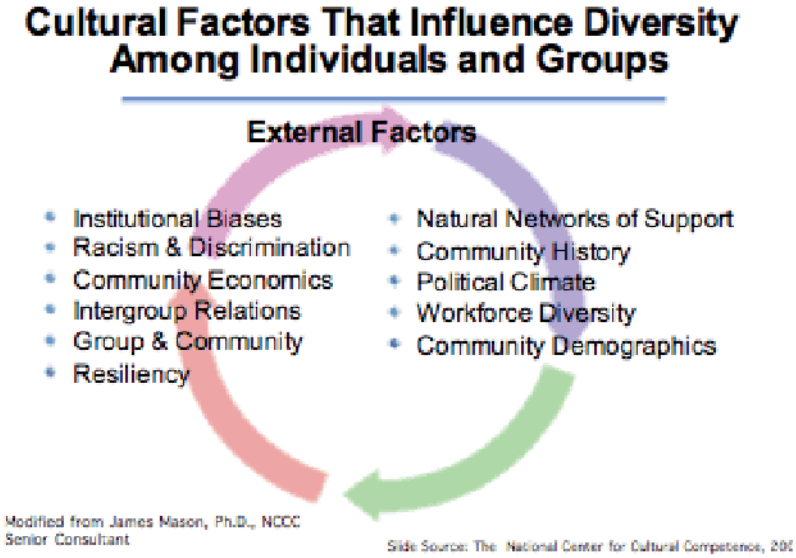
Barnga: A Simulation Game on Cultural Clashes, by Sivasailam Thiagarajan
1990 Intercultural Press.

"What Kind of Black are We?" Afi-Odelia E. Scruggs, (Color Lines) Sunday, 7/29/07 The Washington Post B02. used with permission

"How I Learned to Treat My Bias" Manoj Jain, Sunday, 4/15/07 The Washington Post. B07. used with permission

NCCC training clips





NCCC training clips, continued

Culture is..

- applicable to all peoples
- active & dynamic
  - changes over time
  - changes with migration
  - changes to meet new challenges to group
  - changes through interactions with other groups
  - changes based on climate

Adapted from Vivian Jackson, NCCC, 2003
Slide Source: The National Center for Cultural Competence, 2007

Culture is…

- multi-layered 
  - at personal, family, community level
  - home, school, work/profession levels
- malleable over time
- always considered within a context

Culture is…

- viewed as thick, thin or compartmentalized
  - thick - permeates all aspects of life
  - thin - reflected in surface aspects
  - compartmentalized - different expression of culture at home and in public

Adapted from Vivian Jackson, NCCC, 2010
Slide Source: The National Center for Cultural Competence, 2007

Culture …

- structures perceptions
- shapes behaviors
- is the total way of life – it tells group members how to behave and provides their identity

Adapted from Vivian Jackson, NCCC, 2010
Slide Source: The National Center for Cultural Competence, 2007

References used to prepare this module

Alarcon, R. D., Foulks, E. F., & Vakkur, M. (1998). *Personality disorders and culture: Clinical and conceptual interactions*. New York: Wiley.

Basabe, N., Paez, D., Valencia, J., González, J., Rimé, B., & Diener, E. (2002). Cultural dimensions, socioeconomic development, climate and emotional hedonic level. In A. S. R. Manstead & A. H. Fischer (Eds.), *Culture and emotion*. New York: Taylor & Francis.

Carmody, M.S., & Anderson, J.R. (2007). BiDil (isosorbide dinitrate and hydralazine): a new fixed-dose combination of two older medications for the treatment of heart failure in black patients. Cardiology Review, 15(1), 46-53.

Cross, T., Bazron, B., Dennis, K., & Isaacs, M. (1989). *Towards a culturally competent system of care, a monograph on effective services for minority children who are severely emotionally disturbed*, Vol. I. Washington, DC: Georgetown University Child Development Center.

Fox, R. C. (2005, September 29). Cultural competence and the culture of medicine. *The New England Journal of Medicine*, 353(13), 1316–1319. http://content.nejm.org/cgi/content/full/353/13/1316

Goode, T. (2001, revised 2006). Key definitions. Washington D.C.: National Center for Cultural Competence, Georgetown University Center for Child and Human Development.

Griffith, E. E. H., & González, C. A. (1994). Essentials of cultural psychiatry. In C. Yudofsky, R. Hales, & J. Talbott (Eds.), *The American Psychiatric Press textbook of psychiatry* (2nd ed., pp. 1379–1404). Washington, DC: American Psychiatric Press.

Hardy, K., & Laszloffy, T. (1995). Cultural genogram: Key to training culturally competent family therapists. J*ournal of Marital and Family Therapy*, 21, 227-237.

Heifetz, R.A. (2002, November). Speech at the *International Leadership Association's Annual Conference*. Summarized by Herb Rubenstein, Herb Rubenstein Consulting, retrieved from the Internet on 7/25/07 from http://www.growth-strategies.com/subpages/articles/073.html

Institute of Medicine. (2003). *Unequal treatment: Confronting racial and ethnic disparities in health care*. Washington, DC: National Academies Press.

LeVine, R. (1984). Properties of culture: An ethnographic view. In R. Schweder & R. LeVine (Eds.), *Culture theory: Essays on mind, self, and emotion*. Cambridge University Press.

Lotrecchiano, G. (2005, September 28). Definition of culture. Cited in a presentation, *Methods for cultural understanding: Assumptions and definitions of culture*, Washington, DC.

Mazel, E. (1998). *"And don't call me a racist!": A treasury of quotes on the past, present, and future of the color line in America*. Lexington, MA: Argonaut Press.

McGaghie, W. C. (2002, September 4). Assessing readiness for medical education: Evolution of the medical college admission test. *Journal of American Medical Association*, 288(9), 1085–1090.

National Center for Cultural Competence. (2001). Definitions of culture. Washington, DC: Author.

National Research Council and Institute of Medicine. (2000). *From neurons to neighborhoods: The science of early childhood development*. Washington, DC: National Academies Press.

Rowe, M. P. (1990). Barriers to equality: The power of subtle discrimination to maintain unequal opportunity. *Employee Responsibilities and Rights Journal*, 3(2), 153–163.

Soto, J. J. (2004). *Racism: a Primer*. Powerpoint presentation at the National Training Institutes, National Technical Assistance Cetner for Children's Mental Health, Georgetown University, July, 2004 San Francisco, CA.

Sockalingam, S. (2004, September 10). Definition of culture. Cited in a presentation, *Diversity and culture*, Bethesda, MD.

Storti, C. (2001) second edition. *The Art of Crossing Cultures*. Boston: Nicholas Brealey Publishing.

Taylor-Gibbs, J., Nahme-Huang, L., et al. (2003). *Children of color: Psychosocial interventions with culturally diverse youth*. San Francisco: Jossey-Bass.

Temple, R., & Stockbridge, N.L. (2007, Jan 2). BiDil for heart failure in black patients: The U.S. Food and Drug Administration perspective. *Annals of Internal Medicine*, 146(1), 57-62.

U.S. Department of Health and Human Services. (1999). *Mental health: A report of the Surgeon General—Executive summary*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health.

Winkelman, M. (2005). *Cultural awareness, sensitivity & competence*. Peosta, Iowa: Eddie Bowers Publishing Co., Inc.

Welch, M. (2003). *Teaching diversity and cultural competence in health care: A trainer's guide* (3rd ed.). San Francisco: Perspectives of Differences, Diversity Training and Consultation Services for Health Professionals (PODSDT).

Yamamoto, J., Silva, A., Ferrari, M., & Nukariya, K. (1997). Culture and psychopathology. In G. Johnson-Powell, & J. Yamamoto (Eds.), *Transcultural child development: Psychological assessment and treatment*. New York: Wiley.

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The mission of the National Center for Cultural Competence (NCCC) is to increase the capacity of health care and mental health programs to design, implement, and evaluate culturally and linguistically competent service delivery systems. The NCCC provides national leadership and contributes to the body of knowledge on cultural and linguistic competency within systems and organizations. Major emphasis is placed on translating evidence into policy and practice for programs and personnel concerned with health and mental health care delivery, administration, education and advocacy. The NCCC uses four major approaches to fulfill its mission including (1) web-based technical assistance, (2) knowledge development and dissemination, (3) supporting a "community of learners" and (4) collaboration and partnerships with diverse constituency groups. These approaches entail the provision of training, technical assistance, and consultation and are intended to facilitate networking, linkages and information exchange. The NCCC has particular expertise in developing instruments and conducting organizational self-assessment processes to advance cultural and linguistic competency.

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