Resources for the learning module in Cultural Competency

What is Culture?

"Culture consists of concepts, values, and assumptions about life that guide behavior and are widely shared by people... (and) are transmitted generation to generation, rarely with explicit instructions, by parents...and other respected elders."

-Brislin and Yoshida (as cited in Crossing Cultures with Competence, Trainer Guide)

What is Cultural Intelligence?

It is a person's ability to adjust their behavior to a new cultural environment. Is **cultural intelligence** common sense? Is it something that you can just "figure out" by living in a new culture? Some people think it is but then they realize that their business interactions aren't going smoothly with their new American colleagues in **New York** and they can't figure out why. **Cultural intelligence** is not always common sense. It is knowledge and skills that many people don't realize that they need until they make a mistake.

Cultural intelligence is, in some ways, rooted in emotional intelligence and social skills. If you are culturally intelligent, you are perceptive of your surroundings. You can easily observe what people are doing around you and how they react to what *you* do.

What is Cultural Competency?

Writing Exercise:

How would you define cultural competence in your own words? Write down a definition that makes sense to you.

Compare the definition you came up with to the following: Cultural competence is "the ability of providers and organizations to effectively deliver health care services that meet the social, cultural, and linguistic needs of patients" (Ihara, 2004, p. 1). A culturally competent health care system can help improve the health outcomes and quality of care for patients, and can contribute to the elimination of racial and ethnic health disparities (Ihara, 2004). Was your definition similar? The specific way we define cultural competence is not nearly as important as our understanding of how it affects the lives of the people we serve.

More on Cultural Competency

Brach and Fraser write, "Cultural competency goes beyond cultural awareness or sensitivity. It includes not only possession of cultural knowledge and respect for different cultural perspectives but also having skills and being able to use them effectively in cross-cultural situations" (2000, p.183). To increase the cultural competence of the health care delivery system, health professionals must be educated on how to provide services in a culturally competent and sensitive manner (Ihara, 2004). Cultural competence can increase the quality of services provided to diverse groups, including older adults.

*A self assessment on cultural competency and/or personal assumptions

http://www.asha.org/uploadedFiles/Cultural-Competence-Checklist-Personal-Reflection.pdf

AMERICAN SPEECH-LANGUAGE-HEARING ASSOCIATION

Cultural Competence Checklist: Personal Reflection

Ratings:
1 Strongly Agree
2 Agree
3 Neutral
4 Disagree
5 Strongly Disagree

This tool was developed to heighten your awareness of how you view clients/patients from culturally and linguistically diverse (CLD) populations.
***There is no answer key; however, you should review responses that you rated 5, 4, and even 3.**

___ I treat all of my clients with respect for their culture.

___ I do not impose my beliefs and value systems on my clients, their family members, or their friends.

___ I believe that it is acceptable to use a language other than English in the U.S.

___ I accept my clients' decisions as to the degree to which they choose to acculturate into the dominant culture.

___ I provide services to clients who are GLBTQ (Gay, Lesbian, Bisexual, Transgender, or Questioning).

___ I am driven to respond to others' insensitive comments or behaviors.

___ I do not participate in insensitive comments or behaviors.

___ I am aware that the roles of family members may differ within or across culture or families.

___ I recognize family members and other designees as decision makers for services and support.

___ I respect non-traditional family structures (e.g., divorced parents, same gender parents, grandparents as caretakers).

___ I understand the difference between a communication disability and a communication difference.

___ I understand that views of the aging process may influence the clients'/families' decision to seek intervention.

___ I understand that there are several American English dialects. I recognize that all English speakers use a dialect of English.

I understand that the use of a foreign accent or limited English skill is not a reflection of:

___ Reduced intellectual capacity

___ The ability to communicate clearly and effectively in a native language

I understand how culture can affect child-rearing practices such as:

___ Discipline

___ Dressing

___ Toileting

___ Feeding

___ Self-help skills

___ Expectations for the future

___ Communication

I understand the impact of culture on life activities, such as:

___ Education

___ Family roles

___ Religion/faith-based practices

___ Gender roles

___ Alternative medicine

___ Customs or superstitions

___ Employment

___ Perception of time

___ Views of wellness

___ Views of disabilities

___ The value of Western medical treatment

I understand my clients' cultural norms may influence communication in many ways, including:

___ Eye contact

___ Interpersonal space

___ Use of gestures

___ Comfort with silence

___ Turn-taking

___ Topics of conversation

___ Asking and responding to questions

___ Greetings

___ Interruptions

___ Use of humor

___ Decision-making roles

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*While several sources were consulted in the development of this checklist, the following document inspired its design: Goode, T. D. (1989, revised 2002). Promoting cultural and linguistic competence self-assessment checklist for personnel Providing services and supports in early intervention and childhood settings.

Reference this material as: American Speech-Language-Hearing Association. (2010). *Cultural Competence Checklist: Personal reflection.* Available from www.asha.org/uploadedFiles/practice/multicultural/personalreflections.pdf.

Cultural Competency Exercise

Who Are the Elderly? Aging in Society

http://cnx.org/content/m42874/latest/

Studying Aging Populations

Figure 1:
How old is this woman? In modern American society, appearance is not a reliable indicator of age. In addition to genetic differences, health habits, hair dyes, Botox, and the like make traditional signs of aging increasingly unreliable. (Photo courtesy of the Sean and Lauren Spectacular/flickr)

Since its creation in 1790, the U.S. Census Bureau has been tracking age in the population. Age is an important factor to analyze with accompanying demographic figures, such as income and health. The population pyramid below shows projected age distribution patterns for the next several decades.

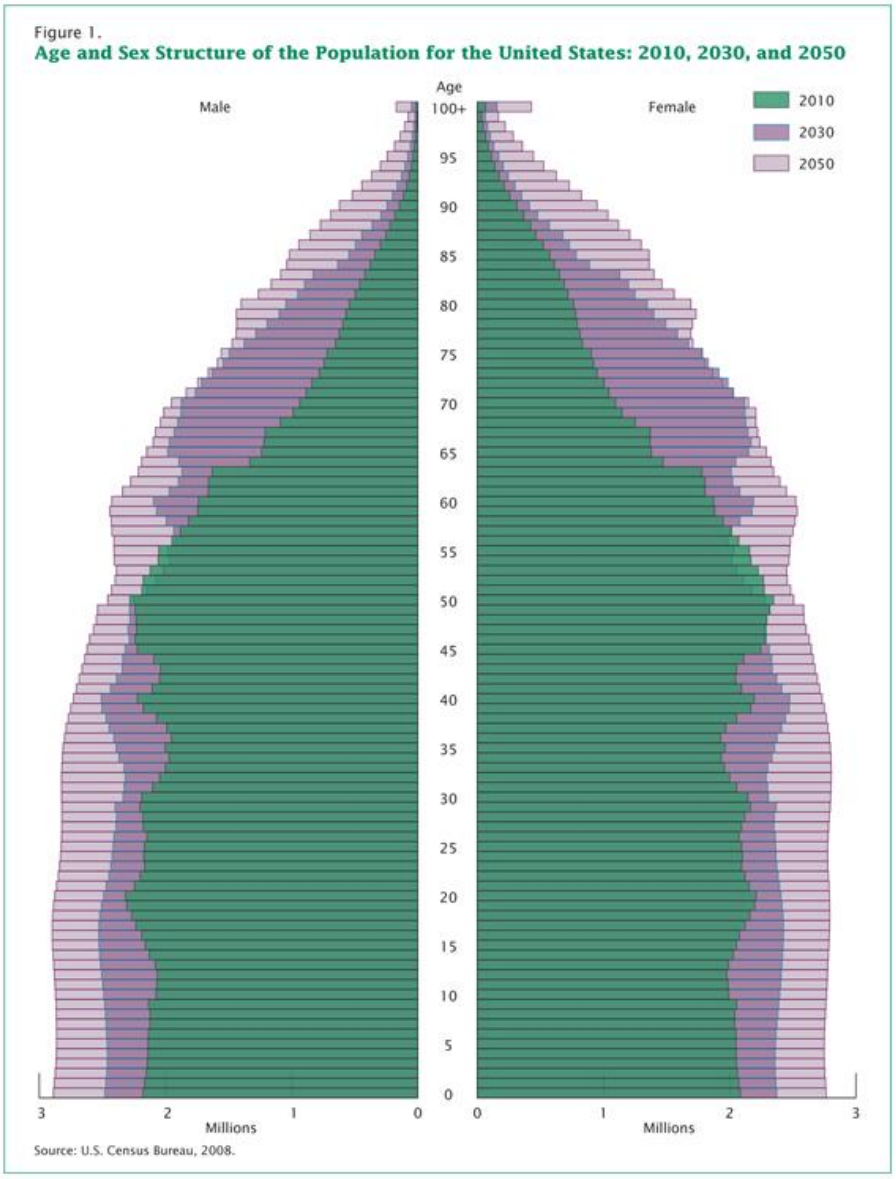

Figure 2: This population pyramid shows the age distribution pattern for 2010 and projected patterns for 2030 and 2050 (Graph courtesy of the U.S. Census Bureau).

Statisticians use data to calculate the median age of a population, that is, the number that marks the halfway point in a group's age range. In the United States, the median age is about 40 (U.S. Census Bureau 2010). That means that about half of Americans are under 40 and about half are over 40. This median age has been increasing, indicating the population as a whole is growing older.

A *cohort* is a group of people who share a statistical or demographic trait. People belonging to the same age cohort were born in the same time frame. Understanding a population's age composition can point to certain social and cultural factors and help governments and societies plan for future social and economic challenges. The cohort below compares the age distribution of the United States as a whole to the indigenous population.

Sociological studies on aging might help explain the difference between Native American age cohorts and the general population. While Native American societies have a strong tradition of revering their elders, they also have a lower life expectancy because of lack of access to health care and high levels of mercury in fish, a traditional part of their diet.

Phases of Aging: The Young-Old, Middle-Old, and Old-Old

In the United States, all people over age 18 are considered adults, but there is a large difference between a person aged 21 and a person who is 45. More specific breakdowns, such as "young adult" and "middle-aged adult," are helpful. In the same way, groupings are helpful in understanding the elderly. The elderly are often lumped together, grouping everyone over the age of 65. But a 65-year-old's experience of life is much different than a 90-year-old's.

The United States' older adult population can be divided into three life-stage subgroups: the young-old (approximately 65–74), the middle-old (ages 75–84), and the old-old (over age 85). Today's young-old age group is generally happier, healthier, and financially better off than the young-old of previous generations. In the United States, people are better able to prepare for aging because resources are more widely available.

Also, many people are making proactive quality-of-life decisions about their old age while they are still young. In the past, family members made care decisions when an elderly person reached a health crisis, often leaving the elderly person with little choice about what would happen. The elderly are now able to choose housing, for example, that allows them some independence while still providing care when it is needed. Living wills, retirement planning, and medical power of attorney are other concerns that are increasingly handled in advance.

The Graying of the United States

Figure 3: As senior citizens make up a larger percentage of the United States, the organizations supporting them grow stronger. (Photo courtesy of Congressman George Miller/flickr)

What does it mean to be elderly? Some define it as an issue of physical health, while others simply define it by chronological age. The U.S. government, for example, typically classifies people aged 65 years old as elderly, at which point citizens are eligible for federal benefits such as Social Security and Medicare. The World Health Organization has no standard, other than noting that 65 years old is the commonly accepted definition in most core nations, but it suggests a cut-off somewhere between 50 and 55 years old for semi-peripheral nations, such as those in Africa (World Health Organization 2012). AARP (formerly the American Association of Retired Persons) cites 50 as the eligible age of membership. It is interesting to note AARP's name change; by taking the word "retired" out of its name, the organization can broaden its base to any older Americans, not just retirees. This is especially important now that many people are working to age 70 and beyond.

There is an element of social construction, both local and global, in the way individuals and nations define who is elderly; that is, the shared meaning of the concept of elderly is created through interactions among people in society. This is exemplified by the truism that you are only as old as you feel.

Demographically, the U.S. population over age 65 increased from 3 million in 1900 to 33 million in 1994 (Hobbs 1994) and to 36.8 million in 2010 (U.S. Census Bureau 2011c). This is a greater than tenfold increase in the elderly population, compared to a mere tripling of both the total population and of the population under 65 (Hobbs 1994). This increase has been called "the graying of America," a term that describes the phenomenon of

a larger and larger percentage of the population getting older and older. There are several reasons why America is graying so rapidly. One of these is *life expectancy*: the average number of years a person born today may expect to live. When reviewing Census Bureau statistics grouping the elderly by age, it is clear that in the United States, at least, we are living longer. Between 2000 and 2012, the number of elderly citizens between 90 and 94 increased by more than 30 percent, and the number of elderly citizens 95 to 99 increased by almost 30 percent. Finally, the number of *centenarians* (those 100 years or older) increased by 2,910: a mere 5.8 percent, but impressive nonetheless (Werner 2011).

It is interesting to note that not all Americans age equally. Most glaring is the difference between men and women; as the graph below shows, women have longer life expectancies than men. In 2010, there were ninety 65-year-old men per one hundred 65-year-old women. However, there were only eighty 75-year-old men per one hundred 75-year-old women, and only sixty 85-year-old men per one hundred 85-year-old women. Nevertheless, as the graph shows, the sex ratio actually increased over time, indicating that men are closing the gap between their life spans and those of women (U.S. Census Bureau 2010).

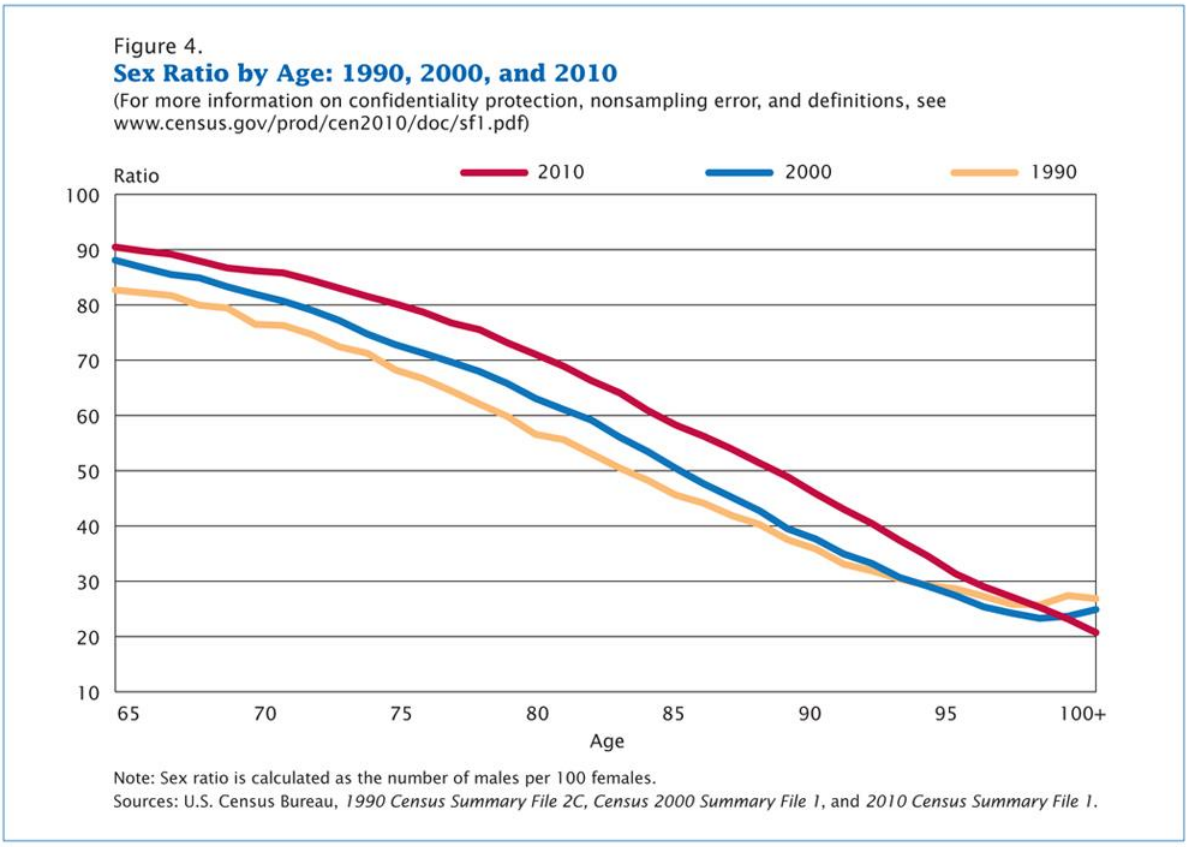

Figure 4: This U.S. Census graph shows that women live significantly longer than men. However, over the past two decades, men have narrowed the percentage by which women outlive them. (Graph courtesy of the U.S. Census Bureau)

Baby Boomers

Of particular interest to gerontologists right now is the population of *baby boomers*, the cohort born between 1946 and 1964 and just now reaching age 65. Coming of age in the 1960s and early 1970s, the baby boom generation was the first group of children and teenagers with their own spending power and therefore their own marketing power (Macunovich 2000). As this group has aged, it has redefined what it means to be young, middle aged, and, now, old. People in the boomer generation do not want to grow old the way their grandparents did; the result is a wide range of products designed to ward off the effects—or the signs—of

aging. Previous generations of people over 65 were "old." Baby boomers are in "later life" or "the third age" (Gilleard and Higgs 2007).

The baby boom generation is the cohort driving much of the dramatic increase in the over-65 population. The figure below shows a comparison of the U.S. population by age and gender between 2000 and 2010. The biggest bulge in the pyramid (representing the largest population group) moves up the pyramid over the course of the decade; in 2000, the largest population group was age 35 to 55. In 2010, that group was age 45 to 65, meaning the oldest baby boomers are just reaching the age at which the U.S. Census considers them elderly. In 2020, we can predict, the baby boom bulge will continue to rise up the pyramid, making the largest U.S. population group between 65 and 85 years old.

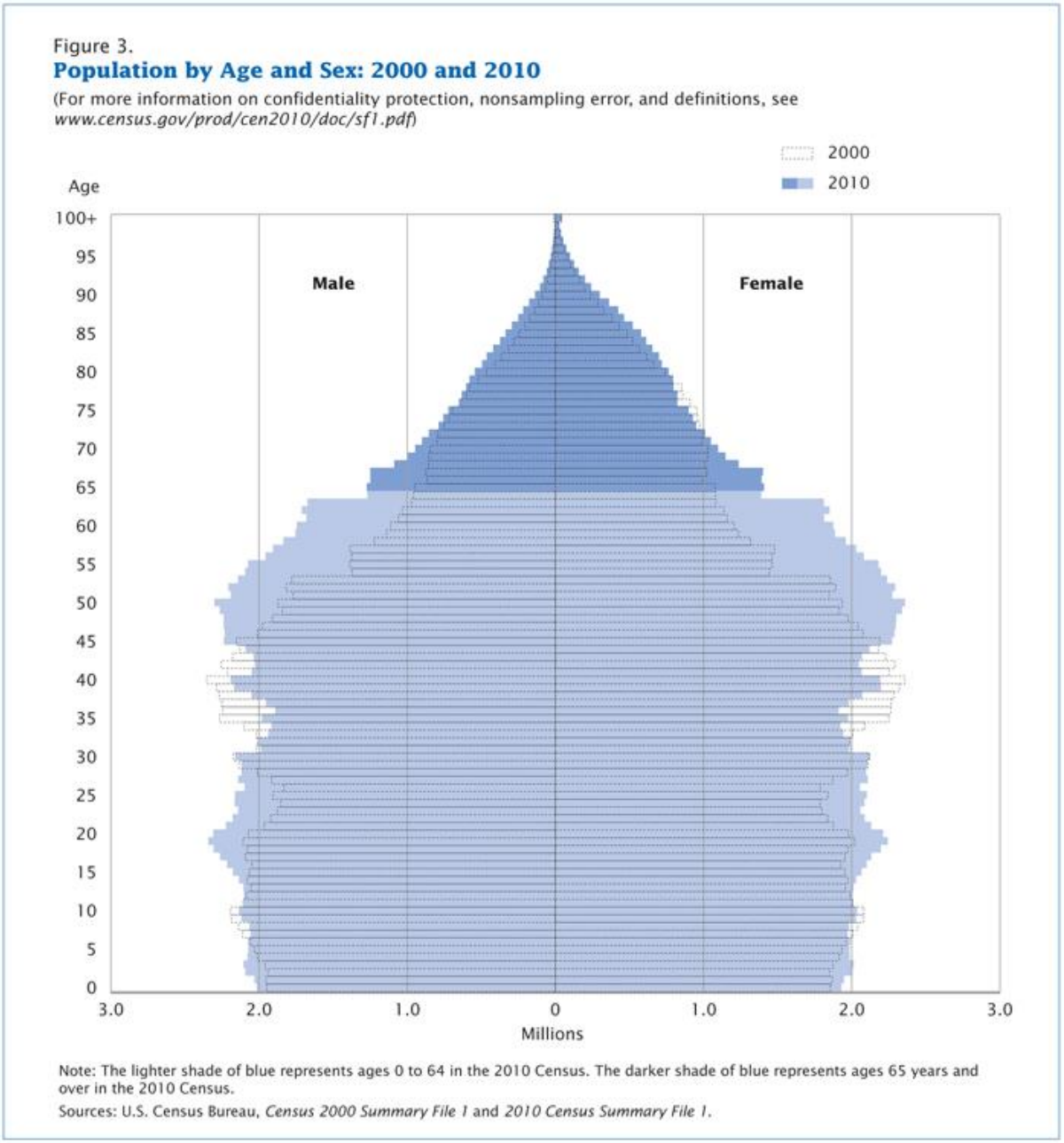

Figure 5: In this U.S. Census pyramid chart, the baby boom bulge was aged 35 to 55 in 2000. In 2010, they were aged 45 to 65. (Graph courtesy of the U.S. Census Bureau)

This aging of the baby boom cohort has serious implications for our society. Health care is one of the areas most impacted by this trend. For years, hand-wringing has abounded about the additional burden the boomer cohort will place on Medicare, a government-funded program that provides health care services to people over 65. And indeed, the Congressional Budget Office's 2008 long-term outlook report shows that Medicare spending is expected to increase from 3 percent of gross domestic product (GDP) in 2009 to 8 percent of GDP in 2030, and to 15 percent in 2080 (Congressional Budget Office 2008).

Certainly, as boomers age, they will put increasing burdens on the entire U.S. health care system. A study from 2008 indicates that medical schools are not producing enough medical professionals who specialize in treating geriatric patients (Gerontological Society of America 2008). However, other studies indicate that aging boomers will bring economic growth to the health care industries, particularly in areas like pharmaceutical manufacturing and home health care services (Bierman 2011). Further, some argue that many of our medical advances of the past few decades are a result of boomers' health requirements. Unlike the elderly of previous generations, boomers do not expect that turning 65 means their active lives are over. They are not willing to abandon work or leisure activities, but they may need more medical support to keep living vigorous lives. This desire of a large group of over-65-year-olds wanting to continue with a high activity level is driving innovation in the medical industry (Shaw).

The economic impact of aging boomers is also an area of concern for many observers. Although the baby boom generation earned more than previous generations and enjoyed a higher standard of living, they also spent their money lavishly and did not adequately prepare for retirement. According to a 2008 report from the McKinsey Global Institute, approximately two-thirds of early boomer households have not accumulated enough savings to maintain their lifestyles. This will have a ripple effect on the economy as boomers work and spend less (Farrel et al. 2008).

Just as some observers are concerned about the possibility of Medicare being overburdened, Social Security is considered to be at risk. Social Security is a government-run retirement program funded primarily through payroll taxes. With enough people paying into the program, there should be enough money for retirees to take out. But with the aging boomer cohort starting to receive Social Security benefits, and with fewer workers paying into the Social Security trust fund, economists warn that the system will collapse by the year 2037. A similar warning came in the 1980s; in response to recommendations from the Greenspan Commission, the retirement age (the age at which people could start receiving Social Security benefits) was raised from 62 to 67 and the payroll tax was increased. A similar hike in retirement age, perhaps to 70, is a possible solution to the current threat to Social Security (Reuteman 2010).

Aging around the World

Figure 6: Cultural values and attitudes can shape people's experience of aging. (Photo courtesy of Tom Coppen/flickr)

From 1950 to approximately 2010, the global population of individuals age 65 and older increased by a range of 5–7 percent (Lee 2009). This percentage is expected to increase and will have a huge impact on the *dependency*

ratio: the number of productive working citizens to non-productive (young, disabled, elderly) (Bartram and Roe 2005). One country that will soon face a serious aging crisis is China, which is on the cusp of an "aging boom": a period when its elderly population will dramatically increase. The number of people above age 60 in China today is about 178 million, which amounts to 13.3 percent of its total population (Xuequan 2011). By 2050, nearly a third of the Chinese population will be age 60 or older, putting a significant burden on the labor force and impacting China's economic growth (Bannister, Bloom, and Rosenberg 2010).

As health care improves and life expectancy increases across the world, elder care will be an emerging issue. Wienclaw (2009) suggests that with fewer working-age citizens available to provide home care and long-term assisted care to the elderly, the costs of elder care will increase.

Worldwide, the expectation governing the amount and type of elder care varies from culture to culture. For example, in Asia the responsibility for elder care lies firmly on the family (Yap, Thang, and Traphagan 2005). This is different from the approach in most Western countries, where the elderly are considered independent and are expected to tend to their own care. It is not uncommon for family members to intervene only if the elderly relative requires assistance, often due to poor health. Even then, caring for the elderly is considered voluntary. In the United States, decisions to care for an elderly relative are often conditionally based on the promise of future returns, such as inheritance or, in some cases, the amount of support the elderly provided to the caregiver in the past (Hashimoto 1996).

These differences are based on cultural attitudes toward aging. In China, several studies have noted the attitude of *filial piety* (deference and respect to one's parents and ancestors in all things)as defining all other virtues (Hsu 1971; Hamilton 1990). Cultural attitudes in Japan prior to approximately 1986 supported the idea that the elderly deserve assistance (Ogawa and Retherford 1993). However, seismic shifts in major social institutions (like family and economy) have created an increased demand for community and government care. For example, the increase in women working outside the home has made it more difficult to provide in-home care to aging parents, leading to an increase in the need for government-supported institutions (Raikhola and Kuroki 2009).

In the United States, by contrast, many people view caring for the elderly as a burden. Even when there is a family member able and willing to provide for an elderly family member, 60 percent of family caregivers are employed outside the home and are unable to provide the needed support. At the same time, however, many middle-class families are unable to bear the financial burden of "outsourcing" professional health care, resulting in gaps in care (Bookman and Kimbrel 2011). It is important to note that even within the United States not all demographic groups treat aging the same way. While most Americans are reluctant to place their elderly members into out-of-home assisted care, demographically speaking, the groups least likely to do so are Latinos, African Americans, and Asians (Bookman and Kimbrel 2011).

Globally, the United States and other core nations are fairly well equipped to handle the demands of an exponentially increasing elderly population. However, peripheral and semi-peripheral nations face similar increases without comparable resources. Poverty among elders is a concern, especially among elderly women. The feminization of the aging poor, evident in peripheral nations, is directly due to the number of elderly women in those countries who are single, illiterate, and not a part of the labor force (Mujahid 2006).

In 2002, the Second World Assembly on Aging was held in Madrid, Spain, resulting in the Madrid Plan, an internationally coordinated effort to create comprehensive social policies to address the needs of the worldwide aging population. The plan identifies three themes to guide international policy on aging: 1) publically acknowledging the global challenges caused by, and the global opportunities created by, a rising global population; 2) empowering the elderly; and 3) linking international policies on aging to international policies on development (Zelenev 2008).

The Madrid Plan has not yet been successful in achieving all its aims. However, it has increased awareness of the various issues associated with a global aging population, as well as raising the international consciousness to the way that the factors influencing the vulnerability of the elderly (social exclusion, prejudice and discrimination, and a lack of socio-legal protection) overlap with other developmental issues (basic human rights, empowerment, and participation), leading to an increase in legal protections (Zelenev 2008).

Summary

The social study of aging uses population data and cohorts to predict social concerns related to aging populations. In the United States, the population is increasingly older (called "the graying of America"), especially due to the baby boomer segment. Global studies on aging reveal a difference in life expectancy between core and peripheral nations as well as a discrepancy in nations' preparedness for the challenges of increasing elderly populations.

Section Quiz

Exercise 1

In most countries, elderly women _____ than elderly men.

1. are mistreated less
2. live a few years longer
3. suffer fewer health problems
4. deal with issues of aging better

Answer

B

Exercise 2

America's baby boomer generation has contributed to all of the following except:

1. Social Security's vulnerability
2. improved medical technology
3. Medicaid being in danger of going bankrupt
4. rising Medicare budgets

Answer

C

Exercise 3

The measure that compares the number of men to women in a population is _____.

1. cohort
2. sex ratio
3. baby boomer
4. disengagement

Answer

B

Exercise 4

The “graying of the United States” refers to _____.

1. the increasing percentage of the population over 65
2. faster aging due to stress
3. dissatisfaction with retirement plans
4. increased health problems such as Alzheimer’s

Answer

A

Exercise 5

What is the approximate median age of the United States?

1. 85
2. 65
3. 37
4. 18

Answer

C

Short Answer

Exercise 1

Baby boomers have been called the “Me Generation.” Do you know any baby boomers? In what way do they exemplify their generation?

Exercise 2

What social issues involve age disaggregation (breakdowns into groups) of a population? What kind of sociological studies would consider age an important factor?

Exercise 3

Conduct a mini-census by counting the members of your extended family, emphasizing age. Try to include three or four generations, if possible. Create a table and include total population plus percentages of each generation. Next, begin to analyze age patterns in your family. What issues are important and specific to each group? What trends can you predict about your own family over the next 10 years based on this census? For example, how will family members’ needs and interests and relationships change the family dynamic?

Further Research

Gregory Bator founded the television show *Graceful Aging* and then developed a web site offering short video clips from the show. The purpose of *Graceful Aging* is to both inform and entertain, with clips on topics such as sleep, driving, health, safety, and legal issues. Bator, a lawyer, works on counseling seniors about their legal needs. Log onto *Graceful Aging* for a visual understanding of aging: http://www.gracefulaging.com

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Glossary

baby boomers: Americans born between approximately 1946 and 1964
centenarians: people 100 years old or older
cohort: a group of people who share a statistical or demographic trait
dependency ratio: the number of productive working citizens to non-productive (young, disabled, or elderly)
filial piety: deference and respect to one’s parents and ancestors in all things
gerontology: a field of science that seeks to understand the process of aging and the challenges encountered as seniors grow older
life expectancy: the number of years a newborn is expected to live
social gerontology: a specialized field of gerontology that examines the social (and sociological) aspects of aging

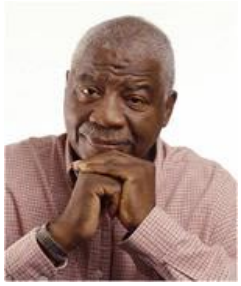
Cultural Competency and Older Adults

A few cases

Case #1 The Wu family recently migrated from Taiwan. Two months after their arrival in Denver, CO, grandmother Wu fell ill and was diagnosed with a metastatic gastric ulcer. The granddaughter, who was instrumental in bringing the family to Denver, is a nurse who is employed in the coronary care unit. The family asked the oncologist and oncology nurse to relay all information to the granddaughter rather than the patient.

What cultural differences and potential barriers exist?

Case #2 Mr. Jones is a 72-year-old African American, who has prostate cancer. As a result, he is receiving chemotherapy. The clinic nurse noted that Mr. Jones is late for his chemotherapy appointments and sometimes comes on the wrong day. The nurses in the clinic prepared a calendar for Mr. Jones, but the schedule did not seem to help him keep his appointments.



How can the nurse collaborate with the patient to reduce alterations in time/space perceptions related to appointments?

Case # 3 While visiting her children in the United States, Mrs. Juana Perez was diagnosed with pancreatitis. She was admitted to the hospital and her daughter, Anna, took charge of her care, pampering her with attention and services, which often interfered with appropriate care. Anna would refuse to have her mother sit on a chair or ambulate, saying that Mrs. Perez was too ill and weak. She insisted that her mother continue taking an herbal tea from Bogota. Even though Anna took charge of her mother's care, Mr. Pedro Perez, made all the decisions regarding the treatment plan for Mrs. Perez.

How can the nurse achieve treatment and care outcomes for the patient while at the same time supporting and appreciating the daughter's role in the care of her mother?

Case #4 Mrs. Sanchez is a 75-year-old Puerto Rican woman living in New York. She has had a colostomy for colon cancer. The home health nurse noted that Mrs. Sanchez adds brandy to her black coffee and takes several varieties of herbal teas.

What are some culture-related behaviors concerning the use of alcoholic beverages for health reasons?

Case # 5 Dr. de la Cruz is a Filipino physician employed as a family practitioner in New Jersey. She was admitted to the hospital for surgery for breast cancer. While caring for Dr. de la Cruz, the nurse noticed a statue of the Virgin Mary, a prayer book, and a rosary on her table. Dr. de la Cruz also had a crucifix pinned to her gown.

What religious icons are present in this scenario? How can the nurse include these articles to provide support?

Case #6 Abu Fulani has terminal pancreatic cancer. Mr. Fulani is an immigrant from Saudi Arabia and practices the Islamic faith. Although he states that he has severe pain, he believes that pain and suffering are manifestations of Allah's will. He refuses pain medications because he believes that they will hasten his death. The family has rearranged the room so that Mr. Fulani faces east at all times.

When Mr. Fulani died, his son insisted on washing and dressing his body, while the family retired to another room.

What were the cultural aspects of pain and pain management in this situation? What are some rituals and burial procedures of other cultures?