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Applying Concepts of Cultural Humility in CSD Education

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In the field of communication sciences and disorders (CSD) which represents both speech-language pathology and audiology, there is an expectation for professionals to be culturally competent. The 2020 Standards for acquiring a certificate of clinical competence in either speech-language pathology or audiology require that professionals be familiar with how linguistic and cultural characteristics impact their areas of certification in the provision of services to clients (American Speech-Language-Hearing Association [ASHA], n.d. a). It also requires that in speech-language pathology for example, applicants for certification demonstrate that they can “communicate effectively, recognizing the needs, values, preferred mode of communication, and cultural/linguistic background of the individual(s) receiving services, family, caregivers, and relevant others” (ASHA, n.d. a, Standard V-B-3a). Our governing body, ASHA, defines cultural competence as “understanding and appropriately responding to the unique combination of cultural variables and the full range of dimensions of diversity that the professionals and client/patient/family bring to interactions” (ASHA, n.d. b, para. 1). Despite the existence of the expectation for cultural competence, there is little to suggest that new clinicians are confident in serving individuals from diverse cultural and linguistic backgrounds (Guiberson & Atkins, 2012; Parveen & Santhanam, 2020).

Part of the need for consideration and reexamination of our view towards cultural competence is due to the fact that just under 92% of ASHA certificate holders are white, while just 8.2% belong to a racial minority (ASHA, 2019). This statistic confirms the disparity between the profession and the cultural and linguistic diversity of the population that we may assess and treat, which currently identifies as a race other than white in approximately 25% of individuals in the United States in 2019 (United States Census Bureau, n.d.). In other words, there appears to be a cultural incongruence between the profession and the population often receiving services (Fuse & Bergen, 2018; Ginsberg, 2018a; Randolph & Bradshaw, 2018). As a result, we find ourselves currently addressing courageous conversations influenced by the socio-political climate that we must now give homage. During listening sessions aimed to identify sources of stress that minority students experience in CSD education, it was noted that students who are black, indigenous, and people of color (BIPOC) experience anxiety due to microaggressions, cultural insensitivity/intolerance of cultural differences, little to no diversity, and isolation in their programs (National Student Speech-Language-Hearing Association [NSSLHA], 2020). Further evidence for the experience of students experiencing discrimination and microaggressions in CSD education have been noted in recent years by Dwivedi (2018), Ginsberg (2018a), and Steed (2014) suggests that the results of this listening session were not new or unique. In their efforts to address and eradicate systemic racism, ASHA’s *Response to Racism* has revised its *Envisioned Future 2025* to address diversity, equity, and inclusion as well as the Strategic Plan to expand existing diversity efforts (ASHA, 2020). As we work towards these goals, we believe that improving how we respond to culturally and linguistically diverse populations, clinically and academically, needs to be reconsidered in terms of the importance of culture in CSD, cultural competence, and cultural humility (Tervalon & Murray-Garcia, 1998). According to ASHA

Culture as a concept may represent a wide range of variables including but not limited to age, disability, ethnicity, gender identity (encompasses gender expression), national origin (encompasses related aspects e.g., ancestry, culture, language, dialect, citizenship, and immigration status), race, religion, sex, sexual orientation, and veteran status. Linguistic diversity can accompany cultural diversity. (ASHA, 2017, para. 3).

It is critical to recognize that culture is not always observable. While it may be tempting to assume that a person associates with a culture based on a visible outward appearance or the audible sound of their dialect, it is not safe to make assumptions about an individual's identity. For most of us, the factors that are part of our own individual culture are a combination of the visible and the invisible, as well as the audible and the inaudible. They go beyond what can be perceived by an outside observer and are often multifactorial in nature. We must acknowledge the sense of intersectionality that we all hold as part of our cultural identity. Intersectionality reflects the multifactorial nature of culture and that we may belong to more than one category or culture at any given time (Crenshaw, 1991; Ortega & Faller, 2011). How people define their diversity may be much less evident than we think. One of the many challenges in demonstrating cultural competence in working with clients and students is determining the many facets of how *they* define their culture(s).

Cultural competence applies to higher education as well as to clinical settings. We use the term educators inclusively to represent faculty, instructors, clinical educators, and clinical supervisors working with learners. As educators, we must bring the same level of cultural competence to our treatment of students as we do to our clinical work. There are two critical reasons for this: the first reason is that demonstrating cultural competence with students is a good way to teach them about how to be culturally competent with their clients. In being culturally competent with students, we walk the walk that matches how we talk the talk, in teaching them about multiculturalism. The second and most critical reason is about respect and effectiveness. We are culturally competent clinicians because it is critical to understand our clients' values, priorities, and life-perspective in order to facilitate their treatment success. We must be culturally competent educators because it is critical to understand our students' values, priorities, and life-perspective in order to facilitate their academic success. Few of us thrive in an environment where we are disrespected, treated poorly, or marginalized. Therefore, we must demonstrate cultural competence with our students in all settings and in all stages of the higher education process.

Cultural competence involves both "self-awareness and cultural humility" (ASHA, n.d. b, Developing Cultural Competence). For many, the term of cultural competence has its shortcomings (Ginsberg, 2018b; Juarez et al., 2006). The use of the term competence may suggest to some that it is a set of skills or knowledge that one simply must learn or master to attain it. Cultural competence implies a tolerance of other cultures and differences, which falls short of appreciating another's cultural perspective (Cross et al., 1989; Ginsberg, 2018b; Kimmons, 2017). Developing a clear sense of self-awareness and focused self-reflection regarding the stages of knowledge acquisition, as outlined originally by Howell (1982) may be instructive as we deepen our appreciation of what we know and what we may not yet recognize that we do not know. In considering how our insights may impact our view of cultures, Ward (2016) and Malau-Aduli et al. (2019) suggest that applying Howell's stages of consciousness and competence to intercultural awareness will result in moving from unconscious incompetence in which the individual fails to recognize the existence and influence of cultural differences, toward Howell's next stage of conscious incompetence where individuals may have an initial awareness of cultural differences but are not yet equipped with enough knowledge to manage situations well. Those who move toward conscious competence are able to manage their behavior but are in a phase of constant monitoring until they reach Howell's fourth and final stage of unconscious competence. At this stage individuals are confident about their awareness and interactions with others and are able to

function in an appropriate way with all individuals (Malau-Aduli et al., 2019; Ward, 2016). By working our way through Howell's stages of consciousness, we may be able to move ourselves from cultural competence towards cultural humility. Ortega and Faller (2011) promote cultural humility as a complement to cultural competence. While cultural competency embraces principles of equitable access and non-discriminatory practices for service delivery and in education, it does not go far enough to be accountable for privilege and power positions that their roles entails. In order to be successful working with culturally and linguistically diverse people as clinicians and educators, we must move towards unconscious competence (Howell, 1982).

Cultural Humility Mindset

If a culturally competent perspective is potentially constricting in our clinical and educational functioning, what is the alternative? We propose, as many have, that cultural humility is a preferable mindset. While it has been noted that cultural humility is one of the facets of cultural competence, we would suggest that it supersedes it. Cultural humility is a perspective to assist you to work effectively with those that are culturally different from you. Cultural humility is a way of thinking about the world and those we interact with as we move through it. It is not a knowledge set whose accuracy can be tested or mastered but represents a more dynamic model of thinking.

Cultural humility was first defined in the medical context as it “incorporates a lifelong commitment to self-evaluation and self-critique, to redressing the power imbalances in the patient-physician dynamic, and to developing mutually beneficial and non-paternalistic clinical and advocacy partnerships with communities” (Tervalon & Murray-Garcia, 1998, p. 117). While it was first described and adopted by physicians and has been applied widely in medical education, it applies equally well to CSD professionals and educators, who use models of caregiving that are often based on medical models in a variety of settings. While medical education has led in addressing cultural humility, measures of success may be based on self-report of intercultural competence and is challenging to measure, suggesting that there is a need for continued work in the education of health care providers (Malau-Aduli et al., 2019; Paparella-Pitzel et al., 2016; Schuessler et al., 2012; Tormala et al., 2018). Mental health professionals, including child welfare workers, social workers, and psychologists (Abe, 2019; Hook, 2014; Ortega & Faller, 2011) have also described the benefits of shifting from cultural competence to a cultural humility mindset in order to reduce power imbalances and improve therapeutic outcomes. Tervalon and Murray-Garcia (1998) advocated that physician training, including immersive community experiences, needed to incorporate a focus on improving cultural humility in order to bring about a change in the profession.

In discussing how we can apply cultural humility to our educational practices, we will consider key aspects of this mindset: (1) self-evaluation (2) addressing power imbalances, and (3) partnerships.

Self-Evaluation. First and foremost, cultural humility requires a commitment to self-evaluation. Many of us grew up believing that one view of the world (ours) was better than others. It might be that our parents raised us to believe that the religion that we practiced was superior to others. It may be that an early negative experience with someone from a different race, led us to believe that people of that race are not trustworthy. Rather than accept our long-held beliefs or views of the world, we must ask ourselves as adults why we continue to hold on to our thinking. Cultural humility requires professionals, clinicians and educators alike, to see each individual as part of the

culture(s) they identify with, as well as their unique characteristics that shape their views and beliefs (Juarez et al., 2006). In cultivating cultural humility, we must begin to understand that cultures that are different than ours are not less than ours in any way. We must question the “primacy of our own perspective” and cease seeing our own culture and perspective as superior to others’ (Guskin, 2015, p. 163).

Applying the Concept. In order to begin your journey of self-evaluation, it may be beneficial to consider that it is indeed a journey, not a destination. There are numerous routes to take and what works for some of us may not work for others. Along the way, we must reflect on our own implicit and explicit bias. We must ask how we view groups of people or cultures that are different from ourselves. Be particularly mindful of thoughts that lead you toward assumptions of differences representing inferiority. There are a variety of tools that may be useful to you. Consider the *Cultural Competence Checklists* which include a Personal Reflection Tool available from ASHA (ASHA, n.d. c). Harvard University offers an *Implicit Association Test* (IAT; Harvard, 2011). This test is anonymous, free, and offered online for you to explore your attitudes and beliefs about a variety of cultures. The results may provide additional insights and understanding of implicit bias that you did not uncover through unguided reflections. Additionally, while the use of the IAT tool alone is not always considered a reliable tool for prediction of discriminatory behavior, it has been shown to be useful when utilized in combination with additional materials, such as case vignettes (Maina et al., 2018 Oswald et al., 2013). We suggest that this tool is useful for providing insights to reflect upon. Remember that taking the first steps towards self-reflection and examination of bias represents a beginning and that it is an ongoing process. We can use insights from a variety of sources as we reflect to move ourselves towards intercultural competence that reflects unconscious competence (Howell, 1982; Ward, 2016).

Addressing Power Imbalances. To further accentuate a cultural humility mindset, one must be open to learning about others’ lived experiences, which will give you a critical sense of who they are. In other words, learn from them what it is to “walk a mile in their shoes.” By embracing shared decision making and affirming the values of other cultures we can help increase the understanding of the power dynamic in professional relationships (Martin & Cooper, 2013). This perspective will help us to consider the impact of the power imbalance so that we can begin to address it.

Power imbalances exist for many of us in academic and clinical cultures. In academia, we may find ourselves feeling inferior to administration that lauds holding power over us and we may feel superior to students enrolled in our courses. It would be foolish to pretend that there is no power imbalance in the teacher-student relationship. The educator holds the power to set the standards for learning and performance expected of the student. The educator sets the terms of relationship, along with the standards for success, and determines a grade at the end of the experience. This power is undeniable and unavoidable. While this power is real, and must be acknowledged, there are ways to manage the relationship that can reduce the overbearing impression of a severe power differential and suggest respect for all participants instead. Research has suggested that students are “rarely consulted about their educational experiences” (Bovill et al., 2011, p. 133). The implications are that the students not only have no power in the educational process, but that they have no insights into how education might be most effective. Delpit (1988) suggested, “the teacher cannot be the only expert in the classroom” and “to deny students their own expert knowledge is to disempower them” (p. 288).

Applying the Concept. One way to begin shifting a power balance is in thinking about the perspectives of those with whom we interact. One of the dangerous assumptions that can rob a person of a sense of power is treating the individual that we are working with as a person whose cultural identity we presume to know. When we operate from these assumptions, we fail to ask how the person defines his/her own cultural identity. In making these assumptions, we fail to recognize the multifaceted aspect of the individual and rob them of their ability to define themselves in any given situation. As noted above, not all aspects of culture are outwardly obvious. Additionally, most individuals' identity is a result of the intersectionality resulting from simultaneous affiliations with more than one culture. The complexity of their cultural identity is best understood by them. It is important to allow the individual to identify all of their cultural associations for themselves and avoid making assumptions. Using a learner-focused approach to teaching, interviewing, or discussion, similar to Tervalon & Murray-Garcia's use of patient-focused interviewing which is less "controlling" and "authoritative" in nature (1998, p. 120), can indicate to the student an openness to self-disclosures on the learner's part. Being treated as the individual that others assume you to be is demeaning. Given that it is treacherous to make assumptions about a person's cultural identity, we must explore our options.

We must ask ourselves how we would like to be treated in a position of lesser power. Think about what actions signal to us that we have someone's respect and how we in turn signal to others that we respect them. Behavior that acknowledges our individual and unique identity feels empowering to most of us. Recognize that the people we work with are in the best position to teach us about their perspectives (Chang et al., 2012) We can indicate to our clients, our colleagues, and our students that we are interested in learning more about them and the intersectionality of their cultural identity. We can invite the person, through informal conversation and interactions to tell us more about themselves. Active listening promotes cultural humility and requires that we withhold our own reactions and responses that may become barriers to listening well, so that others can complete the act of sharing. If we actively listen, we create opportunities for people to share parts of themselves, including their own cultural identity. Consider, for example, asking questions of the learner regarding their view of themselves in the context of the classroom and their larger community. Asking if they feel connected and supported by a community of any sort can be helpful for letting them lead the conversation in the direction that they feel comfortable. Responding to the learner in an affirming, non-judgmental way can signal to them that you are open to their perspective. Paraphrasing what you hear to confirm your understanding can similarly affirm that they are being listened to carefully. Avoiding statements of judgment, suggesting solutions, and acknowledging their concerns are effective strategies (Robertson, 2005). Active listening takes "courage, generosity, and patience" and can be "characterized more by what is not done than what is done" (Robertson, 2005, p. 1053).

In addition to engaging in active listening, ask yourself what purpose is being served in your interactions with others by exerting power over them. Alternatively, consider if allowing the learner to have a voice in their experience might not improve the outcome for everyone involved. Educators can ask students what they need or prefer to support their learning or offer options that allow the learner to choose which form of performance that will be measured to indicate their success. Educators demonstrate respect for the learner's opinion by soliciting feedback and then acting on it. This simple process can convey to the learners that they have some power or voice in their own education, thereby diminishing the perceived power differential. Be sure to offer students opportunities to provide this feedback in more private or anonymous manners, such as writing on

an index card, to ensure that all voices are heard. This negotiation process between educators and learners or between the parties might be difficult for those who are unwilling to relinquish even a small amount of the power. However, it is critical to consider the potential for improved learning outcomes and experiences as students recognize the educator as someone who is there to work with them as a partner in the teaching and learning experience.

Partnerships. Creating opportunities for individuals to define themselves is not only key to addressing power imbalances in working relationships, it is also the first step in developing mutually beneficial relationships (Tervalon & Murray-Garcia, 1998). Providing opportunities for the individual to be a partner in the professional relationship, whether as a client or as a learner, can facilitate a mutually beneficial relationship. Educators partnering with learners will foster communication in which everyone can learn from each other. We can gain their trust with this respect-and they can gain ours. When the relationship between student clinician and clinical educator or between professor and student are solid, learning outcomes can be improved. Human nature will always move us toward people who treat us with dignity and respect which can be facilitated by cultural humility when interacting with people from different backgrounds.

In addition to respect, mutually beneficial relationships require that all parties avoid roadblocks to equality. One of the most common obstacles is for students to experience microaggressions, such as feeling unseen, unempowered, and disrespected. Microaggressions have been defined as “subtle (often unintentional or unconscious) forms of racial discrimination” (Nadal et al., 2014, p. 461) and can be verbal or nonverbal in nature (Pierce et al., 1978; Sue et al., 2007). Microaggressions may impact any marginalized group of individuals. Along with the NSSHLA listening sessions, recent research has demonstrated that microaggressions continue to occur in CSD education, from both academic faculty and clinical educators (Ginsberg, 2018a; NSSLHA, 2020). Microaggressions come in many forms, including questioning the students’ qualifications for being admitted to a CSD program, the use of pejorative language in reference to minorities, or the use of spokesperson pressure in which an individual is called on to represent all people who share some aspect of that culture or dialect (Ginsberg, 2018a; Solorzano et al., 2001). Microaggressions can extend beyond the classroom and may be experienced from peers as well. The cumulative impact of microaggressions can be significant and can lead minority students to have feelings of self-doubt, frustration, and isolation (Nadal et al., 2014; Solorzano et al., 2001; Sue et al., 2007). Educators treating students from different cultures as less than equal to students from a dominant culture is harmful not only to the students’ learning, but to the relationship between the students and the educator. It is our responsibility to recognize microaggressions whether they originate from ourselves or our colleagues and be willing to address them (Sue et al., 2007). Taking steps to address microaggressions includes educating ourselves about them and engaging in professional development to address them at the individual and institutional level. We must work to decrease and avoid microaggressions in the clinical and classroom settings to promote positive and mutually beneficial relationships through self-exploration and professional development opportunities.

Applying the Concept. One way to create mutually respectful, collegial relationships with students from all cultural backgrounds is to offer a holistic and caring approach to mentoring (Ginsberg, 2018b). Minority students and those who feel marginalized need to know that, as educators, we are there to support them. Where students feel unwelcome or unaccepted, learning will be exceedingly difficult for them. A more holistic, caring form of mentoring that is proactive may help students begin to trust their educators and help them feel supported in their learning. Recognize that students are more than their grades or their clinical performance. They are people

who are living their lives, working to pay for tuition, and managing family or personal situations as well. Create opportunities that will allow them to speak with you about their concerns regarding both their academic success and how they feel as students in the program. Welcome students for informal conversations that are not necessarily outcome oriented. Invite them to meet over a cup of coffee in your office and set the tone for a more informal conversation. Ask if they are finding their way, connecting to other students, and getting all of the support that they need. Watch for signs that the student appears to be feeling isolated. Help them identify outside resources that may be useful to them, particularly if they do not see much representation of their culture in the academic program. One way to do this is to connect them to the multicultural constituency groups, such the National Black Association for Speech, Language, and Hearing, the Asian Indian Caucus, or L’GASP-GLBTQ (which includes lesbian, gay, bisexual, transgender, and queer professionals). Work with your colleagues at your institution and others to identify mentors that the students may relate to as co-mentors (Ginsberg, 2018b). Helping students become connected to the program and to the profession through holistic mentoring can be invaluable to their long-term success and retention of minority students in our profession.

Conclusion

CSD educators need to work to overcome the cultural competence limitations and cultural biases that hinder us from internalizing cultural humility. A deep reflection on our own bias is a significant challenge. Allowing students to be partners in their learning experience and sharing power and control can be scary as well. However, being aware of one’s own worldview, becoming more respectful by giving value to others’ culture, beliefs, attitudes, and demonstrating care for others can be invaluable to setting a new tone for education. The move from cultural competence towards cultural humility encompasses demonstrating an appreciation and understanding of all cultures by becoming more welcoming of cultures as defined by the individuals.

As ASHA certified clinicians, we are expected to “communicate effectively, recognizing the needs, values, preferred mode of communication, and cultural/linguistic background of the individual(s) receiving services, family, caregivers, and relevant others” (ASHA, n.d. a, Standard V-B-3a). In thinking about the ability to communicate effectively, we must demand of ourselves as educators that we are as able to work with students from diverse cultural-linguistic backgrounds just as we would with clients. In teaching with cultural humility, we must demonstrate for our students the mindset that we expect them to adopt as future professionals. By establishing cultural humility in higher education, we also create a more welcoming learning environment. Students who feel marginalized and unaccepted are at risk not only for performing poorly in academic and clinical settings, they are at risk for separation from educational programs and from the professions as well (Ginsberg, 2018a). If we are to improve the diversity of CSD, we must not only recruit more culturally and linguistically diverse students, we must make the learning experience a positive one. Cultural humility can help us take steps in the right direction.

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