Clinical Focus

It's Not Such a Small World After All: The Intersection of Food, Identity, and the Speech-Language Pathologist

Paula Leslie,[a] Bridget Xia,[b] and Jaemin Yoo[b]

Purpose: Working with patients and families with different cultural backgrounds is now commonplace in all areas of speech-language pathology. This includes supporting those with eating, drinking, and swallowing problems. Becoming more culturally sensitive as clinicians requires us to think less of *them versus us,* and instead *what matters to them,* and *how best for us to provide* expert care.

Our starting point for this important topic is not how we tweak our clinical recommendations to fit someone's "culture." Rather, let us examine what is culture and how should it factor into our professional work? We need to understand how our patients and families view health and well-being, or lack thereof, in general. This will enable us to frame our support and offer optimal care to all stakeholders. This leads naturally to a consideration of the concepts of autonomy, informed consent, and how these factor into person-centered care, and shared decision making.

Conclusions: As well as gaining an understanding of the frameworks of health and illness, we consider how food and drink are much more than mere nutrition and hydration. Foods signal our individual and collective identities. Thus, to be a respectful and professional clinician, we need to appreciate our role as a cultural guest with all whom we serve. We propose that there is no such thing as being "culturally competent." Expert clinicians possess a respect for the patient and their *expertise-by-experience* of health and illness. Such respect is founded in the position of cultural humility, to be a guest of someone's world view, in the same way that we respect being a guest in a patient's physical home.

The remit for this paper was to address:

"the topic of 'Multicultural Issues in Dysphagia Assessment and Treatment.' … to be able to provide clinicians working with patients and families with different cultural and/or language backgrounds with suggestions of how to do best dysphagia care."

We feel it is important to share our thoughts in setting up this work. The starting point for such a topic should not be *how do we tweak our clinical recommendations* to fit someone's "culture." Rather, we should start with what *is* culture and how should it factor into our professional work? How does perception of health and well-being, or lack thereof, frame the support that we need to offer to our patients and families?

In 1946, the World Health Organization (WHO) founding constitution defined health as:

A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

(WHO, 2020a, p. 1)

This definition was criticized for being too broad and unmeasurable, and the scientific community retreated to a biomedical focus for decades. In 1984, the definition was revised to focus on the dynamic reaction to the environment or resiliency. Health was defined as:

The extent to which an individual or group is able, on the one hand, to realise aspirations and satisfy needs; and, on the other hand, to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living; it is a positive con-cept [sic] emphasising social and personal resources, as well as physical capacities.

(WHO - Regional Office for Europe, 1984, p. 4)

[a]Consultant Scholar, Preston, United Kingdom
[b]Department of Speech Pathology, Virginia Commonwealth University Health System, Richmond
Correspondence to Paula Leslie: profpleslie@outlook.com

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This concept of resiliency draws together the many facets of a person's life: physical abilities, social support, community connections, state infrastructure, as well as the wider determinants of health (WHO, 2020b). The WHO situates the philosophy of health promotion in the local geography and context that an individual finds themselves in. For us as clinical professionals to provide evidence based, person centered care, we must shift our framework to the person-at-the-center-of-our-care. We need to step into their shoes to understand what health, illness, and thus appropriate intervention might look like.

Americans take pride in referring to the nation as a melting pot of diverse immigrants, or more recently, perhaps a salad bowl, a kaleidoscope, or a land that welcomes the dispossessed. Establishing clear-cut ethnic categories is difficult depending on how an individual chooses to align themselves that is one or more. For a basic comparison of population race proportions, we sourced figures from the "*US 2010 Census Bureau (2019) estimates of the population*" of 328,239,523 people, "one race alone" (18.5% Hispanic or Latino; see Figure 1; United States Census Bureau, 2020):

How does this compare to the diversity of ethnicity in American Speech-Language-Hearing (ASHA)–certified speech-language pathologists (SLPs)? In 2019 there were 161,321 certificate of clinical competence in speech-language pathology (CCC-SLP) professionals who declared a single race with 5.4% Hispanic or Latino (see Figure 2; ASHA, 2020).

We can see that the demographics by race and ethnicity between the population SLPs serve, and the SLPs themselves are quite different. For every White CCC-SLP, there are an estimated 1,575 people; for an American Indian/Alaska Native, this rises to 5,403; and if you are Black/African American, there are 7,180 of you per CCC-SLP of the same race—approximately a 450% increase (see Figure 3). Simply trying to increase diversity in the workforce will take a long time before it resembles the population served, so the appreciation of cultural differences is vital to provide good care.

Figure 1. U.S. 2010 Census estimated population one race declared 2019 (%).

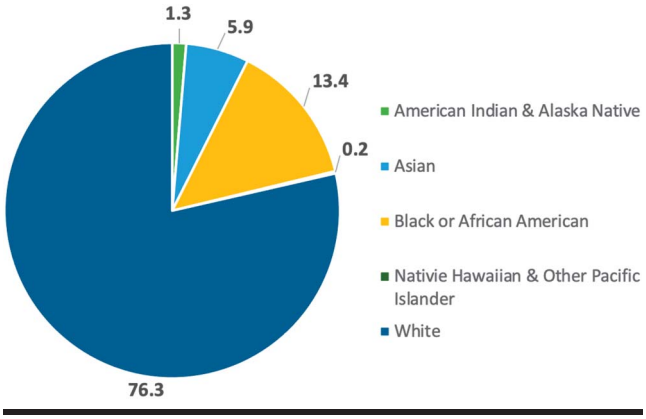
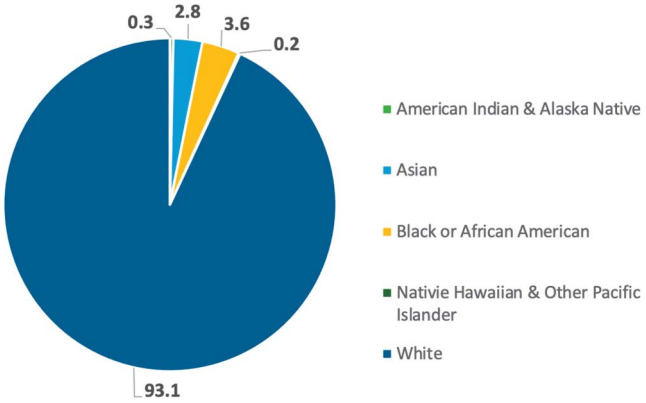


Figure 2. American Speech-Language-Hearing Association certificate of clinical competence in speech-language pathology registered one race declared 2019 (%).



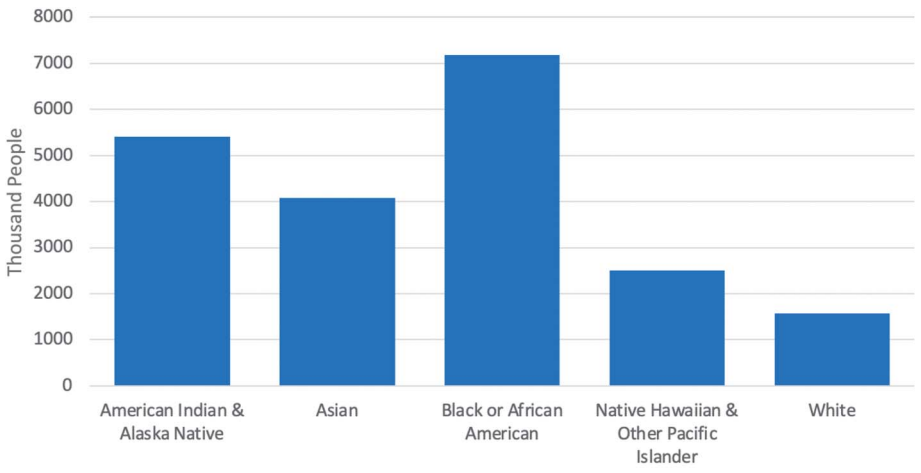
Of course, race and ethnicity are but one small part of what makes up a person's culture. Tasked with being culturally aware in terms of the interventions we offer—we propose that we need to be *culturally aware of the concepts of health and illness* because these influence the fundamentals of whether we should be involved or not, through to the subtleties of aligning our recommendations to fit each patient/family and their goals. Two foundational concepts in decision making are those of the locus of control, and self-governance, which is realized as autonomy. Where a person or group feels the power to influence a situation is termed as the locus of control. In many societies, decisions around health care plans are made by an elder family member or even tribal or societal group rather than the western focus of the individual and we should bear this in mind when supporting our patients and families (Kleinman, 1988a).

Autonomy, Informed Consent, and Decision Making

The great emphasis on individual choice and autonomous decision making in western philosophy has given rise to the concept of informed consent, which is fundamental to medicine and biomedical research. In the clinical practice, obtaining informed consent is a collaborative process that involves effective clinician–patient communication: the clinician discloses relevant information and ensures that the patient understands it so the patient can make an informed decision regarding whether or not to participate in treatment, and with which option (Appelbaum, 2007). Informed consent is sometimes inappropriately reduced to a signature on a form (Cocanour, 2017).

Informed consent is grounded in the ethical principle of respect for autonomy, that is, individuals have the right to make autonomous decisions and determine how to promote their well-being (Beauchamp & Childress, 2019). According to this principle, patients should be respected for their right to accept or refuse medical interventions,

Figure 3. Population by Census projection per American Speech-Language Hearing Association certificate of clinical competence in speech-language pathology in 2019.



and clinicians are obligated to enable patients to make autonomous decisions that best represent their wishes and values. This concept is supported at a federal level in the USA with the Patient Self-Determination Act ("Patient Self-Determination Act, 1990").

Clinicians are also legally required to engage their patients in this shared decision-making process, discuss pertinent information (nature of treatment, costs, benefits, alternatives), and obtain consent before initiating treatment (Berg & Appelbaum, 2001). Clinical decision making is "…a continuous element of the relationship between patients and their caregivers" (Berg & Appelbaum, 2001, p. 167). Ideally, decision making is a process in which information exchange occurs throughout the course of the therapeutic relationship (Meisel et al., 1977). Patients can, and often will, change their minds across the course of a therapy plan. We, as clinicians, are obligated to follow their lead, and ultimately adhere to their wishes (despite what we may think is "best"). The following case example will be used to illustrate the importance of considering clinical decision making as an ongoing process.

Case 1: Joe is a 70-year-old African American man with a past medical history of high blood pressure, chronic obstructive pulmonary disease, and chronic kidney disease. Joe currently lives at home with his daughter and grandson. Joe was retired but started working again to help support his family after his daughter sustained a workplace injury. Several weeks ago, Joe suffered from a stroke resulting in left hemiparesis, mild dysarthria, and trace aspiration with thin liquids seen on videofluoroscopic swallow study. Joe was discharged home with recommendations for outpatient neurological rehabilitation services. The outpatient SLP recommended regular therapy once a week. When Joe returns for his first therapy visit, he reports finding it difficult to keep up with all of his therapy appointments as he does not have a reliable means of transportation. He is also concerned about financial challenges, as he is the primary provider for his family. Joe shares that his main goal is to improve mobility to be able to return to work.

Joe's financial burden has placed much stress on him and his family. He is understandably more motivated to participate in physical and occupational therapies at this time, as his physical limitations prevent him from earning a paycheck and are the biggest barrier to improving the family's financial situation. Despite having agreed to participate in therapy initially, Joe changed his mind, which illustrates that clinical decision making is not a one-time event but a continuous process.

We also see a conflict between patient autonomy and clinician beneficence. Joe wants to suspend SLP services due to different priorities and has the right to make autonomous choices about his treatment. The SLP is obliged to provide education and training to remediate impaired function and promote Joe's physical health. This conflict arises from differences in defining the concept of well-being. After Joe weighs the costs and benefits of therapy services, his understanding of what constitutes his best medical interests may differ considerably from the SLP's perspective. Clinicians should recognize the wide variety of psychosocial and cultural factors that affect participation in treatment. Expanding knowledge of cultural perspectives can help clinicians gain a deepened understanding of the patient's concerns and priorities and facilitate shared decision making.

Perceptions of Health and Illness

In the clinical practice, culture is much more than ethnic foods or linguistic diversity. Culture shapes one's beliefs and practices about their disease and its effect on their life. This influences how individuals perceive their symptoms, what kind of care they pursue, and their response to treatment. There is an important distinction between disease and illness, though the two terms are often used

interchangeably (Kleinman, 1988b; Kleinman et al., 1978). Disease refers to biomedical impairments caused by abnormalities in the structure and function of the body. Illness is a cultural and psychosocial construct that influences individuals' perception and experience of health and disease.

Many problems in the medical world such as litigations and adherence to treatment are thought to be the result of the differing views of the clinical reality (Kleinman et al., 1978). Patients are often dissatisfied with care due to (a) discrepancies between the sociocultural meanings they attach to their illness experience, and (b) the clinicians' explanations and recommendations, which are predominantly focused on biomedical science and a diagnosed disease. Effective provider–patient communication is linked with better therapeutic relationships, greater patient satisfaction, better adherence to treatment, and improved health outcomes (Ha & Longnecker, 2010; Hibbard & Greene, 2013). Age, education, gender identity, and degree of acculturation can all affect patient–clinician communication when working with diverse populations (Cain et al., 2018).

Views on illness and health are influenced by cultural processes, and it is important to understand how these cultural markers may impact service delivery. Many studies examine the effects of culture on overall health; however, these studies often operationalize "culture" as a broad and overly simplistic term to explain discrepancies that are otherwise unaccounted for in health research. Failure to acknowledge the complexities of culture can result in poor health outcomes, greater health inequities, distrust in the medical system, and overgeneralization of findings resulting in perpetuated falsehoods and stereotypes (Kagawa Singer et al., 2016). When working with patients, it is imperative to address the ever-changing, multidimensional, and multilevel impact that culture has on determining human behavior. Singular or dichotic measures such as race or ethnicity are inadequate in fully encompassing a patient's attitudes, beliefs, and identity. It is important to acknowledge the internal and external factors that maintain and reinforce patient–caregiver behaviors including historical, geographical, social, political, generational, and gender factors (Kagawa Singer et al., 2016). Clinicians should take care to fully investigate a patient's background, history, and belief system as it relates to health and illness in order to maximize therapeutic outcomes.

Case 2: Hae-Sung is a 78-year-old Korean-speaking woman with a past medical history that includes type II diabetes and Parkinson's disease. Hae-Sung immigrated to America in the 1960's. Hae-Sung lives alone but has an effective social supportive network. She was recently hospitalized following a fall at home while bathing. An infectious pulmonary process was suspected on the chest radiograph. A videofluoroscopic swallow study revealed prolonged mastication, lingual pumping, intermittent aspiration of thin liquids with delayed post–prandial throat clearing, and a moderate amount of pharyngeal retention with purée and solid. Home health services were set up for Hae-Sung at discharge and she was recommended to follow a pureed diet with thick liquids.

Hae-Sung's daughter tells the Home Health SLP that she does not understand why her mother was put on a modified diet. The family was told by the inpatient medical team that "food is getting into her lungs" but Hae-Sung has been on a soft diet with regular liquids since she got home from the hospital and is reportedly to be doing fine. She drinks traditional Korean herbal tea and chicken broth every day for their medicinal value and believes that this practice will promote healing. She admits to experiencing a "scratchy" feeling in throat during meals but attributes it to throat irritation caused by "cold" foods. She believes in the hot–cold classification of foods and wants her diet to be rich in "hot" foods (Reddy & van Dam, 2020).

Patients and family not following through with diet recommendations is a common problem. They are often labelled as "noncompliant," a term with strong negative connotations. A noncompliant patient is one who is stubborn, refuses to comply with sound medical advice, and is ultimately responsible for therapeutic failure. In Hae-Sung's case, we encourage clinicians to consider the following factors before assigning her the "therapeutic noncompliance" label.

Hae-Sung's family was never provided information regarding food and liquid consistencies at discharge. They do not know the differences between "puree" and "soft solids." No one informed them of where to buy thickeners, what brand to get, or how to make thick liquids. More importantly, since Hae-Sung and her family do not have a good understanding of the rationale for being on a modified diet, it is difficult for them to make sense of the SLP's well-intended recommendations, let alone follow through with them.

Hae-Sung's health practices and illness beliefs are very different from western medicine concepts and terminology regarding health and illness. Interviewing family members and taking a careful history helps clinicians understand the ways in which the patient's cultural background influences their values, beliefs, and health behavior. Respecting cultural frameworks is the key to building an effective therapeutic relationship and improving quality of health care delivery. When working with culturally diverse populations, instead of assuming cultural values, we SLPs should ask for the patient and family's preferences for clinical decisions regarding eating and drinking, and adapt our care to their cultural needs.

Food as Identity

We eat and drink to sustain our existence but eating and drinking are more than nourishment and hydration (Bourdieu, 2013; Crowther, 2013; Mintz, 1996). We attach symbolic values to the experience of eating and drinking, which take place in a sociocultural context. Cecil Helman, a physician and medical anthropologist observed: "In every human society, food is a way of creating and expecting the *relationships* between people." (Helman, 2007, p. 58). For many of us, food, meals, and eating serve different and unique purposes. Large scale efforts such as the International Diet Descriptors, while well intentioned, still focus on *the*

mechanics of the fuel and not *the meaning* of the food (Cichero et al., 2020; Cote et al., 2020).

Each of us has developed rituals around food, meals, and eating, which influence us on an affective, cognitive, social, and cultural level. Rituals are a "coded and scripted set of actions that serve particular social and psychological functions" (Brumberg-Kraus, 2020, p. 335). The ritual of eating serves to create, maintain, and reinforce the social boundaries of family, culture, ethnicity, and class in the "real world." Mealtime rituals can be classified by their form and sequence, their function, the emotions they invoke, and their attributed/signified meanings:

> ***Order of meals*** *- the courses within a meal (appetizer, main dish, then dessert), and where they fit in the day (breakfast, lunch, dinner);* ***Seasonally cued meals*** *- meals that fall on particular days of the year/specific times of year (i.e., harvest festivals, Christmas dinner, Jewish Passover Seder, "break-fast" during Ramadan);* ***Meals occasioned by rites of passage*** *- meals that mark a special occasion/personal milestone (i.e., wedding banquets, birthday parties, Quinceañera);* ***Table etiquette rules*** *- rules that govern seating arrangements, table settings, attire, guest/host responsibilities and expectations, respect for social hierarchies, etc.;* ***Dietary taboos*** *- prohibited or permitted foods which may govern which plant, animal, or other substantive materials can or cannot be eaten; also governs how foods are prepared (i.e., kosher meats, halal meats); can be religiously based, and/or personally driven (vegetarianism, veganism);* ***Scripted meals*** *- meals that involve saying, singing, and/or reading specific words accompanying the meal which can range from prescribed food blessings to formal speeches through to impromptu presentations (as in Jewish Passover Haggadah).*
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> *(Brumberg-Kraus, 2020, pp. 339–340)*

As clinicians, it is important for us to understand the role that food, meals, and eating play in our patients' lives and the impact on their identities and relationships. Dysphagia can negatively impact patients' quality of life, resulting in decreased social interactions, sadness, and disruption of routine and normalcy (Ekberg et al., 2002; Kenny, 2015). As experts in eating and drinking, SLPs are uniquely qualified to engage in an open discussion with our patients about the role of food in their lives and their personal rituals for cooking, eating, and sharing of food. When we begin to acknowledge the role that food plays in a person's life (beyond just nutrition/hydration/medication needs), we can start to offer recommendations that are more in-line with our patients' own set of values, beliefs, and goals.

Case 3: Maria is a 36-year-old Spanish-speaking woman who recently moved to the United States from Mexico. Her medical history includes high blood pressure, hyperlipidemia, hypothyroidism, and gastroesophageal reflux disease. Maria lives with her husband, three children, and her husband's parents. She was recently involved in a motor vehicle accident, resulting in prolonged hospitalization for polytrauma. She was then discharged to a rehabilitation facility. The SLP noted that Maria's attention impairments adversely affected her swallowing safety and recommended a soft diet with thin liquids and supervision during meals. Nursing staff were frustrated at the family's "non-compliance and low health literacy" as they were bringing in homemade, regular-textured food despite the SLP's recommendations. Maria's husband is confused as to why he is getting repeatedly questioned about bringing her food. He tells the interpreter "She misses home-cooked meals. She has not been eating well. This will increase her appetite."

This case illustrates some of the practical challenges SLPs face when caring for patients coming from diverse sociocultural backgrounds: language barriers, different perceptions of diet and care giving, and persistent, "unsafe" behavior that is against medical advice. It is essential that clinicians do not view the challenges as "us vs. Them." This line of reasoning may result in patients receiving poor quality care and experiencing ethnic health disparities. One way to form therapeutic alliances is by exploring the reasons why a family engages in "unsafe" behavior and finding commonalities in goals and expectations.

Maria is not allowed to have desired foods and misses mealtime socialization with her family, an experience fundamental to her and her family's sociocultural identity. The approach to managing her swallowing problems deprive her of the pleasure associated with eating familiar foods and disrupt the social activity of sharing meals. Facilitating safe eating behavior is now a therapeutic goal, which is alien to Maria and her family. They are experiencing the psychosocial sequelae of emotional distress, loss, and social isolation and are adjusting to their new roles as the patient and caregivers, respectively.

We SLPs should be aware of our own biases and respect the patient's preferences and goals that may differ from ours. The SLP's treatment goal (promotion of swallowing safety) is not completely congruent with Maria and her family's goal (restoration of normalcy). Exploring common ground can help the SLP gain a better understanding of the impact of the diet recommendations on the patient's life and frame how the clinician can best support the patient's interests.

Motivational interviewing techniques are one way to support patients and families to actively participate in the decision-making process. Motivational interviewing is "a process whereby an individual's beliefs about their illness and how it fits into the context of their lives are explored" (Bahafzallah et al., 2020, p. 816). Empowering patients to take charge of their own health care, by weighing costs and benefits to make more informed decisions, promotes active participation in the recovery process.

A systematic review and narrative synthesis of motivational interviewing research was recently conducted focusing on studies conducted with "ethnic populations" (Bahafzallah et al., 2020). The findings showed that when researchers identified and acknowledged cultural differences and adapted interviewing techniques based on those differences the effectiveness of motivational interviewing was enhanced:

> *Cultural adaptations of the intervention, and clinicians acknowledging the cultural values of patients were central*

elements in enhancing the effectiveness of MI [sic]. Culture exemplifies elements beyond biological characteristics such as gender, age, language, values, goals, and life experiences. When these elements were considered, participants seemed to be able to identify more with the counsellors and have a better outcome.

(Bahafzallah et al., 2020, p. 848)

The shared decision-making process takes place within a sociocultural context. Maria's family may be more accepting of SLP recommendations if the treatment plan is aligned with their lifestyle. Explaining the medical problems in clear, patient-friendly language can help them understand the rationale and duration of the treatment, which may facilitate the family's buy-in for the treatment plan. Actively involving family members in caregiver training can promote adherence and improve therapeutic outcomes. The more we acknowledge a patient and family's feelings, including how cultural differences influence values and behaviors, the easier it is to develop a treatment plan in relation to the patient's personal and social identity.

The Cultural Guest: Cultural Awareness, Respect, and Appreciation Rather Than "Competence"

Kleinman and Benson (2006) point out that it is dangerous for clinicians to see culture as an ethnic stereotype and that interpreting culture as a set of cultural beliefs on a checklist is inadequate (Kleinman & Benson, 2006). They suggested that culture is not static but *"… a process through which ordinary activities and conditions take on emotional tone and moral meaning for participants*" (Kleinman & Benson, 2006, p. 1674). The development of interpersonal attachments, the serious performance of religious practices, the cultivation of an identity, and the embodiment of meaning in physiological reactions—these are all cultural processes.

Stereotypes ignore diversity and variations *within* ethnic and cultural groups, but there are also cross-cultural commonalities (Cain et al., 2018). For instance, the aging population is a heterogenous group but older adults from various backgrounds may demonstrate similar problems and needs, such as chronic conditions, decreased mobility, and changes in cognition (Cuellar, 2015).

One of our favorite concepts is that of cultural humility:

…cultural competence in clinical practice is best defined not by a discrete endpoint but as a commitment and active engagement in a lifelong process that individuals enter into on an ongoing basis with patient, communities, colleagues, and with themselves. This training outcome is better described as cultural humility...It is a process that requires humility as individuals continually engage in self-reflection and self-critique as lifelong learners and reflective practitioners.

(Tervalon & Murray-Garcia, 1998, p. 118)

Shepherd et al. (2019) explored health care professionals' perception of culturally competent care and their experience working with culturally diverse populations (Shepherd et al., 2019). Most of the participants understood cross-cultural care in terms of learning about the traditions and customs of other cultures and using interpreting services. Few acknowledged institutional changes that needed to be made, and even fewer acknowledged their own personal biases and how this impacts service delivery. Cultural training in the workplace is important but many viewed the information as an immediate practical skill rather than a dynamic, ever-evolving process to engage in (Shepherd et al., 2019).

Our understanding of culture has evolved over the years. As clinical professionals, we are obligated to reflect on this evolving definition in our own practice. Previous definitions of culture were grossly dichotic, largely limited to race and ethnicity. Race and ethnicity are important factors, but they alone do not define a person's culture. Previous definitions failed to adequately encapsulate an individual's identity, beliefs, and life experiences. We all belong to different cultural groups and subgroups that impact our individual (and collective) perceptions, judgments, and attitudes. As health care practitioners, we need to understand and acknowledge our own cultural identities (and inherent biases) in order to improve service delivery for those we serve.

When working with patients, we might think of ourselves as *cultural guests*. This idea draws on established approaches to cultural brokering: cultural awareness, cultural safety, cultural humility, and cultural intelligence (Shepherd et al., 2019). Principles of autonomy and informed consent are woven into the approach. As cultural guests, we offer our expertise while acknowledging potential biases, and thus empower our patients to make clinically informed decisions regarding their health, wellness, and care. When acting as a cultural guest:

1. Reflect on personal biases and how they impact clinical care/decision making.
2. Establish clear boundaries between clinical knowledge and patient autonomy.
3. Do not make assumptions and avoid overgeneralization of patient experiences.
4. Practice patient centered care; prioritize the patient and their goals.
5. Use active listening techniques; know the right questions to ask.
6. Check in often, reassess, and make changes to the therapy plan.

Our responsibility as clinicians is to empower our patients to make informed decisions, appropriately weigh costs and benefits, and increase autonomy in the management of their health and wellness. We all understand that our field does not work well when using a one-size-fits-all approach, each case is unique, and even similar diagnoses can differ drastically from patient-to-patient. By individualizing our assessments, therapy plans, and intervention, we tailor our service delivery to each individual patient and their specific concerns.

Where Do We Start?

ASHA and the Council on Academic Accreditation requires speech-language pathology programs to include curriculum on diversity and multiculturalism. The content, delivery of information, and curriculum model are at the discretion of the programs. On the surface, SLP programs are committed to producing culturally competent clinicians, but there is little guidance in instructional practice and thus on perceived levels of preparedness (Churchill, 2019). Hernández and Hadley (2020) discuss the importance of training students in preprofessional SLP programs to understand "the impact of their own set of cultural/linguistic factors on service delivery, the interactions of cultural/linguistic factors between caregiver and patient, and the characteristics of individuals served" (Hernández & Hadley, 2020, p. 4).

Programs address the dissemination of education and training for cultural-linguistic diversity, but few address the biases, perceptions, and confidence of *students* enrolled in the program when working with culturally and linguistically diverse populations. Hernández and Hadley posit that assessment of students' awareness of their own competence helps students to identify their own beliefs/values and how they may impact clinical interactions (Hernández & Hadley, 2020). Assessment of students' views help to create a more responsive curriculum model, allowing programs to adjust taught material in response to data taken from assessment of students. Programs can (and should) assess students' *cultural awareness* throughout the program: "increased awareness of or exposure to a new culture can cause a cultural shift within the student. Cultural shifts that occur as a result of new learning and experience can change previously held beliefs and values."(Hernández & Hadley, 2020, p. 5). Students' attitudes and perceptions can be reassessed throughout the program, adapting content to their level of awareness and understanding accordingly. These measures can help track student growth over time and determine the overall effectiveness of the designed curriculum. Ideally, this would be done in an interdisciplinary context (States et al., 2006).

Hernández and Hadley (2020) developed a self-reported questionnaire assessing changes in feelings and attitudes brought on by exposure to new and/or differing ideas. Learners move through stages of self-awareness (including being aware of and receiving new information, actively responding to information, valuing the content and ideas, organization of new information into personal schemas, and finally, characterization and internalization of learned information) based on affective response, emotional tone, and acceptance (or rejection) of ideas (Hernández & Hadley, 2020). Successful multicultural curricula help train clinicians to be more self-aware and understand the impact that culture has when working with patients and caregivers. Assessment, (and reassessment) of the efficacy of curricula, and the impact it has on students' perceptions and attitudes when working with diverse clientele, can help graduate programs adapt and grow the curriculum to meet the needs of an increasingly diverse and pluralistic population.

Culture in Clinical Care

Institutions and workplaces appreciate the idea of increased diversity, inclusivity, and cultural competence, but application can prove more challenging. Health care providers often overestimate their own cultural knowledge and underestimate the role of individual patient's cultural identities in clinical interactions (Shepherd et al., 2019). Clinicians also report feeling uncomfortable addressing and meeting the cultural needs of their patients, particularly patients from cultural groups different than their own (Shepherd et al., 2019). How does this discrepancy occur, and how can we rectify these clinical misinterpretations? Shepard et al. posit successful models of cultural training in health care setting rely on acknowledgement and incorporation of the following principles:

Cultural awareness - *learning the norms and customs of multicultural groups;* ***Cultural safety -*** *protecting the culture of vulnerable groups by identifying biases and power imbalances;* ***Cultural humility -*** *openness and non-judgment to allow the patient to determine how their culture impacts experiential reality/clinical encounter;* ***Cultural intelligence -*** *focus on an individual's capacity to recognize, and then function in various cultural environments foreign to their own;* ***Cultural competence -*** *an organization's internal and external capacity to support and implement protocols that improve worker attitudes, cross-cultural communication, staff diversity, and ongoing relationships with multi-cultural communities and stake holders.*

(Shepherd et al., 2019, p. 2)

The goal of effective cultural training is not for the clinician to merely gain knowledge of cultural traditions and norms, but rather for the clinician to engage in a lifelong process of learning and self-reflection. Such clinicians do not presume cultural preferences and are aware of how cultures influence us individually. These clinicians respect individual differences within groups and recognize their own perspectives and biases (Cain et al., 2018). They use effective communication skills to explore patients' and families' values and practices and empower them in the clinical decision-making process. They understand that cultural competence extends past just "providing interpreter services," and instead, relies on open communication, ongoing discussion, and assessment of patients' beliefs, and goals.

How Can I Improve in My Practice?

Respecting *culture* is no different to how we respect the many facets of the patients and families we serve. Firstly, accept that everyone has *culture* and we need to appreciate its relevance to our area of professional intervention. This fits with how we are already much more appreciative of the effects of social support systems, education, access to transport, and so forth on our patients' lives.

We bring a lens to all our clinical interactions and it is okay to have that, just knowing that we do helps to start

to reduce unconscious biases. We all have our own values that we defend until death. Respecting and working with someone else's values does not mean that you have given up on yours. We, the authors, think that SLP is *the best* profession in the world! But we still respect those physical and occupational therapists, and their focus of care. Accepting upfront that we all have biases would do a lot towards mitigating the effects of the unconscious.

The principle of "ask, don't tell" is a good starting place (Back et al., 2005). Our patients and families know that there is something wrong—or they would not be seeing us. As with any area of our practice, it is important to find out what patients and families know about the situation. All learners (patients and students) take onboard new information based on their existing framework. So as clinicians (and teachers), we need to establish what that framework is and then scaffold the new information in.

Explore patient and family goals *before* discussing intervention options. A few moments spent doing this will save countless wasted minutes, therapy sessions, and review reports. If a certain option is not even on the table of consideration, then we need to know that from the start. That said, patients and families with eating, drinking, and swallowing difficulties often do not know what the impact might be, what the clinician can offer, or what questions to ask. Kleinman and Benson (2006) list some good questions about the patient's explanatory model:

- What do you call this problem?
- What do you believe is the cause of this problem?
- What course do you expect it to take? How serious is it?
- What do you think this problem does inside your body?
- How does it affect your body and your mind?
- What do you most fear about this condition?
- What do you most fear about the treatment?

(Kleinman & Benson, 2006, p. 1674)

Our job as experts on the clinical side is to enable the patient and family to ask the questions they need to in order to find out relevant information. Some patient and family preferences are grounded in previous experiences: some real, some urban myth. Trying to drag them out of this perception simply will not work. Delving a little deeper: "*tell me more about*…," "*what would good/bad look like*…," allows us to learn what is framing a standpoint. This helps the speaker to feel heard. And when we feel heard, we are more likely to compromise and join forces—even if we are from different cultural homes.

Resources

We hope you find this list of resources of use in your culturally sensitive clinical care. It is a journey for each one of us. Start with one step wherever you are coming from just now, that is one more than yesterday.

- https://www.youtube.com/watch?v=SaSHLbS1V4w&feature=youtu.be
- https://www.youtube.com/watch?v=UxosTKujwWQ
- https://www.npr.org/sections/thesalt/2016/11/18/502025877/tribes-revive-indigenous-crops-and-the-food-traditions-that-go-with-them?t=1604751049518
- https://i0.wp.com/indigenousvalues.org/wp-content/uploads/2017/06/food-is-center-of-culture-nortwest-indian-college.jpg?ssl=1
- https://www.ihs.gov/
- https://www.hinduwebsite.com/hinduism/essays/food-in-hindu-worship.asp
- https://minoritynurse.com/understanding-buddhist-patients-dietary-needs/
- https://www.crculturevision.com/ (Organizational subscription: how beliefs and practices of cultural groups influence one's perception of health and illness and choice of health care.)
- https://www.linguisticsociety.org/resource/language-and-diversity
- https://www.nationalgeographic.org/maps/language-diversity-index/
- https://thrillist.com/eat/nation/what-is-mukbang

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