

have you **HEARD?**

Culture covers more than you think.

Cultural competence encompasses knowledge and understanding of any number of dimensions of diversity, such as: age, disability, ethnicity, gender identity, gender expression, national origin, race, religion, sex, sexual orientation, and veteran status.

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Competence matters.

Cultural competence empowers you to provide high-quality care; reduce long-standing disparities in the health status of people based on racial, ethnic, and cultural backgrounds; improve the quality of services and health outcomes; and meet legislative, regulatory, and accreditation mandates.

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Competence improves the odds of better outcomes.

Just over 25% of the population identifies as a member of a racial minority group, so cultural competence is a key part of providing better services . . . and better outcomes.

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Can you name the six continuum stages of Cultural Competence?

Cultural Destructiveness
Cultural Incapacity
Cultural Blindness
Cultural Pre-Competence
Cultural Competence
Cultural Proficiency

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Two (or more) is the
new one.

The number of bilingual children in the
United States has risen 2% since 2010.

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Never assume.

When it comes to procedures like cochlear
implants, not every parent wants them for
their child. Ethnic, cultural, and religious
differences are just a few factors that can
influence decisions about medical
interventions, especially any that involve
surgical procedures.

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Know the difference.

Race refers to a person's physical
characteristics, such as bone structure and
skin, hair, or eye color. Ethnicity, however,
refers to cultural factors, including
nationality, regional culture, ancestry,
and language.

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The same for
everyone.

The ASHA Code of Ethics prohibits
discrimination in the provision of services
based on race, ethnicity, sex, gender
identity/gender expression, sexual
orientation, age, religion, national origin,
disability, culture, language, or dialect.

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It's the law.

The Individuals with Disabilities Education Act (IDEA) ensures an individualized education program, or IEP, as well as critical civil rights and due process protections for children with disabilities, including students with communication disorders from all linguistic backgrounds.

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YOU make a huge difference.

Professional competence requires that audiologists and speech-language pathologists (SLPs) practice in a manner that considers each client's/patient's/family's cultural and linguistic characteristics and unique values so that the most effective assessment and intervention services can be provided.

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You're the "quarterback."

When collaborating with interpreters, transliterators, or translators, audiologists and speech-language pathologists (SLPs) remain responsible for planning the session, selecting culturally relevant materials, and appropriately administering assessment and treatment.

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Mind the gap.

In a 2019 ASHA member survey, 95% of speech-language pathologists (SLPs) and audiologists indicated that they speak only one language. This indicates a 15% gap between members and the U.S. population.

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Universal isn't always "universal."

Some gestures don't always mean what you think. For example, in some Asian communities, bowing, smiling, and nodding do not necessarily indicate agreement or understanding.

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Understand populations.

The incidence of cleft palate (per 1,000 people) in the United States is higher in Chinese populations than in Native American, Japanese, or African American/Black populations.

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Perception is everything.

Internationally speaking, stuttering has been perceived to be an indicator of intellectual ability and even tied to spiritual implications. These perceptions may impact an individual's willingness to speak, along with familial and societal acceptance.

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Are you a bilingual professional?

ASHA defines a bilingual professional as one who is not only fluent in multiple languages—but who can also describe the process of normal language acquisition for both monolingual and bilingual individuals—and how those processes are manifested in oral (or manually coded) and written language.

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Meet them where they're at.

From time to time, bilingual learners may mix grammar rules. They might use words from both languages in the same sentence. This is a typical part of becoming bilingual.

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Pop quiz!

Recent studies have shown that bilingual children will have _____ IQs when compared to monolingual children.

A. Higher, B. Lower, C. Comparable

A. Higher

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Mark those milestones.

Studies indicate that both monolingual language learners and bilingual language learners will babble, use their first words, and develop two-word utterances within the same age range.

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ASL is not just semantics.

American Sign Language varies from spoken English in morphology, pragmatics, and syntax.

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Learning is a journey.

Understand that for all you learn, cultural competence is an ever-changing journey of empathy, flexibility, and understanding—all with the purpose of providing the best possible care while respecting cultures and beliefs that may be different than your own. There is no “finish line.”

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Articulation isn't always a problem.

It's easy to mistake typical differences in articulation as a disorder if a client is transferring rules of speech from their primary language into a second language. Learning these typical differences will help avoid misdiagnosing a bilingual patient.

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Don't get lost in translation.

Every language has its own prosody and nuances, which you should be aware of when communicating with individuals who are English language learners.

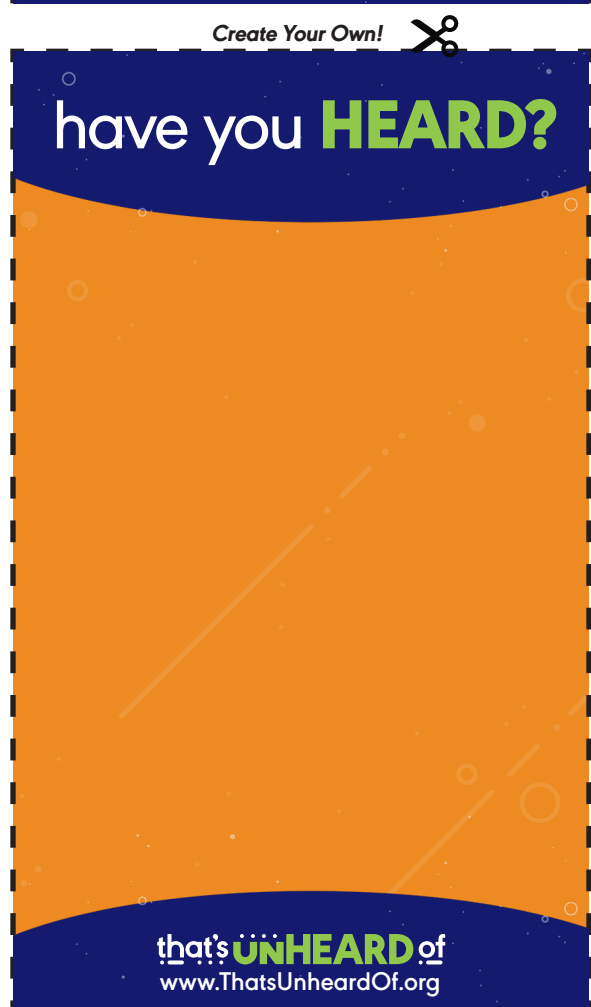
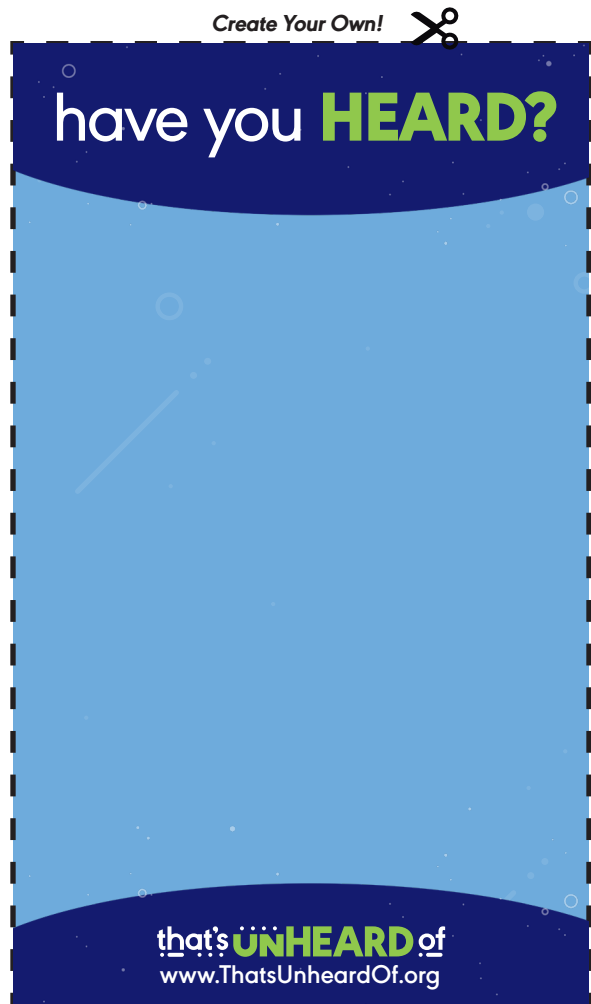
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Subtle speech differences.

In studies of masculine and feminine speech patterns, masculine speech patterns more frequently use slang, while feminine speech patterns tend to use tag questions such as “Don't you think . . . ?” more often.

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