The Complexity of Social/Cultural Dimension in Communication Disorders

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Communication disorders • Cultural diversity

Abstract

There has been growing recognition in the field of communication disorders concerning the importance of multicultural and diversity issues. This discussion needs to move beyond the theoretical and descriptive stage to the clinical use of this knowledge to improve the communicative functioning of diverse populations. This paper argues that the tenets of evidence-based practice and the International Classification of Functioning, Disability and Health (ICF) by the World Health Organization can be used to advance the scholarship and service concerning diversity issues. Both evidence-based practice and the ICF are client-based approaches that can facilitate the achievement of culturally relevant rehabilitation outcomes. This article discusses the use of evidence-based practice and the ICF for providing assessment and intervention that address the social and cultural complexities of the persons we serve. In addition, the author states that work on diversity issues can also be used to discover crucial underlying knowledge regarding communication and communication disorders.

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There is growing recognition in all clinical fields of a deeper understanding of cultural diversity issues. These issues are acutely evident in the field of communication disorders, given the profound effect of culture on communication. An examination of guiding documents and conference topics demonstrates that this is an international concern in the field. The CPLOL (Comité Permanent de Liaison des Orthophonistes/Logopèdes de l'Union Européenne), which is the Standing Liaison Committee of Speech and Language Therapists/Logopedists in the European Union, had as the theme of their 2006 conference 'a multilingual and multicultural Europe: a challenge for speech and language therapists'. Similarly, the International Association of Logopedics and Phoniatrics has also had sections of conventions devoted to cultural diversity issues. The national organizations around the world in the field also make position statements and have given considerable attention to multicultural and diversity issues.

In addition to knowing about specific communication disorders, clinicians are now also expected to be culturally competent. Battle [1] describes cultural competence as follows:

[A] process through which one develops an understanding of self, while developing the ability to develop responsive, reciprocal, and respectful relationships with others. Becoming a culturally competent clinician is a process that begins with a review of personal values, beliefs, and biases about a culturally diverse society and culturally diverse clients and families. It requires a review of one's own life story, one's own personal history as reflected in the

perception of the communication ability of others, and one's understanding of a diverse body of clients and how those perceptions may affect clinical service delivery. Culturally competent clinicians continually assess whether they have allowed bias or stereotypes to enter into the decisions that they make concerning clients.

In this view, clinicians are required to have self-reflection in order to effectively take into consideration the cultural complexities of their clients. This level of self-reflection requires a skill perhaps more difficult than learning the academic components of the field. The first step involves knowing that one belongs to a culture, with its inherent biases and even inconsistencies.

To be effective in this introspection, it is necessary to know exactly what 'culture' is. There is no one universally agreed upon definition of culture. However, one used in the field by Anderson [2] is one by Porter and Samovar [3, p 7] which is

the cumulative deposit of knowledge, experience, meanings, beliefs, values, attitudes, religions, concepts of self, the universe, and self-universe relationships, hierarchies of status, role expectations, spatial relations, and time concepts, acquired by a large group of people in the course of generations through individual and group striving. Culture manifests itself both in patterns of language and thought and in forms of activity and behavior. These patterns become models for common adaptive acts and styles of expressive behavior, which enable people to live in a society within a given geographical environment at a given state of technical development.

Each part of this definition needs to be addressed to fully appreciate the concept of culture. The first part talks about 'cumulative deposits'. In this increasingly complex and interconnected world, this is a key concept. Few people are now part of a single unitary culture. In fact, the term 'multicultural' could apply to a great majority of all people. For example, immigrants bring to a country their original culture, but it is quickly influenced by the culture(s) they encounter in the new land. The culture of the immigrants thus becomes a mix of old and new. Even the so-called 'dominant' culture of a given country is greatly influenced by people from other cultures, including the arts and language.

The next part of this definition continues with the dynamic nature of culture when it states that culture is 'acquired by a large group of people in the course of generations through individual and group striving.' Thus, there is no one dominant person or outside mysterious force that imposes a culture on a group. Culture, therefore, is not a passive but active process. The group grows organically over time and through beliefs and actions of individuals within the group. For example, in Western cul-

tures, there is a drive toward individualism and achievement. Over time, this has shaped the directions in which cultures have grown. Culture helps set some basic guidelines and rules. People often operate best when there are rules of behavior and expectations, and culture serves these important functions.

The definition concludes with: '[t]hese patterns become models for common adaptive acts and styles of expressive behavior, which enable people to live in a society within a given geographical environment at a given state of technical development.' To put it more colloquially, people play the hand that life has given them. If one lives in a sparsely populated rural area, then different cultural characteristics will develop than in a densely populated urban setting.

The relationships between setting and culture are studied in many academic fields. One such field is called cultural geography, which is concerned with the interaction between cultural traits and geography. One concept in cultural geography is cultural diffusion. In a discussion of cultural diffusion, Heatwole [4] states the following:

Cultural diffusion concerns the spread of culture and the factors that account for it, such as migration, communications, trade, and commerce. Because culture moves over space, the geography of culture is constantly changing. Generally, culture traits originate in a particular area and spread outward, ultimately to characterize a larger expanse of territory. *Culture region* describes the location of culture traits or cultural communities; *cultural diffusion* helps explain how they got there... People's tendency to copy one another characterizes another type of cultural diffusion. An example occurs when a farmer looks over the fence, sees a neighboring farmer using a new or different agricultural technique, and adopts it. Similarly, people sometimes adopt a new cultural trait in response to contact with an advertisement, or by seeing something on TV or in a movie, or by interacting directly with people who display a particular cultural trait... For much of human history, therefore, barrier effects tended to isolate cultural communities from each other, inhibiting their ability to share cultural characteristics. Today, however, traditional barrier effects are being overwhelmed by modern means of communication. Isolation is on the decline. Cultural characteristics are diffusing as never before. Adoption of a new culture item is often accompanied by disuse of an old one. Hence, global decline in cultural diversity is a significant modern trend. Virtually hundreds of languages spoken by formerly isolated peoples will disappear during the next 50 years because, due to diffusion of 'modern global languages' (such as English, Spanish, and French), they are not being passed on to the next generation.

Thus, it can be seen that it is unwise to simply discuss culture as a list of traits belonging to a certain subset of the population. All of the above definitions and variations point to the dynamic nature of cultures and indicate

that the cultures being studied now may be markedly different in 10 or 20 years. This quote also illustrates that culture is bidirectional. With such variations, research on culture and, specifically, the effects of culture on communication becomes quite challenging.

As with cultural diversity issues, evidence-based practice is embraced by professional communication disorder organizations and scholars around the world. The American Speech-Language-Hearing Association (ASHA) [5] defines evidence-based practice as 'an approach in which current, high-quality research evidence is integrated with practitioner expertise and client preferences and values into the process of making clinical decisions.' The cultural diversity component of this definition is 'client preferences and values'. Simply put, the improvements of clients must be improvements that are personally relevant to them. One possible significant component of personal relevance is culture. This is especially true for communication, which involves complex rules and requirements for successful interaction. For example, if a person wants to be able to participate in the verbal aspects of his or her religious ceremony, then this behavior is more important than a clinician-driven goal such as to increase the ability to name pictures.

Thus, evidence-based practice does not portend to find a 'one-size-fits-all' approach to intervention effectiveness research. The tendency of some researchers to imply that evidence-based practice tries to prescribe rigid treatment protocols has been criticized by the founders of evidence-based practice. In a letter to the editor of the *British Medical Journal*, Sackett et al. [6, p 72] state the following:

Evidence based medicine is not 'cookbook' medicine. Because it requires a bottom up approach that integrates the best external evidence with individual clinical expertise and patient's choice, it cannot result in lavish, cookbook approaches to individual clinical expertise. External clinical evidence can inform, but can never replace, individual clinical expertise, and it is this expertise that decides whether the external evidence applies to the individual patient at all, and, if so, how it should be integrated into a clinical decision.

Looking at cultural diversity from an evidence-based practice perspective, it is not sufficient that clinicians be culturally sensitive and aware. Abstract knowledge of cultural theory and extensive lists of characteristics of different cultural groups cannot by themselves prepare clinicians for the most important questions. One central question is which cultural traits require a modification of therapy goals. For example, for a child with a cleft palate, which cultural traits should influence how intervention

is executed? Is the race of the child important? Is the socioeconomic level of the family important? Are religious beliefs important? The 'easiest' answer is that all are important. But this global approach may not be either practical or even the best one. Perhaps all aspects of culture are important, but some have more of an effect on specific outcomes than others. In this case, treating all aspects with equal attention may result in an inefficient intervention.

Just as biases can affect clinical performance, they can also cloud scientific judgment. Biases can go either direction. One scholar may say that a disorder is a disorder, and that all this attention to diversity is, at minimum, a distraction. However, bias could also lead to the belief that all different racial or ethnic groups need, by definition, different intervention approaches. This search for differences could mask the similarities between groups. This type of thinking could also limit trying to develop approaches that work across many cultural groups.

If intervention effectiveness is affected by culture, how do the different aspects of culture interact? As stated previously in this paper, there is considerable cultural diffusion. This issue is addressed by Threats [7, p 3] in the following excerpt:

The culture of a Vietnamese Catholic immigrant may differ from the Vietnamese Buddhist immigrant. A person who grew up in the rural South may become a partner in a Wall Street law firm... [the] lawyer may seem in dress and speech the prototypical Wall Street type, but attend church services similar to the ones from his childhood and turn to his faith when faced with some level of disability.

A clinician working with a Vietnamese immigrant parent might do diligent research on this population's reaction to being told that their child has a developmental disability. This information may be based upon work with studies done on Vietnamese subjects in Vietnam who were predominantly Buddhist, whereas the client of this clinician is Catholic. In this case, is the culture of origin more important or equally as important as religious orientation? To further complicate the example, the Vietnamese parent has been in the new country for several years and thus has adopted some the new country's views toward childhood disability.

The lawyer in the above example appears to have adopted a different culture than his native one. Keeping in mind cultural variance, the clinician finds research on upper-class high-income white males and how they react to a communication disability such as a stroke. This particular client may indeed exhibit some traits of this study. However, in the face of severe illness and disability, he

may react very similarly to people in his native region of the country. The clinician may be perplexed that the client's reaction is not what is expected from his cultural group.

Culture influences, but does not determine, individual behavior. Thus, even research on people from different cultures does not tell the clinician how the client sitting in front of him or her will react. However, even the originators of evidence-based practice did not assume that all people or even specific subsets of people were the same. Adherence to the principles of cultural diversity could unwittingly become just another form of cultural stereotyping, albeit under the cover of just following research findings. People may be typical of their cultural group, typical of some aspects of their cultural group, or even reject the major characteristics of their cultural group.

This choice has especially come up with the advent of global communication via the Internet and other media. This applies to language usage as described in these passages from a Chinese blog [8] which demonstrate how cultures mix:

As hip hop began to creep its way into microphones across China, the rapping was mostly done in English. For a long time it was believed that Chinese wasn't a suitable language to rap with, using drastically sentence structuring and rhythm patterns quite different from English, with the main obstacle being that Chinese is a tonal language, where words change meaning according to the pitch used for each syllable... I've actually come to like these Chinese battles more than the stuff going on at home in America. It's a totally different direction they're taking it, with the rhyming skills and the wordplay and how they perform. The energy level is much more intense with Chinese rap. There are more theatrics. The flow is faster. They're rhyming words at a faster pace. And they're starting now to use rhythm a bit more... As is the nature of most Chinese art, Chinese hip hop is a reflection of their culture, as opposed to the Western obsession with the self. Often referred to as 'polite hip hop', Chinese artists are more prone to rap about the monotonies of everyday life, love, and even food. It's extremely rare to hear profane lyrics about drugs, violence, and racial oppression. Then again, theirs is not a musical genre that was forged in the fires of systematic and institutional racism, broken homes, drug-infested neighborhoods, a lack of well paying jobs, police misconduct, and inadequate educational facilities in the same way American hip hop was born.

Even within a given family, there may be cultural differences in communication. Ciccio [9] points out that the electronic communication of adolescents differs markedly from that of their parents. This researcher states that if an adolescent has an acquired communication disorder such as a traumatic brain injury, one of his or her pressing communication needs may be to be able to communicate via Facebook or texting, as this is a valued communication skill in the culture of the adolescent. In the previous

example of musical cultural diffusion in China, the new Chinese adolescent immigrant to the UK may have set his or her top communication priority to be able to sing hip hop in his native language. It is evident that speech-language pathologists must be aware of the cultural influences on individual clients. The professional treats people, not cultures.

A third international influence on the field is the International Classification of Functioning, Disability, and Health (ICF) [10]. As with evidence-based practice and cultural competence practice, the ICF has been actively presented and published on internationally. Two international journals of communication disorders have dedicated issues concerning the use of the ICF. Between the two journals, authors from the USA, Canada, South Africa, UK, Australia, Hong Kong and New Zealand were included. In a 2007 issue of the journal *Seminars in Speech and Language*, the use of the ICF for specific communication disorders was addressed, and the issue included articles pertaining to aphasia [11], child articulation/phonological disorders [12], child language disorders [13], dementia [14], acquired hearing disorders [15], laryngectomy [16], motor speech disorders [17], fluency disorders [18], dysphagia [19], cognitive communication disorders [20] and voice disorders [21]. In 2008, the journal *International Journal in Speech-Language Pathology* published a special double issue that addressed the various components and applications of the ICF in relationship to communication disorders, which addressed the following: 'body functions/structures' [22], 'activities and participation' [23], 'contextual factors' [24], 'quality of life' [25], 'clinical practice' [26], 'research' [27], 'teaching' [28], 'professional policy' [29], 'epidemiology' [30] and the ICF for 'children and youth' [31]. These two journal issues represent a broad survey of the state of the art of using the ICF in the field of communication disorders.

The components of the ICF most relevant to cultural diversity issues are the 'contextual factors', which include 'environment factors' and 'personal factors'. Environmental factors are external to the person and can either be facilitators of or barriers against an individual's interaction with and performance in society. The ICF states that 'environmental factors make up the physical, social, and attitudinal environment in which people live and conduct their lives'.

Environmental factors are further defined as occurring at the individual or the societal level. Individual-level factors are defined by the World Health Organization [10] as

the immediate environment of the individual, including settings such as home, workplace, and school. Included at this level are the physical and material features of the environment that an individual comes face to face with, as well as direct contact with others such as family, acquaintances, peers, and strangers.

The societal-level factors are defined as

formal and informal social structures, services, and overarching approaches or systems in the community or society that have an impact on individuals. This level includes organisations and services related to the work environment, community activities, government agencies, communication and transportation services, and informal social networks as well as laws, regulations, formal and informal rules, attitudes, and ideologies.

Personal factors are defined as

[a] particular background of an individual's life and living, and comprising features of the individual that are not part of a health condition or health states. These factors may include gender, race, age, other health conditions, fitness, lifestyle, habits, upbringing, coping styles, social background, education, profession, past and current experience (past life events and concurrent events), overall behaviour pattern and character style, individual psychological assets, and other characteristics.

The ICF category 'personal factors' contains both the characteristics considered as cultural and those considered as personality characteristics. The personality characteristics may or may not be influenced by culture. The cultural characteristics are gender, race, age, ethnicity, socioeconomic level and nationality. The personality characteristics include such traits as coping styles and individual psychological assets.

These two 'contextual factors' are presented in the ICF as influences on a wide range of complex behaviors including communication and eating. The level of disability a person has is influenced by whether his or her limitations have an effect on their day-to-day functioning. For example, in a culture without a written language, a person who has become alexic after a stroke does not have a disability. Similarly, a person who is illiterate would not realize that he or she has alexia.

As with culture itself, the 'contextual factors' category of the ICF has a paucity of evidence-based practice research. Threats [32, 33] states that the relationship between the ICF components of 'personal factors' and 'environmental factors' needs more study, as well as how these factors influence clinical intervention. Research incorporating these complex ICF factors is difficult and, thus, there is a great need to expand the research paradigms used in disability research in general [34, 35].

One criticism of the ICF is that it is not a model. It does not try to predict behavior or even say that given codes covary or influence one another. It is, at its most basic,

simply a list of behaviors and factors. In terms of fully exploring cultural diversity, this trait may be an asset. By not trying to do anything but describe behaviors and their level of limitations, the ICF allows for the person sitting in front of the clinician to be comprehensively and globally evaluated in terms of function. For a given area of limitation, a certain environment might help or it might hinder functioning. A given personality trait or behavior could be the result of environmental influences or it could stand in stark contrast to it. In fact, the ICF [10] specifically warns against use of the codes to artificially group persons. It states:

[i]t is important to stress, moreover, that ICF is not a classification of people at all. It is classification of people's health characteristics within the context of their individual life situations and environmental impacts. It is the interaction of the health characteristics and the contextual factors that produces disability. This being so, individuals must not be reduced to, or characterized solely in terms of their impairments, activity limitations, or participation restrictions

and

[i]ndividuals classed together under ICF may still differ in many ways. Laws and regulations that refer to ICF classifications should not assume more homogeneity than intended and should ensure that those whose levels of functioning are being classified are considered as individuals.

The ASHA scope of practice for speech-language pathology [36] incorporates cultural diversity, evidence-based practice and the ICF. It states:

[a]s part of the review process for updating the *Scope of Practice in Speech-Language Pathology*, the committee made changes to the previous scope of practice document that reflected recent advances in knowledge, understanding, and research in the discipline... The revised document also was framed squarely on two guiding principles: evidence-based practice and cultural and linguistic diversity... World Health Organization (WHO) has developed a multipurpose health classification system known as the International Classification of Functioning, Disability and Health (ICF WHO, 2001). The purpose of this classification system is to provide a standard language and framework for the description of functioning and health. The ICF framework is useful in describing the breadth of the role of the speech-language pathologist in the prevention, assessment, and habilitation/rehabilitation, enhancement, and scientific investigation of communication and swallowing. Speech-language pathologists work to improve quality of life by reducing impairments of body functions and structures, activity limitations, participation restrictions, and barriers created by contextual factors.

The ASHA preferred practice patterns [37] succinctly capture all three tenets when they state that therapy is to 'enhance participation and improve functioning in life activities that the patient/client, family, and others deem important.' In both recent ASHA documents, there has

been an evolution in the treatment of cultural diversity issues. As recently as 2001, in the ASHA Scope of Practice for Speech-Language Pathology [36], cultural diversity was literally on the last page of the document, whereas now it is in the preamble to the document.

Cultural diversity, evidence-based practice and the ICF all have one overriding theme: respect for the individual. Cultural diversity seeks to have clinicians see all the influences that might affect personal communication styles, as well as cultural influences on views toward communication disability. Evidence-based practice has as its third tenet the need to take individual personal and cultural values into consideration when deciding on an intervention. The ICF is a classification system that allows the complexity of functioning of individuals to be captured.

Although each has this central tenet, they contribute to it in different, yet complementary ways. Cultural competence includes a self-reflective component not present in the other two. As stated earlier, to be culturally competent requires that the clinician examine his or her own culture, biases, and views toward communication and communication disability. Thus, in order to effectively realize the influence of culture, persons must first realize the influence of culture on themselves.

Evidence-based practice takes the clinician from simply having self-knowledge and an appreciation of and respect for other cultures to the fact that there must be a scientific basis for the clinical application of this knowledge. A clinician could truly understand the nuances of a different culture and have a genuine belief in the basic equality of all people, and yet still not have sufficient scientific knowledge to conduct the most effective intervention. This research must reach beyond simplistic statements saying that cultural group X is best treated with intervention Y. Culture should be a factor in intervention research, but not the sole independent variable. Casting culture too broadly will lead to inconclusive research at best, and could at worst lead to erroneous conclusions. More sophisticated research designs may need to be developed to capture these important cultural variables.

The ICF contributes a framework, classification system and language for both research and clinical use that can develop more client-centered evaluation and intervention. Concerning its clinical use, the ICF states that codes are always to be assigned in a collaborative effort with the individuals and/or their proxies. This process of mutually deciding upon ICF codes is an excellent vehicle to find out what activities are most important to a given

person, and what the facilitators and barriers in the person's environments are. The best multicultural assessment tool may turn out to be as simple as: 'tell me about yourself, what do you want to do that you have difficulty with, and what are those things that help you in or keep you from succeeding.' The common language of the ICF can help bridge the gap between researchers and clinicians to reach the shared goal of helping those persons with communication disorders lead more fulfilling lives.

In many academic fields of study, there has been a conflict between those who seek to find unitary 'truths' and those who seek a diversity of 'truths'. In education, there are arguments for studying Shakespeare for the universal truths, and opposing arguments stating that people should study literature that is culturally relevant to them, such as Latino literature. As with most dichotomies, it is a false choice. There are great truths that apply to humanity as a whole, but there are variations in the expression of the same truths. From the outside, it may appear that these differences are vast. For example, watching a religious ceremony from a different religion than your own may not only seem foreign but even bizarre. How can they think that this object possibly represents that? However, upon deeper inspection, the religious ceremony may not differ much in substance from the one the bewildered observer practices.

Many scholars looked for the Human Genome Project to demonstrate in our genes the differences among humans. However, it has proven more difficult to isolate differences between groups and races than many scientists expected. The Morrison Institute for Population and Resource Studies at Stanford University, USA, [38] states: '[a]lthough there are genetic differences between groups, the extent of such difference is small compared with the amount of difference found within a group. People within "ethnic groups" are genetically more different from each other than their group is from other groups.' A lead researcher of the Human Genome Project, Dr. Lindquist, [39] states:

indeed, those differences do exist, but they derive from junk regions of the genetic code that are free to vary precisely because they don't do anything important. In truth, where it matters, human beings differ from each other hardly at all. This doesn't mean we are 'our brother's keepers'; it means we practically are our brothers. The 'family of man' is not a cliché but an irrefutable fact. This seems to go against the grain for many nonscientists. When they look around, they see people who are clearly unique. Indeed, human beings have been exquisitely shaped by nature to recognize differences among people. This is an essential survival strategy that enables us to know which neighbor is likely to shake our hand and which to lift our wallet.

The truth is that we are both different and the same: different in the details, the same in the basics. All humans have language and use it for ceremonies, work, friendship, sexual advances, war and art. All humans use language for setting social rules and order. And no matter what the culture, a disorder of communication can separate people from fully interacting with others and participation in life. The purpose of good evidence-based practice research is to both ascertain differences as well as underlying similarities. In research on cognition, Vogel and Awh [40, p 171] state the following:

[m]ost cognitive neuroscientists are interested how everyone thinks, not trying to catalog and characterize the entire range of abilities across the population or understand how and why a given individual thinks differently from another. We argue that these are not mutually exclusive goals, and that by characterizing individual differences in ability within the context of sound experimental design, one can often learn a great deal more about how a cognitive process operates at a basic level.

Thus, the scientific study of diversity can indeed help us to be more effective with different populations. However, this same research can help us realize the similarities among populations. If there are therapy techniques

that are effective across all populations, then that would be as important a discovery as the techniques that should vary by groups. These similarities, the great truths about communication, may turn out to be the most important knowledge to have to advance our field.

The framework of the ICF promotes our view of the variability within groups. As stated before, we treat individuals, not groups. An individual is composed of many factors. We are a unique combination of genetics, upbringing, culture, the decisions we make, and the experiences we have had. Culture influences us, but does not define us. We are, in short, complex. That complexity does not need to separate us from each other. Indeed, our complexity is what makes us human. However, our basic needs are not complex. We need food, water, and to make connections and bonds with others. We seek, meet and express these needs in a vast array of complexity around the world and even within a given subculture. As professionals in communication disorders, we need to embrace the complexities of communication interaction, while realizing the commonality of their purposes.

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