

PDH Academy

Advancing Cultural Sensitivity in Social Work

4 Hours

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ANSWER SHEET

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** See instructions on the cover page to submit your exams and pay for your course.

By signing and submitting this final exam for grading, I hereby certify that I have spent the required time to study this course material and that I have personally completed each module/session of instruction.

Signature: _____ Date: _____

Advancing Cultural Sensitivity in Social Work Final Exam

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Advancing Cultural Sensitivity in Social Work

FINAL EXAM (4 CE HOURS)

1. **How would you explain the concept of diversity?**
 - a. it refers primarily to race and ethnicity
 - b. it refers to the customs, rituals, food, and dress of an ethnic group
 - c. it is an intersectionality of multiple dimensions, such as age, disability, ethnicity, etc.
 - d. it is a politically correct term used to avoid the terminology of race.
2. **Why do social workers need to continually strive to be culturally competent?**
 - a. Lyndon Johnson proved it was necessary.
 - b. It is important to be politically correct.
 - c. Social work schools are deficient in teaching it.
 - d. The world is increasingly diverse
3. **If you were brought up in the dominant culture, how might that have shaped your life experiences?**
 - a. I can turn on the television or open the front page of the newspaper and see people like me widely represented.
 - b. I may have to educate my children to be aware of systemic racism for their own daily protection.
 - c. I may have to worry that I won't be welcome in certain neighborhoods.
 - d. When I am shopping, I may be followed with suspicion by store personnel.
4. **What is cultural diversity?**
 - a. It refers to differences in areas such as race, gender, age, social class, etc.
 - b. It only includes people of different racial groups such as Black, White, or Hispanic.
 - c. It refers to when a company achieves a quota of people from different countries.
 - d. It is intended to serve as a code word for race.
5. **What is cultural competence?**
 - a. Using terminology and names of groups that are considered to be politically correct.
 - b. The response of individuals and systems that affirms and respects different groups.
 - c. Limited to the ability to not offend people from different racial and cultural groups.
 - d. Being capable of communicating in more than one language.
6. **Why is cultural competence sometimes described as a journey?**
 - a. it is a process of learning throughout our lives.
 - b. we must travel in order to understand others.
 - c. we must work outside our comfort zone to achieve it.
 - d. it requires a roadmap to feel totally competent.
7. **Why is reflection an important part of cultural competence?**
 - a. It is necessary for the appreciation of people from different religions
 - b. It is necessary to increase awareness of unconscious thoughts and beliefs.
 - c. It is necessary to gain knowledge about cultural artifacts.
 - d. It is necessary to professional practice in ways that are not offensive to others.
8. **What is the first step in changing our biases?**
 - a. Challenging them.
 - b. Feeling guilty about them.
 - c. Ignoring them.
 - d. Recognizing them.
9. **What events have contributed to African Americans being mistrustful of the U. S. system of health care?**
 - a. the implementation of the Affordable Care Act, also known as Obamacare, which requires health insurance
 - b. a systematic distribution of separate, but equal, preventive, curative, and palliative health care.
 - c. being blamed and labeled as "noncompliant" by refusing to follow health care treatments and regimens.
 - d. being victimized by, experimented on, and receiving inadequate treatment since the early days of slavery.
10. **When working with Arab families, it is recommended that therapists be mindful of**
 - a. the patriarchal family structure
 - b. the guidance of the Q'uran
 - c. the availability of all family members
 - d. whether members practice Islam or Christianity

11. **When working with Hispanic families, clinicians can facilitate engagement by**
 - a. asking if clients are documented
 - b. defining who is in the nuclear family unit
 - c. asking clients to tell about their country of origin
 - d. self-disclosure about the clinician's own family
12. **When Native Americans come to therapy, they expect the social worker to take the role of**
 - a. facilitator
 - b. observer
 - c. participant
 - d. expert
13. **In the social model of disability, the disability is considered to be**
 - a. a problem to be fixed
 - b. responsive to treatment
 - c. different way of functioning
 - d. a part of the person
14. **The Greatest Generation was affected by the deprivation of**
 - a. the Vietnam War
 - b. the Depression
 - c. McCarthyism
 - d. social turmoil
15. **A factor that contributes to the poor health outcomes and short life expectancy of the poor is**
 - a. exposure to environmental hazards such as lead and asbestos
 - b. diets rich in fiber
 - c. alcohol abuse
 - d. noncompliance with treatment
16. **Uncommon family structures in African American families are**
 - a. usually problematic
 - b. not necessarily dysfunctional
 - c. preferable to two-parent families
 - d. stigmatizing for young children.
17. **Rather than using person-first language, some people with autism prefer to be called**
 - a. a person with autism
 - b. a person who is neurologically impaired
 - c. autistic
 - d. autism-spectrum challenged
18. **What is the difference between political correctness and person-first language?**
 - a. Political correctness is the same thing as being culturally sensitive.
 - b. Political correctness is a politically motivated constraint of free speech.
 - c. Person-first language is part of a liberal agenda
 - d. Person-first language is preferred only by Democrats.
19. **Because language is a collection of letters and sounds that represent a concept, it is known as**
 - a. a symbol
 - b. political correctness
 - c. liberal propaganda
 - d. free speech
20. **Knowledge about what type of information can help social workers be more sensitive to a person's cultural story?**
 - a. Individual and group oppression
 - b. Typical stereotypes about characteristics
 - c. Clothing and personal demeanor
 - d. Social media postings
21. **Most people report _____ views about Islam.**
 - a. positive
 - b. neutral
 - c. negative
 - d. mixed
22. **One way to become more culturally competent is to**
 - a. view multiculturalism as a gimmick
 - b. pass a cultural competence exam.
 - c. act as if you are "color blind"
 - d. learn more about your own culture.
23. **An example of a cultural difference that could cause problems in a cross cultural relationship is.**
 - a. the importance of being on time
 - b. a preference for spicy foods
 - c. counter transference
 - d. educational differences
24. **A lack of cultural competence is problematic because**
 - a. it can cause stress for the social worker
 - b. it can result in a poor outcome for clients
 - c. it is a legal violation
 - d. not everyone likes social workers
25. **An important element of cultural competence is**
 - a. free expression of ideas
 - b. behaviors toward others
 - c. being bi-lingual
 - d. visiting another country

CONTINUING EDUCATION for Social Workers

Advancing Cultural Sensitivity in Social Work PDH Academy Course #7255 (4 CE HOURS)

Course Author Bio

Laura Gibson, PhD, LCSW, has been practicing clinical social work for more than 18 years. She earned a bachelor of science degree in psychology from Bridgewater State College (now Bridgewater State University), a master's degree in social work from the University of Southern Indiana, and a doctor of philosophy degree in social work from the University of Louisville. Dr. Gibson is a licensed clinical social worker in both Indiana and Kentucky. She is an item writer for the Association of Social Work Board's (ASWB) master's-level licensing examination for social workers and is a former member of the Examination Committee. She is a book review editor for the *Journal of Social Work Values & Ethics*. Dr. Gibson is an assistant professor and the MSW Program Director for Brescia University in Owensboro, Kentucky.

Course Abstract

This course is an introduction to the importance of cultural competence to include the many dimensions of diversity, recognizing diversity exists and how it has shaped the lives of our clients, and learning how to challenge our own biases to be able to establish culturally competent client management. Participants of this course will identify strategies to break cultural barriers so that they can give clients the appropriate direction and realistic resources. Level of learner for this course would be beginning practitioners.

Learning Objectives

1. Recognize the multiple dimensions of diversity, such as age, class, culture, disability, ethnicity, etc.
2. Recognize the importance of diversity in shaping the life experiences of people.
3. Identify personal biases and values to minimize their influence on relationships with people who are different.
4. Apply a strategy for challenging unconscious biases.
5. Recall at least 1 characteristic or behavior related to a diverse group.
6. Demonstrate understanding of the skills that contribute to cultural competence.
7. Identify strategies that contribute to cultural competence.

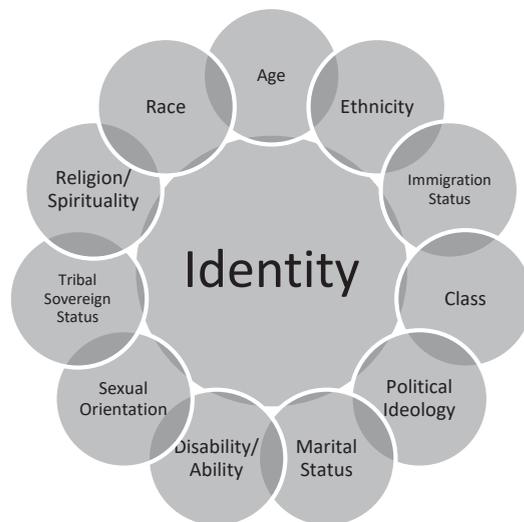
Advancing Cultural Sensitivity in Social Work Outline

- I. The Importance of Cultural Competence
 - A. The Many Dimension of Diversity
 - B. Statistics in the U.S.
 - C. Diversity Shapes the Experience In Our Lives
 - D. The Value of Diversity
 - E. What is Cultural Competence
- II. Self Awareness
 - A. Recognizing Unconscious Biases
- III. Culture Specific Knowledge
 - A. African Americans
 - B. Arab/Muslim Families
 - C. Hispanic or Latino Families
 - D. Native Americans
 - E. People with Disabilities
 - F. Older Adults
 - G. Sexual Orientation
 - H. Gender Identity
 - I. Marital Status
 - J. Lower Social Class
 - K. Immigration Status
 - L. Cultural Relativism versus Ethnocentrism
- IV. Building Cultural Competence
- V. Strategies for Becoming More Culturally Competent
 - A. How Do We Learn About Each Other
 - B. Using Language as a Symbol
- VI. Summary

The Importance of Cultural Competence

The Many Dimensions of Diversity

Diversity is not a code word for race, although for a long time it was seen as just that (Saunders, Haskins, & Vasquez, 2015). Diversity refers to a range of differences, including age, class, color, culture, disability and ability, ethnicity, gender, gender identity and expression, immigration status, marital status, political ideology, race, religion/spirituality, sex, sexual orientation, and tribal sovereign status (CSWE, 2015). We all identify ourselves with more than one group, experiencing the intersectionality of ways in which they differ from the dominant culture.



Statistics in the U. S.

It is necessary to first explain the depth and breadth of diversity and why this should be important to social workers. Because diversity refers to a broad range of differences, a brief review of the relevant statistics is in order.

- The U. S. has become increasingly racially diverse over the last 50 years, and this trend is expected to continue. Arguably, the United States may be more diverse than it has ever been. In the 2010 census, the number of people who reported their race as white-only grew by just 1%. In fact, by 2055, largely due to Asian and Hispanic immigration, the U. S. will not have a racial or ethnic majority at all (Cohn & Caumont, 2016). In that same year, it is expected that Asians will have the distinction of replacing Hispanics as the largest source of new immigrants.
- Forty three percent of Americans are political independents, a trend that has been occurring since 2008 (Jones, 2015). In the U.S., there are roughly 30% Democrats and 26% Republicans (Jones, 2015). Fifty percent of millennials identify themselves as political “independents,” rather than as Democratic or Republican (Cohn & Caumont, 2016). Those who identify with a political party have become more and more polarized to the ideological left and right. The Pew Foundation reports that “the level of partisan hostility has grown dramatically in the past 20 years.” (Pew, 2014, para 7). When people who share political stances group together, it can make it difficult for someone who does not identify with that group to join it in any meaningful way. For example, the social work profession is known for attracting politically liberal members. However, this can sometimes make it uncomfortable for politically conservative members who want to join the profession. Intentionally or unintentionally

excluding politically conservative members serves to exclude the potential contributions of a political minority.

- The family structure is changing in that there are more adults who have never married than ever before, and the number of two-parent households continues to decline. Thirty four percent of children currently live in unmarried, primarily single parent families (Livingston, 2014). . More children are being raised by unmarried couples and by gay and lesbian couples than ever before. More women are not having children at all. Family is defined in many ways. It may be defined legally as the marriage of two people, of either the same or different sexes, or as a household of people who are biologically related. It may also be defined culturally as a group of people with enduring bonds who may or may not be related by blood. It may be comprised of people who joined through remarriage, foster care, or adoption.
- The percentage of people in the world who practice Christianity is expected to remain about the same, but the percentage of people who practice Islam is growing and is expected to nearly equal the percentage of people who practice Christianity, by 2050 (Lipka & Hackett, 2015). Approximately 70% of Americans are Christians, down from 78% in 2007, while the percentage of Americans who claim no religion has increased. (Lipka, 2015). The In the U.S., attitudes about Islam have deteriorated since the 9/11 attacks. Currently, 61% of Americans report negative views about Islam (Telhami, 2015). A survey by Brookings found that although 88% of Americans strongly believe in religious freedom for everyone, 47% say that Islamic values are not compatible with American values (Jones, Cox, Dionne, & Galston, 2011).
- The number of people around the world who are aging is growing rapidly, and they are quickly outnumbering the number of people available to support them. In the U.S., largely due to the baby boomers, the number of adults over age 65 is expected to double between 2012 and 2015, to over 83 million people. Ageism and the perception of aging influences the role that older adults play in our society. Robins reported a study that found 70% of older adults had been insulted or mistreated in some way due to their age. The assumption that older adults have less to contribute socially and economically contributes to their subtle exclusion from everyday life, sometimes leading to feelings of being invisible.
- Vander Putten (2001) tells us that we also need to consider social class as part of the picture of diversity, just as we do with race and gender. In the U. S., two presidents 175 years apart, John Adams and Lyndon Johnson observed that people seem to have a need to disparage those who are poor

(Isenberg, 2016). The life experiences and attitudes differ from people based on social class. For example, these are some of the benefits of social privilege experienced by people in the middle-to-upper classes.

- Politicians fight for you rather than assume you want a handout.
- You can see a doctor when you are sick rather than hoping it gets better on its own.
- In school, your creativity and critical thinking are valued rather than your obedience.
- You've never gotten a high-interest payday loan.
- You work toward developing a career based upon your interests rather than just finding a job.
- You care about the taste and presentation of food rather than whether there will be enough.
- As a child, your parents talked about college often as if it was assumed that you would go.

If you are a seasoned social worker, the world is likely not the world that existed when you went to social work school. Today's world certainly will not be the same as the world of tomorrow. The areas of race, ethnicity, politics, families, religion, aging, economics, and social class are part of the world of social workers. It's important that social workers adapt and change to meet the changing needs of a diverse world.

review question...

The following question will be a review of the content from this section. The question will NOT be graded. The answer to the review question can be found below.

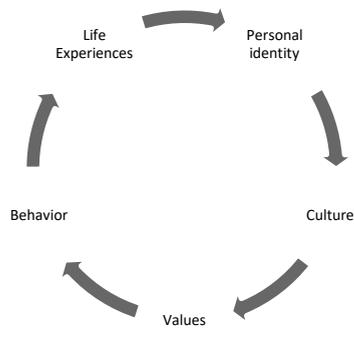
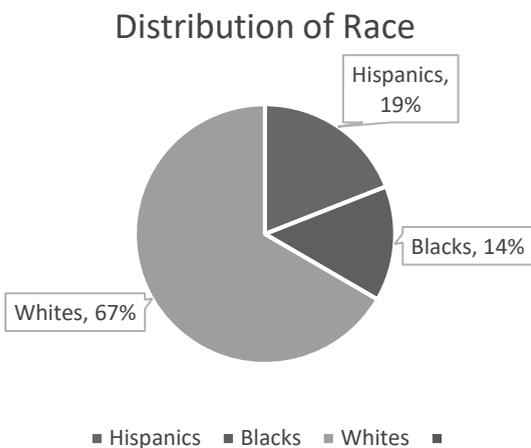
1. **Intersectionality means the experience of our**
 - a. association with multiple groups.
 - b. race and gender
 - c. entering a crossroad in life
 - d. choosing how people see us.

Review Question Answer:
1. a

Reflection

Draw a circle and divide it into three pie-shaped sections based upon what you would estimate the proportions of people in the U.S. to be who are White, Black, and Latino. In other words, the groups that you think are larger should be represented by a larger slice of pie. The groups you think are smaller should be represented by a smaller slice of pie. No matter how many times I have asked my students to do this exercise, the vast majority

always estimate there to be a much larger number of Blacks in this country than there really are. Why do you think they have this perception? How does your own drawing compare to the pie chart below?



The Value of Diversity

Since its beginning, social work has supported and respected cultural diversity and promoted social justice. The National Association of Social Workers first developed standards for cultural competence in 2001. This was revised in 2015. The Council on Social Work Education includes in its Educational Policy and Accreditation Standards the requirement that schools of social work teach students to “engage diversity and difference in practice.” (CSWE, 2015, p. 7).

Diversity shapes the experience of our lives.

As you can see, we do not fall into only a single group. We express our identities through a sense of belonging to a number of groups, with some groups holding more importance for us than others. How many times have you heard something similar to what I heard on the subway today such as a reference to “that black guy over there”? In this instance, the speaker conceptualized the person primarily based on race and gender. When we see people through a narrow lens, we do not take into account the other dimensions that are part of their identity. It’s hard for us to meet a new person and immediately see him or her through all of these dimensions, so our brains pick one or two of the ones that have the most significance to us. Our challenge is to explore and overcome the barriers to learning about who people are, beyond all stereotypes.

Our view of the world, as that of a place that is dangerous, safe, exciting, fair, just, etc., is influenced by our life experiences and through our cultural lens. For example, if we grew up with a cultural heritage of religious persecution and torture of our ancestors, we may see the world as less tolerant than a person who has not had that experience. Likewise, our understanding of our culture is also influenced by our life experiences and view of the world. Our worldview shapes our values, which guides our behavior, which ultimately shapes our culture. We live our lives by relating to a world of diversity, regardless of whether we identify with a dominant or non- dominant culture. These have a reciprocal relationship, and in this way, diversity shapes the life experiences of people.

Diversity and the Dynamics of Difference

- | | |
|--------------------------------|-----------------------|
| age | |
| social class | |
| color | |
| culture | |
| disability and ability | oppression |
| ethnicity | economic justice |
| gender | environmental justice |
| gender identity and expression | social justice |
| immigration status | marginalization |
| marital status | alienation |
| political ideology | privilege |
| race | acclaim |
| religion & spirituality | power |
| sex | |
| sexual orientation | |
| tribal sovereign status | |

Social diversity not only makes our world richer, it fosters creativity, innovation, and problem solving. But it’s more than just bringing different perspectives and points of view to a task. Phillips (2014) says that research over a period of decades bears this out. She reports that diversity with respect to race, gender, age, political affiliation, and other dimensions has been shown to actually make people think differently, and as a result more effectively, about the task at hand.

What is cultural competence?

According to the NASW Standards and Indicators for Cultural Competence in Social Work Practice (2015),

Cultural competence refers to the process by which individuals and systems respond respectfully and effectively to people of all cultures, languages, classes, races, ethnic backgrounds, religions, and other diversity factors in a manner that recognizes, affirms, and values the worth of individuals, families, and communities and protects and preserves the dignity of each. (p. 13)

The Association of Social Work Boards (ASWB) further proposes that cultural competence includes an *awareness* of personal biases and beliefs about the differences of others, an *attitude* that conveys positive beliefs about differences, *knowledge* about other cultures, and *skills* that facilitate inclusion (ASWB, 2013). Personal reflection is necessary to increase awareness of biased thoughts and beliefs that may be unconscious, yet motivate behavior. An attitude is cultivated through genuine appreciation of people who are different from you. Knowledge is learned through experience, formal educational programs, and exploration of information. Skills are acquired through the practice of what is gained through knowledge.

Cultural competence has been described as a journey rather than a destination (Saunders, Haskins, & Vasquez, 2015). It is a journey because the goal of cultural competence can never be achieved; it can only be a process of learning throughout our whole lives. Saunders and colleagues (2015) suggest that no one ever feels completely competent to work with all the diverse groups. In fact, rarely do we feel completely competent to work with even one group that is different from us. That makes the term *cultural competence* somewhat misleading because competence suggests an endpoint, a standard that has been met, or a goal that has been reached. Perhaps a more fitting term might be “cultural sensitivity” or “cultural humility.”

Developing Cultural Competence in Practice . . .

I once worked at a group home for people with psychiatric disabilities. It was located in a major city that was rich with diversity. The group home was staffed around the clock, so we had a Communication book in the office that we used to relay information to each other. For example, the 3-11 staff might write something like, “Please remind J. to take his meds tonight when he comes in” to the overnight staff. Every staff person there was nice to work with, but it seemed that we had near-daily miscommunications. We had the most diverse group of staff I’ve ever worked with at that time, and since. Most of the staff were African American, but they came from New York City, the Deep South, the British West Indies, and South Korea, and West Africa. Two people were gay. One person was Jewish and one a WASP. Their ages ranged from early 20s to about mid-50s. We realized that the source of most of our conflicts was that we all had different ways of communicating. Some were more direct than others; others

worried their banal comments might be seen as challenging authority. We had to stop assuming that messages were received with the same meaning in which they were sent. We had to be curious about the perspective of others and respectful when we didn’t understand. It was the first time that I truly appreciated the importance of cultural competence.

Reflection

Imagine a time when you felt misunderstood by someone. You tried to communicate a problem of some kind, and although the listener may have seemed caring, you perhaps had the thought that “they just don’t get it.” Did you keep trying to make the person understand, or did you give up? What emotions did you feel? Would you go back to that person for help?

review question...

The following question will be a review of the content from this section. The question will NOT be graded. The answer to the review question can be found below.

1. What does NASW expect from social workers with respect to cultural diversity?
 - a. Understand the role of culture in human behavior and societies.
 - b. Have a knowledge base of your clients’ cultures.
 - c. Obtain education about the nature of oppression and diversity.
 - d. All of the above.

Review Question Answer:
1. d

Self-Awareness

Our identities may be based on a number of qualities and characteristics. If I asked you to introduce yourself, what do you think you would say first? Would you introduce yourself differently depending upon the setting, like whether you were at work or a party? We come to understand and express ourselves in terms of many different dimensions such as gender, race, ethnicity, religion, role in the family, career, etc. But how do we learn about the identities of others? We take in messages at a very early age about others and how they are different from or like us. If they are like us, they are part of the “in” group. If they are unlike us, they are part of the “out” group. Not only do we learn early on about differences, but we also learn to attach a meaning to those differences. For example, as a kindergartener, you might have been shopping with an adult and saw someone using a wheelchair. You immediately recognized this situation as something outside of your own experience, something unfamiliar.

You may have pointed to the person and asked the adult with you for some information to help you make sense of this difference. If the adult responded with scolding, saying “Sh! Don’t point. I’ll tell you about it later,” you would have learned that this wasn’t a difference that was openly talked about. There is something taboo here, maybe even bad, depending upon the level of the adult’s discomfort. In these few moments you may have learned that not only is someone using a wheelchair different from you and not in the “in” group, but different in a negative way. Perhaps you have no other words to describe or understand it – your understanding is primarily affective, not intellectual. We learn powerful messages very early from our family, our peers, our teachers, and through the media. You may find that you hold a certain attitude about a group that is different from you and don’t even know where you learned it, so insidious is the process. You may have learned this on an emotional level, based on the responses of the trusted people around you, before you even had the language skills to make sense of the information.

Recognizing Unconscious Biases

We must recognize our own biases before we can change them. Doing so is the first, perhaps most important step toward the journey of cultural competence. Self-reflection is an essential skill in identifying, understanding, and challenges the biases that all of us hold. We grow up in a society in which certain groups have privileges that others do not. Even in families that embrace and value diversity, we are bombarded by messages that we internalize and are scarcely aware of.

We all hold biases. Some are deeply planted, whereas others are the whispers of false beliefs that remain after we have rooted them out.

Saying that you are not a racist, does not make it so. Actually, I’ve never met anyone who claimed to be a racist, even while spouting racism ideology. Denying having biased beliefs about others most likely means people have not yet been able to recognize those unconscious beliefs. It does not mean that prejudices are truly absent. As I mentioned before, cultural competence is a journey. Some have traveled a lot farther than others. Some haven’t packed their bags yet!

So how do you recognize unconscious beliefs when they are hidden from you?

1. Acknowledge that we all hold biases. It is a part of being human, and doesn’t make you a bad person.
2. Increase your awareness of your comfort level when you are around people who are different from you. Notice when you feel like you want to withdraw, when you feel tense, suspicious, worried, critical, or judgmental.
3. Give yourself permission to explore the thoughts and beliefs that are related to those feelings of discomfort.
4. Challenge whether those beliefs are actually true.
5. Imagine alternative beliefs that could possibly be true.
6. Accept that your beliefs may be faulty and need to be revised.

How to Recognize and Challenge Unconscious Biases.

Scenario	Steps you can take	What that might look like
You see a large group of teenagers walking together inside the mall. You see one teenager whisper to another and point toward the store on the left.	Acknowledge that we all hold biases.	“What assumptions am I making about these people?”
	Increase your awareness of your comfort level.	“I feel extra alert, like something negative might happen.”
	Explore the thoughts and beliefs that are related to those feelings of discomfort.	“It’s a large group.” “I feel outnumbered.” “I’ve seen teenagers be mean to people and think it’s funny.” “I think they’re up to something.” “Are they planning to shoplift?” “Why are they whispering?” “What’s so secret?”
	Challenge whether those beliefs are actually true.	“Is there any evidence that I should feel unsafe?” “Would I feel differently if it was a <i>different</i> group, such as older adults, women pushing strollers, [fill in the blank], or if it was a group of people more like me?”
	Imagine alternative beliefs that could possibly be true.	“If they feel powerless/disenfranchised, it might be the teenagers who feel a sense of safety in numbers – that might be why they congregate.” “Maybe the teenager just didn’t want to go into the store alone and asked a friend to come along.” “Maybe the one teenager saw something awesome for sale and wanted to see it.” “Maybe they saw someone attractive and didn’t want the others to hear and make fun.”
	Accept that your beliefs might be faulty and may need to be revised.	“Maybe I’m making assumptions about people based on their age that aren’t necessarily true.”

Recognizing Unconscious Biases in Practice . . .

Like many white people in this country, if you had inquired many years ago about my ethnicity, I would have given you a puzzled look. I enrolled in a social work class that challenged me to explore my cultural heritage. I learned some interesting things about my German heritage on my father's side, and my Irish heritage on my mother's side. But what surprised me is what I learned when the others in the class shared their heritage and it contrasted with my own. For example,

one student talked about emotionally expressive her family was, in contrast to my family, which was not. As I reflected on this, I started to realize that our beliefs were not shared by everyone. One student talked about how she was dreading telling her parents she was moving out of their home because they believed single women should remain at home until they were married. I, on the other hand, was taught that adults were launched earlier and encouraged to strike out on their own as soon as they were able. We developed a new found appreciation for the stories and traditions of our families.

Reflection

Imagine you have just driven to a part of town that is unfamiliar to you. You are a little lost, so you pull over to check your directions. You suddenly notice an African American man walking down the sidewalk in your direction, and without thinking, your first response is to check to make sure your doors are locked. What is it about this situation that prompted you to check your doors? What was the man doing that related to your sense of safety? What if the person had been a gray-haired woman? Does the person's being the same as you in terms of gender, ethnicity, disability, etc. influence how you feel? Would you have responded in the same way? Why or why not?

review question...

The following question will be a review of the content from this section. The question will NOT be graded. The answer to the review question can be found below.

- You've realized that you make certain assumptions about people who are much older than you. For example, when you see an older adult, your natural inclination is to be protective. You've become increasingly aware of this belief, that you were previously not consciously aware of. What is the NEXT step you should take to address this bias?**
 - Challenge whether this is actually true of all people who are older.
 - Imagine alternative beliefs such as "some" older people need protection.
 - Accept that your belief that all older adults need protection might be false.
 - Ask the next older person you meet if he or she is in need of protection.

Review Question Answer:
1. a



Culture-Specific Knowledge

Why is it important to learn about other cultures? Cross cultural misunderstandings between social workers and clients can lead to mistrust, conflict, poor relationships, incorrect assessments, misguided treatment directions, and poor overall outcomes for clients. Cross cultural misunderstandings between social workers and other colleagues in the workplace can lead to mistrust, poor morale, hurt feelings, and a tense working environment. Unrecognized differences in values such as individualism versus collectivism, orientation to time, beliefs about health and mental health, and the role of the client and social worker can leave all parties feeling frustrated and upset. Understanding these differences can bring a new perspective that facilitates positive relationships as well as the helping process.

I'll admit, it's risky trying to identify characteristics about diverse groups that hold true without being stereotypical. The fact is, as human beings, we have much more in common with each other than not. We can make some broad generalizations, but realize that there is tremendous diversity within groups, as well. For example, I could tell you that Italian families tend to be emotionally expressive, but that is certainly not true of everyone within that group. To give you a description of every possible group is an impossible task, of course, as is a comprehensive description of any one group. From my experience, though, social workers do want concrete suggestions, even limited ones that will help them work with diverse groups.

Stereotypes usually develop in early childhood. It is normal to create stereotypes, or generalizations, about people. Our human brains do this as a mental "shortcut." We can't store all of the information about every person, so cognitively, our brains condense that vast amount of information into a few salient points. There's nothing inherently wrong with that as long as you realize that these are generalizations that do not apply to all people within any specific group. So bear with me as I make some generalizations about a few different groups. They are presented in no particular order. To explain the culture of any of these groups would be task far beyond the scope of this course. Therefore, I have tried to organize information around history (including experiences of oppression), family life, and attitudes about health and mental health. The purpose is to give you a starting point for understanding a particular group and to help you begin to think about additional information that will increase your level of cultural competence with this group.

review question...

The following question will be a review of the content from this section. The question will NOT be graded. The answer to the review question can be found below.

1. We develop stereotypes because they are
 - a. a legitimate defense for discrimination
 - b. a way to more easily manage large amounts of information.
 - c. a system of beliefs that we are born with.
 - d. something that only happens to bigoted people.

Review Question Answer:
1. b

African Americans

History: The history of Black Americans has not been reliably documented in traditional history books dominated by White European culture. From approximately 1619, the first Africans were abducted from their homeland and forced into servitude near Jamestown, Virginia (History.com staff, 2009). In total, it is estimated that approximately 10-12 million Africans were brought to the U.S. West Indies, and Brazil as slaves, and many died due to disease, starvation, and the conditions of transport. During the 18th century alone, it's estimated that approximately 6 to 7 million Africans were enslaved. Most came from the West African coast.

Massachusetts was the first state (then a colony) to legalize slavery. Both northern and southern states initially supported slavery. A major entry point to the northern states was through Plymouth and Boston Harbor; a major entry point to the southern states was Jamestown harbor. Northern and southern territories were settled for differed reasons, and these reasons influenced the regions' reliance upon slaves. The north was settled by Pilgrims who came here to exercise religious freedom. Slaves were used primarily as personal servants. The south was settled to grow crops and export them to Britain. The south experienced continually expanding plantations that had increasing need for free labor to sustain them. The north, on the other hand, became more urbanized and its economy did not require slavery.

The church became the center of the African American community. It was a place to celebrate African heritage and became a blending of African spirituality and Christianity. White clergy preached that all were equal in the eyes of God, and this message offered hope to those who were not equal in their day-to-day lives. Around 1800, the African Methodist Episcopal (AME) church grew to be a central source of support for the Black community. Once they were emancipated, African Americans took an active role in forming mostly Baptist or Methodist congregations.

From the courageous revolt of Nat Turner, to the Underground Railroad, to the civil rights protests of the 1960s, African Americans have had to fight for everything they've achieved. They have played a major role as builders of America. This spirit of survival, independence and reliance upon their own community has evolved into what is sometimes seen as a general mistrust of government institutions.

Family Life: African Americans face racism, both from individuals and from beliefs and practices that have been institutionalized in policies and laws. African American families living in poverty may be involved with many agencies, and may benefit from help learning how to negotiate complicated and often confusing bureaucracies (Hines & Boyd-Franklin, 2005). Those who are middle-class also face racism, but often have no role models to show them how to negotiate obstacles in their daily lives (Hines & Boyd-Franklin, 2005).

Families often have an extended kinship system, a network of close relationships that serve as an extended family. (Hines & Boyd-Franklin, 2005). Family boundaries can seem blurred by outsiders, but individuals can usually identify who can be relied upon in times of crisis such as illness, unemployment, or incarceration, Family structures may vary and include up to three generations or more, sometimes living in one household, or sometimes living in close proximity. It's a mistake to assume that uncommon family structures are necessarily dysfunctional. Therefore, it's important to explore the functionality of the family.

Example:

A client has seven children, and all but one are living with extended family members due to the mother's history of substance abuse. The seventh child lives with the mother, who is now clean and sober. There is no plan to reunite the children with their biological mother; however, the mother has a relationship with all of the children, and they visit her occasionally. The mother worries that the stress of potentially having the children move into her home would increase her risk of relapse. The arrangement has proven to be working for this family.

Engagement is improved by conveying genuine respect, expressing interest in learning about the client's life experiences and worldview, and communicating a sense of hope and belief in the ability to make changes that will enhance well-being (Hines & Boyd-Franklin, 2005). It may be helpful to convey respect during initial meetings by using language such as sir and ma'am. Addressing adults as *Mr.*, *Ms.*, or *Dr.* is appropriate unless you are invited to use more casual language.

Example:

A school social worker, who is White, visits the home of D'Anthony, a student who is Black. He lives with his grandmother, father, and three cousins. The home visit feels casual to the social worker when compared to the more formal setting of the school's counseling

office. The social worker introduces herself and invites the grandmother and grandfather to call her by her first name. She addresses the grandmother and father by their first names, as well. During the visit, the social worker has difficulty developing rapport with the adults, who are not very forthcoming about D'Anthony's life at home. Unbeknownst to her, the adults experienced the social worker as being disrespectful and impolite. The social worker returned to the school feeling like the home visit was unsuccessful. Had the social worker called the grandmother and father by their surnames until they invited her to do otherwise, she would have conveyed respect rather than assuming a familiarity that had not yet developed.

Health/Mental Health. African Americans have a long history of being victimized by, experimented on, and receiving inadequate treatment from the medical community from the early days of slavery to relatively modern times. Beginning with the experiences of slaves bought by physicians for experimental surgeries, to Thomas Jefferson's testing an experimental small pox vaccine on slaves, to the Tuskegee Syphilis Study, to the radiation experiments Lyles Station, Indiana, to the more recent experimental administration of a toxic drug to poor black boys from New York City, it becomes easy to understand why African Americans would be mistrustful of the medical community and resist care from those in it, however well-intentioned (Washington, 2009). Partly as a result of this and partly from the resulting reluctance to engage with the medical community, "medical experts of every persuasion agree that African Americans share the most deplorable health profile in the nation by far, one that resembles that of Third World countries" (Washington, 2009, p. 20).

Example:

A school social worker reaches out to an African American family with two parents, one grandparent, and six children living in the home. The two younger children are those of the parents. The three older children are actually cousins and are being cared for by the grandmother. The youngest child is not biologically related to the family but is actually the child of a woman from their church who has been ill. It is this youngest child who was referred to the social worker after being unable or unwilling to draw a picture for his kindergarten teacher of his family. If you were the social worker, what things would you consider when assessing the family? For example, ask yourself

1. Who is considered to be a member of the family, even if not necessarily defined by biological ties?
2. What are possible explanations for the child not drawing a picture? Does not drawing a picture in school relate to lack of developmental skills of the child, the child's lack of clarity about family membership, being told to keep family business private, or some other reason?

3. How are the youngest child's mother's medical needs being met or unmet? Does the youngest child's mother have access to needed medical care? What are possible barriers?
4. How will gaining the family's trust be key to the social worker's ability to provide services?

review question...

The following question will be a review of the content from this section. The question will NOT be graded. The answer to the review question can be found below.

1. **When meeting an African American family for the first time, how can a social worker develop rapport with the family?**
 - a. Explain the social worker's qualifications, including education, job experience, and expertise.
 - b. Assume an atmosphere of familiarity by addressing both adults and children by their first names.
 - c. Take the role of expert with families and impart information from a position of professional authority.
 - d. Convey genuine respect and use titles such as Mr., Ms., or Dr. unless invited to do otherwise.

Review Question Answer:
I. D

Working with an African American Boy in Practice . . .

I once worked with an 8-year-old Haitian boy who constantly got into fights at school. With me, he was soft-spoken and polite, not the aggressive person that teachers described. He didn't want to get into fights, he just seemed at a loss as to how to handle conflicts in any other way. I remember asking him about his life in Haiti and he told me a story about witnessing the police beating someone up for stealing food. My supervisor helped me understand some of the history of Haiti, and my own research revealed a fuller perspective of the conditions this boy had lived through and the things he might have seen. He had probably witnessed extreme poverty, police corruption, and the mass exodus of thousands of Haitians to the U. S. When I was his age, I assumed the police were a source of help and safety. This boy grew up learning that you do what you need to do to survive, problems are solved through violence, and you cannot trust the police. Once I knew this, I could better appreciate his view of the world. The more you know about someone's cultural history, experiences with oppression and discrimination, family values, and attitudes about health, the more culturally competent you will be.

Arab Muslim families

History. Asad (2016) suggests that origins of Western biases against Islam come from the fact that the values of Islam are so similar to the values of Christianity that they pose a threat to Western ideals of spirituality. Asad uses the analogy that contemporary nations are influenced by early historical experiences just as people are influenced by their early childhood experiences.

He proposes that even though modern-day people didn't take part in historical conflicts, those conflicts fostered fear, misunderstandings, and resentments that we carry with us and unconsciously influence how we think about people today. Understanding the history of individual and group oppression can help social workers be more sensitive to a person's cultural story (Asad, 2016).

The introduction of Islam in the 7th century had profound implications for Arab countries. Between the 7th and 10th centuries, the countries were united by Islam, and a new empire was created, which was called the Caliphate. In the West, religion was practiced within the context of Christendom, the conceptualization of Christianity as the central unifying force of a geographic area. In 1095, Pope Urban II called upon Christians to wage war to conquer the Muslims and retake the Holy land, where they were living. This constituted the beginning of the Crusades.

The Crusades were a series of battles led by the Roman Catholic Church between 1000 AD and 1400 AD. These efforts to conquer the Muslims established four western settlements: Jerusalem, Edessa, Antioch, and Tripoli (history.com). The Crusades, through uniting against a common enemy, facilitated the unity of Europe.

Muslims waged war to retake their land (jihad) and they soon captured Edessa. Europe redoubled its effort and attacked Damascus (now Syria). Muslims beat them back and retook Damascus. In 1187, Saladin, a Muslim, led a battle against Jerusalem and took the city. Richard the Lionhearted defeated Saladin and regained some of that territory. He and Saladin eventually signed a treaty in 1192 that reestablished the Kingdom of Jerusalem. In the 6th Crusade, Christians regained control over Jerusalem, only to lose it again 10 years later when the peace treaty expired. The Crusades ended after two centuries of bloody battles, the rise of the Reformation of the Catholic Church, and the declining authority of the Pope.

The roots of Western bias were firmly established by distorting and perverting the tenets of Islam. Islam was characterized as immoral, brutally violent, and deserving of hatred. The basic objection was religious in nature, and Asad points out that the "shadow of the crusades" continues to affect the current-day attitudes about Islam.

After WWI, the Arab world was divided among the European nations. The evolving culture adopted European ideas while maintaining a firm belief in Islam. Islam became a multi-ethnic, multi-racial religion, but it was misrepresented as a political ideology of a homogenous people. From 1790 to 1952, "whiteness" was a legal prerequisite for American citizenship, and Islam was viewed as irreconcilable with whiteness." (BBC News). The conceptualization of "us" and "them" was perpetuated. The Gulf War in 1991 further alienated some Arabs from the Western world and promoted conflict among Arabs.

Events such as the response to Salman Rushdie's novel, *Satanic Verses*, fueled fear of Muslims when Rushdie was forced into hiding when the Ayatollah Khomeini of Iran ordered him to be killed. The Runnymede report on Islamophobia (1997) stated that Islam is often seen by the West as barbaric, violent, aggressive, threatening, and supportive of terrorism. The bombing of the towers in New York City in 2001 has led many more Americans to associate Islam with terrorists, strengthening prejudice toward all Arab people.

Despite the differences between Islam, which is practiced by nearly 1% of Americans and Christianity, which is practiced by 70% of Americans, there are many similarities between the two (Pew, 2015). For example, both religions are monotheistic, recognize many of the same prophets, and recognize Jesus Christ as having been born from the Virgin Mary. However, Islam sees Jesus as a prophet; whereas, Christianity views Jesus as a divine person born as the Son of God. Both believe in heaven and hell as real places, and have core beliefs of promoting good and avoiding evil. With differing levels of importance, both religions believe in prayer, fasting, helping the needy, pilgrimage to the Holy Lands, and fostering both an internal and external struggle to follow God's purpose (Bond, & Imame, 2013).

Similarities of Islam and Christianity

Tenet	Islam	Christianity
Creator of the Universe	One God	One, triune God, manifested in the Father, Son, and Holy Spirit.
Role of Abraham	Leader of all Nations	Father of all nations
Recognized as Prophets	Noah, Abraham, Moses, David, Joseph, John the Baptist, Jesus, Muhammad	Noah, Abraham, Moses, David, Joseph, John the Baptist, Jesus
Mary	Virgin mother of Jesus	Virgin mother of Jesus
Jesus Christ	Jesus is a messenger of God. He performed miracles. Lifted to heaven by Allah He will return one day from heaven.	Jesus is the Son of God. He performed miracles. Ascended into heaven after crucifixion. He will return one day from heaven.
Holy Spirit	Named the angel Gabriel	A divine member of the Trinity
Satan	Real	Real
Core Beliefs	Branches of faith: fostering good, avoiding evil, love of the righteous, avoidance of the wicked.	The Great Commission: Love God Love thy neighbor
Principal practices	Prayer Fasting Helping the needy Pilgrimage “jihad” (internal and external struggles that defend good over evil; to serve the purposes of God; not a violent concept)	Prayer Fasting Helping the Needy Pilgrimage Proselytizing/missionary work (historically Christianizing through military conquest”
Salvation	Through faith, repentance and through the mercy of God alone.	Through belief in Jesus as Savior. Salvation is provided through God’s grace and Jesus’ atonement for man’s sin.
Sacraments	None specifically because there is no need for an intermediary such as the church between individuals and God.	Baptism, communion, confirmation, holy orders, penance, anointing of the sick; matrimony
Denomenational Distinctions	Sunni Shia	Catholicism Protestantism

Family Life. Arab families are patriarchal in nature, with a somewhat nuclear structure as well as importance given to the extended family. Conversational patterns are primarily vertical, between patriarchal authorities, spouses, and children. The majority of Arab families are Muslim. Muslim men are allowed to marry non-Muslim women, but the reverse is not true. Marriages are arranged and divorce is discouraged. Parents typically use an authoritarian style with their children. Obedience is required of children rather than dialogue. The father has final authority over the family. Family members strive to avoid conflict by not communicating openly or directly, which is considered to be rude (Abudabbeh, 2005).

Maintaining the honor of the family is an important value in Arab families. Privacy is important, and sexuality is a taboo subject. There is relatively little tolerance for being gay or lesbian, which can bring shame to a family.

Example:

A young Arab man comes to a social worker due to distress over being asked to marry someone he does not know. The man is reluctant to share information about the family and worries how they will feel if they find out he is in counseling. If you were the social worker, what things would you consider important to explore?

1. How can you help the client to feel comfortable sharing feelings about the process of his parents arranging a marriage?
2. Does the client feel that any criticisms of his parents are shameful?
3. Is it possible that the client is gay or bisexual?
4. Can the visit to a social worker be framed as seeking consultation to avoid some of the stigma of sharing personal information?

Health/Mental Health. Social stigma against mental health issues is strong. Family members may feel ashamed of mental illness and unwilling to share their emotional pain or seek help from counselors. Some researchers have found a tendency for women expressing higher levels of need, but men have more negative attitudes about seeking help (Khan, 2006). However, there is a common belief that both health and mental health problems are Allah's will, which may moderate some of the feelings of shame (Ciftci, Jones, & Corrigan, 2012). Abudabbeh (2005) recommends using didactic and structured therapies and being open to family therapy even when all family members cannot be present. She urges clinicians to be mindful of the patriarchal family structure and allow the family to define who is a member, regardless of biological kinship.

Example:

A Muslim woman and her two young children come to an initial appointment with a social worker at a mental health center. The woman is asked about what brought her there today, and she responds that her sons argue and fight so much that it is causing problems in the family. She wonders if peace at home is possible since Allah has given them such strong wills. When going on to discuss her family, she reports that her family consists of herself, her husband, their three children, and her mother-in-law. What things would you consider when exploring the presenting problem?

- First, relating the boys' behavior to Allah may not mean that the client is in denial – it may just be how she understands mental health symptoms within the context of Islam.
- Ask about everyone who is in the family and how they view the problem.
- Don't assume that the absence of the client's husband rules out the option of family therapy, should the need for that become evident.

review question...

The following question will be a review of the content from this section. The question will NOT be graded. The answer to the review question can be found below.

1. **Assad suggests that today's fear of and prejudice against Islam originated in**
 - a. The religious fervor of the Crusades
 - b. The threat against Salman Rushdie
 - c. The attacks on New York on 9/11.
 - d. The initiation of the first Gulf War.

Review Question Answer:
1. a

Hispanic or Latino Families

History. The term Latino is often used as a label for Spanish-speaking people from South American, Central America, and some of the Caribbean islands, regardless of their cultural background (Garcia-Preto, 2005). Latino is considered to be the preferred term because a) it is a Spanish word, and b) it is both sensitive to gender (Latina) and can be used to refer to both males and females collectively (Latinos). Latinos tend to identify more strongly with the specific country they are from and its unique history (Garcia-Preto, 2005). The term Hispanic has been used by the U.S. Census Bureau to track things like population growth, etc. Hispanic refers more to the influence of culture and language on a group of people (Garcia-Preto, 2005).

The largest groups of Latinos in this country are from Mexico (63.9%), Puerto Rico (9.1%), and Cuba (3.5%), although there is increased migration of people from Central and South America (7.5%) (Longres & Aisenbert, 2013). Mexicans have lived in this country since the 17th and 18th centuries, but the first large immigration of Mexicans occurred in the early 1900s in response to economic depression and violence in their native country. Currently, the majority live below the poverty line in spite of their dream of escaping from poverty and achieving financial success in the U. S. The current political climate has created great uncertainty for families comprised of adults who have come here illegally, teens and young adults who were brought here as small children and identify as Americans, and U. S. -born children who have the legal right to remain here.

Before 1966, Latinos could emigrate to this country freely. After that year, their entry was stemmed by requiring them to follow the same quotas as other immigrants. The first large wave of immigrants came to the U.S. from Mexico because of the Mexican Revolution in 1910 and continued through the Korean War. Puerto Ricans began coming in the 1920s, not long after the U.S. took possession following the Spanish American War in 1898. A larger migration of Puerto Ricans came after World War II. The revolution of Fidel Castro brought large numbers of Cubans to this country (Longres & Aisenbert, 2013). In 1986, amnesty was granted to undocumented immigrants who had lived in the U. S. for at least four years; it did not stop illegal immigration. This continues to be a source of divisiveness in the U.S.

Family Life. A value that most Latino groups have in common is their value of family. The needs of the group take priority over the needs of the individual. Families are a haven for its members, who are guaranteed its belonging, safety, and protection for life (Garcia-Preto, 2005). The family is defined by its extensive network of extended relatives, related by blood or simply through informal kinship adoption.

Health/Mental Health.

For people who are here illegally, or may have a family member here illegally, seeking health care or social services is a very threatening prospect. Engagement is improved by asking clients to tell about their country of origin and the story of their immigration to this country, as well as how their lives have changed coming to this country (Garcia-Preto, 2005)).

Social workers should honor and respect the diversity of people labeled “Hispanic” by recognizing their culture, racial identity, religious beliefs, and cultural pride. They should recognize the importance of family, not only in the traditional sense, but as it has evolved in U. S. society. They should build on family and community strengths common to Latinos.

Example:

A social worker sees a Latino client in the hospital emergency department where a close relative has just died. The social worker is called to help support the family in this time of crisis and help them take the steps necessary following the death of a family member. What should you be thinking about?

1. What is the family's cultural background and/or country of origin?
2. What are the family's beliefs about death, handling of the body, funeral practices, religious rites, and afterlife?
3. What are the circumstances around the death, and does that affect the family's understanding and acceptance of it?
4. Who is included in the family and who has the role of decision maker?
5. Does everyone in the family speak English? If not, how will you communicate with all family members?

review question...

The following question will be a review of the content from this section. The question will NOT be graded. The answer to the review question can be found below.

1. **A collection of a group of agricultural producers ask a social worker to consult on effective strategies for engaging newly immigrated Latino workers and developing positive relationships with them. Based on the generalized belief that Latinos feel a great sense of national pride, what should the social worker advise the producers?**
 - a. Tell the workers to speak English with other employees.
 - b. Report illegal immigrants to the authorities.
 - c. Ask workers to tell them about their country of origin.
 - d. Learn to speak Spanglish.

Review Question Answer:
1. a

Native Americans

History: Native Americans are also known by the names American Indians, Indigenous Peoples, and First Nations Peoples. The term American Indian is commonly used in the Southwest (Weaver, 2013). This is also the term used by the federal government. The term Native American is more often used in the Northeast (Weaver, 2013). The term First Nations Peoples is most often used in Canada. Whenever possible, it is preferable to use specific tribal names. We sometimes think of Native Americans as one general group, maybe recognizing that there are different tribes, but attributing to all a similar culture. Scholars today break North America (excluding Mexico) into 10 broad groupings of people who share similar, but not identical, cultural characteristics: the Arctic, the Subarctic, the Northeast, the Southeast, the Plains, the Southwest, the Great Basin, California, the Northwest Coast, and the Plateau (History.com). Their cultures differed based upon the need to adapt to the environment, making some nomadic, some hunters and gatherers, and others more agrarian. At the time the Europeans arrive to this continent, at least 2,000 Native American cultures thrived and practiced a variety of customs, lifestyles, and languages that were unfamiliar to each other (Sutton & Broken Nose, 2005). There are currently 567 tribes in the lower 48 states and Alaska that are federally recognized (Bureau of Indian Affairs, 2016). “History and culture are living entities in Native communities, and they exert a great deal of influence.” (Yeager, 2011, p. 8)

Native Americans experienced wide-scale genocide by Europeans, who through disease and warfare, contributed to the deaths of millions of people, 99% of the Native Americans in the United States. (Sutton & Broken Nose, 2005; Weaver, 1999). The remaining people were forced onto reservations during the late 1800s. The Wheeler-Howard Act of 1934 imposed political structures onto tribes that were foreign to them. Think about trying to fit a square peg into a round hole – rather than empowering tribal sovereignty, where tribes could develop their own governmental systems that fit for their communities, tribes continue to have alternative power structures imposed upon them (Yeager, 2011). Native Americans have a legal standing that is different from other cultural groups in the U. S.: tribal sovereignty. The U. S. Constitution recognizes Native Americans as a sovereign nation that *exists within* the United States and has the right to govern itself, unless those rights are specifically limited by Congress. Their rights cannot be limited by individual states.

Survivors were forced to assimilate into Western culture. Beginning in 1879, and for nearly a century afterward, Native American children were forced into residential schools intended to strip them of their culture. They were forbidden to dress in Native clothing, communicate in their Native language, or follow Native customs (Yeager, 2011). Others were required to live on reservations far from the areas they called home. These combined acts

have been referred to as a “soul wound” that has been passed down from generation to generation. Mistrust of the U. S. government continues to run deep among some Native people.

The spirituality of Native Americans and reverence for the earth is described in a Native American legend, told by Marilou Awiakta, who is of Cherokee and Appalachian heritage. She tells a story about a time when people and animals could speak to each other and they lived together peacefully. But before long, the humans made weapons and hunted more animals than they needed for food, upsetting the delicate balance of nature. The Deer Clan created a plan that every hunter must first prepare a ceremony of before hunting and ask permission of the Deer Clan chief before killing the deer. The hunter must then ask pardon of the deer’s spirit, with respect and gratitude, for taking its life and allowing the hunter’s spirit to go on. For the hunters who did not, The Deer Clan’s chief sent Little Deer, who lived in the mist, to cripple the hunter so he could never hunt again. But once in a lifetime, a hunter may catch a glimpse of Little Deer and take a piece of his horn as a talisman. Awiakta concludes her story with the message, “When we take only what we need, blessing comes to all.” (Awiakta, 2012, 5:48)

Family Life. When working with Native American families, it is helpful to first understand the community’s history, such as the tribe’s first contact with Europeans and the events that transpired as a result of that experience (Social Work Today). Native Americans often feel close ties to ancestors, so the things that happened to the generations before them continue to carry heavy influence over how children are raised and the family stories they learn about.

In many Native American families, the primary relationship is with the grandparents, not the parents. Grandparents have the role of caregivers, transmitting cultural teaching and providing structure and discipline (Sutton & Broken Nose, 2005). When families come together through marriage, they blend into one, with in-laws having the same family status as blood relatives.

Example:

A Native American family has recently moved to the area from a reservation due to economic opportunities. How can you help the family maintain their cultural identity?

- a. Ask about the family’s specific tribal history.
- b. Help the family locate local resources related to their cultural history.
- c. Openly acknowledge the depth of the family’s loss.

Health/Mental Health. Native Americans have higher death rates than any other Americans due to alcoholism, tuberculosis, diabetes, accidents, suicide, and homicide (Getz, 2016). Many people are reluctant to seek help from therapists because of the historical efforts of helpers, such as social workers, missionaries, and teachers trying

to change their cultural values. However, when Native Americans come to therapy, they expect the therapist to take the role of expert who can offer advice and wisdom. A helping relationship cannot occur without trust, and trust is built by self-disclosure about the therapist’s authentic self. In considering trustworthiness, they consider the authenticity of the therapist, the level of respect given, and genuine concern for the client (Sutton & Broken Nose, 2005). Sutton and Broken Nose suggest three elements necessary to working with Native Americans: a) awareness of the impact of genocide, b) recognize differences between clients’ values and those of the dominant culture, and c) the client’s level of assimilation. They recommend treatment approaches that involve the family, as opposed to interventions focused on individuals, the use of storytelling and metaphors, and the use of rituals and ceremony. Weaver (1999) adds another: using a problem-solving approach in which the Native American client defines the problem.

Example

A Native American client comes to a social worker at a campus counseling center. The client is getting behind in school work and has recently started drinking. The client feels a lot of pressure from the tribe to succeed in school and to contribute to the life of the tribe after graduation. What issues should you be thinking about?

- 1. Although the client may be feeling pressure to succeed, the extended family and community of the student can also be a source of support to draw upon.
- 2. Is the client in need of educational assistance? Many Native Americans have attended schools that did not prepare them with the academic skills needed for college.
- 3. Is the client in need of a substance abuse assessment? Native Americans experience high rates of alcoholism.
- 4. How can culture be used as a source of strength? Native American culture has survived centuries of trauma, disadvantage, and violence, proving that its people possess skills to survive tremendous hardships and adversity.

review question...

The following question will be a review of the content from this section. The question will NOT be graded. The answer to the review question can be found below.

- 1. **An important element to engaging with Native American clients is to**
 - a. Understand the problem from the client’s perspective.
 - b. Explain the problem to the client.
 - c. Maintain a professional distance from the family.
 - d. Avoid personal self-disclosures.

Review Question Answer: 1. a

People with Disabilities

History. In the late 19th century, the idea of social Darwinism became popular – credence was given to an idea of, similar to biological natural selection, “survival of the fittest.” In other words, people who had disabilities were considered weak, defective, unproductive members of society and were deemed to have little social value. This was the precursor of the eugenics movement: the forced castration and sterilization of people in institutions. Indiana became the first state to have a forced sterilization law, which the Supreme Court supported. “By the 1970s more than 60,000 individuals had been forcibly sterilized under thirty-three state laws (Smithsonian Institute, n.d., para 3).

The disability rights movement could perhaps be described as having sprung from the parent activists in the 1940s who organized to fight for educational services for their children with disabilities. As those children reached adulthood, they built upon this in the early 1970s with the passage of Section 504 of the 1973 Rehabilitation Act. At this point in history, following the discovery of antipsychotic medications, there was a huge push to deinstitutionalize people with mental illness. Thousands were released to the streets where community support services were inadequate. This legislation prohibited discrimination on the basis of disability. This was the first time that people with disabilities were given the status of a class, or minority group, deserving of government protection. This served as the foundation for the American with Disabilities Act (ADA), which passed in 1990. Yet, people with disabilities continue to be treated as if they have less to contribute to the world than people without disabilities.

Family Life. Perhaps the most eloquent description of disability I have ever heard is Christine Miserandino’s “spoon theory.” A friend asked her about her personal experience with chronic illness, and Ms. Miserandino used



spoons to illustrate her experience. She explained that she starts every day with a finite number of spoons, and her physical limitations mean that every activity for the day must be weighed carefully because each will “cost” her a spoon, and she only has so many to give. She is continually aware of her illness and is never able to do any activity without giving thought to how many spoons it will cost and would her spoons be better “spent” elsewhere. While people without disabilities may do things other people take for granted, Ms. Miserandino cannot do those same things without first considering how many spoons she has to give. For example, her friend might choose to go to a downtown restaurant for lunch, but Ms. Miserandino would need to consider that if she goes with her friend, it will cost

a “spoon” in terms of the energy it takes to get herself there, finding a place to park, walking from wherever she parks to the restaurant, etc., versus her need to buy groceries after work, which she would not be able to do because she would be so worn out by going out to a restaurant for lunch. She could put off her grocery shopping until tomorrow, but she would need to weigh that decision against any other responsibilities she needed to complete that day.

Clients are the experts on their own families, and their experiences should be recognized as uniquely theirs. The experiences on families will differ depending upon whether the disability is physical, intellectual, or psychological. It will differ depending upon the level of care needed by the family member and how accepting the person is of that care. Parents experience grief and loss when they first learn about a disability that will interfere with the hopes and dreams they had for that child. The coping skills of the family, as well as the available support systems, will influence how well the family processes that grief and goes on to have healthy, mutually supportive relationships. Families can become more resilient through open communication, using professional counseling and support groups as necessary, developing a social support network to avoid isolation, participating in enjoyable activities, and taking advantage of respite care when it is available.

Health/Mental Health. There is some dissonance between the medical model of disability and the social model of disability. Using a medical model, which is familiar to most people, disability is viewed as a deficit or problem to be fixed or at least ameliorated. The disability is seen as part of the individual, and professional treatment is required to improve the disability in some way. In a social model of disability, disability is a difference in functioning, not a deficit. The disability does not lie within the person; it is the result of the person interacting with the environment. Intervention might be focused on the individual, the environment, or the interaction between the two. Attitudes by persons with disabilities toward health and mental health services are likely to depend upon the degree to which the persons’ attitudes about disability are syntonetic with the providers’ attitudes about disability.

Example

A veteran returns home after being wounded in combat. The veteran had both legs amputated, is experiencing post-traumatic symptoms, and now uses a wheelchair. The person lives alone, the home is not-handicapped accessible, she cannot drive a car, and the noise in the neighborhood is causing her a great deal of anxiety. As the VA social worker, how can you help this person?



- Would you be more likely to see the person's problems as symptoms to be managed or as not having a good fit with the environment?
- Would you recommend medication for the anxiety or using headphones to block out noise?
- Would you recommend making the home or accessible or moving to a different house?
- Would you recommend adaptive controls for the car or using public transportation?
- What other challenges does this person face?
- What resources are available? If you aren't aware of any, how could you find out?

Reflection

Do you think you would be more likely to see a situation as the person's problem or as an environmental problem? How might your perspective be influenced by a setting that follows a medical model like a hospital?

review question...

The following question will be a review of the content from this section. The question will NOT be graded. The answer to the review question can be found below.

1. In a social model of disability, the disability is viewed as a result of
 - a. contracting a socially transmitted illness
 - b. being born with a congenital condition
 - c. interacting with the environment
 - d. inability to climb stairs

Review Question Answer:
1. c

Older Adults

Older adults are saddled with both negative and positive stereotypes about aging, and because they grew up with the same media messages that we all hear, they may have even internalized these messages. Please note that adolescents are also stereotyped, but I will not address that group here. Here are some common myths about aging:

- Myth: Aging leads eventually to frailty and disability.

Truth: It is chronic diseases like diabetes, heart disease and osteoporosis that are strongly correlated with disability . . . not aging alone. In fact, the majority of people who live to be 100 can live independently into their 90s (Kotz, 2009).

- Myth: The more weight you can lose, the longer you'll live.

Truth: A recent study found that people with a body mass index of 27 lived longer than those with a body mass index range of 19-25 (Kotz, 2009).

- Myth: Most older people become cranky and withdrawn.

Truth: Significant personality changes are more likely to be related to a disease process than to normal aging (Kotz, 2009), and socializing may be a critical element to successful aging ("Aging myths...", 2012).

- Myth: Older people can't learn things.

Truth: Research findings about neuroplasticity have challenged our earlier (false) beliefs that the brain couldn't change and grow after adulthood. The aging brain can still change its structure and function in response to changes in thinking and new experiences. ("Aging myths ..., 2012).

History. Older adults today, those who are 65 and older, were born before 1951. They include the Greatest Generation, born between 1900 and 1924 (now in their 90s and older), The Silent Generation, born from 1925 to 1942 (now in their 70s and 80s), and the first wave of the Baby Boomer Generation, born from 1946 to 1964 (now in their 60s).

The term *Greatest Generation* was coined by journalist Tom Brokaw, who used this as a title for his book about people from this generation (Sanburn, 2015). The *Silent Generation* got their name from a reference in an essay in Time magazine in 1951 in which the author compared the group as silent in comparison to the "flaming youth" of their mothers and fathers (Sanburn, 2015, para 6). The term of *Baby Boomer* generation appeared in the Washington Post in 1977 to refer to the "boom" in births related to soldiers returning from World War II (Sanburn, 2015).

The Greatest Generation grew up experiencing the Progressive era, Industrial Revolution, the deprivation of Great Depression, and World War II. They were the first generation with large numbers to enter college, especially with the GI Bill. They valued community, unions, civic efforts such as New Deal programs, and the Civilian Conservation Corps (CCC) (Howe, 2014a).

The Silent Generation grew up experiencing fighting in the Korean and Vietnam Wars. They were known for working within the system, rather than fighting it, playing by the rules, and keeping their heads down in the era of McCarthyism. They grew up in a strong economy that had bounced back in the affluence of the 1950s. They are the healthiest, most educated, and wealthiest generation (Howe, 2014b).

The Baby Boomer Generation grew up experiencing the Vietnam War, rejection of traditional values, and a surplus of resources. They experienced social turmoil, the sexual revolution, and the first wave of women who were economically independent. Perhaps as a result of their anti-establishment orientation, they have shifted away from civic participation. They have a history of risk taking and experience higher levels of life-style related chronic disease from drug use, smoking, non-

marital sex. They are less affluent than the previous generation, (Howe, 2014c).

Family Life. Behavioral patterns in family life are greatly influenced by other factors, in addition to aging, such as ethnicity and socioeconomic status. However, we can make some generalizations about elders related to their age cohort. For example, adults born between 1929 and 1940 experienced the hardship and deprivation of the Great Depression. As a result, they learned to do with what they had, to work hard, and follow clearly-defined gender roles. They learned to tolerate delayed gratification, and they often gave work priority over the needs of their family. (“Generalizations about Generations,” 1995).

Health/Mental Health. Adults from older generations are more likely to have grown up in an era where a doctor’s word was not questioned, and it was considered inappropriate and disrespectful to disagree with a doctor. Instead of communicating directly, they may be more likely to express their disagreement with a prescribed treatment regimen by simply not adhering to it.

Example

An 82-year-old woman is prescribed medication to lower her blood pressure. She finds that a side effect of the medication is that it causes her to urinate much more frequently, which makes it inconvenient and also embarrassing when she doesn’t make it to the bathroom in time. At the next visit, her doctor asks how she’s feeling, and she says, “Fine.” The issue is not only difficult to talk about but she is afraid that the doctor will feel criticized if she “complains” about the side effects. She is considering whether to cut back on drinking liquids or cut back on the medication. If you were the social worker assigned to this client, what would you do?

- How would you develop rapport with this client?
- How would you encourage the client to discuss her concerns with you?
- How could you help her to advocate for herself with her doctor?

review question...

The following question will be a review of the content from this section. The question will NOT be graded. The answer to the review question can be found below.

1. **The baby boomer generation was greatly affected by what change for women?**
 - a. They became financially independent of men.
 - b. They chose to have larger families.
 - c. They got married at a very young age.
 - d. They became disinterested in being a mother.

Review Question Answer:
1. a

Reflection

What do you think are the cultural hallmarks of your generation? What world events has your generation experienced that are significant. How does your world view affect your relationships with the generation before you and the generation after you?

Sexual Orientation

History. Historically, attitudes and beliefs about what we now think of as sexual orientation have changed over the years. Prior to 1850, attitudes about sexual orientation were influenced by moral, legal, and religious values (De Block & Adriaens, 2013). In the early 1800’s Heinroth wrote a handbook where he conceptualized mental disorders as sins, including those of “sexual deviants,” who should be held accountable for their crimes because they freely chose certain behaviors (De Block & Adriaens, 2013).

As the field of psychiatry developed and gained status, same-sex relationships became increasingly medicalized, being viewed as related to medical conditions, psychological problems and/or “deviant” sexual instincts. In the second half of this century, psychiatrists became almost fascinated as they engaged in describing, categorizing, and exploring the causes of paraphilias (De Block & Adriaens, 2013). Freud went in a different direction, writing *Three Essays on the Theory of Sexuality* in 1905. He disagreed with the prevailing view at this point in history, “homosexuality was not considered to be a psychiatric illness” (De Block & Adriaens, 2013, p. 282). It was considered to be merely a variation of sexuality. Psychiatry has vacillated between two perspectives: pathology versus normal sexual variation (De Block & Adriaens, 2013).

Kinsey believed that sexual differences were not a sign of pathology, but a sign of dissonance between the person and the environment. In 1973, the American Psychiatric Association removed homosexuality from its Diagnostic and Statistical Manual of Mental Disorders. In 2004, Massachusetts became the first state to legalize same-sex marriage, with others soon to follow. The U. S. Supreme Court, in 2015, upheld same-sex couples’ Constitutional right to marry, with all the benefits that conveys.

Family Life. “According to the U.S. census in 2000, one third of lesbian-headed couples and one fifth of gay-headed couples were raising children (Cooper & Cates, as cited in Lev, 2010, p. 269). Most other groups do not have the same history of being labeled as mentally ill or deviant, therefore, let’s begin by clearing up some remaining misconceptions. Once thought to be dysfunctional, pathological, and inferior, research has *unambiguously demonstrated* that lesbian, gay, bisexual, transgender, and queer/questioning (LGBTQ) families are as healthy, stable, and functional as heterosexual families (Foran, Whisman, & Beach, as cited in Lebow,

2015). Parents' sexual orientation is not relevant to their ability to provide a healthy environment for their children (Thompson, 2007). Their children are just as well-adjusted as children of heterosexual couples. There is no evidence that children of LGBTQ parents are more or less likely to grow up gay themselves, although their parents may feel societal pressure to raise children who are heterosexual (Lev, 2010).

One difference of LGBTQ families is the way they form their families. The most common way is to use donor sperm from either a known or unknown donor (Lev, 2010). Other avenues to parenthood include adoption, surrogacy, step-parenting, and sexual relations with other gay individuals. Lev (2010) notes that some lesbians go to great lengths to conceive a child whose physical characteristics are consistent with both parents. With regard to gender roles, same-sex families are sometimes accused of not providing a same-gendered parent as a role model for a child. In our heteronormative culture, both parents and their children experience pressure for the children to conform to traditional gender roles.

Health/Mental Health. Licensed Marriage and Family Therapists have reported that at least 10% of their practice consisted of gay, lesbian, or bisexual clients (Green & Bobele, as cited in Addison & Coolhart, 2015). Addison and Coolhart (2015) encourage the use of a relational intersectional lens when working with queer families. They suggest a number of steps to help practitioners through the process. These steps include identifying the multiple intersections, including those of therapist; recognize the limitations and biases in the therapeutic relationship; openly acknowledge cultural differences; ask open-ended questions about the clients' experiences with these cultural differences; explore the ways in which the clients' reality fits a clinical model and how it does not.

Addison & Coolhart (2015) recommend that mental health professionals be cognizant of the following factors as they affect LGBTQ families:

- Living with heterosexism and other avenues of social oppression creates chronic stress for families.
- There is a lack of positive role models available to provide social support.
- Partners may differ in the degree to which they are openly gay to family, friends, and coworkers.
- Partners in cross cultural relationships may be at risk of discrimination due to the layers of bias related to not only sexual orientation, but culture, race, and ethnicity.
- The health risks for couples in non-exclusive relationships.
- The lack of clear gender roles for individuals in relationships.
- When both people in a relationship are strongly gender-conforming, there may be an increased level of socialized traits, such as both being

extremely nurturing, or both being extremely competitive.

- Therapist bias may be unconscious and/or unacknowledged.

review question...

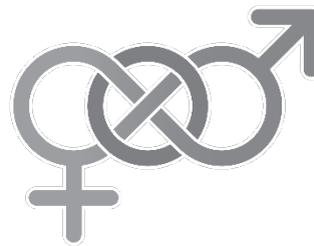
The following question will be a review of the content from this section. The question will NOT be graded. The answer to the review question can be found below.

1. **The most common way that lesbians form families is through**
 - a. Adoption
 - b. Sexual relations with male friends
 - c. Surrogacy
 - d. Sperm from known or unknown donor

Review Question Answer:
1. d

Reflection

Being married is associated with a more conservative lifestyle than being single. You are more likely to be happy, have a stable relationship and a have routine in your life. Think about the concept of "family values" that is commonly discussed in the media. Often, people who promote family values are against same-sex marriage – the very institution that is associated with stability and love. The paradox is that they are against the very thing they claim to be in favor of. How would you explain that?



Gender Identity

History. Gender is the manifestation of behaviors and social interactions that are associated with a culture's definition of male or female. Gender identity is the intrinsic sense of being male, female, or other, regardless of secondary sexual characteristics. For most people, their internal sense of being male or female is consistent with their biological sex. However, some experience a dissonance between gender and gender identity, also referred to as gender nonconformity. This appears to be due to a combination of genetic, neurobiological, prenatal and postnatal hormones, psychological factors, and cultural environment (Janicka & Forcier, 2016). This is not the same thing as sexual orientation. Transgender is the gender the person has claimed. Sexual orientation refers to whomever he or she is emotionally and physical attracted to.

Gender diversity is prevalent in all cultural groups. "Prevalence is estimated to be between 1:7,000 to 1:20,000 for transgender females, and from 1:33,000

to 1:50,000 for transgender males (Janicka & Forcier, 2016). Mizock, Mougianis, and Meier (n.d.) estimate that the prevalence for transgender youth may be as high as 0.5%. Transgendered people want to be referred to with the pronoun that matches their presented gender. For example, a person who is born a woman but presents himself as a man, should be referred to with the pronouns he or him. If you are unsure: Ask the person.

Family Life. The dynamics of the family will differ, depending upon whether the transgender person is a parent, a young child, an adolescent, or an adult child and whether the person is openly transgender. Nuttbrock et al. (2009) notes that

“Male-to-female transgender persons over the age of 40 were born in 1969 or earlier and experienced adolescence and young adulthood at a time when knowledge about transgenderism was non-existent or rudimentary and attitudes toward transgender persons were typically ambivalent or negative. Male-to-female transgender persons under the age of 40 were born in 1970 or later and experienced adolescence and young adulthood at a time when attitudes toward transgender persons were, at least marginally, improved.” (p. 110)

Parents. Parents often must navigate the experience of grief and loss as they challenge a binary notion of gender and accept that their child is transgender. The support of other parents who have similar experiences, such as in a support group, can be helpful. It is not just the transgender children who experience stigma and ostracism – parents may experience these things too. Parents of transgender children may need guidance and education about non-binary conceptualizations of gender identity.

Transgender parents. In couples where one partner becomes openly transgender, divorce is not automatically imminent (Giammattei, 2015). When one partner is a transgender male, the female partner sometimes stays. Because of the limited amount of research, it is not known if the reverse is true (Giammattei, 2015). Couples also go through a grieving process over loss of both their identities as individuals and as a couple (Giammattei, 2015).

Transgender children. Wallien & Cohen-Kettenis found that of children who expressed gender identity issues between the ages of 5 and 12, only 27% continued to feel this way after puberty (Russo, 2016). Researchers found that overall, children who intensely and persistently identified with a nonconforming gender were likely to remain transgender after puberty but cautioned that it cannot be reliably predicted whether an individual child will persist (Russo, 2016). Parents who are facing the question of whether to support a social transition for their child should consider how it affects that child's ability to thrive. The children of parents who successfully transition their child to a transgender role do not seem to experience the high anxiety and depression of children who lack this experience.

Transgender adolescents. Adolescents are more likely

to disclose their identity, especially to persons they anticipated would be the most accepting. Hispanic and African American transgender females are more likely to openly disclose their gender in adolescence (Nuttbrock et al, 2009). This group is two to three times more likely to develop issues such as depression, anxiety, self-harm, and suicide. Mizock et al. (n.d.) indicate that externalizing behaviors, such as aggression, and internalizing behaviors, such as withdrawal, are indicators that the need for intervention is urgent. They report that some youth may disclose their gender nonconformity just prior to considering self-harm.

Sometimes, adolescence is the time when a person first recognizes being transgender. At some point, a decision must be made as to whether to provide the adolescent, who has a limited ability to understand long-term consequences, with cross hormones. Taking medication that suppresses hormones is generally considered safe; cross hormones, however, may permanently eliminate the ability to have biological children.

Health/Mental Health. The World Professional Association for Transgender Health (WPATH) recommends that health professionals assist youth with a staged transition to the identified gender. This includes mental health care, social support, and hormones that suppress puberty, giving youth time to explore their gender and their family time to make the adjustment (Janicka & Forcier, 2016). Mental health clinicians should follow evidence-based assessment, to include the following domains (Mizock, Mougianis, & Meier, n.d.):

- Gender history (including behaviors, beliefs, appearance, preferences, sense of self, consistency, and development), goals, and expectations of treatment.
- Current health and psychological functioning, individual and family health history, the extent of distress of family members, physical and mental health history, legal history, substance use, history of physical and sexual abuse, self-esteem, trauma, co-occurring mental disorders, hobbies and interests, strengths, components of resilience, and religious background and beliefs.
- Interpersonal relationships, family dynamics, sexual/relationship development, risky sexual behavior, social history, current intimate relationships, and relationships with family, peers, and teachers.
- Resources such as living conditions, housing, transportation, medical care, etc.

A minority stress model has been used to guide assessment and treatment. This model explains that stigma, prejudice, and discrimination increases psychosocial distress. Researchers in Minnesota studied 402 transgendered people who reported verbal harassment (56%), employment discrimination (37%), and physical violence (19%) (Lombardi, Wilchins, Priesing, & Malouf, as cited by Bocktin, et al., 2013). Such stressors are thought to be related to the higher prevalence of depression, anxiety,

and substance abuse. Bocktin et al. (2013) found higher rates of depression, anxiety, somatization, and overall distress (Bocktin, et al., 2013).

Affirmation, peer support, and developing pride in identity mitigated the negative effects of stress. Evidence-based interventions include cognitive-behavioral therapy to improve coping with stressors, strengthened social support, and making referrals as necessary (Mizock et al., n.d.) and solution-focused therapy that is affirming, non-binary, and sensitive to identities (Giammattei, 2015).

Transgender persons also experience stigma and minority stress from mental health practitioners. Ellis, Bailey, and McNeil (2015) acknowledged that practitioners have historically asked unnecessary questions, been overly intrusive, administered tests excessively, exhibited prejudicial attitudes, and restricted avenues to treatment.

Reflection

Imagine that you wake up tomorrow in a body that is not your own. And if that isn't confusing enough, your body does not match your gender. You wonder if anyone else notices that you are in the wrong body, and it appears that they do not. Should you tell them? Will they believe you or think you are crazy? You think you must be dreaming, but you wake up the next day, still in that stranger's body. Days, months, years go by and still, you are in the wrong body. Because people still treat you as if you are in your old body, you feel they do not know you at all. You feel distanced from the people you care about because they do not understand, and perhaps do not even try to understand, the position you are in. What do you think that would feel like? How would you respond to those who insist your body is the correct one? How would it feel to have no one in your life who truly knows and understands you?

Marital Status

History. Historically, “illegitimate” children, e.g., born to unmarried parents, have been stigmatized and discriminated against. Until the 1960s, cohabitation of interracial couples was illegal. Florida, Michigan, and Mississippi still have laws that criminalize cohabitation. Cohabitation was been called the “poor person’s marriage” because it allowed the flexibility of separating without worrying about issues of support or division of property (Martin, 2013). The government has also had a vested interest in promoting marriage, either through “midnight raids” of welfare recipients or more modern-day benefit restrictions, based on the belief that it could save money. (Martin, 2013). Pleck argues that anti-cohabitation laws cannot be examined separately from the legacy of racial segregation because the “anti-cohabitation laws have historically targeted interracial couples and the poor” (Martin, 2013, para 10).

DePaulo and Morris (2005) suggest people who are single are more stigmatized than couples who cohabit. They claim that there is a cultural presumption that “Those who have a sexual partnership are better people –

more valuable, worthy, and important” (p. 58). When they asked 1,000 college students about their perceptions of married people, the students used the following terms: happy, loving, secure, kind, caring, giving, faithful, loyal, compromising, reliable, and dependent. When they asked participants about their perceptions of single people, the students used these terms: lonely, shy, unhappy, insecure, inflexible, independent, sociable, friendly, and fun. DePaulo and Morris (2006) also assert that discrimination against single people is legally permitted. For example, employers subsidize health insurance policies for spouses of married employees, yet they do not offer the same benefit to a parent, sibling, or friend. “That amounts to unequal compensation for the same work”

Byrne and Carr (2005) used the term “singlism” as a label for the prejudice and discrimination aimed at unmarried people. Revisiting the topic of intersectionality, Martin discussed an example of a lesbian who was denied fertility services. The state law prohibited discrimination based on sexual orientation, but did not prohibit discrimination based on marital status. The physician denied services to her, stating the reason being she was unmarried. This was racial and sexual orientation discrimination under the permissible discrimination against an unmarried person.

“Bias against nonmarital families continues to be widespread” (Joslin, 2015, p. 807). A broad base in this country believes that nonmarital families are deficient, of less value (than marital families), and a threat to the institution of marriage. In 1960, approximately 450,000 couples were cohabiting. In 2010, this number has risen to 7.5 billion (Joslin, 2015).

Although nearly half the states prohibit discrimination against single, married, or divorced people, the protection does not extend to couples who are unmarried but living together (Joslin, 2015). Some statutes explicitly do not protect unmarried couples. This population is disproportionately represented by people who already marginalized – people of color, lower- income, and less educated (Joslin, 2015).

Family Life. Families are formed in a multitude of ways:

- More than one generation (extended family), living together or not
- Adoption
- Step-families
- Blended families
- Single parenting by default (death, divorce, accidental pregnancy)
- Single parenting by choice (assisted insemination; known or unknown donor)
- Two parents, married, with no, one or more children
- Two parents, unmarried, with no, one or more children
- Adults in a family orientation but without biological ties

Some people cohabit as a sort of dress rehearsal for marriage. Others do so for financial benefits, the desire to spend more time together, or increased availability of sex. Newer research has contradicted previous findings and demonstrated that there is no relationship between cohabitation and later divorce. It is the age at which people move in together that is likely to determine the success of the relationship. Couples who either marry or cohabit at younger ages are less likely to have enduring relationships (Hillin, 2014).

Health/Mental Health. There is a relationship between quality of life and marital status. Generally, better health and mental health is associated with being married, especially for men. Contributing factors include increased social support, mutual encouragement to make healthy choices, lower levels of stress hormones, and engaging in fewer risky behaviors. One exception to this is the association of weight gain and obesity with being married. Quality of life, also, is better for married men than single or divorced men, especially as they get older. Quality of life is better for single women, but tends to decline as they get older (Han et al., 2014). Married men seem to have less depression and in general, a higher satisfaction with life. This translates to beneficial effects on cardiac health. Marriage is also linked to lower risk of cognitive problems and lower risk of Alzheimer's disease. There's also higher risk of death subsequent to being a widower (Harvard, 2010).

Arnold and Campbell (2013) compared the expenses of four fictional women in Virginia. One was married making \$40,000 a year; a second one was married, making \$80,000 a year. A third woman was single, making \$40,000 a year; a fourth was single, making \$80,000 a year. Of particular interest was their comparison of what these women spent on healthcare.

“Our single woman with an income of \$40,000 spent \$189,600 on health over 60 years; whereas our married woman with the same income spent \$165,600—a difference of \$24,000.” (para 37). Note that the single woman paid more.

“Our married woman with an income of \$80,000 spent \$331,200 on health over 60 years, and our unmarried woman with the same income spent \$379,200—a difference of \$48,000.” (para 38). Again, note that the single woman paid more.

The authors based their calculations upon the figures of the Bureau of Labor Statistics, which reported the percentage of income that single and married women paid for healthcare, 7.9% and 6.9% respectively. They calculated what these women spent in a 60-year lifetime. When they factored in other things such as income tax, Social Security, housing, IRAs, they found that single women in both categories paid significantly more than their married counterparts. The single woman who made \$80,000 paid over \$1 million over a 60-year period!

Reflection

Women continue to make 80 cents for every \$1 a man makes. The American Association of University Women (AAUW) says that there are things that can be done at the individual, organizational, and policy levels to close this gap. At the individual level, they recommend that women do a better job at negotiating their pay (AAUW, 2016). Have you ever negotiated your pay when you accepted a job or asked for a pay raise after you were employed? Do you think women are more reluctant to negotiate than men? The AAUW offers workshops to help women learn these skills. Why do you think workshops are necessary for women but aren't as frequently marketed to men?

Lower Social Class

History. Although not true in all countries, money is the basis for social stratification in the U. S. (Ritzer, 2015). Ritzer says that the lowest social class in this country is comprised of part-time workers and the unemployed, who have income of approximately \$10,000 per year. The working class is comprised of manual laborers, clerical staff, and service workers who make about \$20,000 to \$30,000 per year. A person's economic position, especially occupation, defines his or her social class in this country. There are a number of stereotypes about poor people. Here are a few, including their corrections.

- Myth: Poor people do not value education.
Truth: The most popular measure of this is family involvement, which typically focuses only on in-school involvement, like visiting classrooms. Poor people do tend to experience class-specific barriers to in-school involvement, like not being able to miss work, or not having childcare or transportation. Attitudes of poor people about the value of education are identical to people of higher social classes. “Poor people, demonstrating impressive resilience, value education just as much as wealthy people” (Strauss, 2013, para 16).
- Myth: Poor people are lazy.
Truth: Working class and poor people who are employed work at the lowest-paying jobs with few opportunities for advancement, requiring intense manual labor, and virtually no benefits such as sick leave. “All indications are that poor people work just as hard as, and perhaps harder than, people from higher socioeconomic brackets” (Strauss, 2013, para 27).
- Myth: Poor people are substance abusers.
Truth: Poor people are less likely to abuse alcohol than wealthier people – alcohol use and addiction are correlated with income. Drug use is distributed rather evenly across income levels. Substance use should not be viewed as part of the culture of poverty (Strauss, 2013).

Ruby Payne, with a PhD in educational leadership from Loyola, is a self-proclaimed expert on poverty and a professional educator since 1972 (Ruby Payne, 2016). She embraced the No Child Left Behind legislation of 2002 and saw the need for school systems to respond to the

Congressional demand to improve the test scores of poor children (Bomer, Dworin, May, & Semingson, 2008). She sought to meet this need by developing her training program and professional development workshops that claim to help teachers better educate children who are growing up in a culture of poverty. She claims to have trained “hundreds of thousands of professionals, certified more than 7,000 trainers in her program “A Framework for Understanding Poverty, and presented to groups in every state in the U.S. and in more than 10 countries (Ruby Payne, 2016).

Bomer, Dworin, May, and Semingson (2008) conducted a qualitative review of the truth claims of Payne and compared them to the existing research about families who live in poverty. They concluded that although Payne refers to her claims as data, she has conducted no actual research and cites few sources, often inaccurately. Her claims about hidden rules, divisions of social classes, culture of poverty, representations of the daily lives of people in poverty, family structures and dynamics, language deficits, cognitive abilities, and worldview, are not supported by research or evidence in the fields of education, anthropology, or sociology. Bomer, Dworin, May, and Semingson (2008) conclude that Payne is misleading teachers with her claims that blame the victim, and she’s making a lot of money doing it. They assert that she might be considered merely to be a self-published former principal with faulty claims based on personal opinion except for the damage she causes through her influence of educators all over the country. They cite a number of authors to support this chilling statement:

It has been demonstrated repeatedly that when people with-out advantage, social position, or opportunity internalize US middle-class values, those very values cause significantly more damage in their lives than they offer new opportunity partly because by internalizing the views of those who are financially better-off, poor individuals come to blame themselves for their failure to get ahead. (pp. 2525-2526)

Family Life. Since higher levels of parents’ education are associated with lower risk of living in a poor family, families living in poverty are likely to have lower levels of education. This should not, however, be confused with them attributing low value to education. Eighty six percent of children who live with parents who didn’t finish high school live in low-income situations (Addy, Engelhardt, & Sinner, 2013). Seventy percent of children who live in single-parent households live in low income situations. This makes sense, given that single-parent households are supported by one wage-earner, rather than two.

Health/Mental Health. People who live in poverty have the poorest health outcomes and the shortest life expectancy. A few of the factors that contribute to this are lack of health insurance, inability to take time off from work for both preventive and primary care, exposure to environmental hazards (lead, asbestos, dangerous work conditions), living in areas at higher risk of crime, diets that lack fresh fruit and vegetables but high in fat, and

having increased cortisol levels – the hormone associated with stress).

Poverty is a risk factor for mental illness (Jakovljevic, Miller, & Fitzgerald, 2016). For example, depression is 1 and ½ times more prevalent and schizophrenia is eight times more prevalent in low income groups (Mills 2015). Although the relationship is clear, the nature of the relationship is not. It is unclear as to whether poverty causes poor mental health, or does poor mental health cause poverty? The relationship is probably more complicated than this, suggesting the need to consider the multiple dimensions of oppression, economy, biological structures, and social construction of disorders. Mills (2015) suggests that as we view the situation, we need to “zoom out” from the point of looking at a close-up of biochemical markers and organic features of individuals to social behavior and psychological health, and out even further to environments where poverty is lived, the politics of pharmaceutical marketing and prescribing policies, and ultimately to systemic causes of poverty and economic inequality (p. 219). Only when we consider this entire landscape can we better understand the relationship between poverty and mental illness.

review question...

The following question will be a review of the content from this section. The question will NOT be graded. The answer to the review question can be found below.

1. **People who are poor are more likely to experience problems with drug abuse than wealthier families.**

- a. False
- b. True

Review Question Answer:
1. a

Reflection

Think about a group with which you currently identify. It might be a culturally dominant group with a history of access, privilege, and power, or it might be a non-dominant group with a history of deprivation, oppression, and discrimination. How do you think the cultural history of your group might be relevant to present-day struggles? What attitudes, coping strategies, or assumptions about the world might have been handed down to you from previous generations and affect your outlook on life? How might significant events in your cultural history be manifested in your life today?

Immigration Status

History. The percentage of immigrants in the country has fluctuated over the last 100 years, with

10% of the population being foreign-born in 1850, to 14.7% of the population by 1910 being foreign-born

(Zeigler & Camarota; Zong & Batalova, 2016). This percentage steadily decreased to a low of 4.7% in 1970, then increased to 13.3% in 2014 (Zeigler & Camarota, 2016). The population share is expected to continue to increase through 2060 (Zeigler & Camarota, 2016).

A major wave of immigrants, 20 million people, came between the 1880s to about 1920, primarily from Central, Eastern and Southern Europe (“U. S. Immigration Before,” n.d.). It was also during this period (1889) that Jane Addams and Ellen Gates Starr founded Hull House, a Settlement House that addressed the needs of immigrants. During the period of WWI, immigration declined. In the early 1920s, the U. S. tried to stem the tide of immigrants by implementing a literacy test and a quota system. The quota system limited immigration to 3% of the number of that particular group already in the U. S. The consequence of this system was that white immigrants were favored and Asian immigrants were not. During WWII, there was such fear of German and Italian immigrants that they were detained, and U.S citizens of Japanese descent were confined to internment camps. In 1965, the quota system was dismantled, and refugees from the Vietnam War flooded in.

Over 10 million new immigrants have come to the U.S. since 2000 (Chung, Bemak, & Grabosky, 2011). In 1980, 1 in 16 people in the U.S. was an immigrant (Camarota, 2011). Immigrants used to be drawn primarily to existing subpopulations; however, states with the largest increases are North Dakota, Wyoming, District of Columbia, Montana, Kentucky, New Hampshire, Minnesota, and West Virginia (Zeigler & Camarota, 2016). Whereas most immigrants come here from Latin America, the percentage of immigrant nations increasing include Saudi Arabia, Bangladesh, Iraq, Egypt, Pakistan, India, and Ethiopia (Zeigler & Camarota). There are currently 42.4 million immigrants (13.3% of the population) living in the United States (Zong & Batalova, 2016). “More than 1 in 8 Americans are immigrants” (Kuzoian, 2015, 3:25). Twenty six percent of the U. S. population is comprised of immigrants and their U. S.-born children (Zong & Batalova, 2016).

Share of the of the US Population Who are Foreign-Born

Year	Immigrant Share of Total U.S. Population (%)
1850	10%
1890	14.8%
1910	14.7%
1970	4.7%
1980	6.2%
1990	7.9%
2000	11.1%
2010	12.9%
2014	13.3%

Source: Zong & Batalova, 2016, based on U.S. Census data

Family Life. It’s impossible to talk definitively about the influence of immigration status on families because of intersectionality issues. People immigrate here for many reasons, from many countries, and with diverse histories. Some want very much to assimilate into American culture; others fight to preserve their culture. Some are here legally; some are undocumented. Immigrants are vulnerable to not only the challenges that precipitated their move, but also to things such as culture shock, not speaking the language, finding a job, coping with xenophobia, etc. Cole (2015) suggests that service providers ask these questions;

“Does the family have information about systems including health services and legal rights?”

“Do they feel safe to ask for Welfare Services?”

“Can family reunion be helped?”

“Do they have supports to deal with post-traumatic stress?”

“Have they undergone medical screening to identify risks?”

“Are there unaccompanied children and youth?”

Health/Mental Health. Chung, Bemak, and Grabosky (2011) urge us to “recognize, acknowledge, and understand our own political countertransference.” (p. 89). They recommend that for mental health professionals to be effective, we must first challenge and dispel myths we hold about undocumented immigrants. Cole (2015) suggest that practitioners ask questions about whether the family came from an urban or rural area, if all family members live together, who is the primary financial provider, if English is spoken, and if not, who translates for the family. Additional areas to explore include the family’s support system, any changes in their socioeconomic status, feelings of cultural isolation, and decision making for the family (Cole, 2015).

Chung, Bemak, and Grabosky (2011) recommend that mental health practitioners should provide education to immigrants about U. S. laws pertaining to parenting and discipline. They recommend that we also educate the larger community about differences in disciplining children as an expression of culture. They describe the five intervention levels of the Multi-level Model of Psychotherapy, Counseling, Social justice, and Human Rights (MLM).

1. Educating the client about mental health and the counseling process.
2. Provide culturally sensitive interventions to individuals, families and groups.
3. Empower clients to successfully navigate U. S. culture.
4. Appreciate the traditional healing practices of the cultural group and integrate those practices with Western medicine.
5. Advocate for and support social justice issues.

Cultural Relativism versus Ethnocentrism

Cultural relativism is “The idea that aspects of culture such as norms and values need to be understood within the context of a person’s own culture and that there are no universal accepted norms and values” (Ritter, 2015, p. 125). It is believed that there are no norms and values that are accepted universally by everyone in the world. For example, in the U. S., we treat dogs as pets, sometimes even as beloved members of our families. How can we possibly judge another culture that views dogs as food for a starving people?

The benefit of cultural relativism is that it shows respect for other cultures. Because other cultures are honored, it serves to support and preserve those cultures. For example, for Christians, Sunday is generally considered a day of rest. However, for Jews, Friday at sundown through Saturday is considered a day of rest. One is not “better” than another – they are just different. A weakness of cultural relativism is that any behavior, no matter how negative, can be excused as being an accepted part of that culture. An example of a practice that can be assessed through cultural relativism is the mutilation of young women through female circumcision – a clitorrectomy, which is a partial or complete removal of the clitoris. In this instance, a cultural relativist point of view would have us accept and value a behavior that is harmful to other human beings.

Ethnocentrism is “The belief that one’s own group or culture – including its norms, values, customs, and so on – is superior to, or better than, others” (Ritter, 2015, p. 125). In other words, we measure the rightness or wrongness of another culture against our own as if it were the gold standard. A less dramatic definition, and probably more common, is that we make assumptions that certain phenomena affect other groups in the same way they affect the dominant group. For example, most people are heterosexual. We can therefore extrapolate that the majority of mental health professionals are also heterosexual. Yet that isn’t truly the experience of every client we might see, and psychosocial assessments are often done with the assumption that the person is heterosexual without us thinking to ask. It shows an inability to look outside our own personal experience. Another weakness of ethnocentrism is that it isolates us from people who are different, causing us to miss out on new experiences. This isolation can, in turn, make it difficult for groups to assimilate with the dominant group, reinforcing the walls between us.

Differing Cultural Beliefs in Practice . . .

A couple from Denmark visited New York City with their infant. The parents, Annette Sorensen and Xavier Wardlaw left their 14-month-old daughter, Liv, sleeping in a stroller outside a New York City restaurant, placed among tables in an outside eating area. The parents watched the baby six feet away, through a plate glass window. Patrons of the restaurant were horrified, and believing the child to be neglected, they called the police, who arrested the parents and placed the

baby in foster care. In New York City, as in virtually all large U.S. cities, it is not generally considered safe to leave a child outside unattended and vulnerable to passersby (Tribune News Services, 1997).

The parents sought the assistance of the Danish consulate. They argued that there was a misunderstanding and they were practicing a behavior that was actually healthy for the child. It was reported that diners in Copenhagen routinely leave their babies outside restaurants because parents try to protect them from being exposed to noisy, smoke-filled restaurants. Parents in Denmark value their children being able to nap in fresh air.

After investigating the incident, the New York Administration for Children’s Services concluded that there was no abuse or neglect. They withdrew the neglect petition and requested that the child be returned to the mother.

Reflection

Knowing what you know now about the practice in Denmark of leaving children in their strollers outside restaurants while the parents are inside, do you think the Danish couple was abusive or neglectful of their young child? Did they show bad judgment by leaving their child outside the restaurant in a stroller? Or did they show good judgment by letting their child nap in the fresh air? On what do you base your opinion? Do you think your opinion reflects cultural relativism, or does it reflect ethnocentrism? Would your opinion change if you went to Denmark and took your young child into a restaurant and were accused of child neglect by exposing him to a smoke-filled room? Should your child be placed into foster care? Not all behaviors are inherently right or wrong. Sometimes their “rightness” or “wrongness” just depends upon what our cultural beliefs are.

review question...

The following question will be a review of the content from this section. The question will **NOT** be graded. The answer to the review question can be found below.

- 1. A weakness of an ethnocentric position is that**
 - a. we measure the culture of others against our own as if ours was the gold standard.
 - b. it promotes an “anything goes” approach that condones harmful behavior
 - c. it supports and nurtures the other culture’s norms, traditions, and beliefs.
 - d. It encourages a “color blind” attitude where everyone is treated equally.

Review Question Answer:
1. a

Building Cultural Competence

NASW has established the following 10 standards for cultural competence of social workers and indicators that show if we meet those standards (2015):

Standard 1: Recognize that cultural competence is necessary for competent, effective, and ethical practice.

Understand the ethical requirements of social workers and follow them. Realize that cultural humility is like a fulcrum that balances client self-determination and the social worker's self-awareness. Social justice and human rights are the foundation of the social work profession, and present-day social workers are expected to maintain a commitment to those ideals. Social workers need to be able to negotiate the sometimes conflicting values of other cultures and the personal values of the social worker and of the profession and to respect the differences. We serve populations that have been disenfranchised from society, had their social, economic, and personal needs neglected, and yet must reconcile that with being a participant in that society that has perpetuated that. Finally, social workers must be able to effectively manage ethical dilemmas related to boundaries, conflicts in values, power and privilege, norms and deviance from those norms, different advocacy styles, different beliefs, and dual relationships (NASW, 2015)

Standard 2: Develop awareness of your own privilege, power, oppression, or disenfranchisement and how this affects your work with clients who come from similar and dissimilar backgrounds.

Recognize, reflect, and describe their own cultural background to appreciate their heritage of assumptions, values, beliefs, stereotypes, and biases. All of these things have the potential to interfere with interactions with clients. Social workers cannot mediate the effect of these factors without being able to acknowledge and process them. Through thoughtful self-reflection, understand how fears and biases related to race, sex, ethnicity, sexual orientation, age, disability, and social class exert influence over personal attitudes, cognitive processes, and emotions and that to change those things, social workers must develop intentional strategies to do so. Social workers are human beings, and as such, they have personal and professional limitations, just like everybody else. When confronted by those limitations, social workers should use the process of referral to make sure the needs of clients are met. Through a continual process of deepening self-awareness and challenging biases, social workers develop increased comfort with issues of diversity and difference. (NASW, 2015).

Standard 3: Increase knowledge of the history, traditions, values, family systems, artistic expressions, etc. of other cultural groups.

Expand the breadth and depth of their cultural knowledge by learning about other cultures, relevant social policies, and community resources. Social workers learn about the historical experiences of client groups,

immigration experiences, adjustment to resettling, their socioeconomic levels, and life events. We are savvy about power dynamics between clients and community systems and how privilege is manifested. We understand how clients interact with U.S., global, social, cultural, and political systems. When using theories and practice models, we identify their limitations with cultural groups and the limits of their applicability. We realize that different groups may share a lot of similarities, while individuals within any one particular group may demonstrate great differences. We recognize that people experience discrimination based upon the intersection of their identification of more than one group, such as a lesbian who is a person of color and also has a disability. This person must cope with the prejudices against four different groups: gender, sexual orientation, race, and disability (NASW, 2015).

Standard 4: Learn skills for working with diverse groups within micro, mezzo, and macro contexts.

Work with individuals and groups who have multiple identities in multiple contexts. Openly discuss difference with clients, be curious about their experiences and be willing to learn about them. Assess clients within a cultural context and respond to cultural bias, rather than ignoring it. Use interview skills that attend to diverse languages and non-verbal communication of different cultures. Use interpreters as appropriate but be sensitive to the challenges they pose to issues such as trust, relationship building, confidentiality, client privacy, and status within the community. Engage in assessments and interventions that are culturally sensitive, appropriate, and empowering. Use clients' natural support systems whenever possible (NASW, 2015).

Standard 5: Know the services, resources, and agencies available in the community that are culturally appropriate and sensitive to the needs of diverse groups.

Locate formal and informal culturally sensitive resources in the community and refer clients as appropriate. When such services are lacking or inadequate, advocate for culturally sensitive resources and program. Clients are major stakeholders, and they should be included in decision making and evaluation of service delivery systems. Hire staff who reflect the population to be served (NASW, 2015).

Standard 6: Commit to practices that empower marginalized and oppressed groups and provide advocacy whenever necessary.

Advocate for social policies that address social justice issues and respect the strengths and the rich cultural values of diverse client groups. Challenge and intervene with colleagues, community partners, and public representatives when necessary to raise their awareness of language, actions, or policies that are oppressive or culturally insensitive. Help clients find their own personal power as it is consistent with their culture. Support groups who represent and who are advocating

for their own disenfranchised members. Partner with client stakeholders to engage in advocacy. Resist the unconscious impulse to allow personal values to dominate those of the clients.

Standard 7: Support the efforts of organizations and agencies to develop, support, and maintain a diverse workforce.

Support and advocate for policies in your own organizations that value a diverse workforce. Strive for a workforce that mirrors the demographic makeup of the community it serves. Recommend that colleagues who bring specialized skills related to diverse groups, are appropriately compensated. Engage in strategies for the recruitment, promotion, and advancement of social workers who reflect a diverse profession. Advocate that all staff continuously work to improve their own cultural knowledge and sensitivity (NASW, 2015).

Standard 8: Understand cultural competence as a lifelong journey, rather than a destination.

Make cultural competence a part of the expectation of ongoing professional development. Integrate cultural diversity within the social work curricula at all educational levels. Engage in research that enhances culturally competent practice skills. Educate staff about cross cultural skills that will help them manage and resolve conflicts with each other and with clients (NASW, 2015).

Standard 9: Communicate in ways that are understandable to all people, including those who may not understand English, who may be unfamiliar with certain communication styles, who have poor vision or are unable to read, who are deaf, or who have other disabilities that affect their abilities to give or receive messages accurately.

Recognize language as a part of people's social identity and advocate for them to receive services and resources in their preferred language. Avoid the use of professional jargon. Use nonverbal methods of communication, such as pictures and symbols, with clients who have limited literacy skills. Advocate for reasonable accommodations to be made for people who need interpreters and assistive devices. Improve your own ability to communicate with clients in their own languages (NASW, 2015).

Standard 10: Lead agency or community efforts to advance cultural competence and build inclusiveness.

Promote culturally competent practice through work with professional activities, committee work, scholarship, and research. Engage the assistance and support of colleagues, and develop the confidence required to serve in roles where you can make a difference (NASW, 2015)

In Practice, Cultural Competence Requires an Understanding of Context . . .

I knew a woman once who never disagreed with me. Ever. Even if over the smallest thing. I should also add that I was her supervisor. You might think that it's kind of nice to have someone agree with you all the time. After all, it does eliminate conflict. But it's not nice at all because it's false. And it doesn't really eliminate conflict; it masks it. She was an African American woman brought up in the hills of Tennessee. I never saw her without a smile. I always sensed that she didn't feel comfortable enough with me to disagree, and it took some time for us to get there. I didn't think it had anything to do with race (as most White people would think) until I noticed her acting differently with other African American staff, one of whom was also a supervisor. I often wondered but never asked her about why it took her so long to feel comfortable with me. I'm pretty sure it wasn't because I was a tyrant! A person's life story is created by their experiences with discrimination or fairness, by oppression or privilege, by marginalization or inclusion, a community of safety or of danger. A person cannot be truly known and understood without an understanding of the context of his or her life.

Reflection

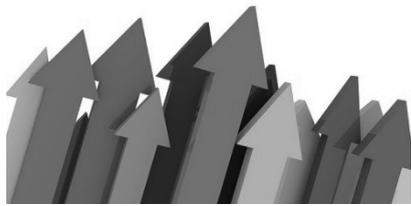
You may have heard someone say to you, "I am color-blind when it comes to race. Everyone is the same to me. I don't treat anyone any differently." What do you think the person means by saying he or she is "color-blind"? What are the pros and cons of this type of orientation? How does an orientation of being "color-blind" keep us from seeing and understanding White privilege? How might being color-blind hinder you on your journey toward cultural competence?

review question...

The following question will be a review of the content from this section. The question will NOT be graded. The answer to the review question can be found below.

1. NASW believes that cultural competence is necessary for competent, effective, and ethical practice?
 - a. True
 - b. False

Review Question Answer:
1. a



Strategies for Becoming More Culturally Competent

- Learn more about your own culture. Sometimes it's "hard to see the forest for the trees" and it's hardest to see something when you're standing in the middle of it. It's easy to make assumptions that the way we believe is "the right way."
- Increase self-awareness. Become more sensitive to your internalized beliefs. Connect those emotional responses to beliefs that have been hiding from you.
- Expand your cultural knowledge about help-seeking behaviors, historical context, communication style, beliefs about wellness and illness, family roles and childrearing practices, relationship of the group to social service agencies, and services that can be mobilized (NASW, 2015).
- Ask questions and engage clients as experts of their own experiences. Just as there is diversity across groups, there is diversity within groups. Not everyone within a particular group shares all of the same cultural experiences. The best way to get to know your clients is to ask them about themselves.
- Increase your exposure to people who are dissimilar to you. In other words, move outside of your comfort zone and put yourself in situations where you will encounter diversity in some way. Step out of the boundaries of your "in" group.
- Be curious about the world. This is kind of the opposite of the first one, which was learning more about your culture. It means learn about cultures outside of your own and avoid the assumption that everyone sees and experiences the world in the same way that you do. For example, you may believe that infants should not sleep in their parents' bed and can think of all sorts of reasons why this is a bad idea, but you find out that some cultures place high value on what they call "the family bed."
- Develop resources and partnerships. Be active in your community. Network with others. Consider social media applications such as Facebook, Twitter and LinkedIn to stay up-to-date on current services, policies, and learning opportunities.

Attitudes toward Cultural Differences in Practice . . .

As I mentioned previously, the problem with using the term 'cultural competence' is that it implies an endpoint, but in reality, cultural competence is a quest that should never end. We should never stop being learners and engaging clients as experts of their own experiences. Cultural competence is not a spectator sport and sometimes it requires intentional acts to move away from your comfort zone. There are ways to learn about other cultures, but the thing that has worked best for me is maintaining the belief that I don't know it all and always strive to learn more about people. I can offer some specific strategies, but you need to find the best fit for you.

Reflection

Think of an aspect of diversity that you would like to know more about. What would you like to know? How could you find out the answer? Would you be embarrassed to ask someone? Why or why not? Make a commitment to learn one new thing this week about a group that is different from you. How will this contribute to cultural competence?

review question...

The following question will be a review of the content from this section. The question will NOT be graded. The answer to the review question can be found below.

1. **How can you develop your relationships with diverse groups within the community?**
 - a. Use social media applications such as Twitter or LinkedIn to network with others.
 - b. Read about new community events in the local newspaper.
 - c. Look for continuing education about certain groups.
 - d. Wait for a good opportunity to meet new people.

Review Question Answer:
1. a

How Do We Learn About Each Other?

We can look to symbolic interactionism as a theory that can frame our understanding of how we experience diversity. Symbolic interactionism is a sociological theory that sprang from the early work of Charles Cooley around the turn of the last century and George Herbert Mead in the early 20th century. Cooley proposed the idea of "the looking glass self." He believed that we use social exchanges to see ourselves as others do, resulting in the development of our self-concept. This concept is dynamic and changes as we continually interact with others who validate us, criticize us, or are indifferent to us. Mead also wanted to better understand our

social world. To do so, he felt we should focus on the interactions between people and how those interactions change and shape not just our understanding of ourselves, but of each other.

We make meaning of things through the use of symbols. These symbols signify ideas, and they may be images, or even language. We use these symbols through every-day social interactions, and through this process, we make meaning of the world. Human behavior, in turn, is based upon the meaning we make. For example, when we see a particular symbol, we know through our experience whether that signifies a good thing or a bad thing or what kind of meaning is otherwise attached to it. There are three main principles to symbolic interactionism:

First, people acquire meanings through social interactions. For example, we go to grocery store and see a person at the checkout counter. We assume that this person is an employee of the store. How do we know that? Through our history of social interactions and experiences, we come to understand the role of the person at the checkout counter. We don't necessarily ask the person in line with us about the price of this item, because that isn't his or her role. But we might ask the checkout person because of our understanding of that person's role. It reminds me of when my daughter was little – about 4- or 5-years-old. We were at the grocery store paying for our groceries and at the checkout and there was a person who was bagging groceries. My daughter started to talk to him. Although there was no immediate danger, when we got out of the store, I reminded her not to talk to strangers, and I defined a stranger as someone mommy doesn't know. She said "We know him." I said, "We do? How do we know him?" And she gestured to her shirt pocket and said "He has a name tag right here." That was how she made meaning of it of our relationship to this person I'd never met before – if someone had a name tag, it made them look official and made it okay to talk to them.

The second principle is that not only do we make meaning through social interactions, but we act as a result of how we interpret those meanings. Symbolic meanings influence our emotions, our behavior, and our social interactions. We behave based on what we believe, not necessarily based on what is objectively true. For example, I know a person who believes that seatbelts do not increase safety in the car. She would argue that there is no proof that seatbelts make anybody any safer than anybody else, in spite of the evidence that supports the use of seatbelts and their ability to help people survive crashes. She acts based on what she believes, not based on what is objectively true.

The third principle is that this meaning-making is a dynamic, ongoing process. Meanings are not set in stone. They differ based on context and they change over time. For example, if you were to look at a picture of a Christian cross, I would suggest that most people in the Western world have a positive or neutral association with that symbol. But a lot of people who practice Islam

don't see a Christian cross as a positive symbol. Their history goes back to the Christian crusades, which associates this symbol with violence. So that's how it differs in context.

Meaning-making changes over time, too. Smoking cigarettes used to be considered cool. For example, anyone who has ever watched the television show *Mad Men* can testify as to how much smoking and drinking there is. They smoke in every situation, whether it's at work, at home, attending their kids' school events, etc. This was the era of the Marlboro Man – a symbol to associate smoking with being rugged, tough, and macho. Soon after, Virginia Slims entered the picture. They were cigarettes marketed specifically to women, and they had a jingle that associated smoking with a modern, independent woman who was exercising her right to smoke. What would you think about smoking today? Most people would probably say it isn't cool at all. And most people who I know don't say they smoke to look cool – they say they just smoke because they are addicted. Today we associate smoking with being unhealthy. The meaning of cigarettes and smoking has changed over time.

Words are symbols, as well. Think about the way that you can say hello in different languages: *hola*, *bonjour*, *ciao*. These words are just different letters put together to express the essentially the same concept. If I say the word *thongs*, what do you think of? Those letters are put together to represent what concept? Most people today would answer *underwear*. But thongs used to be the name for flip flops, a type of shoe. The symbol has changed over time.

Symbols of beauty have changed over the last 50 years or 100 years, such as the concept of what is beautiful, preferred body shapes of women, weight, and sizes. We used to associate a larger body size with health and economic security – 100 years ago it was considered a sign that you could afford to feed yourself if you had substantial body weight –. Nowadays, Western culture associates thinness with health and beauty.

review question...

The following question will be a review of the content from this section. The question will NOT be graded. The answer to the review question can be found below.

1. According to symbolic interactionism, what is the main way we make sense of each other and the world?
 - a. through social interactions
 - b. through knowledge of stereotypes
 - c. through continuing education
 - d. through marketing campaigns

Review Question Answer:
1. a

Using Language as a Symbol

The words we use to describe people affect how we think about them and consequently, how we act toward them. Being aware of language can help us modify our thoughts about a particular group. For example, when we refer to someone by a particular disability such as “schizophrenics” our brains tend to associate that language (think symbol!) with the person, sometimes to the exclusion of other parts of his or her identity. It should be no surprise that there are other things that contribute to identity. Remember that idea of intersectionality? It is the experience of our association with multiple groups. That person has a number of possible social roles, such as son, husband, painter, confidante, employee, or scientist. In addition, the person’s schizophrenic symptoms may change, sometimes playing a dominant role and sometimes being so well managed as to be barely perceptible. By using the term schizophrenic as a noun (i.e., a schizophrenic), we have a tendency to think about the person primarily in terms of this label. By using person first language (person with schizophrenia), we shape our thinking about the person as being a human being first, who happens to also have an illness, but this is not his or her primary identity. We want to honor people’s humanity.

There is a growing movement to reject person-first language, especially by the deaf community and some people in the disability community. These folks embrace the very opposite of person- first language. For example, most people who are deaf prefer that term, not “people with a hearing impairment.” Some people with autism prefer the term autistic to describe who they are. Why? For the very reason others prefer person-first language. Using a term such as autistic person helps us think about that person as if autism was a part of his or her identity, and in some cases, it is. Some will argue that their disability or difference is a major part of their identity. It is an important and valued part of who they are. To say “a person with autism” is separate that person from his or her very identity.

But wait! Isn’t this nothing more than political correctness? First, let’s think about what political correctness actually means. Political correctness has come to be a derogatory term. Its implementation is resented as a prohibition of the right of people to express themselves in any way they wish, restraining freedom of speech, even to the point of being ridiculous (Baa Baa Black Sheep versus Baa Baa Rainbow Sheep [Blair, 2006]). It is typically used as a label by conservatives as a criticism of liberal views. However, the concept of *conservative* correctness has also been introduced, in which language is equally constrained by those on the political right in a way that makes it more difficult to challenge social order (e.g., using *right to life* versus *anti-abortion*). Thus, the concept of political correctness is actually a tactic to criticize and influence a political agenda. Using person-first language is not a manifestation of political

correctness because it is a sincere effort to respect and value people who are different or marginalized in some way. So, how do you know if you should person-first language or identity-first language? Ask. Part of cultural competence is communicating to people that you value their difference, honor their life experiences, and respect who they are as people. Asking people how they want to be referred is empowering and respectful. It puts the client first, challenges social injustice through empowerment, respects the dignity and worth of the person, and contributes to the development of human relationships – all important values in social work.

review questions...

The following questions will be a review of the content from this section. The questions will **NOT** be graded. The answer to the review questions can be found below.

- 1. What is the argument in favor of person-first language?**
 - a. Our brains have a tendency to associate language with how we feel about the person
 - b. It’s important to speak in a politically correct fashion.
 - c. Using this style strips the person of their identity.
 - d. Language is symbolic, and therefore has no true meaning.
- 2. Why do deaf people generally want to be referred to as deaf, and not a person with deafness?**
 - a. They value being deaf as part of their identity.
 - b. They don’t realize how stigmatizing it is.
 - c. They just want to be distinguished from other disabilities.
 - d. All of the above.

1. a
Review Question Answer:

Summary

We have discussed the many dimensions of diversity, such as age, class, culture, disability, ethnicity, etc. People are not unidimensional beings and do not claim just one category of identity. The identity categories are linked together and interrelated in a way that is necessary for us to understand others: a term known as intersectionality. The topic of cultural diversity is an important one to social workers because our work often focuses on people who are not in the dominant culture group, who do not claim social privilege that is enjoyed by others, and who are often oppressed and marginalized.

As we discussed the different types of diversity, you hopefully increased your knowledge and may also

have realized personal biases that you that you weren't previously aware of. It's important to recognize and identify personal values in order to minimize their influence on the relationships you have with people who are different from you. Recall some of the strategies you read about to help you challenge unconscious biases.

You read about the history, characteristics, behaviors, family dynamics, and health and/or mental health of many different groups of people. I caution you to consider these as the generalizations they are, to use them to inform your practice and your approach with different groups, but to also be sensitive to the very real possibility of individual differences *within* the same cultural groups.

Finally, you learned about the skills that contribute to cultural competence, and you identified strategies that can contribute to your own growth of cultural competence. You have some tools to help you improve your ability to be culturally sensitive throughout the process of becoming culturally competent.

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Resources

Blackfeet Nation

This site provides information about the culture of the Blackfeet people from the Rocky Mountain region; their Constitution, treaties, and courts; a tribal directory of businesses and frequently used forms; and the Water Compact and Settlement Act. It also provides information about the fight to protect the Badger-Two Medicine region from oil and gas drilling.

<http://blackfeetnation.com/>

Cherokee Nation

This site provides information about the tribe's government, as well its culture, history, language, maps, national holidays, and national treasures. It also has video recordings of tribal council meeting and various committee meetings. It highlights the latest news about accessing education, housing, and employment; a \$100 million healthcare initiative; and a new hunting and fishing program.

<http://www.cherokee.org/>

<https://www.facebook.com/TheCherokeeNation>

The Chickasaw Nation

This site has information about programs and services, events, facilities, history, and culture of the Chickasaw Nation. You can find the Chickasaw Constitution and Chickasaw Code. Information about culture includes arts, foods, housing, language, religion, and society. There is also information about their history, including their first encounters with Europeans, the "Great Removal" and relocation to Indian Territory, and Eula "Pearl" Carter Scott, the first Chickasaw aviator.

<https://www.chickasaw.net/>

<https://www.facebook.com/TheChickasawNation>

Dimensions of Culture

This site provides cross-cultural educational materials and resources for health care professionals. They also provide trainings for healthcare professionals. They have articles about different cultural groups. Some titles include African American Culture, African Cultures, Asian Cultures, Latino Cultures, and Middle Eastern Cultures. They address different cultural beliefs about healthcare and cross-cultural communication.

<http://www.dimensionsofculture.com>

Disability Rights Advocacy (DRA)

The DRA is a nonprofit, disability rights legal center. Its mission is "to advance equal rights and opportunity for people with all types of disabilities nationwide . . . it uses litigation, structured negotiations, advocacy, community education, and media to reform systems and practices that discriminate against people with disabilities."

<http://dralegal.org/>

<https://www.facebook.com/dralegal>

Health & Disability Advocates (HDA)

HDA represents itself as a "social innovator" that works with low income families, older adults, people with disabilities, and veterans to promote their health and economic security. They provide trainings about topics such as the Affordable Care Act and its impact on Vocational Rehabilitation, Military Sexual Trauma, and Children with Disabilities. They coordinate the services of other agencies, they advocate for vulnerable groups to identify and eliminate barriers to self-sufficiency. They also provide technical assistance to expand health care eligibility and access.

<http://www.hdadvocates.org/>

<https://www.facebook.com/HealthAndDisabilityAdvocates>

His/Her Name is Today

This site, maintained by the University of Southern Florida. It provides information about Hispanic/Latino families, religion, language, and culture. It is specifically for educators,

but would be of benefit to anyone wanting to understand Hispanic/Latino characteristics and contributions.

www.coedu.usf.edu/zalaquett/hoy/culture.html

International Museum of Muslim Culture

The International Museum of Muslim Cultures was created to educate the public about the history of Islam and contributions made to the world's civilization by Muslims. It is located in Jackson, Mississippi. It claims to be "a pioneer in sharing the beauty and majesty of the world's Muslim cultures." It also offers a Traveling Exhibition Program.

<http://www.muslimmuseum.org/>

<https://www.facebook.com/muslimmuseum>

Laurent Clerc National Deaf Education Center at Gallaudet University

This organization provides information about deaf culture, including literacy, family resources, and multicultural considerations. It discusses the values, behaviors, language and traditions of deaf culture

<https://www.gallaudet.edu/clerc-center/info-to-go/deaf-culture/laurent-clerc.html> <https://www.facebook.com/DepartmentOfEducationGallaudetUniversity/?ref=ts&fref=ts>

National Center for Learning Disabilities (NCLD)

The mission of NCLD is "to improve the lives of the 1 in 5 children and adults nationwide with learning and attention issues – by empowering parents and young adults, transforming schools and advocating for equal rights and opportunities." A number of programs are indicated on their website: For parents, they provide an online resource called Understood, that offers personalized support and daily access to experts. For young adults, a program called Friends of Quinn is an online community that provides support for young adults with learning disabilities. For professionals, a program called LD Navigator is a guide about learning and attention issues for pediatricians and pediatric nurse practitioners. For educators, the organization offers a program called Get Ready to Read! is a collection of tools for helping learners develop literacy skills and a site called RTI Action Network, that offers help to implement learning programs. <http://www.nclid.org/>

<https://www.facebook.com/NCLD.org>

National Disability Rights Network (NDRN)

The NDRN is a nonprofit, voluntary membership association for Protection and Advocacy (P & A) agencies and Client Assistance Programs (CAP). P & A agencies provide legal and advocacy services to people with disabilities, so that they have full access to educational programs, financial entitlements, health care, housing, and employment. CAP agencies help people who are seeking vocational rehabilitation services under the Rehabilitation Act. <http://>

www.ndrn.org/index.php

<https://www.facebook.com/pages/The-National-Disability-Rights-Network/109074605801200>

National Museum of African American History and Culture.

"The National Museum of African American History and Culture is the only national museum devoted exclusively to the documentation of African American life, history, and culture. It was established by Act of Congress in 2003, following decades of efforts to promote and highlight the contributions of African Americans. To date, the Museum has collected more than 36,000 artifacts and nearly 100,000 individuals have become charter members. The Museum opened to the public on September 24, 2016, as the 19th and newest museum of the Smithsonian Institution."

<https://nmaahc.si.edu/>

<https://www.facebook.com/NMAAHC>

Native Nations

This site provides links to the sites of more than 43 different Native American tribes. It has other links, as well, that provide information about the culture of various tribes.

<http://www.ewebtribe.com/NACulture/nations.htm>

Pew Research Center: Hispanic Trends

The Pew Research Center is a "nonpartisan fact tank that informs the public about the issues, attitudes and trends shaping America and the world." It reports on public opinion polling related to U. S. politics, social trends, religion, technology, and science. It does demographic research, analyzes media content, and conducts social science research. Pew Research Center Hispanic Trends offers publications, interactives, data and resources, and expert commentary by Hispanics.

<http://www.pewhispanic.org>

Teaching Tolerance

Teaching Tolerance is a magazine of the Southern Poverty Law Center. In the essay, The Question of Class, the author challenges educators to think beyond a one-dimensional understanding of a culture of poverty and reflect on their own classist beliefs. www.tolerance.org/magazine/number-31-spring-2007/feature/question-class

World Professional Association for Transgender Health (WPATH)

Their mission is "to promote evidence based care, education, research, advocacy, public policy, and respect in transgender health."

http://www.wpath.org/site_home.cfm

PARTICIPANT TRAINING EVALUATION

Course Title: Advancing Cultural Sensitivity in Social Work

Date:

Sponsored By:

Student Name (Optional)

To the participant:

Please complete the following evaluation at the conclusion of the program. Your comments are necessary to assist us in offering the best continuing education programs possible in the future.

Use the following rating scale: 5 – strongly agree, 4 – agree, 3 – neither agree nor disagree, 2 – disagree, 1 – disagree strongly
Circle N/A if the topic is not applicable to you.

Program Content

Topic	Rating						Comment:
The stated goals and objectives of the course were met	5	4	3	2	1	N/A	
The topics were covered in sufficient detail	5	4	3	2	1	N/A	
The topics covered in this course will improve my social work practice	5	4	3	2	1	N/A	
Content was well-organized and informative	5	4	3	2	1	N/A	

Instruction/Final Exam

Orientation was thorough and clear	5	4	3	2	1	N/A	
Completion requirements were clearly stated	5	4	3	2	1	N/A	
Exam assessed stated learning objectives	5	4	3	2	1	N/A	
Exam was graded promptly	5	4	3	2	1	N/A	
The course presentation style was effective	5	4	3	2	1	N/A	

COURSE MATERIALS/CUSTOMER SERVICE

Satisfied with format of the course	5	4	3	2	1	N/A	
Satisfied with overall learning experience	5	4	3	2	1	N/A	
Sponsor was well organized and responsive to participant needs (customer service, registration, certificates, etc.)	5	4	3	2	1	N/A	
I would recommend this course to others	5	4	3	2	1	N/A	