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Cultural Competency: Values, Traditions and Effective Practice

2009 Edition

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Course ID code: CUC09

Suggested CDR Learning Codes: 1040, 1060, 6000, 6070

Level I

See Continuing Education credit information on page 14

Learning Objectives

At the conclusion of this course, the student will be able to:

1. Define “cultural competency” and explain why it is important.
2. Define “diversity” and “multiculturalism” and explain the difference.
3. List, define and discuss the 6 steps of the Cultural Competency Continuum.
4. Define the concepts “stereotyping” and “intra-ethnic variation.”
5. Explain these components of the dominant US cultural paradigm: right to privacy, right to know, self-determination, future orientation, monochronism. Show how they differ from our cultures.
6. Explain why cultural values, more than income or race, can determine the quality of healthcare an individual receives.
7. Explain how regulations and standardization can reduce effectiveness of health care and nutrition protocols when dealing with minority cultures.

In the midst of a seemingly homogenous world culture, created by mass media, global commerce, and easy travel, many find life increasingly complex. The more choices we have, the more separated we are from our cultural roots. Yet, paradoxically, we seek new experiences, while trying to find “comfort zones” of familiar places and things. The lure of a new “ethnic” restaurant, and a yen for traditional or “heirloom” foods, combine to make the American diet evermore diverse. We eat traditional or “culturally authentic” meals that our great-grandfathers wouldn’t even have known about.

In response to the increase in diet diversity, nutrition and health professionals are asking, “Are traditional cultural meals healthful, or at least compatible with modern dietary goals?” Often it is lack of knowledge about unusual or authentic foods that makes providing effective nutrition education and counseling difficult. However, to understand authentic cultural foods, one must understand the culture behind it. This course will explore the differences between Anglo-American culture and traditional cultures.

To your professional goal of “core competency” — understanding and applying nutrition science and dietetic standards of practice — add “cultural competency.” The purpose of this course is to educate and motivate you to take steps toward developing cultural sensitivity and competency. Diversity affects everyone, whether you are an employee or an employer, regardless of your specialty. Seeking out opportunities to develop culturally competent skills will take you to new heights professionally and personally. In this article, we’ll explore what that means, and how to achieve it.

The dictionary defines culture as “. . . the integrated pattern of human knowledge, belief, and behavior that depends upon man’s capacity for learning and transmitting knowledge to succeeding generations” (Merriam-Webster Dictionary). Culture is not something one inherits biologically. It encompasses more than simple race or ethnicity — a word used to describe large groups of people classed according to common racial, national, tribal, religious, linguistic, or cultural origin or background (Merriam-Webster Dictionary). Culture is learned and passed on from one generation to the next through enculturation, the repetitious and systematic inculcation of a shared system of values, beliefs, attitudes, and learned behaviors (Kittler, 2001; Pauly, 2003). These include dress, family structure, language, and food habits.

“Diversity” — today’s fashionable term that can stimulate both positive and negative thoughts and attitudes— means dissimilarity and variance between things or people. Cultural diversity is the recognition that people come from a variety of ethnic, geographic, economic, and religious backgrounds (Merriam-Webster Dictionary; Kittler, 2001; Pauly, 2003).

Melting Pot or Salad Bowl?

Currently about 25 percent of the US population consists of ethnic subpopulations. According to the Census 2000, 284 million people live in the US; 75 percent are white alone, or in combination with another race, and non-Latino; 13 percent are Latino or Hispanic; and 12 percent African American (Census 2000).

The census data on race and ethnic origins are more detailed for 2000 than for 1990. The categories used in 2000 included white, black or African American, American Indian and Alaska Native, Asian, Native Hawaiian and other Pacific Islander, and “some other ‘race.’” Within each of these categories were many subgroups (Census 2000).

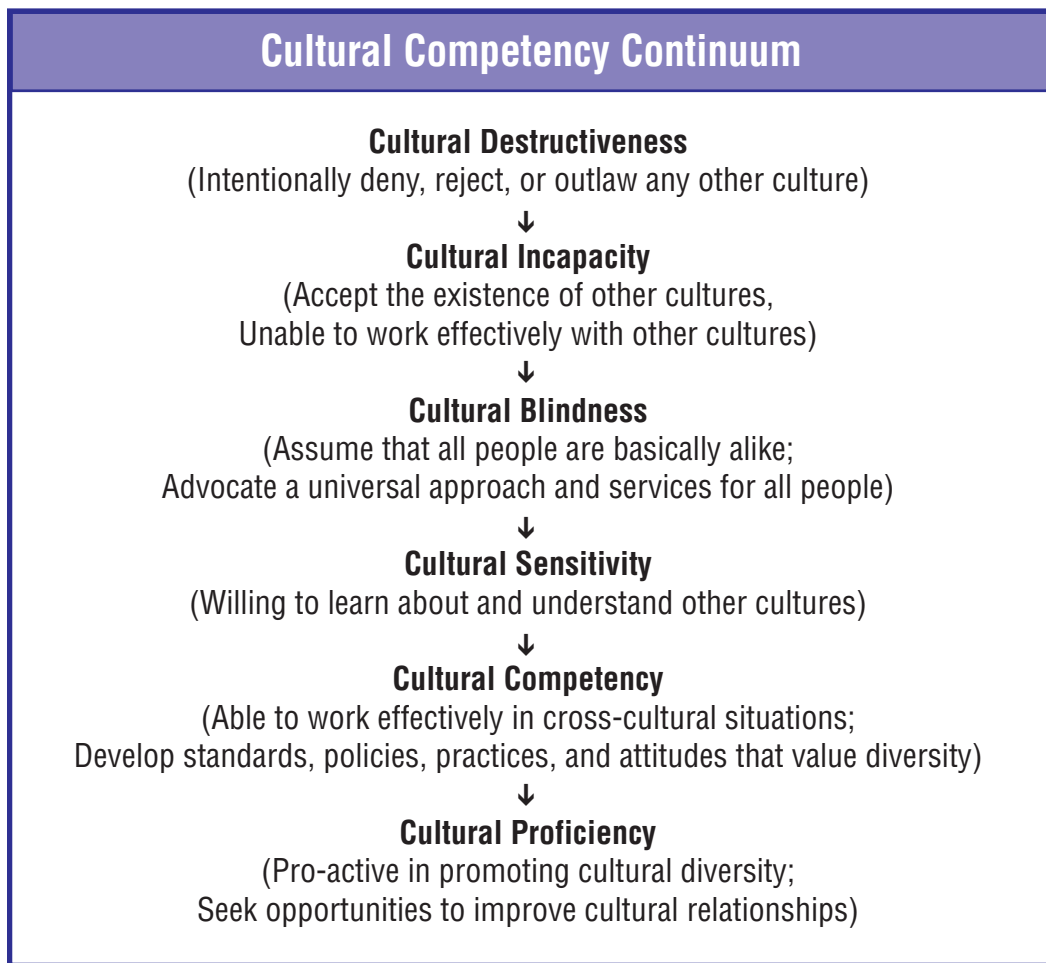
This reflects the increased diversity of the US population. The percentage of ethnic subpopulation groups is expected to increase to approximately 47.5 percent by 2050; Latinos will be the largest minority group by 2050. Non-Hispanic whites will most likely be a minority group by 2065 (Lavizzo-Mourey, 1996; Tripp-Reimer, *et al.*, 1999). There is great diversity within these ethnic subpopulations as well (National Center for Cultural Competence), and a “melting pot” effect, wherein younger generations move away from some, but not all, defining characteristics of their ancestral cultures. The increasing diversity of the US population affects us all, especially as employees or employers. The American work force looks very different than it did 10 years ago; in 10 years it will look very different from today.

Not only is there more diversity in the work force, prospective clients and customers (patients) are also more diverse. Multicultural marketing, a relatively new development, will most likely become “mainstream” marketing practice.

Developing Cultural Competency

It is not enough to simply recognize and accept cultural diversity. Cultural competency, especially in healthcare, is the ability to understand and respond effectively to the cultural and linguistic needs of patients or clients. Implied is the acceptance and tolerance of different backgrounds and their associated traits, beliefs, etc., and absence of prejudice against unfamiliar cultures. “Multicultural” is a term often used to describe an organization which promotes an environment free of discrimination and promotes policies, processes, and procedures that recognize and value cultural diversity (National Center for Cultural Competence, 1999).

The development of cultural competency is a process that occurs along a continuum. At one end of the continuum is cultural destructiveness and cultural proficiency is at the other end (National Center for Cultural Competence, 1999). The chart below illustrates and briefly explains the six proposed “stages” along this continuum (King, *et al.*, 2003; McLeod and Shantzis, 1992).



Cultural competency is about learning to value diversity and being open-minded about other cultures. A culturally competent professional recognizes and understands the differences in his or her culture and the culture of their patient or client. Cultural competency is reflected in a professional's attitude and communication style. Are you enthusiastic, cooperative, creative, and flexible in working with people from different cultures (Lavizzo-Mourey, 1996; *JADA*, 2002). The steps involved in developing personal cultural competency are (Univ of Michigan Health System, 2003):

- Recognize your own personal cultural biases and preconceived ideas/opinions;
- Desire to learn about and become involved with people from diverse cultures;
- Seek out and increase your knowledge about other cultures; and
- Learn and develop multicultural communication and counseling skills.

Developing cultural sensitivity is essential to developing cultural competency. Cultural sensitivity means recognizing subtle but important facets of another person's culture, and accepting their expression of their culture. People in minority population groups no longer feel compelled to emulate middle class Anglo-American culture (Curry, 2000); many desire to maintain their cultural uniqueness and individuality. In this way, the US population is currently more like a "salad bowl" than a "melting pot." A salad may contain many ingredients, and blend into a harmonious whole, but each ingredient retains its unique taste and texture (Kittler and Sucher, 2001; Curry, 2000). KR Curry, Professor Emeritus of Dietetics and Nutrition at Florida International University, has written:

In nutrition counseling, where many therapeutic interventions are on a personal level, sensitivity to the strong influence of culture on an individual's food intake, attitudes, and behaviors is especially imperative (Curry, 2000).

Stereotypes and Generalizations

Every person has a unique worldview, how they look at the universe, and their place in it, to form values, beliefs, and opinions about themselves and others (Pauly, 2003).

Cultural sensitivity has a pitfall: stereotyping. A stereotype is an assumption that *all* people in a particular group behave and think alike. Stereotypes are often judgmental and do not allow for individual differences — for this reason, a stereotype is an ending point (Galanti, 2000). An example of a dietetic stereotype is “All white southerners eat pork, have buttered grits for breakfast, and drink sugared tea.”

In contrast, generalizations refer to the trends or behaviors within a group, but with the knowledge that further information is needed to determine if the generalization applies to a particular person. A generalization is a starting point (Galanti, 2000). An example of a generalization-based question is asking a Jewish client “Do you follow traditional Jewish dietary laws?” This question would provide a starting point from which to work with this client — as opposed to assuming all Jewish clients follow traditional dietary laws.

Generalizations take into consideration the uniqueness, individuality, and distinctive characteristics of each person. “Intra-ethnic variation” refers to the individuality, racial, regional, and economic differences or diversity *within* each culture (Kittler and Sucher, 2001; Harwood, 1981). Just as individuals within a cultural group are unique, so are their diets. As dietary options proliferate, there will be more such variations.

Outcome Orientation

Culturally competent health care fosters more favorable clinical outcome, results in positive and rewarding interpersonal experiences, and promotes patient or client satisfaction. In order for health care to be successful, services must be received and accepted (National Center for Cultural Competence, 1999). While fairness and civility are laudable, the real benefit of cultural competency is improved outcomes.

Cultural competency helps ensure (National Center for Cultural Competence, 1999; Sindler, 2001): delivery of quality of health and nutrition services, effective communication, rewarding interpersonal experience, client or patient satisfaction, and better compliance with treatment plan, all of which leads to improved health outcomes.

Cultural competency is not an optional skill to learn, it is a necessity for all dietitians and health care professional, regardless of their specialty (Curry, 2000; Sindler, 2001). There is a need to effectively communicate and bring about desirable behavior changes in patients and clients, regardless of their cultural background. The goal of dietitians and other health care professionals is to promote positive behavior changes in their patients or clients (Curry, 2000; Gordon, 2001).

In fact, effectiveness is determined by evidence of behavior change in clients and patients. Indeed, health care providers are beginning to recognize that addressing the cultural uniqueness of their patients is essential to positive health outcomes (Preboth, 2000).

In order to ensure positive outcomes in working with patients or clients it is necessary to understand their culture, including their language, dietary habits, lifestyle, beliefs, and attitudes and values about health (Hall, 2001). Likewise, health professionals must be culturally competent in working with fellow health professionals from different cultures. Administrative dietitians and food service managers must be culturally competent in working with culturally diverse food service staff (National Center for Cultural Competence, 1999).

Common and Uncommon Ground

We all share some fundamental needs regarding our health. These fundamental needs include the need to tell about our illness or express our health concerns, the need to receive competent care, and perhaps most important of all, the need to be understood, acknowledged, and valued (Levi and Hawks, 1996) — we all need a social support system. In order to deliver culturally competent care, health care providers should understand: beliefs, values, traditions and practices of a person’s culture, family structure and the roles within the family in making decisions, health-related needs of individuals, families, and communities, cultural beliefs about health and the etiology of diseases, cultural beliefs about healing and disease treatments, and attitudes about seeking help from health care providers (National Center for Cultural Competence, 1999).

It is important to recognize and understand the dominant American cultural paradigm, which is derived largely from an Anglo-American heritage that has shaped our laws and administrative organization. Anglo-American culture places a high value on individualism, privacy, and personal responsibility and control. Emphasis is placed on the nuclear family, but what is best for an individual often takes priority over what may be best for the family as a whole. The family will sacrifice its economic well-being to finance care for a member. Extended family usually does not play a role in major decision-making (Kittler, 2001; Hall, 2001).

Though a “right to privacy” and confidentiality is prioritized, we value direct, open, and honest communication. Hiding unpleasant news about a health condition is unacceptable — we have a “right to know.” Informality is considered synonymous with friendliness. For example, it is common and acceptable in American culture to call someone, regardless of their age, by their first name upon first meeting them (Kittler, 2001; Hall, 2001).

Anglo-Americans are future-oriented, setting and working toward long-range goals. Immediate gratification is a low priority; there is a desire to work hard to provide a better future for our children. We are a task-oriented society, with a near-compulsion to always be *doing* something. Value is placed on promptness and “staying on schedule” (Kittler, 2001; Hall, 2001). Self-worth in American culture is often determined by a person’s accomplishments (Kittler, 2001; Hall, 2001). Self-esteem is often associated with physical appearance. Dietitians know that despite widespread obesity, there is an obsession with thinness (Sobal, 2001). Though overwhelmingly religious, we are largely self-determiners — “fate” is not an overwhelming force, but an opportunity.

The values of many traditional cultures are very different. Many traditional cultures believe, for instance, that fate, God or other supernatural factors determine a person’s destiny and directly influences their health. Personal relationships determine self-worth and take priority over time schedules — promptness is not a priority. Family almost always includes extended family, and the extended family participates in decision-making, especially regarding health care. There is a family hierarchy in many traditional cultures in which men are the head of the household, make decisions and speak for the women. The welfare of the family takes precedent over the welfare of the individual (Kittler, 2001; Hall, 2001).

Informality is associated with rudeness in certain cultures. For example, it would be better to call your client Juan Garcia, “Mr. Garcia” rather than “Juan” (Kittler, 2001; Hall, 2001). To Japanese, formality equals respect and politeness.

Many traditional cultures are *polychronistic*, which means people are comfortable doing many things at once — “multi-tasking” — but not at the expense of personal relationships. It is more important to be kind and courteous than to be punctual. For example, a Brazilian may be late for a doctor’s appointment because he does not want to cut short a visit with his aunt. While talking with his aunt he may also repair her stove, and at the same time watch a soccer game on TV. In contrast, most Anglo-Americans are *monochronistic*, which means they prefer to focus on and perform tasks in a sequential manner (Kittler, 2001; Hall, 2001). There is no pressure to constantly be busy *doing* because value is placed on just *being*. In Latin countries, siesta time follows lunch; in America people eat lunch at their desks (Kittler, 2001; Hall, 2001).

Other differences of note: traditional cultures give more power to one gender or another (women may be “the power behind the throne” or control finances, but the men are considered the head of the household and

women often must seek her husband's permission before making a decision. In traditional cultures plumpness is associated with good health, while thinness is considered unattractive. Cooperation is preferred to competition; tradition and continuity are valued over change (a reverence for the past takes precedence over efficiency of striving); idealism is stressed over practicality or expedience (Sobal, 2001; Cross-Cultural Counseling, 1983).

Healthcare Culture

The “culture” of healthcare in the US reflects Anglo-American values. The US healthcare system is complex, time oriented, focussed on disease management and treatment, and dedicated to preserving life at any cost. Conventional medical care is standard practice in the US (Kittler, 2001; Hall, 2001), although personal responsibility for prevention, and direct participation in treatment, may include alternative care. In contrast, people from traditional cultures often defer healthcare decisions to their healthcare provider. In traditional cultures, the role of the physician is to “take charge” or determine and direct their care. Beliefs about disease prevention, causes, and treatment vary from culture to culture. Folk, spiritual or psychic healing may be preferred and sought before conventional medical assistance (Kittler, 2001).

Health professionals should not assume the superiority of one set of values over another. It is important to know and understand the implications of these differences, particularly when it comes to decision-making. While we would normally address an Anglo American woman when giving family dietary instructions, this approach may be perceived as disrespectful by a Vietnamese family, and the results might be less than ideal.

In the US there are four historically under-represented people groups, African Americans, Native American/American Indians, Latinos, and Asian Americans/Pacific Islanders. In general, there is a higher incidence of certain cancers, cardiovascular disease, diabetes, obesity, and mortality in these population groups compared to non-Hispanic whites. African-Americans and Latin Americans have a higher incidence of HIV. In addition, the immunization and vaccination rates for childhood diseases are lower in these population groups (Pauly, 2003; National Center for Cultural Competence, 1999).

Racial and ethnic groups often receive lower quality healthcare regardless of their insurance coverage and socioeconomic status (Pauly, 2003, Healthy People 2010). The reasons are not completely understood, but a contributing factor is failure to deliver culturally competent care. The Asian father whose power and status have been eroded by a dietitian giving his wife instructions on cooking might forbid compliance or follow-up to avoid losing more “face.” Meeting with aunts, uncles and cousins of a Middle Eastern family may be more effective than giving one-on-one instruction. Shoving a handout with hurried instructions to “call if you have questions” might offend a Japanese — and make compliance tenuous.

A culturally competent and eclectic health care system would incorporate or accommodate all nuances of culture, including non-conventional healing practices. However, universal cultural competency is impossible due to the major intra-cultural differences, and the need to provide uniform modern care. Attempts to rationalize care in a diverse world pose great challenges.

Regulatory Dilemmas

Health care organizations and food and nutrition programs must comply with legislative, regulatory, and accreditation requirements or standards, including those designed to ensure the delivery of culturally competent services. The Joint Commission on the Accreditation of Healthcare Organizations and the National Committee for Quality Assurance, which accredits managed care organizations and behavioral health managed care organizations, advocate standards that require cultural and linguistic competence in health care (National Center for Cultural Competence, 1999) — and therein lies a challenge. Older Americans Act Nutrition Programs are being challenged to meet the needs of a variety of cultural groups, including African-Americans, Asian or Pacific Islanders, Hispanic or Latino, American Indians, and Eskimos.

At a minimum, institutional food services should include a variety of ethnic foods reflective of their client base, with flexibility for the “unusual” request. Offering familiar foods increases satisfaction and enjoyment; elderly clients, especially, are more likely to eat culturally familiar foods. Food service staff should be culturally sensitive and competent in order to deliver quality food and nutrition services (Reppas, *et al.*, 2001).

Nutrition counseling poses a greater challenge. The good news is that almost all cultures believe that a healthy diet plays a major role in maintaining good health and recognize that certain foods have “functional” or medicinal purposes (Kittler and Sucher, 2001).

Before recommending dietary or lifestyle changes, you must first have a clear understanding of the person’s dietary habits within the context of a person’s culture. Dietary changes or recommendations, if they are to be effective, should incorporate familiar cultural foods (Curry, 2000). The use of universal dietary recommendations is not practical or effective.

Fortunately, new information on the nutritional composition of many traditional foods is becoming available. A variety of tools, including the Asian Diet Pyramid, Mediterranean Diet Pyramid, Vegetarian Pyramid, and the Native American Food pyramid, have been developed. They can be found at the Food and Nutrition Information Center website (www.nal.usda.gov/fnic) and the Georgia State University Nutrition for New Americans Project website (www.monarch.gsu.edu/multiculturalhealth). Many publications are available in Spanish.

Food restrictions based on ideational, moral or religious precepts are hardest to work with, whether those restrictions are based on inherited culture or “received information.” Teenaged vegetarians and Hindus believe that animal flesh is forbidden — the teenager may abandon that belief, but the Hindu cannot without extreme anxiety and guilt. Islam forbids pork, as does Orthodox Judaism. Certain cultures would rather eat snakes than sausage — and, objectively, who could fault them?

Like language, food distinguishes one culture from another. A culture is strongly identified with its foods, and its food preferences will out last nearly any other cultural practice. The meal size, meal composition, social setting and rules vary from culture to culture (Kittler and Sucher, 2001; Rozin, 2000). However, in order to positively impact the diet and health of a person or family from another culture, one must understand their culture, their communication style, values, and health beliefs. The following section includes some profiles or case studies and discussions that will provide you with strategies to use in working with people from other cultures.

Case Study #1

Mary, the outpatient dietitian at a large teaching hospital, was extremely annoyed when Juan Martinez, a 44-year-old man recently diagnosed with hypertension and type 2 diabetes arrived 20 minutes late for his appointment. She became more agitated when he arrived with three other adults and two children.

In order to keep to her schedule, Mary asked the family members to sit in the outer office and omitted taking a diet history. She got “right to the point” and immediately began explaining how to count carbohydrates, frequently asking “Juan, do you understand?” Mary was satisfied when Juan responded yes.

Mary was able to finish Juan’s diet instruction in a record 30 minutes. Rather than seeing Juan to the door and shaking his hand, Mary explained that she had another meeting and gestured for Juan and his relatives to exit. Two weeks later Mary was surprised when Juan did not return for his follow-up appointment.

Why did Juan most likely not return for his follow-up appointment? Simply, Mary failed to “connect” to Juan and his family through cultural blindness.

First, she could have recognized that Latinos are generally less focused on time schedules. Mary most likely offended Juan by her informal approach (calling him by his first name). In addition, Mary failed to recognize the importance of involving the entire family in the nutrition counseling session. Although Juan did not grasp the concept of counting carbohydrates, he responded he understood because it would be considered impolite or disrespectful to Mary to tell her he really did not understand her instructions (Cultural Cues, 2006;

Transcultural Nursing, 2006), as well as losing “face” before an authority figure.

What strategies should have been used to ensure positive health outcomes for Juan?

First, ALL family members should be welcomed and included in the diet education session, even if it meant there would be standing room only. Families provide a valuable emotional support.

Adults should be addressed by their last name (Mr. Martinez) and shaking hands is important as Latino people are very affectionate. Keep in mind that eye contact may be avoided as a sign of respect. Some Latinos consider eye contact to be related to evil spirits. It is believed that an illness can result from receiving a “*mal ojo*” or “evil eye” from another person (Cultural Cues, 2006; Transcultural Nursing, 2006; Galanti, 2004).

Spending time establishing a rapport with the family is crucial to building trust and promoting treatment compliance. Asking questions for clarification of generalizations is crucial. For example, “What do you think is the reason for your illness?” “What things have you been doing to treat your condition?”

If language is NOT a barrier ask open-ended questions. Many Latinos view illness as the result of an imbalance, such as an imbalance between internal and external sources like hot and cold or natural versus supernatural. Religion or faith often plays a central role in a Latino’s worldview. The outcome of an illness is believed to be solely in God’s control. Thus, the person may have a passive attitude toward their healthcare. You may validate a person’s belief in God and encourage them to participate in their healthcare by asking, “Will God be served if you take very good care of yourself?” (Cultural Cues, 2006; Transcultural Nursing, 2006; Galanti, 2004).

Keep diet instructions simple and manageable. Be open-minded and non-judgmental about the use of home remedies, unless you perceive the remedy to be harmful (Cultural Cues, 2006; Transcultural Nursing, 2006).

Case Study #2

A 25-year-old Chinese woman had just given birth. The nurses became concerned when she would not eat the hospital food and did not bathe. She would only eat foods her family brought to her. The young woman avoided making eye contact with the hospital staff and would take a long time to respond to the nurse’s questions (Transcultural Nursing, 2006; Galanti, 2004).

Mae, the Clinical Nutrition Manager, was notified. She explained to the nursing and nutrition staff that making direct eye contact is not a sign of disinterest. In many Asian cultures, making direct eye contact is considered rude and pauses in conversation are considered polite. Mae also explained that the patient was practicing the traditional lying-in period observed in much of Asia and Latin America. It is believed that the women’s body is weak and susceptible to outside forces for a certain period of time after childbirth. New mothers are encouraged to avoid bathing, which could introduce organisms into the body and cause illness (Galanti, 2004).

Traditional cultures, especially Asian and Latino cultures, believe that pregnancy is a “hot” condition. In Asian cultures, giving birth causes a loss of heat or yang. This heat must be restored by eating yang foods such as chicken and avoiding cold liquids. The woman is to rest, stay very warm, and avoid bathing and exercise. Failure to adhere to this custom means that later in life a woman will experience aches, pains, arthritis, and other ailments (Transcultural Nursing, 2006; Galanti, 2004).

It is possible to make compromises when working with people from other cultures. For example, the use of boiled water, which removes impurities, may make a sponge bath more acceptable. Healthcare professionals should not assume that patients are being “difficult,” but should explore the possible reasons for their resistance to conventional medical practices (Cultural Cues, 2006; Transcultural Nursing, 2006).

A culturally competent healthcare professional will allow a patient or client to follow their traditions and wisdom’s of their own culture. The culturally competent dietitian will learn from each client, keep a mental “book” of cultural characteristics, and always, always treat individuals with respect and understanding (Cultural Cues, 2006; Transcultural Nursing, 2006).

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Examination for CUC09

1. Cultural competency is:
 - a. willingness to learn about other cultures
 - b. acceptance that cultures are different, but people are basically the same
 - c. valuing diversity and being able to work effectively cross-culturally
 - d. all of the above
 - e. b and c only

2. It is proposed that the largest minority population in the US by the year 2050 will be:
 - a. Southeast Asians
 - b. African American
 - c. Hispanics or Latinos
 - d. Pacific Islanders
 - e. Chinese, Japanese, and Koreans

3. Cultural sensitivity is:
 - a. tolerance of cultural diversity
 - b. important in becoming culturally competent
 - c. an attitude of respect and acceptance for another person's culture
 - d. all of the above
 - e. a and c only

4. The first step in developing cultural competency is:
 - a. recognize your personal cultural biases and preconceptions
 - b. desire to learn about diverse cultures
 - c. seek out and increase your knowledge about other cultures
 - d. learn a different language
 - e. develop multicultural counseling skills

5. Health disparities in the US:
 - a. are found culturally diverse groups of people regardless of socioeconomic level
 - b. are limited to African Americans and Latinos
 - c. are NOT limited to only minority groups of people without health insurance
 - d. may be partly blamed upon cultural incompetence by practitioners
 - e. all of the above

6. Traditional cultures value:
 - a. time schedules and being prompt
 - b. individualism
 - c. spiritualism
 - d. equality between men and women
 - e. all of the above

7. A stereotype:
- is useful in working with diverse population groups
 - assumes that all people in a particular group are alike
 - a starting point in working with diverse groups of people
 - allows for individual differences
 - all of the above
8. Most traditional cultures:
- recognize the relationship of diet and disease
 - recognize the medicinal properties of food
 - value thinness
 - all of the above
 - a and b only
9. Dietitians should:
- use the USDA Food Pyramid regardless of cultural background
 - use culturally appropriate nutrition education material
 - assume all people are basically alike and use a universal approach
 - develop universal nutrition services
 - none of the above
10. In general, ethnic and racial groups in the US have an increased incidence of:
- diabetes
 - obesity
 - certain cancers
 - mortality
 - all of the above
11. Which of the following behaviors is NOT perceived as disrespectful or impolite in Latino culture:
- focusing on time and schedule
 - making direct eye contact
 - avoiding physical contact
 - making small talk rather than getting “right to the point”
 - all of the above
12. Traditional cultures are more likely to view illness as:
- an imbalance of external and internal forces
 - the result of environmental exposure to pollutants
 - out of God’s control
 - unrelated to their spirit
 - all of the above

13. When taking a diet history it is best to:
- speaking loudly and slowly
 - asking questions that only require a yes or no response
 - asking open ended questions whenever possible
 - explaining why home remedies are not effective
 - none of the above
14. During a nutrition counseling session with a client or patient from a different culture, which is the LEAST effective strategy or technique?
- Asking what the client or patient believes is the cause of their illness or condition
 - politely explaining why their beliefs are incorrect and discounting the role of faith or God in health and healing
 - politely offering the “Western” medicine beliefs for the cause of their illness or condition
 - being open minded and non-judgemental
 - engaging in “small talk” or establishing a rapport before beginning diet instruction
15. When a patient is not adhering to their prescribed treatment plan, what approach is NOT LIKELY to motivate compliance?
- Exploring ways to compromise
 - involving family members
 - spend time listening to discussions of possible home remedies
 - focusing on one positive change
 - repeating diet instructions and quizzing the patient to ensure their understanding
16. Which of the following statements is TRUE?
- People from the same country have the same culture.
 - All Latin Americans speak Spanish
 - All Latinos are Catholic
 - the majority of Asians are vegetarians
 - within every culture there are individual variations; each individual is unique
17. Multicultural marketing is a relatively new development, but is considered only a trend and is not expected to be effective.
- True
 - False
18. Diversity:
- involves more than just fair policies toward women and minorities in the workplace
 - affects everyone
 - involves developing a workplace that recognizes and respects the uniqueness of individuals
 - in the US work force is anticipated to increase in the next 10 years
 - All of the above

19. Anglo-American culture:
- a. advocates individualism
 - b. is present-oriented
 - c. values formality
 - d. is polychronistic
 - e. all of the above
20. When talking with someone from an Asian culture it is important to:
- a. make direct eye contact
 - b. shake hands
 - c. speak quickly
 - d. use an informal communication style
 - e. None of the above



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