

Cultural Competence and Health



First Edition, 2006



California Childcare Health Program
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California Childcare Health Program

The mission of the California Childcare Health Program is to improve the quality of child care by initiating and strengthening linkages between the health, safety and child care communities and the families they serve.

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LEARNING OBJECTIVES

To define cultural competence.

To describe how Child Care Health Consultants (CCHCs) can strive for cultural competence in their practice.

To identify three ways a CCHC can assist early care and education (ECE) programs in developing and maintaining cultural competence.

WHY ARE CULTURAL COMPETENCE AND HEALTH IMPORTANT?

America is a land of people with diverse cultural and ethnic backgrounds. Cultures vary in their beliefs of cause, prevention and treatment of illness. These beliefs indicate the practices used to maintain health or cure illnesses, and may also delay or prevent access to health services.

ECE professionals are faced with the challenge of providing care and assistance to children and families with cultures that may be quite different from their own. Knowledge, skills and self-awareness are needed to provide quality care to people of different cultures, and to challenge discrimination.

CCHCs working in ECE programs have an excellent opportunity to educate ECE providers, children and their families about issues related to health, culture and ethnicity. Providers need to take into account the impact of various genetic, cultural, social, class and environmental factors that impact children from various backgrounds.

WHAT THE CCHC NEEDS TO KNOW

What Is Cultural Competence?

Cultural competence is a set of congruent behaviors, attitudes, policies, structures and practices that come together in a system or organization that enable that system or organization to work effectively in cross-cultural situations (Hepburn, 2004; Cross, Bazron, Dennis, Isaacs, 1989). There are five essential elements for a culturally competent system of care (i.e., a culturally competent ECE program) (Hepburn, 2004):

- value, accept and respect diversity
- have the capacity, commitment, and systems in place for cultural self-assessment
- be aware of the dynamics that occur when cultures interact
- have continuous expansion of institutionalized cultural knowledge
- create adaptations to accommodate diversity

The Reality: California’s Changing Demographics

Nearly 34 million people live in California, and the population is expected to increase by 16 percent by the year 2010. California’s population increased by over 4 million from 1990 to 2000.

The state’s race/ethnic distribution has shifted since the 1990s, according to the U.S. Census. The White population’s share of the total decreased from 57 percent to 47 percent, while the Hispanic population increased from 26 percent to 32 percent, and the Asian/Pacific Islander population increased from 9 percent to 12 percent. The shares of the Black and Native American populations have remained constant over the course of the decade, at 7 and 1 percent, respectively (U.S. Census, 2000).

Biracial and Bicultural influences

The statistics below are an indication of the rapidly changing demographics covering interracial marriage, numbers of biracial/bi-ethnic children and transracial adoption.

- In 2000, 7 million people, or 2.4 percent of the U.S. population, identified themselves as “more than one race.” Of that group, 98 percent identified themselves as being of two races.
- Four million married couple households indicated on Census 2000 that the spouses are of different races or origins.
- Census 2000 identified nearly 4 million multiracial children in the United States.
- Almost one-third of the children adopted from the foster care system are placed with families of a different race, and 75 percent of children adopted from other countries by Americans are transracial (adoptive parents are a different race than the child).

(Source: Childcare Health Program, 2003.)

Spanish	84.3%
Vietnamese	2.3%
Hmong	1.6%
Cantonese	1.5%
Filipino (Tagalog)	1.3%
Korean	1.1%
Other Non-English	0.9%
Mandarin (Putonghua)	0.8%
Armenian	0.7%
Khmer (Cambodian)	0.7%
California Department of Education, Educational Demographics Unit	

Bilingual Families

Because of California's diverse population, a large percentage of children enter the public school system as English learner students. These are students for whom English is not the primary language. Table 1 shows the wide range of languages other than English that are spoken by children in California. Children also come into ECE programs speaking many different languages, and ECE providers need to be prepared to communicate with these families either through interpreters or other families whom are bilingual.

Diversity of the ECE Workforce

One only needs to walk into an ECE program to see the diversity of the staff. Many may represent the cultures of the children in the program, which improves culturally responsive care. Numerous caregivers are immigrant women who speak limited English. While most of the workforce are women, there are increasingly more men entering early childhood education. What may not be so apparent are religious beliefs, sexual orientation, socio-economic status, and child-rearing beliefs. All of these differences must be melded into a common mission to create a harmonious workplace.

ECE Programs: A Dynamic Intersection for Honoring Cultures

Multicultural changes occurring across the United States and especially in California have a profound impact on ECE programs where families and staff from different cultural and generational backgrounds interact in one of life's most intimate realms—the care and rearing of young children (Okagaki & Diamond, 2000).

The early childhood community has a long history of honoring and celebrating diversity. "Responding to Linguistic and Cultural Diversity: Recommendations for Effective Early Childhood Education" is a position statement of the National Association for the Education of Young Children (1996) that asserts that the nation's children all deserve an early childhood education that is responsive to their families, communities, and racial, ethnic and cultural backgrounds.

Head Start has a statement of multicultural principles which must be honored in their programs (see *Handout: Head Start Multicultural Principles*). California state child care regulations and the State Department of Education (CDE) program evaluation tool "Desired Outcomes for Children and Families" both support individualized programming with input from families. Additionally, there are numerous early childhood curricula and initiatives that address diversity and inclusive ECE programs, including the following:

The Anti-Bias Curriculum: Tools for Empowering Young Children

This 1988 NAEYC publication was one of the first in-depth anti-bias guides. Its goals were to increase awareness of attitudes about gender, race, ethnicity, and different physical abilities; to help readers identify ways that institutional racism, sexism, and handicapism affect programs; to gain an understanding of how young children develop identity and attitudes; and to plan ways to introduce anti-bias curriculum into ECE programs. Also available is a companion brochure "Teaching Young Children to Resist Bias: What Parents Can Do."

Ten Keys to Culturally Sensitive Child Care

This publication by Lally, Mangione, Signer, Butterfield & Gilford (1993) is a unit within the "Program for Infant Toddler Caregivers" developed by West Ed and distributed by the California Department of Education. This in-depth and interactive training program highlights the 10 keys to culturally sensitive child care: provide cultural consistency, work towards representative staff, create small groups, use the home language, make environments relevant, uncover cultural beliefs, be open to the perspectives of others, seek out cultural and family information, clarify values, and negotiate cultural conflicts. This is a useful tool for any CCHC who wants to effectively transmit cross-cultural knowledge and skills to ECE providers.

Serving Biracial and Multiethnic Children and Their Families

This video and early childhood educator's guide, by the Childcare Health Program (2003), highlights the unique issues facing biracial and multiethnic chil-

dren and offers guidance on helping them process their dual identities. The guide includes the following topics: ages and stages of identity development, identifying and responding to the unique needs of biracial/bi-ethnic families, and insuring cultural sensitivity in child care programs.

Disparities in Health Status of Racial/Ethnic Groups

Reports and research studies have shown that many racial/ethnic minorities have higher levels of diseases, disabilities and deaths than White populations. African Americans, Hispanics/Latinos, Native Americans, Pacific Islanders, and Asian Americans, as well as immigrant groups, rural residents, and the poor face increased health risks and suffer from poor health. Knowledge of health status and underlying factors for poor health in children and families of racial/ethnic minorities will help CCHCs to play an important role in supporting the healthy development of all children in ECE programs.

What Are the Major Areas of Discrepancies?

The list below highlights some of the major areas of discrepancies between the health status of racial/ethnic minorities and the White population:

- life expectancy
- infant mortality rates
- Sudden Infant Death Syndrome (SIDS)
- cancer screening and management
- heart disease and stroke
- diabetes
- HIV infection/AIDS
- infectious disease
- breastfeeding practice
- immunization rates

In addition, immigrant children may have infectious diseases that U.S. pediatricians may be inexperienced in diagnosing and treating. These include conditions

such as malaria, amebiasis, schistosomiasis, intestinal parasites, congenital syphilis (for which foreign-born children are not necessary screened at birth), hepatitis A, hepatitis B, and tuberculosis.

What Are the Underlying Factors that Account for These Discrepancies?

- Socioeconomic status (e.g., low income and low education of parents)
- Lack of access to quality health care (e.g., insurance coverage, preventive health services)
- Behavioral and life style risk factors (e.g., smoking, substance abuse, excessive use of alcohol, high-fat/high-cholesterol diet, lack of physical exercise)
- Environmental hazards in home and neighborhood (e.g., exposure to lead, asbestos, etc.)
- Medical problems and chronic illnesses
- Genetic factors (e.g., hereditary disease that passes on from generation to generation)
- Discrimination and racism leading to increased poverty, unemployment, poor housing, etc.

Issues That Arise in ECE Programs

CCHCs may be called upon to mediate cultural differences that occur between parents and staff, between staff members, or between parents in an ECE program. Or, CCHCs may be asked to develop policies that may have cultural implications, such as administering herbal medication. Whatever the challenge, it is incumbent upon CCHCs to explore the belief systems of everyone involved in order to determine if compromise is needed. Hopefully, this compromise will honor the integrity of the family and the community feeling of the ECE program while being healthy and safe for children, staff and family.

The following issues are those in which CCHCs may be involved and may want to explore more fully knowing there are great differences among cultures, between individuals in each culture, and between generations.

Causes of Physical Illness

There are differences among cultures about why children get sick, including being exposed to cold or rain, improper diet, excessive emotions, the system being out of balance or having too much or too little wind, a curse or evil eye, God's will, and the germ theory. Since illness occurs frequently in group care, conflicts about causation and subsequent blame often arise.

Causes of Disability

There is often guilt and anger associated with having a child with a disability and this varies greatly among cultures. In some cultures a disability is highly stigmatized and in others it's accepted as "God's will." Attribution to events that occurred during pregnancy is common, such as experiencing a fright or other powerful emotion, ingesting certain foods, having a curse or exposure to environmental teratogens. Multi-disciplinary early intervention may seem foreign to some families and that discomfort may lead to lack of compliance or a misunderstanding of the parents' concern for their child.

Causes of Mental Illness

In some cultures, causes of mental illness may be attributed to evil spirits, curses or imbalances. Other cultures view mental illness as a personal failing; some attribute it to an organic cause such as a chemical imbalance. Parents are often blamed for their child's behavior and every effort to be non-judgmental and supportive must be made.

Treatment of Illness and Specific Symptoms

The treatment of illness often corresponds to the beliefs about the cause of illness and the array of treatments is extensive. Some families deeply believe in certain "cures" and these are used exclusively. Some families are very agreeable to using complementary treatments from different cultures as long as they are asked not to give up their own beliefs. Some practices may be confused with signs of child abuse and families may need to know of your concern when you see marks from coining or cupping. ECE providers may be asked to administer treatment, such as herbal medication not prescribed by a licensed professional; this is not allowed by the child care regulations and should not be done, per *Caring for Our Children: National*

Health and Safety Performance Standards: Guidelines for Out-of-Home Child Care Programs, Second Edition (CFOC) (American Academy of Pediatrics [AAP], American Public Health Association, & National Resource Center for Health and Safety in Child Care, 2002).

Beliefs About Immunizations

Parents may not have their children immunized because of fears of needles or side effects, because of cultural or religious beliefs, or because of a misunderstanding of the importance of immunization. While immunization regulations allow a waiver for personal or religious beliefs, CCHCs should make every effort to determine and respond to parents' reasons not to immunize.

Child-Rearing Practices

Differences in toileting, feeding, sleeping, and discipline are the practices most likely to come to the attention of CCHCs. Toileting practices vary and often depend on when a child is expected to be trained. In some cultures, children as early as 6 months are put on the potty chair and caregivers are trained to be alert to the child's "potty" cues. Current toilet training practices in this country are guided by a child's "readiness" cues which can begin as early as 18 months or extend to 3 1/2 years of age. Individualized toilet training plans developed by the parent and caregiver are encouraged. Feeding practices can be very contentious unless ECE providers and parents engage in mutual problem-solving which can be facilitated by the consultant. Community Care Licensing regulations (State of California, Health and Human Services, Department of Social Services, 2002) and CFOC offer some guidance on nutrition and allow for some flexibility. Individual families' view of discipline and punishment may conflict with the child abuse reporting laws and must be handled with respect and sensitivity while still informing the family about the child care reporting obligations.

WHAT THE CCHC NEEDS TO DO

It is very important for the CCHC to develop cultural competence. There are three ways a CCHC can assist an ECE program in developing and maintaining cultural competence without sacrificing health and safety standards.

1. Learn about yourself, your culture, and your own health beliefs.
2. Learn about other cultures, especially their child-rearing practices, family interactions, and their health beliefs.
3. Model and utilize creative problem-solving strategies to negotiate cultural differences that may impede health and safety.

Learn About Yourself

In order to fully appreciate the diversity that exists among people at work or in the community, a CCHC must first understand his or her own culture. *“Each of us tends to think we see things as they are, that we are objective. But this is not the case. We see the world, not as it is, but as we are—or, as we are conditioned to see it. When we open our mouths to describe what we see, we in effect describe ourselves, our perceptions, our paradigms”* (Covey, 1989 p. 28-29).

Based on work by Lynch and Hanson (1992), CCHCs must follow two steps to achieve understanding of their own culture. First, they must define their own unique cultural heritage by answering questions about their own families, such as place of origin, when and why the family immigrated, where they first settled, foreign languages that were and still may be spoken, political leanings, jobs, education, social status, and any economic, social or vocational changes made in previous generations. The second step is to examine the values, behaviors, beliefs and customs of their own cultural heritage. Only after CCHCs have assessed their own attitudes and values toward diversity are they able to promote understanding, acceptance and appreciation of the diversity that exists among us all.

Learn About Others

The CCHC can learn about other cultures by reading, observing, listening and asking questions. One of the best ways to learn is by talking personally with members of other cultures. One can establish a “cultural guide,” ideally a friend, colleague or neighbor with whom there is an established degree of mutual trust and respect.

There are many sources that attempt to describe the characteristics of various cultural groups. While these references can be extremely helpful in understanding characteristics of groups, the information may add to generalized assumptions and stereotyping that may not apply to the individuals you are working with.

In addition to seeking general information, it’s useful for CCHCs to develop a series of questions to explore individual differences such as: “What do you think caused your child’s illness?” “What do you think keeps you and your family healthy?” “How do you usually treat this illness?” “Who do you usually see for treatment?”

Achieving cross-cultural competence requires that we lower our defenses, take risks and practice behaviors that may feel unfamiliar and uncomfortable. It may mean setting aside some beliefs that are cherished to make room for others whose value is unknown, and it may mean changing what we think, what we say, and how we behave (Lynch & Hanson, 1992, page 35).

Negotiate Cultural Differences

One of the most important tasks of CCHCs is to facilitate collaboration among culturally diverse ECE providers, families and community resource agencies. To do this, they must be aware of what others are saying, thinking and feeling, communicate ideas effectively, and creatively address problems which arise.

One useful tool in negotiating differences is “dialoguing” (Gonzalez-Mena & Tobiassen, 1999). Dialoguing aims to reach agreement and solve problems. The goal is not to win, but to gather information and understand the other’s perspective, then find the best solution for all concerned. In contrast, the object of an argument is to win. Other differences between dialoguing and arguing include:

- The arguer tells; the dialoguer asks.
- The arguer tries to persuade and convince; the dialoguer seeks to learn.
- The arguer considers her point of view the best one; the dialoguer is willing to understand multiple viewpoints.
- The arguer tries to prove the other person wrong; the dialoguer considers that she has a gap in her knowledge.
- Make home visits to families you would like to get to know better. Make the first visit positive and bring along an interpreter if necessary.
- Take it slow when conflict arises, and don't push a change—dialogue and explore the issue with the person(s) involved and determine what's safe, effective and acceptable.
- Use “I” messages when explaining your belief. “I believe that when a child has a cold, it is good for her to get plenty of fresh air outside.”

CCHCs can improve their abilities to negotiate cultural differences by adopting these behaviors (Lynch & Hanson, 1992):

- respect individuals from other cultures
- make continued and sincere attempts to understand the world from another person's point of view
- be open to new learning
- be flexible
- have a sense of humor
- tolerate ambiguity well
- approach others with a desire to learn

Other steps CCHCs can take when negotiating cultural differences include:

- Seek out or get translations of critical child health and development information and forms in the languages and literacy level of parents and staff in the program. The internet and the California Child Care Healthline can be great resources.
- Talk to others in the community who represent other groups and who can inform you about cultures that are new to you.
- Learn about training techniques to include non-English speakers and always anticipate that you may have limited-English speakers in your classes and workshops.
- Learn some essential words, such as “hello,” “please” and “thank you” in the languages of the families you serve.

WAYS TO WORK WITH CCHAs

With the help of Child Care Health Advocates (CCHAs), identify staff who can:

- help you interpret and assist with parent communication
- act as your cultural bridge in understanding cultural beliefs and practices and individual variations among the staff and parents in the program
- assess the appropriateness of written non-English materials you wish to distribute
- remember that someone who is verbally fluent (interpreter) may not do well with written communications (translator)
- assist you in problem-solving issues related to cultural differences
- accompany you to social-cultural events focused on children and parents

ACTIVITY 1: FAMILY PRACTICES AND ATTITUDES (THEN AND NOW)

In the spaces below, comment on the practices and attitudes in the household in which you grew up compared to your current household.

1. The person who was the authority figure:

Then:

Now:

2. Behavior towards elders:

Then:

Now:

3. Children's right to be heard:

Then:

Now:

4. Talking openly about feelings:

Then:

Now:

5. Disagreements and confrontations:

Then:

Now:

6. How affection was expressed:

Then:

Now:

7. How anger was expressed:

Then:

Now:

8. Differences in treatment between boys and girls:

Then:

Now:

9. How children were disciplined:

Then:

Now:

10. Value of education:

Then:

Now:

11. Eating habits:

Then:

Now:

12. Daily routines and schedules:

Then:

Now:

13. Being punctual:

Then:

Now:

14. Feelings and attitudes about people from other cultures/ethnic groups:

Then:

Now:

15. Feelings and attitudes about people with special needs:

Then:

Now:

In what areas have the greatest changes taken place?

Adapted from The Program for Infant/Toddler Caregivers Handout #20, CISS Conference

ACTIVITY 2: PROMOTING CULTURAL DIVERSITY AND CULTURAL COMPETENCY

Complete the *Handout: Self-Assessment Checklist*. The trainer will lead discussion on the items which score a C. Why are these items important? What are the barriers to implementing the practice? How can they be overcome?

ACTIVITY 3: CULTURAL NEGOTIATIONS SCENARIOS

Berlin and Fowkes (1983) in “ A Teaching Framework for Cross-Cultural Health Care” recommend a mnemonic tool for cross-cultural communication and negotiation called “LEARN.”

- L Listen with sympathy and understanding to the patient’s perception of the problem.
- E Explain your perceptions of the problem
- A Acknowledge and discuss the differences and similarities
- R Recommend treatment (or solution)
- N Negotiate agreement

Divide into groups, discuss and apply the LEARN guidelines to the scenarios below. Report back to the larger group.

1. An Asian parent new to the program brings her 18-month-old to the center and asks the teacher to keep her child indoors today because she has a cold. Because the teacher has no time to stay indoors with the toddler, she asks you to talk to the parent, who seems upset that her request cannot be granted.
2. A Mexican-American staff member comes to you crying because she just had an argument with the food service clerk. A parent (also from Mexico) of a child in the caretaker’s room requested that no milk be given to her child today because the child has a cold and the milk will only make more mucus. The staff member agrees with the parent. The food service clerk comes in very upset because the Federal Food Program rules say they have to offer children milk every day. The program is expecting a federal food program review and she was told by the director to “follow the rules.” The angry clerk says, “milk has nothing to do with making more mucus and I’m not getting in trouble by breaking the rules.”
3. A staff member comes to you because she has noticed red lines on the back of a 3-year-old in her class. She thinks it’s due to child abuse. She is angry, and wants to report the family. You observe the child, whose family recently arrived from China, and your assessment of the marks is that they are the result of coining.
4. A limited-English-speaking Latina parent with whom you are speaking starts weeping and repeatedly saying to you through the interpreter, “it is all my fault, it is all my fault.” Her child is 2 years old and has Down’s Syndrome.
5. A parent who recently emigrated from Laos is referred to you by the director because she does not want her baby immunized. During the conversation the mother tells you that she doesn’t want germs put in her baby’s body and would rather take a chance on the baby getting sick.

NATIONAL STANDARDS

From *Caring for Our Children: National Health and Safety Performance Standards: Guidelines for Out-of-Home Child Care Programs, Second Edition*

- 1.011 Qualifications for Caregivers Serving Children
- 2.006 Communication in Native Language
- 2.007 Diversity in Enrollment and Curriculum

CALIFORNIA REGULATIONS

From *Manual of Policies and Procedures for Community Care Licensing Division*

None

RESOURCES

Organizations and Resources	
Organization and Contact Information	Description of Resources
Association for Library Service to Children www.ala.org/ala/alsc/alscresources/booklists/booklists.htm	Develops and supports the profession of children’s librarianship by enabling and encouraging its practitioners to provide the best library service to our nation’s children. Web site lists books on diversity and multiculturalism for children.
Cross-Cultural Health Care Program www.xculture.org	Mission is to serve as a bridge between communities and health care institutions to ensure full access to quality health care that is culturally and linguistically appropriate. Training and educational materials available.
Diversity Rx www.diversityrx.org	Funded by National Conference of State Legislatures, Resources for Cross Cultural Health Care, and Henry J. Kaiser Family Foundation of Menlo Park, CA. Promotes language and cultural competence to improve the quality of health care for minority, immigrant, and ethnically diverse communities.
Intercultural Communication Institute www.intercultural.org	A nonprofit foundation designed to foster an awareness and appreciation of cultural difference in both the International and domestic arenas. Resources for training and education.
Jamarda Resources Inc. www.jamardaresources.com	Works to increase health care workers’ understanding of cultures, ethnic groups and religions through consulting, diversity training, workshops, and continuing education products.
Multicultural Paths: EdChange Multicultural Pavilion http://curry.edschool.Virginia.EDU/go/multicultural/sites1.html	Provides resources for educators, students, and activists to explore and discuss multicultural education; facilitates opportunities for educators to work toward self-awareness and development; provides forums for educators to interact and collaborate toward multicultural education.
National Alliance for Hispanic Health www.hispanichealth.org	The nation’s oldest and largest network of Hispanic health and human services providers. Health fact sheets available on a wide array of health topics in English and Spanish. Lists helplines and hotlines with services available in Spanish.
National Center for Cultural Competence (NCCC) http://gucchd.georgetown.edu/nccc/index.html	The mission is to increase the capacity of health and mental health programs to design, implement, and evaluate culturally and linguistically competent service delivery systems. Web site contains a searchable resource database.
Office of Minority Health www.omhrc.gov	Mission is to improve and protect the health of racial and ethnic minority populations through the development of health policies and programs to eliminate health disparities.

Organization and Contact Information	Description of Resources
Transcultural Nursing Society www.tcns.org	Transcultural nursing is “a formal area of study and practice focused on comparative human-care (caring) differences and similarities of the beliefs, values, and patterned lifeways of cultures to provide culturally congruent, meaningful, and beneficial health care to people.” The Transcultural Nursing Society is an international nursing forum for scholarly discussion of global culture care needs.

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HANDOUTS FOR CULTURAL COMPETENCE AND HEALTH MODULE

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AGES AND STAGES OF RACIAL/ETHNIC IDENTITY DEVELOPMENT

Stage	Racial Self-Identification	Racial Constancy	Origin of Racial Identity	Racial Classification	Racial Attitudes
I. Racial Innocence Age 3	Most children are unable to accurately identify their skin color, much less their race.	Children reside in a world where anything is possible, including changes in skin color and gender.	Children are unaware of the biological origin of their skin color.	Children are unable to correctly categorize people by race.	Preschoolers are developmentally inclined to see people as individuals rather than as members of racial groups.
II. Color Awareness Ages 3-5	When asked, "What color are you?" children are just as likely to describe the color of their clothes as their skin. Children can accurately identify their skin color using words like brown, white, tan, and black. Some children also use familiar words related to food like chocolate, peach and vanilla.	Children believe that if they desire, they can change their skin color by magical means like wishing and painting.	Preschoolers believe that God, their parents, or they themselves have used magical means to produce their color.	Children can accurately group people by skin color but not by race. Children describe others in their own terms like chocolate, vanilla, pink, and peach. Some children use other words like lemon girl (for an Asian girl) and cherry girl (for a red-haired white girl). All light-complexioned people, including Asians, whites and blacks, are seen as "white." Children describe people as "brown" who have medium-brown complexion; "black" is used only to describe dark-skinned people.	Children are predisposed to be friendly to anyone who acts positively toward them. Children at this stage continue to see people of their own and other races without skin color and racial prejudices. However, children who are routinely taught racial bigotry begin to form negative association with certain skin colors.

Stage	Racial Self-Identification	Racial Constancy	Origin of Racial Identity	Racial Classification	Racial Attitudes
III. Awakening to Social Color Ages 5-7	Children can accurately identify their skin color and begin to make relative skin-color distinctions, like light-skinned and dark-skinned. Most children are unable to reliably identify their race.	Children begin to perceive that their skin color is a permanent feature of their bodies and understand that the effect of the sun on the skin is only temporary.	They begin to grasp the connection between their color and their parents' and expect skin colors of family members to be similar. However, they do not yet fully comprehend the genetic basis of skin color.	Children begin to understand that skin color means something more than mere color, but they are inclined to categorize people by color, rather than race. They use conventional terms - brown, black, white - to describe people. Black is used to describe only brown and dark-skinned blacks and white to describe Asians and whites. When asked, children can identify Chinese people. Children begin to use ethnic labels, like Puerto Rican and Italian, sometimes inaccurately.	Although they do not yet fully understand them, children begin to adopt skin-color prejudices of their family and friends as well as those presented by the media. For example, children may begin to express a preference for light or dark skin and to see "white" or "black" people as negative stereotypes.
IV. Racial Awareness Ages 8-10	Children can accurately identify their race using terms like black and African American. Some biracial children say they are "part" black or African American and "part" another race, like white.	Children comprehend that racial identity is permanent.	Children understand the genetic basis of racial identity. Unlike younger children, they understand the reason members of the same family can have different skin tones.	Children rely not only on skin color but also other physical cues, such as hair color and textures, as well as facial features to determine a person's group - white, black or African American Chinese, and so forth. As they mature, children realize that physical cues can be unreliable in determining some people's race. Children begin to also rely on more subtle cues - including social and behavioral ones - when making racial identifications.	Unless they are sensitively taught not to prejudice people based on their race, children may adopt full-fledged racial stereotypes, common in the culture and their own racial group.

Adapted from "I'm Chocolate, You're Vanilla" by Marguerite Wright

SELF-ASSESSMENT CHECKLIST

This checklist is intended to heighten the awareness and sensitivity of personnel to the importance of cultural diversity and cultural competence in human service settings. It provides concrete examples of the kinds of values and practices which foster such an environment.

Directions: Select A, B, or C for each item listed below.

A = Things I do frequently

B = Things I do occasionally

C = Things I do rarely or never

Physical Environment, Materials and Resources

_____ 1. I display pictures, posters and other materials which reflect the cultures and ethnic backgrounds of children and families served by my program or agency.

_____ 2. I insure that magazines, brochures, and other printed materials in reception areas are of interest to and reflect the different cultures of children and families served by my program or agency.

_____ 3. When using videos, films or other media resources for health education, treatment or other interventions, I insure that they reflect the cultures of children and families served by my program or agency.

_____ 4. When using food during an assessment, I insure that meals provided include foods that are unique to the cultural and ethnic backgrounds of children and families served by my program or agency.

_____ 5. I insure that toys and other play accessories in reception areas and those which are used during assessment are representative of the various cultural and ethnic groups within the local community and the society in general.

Communication Styles

_____ 6. For children who speak languages or dialects other than English, I attempt to learn and use key words in their language so that I am better able to communicate with them during assessment, treatment or other interventions.

_____ 7. I attempt to determine any familial colloquialisms used by children and families that may impact on assessment, treatment or other interventions.

_____ 8. I use visual aids, gestures, and physical prompts in my interactions with children who have limited English proficiency.

_____ 9. I use bilingual staff or trained volunteers to serve as interpreters during assessment, meetings, or other events for parents who would require this level of assistance.

_____ 10. When interacting with parents who have limited English proficiency I always keep in mind that:

_____ limitations in English proficiency is in no way a reflection of their level of intellectual functioning.

_____ their limited ability to speak the language of the dominant culture has no bearing on their ability to communicate effectively in their language of origin.

_____ they may or may not be literate in their language of origin or English.

_____ 11. When possible, I insure that all notices and communiqués to parents are written in their language of origin.

_____ 12. I understand that it may be necessary to use alternatives to written communications for some families, as word of mouth may be a preferred method of receiving information.

Values and Attitudes

_____ 13. I avoid imposing values that may conflict or be inconsistent with those of cultures or ethnic groups other than my own.

_____ 14. In group therapy or treatment situations, I discourage children from using racial and ethnic slurs by helping them understand that certain words can hurt others.

_____ 15. I screen books, movies, and other media resources for negative cultural, ethnic, or racial stereotypes before sharing them with children and their parents served by my program or agency.

_____ 16. I intervene in an appropriate manner when I observe other staff or parents within my program or agency engaging in behaviors that show cultural insensitivity or prejudice.

_____ 17. I understand and accept that family is defined differently by different cultures (e.g. extended family members, fictive kin, godparents).

_____ 18. I recognize and accept that individuals from culturally diverse backgrounds may desire varying degrees of acculturation into the dominant culture.

_____ 19. I accept and respect that male-female roles in families may vary significantly among different cultures (e.g. who makes major decisions for the family, play and social interactions expected of male and female children).

_____ 20. I understand that age and life cycle factors must be considered in interactions with individuals and families (e.g. high value placed on the decisions of elders or the role of the eldest male in families).

_____ 21. Even if my professional or moral viewpoints may differ, I accept the family/parents as the ultimate decision makers for services and supports for their children.

_____ 22. I recognize that the meaning or value of medical treatment and health education may vary greatly among cultures.

_____ 23. I accept that religion and other beliefs may influence how families respond to illnesses, disease, and death.

_____ 24. I recognize and accept that folk and religious beliefs may influence a family's reaction and approach to a child born with a disability or later diagnosed with a disability or special health care needs.

_____ 25. I understand that traditional approaches to disciplining children are influenced by culture.

_____ 26. I understand that families from different cultures will have different expectations of their children for acquiring toileting, dressing, feeding, and other self help skills.

_____ 27. I accept and respect that customs and beliefs about food, its value, preparation, and use are different from culture to culture.

_____ 28. Before visiting or providing services in the home setting, I seek information on acceptable behaviors, courtesies, customs and expectations that are unique to families of specific cultures and ethnic groups served by my program or agency.

_____ 29. I seek information from family members or other key community informants, which will assist in service adaptation to respond to the needs and preferences of culturally and ethnically diverse children and families served by my program or agency.

_____ 30. I advocate for the review of my program's or agency's mission statement, goals, policies, and procedures to insure that they incorporate principles and practices that promote cultural diversity and cultural competence.

There is no answer key with correct responses. However, if you frequently responded "C", you may not necessarily demonstrate values and engage in practices that promote a culturally diverse and culturally competent service delivery system for children and families.

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HEAD START MULTICULTURAL PRINCIPLES

1. Every individual is rooted in culture.
2. The cultural groups represented in the communities and families of each Head Start program are the primary sources for culturally relevant programming.
3. Culturally relevant and diverse programming requires learning accurate information about the culture of different groups and discarding stereotypes.
4. Addressing cultural relevance in making curriculum choices is a necessary, developmentally appropriate practice.
5. Every individual has the right to maintain his or her own identity while acquiring the skills required to function in our diverse society.
6. Effective programs for children with limited English speaking ability require continued development of the primary language while the acquisition of English is facilitated.
7. Culturally relevant programming requires reflects the community and families served.
8. Multicultural programming for children enables children to develop an awareness of, respect for, and appreciation of individual cultural differences. It is beneficial to all children.
9. Culturally relevant and diverse programming examines and challenges institutional and personal biases.
10. Culturally relevant and diverse programming and practices are incorporated in all components and services.

Head Start Bureau, Administration on Children, Youth and Families, Administration for Children and Families, U.S. Department of Health and Human Services. Principles Supporting the Framework for Multicultural Programming in Head Start [online version]. Retrieved August 2, 2005, from <http://www.bmcc.org/Headstart/Cultural>.

WHEN PARENTS AND STAFF DISAGREE OVER CAREGIVING ROUTINES

By Janet Gonzalez-Mena

Parents and caregivers sometimes hold very strong views about how babies are supposed to be cared for.

These deep-seated ideas are embedded in each of us and remain mostly subconscious and nonverbal until challenged by someone with a conflicting view. We must find ways to manage and resolve conflicts, both cultural and individual, especially those conflicts relating to caregiving practices. For several years now I've been examining areas of disagreement around infant routines such as diapering, feeding, toilet training, holding, comforting and "educating" babies. My aim is to help people find ways to manage and resolve conflicts so they can make a better match. The more the adults in their lives work at settling disagreements, the fewer inconsistencies in approach the babies will experience. My theory is that with adults working hard to manage their conflicts the child will be exposed to fewer culturally assaultive experiences.

So what do you do when you're a caregiver and you and a parent disagree about what's good for babies? I see four outcomes to cultural and individual conflicts in infant/toddler caregiving situations.

1. Resolution through mutual understanding and negotiation. Both parties see the other's perspective, both parties give a little or a lot.
2. Resolution through caregiver education. Caregiver sees parent's perspective. Caregiver changes.
3. Resolution through parent education. Parent sees caregiver's perspective. Parent changes.
4. No resolution.

*The worst "no resolution" scenario is that neither side see the other's perspective—neither changes. There is no respect and conflict continues uncontained or escalates. Sneaking around may occur, or underhanded fighting.

*The best "no resolution" scenario is that each has a view of the other's perspective, each is sensitive and respectful but unable, because of differing values and beliefs, to change their stance. Here conflict management skills come into play as both learn to cope with differences. The conflict stays above board—though perhaps not always in the open.

The fourth outcome is a fairly common outcome as people deal with diversity, while hanging on to their own cultures. Conflict management skills (as opposed to conflict resolution skills) are important for all of us to learn as we go through life bumping in to conflicts that can't be resolved. Handled sensitively and with respect, learning to manage these conflicts in healthy ways provide the challenges that make life interesting.

Here are examples of each of these outcomes.

1. Resolution Through Mutual Understanding And Negotiation.

These conflicts involve "win-win" negotiations with movement from both sides.

Here's the scene: We have on the one hand a parent who hates to see her child messy. On the other hand we have a caregiver who provides messy sensory activities. At first, these two expressed angry feelings to each other. But they were developing a relationship at the same time they clashed over this one issue. They talked about their feelings and their perspectives regularly. Gradually they began to understand each other.

The caregiver educated herself. She went to some trouble to find out why being clean was so important to this parent. It took lots of talking before she understood that clean meant “decent” to this family. She found out that this family had an experience with Child Protective Services accusing a neighbor of neglect because her child looked dirty a lot. But it wasn’t just a defensive stance this family took. They felt clothes show the quality of the family. They felt they were sending their child to “school” and when the child goes to school clean and well dressed it shows the parents’ respect for education. So naturally it was upsetting to them when the child was picked up with clothes full of grass stains, food, or finger paint. They couldn’t accept the suggestion of sending their child in old clothes. I didn’t fit in with their image of decency or “school.”

While the caregiver was getting educated, she was also educating the parents about the importance of sensory experiences that involve messes. Finally they came to an agreement that the caregiver would change the clothes of the child during messy play, or at least make sure she was covered up, so that when the parents returned they would find their child as they left her. The parents were not completely convinced that messy experiences were important but they said it would be okay as long as their daughter’s clothes weren’t involved. The teacher continued to feel they were overly concerned with appearances. Neither side completely gave up on reforming the other side, but both felt okay about the arrangement.

2. Resolution Through Caregiver Education. Caregiver sees parent’s perspective. Caregiver changes.

Here’s the situation: The caregiver believed that babies should sleep alone in a crib—tucked away in a darkened, quiet spot (the naproom). Licensing agreed. But along came a baby who couldn’t sleep alone. He cried and got very upset when put in a crib by himself.

At first the caregiver thought he would get used to the center’s approach, but he didn’t. He became distraught and refused to sleep when he was put into a crib in the naproom. So after talking to the parents, the caregiver discovered that he had never slept alone in his life and the parents didn’t even have a crib. He came from a large family and was used to sleeping in the midst of activity. The caregiver had already discovered that he went to sleep easily in the play area on a mattress with other children snuggling or playing around him. She had no objection to letting him nap in the play area, but that approach to napping was against regulations, so going along with what the parents wanted presented a problem. Instead of trying to convince the parents (and the baby) to change she went to work to convince licensing. She was able to get a waiver once she convinced them that she was only able to fulfill the spirit of the regulation—that each child has a right to quiet undisturbed sleep—if she didn’t isolate the child in a crib in the naproom. In this case the caregiver made the changes—accommodated the wishes of the parent and the needs of the child. You might not agree that she should have done what she did, but she felt quite comfortable about what she considered a culturally sensitive decision.

3. Resolution Through Parent Education. Parent sees caregiver’s perspective. Parent changes.

Here’s the story. The caregiver kept putting babies on the floor to move around and explore toys. She found out that most of the parents in the program wanted their babies to be held all the time. Although they complained to the caregiver, instead of stopping the practice, she started a series of discussions—both individual and group. She educated the parents about the value of freedom of movement. She knew that safety issues were a big concern, as well as dirt, germs, drafts. She knew that in their own home the floor wasn’t a safe place for babies. She discussed the subject more than once. She didn’t resolve the conflict with all the parents, but she continued to work at it. Once she helped them clarify their goals for their children they realized that freedom to move was vital to their children’s development! Because she had a philosophy that babies should not be confined either by being held all the time or by being in infant swings, high chairs, infant seats, she didn’t compromise. She showed the parents how their children would be safe on the floor by having the immobile ones fenced off from the mobile ones. She practiced in the open what she felt was so important, and after she convinced a few parents they began to convince the others. This caregiver was of the same culture as the parents, so she wasn’t an outsider

coming in telling them what to do without understanding their culture. She was an insider who had a different perspective and was able to help them see that their goals and their practices were in conflict with each other. You may not agree with what she did, but she felt very strongly that she was right in changing the parents – in educating them to another view.

4. Conflict Management When There Is No Resolution.

The caregiver in this example was uncomfortable when a new parent told her that her one year old was toilet trained. She didn't believe it and felt that parent was trained, not the baby. She and the parent started a series of conversations about this subject. Even though the caregiver didn't change her approach to toilet training, through the discussions the caregiver was able to quit feeling critical of this parent as she was eventually to see where she was coming from.

The caregiver came to understand that toilet training means different things to different people. To the caregiver it meant teaching the child to go to the toilet by herself, wipe, wash hands, etc. The child must be old enough to walk, talk, hold on to urine and feces, let go after getting clothes off, and wash hands. In other cultures, where interdependence is important, adult and child are partners and the adult reads the child's signals and as well as trains the child to let go at a certain time, or to a certain signal, even though the child is only a year old, or perhaps even younger. This approach works best without diapers or complicated clothing like overalls. Although this caregiver did not change her own approach to toilet training she was respectful of someone who does something different from what she did. She was accepting of the difference and quit feeling angry or superior to the parent.

The parent came to understand the caregiver's perspective, too, though she still wanted her to give it a try. The very few times the caregiver did try, it didn't work because she didn't have the time, or the relationship, or the techniques, or an understanding of the interdependence point of view.

This conflict was unresolved but was managed by both parties. The mother continued to "catch" her child at home, and put diapers on when she was in day care. Neither parent nor caregiver felt entirely satisfied, but both parties managed to cope and weather it through until the child was old enough to become independent about her toileting.

Responding to conflict in sensitive, respectful ways.

It's much easier to do parent education (if that is appropriate) if you are of the same culture as the parents. You can see their perspective better. You can work from the inside. Working from the inside of the culture is very important.

Is it ever okay to go along with something you don't feel good about? I can't tell you if it's okay or not. It depends on your bottom line and how flexible you are above that. It's not okay from my point of view to go along with sexism, oppression, or abuse, even if you are told that it is cultural.

Below are some tips about allowing cultural conflicts to rise and responding in sensitive, respecting ways.

Know what each parent in your program wants for his or her child.

Find out their goals. What are their caregiving practices? What concerns do they have about their child in your program? Encourage them to talk about all this. Encourage them to ask questions. Encourage the conflicts to come to the surface—to come out in the open.

Become clear about your own values and goals.

Know what you believe in. Have a bottom line, but leave space above it to be flexible. When you are clear you

are less likely to present a strong defensive stance in the face of conflict. It is when we are ambiguous that we come on the strongest.

Become sensitive to your own discomfort.

Tune in on those times when something bothers you, instead of just ignoring it and hoping it will go away. Work to identify what specific behaviors of others make you uncomfortable. Try to discover what exactly in yourself creates this discomfort. A conflict may be brewing.

Build relationships

You'll enhance your chances for conflict management or resolution if a relationship exists. Be patient. Building relationships takes time but they enhance communications and understandings. You'll communicate better if you have a relationship. And, you'll have a relationship if you learn to communicate.

Become an effective cross cultural communicator.

It is possible to learn these communication skills. Learn about communications styles that are different from yours. Teach your own communications styles. What you think a person means may not be what he or she really means. Do not make assumptions. Listen carefully. Ask for clarification. Find ways to test for understanding. This is a complex subject but it has to do with reading body language, along with verbal content. It has to do with how feelings are expressed. It even has to do with such basic things as your sense of timing, and perception of space, including how close you stand. Even tone of voice can be grossly misinterpreted. All of these are to some extent culturally determined and influence the messages we send and receive. If you are in a conflict, try to determine whether the conflict is a difference in communication styles or process or if it is about content or motives.

Learn how to create dialogues – how to open up communication instead of shutting it down.

Often if you accept and acknowledge the other person's feelings you may encourage him or her to open up. Learn ways to let others know that you are aware of and sensitive to their feelings. Notice when your own expression of feelings gets in the way of continuing the dialogue – or perhaps it's a judgmental attitude that's keeping you from listening to the other person in a conflict situation. Keep at it. Use gently firm persistence. Don't give up. Keep trying to see their point of view and make your own known. It helps if you listen at least as much as you talk.

Use a problem solving approach to conflicts rather than a power approach.

Be flexible when you can. Negotiate when possible. Look at your willingness to share power. Is it a control issue you are dealing with?

Commit yourself to education – both your own and that of the parents.

Sometimes lack of information or understanding each other's perspective is what is keeping the conflict going.

I am concerned that each infant find the kind of consistency between his or her care at home and that in child care that will allow him or her to become a solid member of his or her own culture. Culture is learned unconsciously and carried on most unconsciously for the rest of one's life. Those with too varied an input in the early years may wind up to be cultural chameleons—which may be a good thing—but they may also end up being marginal people who never feel that they fit anywhere. Babies who encounter constant cultural assault may develop low self-esteem. I believe we need a lot more studies and thought about exposing infants to cultural assaults in the early years.

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