How to (Un)-Learn Cultural (In)-Competency in Social Work: A Critical Discourse Analysis of Cultural Competency Trainings in Community Mental Health

Author

Fatima Tahir, York University, Canada

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Cultural competency, critical race theory, diversity, homogenisation, oppression, race, social work, whiteness.

Abstract

This research project seeks to investigate the ways in which professional cultural competency training in social work settings perpetuates mainstream stereotypes of racialised clients and to deconstruct how non-white communities are represented in within these models. Using critical race theory (CRT) and social justice lenses, the study entails conducting a critical discourse analysis (CDA) with thematic and framing analyses to deconstructed a community mental health organisation's cultural competency training derived from a 'cultural competency resource kit' by the Alberta Health Service's (2009). The research engages in an exploration of existing cultural competency literature in social work in order to highlight themes of whiteness and diversity. The findings of the study address gaps in existing cultural competency scholarship and unpack dominant discourses of whiteness and homogenisation that continue to perpetuate racial oppression and injustice for racialised individuals and communities who access social services. The paper concludes by acknowledging that the idea of 'cultural competency' can never be congruent with critical social work pedagogy and practice and provides clinical implications for future social work practice.

Introduction

This study examined cultural competency training within social work practice to deconstruct how professionals portray racialised clients. The study focused on a 2017 'cultural competency' training that derived from a 'resource kit' from the Alberta Health Services' (2009). It was conducted by a consulting company for a community mental health agency in York Region for social service professionals with a Bachelor of Social Work or Social Service Worker diploma or equivalent. As this training module was

circulated within the community mental health organisation for years, the content that was learned through the training was analysed using a critical lens to understand how it frames clients and informs practice. This research posed several questions, including: How professional cultural competency training in social work settings perpetuate mainstream stereotypes of racialised clients? How are racialised clients portrayed and represented within cultural competency training? Can one learn cultural competency within social work practice?

Cultural competency was intended to assist professionals in working with individuals/groups from racialised groups. However, critical scholars maintain that it is "ineffective" and "its tendency equalizes oppressions under a 'multicultural umbrella' and unintentionally promotes a colour-blind mentality that eclipses the significance of institutionalized racism" (Abrams & Moio, 2009, p. 247). Research has identified the harm in utilising cultural competency frameworks as culture is considered to be a tool in understanding subject-formation and thus limiting a person's autonomy in defining their self (Alvarez-Hernandez & Choi, 2017). By exploring this fundamental issue within social work, this research can guide professionals in reflecting on their privilege, to increase their racial consciousness, and to challenge "unconscious products of enculturation" (Mlcek, 2014, p. 1987).

This is crucial for the advancement of critical social work as the field continues to develop an anti-oppressive framework to promote cultural sensitivity, social justice, and advocacy and help professionals respond to institutional oppressions, such as racism (Abrams & Moio, 2009). Researchers have suggested that social work increase its legitimisation of race scholarship, as well as minority scholarship on race and oppression within the field, to increase attention towards race on a global scale (Abrams & Moio, 2009). This study allows for social work to commit to cultural consciousness to continue strengthening its foundational values of social justice and anti-oppressive practices to address cultural competency within social work (Azzopardi & McNeill, 2016).

As a racialised social worker and advocate for mental health, this research demonstrates 'solidarity' (Van Djik, 1993) with non-white clients accessing mental health services as they can experience stigma due to race, ethnicity, and mental health. As this population can be underrepresented and underserved, this researcher applied a "political critique of those responsible for its prevision in the reproduction of dominance and equality" (Van Djik, 1993, p. 253) through greater insight into larger, structural power relations between the worker/institution and the client. This can reduce the barrier to access of this information and communicate issues of marginalisation and power in comprehensible

language (Van Djik, 1993). As the researcher, this was important in order to limit the notion of 'elite' groups reinforcing dominancy, as well as to give language to harmful experiences of marginalised groups and advocate against social injustices.

Literature Review

Cultural competency insinuates having an understanding of individuals/groups who are racialised. This concept has evolved to include differences of religion, sexuality and ability (Abrams & Moio, 2009). As culture is a tool in understanding and defining reality for individuals/groups, people are able to define their individual purpose in life while also learning appropriate norms/roles/behaviours (Alvarez-Hernandez & Choi, 2017).

Abrams and Moio (2009) state that "knowledge about the complexity of personal and social identity formation as well as intersectionality of multiple axes of oppression that underscore social work problems, practices and interventions led to the broadening of cultural competence beyond racial and ethnic categories" (p. 245). Through this, concepts emerged, such as *cultural sensitivity* or *multicultural* models. This was the result of social workers of colour, in collaboration with white advocates, challenging Eurocentric biases that were embedded in social work practice to shift from a deficit-oriented view of non-white individuals/groups (Abrams & Moio, 2009; Small, Nikolova & Sharma, 2017).

Whiteness and Cultural Competency

Mlceck (2014) aimed to evaluate how cultural competency models are delivered to 86 diverse-background students, and the level of engagement of the students over the span of 3 years. The study found that "being 'white' was seen as a marker for how other racial categories were compared; that is, 'being white' was seen as a 'sign of normalcy, importance and privilege" (p. 1987). The study established that whiteness was considered to be a social construction that advances privileges for white people, as they appear to be *neutral* and maintain power and status of the 'dominant' culture versus their non-white counterparts (Mlcek, 2014). It was important to question "*whose interest is really being served?"* (Mlcek, 2014, p. 1987) in order to analyse how inequities are maintained within Western worldviews and mainstream social work education to reinforce assimilation and uphold hegemony of normativity.

Park (2000) aimed to examine language and its social and political implications in which 'culture' is inscribed within social work discourse. Park's (2000) findings concluded that there is an underlying belief that culture distinguishes immigrants, minorities and refugees from the rest of (dominant) society, resulting in scholars continuing to argue for the significance of the question, "*different from what?*" (p. 21). The unfortunate reality

involved having an implied consensus that the dominant white race is the point of comparison, which influences the assumptions that shape cultural competency within social work.

Criticisms of Cultural Competency

The challenge lies in the fact that cultural competency practices tend to construct borders around culture, rather than discover the contents (Alvarez-Hernandez & Choi, 2017). This becomes problematic as labelling others as 'cultured', can hinder the social worker's ability to recognise their positioning, power, and privilege. "Culture in this arithmetic as a market for periphery, a contradictory descriptor for a deficit, since to have culture, in this schema, is to be assigned a position subordinate to that of those inscribed to be without culture" (Alvarez-Hernandez & Choi, 2017, p. 385). Cultural competency continues to dichotomise individuals/groups as 'us' and 'them' through the process of othering based on learned notions of similarities and differences to dominant, white culture. An individual's experiences become shaped by the extent to which they have been subordinated against dominant white privilege, based on their diverse identity (Azzopardi & McNeill, 2016).

An important critique of cultural competency challenges the assumption that social workers can achieve 'competency', as it implies that practitioners are able to develop a static skillset that can be measured as 'expert' (Azzopardi & McNeill, 2016). Azzopardi and McNeill (2016) and Collins and Arthur (2010) found that cultural competency models have been scrutinised based on the assumption that social workers identify with the dominant culture, which strongly ignores diversity amongst practitioners. Cultural competency has been identified as an "apolitical stance, weak or absent analysis of power relations, promotion of othering, and inadequate approach to addressing oppression at systemic and structural levels" (Azzopardi & McNeill, 2016, p. 284).

Brach and Fraserierector (2000) found that it is difficult to develop a conceptual model for cultural competency and its potential to reduce health disparities as cultural competency often overlooks the concepts of complexity, diversity and intersectionality, and therefore ignoring subcultures, as well as within-group and between-group differences. An analysis of approaches to teaching diversity in social work education by Jani, Pierece, Oritz and Sowbel (2011) extends this idea of a one-dimensional understanding of culture, discounting the reality that the multiple social locations a person occupies can place them in a conflicting and coexisting role of being both the oppressor and the oppressed. This misrepresentation overlooks education and service delivery that manifests cultural racism, which the profession of social work aims to advocate against.

A Critical Approach

Researchers have identified the importance of integrating critical scholarship into cultural competency models within social work to challenge existing agendas which perpetuate racism through colour-blindness and ignore the structural inequities which impact non-white individuals/groups. Six different tenets emphasise the importance of critical approaches to cultural competency within social work. These include: (1) race as a social construction, (2) voices of colour, (3) endemic racism, (4) differential racialisation, (5) anti-essentialism/intersectionality, and (6) interest convergence/materialist determinism (Abrams & Moio, 2009).

By incorporating anti-racist pedagogy, such as Critical Race Theory (CRT), the profession of social work would be "identifying exclusionary practices, locating the source of these practices within structures, identifying the racist nature of structures, and exploring how they are maintained and reproduced through the social construction of race and privilege" (Abrams & Moio, 2009, p. 251). To consider race as socially constructed would help alter the relationship between race and power in order to advocate for the recognition of intersectionalities. In order to progress and continue advancing critical race discourse, Abrams and Moio (2009) recommended that social work education and cultural 'competency' training must address the following: (1) whiteness as normative and non-racial, (2) the silence of marginalised narratives, (3) liberal principles of neutrality; fairness and meritocracy, (4) colour-blindness, (5) the inextricability of race, (6) power and privilege, (7) the legitimising of race scholarship within the field, (8) legitimising the voice of minority scholarship on race and oppression, and (9) the need to acknowledge the implication of race on a global scale.

Alvarez-Hernandez and Choi (2017) also recognise CRT as a commitment to social justice through its transformative response. However, the authors argue that the difficulty is the lack of a clear "road map" to teach all forms of structural injustice and oppression at the same time (p. 389). Requiring white social workers to examine their privilege can be considered problematic as anti-racist education, such as CRT, can essentially re-inscribe a newfound form of white dominance to impact professional identity, competence, and practice (Jeffery, 2005).

Difference, Diversity, and Cultural Consciousness

Furlong and Wight (2011) wrote "a different kind of relationship to practice with diversity is to regard the other's difference as a particular kind of gift, one that has the power to act as a mirror for the practitioner" (p. 49). Using Indigenous understandings of difference, the viewpoint of Furlong and Wight (2011) can contest the western-colonial assumption of the self as being a separate entity that requires the construction of clear boundaries. Although this disrupts pathologising individuals outside the normative white population, it is important for social work to recognise its participation in assimilation and colonisation to ensure avoiding appropriating Indigenous viewpoints and practices. Social workers should advocate for the recognition of the true knowledge production of this understanding of difference within western-dominated education and scholarship.

Azzopardi and McNeill (2016) state "social workers function at the boundary between individuals and their social context and thus are in a pivotal position to recognize the harmful impact of social forces, particularly in relation to minority group" (p. 296). Efforts to help shift cultural competency towards cultural consciousness should be placed at the centre of social work as a pivotal step to reflect the discipline's commitment to advocating towards transformative social justice and change.

Methodological and Theoretical Framework

Critical discourse analysis (CDA) was chosen as the methodology to examine 'cultural competency' in social work to determine how macro-systems and social work institutions legitimise and reproduce stereotypes of racialised clients and perpetuate institutional racism (Van Dijk, 1993). Racial dominance and whiteness were deconstructed to understand how they shape the social inequities of racialised clients through less direct and overt representation and concealment of dominance. This research deconstructed how the strategies, structures and properties of the text of the training contributed towards modes of reproduction (Van Dijk, 1993).

This research utilised **Critical Race Theory (CRT)** to deconstruct and problematise certain themes and languages within the training. This study focused on the 'noble' idea of cultural competency training as an attempt to generate cultural inclusivity, when in actuality, it further oppresses by grouping and 'othering' people, while also creating power differentials. The use of CRT aimed to empower racialised individuals to act as their *own* creators of knowledge, to voice their narrative, and move towards social justice

(Museus, Ledesma & Parker, 2015). Using CRT also helped to reduce the use of deficit-oriented frameworks that marginalise racialised identities (Museus et al., 2015).

Working with the Data

As a previous participant in the training based on the 'cultural competency resource kit' utilised by Alberta Health Services (2009), the document was easily accessible and familiar to this researcher. The source of data was selected through theoretical sampling; that is, this researcher strategically selected the data set based on certain characteristics of the specific training that were relevant to this research. This researcher's interest centred around how cultural competency training contribute to social workers perpetuating mainstream stereotypes when working with racialised clients and ultimately impacting providing true 'culturally competent' services. As social work pedagogy relies on qualitative and quantitative evidence to shape practice, it was important to go to the roots of certain knowledge bases, such as cultural competency, by looking at the content that informs professional interventions.

The document focused on five racialised groups: Chinese, South Asian, Latin American, Southeast Asian and Filipino. The content covered greetings, eye contact, smiling, gestures, the concept of time, and touching of the head for all groups. Guidelines provided to help professionals included cultivating patience, avoiding making judgments/resisting stereotypes, paying attention to their verbal and non-verbal signals, indirect communication techniques, awareness of their own language and general tips for working with non-white clients/communities. Best practice guidelines for working with the five specific groups were provided in the final part of the document.

Indexing was used as a first step to flag important pieces of data and prevent jumping to conclusions that represent final arguments about meanings (Barbour, 2014). A *provisional coding frame* (Barbour, 2014) was developed by using a "brainstorming approach" in order to remain open to all possibilities contained within the dataset (Corbin & Strauss, 2008, p. 2). This process allowed for initial coding to be completed (see Appendix C).

Interpretive conceptual labels were then placed on the information to ensure focus on specific components of the data, while offering a language for talking about the data to differentiate between lower-level and higher-level concepts to separate *categories* and *themes* from what the concepts were indicating (Corbin & Strauss, 2008) (see Appendix B). As qualitative research can involve misguided efforts to quantify data through the use of percentages and numbers, an alternative to this involved using a form of counting by

referring to the *extent of repetition*. This helped to establish patterns or themes to determine their prevalence within the data set (Barbour, 2014).

Thematic analysis was utilised to identify, analyse and report 'patterns,' which are referred to as *themes* within the data. This process involved organising the codes derived from the coding matrix and using colours to identify and categorise patterns within the data. The data was then examined to identify the relationship between the categories to establish overarching *themes*. Based on the twelve categories within the coding matrix, four main themes were identified and defined in the codebook (see Appendix A).

Framing analysis was incorporated to understand how institutions shape the social systems in which they are entrenched (Creed, Langstraat & Scully, 2002). Framing strategies included: consequences, appeals to principles, exemplars, depictions, and roots. Framing analysis was beneficial as it brought attention to subjected voices, surfacing politics and implicit ideologies. This method allowed for the research to understand contextual and societal issues relating to servicing racialised clients in order to bring social progression into organisational contexts with regard to policies, resource allocation, and livelihood (Creed et al., 2002).

Ethical Considerations

It is important to recognise this researcher's position as a racialised person and experience with accessing 'culturally competent' services (Clark & Shraf, 2007). At the time of this study, this researcher was working for a community mental health organisation and had previously participated in the 'cultural competency' training analysed in this research. This research involved separating personal experience and previous knowledge by constantly engaging in critical reflexivity. This was crucial in conducting this research as it may "probe the very personal, subjective truth of peoples' lives" and "in doing so… expose our own frailties, concerns, and questions" (Clark & Shraf, 2007).

Data Analysis

Findings from thematic and framing analysis to explore how one can, if at all, learn cultural competency, suggest four main themes: language diversity, service delivery, cross-cultural knowledge and skills, and characteristics of cultural groups.

Language Diversity

The theme of language diversity was prominent throughout the text by highlighting different linguistic traits such as language family, vocabulary and grammar to 'enhance' communication with racialised clients. The following consequence-frame illustrated

language as a barrier for racialised clients receiving services. “As already identified, language and communication can be major barriers to receiving and providing quality health care” (Alberta Health Services, 2009, p. 77). The training then provided different exemplar-frames for what is deemed as ‘appropriate’ language and communication when working with racialised clients:

> The use of simplistic, direct language (i.e. avoidance of technical jargon, idiomatic expressions, metaphors, etc.), speaking in short units of speech (i.e. avoidance of lengthy discussions) and patience will help in the transmission of a comprehendible message (Alberta Health Services, 2009, p. 77).

The training also used an appeal to principal-frame to suggest to “not assume that accented English means there are significant cultural differences or that the speaker is not intelligent or knowledgeable” (Alberta Health Services, 2009, p. 85). These framing strategies spoke to the importance of examining language and its social and political implications within social work discourse (Park, 2000). With an implied understanding that racialised people are being compared to the dominant white race, participants in this training were taught to communicate differently to non-white service recipients. Readers are encouraged to reflect on and interrogate Park’s (2000) question posing “*different from what?*” (p. 21) in examining why social workers are encouraged, for example, to use simple and direct language while maintaining patience when communicating with racialised people.

Within the document, non-white clients were also portrayed as difficult to communicate with:

> If you’re not being understood, do not raise your voice or merely repeat what you’ve been saying. Try other words or paraphrasing. Remain calm and understanding. As the native speaker, it is your responsibility to communicate in a different way” (Alberta Health Services, 2009, p. 6).

There is an assumption that professionals will get frustrated when working with racialised clients. The social worker as the ‘native speaker’ upholds Park’s (2000) underlying belief that ‘culture’ refers to minorities, immigrants and refugees. As the dominant, white race is considered the point of comparison, the training assumes and frames a racialised person’s communication as being lesser than (Mlcek, 2014). This portrayal of racialised clients through a deficit-oriented lens complemented Alvarez-Hernandez and Choi’s (2017) assertion regarding the schema of culture/racialised identity being assigned to a

subordinate position to justify systemic racism and racial oppression/injustice for non-white clients through mandatory training advertised as 'progressive'.

The examination of language and communication within the training highlighted Alvarez-Hernandez and Choi's (2017) emphasis on the perils and contradictions of linguistics and its uses in social work. When looking at the field of social work, there is an increased sensitivity to the use of power labels and language (Alvarez-Hernandez & Choi, 2017) that is not acknowledged within the training. This hinders the practitioner's recognition of their power and privilege, rendering them, as the training refers, as 'native' (a strong reflection of western-colonial values).

Service Delivery

Another theme that emerged from the training concerns service delivery and the interactions between professionals and racialised clients. The module identified interactions with 'diverse' populations as a barrier for racialised clients to access appropriate healthcare, with an emphasis on the importance of 'enhancing' interactions with non-white groups. Suggestions strategically employed as an appeal to principle-frames included:

> (1) Find individuals willing to work as guides or interpreters.
>
> (2) Note things you do not understand. Ask your guide.
>
> (3) Introduce yourself to community leaders for respect and support (Alberta Health Services, 2009, p. 7).

These strategies were marketed as helpful for professionals to avoid assumptions about culture, while using appropriate resources to obtain accurate information.

However, the training module included contradictions with the aforementioned suggestions which disregard progressive, non-judgmental actions. Using an exemplar-frame, the module identified that for Chinese people, "… it is prudent that outsiders avoid touching the heads and upper torsos of all Asians, including children, as it is believed that when another person touches their head they are placed in jeopardy" (Alberta Health Services, 2009, p. 78). A second exemplar-frame described interacting with Latin Americans through "broad non-verbal behaviour, emotionally expressive and willing to show sensitivity" (Alberta Health Services, 2009, p. 88). For Filipino people, the exemplar-frame strongly advised not using "nicknames unless invited to do so!" (Alberta Health Services, 2009, p. 89).

As mentioned by Garran and Werkmeister Rozas (2013), power and privilege have the ability to complicate constructions of an individual's identity. These examples standardise a one-dimensional and static construction of racialised groups, without acknowledging how larger social structures can shape fixed, homogenised identities (Garran & Werkmeister Rozas, 2013). The professional is presuming that the non-white person's culture is static and does not change overtime, to encourage service delivery which manifests racism and systemic injustice for racialised clients (Fisher-Borne, Cain & Martin, 2015). This contradicts social work which advertises itself to fundamentally advocate against such oppressions.

When looking at the findings of Fisher-Borne and colleagues (2015), as cultural competency shapes the experiences of racialised clients and impacts the provider's approaches to care, the training lacked the critical component of encouraging professionals to unpack their power and privilege to reflect on how their practices uphold fixed subject-identities of non-white clients. Abrams and Moio (2009) addressed the difficulties in practitioners identifying their positionality, which indicates the need for professional support within cultural competency training to address feelings that may come about when unpacking one's power and privilege. It may be necessary for training to require appropriate allocation of time and space needed to unpack these heavy issues, rather than compressing content in a 'one-day crash course'. Follow-ups and one-to-one support would be beneficial to continue fostering a soundboard for practitioners to address these challenges within social work practice.

Cross Cultural Knowledge and Skills

A third theme throughout the training was the idea of cross-cultural knowledge and skills that social workers acquire and utilise to be 'culturally competent'. The training employed catchphrase-frames as *'multicultural etiquette'* for professionals to question their own biases and assumptions. These included:

> (1) Do not assume your knowledge of another's culture is correct. Your knowledge may not be accurate or applicable for that individual
> (2) Be aware and willing to admit to your own lack of knowledge when approaching or preparing to enter an ethno-cultural community that is not your own.
> (3) Put your own assumptions and evaluate judgments aside to be open to new ideas, values, and behaviours. (Alberta Health Services, 2009, p. 86).

This section fostered feelings of the hopefulness of a critical lens to challenge mainstream knowledge and comprehension of culturally 'competent' information about racialised groups.

However, the training did not employ tools for practitioners to question their own biases and pre-fixed notions of racialised people. This was congruent with the research of Jeffrey (2005) and Abrams and Moio (2009) who found that cultural competency training tends to avoid addressing heavy topics of race, racism and systemic oppression, that is needed in order to name people's feelings of discomfort, anger, resentment, guilt, and anxiety. Is it fair to expect one 'crash course' training to deconstruct notions of race, subjectivity and power within a 6-hour training?

Yet, the training does caution the participants that the material is based on generalisations.

> Please remember that the following are gross generalizations based on traditional cultural values for each community. They are offered as GUIDELINES only and should only be applied to an individual/family with extreme caution. Culture is changing over time and members of a particular culture will display its values, beliefs, and behaviours to different degrees – or not at all! (Alberta Health Services, 2009, p. 86).

The reproduction of stereotypes and fixed-subject identities of racialised people aligned with the findings of Hollinsworth (2013), which explains that homogenisation, labelling and categorisation of cultural groups can misrepresent complexity and diversity. This one-sentence alert implied the justification of propagating fixed-subject identities of non-white groups, based on assumptions made about racialised cultures stemming from the dominant narrative of whiteness, to continue reproducing racism and oppression.

As Park (2000) describes the *culture free* and white narrative constructing and dictating the conceptualisation of culture and racialisation, the training failed to address the influence of whiteness on cultural competency principles and knowledge. The training did not recognise that 'whiteness' and white culture is often obstructed (Park, 2000) and neutralised (Mlcek, 2014) to uphold the notion that white culture is understood by all members of society, regardless of their race. Does contemporary social work practice provide training for professionals to acquire appropriate knowledge and skills in working with white populations?

With limited understanding of intersectionality and multiple identities of individuals (Azzopardi & McNeill, 2016), the training module maintained a surface-level and one-dimensional lens when learning about the cultural identities of non-white people.

Without the discussion shaping a multidimensional understanding of culture (Azzopardi & McNeill, 2016), the training continued to bracket the social worker's own cultural influences and assumptions, rather than engaging in what Yan and Wong (2005) described as a dialogic space to allow for the client to invite the worker to be included into their own world. Instead, the training provided information for the practitioner of an already established racialised person's relationship to culture to continue confining non-white groups to homogenised cultural identities.

Characteristics of Cultural Groups

A final theme concerns the characteristics of the cultural groups defined in the training. The document provided exemplar and depiction-frames of the following racialised groups: Chinese, South Asian (Indian sub-continent), Latin American, Southeast Asian (specifically Vietnamese, Laotian and Cambodian), and Filipino. The descriptions targeted the following categories: body contact, eye contact, gestures, time, obligations, decision making/conflict resolution, education, values, and family structure.

Although it is helpful to know this information about a client, the characteristics within the training are fixed generalisations of racialised groups, which endorse the findings of Garran and Werkmeister (2013) to depict how cultural competency provides a one-dimensional understanding of culture that discredits the reality of multiple social locations a person occupies. The Depiction-frame "punctuality is less important" illustrated that South Asian, Latin American, Southeast Asian and Filipino people are not on time, whereas for Chinese people, "punctuality is valued" (Alberta Health Services, 2009, pp. 87-89). This can impact the service delivery of professionals working with these racialised groups. For instance, this communicates to professionals that it may be permissible to be late to appointments with a South Asian client versus Chinese.

The module also included other depiction-frames that uphold the deficit-based, lesser than, subject identity of non-white people, such as:

> (1) South Asians, especially males, may speak loudly with animated gestures. This should not be seen as hostility or an argument.
> (2) [Latin American] women may be actively prevented/discouraged from seeking jobs or higher education. (Alberta Health Services, 2009, p. 88).

As per Park's (2000) recognition that dominant, white culture is the point of comparison for differentiation and divergence, these assumed characteristics support how social work is at fault for continuing the dichotomisation of non-white people and groups as 'us/them' through the process of othering based on learned notions of similarities and differences.

These excerpts relate to Azzopardi and McNeill's (2016) explanation of how non-white people are shaped by the extent to which they have been subordinated against dominant, white privilege in society to determine features of their racialised identity. These depictions perpetuate the consequences of the mainstream, ethnocentric monoculturalism that informs social work practice to act as what Mlceck (2014) describes as an "unconscious part of enculturation" (p. 1987).

It is important to note that the module included appeals to principle-frames when talking only about Latin American and Southeast Asian groups, stating that for a "wide range of cultures/countries of origin therefore generalizations are very difficult" (Alberta Health Services, 2009, p. 88). Although this acted as a disclaimer and raised critical awareness within the training, the document continued to contradict this by providing depictions and exemplar-frames to uphold one-dimensional, homogenised identities of these racialised groups. The content in the training module coincided with Azzopardi and McNeill's (2016) belief that speaking on behalf of the 'other' can be problematic within cultural competency frameworks, due to the increased risk of disempowerment and harm endured onto the person/group identifying with the culture. As the training influences professionals to pre-determine a racialised person's identity and relationship with culture, the practitioner is at risk of making judgments about the behaviours, actions and values of the client.

These pre-fixed identities concurred with Bach and Fraserector (2000), who found that cultural competency models often overlook the complexity and diversity of non-white groups as they fail to recognise the concept of intersectionality. The following depiction-frames generalised all Southeast Asian and South Asian households to function within patriarchy:

> (1) [Southeast Asian] men are the authority in the home.
> (2) The traditional [South Asian] family is male centered. (Alberta Health Services, 2009, p. 88)

This oversimplification of these racialised groups did not acknowledge the diversity amongst Southeast Asian and South Asian families, minimising complexity and promoting homogenisation. Further supporting Bach and Fraserector (2000), the depiction-frames ignored within-group differences and subcultures, overlooking substantial between-group differences. These pre-determined characteristics and subject-identities of non-white groups are problematic as it makes it difficult for an individual to formulate their own subject-identity and share their relationship with culture within the therapeutic relationship. These depiction-frames also aligned with the findings of

Hollinsworth (2013) and Garran and Werkmeister (2013) who recognised the misrepresentation of diversity within homogenised categories and labels of non-white groups to prioritise the essentialisation of racialised populations, rather than promote reflexivity.

Challenging Dominant Discourses of Marginalised Subject-Identities

Two depiction-frames influenced the audience to deconstruct mainstream stereotypes and generalizations about specific racialised groups:

> (1) However, do not make assumptions about South Asian women. Many are very influential in the family and are highly educated.
> (2) Do not assume lack of language skills equals lack of intelligence. Many Latin Americans are highly educated. (Alberta Health Services, 2009, p. 88).

These depiction-frames helped to challenge and unlearn marginalised subject-identities of both South Asian and Latin American women. Assumptions about these two racialised groups were addressed in order to disprove dominant discourses and empower non-white people and their identity formation. Nevertheless, the training continued to contradict these depiction-frames so as to continue upholding the dominant and homogenised narrative of racialised identities.

Implications for Social Work Pedagogy and Practice

Using a critical race and social justice lens, the findings and discussion have identified how the idea of 'cultural competency' cannot exist in social work practice and pedagogy. Suggestions will be provided for future clinical directions for the profession of social work to work towards *un*learning cultural *in*competency.

Similar to the findings of Nakoka and Ortiz (2018) who found higher education often privileging the dominant narrative of whiteness to maintain structural marginalisation of racialised people, the critical discourse analysis of the training also brings awareness to how whiteness informs cultural competency frameworks. Training must be reframed to dismantle 'cultural competency' by centring the idea of whiteness and unpacking dominant discourses and power relations that construct and contribute to racialised subject-identities. This means going beyond white social workers examining their white privilege. Training needs to address whiteness as a global ideology through acculturation and assimilation. Whiteness must be examined as a political agenda that has influenced dominant discourses, power relations and subject-identities cross-culturally to maintain

the status quo and neutrality in society of both knowledge production and meaning-making.

It is important for training to recognise the complexity of injustice and oppression. As noted by Alvarez-Hernandez and Choi (2017), it is difficult to provide a clear 'road map' to teach professionals about different structural injustice and oppression at the same time. Issues of systemic racism cannot be separated from different power systems that shape the marginalised experiences of racialised people, such as patriarchy, heteronormativity and ableism. Training must highlight intersectionality to understand how class, race, age, religion, sexual orientation, gender and ability cannot exist separately. Conversations must be facilitated to understand that the concept of oppression and privilege go beyond fixed binaries and are complicated based on a person's social location. Without understanding the interconnectedness of marginalised experiences and oppressions, larger structural systems of dominance and power will continue to shape contemporary society, and social work pedagogy and practice.

Training programs must allow for discussion around normalising empowered subject-identities of non-white people. As Freeman (2011) in Alvarez-Hernandez and Choi (2017) explained, often a critical race lens can unknowingly reinforce notions of racialised people being inferior. A critical race lens upholds the assumption that racialised people are different from the dominant white race, which can shape a deficit-oriented subject-identity. This can influence the internalised oppression of non-white people to uphold these marginalised subject identities and ignore the reality of power and privilege being negotiated based on the different layers of an individual's subject identity.

This researcher, for example, identifies as a South Asian female, where power and privilege may increase in a group of Pakistani females, in comparison to a group that is predominately white. As mentioned by Jani and colleagues (2011), these multiple subject identities and social locations that people occupy can coexist as both the oppressor and the oppressed. There must be a shift in conversation regarding culture to bring awareness of how racialised people's power and privilege is negotiated and constructed within different subject-identities. Social work pedagogy and practice can build on this by challenging fixed and deficit-oriented subject-identities that are formulated by whiteness for training professionals, to unlearn these dominant discourses and allow for the creation of empowered narratives of non-white groups. Training should encourage professionals to unlearn generalisations and assumptions of non-white people by including content which confronts these stereotypes and prejudices.

Concluding Thoughts

This paper has presented the findings of a critical discourse analysis using a critical race and social justice lens to explore how professional cultural competency training in social work settings perpetuate mainstream stereotypes of racialised clients. A limitation of this research includes only analysing a limited data set of *one* community mental health agency's cultural competency training. Future research may involve building on this data set to include other training. The research design can also be extended to include the voices of racialised clients who have accessed community mental health services so that the realities of participants is captured, rather than inferring information as a researcher.

This research investigated how racialised clients are portrayed and represented in cultural competency training to understand how to teach cultural competency in social work. This involves shifting the question from how one can truly *learn* 'cultural competency' to *how can practitioners be educated to respond effectively to racism and other forms of oppression on a micro and macro level?* Through this reframing, it can be understood that social work cannot subscribe to 'cultural competency' due to its aim to excuse dominant moves to innocence to absolve and excuse the problem of the framework as a whole.

Elements of social work practice, such as language and communication, service-delivery, and cross-cultural knowledge and skills must be examined to recognise how social work pedagogy and practice contribute to the narrative of racialised people. The homogenisation of non-white subject identities perpetuates othering and allows for systemic oppression to be entrenched in both social work and society by giving meaning to fixed values and behaviours of racialised people. Social work practice and education must move the conversation to deconstructing whiteness as a global ideology, understanding the complexity of injustice and oppression, and exploring the fluidity of power and privilege. This will allow for social work to commit to legitimising the diverse experiences of racialised people by disrupting the neutrality and dominant power relations that influence the profession.

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Appendix A

Code Book

Language diversity: different linguistic traits, such as language family, vocabulary and grammar to enhance communication with racialized clients

Service delivery: ability of the worker and organization to effectively deliver culturally-competent mental health services that meet the cultural, social and linguistic needs of racialized clients

Cross-cultural knowledge and skills: knowledge of different cultural practices and skills that increase one's ability to understand, communicate and interact effectively with racialized people

Characteristics of cultural groups: fixed subject identities of racialized groups to define their values, beliefs and norms

Appendix B:

Thematic Analysis

Decontextualizing Phase II: Thematic analysis – Color coding

Colour	Codes	Frequency	Main Theme
Yellow	Language/Communication	31	Language Diversity
Lime Green	Interactions	13	Service Delivery
Plum	Expectations/Assumptions	23	Cross-Cultural Knowledge and Skills
Light Blue	Body Contact	9	Characteristics of Cultural Groups
Hot Pink	Eye Contact	5	
Red	Gestures	6	
Teal	Time	6	
Olive	Obligations	2	
Light Grey	Decision Making/Conflict	12	
Dark Gray	Education	4	
Dark Green	Values	16	
Maroon	Family Structure	6	

Appendix C:

Coding Matrix with a Framing Analysis – Sample

Fatima's Coding Matrix
Document analysis

CENTRAL RESEARCH QUESTION/S:

- How do professional cultural competency trainings in social work settings perpetuate mainstream stereotypes of racialized clients?
- How are racialized clients portrayed and represented within cultural competency trainings?
- How can one learn cultural competency within social work practice?

Decontextualizing Phase I:

DOCUMENT SECTION	TEXT OF DOCUMENT	CODE	FIELD NOTES/IMPRESSIONS	FRAMING STRATEGY
Pg. 3: *Multicultural Etiquette*	"As already identified, language and communication can be major barriers to receiving and providing quality health care"	LANGUAGE AND COMMINICATION BARRIERS TO SERVICE	Is this because we are delivering in English?	CONSEQUENCE
Pg. 3: *Multicultural Etiquette*	"There are some ways to enhance interactions with diverse populations"	ENHANCING INTERACTIONS WITH DIVERSE PEOPLE		APPEALS TO PRINCIPLE
Pg. 3: *Multicultural Etiquette*	"The use of simplistic, direct language (i.e. avoidance of technical jargon, idiomatic expressions, metaphors, etc.), speaking in short units of speech (i.e. avoidance of lengthy discussions) and patience will help in the transmission of a comprehendible message"	USE SIMPLISTIC LANGUAGE AND PATIENCE WITH DIVERSE PEOPLE	Taking on the assumption that non-white, racialized clients are not able to comprehend these elements of language	EXEMPLAR
Pg. 3: *Multicultural Etiquette*	"As Canadian demographics continue to change, it is crucial that health care providers become familiar with, and sensitive to proper etiquette when interacting with diverse populations"	INTERACATIONS WITH HEALTHCARE PROVIDERS	What are the implications behind the idea of being "sensitive" to "proper" etiquette?	APPEALS TO PRINCIPLE

Appendix D:

Culturally Competency Resource Kit for Healthcare Professionals

Summary:

Cultural Competency Resource Kit for Healthcare Professionals

Summarized from:

Enhancing Cultural Competency Resource Kit by Alberta Health Services

See full report by accessing the link below:

http://fcrc.albertahealthservices.ca/pdfs/Enhancing_Cultural_Competency_Resource_Kit.pdf

Cultural Summaries: (Page 20 – 72)

Provides descriptive information on the following ethno-cultural communities:

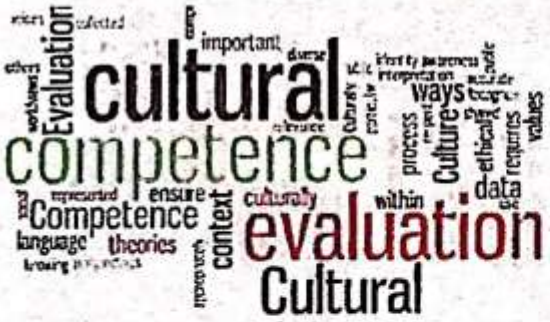
1. Cambodians
2. Central & South Americans
3. Chinese
4. Filipinos
5. Koreans
6. Somalis
7. Sudanese
8. West Africans
9. South Asians
10. Vietnamese

For each of the above communities, the descriptive information includes the following:

1. Family Structure
2. Acculturation Issues
3. Cross-Cultural Interactions
4. Religion
5. Children
6. The Elderly
7. Food and Diet
8. Literacy
9. Census Information
10. History, Beliefs & Health Practices
11. Immigrant History
12. Traditional Health Practices & Beliefs
13. Healthcare Systems
14. Medication & Treatment
15. Hospitalization
16. Death and Dying
17. Mental Health
18. Family Planning
19. Pregnancy
20. Childbirth
21. Post-Partum Period
22. Rehabilitation
23. Delivering Culturally Sensitive Healthcare

The report also includes other valuable cultural competence resources that are listed below:

1. Multi-Cultural Etiquette (Page 77 – 78) – ***attached***
2. Verbal and Non-Verbal Communication Guidelines (Page 79 – 81)
3. Five Steps to better communication across cultures (Page 85) – ***attached***
4. General Tips for Approaching Minority Clients & Communities (Page 86 – 89) - ***attached***
5. Cultural Perspectives on Health and Illness (Page 93-94)
6. Culturally Sensitive Assessment Guidelines, Vancouver Community Health Services (Page 104 – 109)



Multicultural Etiquette

As already identified, language and communication can be major barriers to receiving and providing quality health care. There are some ways to enhance interactions with diverse populations. The use of simplistic, direct language (i.e. avoidance of technical jargon, idiomatic expressions, metaphors, etc), speaking in short units of speech (i.e. avoidance of lengthy discussions) and patience will help in the transmission of a comprehendible message.

As Canadian demographics continue to change, it is critical that health care providers become familiar with, and sensitive to proper etiquette when interacting with diverse populations. The following are some examples of things to keep in mind.

Greetings

The rituals surrounding greetings vary greatly among cultures, especially in terms of body contact when initially establishing a relationship. In general, avoid body contact (handshakes) with Asians, Middle Easterners, and Orthodox Jews. Latinos, Europeans and Armenians generally expect some body contact. Following the lead of the recipient is a safe way to avoid being offensive. Addressing individuals in a formal way (Mr., Mrs.) is also expected in many cultures, especially when addressing the elderly.

Eye Contact

Avoidance of eye contact may be intended as a sign of respect, especially by people from many Asian, Latin American, South African and Caribbean cultures. Alternately many African Americans when speaking tend to stare intently at the listener, but while listening will mostly look away.

Smiling

While North Americans smile primarily as an expression of friendliness, in many Asian countries it is used to signal sadness, happiness, anger, apology, confusion, or gratitude. Other cues such as eye expression and forehead movements help clarify the intended meaning.

Thumbs-Up & Other Gestures

It is important to keep in mind that gestures do not have universal meaning. For instance, in many parts of the world including Nigeria, Australia and Middle Eastern countries, the thumbs-up sign has the same sexual connotation as the American middle-finger gesture. The North American 'good-bye' gesture means "come here" in many Southeast Asian cultures. Finally, pointing the index finger at a person is considered especially rude to people from South Asian cultures. The crooked finger (to indicate "come here") is also considered obscene to people of South Asian cultures.

Concept of Time

Both Japanese and Korean cultures view being "on time" as arriving early for the scheduled appointment, whereas many Spanish- speaking cultures do not hold great importance to appointed time. It is useful to explain what your expectations are about time, and inquire as to what the cultural customs are in exchange.

Touching the Head

Many Asian cultures hold the belief that the soul is housed in the head. For this reason, it is prudent that outsiders avoid touching the heads and upper torsos of all Asians, including children, as it is believed that when another person touches their head they are placed in jeopardy.

(Source: Dresser, Norine, Multicultural Manners New Rules of Etiquette for a Changing Society, John Wiley & Sons, 1996)

5 Steps to Better Communication Across Cultures

(adapted by Dr. Valerie Pruegger from the McDonald Guide to Communication Across Cultures, Cross-Cultural Communications, Inc.)

1. Cultivate Patience

- Allow extra time to establish rapport.
- Take the time to listen carefully, or pause after you speak to be very sure you are being understood. Check for understanding with questions.
- Never interrupt. Listen until you are sure the speaker has finished.

2. Avoid Making Quick Judgments & Resist Stereotypes

- Do not assume your knowledge of another's culture is correct. Your knowledge may not be accurate or applicable for that individual.
- Do not assume that accented English means there are significant cultural differences or that the speaker is not intelligent or knowledgeable.
- Don't assume that specific physical features (e.g., skin colour) indicate predictable differences in cultural and/or linguistic backgrounds.

3. Pay Attention to Verbal and Non-Verbal Signals

- Be aware of the different ways people structure their statements and replies. Important information may come at the end.
- Be constantly aware of your body language, pitch and tone of voice.
- If a response seems evasive or confused, ask yourself "What is really happening here? Where is the communication breaking down?" before leaping to conclusions.
- Take body gestures and facial expressions into account, but be careful not to impose your own cultural norms/standards too rigidly.

4. Don't be Afraid to Use Indirect Communication Techniques

- Use analogies or relevant stories, illustrations, and examples as they are often viewed to be less threatening.
- Ask for assistance from others more familiar with the culture.
- Employ props, sketches, or sign language.

5. Be Aware of Your Own Language Use

- Avoid expressions specific to English.
- Try not to use abbreviations, acronyms or technical jargon.
- If you're not being understood, do not raise your voice or merely repeat what you've been saying. Try other words or paraphrasing. Remain calm and understanding. As the native speaker, it is your responsibility to communicate in a different way.

General Tips for Approaching Minority Clients & Communities

1. Be aware of and willing to admit to your own lack of knowledge when approaching or preparing to enter an ethnocultural community that is not your own.
2. Be willing to learn through observation, analysis, and questioning.
3. Recognize that you need assistance and information.
4. Conduct preliminary reading of reliable factual materials regarding the community, but do not over-generalize.
5. Find individuals willing to work as guides or interpreters. These could be community members, leaders, elders, or non-community members who have been successful in gaining access.
6. Put your own assumptions and evaluate judgments aside to be open to new ideas, values and behaviors.
7. Introduce yourself to community leaders to show respect and gain support. Focus on how you can benefit the community and show a willingness to adapt to its needs.
8. Be prepared for initial reactions of distrust, rebuff, prejudice, stereotypes, and/or resentment. Take your time to establish relationships before focusing on interventions.
9. Do not enter the community until you know what your goals are. What do you want from the relationship?
10. Observe communication patterns, e.g., giving feedback, expressing emotions, touching and personal space, meaning of silence, non-verbal behavior such as eye contact, and taboo topics.
11. Note things you do not understand. Ask your guide.
12. Learn some key words of the language and appropriately adapt your communication style and behavior to fit the community.
13. Choose language carefully to avoid unconscious offenses, e.g., not 'disabled', but 'people with disabilities'.

Above all, relax, enjoy, be accepting, avoid defensiveness, be humble, be able to laugh at yourself, learn from your mistakes, and keep learning!

Please remember that the following are gross generalizations based on traditional cultural values for each community. They are offered as GUIDELINES only and should only be applied to an individual/family with extreme caution. Culture is constantly changing over time and members of a particular culture will display its values, beliefs, and behaviors to different degrees – or not at all!

Community Specifics

Chinese

1. Do not assume the person is an immigrant e.g., "How long have you been here". If you need to ask, ask "Were you born in Calgary?" which allows him/her to fill in details.

2. Reciprocity and obligations are important. A favor asked is a favor returned.

3. Punctuality is valued.

4. Avoid face- to- face confrontation. Use a mediator or a third party.

5. Public display of anger or other strong emotions are seen as a lack of control, immaturity. Lose trust/respect.

6. Be very tactful. The concept of face is important. Open confrontations, accusations, disagreements, disapproval are very embarrassing.

7. May be unwilling to interrupt a discussion. Pause to give the individual a chance to participate.

8. Feedback behavior is minimal. Little nodding, attentive listening behavior.

9. Taboo topics include death and sex.

10. Uncomfortable with opposite sexes touching in public. Same sex may touch.

11. Young people may avoid eye contact with elders/authority as a sign of respect.

12. Decision-making and problem solving are group activities.

13. Deflect praise to group. Direct praise may make individuals uncomfortable.

14. Speakers of tonal language may inadvertently place tone or stress on a word. Check for understanding. For example, 'No' may sound like a question or be very abrupt. These do not indicate uncertainty or rudeness.

South Asian – India Sub-Continent

1. 'East Indian' is geographically incorrect and may be offensive. Use "South Asian".

2. Major groups include Sikhs, Pakistanis, Indians.

3. Many are highly educated professionals, males and females.

4. Personal relations take priority over task completion. Socialize before getting 'down to business'. Personal networking is important.

5. Punctuality is less important.

6. Shaking the head may mean "yes" or "I understand", or "I'm listening." Eye contact with elders/authority may be avoided as a sign of respect.

7. Personal and family honor is valued. Direct, especially public criticism should be avoided.

8. Loss of status upon entry to Canada is common in these groups. Be sensitive to resulting loss of dignity.

9. May avoid conflict. May not say "no" directly. May say "I'll try" or "Maybe". Failure to respond at all may be polite way of saying "no."

10. Problem solving and decision- making are formal processes. Slow, careful examination of documents, methodical.

11. Serve refreshments.

12. Religion and language may be more important than "race".

13. The traditional family is male-centered.

14. Women may be reluctant to shake hands with men or women.

15. Compliments to a South Asian woman by an unrelated man may be considered inappropriate. However, do not make assumptions about South Asian women. Many are very influential in the family and are highly educated.

16. South Asians, especially males, may speak loudly with animated gestures. This should not be seen as hostility or argument.

Latin American

1. Wide range of cultures/ countries of origin therefore generalizations are very difficult. Always check.

2. Small personal space requirements especially if interacting positively with an individual.

3. Touching is common for people of the same sex, and is often used as a sign of warmth or acceptance.

4. Personal dignity/honor is very important. Direct criticism, especially in front of others should be avoided.

5. Broad non-verbal behavior, emotionally expressive and willing to show sensitivity.

6. Punctuality is less important.

7. Problem solving and decision- making may involve passionate argumentation, use of power.

8. Intuition and impulsivity are valued.

9. Loyalty is valued.

10. Traditionally, men are leaders.

11. Mothers/sisters are highly honored and must not be insulted. Women may be actively prevented/ discouraged from seeking jobs or higher education (this varies greatly across cultures).

12. Many Latin Americans may have had traumatic experiences in their homeland.

13. Do not assume lack of language skills equals lack of intelligence. Many Latin Americans are highly educated.

Southeast Asian (Vietnamese, Laotian, Cambodian)

1. Southeast Asia represents a wide range of cultures therefore generalizations are very difficult. Always check.

2. Time is not an important value.

3. Patience is admired and respected.

4. Reciprocity is valued in favors, therefore offers of assistance may not be accepted easily.

5. Third party mediation is preferable to direct confrontation. "Saving face" is important. Avoid direct criticism. Prefer to avoid open conflict.

6. Phrases such as "thank you" "please" "may I" "sorry" "pardon" etc...are used sparingly and only when sincerely meant.

7. Physical touching in public between opposite sexes is forbidden. Same sex, males or females, may hold hands or walk arm in arm.

8. Personal relationships/networking important to success. Maintenance of these relationships is important.

9. Problem solving and decision making requires a trusting personal relationship. Do not get straight to the point. "Yes" may mean uncertainly or possible "no". Paraphrase to ensure you understand.

10. Respect for elders/authority figures, and personal humility important. Ancestors are often revered.

11. Discomfort with praise (may minimize own achievements).

12. Uncomfortable topics include personal or emotional problems, intergenerational conflict, finances.

13. Family comes before self or work. Men are the authority in the home.

14. Be sensitive to the possibility that this person may have experienced traumatic events in the homeland.

Filipinos

1. Punctuality for social gatherings may not be important.

2. Individual and group dignity is important. Avoid direct criticism, open displays of anger. Third party mediation is valued.

3. Open conflict or questioning may be avoided. "Perhaps" or "maybe" may signal disagreement.

4. Taboo topics: marital status, children, family, money, & age.

5. Decision making and problem solving involve well thought out plans prepared for group consensus.

6. Women and men rarely show affection in public.

7. Family commitments over-ride personal desires.

8. Wife may have a great deal of power in the family, also financially. Women enjoy equality with men.

9. When greeting a group, the eldest or most important individual should be greeted first.

10. Do not use nicknames unless invited to do so!

11. Keep in mind that the Philippines are the third largest English speaking country in the world. Most Filipinos speak English very well.

12. May be reluctant to question those in authority.