Cultural Sensitivity and Diabetes Education

American Association of Diabetes Educators (AADE) Position Statement

Introduction

Diabetes in the United States is a serious public health problem that disproportionately affects African-Americans, Hispanics, Asian and Pacific Islanders, American Indians and Alaskan Natives.[1] By the year 2050, the Asian population is estimated to increase by 212.9%, the Hispanics by 187.9%, and African Americans by 71.3% in comparison to 32.4% growth in Whites[2]. Diabetes prevalence among these groups is 12.6% in African Americans, 11.8% in Hispanics, and 8.4% in Asian Americans compared to 7.1% in Whites.[3] Reasons postulated to explain this disproportionate burden of diabetes include genetic predisposition, family history, dietary patterns, limited physical activity, socioeconomic position, gender, and lack of access to overall quality health care.[4,5,6,7] Further, the role of the environment-both physical (e.g. restaurants serving healthy foods, walking trails, safe neighborhoods) and social (e.g. families, workplaces, social support) contributes to cultural norms, views and perspectives of individuals. These perspectives establish rules for living that extend to the cultural meaning of disease and its management.[5,8]

Background

Our patients come to us with health beliefs developed within the context of their respective cultures. In order to provide quality care, it is crucial to incorporate important aspects of culture into direct patient care and diabetes education programs targeting ethnically diverse populations. Factors such as relevance in a culture, credibility of the educator, and even the target of education efforts can vary based on cultural norms. When these issues are addressed it is far more likely that patients will benefit from education efforts. Consideration of the impact of the larger culture is essential as it appears that poverty and cultural oppression may be a cause of higher diabetes rates in some cultures.[9] Prevention efforts need to be aware of and address these larger issues to be successful.

Working with communities to identify culturally relevant needs and topics of interest is essential to developing meaningful relationships with our patients to promote positive health behaviors. In recent years, community-based participatory research (CBPR) has become an internationally recognized ‘gold standard’ of practice for health workers collaborating with communities to promote health and prevent illness, particularly chronic diseases including diabetes.[10,11] This approach invites the direct participation of those affected in all aspects of the research and the application of the benefits. It enables people to consider the decisions that are best in their communities and to take power for themselves to shape applications and outcomes.

Cultural humility is necessary when working with individuals and communities from different subcultures. Cultural humility is defined as a “…process that requires humility as individuals continually engage in self-reflection and self-critique as lifelong learners and reflective practitioners”. It requires health care professionals to bring into check the power

imbalances that exist within the dynamics of provider-patient communication by using patient-focused interviewing and care to develop and maintain mutually respectful and dynamic partnerships with communities.[12] Cultural humility focuses less on differences in beliefs, behaviors, or characteristics unique to subcultures, but charges health care professionals to find commonalities with their patients. This can position diabetes educators to become aware of how their own worldview influences their belief systems and behavior toward their patients.

Role of the Diabetes Educator

Awareness of the socio-economic and racial inequalities of health, while exploring the impact of our society on different subcultures, is the first step to becoming more culturally sensitive and promotes the development of cultural humility. Information provided in the documentary series "Unnatural Causes" discusses certain inequalities and their impact on the health of cultures.[9]

Domain II of the Competencies for Diabetes Educators calls for "culturally competent supportive care across the lifespan" and states that the educator will "provide diabetes support and care in a culturally-competent manner across the lifespan".[13] It is important to know as much as possible about the practices of the communities we serve. However, cultural humility and respect for individuals takes this competency to its fullest impact. We need to be willing to continually learn and grow in our knowledge regarding the subcultures we serve. Stereotyping produces a false sense of security that is best avoided.[12] Instead we need to incorporate self reflection, lifelong learning, and continually assess anew the cultural dimensions and experiences of each patient.

Diabetes educators are encouraged to:

- Develop a basic understanding of key terminology such as cultural sensitivity, cultural humility, cultural competence, multi-cultural, cultural tailoring, racial identity, and ethnic identity (see sidebar).
- Develop cultural humility by continually reassessing and re-evaluating our own intentional and unintentional processes of racism, classism, homophobia, and sexism[12]
- Practice active listening to permit identification of what is meaningful to patients[14]
- Become familiar with cultural variations in families, health beliefs, socioeconomic status, residential settings, and work of the patient with diabetes and his/her family members to expose patterns of community practice as well as medical practice that enhance or undermine good diabetes management. [15]
- Respect and understand how your patient, as a member of an ethnic group, views him/herself, regardless of how the group is classified or viewed by others.
- Ensure at a minimum that important aspects of surface structure are addressed when developing diabetes educational materials.
- Acknowledge and accept responsibility to identify and utilize strategies to eliminate personal biases that can influence interactions with ethnic groups other than your own.
- Utilize a collaboration care model that places emphasis on principles of community participation in the design of diabetes self-management practices.
- Become involved in continuing education to gain familiarity with the various cultural competency models and their application in diabetes education.
- Ensure that patients receive effective, understandable, and respectful care provided in a manner compatible with their cultural health beliefs, practices, and preferred language.
- Participate and or support original research exploring the relationship between culture, health, and medicine.
- Utilize findings from research that examine the relationship between culture, health, and

medicine in diabetes education to develop new therapeutic approaches to improve diabetes care.

Why is this topic important for Diabetes Educators?

Awareness of the need for cultural sensitivity is the first step toward providing culturally sensitive and culturally competent diabetes education. Cultural competence is more than a finite knowledge of cultural values, beliefs, customs, language, thoughts, and actions. The need to gain relevant cultural insight necessitates the need to develop a certain amount of cultural humility. Cultural humility will help develop a mutually respectful and positive relationship among patients and healthcare providers. The more engaged in health care our patients and their support members are the more likely they are to achieve desired outcomes and improve their quality of life.

Why is this topic important for people with diabetes?

The need for individual educators and organizations to become culturally sensitive and develop deeper connections with the people and the communities we serve is based in part on our understanding of the role culture plays in cognition and in mediating behavior.[16] Integral to health, culture profoundly affects the way people define and experience health and disease. For example, people with diabetes make decisions about health seeking behaviors, food selection, level of physical activity,[17,18] use of prescription and over the counter drugs[19], and patient-provider interactions based on their cultural perspective.[20] Similarities and differences between and among ethnic groups are manifested in their life experiences, family backgrounds, individual beliefs, attitudes, practices, socioeconomic status, environmental surroundings, and perception and experience of racism.[20] These similarities and differences must be understood and considered when designing, delivering, and evaluating primary or secondary focused lifestyle interventions. This is particularly the case given culturally appropriate interventions greatly impact adoption and maintenance of healthy behaviors over time.

A culturally sensitive approach will reinforce to the people we serve that we as educators value what is important to them. By relinquishing our role as ‘expert’ and becoming a ‘student’ in regard to individual values, norms, beliefs, and goals, we are inviting our patients to become an engaged and active participant in their care.

Why is AADE addressing this issue?

The code of ethics for AADE calls for diabetes educators to “respect and uphold basic human rights”, and “respect the uniqueness, dignity, and autonomy of each individual”.[21] This offers a good starting point for investigating the importance of cultural sensitivity in diabetes education. Respect is “the single most powerful ingredient in nourishing relationships and creating a just society,” as Sara Lawrence-Lightfoot, author of Respect: An Exploration, has said.[22] She offers six elements of respect all well known to diabetes educators: dialogue, attention, curiosity, healing, empowerment, and self-respect. Relying on any of these six elements of respect to build cultural competence and cultural sensitivity may require a certain degree of vulnerability. This lifelong process of self-learning and reflection will prompt us to continually hone our skills to provide education in the most amicable way possibly while striving to provide the best possible care.

Future directions

Cultural integration approaches to community based care are necessary and avenues for developing and establishing efforts are warranted. Identifying and soliciting the help of members from the subcultures we serve to become leaders and advocates of health among their peers may improve participation and outcomes. Efforts to solicit and acquire reimbursement for community based approaches (i.e. community based education, community

based health care workers) is essential to ensure these approaches to education are viable and sustainable.

Gaps in research

Studies to determine the impact of community based approaches to care on diabetes outcomes will improve chances of acquiring and sustaining reimbursement. Research is needed to evaluate the use of CBPR and community based health workers and their impact on community participation and outcomes. Efforts researching the effectiveness of diabetes educator led diabetes education interventions that take into account patients' cultural beliefs, language, norms, and behavioral patterns are appropriate. We should support research and practices that link organizational actions to addressing health disparities among diverse racial and ethnic groups. Other worthy approaches include identifying and testing the effectiveness of a collaborative care team of health care providers (which includes diabetes educators) for developing and tailoring disease management among diverse populations.

Summary

The rate of diabetes is rapidly growing among ethnically diverse populations, each with their own cultural beliefs and cultural norms. The most effective diabetes educators are those who have a deep commitment to cultural sensitivity for the populations in which they serve. Respect for our patients as individuals while remaining cognizant of potential influences from their culture of origin is imperative. Embracing and practicing cultural humility is vital to developing a mutually respectful relationship among patients and healthcare providers which will help patients achieve desired outcomes to improve their quality of life.

Definitions:

Cultural sensitivity: the extent to which ethnic/cultural characteristics, experiences, norms, values, behavioral patterns, and beliefs of a target population's relevant historical, environmental, and social forces are incorporated in the design, delivery, and evaluation of targeted health promotion materials and programs.[23]

Cultural sensitivity has 2 primary dimensions:
1) Surface structure involves matching intervention materials and messages to observable, "superficial" (although important) characteristics of a target population. For audiovisual materials, this may involve using people, places, language, music, food, product brands, locations and clothing familiar to and preferred by target audience. Includes identifying what channels and settings are most appropriate. Surface structure refers to the extent to which interventions meet the target population where they are: how well they "fit" within their culture and experience. Viewed as analogous to face validity of psychological measures, surface structure is a necessary but insufficient prerequisite for construct validity. [8]

2) Deep structure can be more elusive and has received less attention. This requires understanding the cultural, social, historical, environmental, and psychological forces that influence the target health behavior in the proposed target population. Whereas surface structure generally increases the "receptivity" or "acceptance" of messages, deep structure conveys salience, and thus it has much more effect on the actual effectiveness of programs. [8]

Cultural humility: a lifelong commitment to self-evaluation and self-critique to redress imbalances and develop and maintain mutually respectful dynamic partnerships based on mutual trust.[12]

Cultural competence: “Cultural and linguistic competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency or among integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious or social groups.”[21]

Multi-cultural: The appreciation and incorporation of multiple race/ethnic groups without assumptions of superiority or inferiority. In this sense, cultural competent individuals and culturally sensitive interventions are implicitly multi-cultural.[8]

Cultural tailoring: The process of creating culturally sensitive interventions, often involving the adaptation of existing materials and programs for racial/ethnic sub-populations.[8]

Racial Identity: Generally refers to physical characteristics of individuals to include skin color, facial features, hair, etc. used to define race categories (e.g., White, African-American, Native American, Asian).

Ethnic Identity: Refers to how individuals self-identify based not only on physical characteristics, but religious background, nationality, and cultural experience.

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