Cultural Competence and Disability Ministry

Christian Churches Disability Ministry

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Cultural Competence and Disability Ministry

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Introduction

Dana Delafield, a psychologist and former member of the CCDM Board of Directors writes:

As ministers of the Good News, it is important that we learn to represent God’s heart to hurting people. We need to reach out to others in a way that lets them see that God understands and that He cares. We need to be mindful not to be like the friends that fell asleep (Matthew 26:40-41). It is our calling to be awakened to the needs of all hurting people in our communities. We need to strive to comprehend it and see hurting people through the eyes of the Father. He lives in us and part of our responsibility is to show others who God is when they hurt. To be like Jesus is to understand this simple truth and work to help others see Him through us.

In order to allow others to see Jesus through us, we must first take an honest introspective look at ourselves. Each of us has likes and dislikes. These may be inherent or learned. Usually we think of our preferences as they relate to inanimate objects or factors (for instance, our fondness for a certain color or smell or flower) as being natural or unlearned. However, even these inclinations may have been affected by our past experiences, cultural influences, historical or family events, and other sources that shape learned behavior.

Others can look at us and see our purity of heart if we cleanse our minds of intolerances that cloud our thinking. We may believe that we can put our prejudices aside as we work in ministry but they are still there. We must acknowledge their presence, seek an understanding of how they originated and ask for God’s grace in purifying our spirit.

We must pray for understanding as we strive to open our minds to the concepts that are presented here. Know that acknowledging our shortcomings, or in some cases shortsightedness, will make us better equipped to serve.

Our goal of inclusion can only be realized if we first see those we serve as individuals and love them in an unblemished manner. This will be a continuous journey, as we travel the road of life seeking a better understanding of others and ourselves.

Our scripture inspiration for this journey is the 15th chapter of Romans. In this letter to the Romans, Paul offers inspiration, encouragement, and tells of his ministry travels. These words of motivation and insight can offer us support as we study ways to strengthen our Christian walk and enhance our ministry efforts.
Lesson One - Charting the course

Each of us should please his neighbor for his good, to build him up.
Romans 15:2 NIV

Though people of the world have different concepts, beliefs, and cultural patterns, we are all neighbors. Looking at the development of religious assembly and the need for outreach is a good way to start our journey to cultural competence in disability ministry.

In this lesson we will:
- Look at how we come together
- Recognize the need for outreach
- Examine differences

How We Come Together
Church buildings today range from mega campuses to small wooden buildings that have stood for centuries. These buildings are usually where most worship services and religious activity take place. We know it is not the building but people who make these structures meaningful.

What is a Church?
The word church is derived probably from the Greek kuriakon (i.e., "the Lord's house"), which was used by ancient authors for the place of worship.

In the New Testament it is the translation of the Greek word ecclesia, which is synonymous with the Hebrew kahal of the Old Testament, both words meaning simply an assembly,...” (Source: Smith’s Bible Names Dictionary)

What constitutes a church congregation?
The bible tells us that: “...where two or three come together in my name, there am I with them.” Matthew 18:20 NIV

This is the way most churches were started, as small homogeneous groups. That is, the founders all had some common characteristic in addition to their love for God. Families in close geographic proximity gathered for worship usually with those of the same ethnicity or nationality.

Today’s churches generally seek to follow the great commission.

Therefore go and make disciples of all nations, baptizing them in the name of the Father and of the Son and of the Holy Spirit, and teaching them to obey everything I have commanded you. And surely I am with you always, to the very end of the age.

Matthew 28:19-20 NIV
This means embracing those who differ from us. The dissimilarity may be disability, ethnicity, culture, language, economics, age, spirituality, gender or literacy.

Reaching out to all “nations” means going beyond our borders. Those borders may be across the street, across town, or around the world. It is imperative that we acknowledge existing differences, examine our own feelings, broaden our understanding, and make inclusion of all a key component of ministry.

The Need for Outreach

“The U. S. Census Bureau defines a person with a disability as someone who has difficulty in performing functional tasks or daily living activities or meets other criteria, such as a learning or developmental disability.”

How do we know that there are disabled people outside our immediate circle of family, friends and acquaintances that need our help?

Take a look at some statistics cited by the U.S. Census bureau in their release CB04-FF.11 dated May 26, 2004:

49.7 million people age 5 and over in the civilian non-institutionalized population are reported with at least one disability, according to Census 2000; this is a ratio of nearly 1-in-5 U.S. residents, or 19%.

1.9 million people ages 18 to 34 who have disabilities are enrolled in school. They comprise 12% of all students in this age group.

9.3 million people age 5 or older in 2000 with a sensory disability involving sight or hearing account for 3.6% of the total population.

21.2 million people age 5 or older with a condition limiting basic physical activities, such as walking, climbing stairs, reaching, lifting or carrying account for 8.2% of the total population.

12.4 million people age 5 or older with a physical, mental or emotional condition causing difficulty in learning, remembering or concentrating account for 4.8% of the total population age.

6.8 million people age 5 or older who have a physical, mental or emotional condition causing difficulty in dressing, bathing or getting around inside the home account for 2.6% of the total population.

18.2 million people age 16 or older who have a condition that makes it difficult to go outside the home to shop or visit a doctor account for 8.6% of people who are of this age.
21.3 million people ages 16 to 64 who have a condition that affects their ability to work at a job or business. They account for 11.9 percent of the people in this age group.

Each of us probably knows one or more people who fit into at least one of the categories listed above. Imagine how many more we do not know and who are in need of ministry.

Examine differences

We must first and foremost recognize the individual with a disability and his family as persons from varied social, economic, ethnic, and cultural backgrounds. We must further acknowledge that age, gender, language and other factors play a part in the way words and actions are construed. This is not to say that we must always look for differences before interacting with others, but we must be cognizant of the fact that distinctions do exist.

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Ethnic, cultural, and life experiences affect the way we receive, interpret, and distribute information. Both actions and words may be perceived differently. Eye contact, shaking hands, hugging, are considered casual greetings to some, but offensive to others.

Define some common terms

At first glance, it may seem strange that we did not include race as a distinction. This is because race has more to do with our perception of a person than with actual attributes of that person. Defining culture, ethnicity and race will help us.

“Although the terms “culture”, “ethnicity” and “race” are often used interchangeably, they are not the same.

Culture is defined as a system of learned and shared standards for perceiving, interpreting, and behaving in interactions with others and with the environment.

Ethnicity refers to groups of people who are united socially, politically, and geographically and possess a common pattern of values, beliefs and behaviors (culture) as well as language. Examples of ethnic groups are Irish, Iranian, German, Italian, and Ethiopian. Culture is a principal force in shaping an ethnic group. Members of an ethnic group also possess a culture. For example, because of the interaction between social, political, geographic and cultural patterns, Irish and Irish Americans differ in their cultural values, beliefs and behaviors that in turn affect and are affected by their social,
geographic and political circumstances. Furthermore, people from the same geographic region but from urban or rural backgrounds may have different cultural traits.

Race, on the other hand, has to do with the biological component of being human. But the term race, as it has evolved, does not help in understanding the biological component of humans. Historically the term race has evolved into political, emotional and social situation constructs that, very often, creates dissention and bias between human groups. For the purpose of understanding the diversity of culture, race has little relevance.

Essentially, race does not form our values, beliefs and behaviors, but our values and beliefs do influence our views on racial differences and mold our behavior toward people of different races.” (Jezewski, 2001 adapted)

These are powerful points for us to think about as we continue our cultural competence journey.

**Exercises - Lesson One**

1. Think about the church you grew up in or knew the most about while growing up. Was there a culturally diverse group of worshippers?
   
   (a) If not, in your opinion, why not?
   (b) If so, what bond(s) existed in addition to Christian love?

2. Have you participated in a charitable or civic project? Was there an opportunity to extend a hand of genuine friendship to someone served by the project?
   
   (a) If not, in your opinion why not?
   (b) If so, what did you do?

3. Paul actually traveled to many places to spread the gospel. Whether we make a physical journey or initiate a local outreach effort, our goal is to help others know Christ. What scripture passage(s) can best give us direction?
Lesson Two - Application to disability ministry

For everything that was written in the past was written to teach us, so that through endurance and the encouragement of the Scriptures we might have hope.

Romans 15:4 NIV

In the church, we deal with the spiritual health of individuals and there is a correlation to their mental and physical health. The healthcare industry has realized the importance of cultural competence. They know that it increases the effectiveness of healthcare providers, meets government mandates, and gives providers a competitive edge. Much information in this publication has been gathered for use by healthcare organizations and it can be adapted to apply to the religious community, especially as related to disability ministry.

In this lesson we will:

- Review the application to disability ministry
- Focus on developing cultural competence

Cultural competence and its relationship to disability ministry

Cultural competence is educating our ministry team to be aware of and sensitive to cultural differences and to compassionately deal with all members of society when working toward our goal of inclusion.

Some ideas that will help us

- We must recognize the distinctiveness of the individual and their family.
- Some families may be bi-cultural or multi-cultural. As a result, they may have a unique set of issues, both mental and physical, that must be recognized and addressed.
- Those we seek to serve may have different views of the world around us. Address these differences in a positive manner.
- Cultural knowledge and sensitivity must be incorporated into the programs and worship opportunities we offer.
- We must do more than offer equal, nondiscriminatory facilities and services; we must adapt our buildings and services to be inclusive and accessible. Existing networks such as neighborhood organizations, community leaders, and natural healers can be a vital source of support. These support systems should be respected and, when appropriate, included as resources.
- When outreach includes those who share the cultural background of those we seek to include, the results tend to be more effective.
- We must make all members of our congregation aware of our goal of inclusion and sensitive to the part they play in creating a welcoming atmosphere.
**Increase cultural knowledge**

Become familiar with ethnic/cultural groups other than your own. Read books and articles about their history, value system, historic beliefs and behaviors. Search the internet for articles. Learn of clubs or organization that are germane to a particular group and ask them for information or interpreters if necessary.

**Develop cultural awareness**

We can develop sensitivity and understanding of other ethnic groups by first making changes in our own attitudes.

We must be open and flexible when dealing with other cultures and not impose our own historical attitudes and value systems.

**Nurture Cultural Sensitivity**

It is important to communicate in ways that make others feel comfortable and get our message across effectively.

Cultural competence must be viewed as a process of continually refining, expanding and updating our understanding of different cultures; it is a **journey**, not a destination.

The challenge is for each of us to do an honest self-introspection. Where do we really stand?

Though the issues we are dealing with in this publication are different from those faced by David, we can use his plea in Psalm 51:10:

Create in me a pure heart, O God, and renew a steadfast spirit within me.

Purity of heart and renewal come with acknowledging our faults, cleansing our minds of ungodly thoughts, and accepting all people simply as children of God.
On the cultural competence journey we must travel several roads

**Recognizing changing population trends**

The U.S. Census Bureau predicts that within the next 50 years, nearly one half (48%) of the nation's population will be from cultures other than White, non-Hispanic. This statistic shows that the United States is becoming a more heterogeneous nation.

Modes of travel and communication are making the whole world “smaller” in terms of the people we will interact with daily.

**What are some of the cultural traits we may encounter?**

On the purely interpersonal level, for example, members of the U.S. culture tend to admire "equality" and "informality." The dominant caregiver population demonstrates caring and compassion by smiling at the patient, patting him/her on the arm, shoulder, or head, and/or addressing him/her by his/her first name. This behavior can be interpreted by members of cultures who use a formal, impersonal form of “you” with anyone who is not a close friend or relative or which address one another in terms of role (i.e. brother, sister, oldest daughter, or aunt) as being impolite and disrespectful.

In some cultures it can be considered intrusive or even a cause of illness to touch someone on the head without permission. In other cultures, one does not smile at someone one does not know - especially if that person is of a higher status - such as a physician or nurse. In the same manner, the behaviors of caregivers who belong to a rather formal culture - or one that is referred to as a "distance" or "non-touch" culture may also be misinterpreted by patients who come from a more informal, "touch" culture such as our mainstream White culture in the U.S. The patient may fail to develop a sense of trust with a caregiver whom they have labeled as "unfeeling" or "unconcerned."

In regards to expression of pain, cultural differences are also seen. Some Asian groups, for example, may deny that they are in pain and refuse medication, while other groups may cry out when pain should be relatively slight as a means of demonstrating their "delicacy." Caregivers often label Latino patients as "crybabies" because they frequently cry-out in pain. What these caregivers don't understand is that the "message" intended by the cries is not, "I expect you to do something!" but "I am sharing the pain with you so that I feel it less intensely." The cultures of each population group may dictate very different pain behavior.

Culture also molds patient and caregiver perceptions about what the
waiting room or clinic should look like and even where certain departments should be located. How would you feel, if either labor and delivery or surgery were on the fourth floor, and you, as an Asian, believe the number four is a very, very unlucky number which signifies death! White has always been the ‘preferred color’ of hospital corridors, waiting rooms, and physician coats. Why? This is because to members of Western European culture, white symbolizes such things as cleanliness, purity, and peacefulness. To many Asian groups, however, white is a color that is reserved for death and funerals!

...Care that does not conflict with a patient's cultural beliefs improves compliance with the taking of medication and recommended lifestyle changes. Patients, too, tend to be more forthcoming in disclosing alternative treatments if they feel that the caregiver will respect, not ridicule, these methods. As a result of greater trust, openness and compliance, the frequency and extent of bad outcomes can be minimized....

(Salimbene, 1999)

Increase knowledge of distinctions

After reading the preceding excerpt, we can see how cultural tendencies or traits may influence actions and perceptions. There are aspects we should be aware of as we study cultural distinctions.

Eye contact/Gestures
Touch/Personal space
Manner of address
Outward show of emotions
Attitude toward authority figures
Historic tendencies
Traditions, rituals and customs

Know that these traits affect the dynamics as cultures interact. As stated at the beginning of this publication:

Each individual is unique.
Do not make the mistake of thinking that ALL members of ANY group ALWAYS act in the same manner.

As we proceed with our studies, it is important to stress that we should not take the facts we learn and assume that they apply to all group members. We must realize that values, beliefs, learned behaviors, education, economics and other factors will influence an individual and how they conform to or differ from other group members. Do not approach an individual from another culture with preconceived ideas about how they will act or react. However, use the information to help you get to know the person and their family and avoid potentially offensive words or behaviors. We will take a look at some of the distinctions listed above.
Eye Contact

In some cultures, most noticeably African or Asian influenced, maintaining eye contact may be viewed as a sign of disrespect. As we deal with those with disabilities, we must remember that avoidance of eye contact is a characteristic of some mental conditions, autism in particular. Do not assume that a person who avoids eye contact is uneasy or not interested in what you are saying. It may be cultural.

Touch/Personal Space

“It is often mentioned that Asians prefer a gentle bow to handshaking, however, when meeting a person you assume to be of Asian cultural descent, do not immediately bow. Gently extend your hand. If not taken, respond with a polite nod. Do not continue to offer your hand or pat them on the arm or shoulder.

Worldwide, initial greetings between people differ among ethnic groups: from a firm handshake (U.S.) to an embrace (South America) to kissing on both cheeks (France) to a bow (Japan).” (Jezewski 2001)

Personal space, the distance we want between ourselves and others at a given time, varies from person to person. Usually after shaking hands, American’s move apart to a comfortable conversation zone. Arabs historically stand closer to converse with associates than Americans (Jezewski 2001).

If you find your personal space being “invaded”, try not to turn your head away, or continually step back. If seating is available, sit down, that will establish some distance.

Gestures

Try to use hand gestures sparingly. What may be perfectly innocent to you may have a completely different implication in another culture. Some examples:

• Crooking the index finger while the arm is extended toward another person in the U.S. means "come here", but it is very offensive and insulting in some Asian countries because it is a gesture used only to call animals.
• In other cultures, crossing one's legs while sitting facing another is impolite.
• The "OK" sign with thumb and forefinger that we use in the U.S. has a vulgar, insulting connotation in Brazil.

Manner of address

Overall American culture tends to be very informal. However, addressing a person as though you are already acquainted with them may not be acceptable to all Americans. African Americans because of a history of deprivation of basic human rights may be particularly sensitive in the area of being addressed in a respectful manner. When first meeting a person, of any ethnicity or culture, as a matter of common courtesy, you should not use their first name until granted permission.
If a person has a name that is challenging for you to pronounce, ask for help with the pronunciation. Ask them how they wish to be addressed. Follow their wishes even if the pronunciation is difficult for you. Remember, your name may not be easy for them to pronounce.

**Exercises - Lesson Two**

Which of the listed reactions would you choose in the following situations?

1. You approach a person, hand extended, to offer a friendly greeting and the person makes no attempt to reach out and shake your hand.
   a. Reach down and grab the person’s hand.
   b. Pat them on the shoulder instead.
   c. Withdraw your hand and walk away without speaking further.
   d. Put down your hand and greet them verbally without contact.

2. While engaged in an animated conversation with a new acquaintance, you sense that you may have said or done something to make the other person feel ill at ease.
   a. Continue what you are saying in the same manner and wonder, “what is their problem?”
   b. Change the subject and ignore their perceived discomfort.
   c. Say you forgot you had to be somewhere else and leave.
   d. Stop and gently inquire about their reaction.

3. A woman is introduced to you as Mrs. Ellen Jones. You greet her and ask her to call you by your first name. She does not state any preference as to how you should address her.
   a. Immediately begin addressing her as Ellen.
   b. Avoid using her name at all.
   c. Ask her if you may call her Ellen.
   d. Call her Mrs. Jones unless she invites you to do otherwise.

4. Your teen Sunday school class has a new member. He appears shy and avoids eye contact and personal touch.
   a. Give him a big hug to put him at ease and make him feel welcome.
   b. As class is in session, ask him if he is paying attention.
   c. Assume he will change eventually and ignore him.
   d. Discreetly talk to the student’s parents or guardians about your observations.
Lesson Three – Explore historic world views about disability

May the God who gives endurance and encouragement give you a spirit of unity among yourselves as you follow Christ Jesus, so that with one heart and mouth you may glorify the God and Father of our Lord Jesus Christ.

Romans 15:5-6 NIV

Glorifying God with one heart and one mouth does not mean we all need to speak the same vocal language or have the same mannerisms or traditions. It means that we must communicate with love.

In this lesson we will:
• Study some historic concepts of cultures making up the largest groups of recent US immigrants
• Discuss concepts of other cultures

Look at historic cultural concepts of disability from around the world

We will approach some distinctions by looking at historic cultural concepts of disability of foreign-born persons. These are generalized views that have been noted by those studying various cultures.

The Center for International Rehabilitation Research Information and Exchange (CIRRIE) has developed and made available to the public a series of monographs on cultural perspectives of foreign-born persons in the U. S.

CIRRIE states: “The monographs focus on the top ten countries of origin of the foreign-born population in the United States, according to the U.S. Census Bureau: Mexico, China, Philippines, India, Vietnam, Dominican Republic, Korea, El Salvador, Jamaica, and Cuba. There is an additional monograph on the culture of Haiti.”

This information is geared specifically to rehabilitation service providers but will be helpful to us as we continue our quest for an enlightened mind to enable us to minister effectively with all.

See the Monographs section in this publication for excerpts or view on line at http://cirrie.buffalo.edu/monographs/index.html#series.

We have included information on the cultural concepts of disability of persons from countries that make up the largest segment of new immigrants to the United States. As groups, their assimilation into the lifestyles and thought patterns of mainstream America may still be geared to those of their country of origin.

Noticeably missing from the countries shown above are any African or European nations. This does not mean that their cultural concept of disabilities does not differ. It simply means that, based on immigration statistics, you may be less likely to encounter group members as unaffected new immigrants.
Concepts of other cultures

If you reside in an area known to have a heavy concentration of a cultural group whose historic roots are foreign and unfamiliar to you, it is likely that you will encounter new immigrants among them. Do some investigation. Approach the situation as you would any learning experience.

If you are making a mission trip to a foreign land whose customs and traditions are unfamiliar to you, cultural indoctrination is as important as inoculations. Do not approach the trip with the attitude that others will let me know what is proper when I get there. Learn as much as you can but keep an open mind. You will not find out everything from your advance studies.

Research at the library, visit the internet, and/or interview a trusted member of the group for information.

Your local library should have books and magazines that will give you background information on locations and their indigenous cultures.

Two internet sources for investigating cultural concepts worldwide are www.disabilityworld.org, a project of the National Institute on Disability and Rehabilitation Research (NIDRR); and www.who.int - the website of the World Health Organization. Be inquisitive. Look for more sites using different search engines and criteria.

Perhaps the best method is the personal interview. Locate someone in your congregation or community who you believe has the same cultural background as the population you wish to learn more about. Do not assume the cultural link is the same. As in the United States, persons from different areas, ethnic groups, religious groups, and income levels may have varying historical value and/or belief systems. Explain your situation to the person you wish to consult. Ask them if they are familiar with concepts and beliefs of people from the country, region and/or ethnic group in question. If the person’s response is unreceptive, thank them and move on. Do not try to force information since there may exist some historic conflict.

When you locate a good source, put them at ease with assurance that you simply want to establish a basis for a good relationship with someone with whom you are ministering. Ask them to state their perceptions and remembrances of how people with disabilities are viewed and treated by the cultural group in question. Do not depend on the person to address all your concerns. Before you meet with them, write down and memorize specific questions so that you cover all your bases. Ask or observe what social courtesies are expected (i.e. handshake, eye contact, seating, etc).

Do not hesitate to minister because you have not had a chance to study the culture of a person. One thing is universal and that is love. Your Christian demeanor can overcome a multitude of differences.
Follow some simple rules of engagement:

- Pray for enlightenment and an open heart and that the message you deliver will be received in the same spirit it is given.
- Ask permission before making an in-home visit.
- If language is an issue, have an interpreter present. Trust your own skills only if you are fluent. Knowing merely scattered words and phrases may do more harm than good by leading to misunderstandings.
- Have at least one person in your party who is of the same sex as the individual(s) with whom you are ministering.
- Speak clearly. Try not to use contractions, slang or colloquialisms.
- Refrain from hand gestures as much as possible.
- If you are offered food or drink during an in-home visit, consider that refusal in some cultures is considered an insult.
- Take your cue from the person. If they seem to back away or not make direct eye contact as you speak; keep your distance; and do not force eye contact.
- Be pleasant, courteous, and sympathetic but not overly demonstrative. A hug, embrace, or even touch on the shoulder may not be welcomed.
- If you detect a negative reaction, ask if you have done anything offensive. If so, apologize and thank them for being understanding.
- Assure the person of your friendship and desire to provide assistance.

As you read the monographs, remember that historic cultural views are affected by the degree of a person’s assimilation into another culture, economic status, and educational background. Think about how you will approach or deal with a person who may honor the tendencies, traditions, rituals, and customs of their historic culture when you invite them to become engaged in your disability ministry. Do not think in terms of converting them to your way of thinking, but about how you will instill a comfort level. Consider ways you can get to know them and get them to know you and to see Christ in you. As they see your shining light, they will want to know more about the God you serve.

**Exercises - Lesson Three**

1. A newly immigrated family attends your church. They have two children, ages nine and eleven. You notice that the nine year old attends Sunday school and has made friends with other students. The eleven year old however does not attend Sunday school and seems unresponsive during worship. What should be your approach to the parents?

2. What is the most diverse cultural experience you have had? What did you bring away from it that made you a better person?

3. A mission worker is invited to attend a social gathering of an unfamiliar cultural group. What potential problems do you see with the actions below?

   a. The men are on one side of the room and the women are on the other. He or she tries to mix with both groups.
   b. Everyone is standing but the mission worker sits without invitation.
   c. The worker has learned a few words of the group’s native language for this meeting and declines the offer of an interpreter.
Lesson Four - Other factors that affect culture.

Accept one another, then, just as Christ accepted you, in order to bring praise to God. Romans 15:7

We all know that language can be a cultural barrier to full participation, but some other aspects such as economics, age, gender, and education may not, at first glance, appear to have an impact. All of these factors do have a bearing on how we are received and perceived.

In this lesson we will:
• Discuss other aspects that contribute to differences and some of the possible accommodations we can make

Language

How many different spoken languages are there in the world today? Estimates differ based on where the separation is drawn between language and dialect. For instance, those who study languages disagree over whether Chinese should be considered a single language because of its speakers' shared cultural and literary tradition, or whether it should be considered several different languages because of the mutual unintelligibility of; for example, Mandarin is spoken in Beijing and in Hong Kong, Cantonese is spoken. If the fact that speakers understand each other is the basic standard, current estimates indicate that there are over 6000 languages spoken in the world today.

The 12 most widely spoken languages, with approximate numbers of native speakers, are as follows: Mandarin Chinese, 836 million; Hindi, 333 million; Spanish, 332 million; English, 322 million; Bengali, 189 million; Arabic, 186 million; Russian, 170 million; Portuguese, 170 million; Japanese, 125 million; German, 98 million; French, 72 million; Malay, 50 million.

Some other language factors we will consider are:
• Dialect - a variety of a language spoken by an identifiable subgroup of people. This applies most often to geographically distinct language varieties. As in the United States where there are distinct patterns of speech in different areas of the country.
• Slang - informal vocabulary, especially short-lived terms, that are not formally a part of a language's standard vocabulary.
• Jargon - this comprises the specialized expressions of a particular trade or profession, especially when it is not easily understood by outsiders, as with legal or medical jargon.
• **Pidgin** – “an auxiliary language (a language used for communication by groups that have different native tongues) that develops when people speaking different languages are brought together and forced to develop a common means of communication without sufficient time to learn each other’s native languages properly. Typically, a pidgin language derives most of its vocabulary from one of the languages. Its grammatical structure, however, will either be highly variable, reflecting the grammatical structures of each speaker’s native language, or it may in time become stabilized in a manner very different from the grammar of the language that contributed most of its vocabulary. Historically, plantation societies in the Caribbean and the South Pacific have originated many pidgin languages. Tok Pisin is the major pidgin language of Papua New Guinea. Both its similarities to and its differences from English can be seen in the sentence “Pik bilong dispela man i kam pinis,” meaning “This man's pig has come,” or, more literally, “Pig belong this-fellow man he come finish.”

• **Creole** – “arises in a contact situation similar to that which produces pidgin languages and perhaps goes through a stage in which it is a pidgin. As with pidgin languages, creoles usually take most of their vocabulary from a single language. Also as with pidgins, the grammatical structure of a creole language reflects the structures of the languages that were originally spoken in the community. A characteristic of creole languages is their simple morphology. In the Jamaican Creole sentence “A fain Jan fain di kluoz,” meaning “John found the clothes,” the vocabulary is of English origin, while the grammatical structure, which doubles the verb for emphasis, reflects West African language patterns. Because the vocabularies of Tok Pisin and Jamaican Creole are largely of English origin, they are called English-based.”

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**Addressing differences in language**

Should we attempt to learn the native language of everyone we meet? Of course not, for most of us, that is impossible. We can learn some basic words of greeting and communication, but use care. Misunderstandings can develop if words are mispronounced or used in the wrong context. Get the help of a capable interpreter if possible. How well a person translates depends on their knowledge of both languages and cultures.

One first hand example: Some years ago, while conducting a financial training seminar, a teenage son was interpreting for his father. As I explained to the son, he relayed information to his father. When I mentioned a checking account, the son said neither he nor his father knew what that was. This was in the business world but the same thing can happen in ministry. You may not be so fortunate as to have the interpreter tell you they do not know what you mean. They may just use another word that may be appropriate or not.
When conversing in English with persons who may have a different dialect or speak English as a second language, we should refrain from using slang or colloquialisms. The most important thing we can do is listen closely to what is being said. If you do not understand, let them know. Listen for key words to try to get a general idea of what they are trying to communicate. Repeat what you think they are trying to say without being condescending.

It is particularly important that we not use jargon unless we are certain that others are fully aware of the meanings. For instance, as we think about the terms used in the world of disability information, many abbreviations are used (TBI, MS, IEP). Do not use such terms unless you are sure that the person you are sharing information with knows their meaning.

**Economics**

A report released by the U.S. Census bureau in 1997 “found that the presence of a severe disability brings with it an increased likelihood of receiving welfare benefits, having low levels of income and being more likely to live in poverty. Also, individuals with a severe disability are less likely to be covered by health insurance than those with no disability. Among people 25-to-64 years of age having a severe disability, only 48 percent had health coverage, compared with 80 percent for people with a non-severe disability and 82 percent of those with no disability.

We know that in order to meet spiritual needs, we sometime have to help satisfy physical needs. However, never make the economic help contingent on whether or not the person accepts our beliefs.

When we attempt to help those who have financial needs, we must do so with maintaining confidentiality and dignity utmost in our minds. If you must discuss a person’s financial status with others in order to provide assistance, obtain their permission first. Do not use the rationalization that what is being done is in their best interest and therefore permission is not needed. If a matter must be brought before a board or committee, inform the person of the procedure.

Our church or organization may not be able to assist with all of the needs of an individual or family. However, one of the greatest gifts we can present is to provide direction and advocacy. Help those we seek to aid find other organizations or agencies that can offer assistance. We can then make available transportation to interviews or to pick up donated items.

**Age**

The U.S. Census Bureau has predicted that the population of those 65 and older will grow at a faster rate than the total population and those seniors will outnumber school-age children in 10 states by the year 2030.

Some people stop going to church as they age. Several of the reasons may be:
Lack of transportation - they no longer drive.
Lack of convenient parking - if they do drive.
Structural challenges they encounter such as stairs, once they are in the building.
Difficulty with vision - lighting in sanctuary or dimly lit passageways.
Problems with acoustics - unable to hear the sermon clearly or sensitive to the volume from speakers or instruments.
Distractions - children talking or moving about during service. Medical conditions such as arthritis prevent them from turning pages in hymnals and bibles as quickly as they need to.
Restrooms are not convenient or insufficient in number.

These may be individuals who have been a part of our congregation for years. As we pursue inclusion, do not forget our seniors. Remember, this is group we all hope to be members of someday, if we are not already.

Most seniors are fiercely independent. Do not insist strongly that they follow your suggestions or plans to get them back to participation in church services and functions. Offer support gently. If it is refused, keep visiting and talking with them. Continue to let them know what is available but, do not push.

Provide transportation. If you do not have a formal transportation system, find a “buddy” for them. This “buddy” should be able to bring them to church services and meetings.

As you learn of health challenges the individual faces, try to be sure someone is seated near them who will open and hold a hymnal or bible, sense if they are not comfortable with their seating (light or sound issues) or if they need assistance in visiting toilet facilities. This interaction can help make subsequent visits to church more accommodating.

If difficult stairs must be negotiated to take part in church services and budgetary or structural concerns prevent correcting this, think about equipping a room that is accessible with closed circuit television. This room should also have accessible toilet facilities conveniently located nearby. If this is done, be certain that a worshipful atmosphere is present in the room.

If possible, have parking spaces assigned for “Senior Challenge” use in addition to “Handicapped” parking. Have wheel chairs or motorized scooters available for use by those who have difficulty walking a long way.

Educate ushers and greeters regarding how to show sensitivity. Advise that if a person appears to have difficulty walking or seeing, gently walk along by their side and engage them in conversation. This distracts from the main purpose which is to be there if needed. Unless there is a loss of balance, do not take their arm in an attempt to assist them without first asking permission.
Gender

As we review cultural patterns and preferences, we will note that some people may be uncomfortable dealing with members of the opposite sex because of gender roles prescribed in their culture.

In some cultures, men and women who are not related do not converse casually. Therefore, be cognizant of the fact that this trait may be reflected in the way a member of the opposite sex is received.

Education

Lack of a formal education may deter some youth and adults from church attendance.

Statistics from the National Organization on Disability (N.O.D.)/Harris 2004 Survey of Americans with Disabilities show that “...people with disabilities lag far behind their non-disabled counterparts in getting a basic education.

- 21% of people with disabilities have not completed high school, compared to 11% of people without disabilities – a gap of 10 percentage points.
- 14% of people with disabilities have graduated from college, compared to 25% of their non-disabled counterparts.
- Although 1 in 5 people with disabilities has not completed high school, there has still been marked progress in the area of education over the past 18 years. While 79% of people with disabilities have graduated from high school today, this share was only 61% in 1986.”

We can provide study aids and audio bibles where possible. Also give direction to literacy and equivalence programs as applicable. If tutoring is needed, think about adding that as a part of your ministry.

Exercises – Lesson 4

1. *Declare His glory among the nations, His wonders among all peoples.*
   Psalm96:3 NKJV
   What separate “nations” exist within your local community?

2. Role play: One individual is a formerly active member of your congregation who has not attended for some time. The other is a ministry visitation worker. Scenario: The ministry worker seeing no apparent barrier to church participation gently probes for reasons for lack of attendance and suggests possible accommodations.

3. Discuss some words or phrases that may differ in meaning from region to region in the United States. Example: soda, soda pop, pop, drink.
Lesson Five - Self awareness and education

*I myself am convinced, my brothers, that you yourselves are full of goodness, complete in knowledge and competent to instruct one another.*

Romans 15:14 NIV

We must be as convinced about ourselves as Paul was of the Romans he wrote to in this letter. If we acknowledge our human shortcomings, study and pray, we will become more effective ministry workers.

In this lesson we will:
- Look at how biases affect our interactions with others
- Examine the way health disparities and health literacy impact culture

Self-Awareness and Education

Biases

Our personal biases affect our interaction with others.

Even though we are committed and work enthusiastically to act without prejudice, we are still influenced by learned and inherent biases.

To deny this is to deny human nature.

It is important to gain an understanding of our feelings so that we can recognize how our beliefs and mind-sets affect our relationships and interactions with others.

As a self-assessment, (Blackman 2004) ask yourself these questions.

Do my feelings toward others:
- Stand in the way of my work?
- Keep me from being myself?
- Stop me from learning?
- Cause me to put up barriers to keep others out?
- Lead me to question myself?
- Prevent me from being tolerant of others?
- Keep me from treating others with dignity & respect?
- Cause me to deny someone’s freedom?
- Block my understanding?
- Cause me to be unfair?
- Keep me from showing compassion?
- Prevent them from seeing God in me?

Tolerance.org, a project of the Southern Poverty Law Center, on its website, www.tolerance.org, offers a booklet entitled 101 Tools for Tolerance. These ideas could be a help tool to use as we formulate our plan to uncover our hidden weaknesses and expand our knowledge of other cultures.
As we continue our cultural competence journey, we must see its relationship to differences, biases, health literacy and health disparities.

Accept Differences

Build Health Literacy

Understand Health Disparities

Recognize Personal Biases

Develop Cultural Competence

Each component is necessary for smooth sailing.
Learn more about Health Disparities

The people we seek to include are usually in one or more underserved groups and are more likely to experience health disparities. As defined by the National Institutes of Health, health disparities are:

...differences in the incidence, prevalence, mortality, and burden of diseases and other adverse health conditions that exist among specific population groups in the United States.

It is important that we know this as we open the door to inclusion. As part of our ministry, we must be able to act as advocates. The need was seen to address this problem on a national level.

Healthy People 2020 is a comprehensive set of disease prevention and health promotion objectives for the Nation to achieve over the first decade of the new century. Created by scientists both inside and outside of Government, it identifies a wide range of public health priorities and specific, measurable objectives.

One of the focus areas of Healthy People 2020 is Disability and Secondary Conditions. The goal in this area is to "Promote the health of people with disabilities, prevent secondary conditions, and eliminate disparities between people with and without disabilities in the U.S. population."

Although rates of disability are relatively stable or falling slightly for people aged 45 years and older, rates are on the rise among the younger population. People with disabilities tend to report more anxiety, pain, sleeplessness, and days of depression and fewer days of vitality than do people without activity limitations. People with disabilities also have other disparities, including lower rates of physical activity and higher rates of obesity. Many people with disabilities lack access to health services and medical care.

Knowing that lack of physical activity may be a problem, seek avenues, such as a church sponsored recreation programs for improving this while taking in to account any medical or physical limitations.

Healthy People 2020 is available online at: http://www.healthypeople.gov/

Understanding the impact of Health Literacy will both increase our ability to serve effectively and relate to others.

Often people with the greatest health burdens have the least access to information, communication technologies, health care, and supporting social services.

Health literacy is the ability to read and understand materials and instructions related to personal health, as well as navigate the health system.
Research indicates that even after targeted health communication interventions, low-education and low-income groups remain less knowledgeable and less likely to change behavior than higher education and income groups, which creates a knowledge gap and leaves some people chronically uninformed.

Many people who are uninformed lack computer knowledge and access. We can assist by offering classes in basic computer usage where possible. Restoring and distributing computers to those in need is also a way we can help if we have the expertise available. Helping to close what is called the “digital divide” will aid in the fight to eliminate health disparities.

Even if we are able to help others gain access to communication tools, disparities may still exist because many people lack health literacy. Health literacy is increasingly vital to help people navigate a complex health system and better manage their own health. People with low health literacy are more likely to report poor health, have an incomplete understanding of their health problems and treatment, and be at greater risk of hospitalization. The average annual health care costs of persons with very low literacy (reading at the grade two level or below) may be four times greater than for the general population. An estimated 75 percent of persons in the United States with chronic physical or mental health problems are in the limited literacy category. People with chronic conditions, such as asthma, hypertension, and diabetes, and low reading skills have been found to have less knowledge of their conditions than people with higher reading skills.

As suggested at the end of the Education section, we can provide study aids, offer tutoring and direct to literacy and equivalence programs to help with basic reading skills. However, in order to improve health literacy, more is needed. Many times, people do not know enough about their own condition and this can be detrimental.

The Partnership for Clear Health Communication is a coalition of national organizations that are working together to promote awareness and solutions around the issue of low health literacy and its effect on health outcomes. It offers a website, http://www.npsf.org/pchc/health-literacy.php which promotes clear communication between patients and providers. They advise that patients should ask their providers three simple yet essential question in every health care interaction. Furthermore, providers should always encourage their patients to understand the answers to:

1. What is my main problem?
2. What do I need to do?
3. Why is it important for me to do this?

They further relate that “although low health literacy can affect everyone regardless of background or educational level, studies on the issue show that limited literacy skills are a stronger predictor of an individual’s health status than age, income, employment status, education level, and or ethnic group.”
Although ethnic minority groups are disproportionately affected by low literacy, the majority of those with low literacy skills in the United States are white, native-born Americans.”

It is imperative that as we act as advocates, we should both use and encourage the use of the Ask Me 3 questions.

We must also be sensitive to the medical conditions of others and know what impact their symptoms or medical routines have on daily life. Discreetly ask about medications schedules, toileting needs, mobility issues, etc. This will help prevent unexpected challenges.

Becoming culturally competent is a powerful undertaking. It can be daunting unless you fully embrace its aim which is to help us see others as God does and to let others see Christ in us.

*Above all, love each other deeply, because love covers over a multitude of sins. Offer hospitality to one another without grumbling. Each one should use whatever gift he has received to serve others, faithfully administering God's grace in its various forms. If anyone speaks, he should do it as one speaking the very words of God. If anyone serves, he should do it with the strength God provides, so that in all things God may be praised through Jesus Christ. To him be the glory and the power for ever and ever. Amen.*

| Peter 4:8-11 |

**Exercises - Lesson Five**

1. What is the primary step to understanding others?

2. What are some things we must do to make others feel welcome in our congregation?

3. How can we act as advocates for those in need of assistance?

4. Think of a time when “ask three questions” would have eased a situation for you. What benefit(s) do you think result from understanding the answers to these questions?
CIRRIE Monograph excerpts

China (CIRRIE 2001)

Cultural Concept of Disability

The traditional Chinese term for disability is "canfei," meaning "handicap" and "useless," or "canji," meaning "handicap" and "illness." This demonstrates how the Chinese used to view disability. The term "canji ren," meaning "handicapped" and "sick people," is also common. The term "gong neng zhang ai zhe," meaning "individuals with disabilities" is rarely used.

In many areas of China, disability is viewed as a punishment for the disabled person's parental or past-life sins. When encountering health problems, many religious people, especially those from rural areas where medical resources are not readily available or sufficient will visit temples or Taoist priest houses to pray, worship or perform rituals in order to find out the cause of and/or the solutions to their diseases or disabilities.

Mental health is believed to be achieved through self-discipline, exercise of power and the avoidance of morbid thoughts. Emotional problems are understood to be associated with weak character. (Lee, 1996). In some cases, mental illness is blamed on evil spirits or punishment from god(s). Another belief is that unbalanced diet, eating food that should be avoided, or emotional disturbance during pregnancy will cause illness or disability of the newborn. For instance, grief or having temper tantrums during pregnancy is perceived to possibly cause the mother to lose her baby or to produce a baby with disabilities. Lam (1992) discussed an example of a mother who blamed her child's epilepsy on the lamb she ate during pregnancy. Epilepsy, "Yang Dian Feng," translates as "shaking of the lamb" in Chinese. The mother believed that the lamb she ate passed the "shaking of the lamb" to her child. In general, disability is viewed as something shameful - and a skeleton in the closet. One of the author's cousins was diagnosed with schizophrenia in his early twenties. No one in the family wanted to talk about it, certainly not to people outside of the family. So it simply remained a well-kept family secret for many years.

Wang, Chan, Thomas, Lin & Larson (1997) summarized Chan and colleagues' 1984 and 1988 study findings that Chinese participants were more positive toward people with physical disabilities than toward people with developmental disabilities and mental disorders but that Chinese students were less positive in their attitudes toward people with physical or mental disabilities than their American counterparts. Chinese people are generally more accepting and sympathetic toward an acquired injury that causes physical limitations than toward a congenital physical or mental disorder.
Cuba (CIRRIE 2002)

Cultural Concept of Disability

Cuban and other Latino cultures typically have very strong beliefs regarding children and adults with handicapping conditions and disabilities (Madding, 2002). Beliefs about what constitutes a disability, its cause and the concurrent conditions related to the disability often have an effect upon the entire family. North Americans and health care professionals typically espouse a medical model orientation towards disabilities and illness. Cuban families and their beliefs may run counter to the medical or etiological approach. Juarabe (1996) stated that Puerto Ricans often believe that the mother is culpable when a child is born with a genetic defect such as Down Syndrome. This may also be applied to Cubans and Cuban Americans. The mother is blamed for not using proper pre-natal care during pregnancy (i.e., taking care of herself). The illnesses or disabilities can be attributed to past sins. Thus, the punishment is carried out on the child. If a child is severely disabled, then she/he typically will be taken care of in the home with the women of the household (e.g., mother, grandmother, aunt, older sister, etc.) taking responsibility.

Although Cuban Americans are reported to have higher education than some other Latino groups, there may be some who hold onto Santería beliefs. Varela (1996) stated the Cuban idea that evil spells or magic may be the cause for such disabilities. It is sometimes believed that a mother who looks at a handicapped child during her pregnancy will deliver an infant with the same handicap.

There is social stigma to having a disabled child. The parents may hide the child at home from outsiders. Parents may seek the help of curanderos (folk healers) or Santero priests to heal the sick or cleanse souls (de Paula, Laganá & Gonzalez-Ramírez, 1996). Latino Catholic parents may resign themselves to the child’s disability and possible handicap. This is seen as God’s hand in that the parents must endure this cross to bear. In some instances, it is seen as a blessing to be the parents of a special child.
**Dominican Republic (CIRRIE 2002)**

**Cultural Concept of Disability**

[Often in the Dominican culture disability is viewed with the] belief that moral violations or supernatural causes are responsible for an individual's disability [this] can result in feelings of guilt or shame for the family and lead to ostracizing the individual with disabilities. Conversely, ascribing environmental or natural causes to a disabling condition can facilitate the development of strategies to overcome barriers that minimize the level of independence and full inclusion of individuals into all aspects of society.

There is no officially recognized disability policy within Dominican society nor is there a clear expectation for full participation of individuals with disabilities in the larger society. However, legislation does exist protecting the rights of individuals with disabilities through a combination of special laws that allow for due process through the courts. General legislation applies to persons with different disabilities with respect to the right to marriage, to parenthood/family, to political rights, to privacy and to property rights. The following benefits are guaranteed by law to persons with disabilities: training, rehabilitation and counseling, employment, health and medical care, financial security, and independent living. Much of the legislation is modeled on the beliefs of disabilities rights models with a focus on the limitations of disabilities as "social constructs." Unfortunately, these laws are not universally applied in the Dominican Republic due to limited fiscal resources, shortages of trained personnel, accessibility barriers, costs associated with assistive devices and prescriptions and the lack of rehabilitation facilities outside of large urban centers.

Due to limited resources and the lack of advocacy, physical disabilities are often seen as more acceptable than mental disabilities. In many cases, the family can accommodate and adapt their surroundings to care for an individual with a physical disability. Dominican families exercise a great deal of creativity in crafting appliances that foster independence.

The same efforts are not exerted in support of individuals with mental disabilities. The root causes of mental disabilities are more closely associated with belief in supernatural and moral violations. As a result, individuals with a mental illness are often isolated, pampered as to not upset, and cared for exclusively by family members. Hospitalization and institutional placements are viewed by the family as a failure of their ability to care for one of their own. It is an option of last resort.
El Salvador (CIRRIE 2001)

Cultural Concept of Disability

For people with disabilities and their families, life in the United States is like living in paradise, in terms of available health care, access to education, employment, public transportation and the possibility of having a handicapped-accessible home and adaptive technology.

A woman with a disability who has spent the last twenty years advocating for the rights of people with disabilities stated, "The first time that I was interviewed by a man from the press, I was telling him that we, people with disabilities, needed access to education as a means to get a good job, and in order to be economically independent." The man listened quietly, and when I finished, he just stared at me. "Why do you want that?" he asked, "are you not happy that, in spite of what you have gone through, you are still alive? What do you need to go to school for?"

The old concept of disability-as-a-disease is very prevalent throughout Salvadoran society. Among the general population, it is very common to hear that persons who are deaf are "ill" or such phrases as "the poor blind". Women with disabilities face double discrimination because, as women, they are already discriminated against in this "macho" (chauvinist, patriarchal) society. For a woman with a disability, going to school, finding a job, or having a family are life challenges. Men with disabilities, have less difficulty getting married and having a family of their own.

Usually people will associate persons with disabilities with beggars because for some, the easiest way to survive in an indifferent society is by begging in the streets.

People with disabilities are not thought of as consumers of the services they receive like the rest of the population. It is considered very normal for someone who has a disability to stay at home and do nothing. It is unfortunate to realize that in most of the rural areas or small villages, there is not much that people can do because there are few basic rehabilitation services available anywhere in El Salvador.

Attitudinal barriers are very difficult to eliminate since they are passed from generation to generation. Among people with disabilities with no access to any information at all, there is a general attitude of passivity, which can be changed only through the strong leadership of other persons with disabilities. This could be supported by ongoing public awareness campaigns.

The philosophy of independent living, so widespread in the United States, Canada and Europe, is virtually unknown in El Salvador. The concept of independent living is not a factor in social policies regarding disability in most developing countries. The concept requires a recognition of personal civil rights. In El Salvador people don't even talk about civil rights. The extreme poverty of the population in general, makes survival challenging, especially for the segments at risk, such as people with disabilities.
It is rare for people in Haiti to discuss disabilities whether acquired or lifelong. Disabilities are thought of as mysterious and dangerous. Typically, disabilities are perceived as having origins in the interaction of the natural and supernatural worlds, rather than being a medical issue. For example, a disability may be the result of a curse from a lwa who is upset. Disability is a punishment - a sign that a lwa was not obeyed. While lwa are voodoo in nature, the same type of explanation holds true within the framework of Christianity. Haitian Christians believe that going against God is the same as going against the lwa. God punishes those who do not obey. Disability may also be the result of a spell cast by an enemy. In this case, a disability may be a sign that the disabled individual mistreated someone else. Again, disability is a punishment. While Protestants have campaigned against voodoo and belief in lwa, many still believe in spells. For this reason, regardless of religious orientation, disabilities are seen as supernatural in origin.

This supernatural origin holds true for both physical and mental disabilities, and for lifelong as well as acquired disabilities. Even when a traffic accident leads to a physical disability, it may be that an offended spirit caused the accident. It could also be the result of a spell. In this case, it was not really an accident, since someone set it upon the person. If there is a rumor about an individual's misbehavior, a disabling accident is taken as confirmation. This framework applies to both children and adults. If a baby is born with a disability, it is believed that someone in that baby's family, most likely a parent, did something wrong to a lwa or to another person. The child is innocent, but must pay the price for their family member's transgression. Innocent adults may also acquire a disability because of a family member's misdeeds.

Most Haitians are afraid of disabilities and are uneasy around people with disabilities who may be called "crazy," "stupid," or "possessed." They may also be labeled "non-functional" or "worthless." Since the disability may have been caused by an angry spirit, there is always the chance that the spirit may come after anyone who makes contact with a person with a disability. Similarly, people may be reluctant to touch an individual with a disability because the spell may transfer to them. Disabilities are treated as if they are contagious. Epilepsy is believed to be contagious, and people may be reluctant to come to the aid of a person having a seizure. A pool will be considered contagious if someone with a disability goes in. Parents may not want their child socializing with a child that has a mental disability for fear that their child may develop the same condition.

Since people are afraid of disabilities and believe them to be a type of supernatural punishment, many parents keep their disabled children away from public view. They do not want to expose their children to public ridicule, mocking or teasing. This is true for both mental and physical disabilities.
India (CIRRIE 2001)

Concept of Disability Within the Culture

The major shifts in thinking about people with disabilities that have occurred in the West for the past three or four decades have only started taking place in India in the recent past. Exposure to disabled people in India is a common occurrence; but the contact is of a very different nature than that in Western society. Walking the street in India exposes one to people with leprosy, amputations or visual impairments who often use their impairments to solicit money. Negative attitudes result from this type of contact in which people with disabilities are viewed as inferior. Furthermore, most adult Indians have not attended school with people with disabilities since integration is only beginning to be implemented in Indian schools (Paterson, Boyce & Jamieson, 1999).

In some villages, people with disabilities are shunned, abused, or abandoned at birth, since parents are ashamed of their disabled child, cannot envision a viable future for the child, and fear social isolation themselves. This may be due to the religious beliefs that may attribute the cause of disabilities as punishment for past deeds. Thus, disabilities are hidden from the public whenever possible. Also, in cities environmental barriers are so severe (few sidewalks, pedestrian traffic signals, curb cuts, or ramps) that most people with disabilities are simply not able to go out in public (Paterson, Boyce & Jamieson, 1999).

Although families go through the natural process of shock and grief when a child is born with a disability, in Indian culture, it is accepted as one's fate or destiny. The belief in karma, or payment for past deeds, underlies the accepting spirit. Because rehabilitation services are not easily available to the majority of the population in India, little help is sought for children with lifelong disabilities. Economic hardship, poor transport facilities and a lack of education make it harder for the parents to access services for their child (Singhi, Goyal, Pershad, Singhi & Walia, 1990).

Indians also see their children as investments for the future. So, when a child is born with a disability, they do not see that child as a source of support or income in the future. Hence, they would rather spend their income on the healthy children, especially the male children.

When a person acquires a disability, people are more sympathetic since they think of the person's level of function prior to the illness or injury. If there is hope that the person will be fully functional again, efforts are made to provide services.

The cross with which disabled women are burdened all through their lives is three times [heavier] because of their gender, their disability and their being the most deprived group. The most severe expressions of gender discrimination are found in the field of disability, frequently cutting across social, economic, political and cultural dimensions. They continue to fall through the cracks in the elaborate network of the country's services and plans.
Cultural Concept of Disability

Cultural concepts that influence views of disability and illness originate in religious beliefs related to Christianity and Afro-Christian sects such as Pocomania and Kumina. There are major beliefs that may have an influence on the way Jamaicans view disability: for example, disability is a punishment for wrongdoing, obeah or guzu, evil spirits, ghosts or duppies, and natural causes (Heinz and Payne-Jackson, 1997; Leavitt, 1992). These belief systems are entrenched in Jamaican society. They have played a major role in shaping the attitudes toward disability and delayed the development of a comprehensive national rehabilitation program. Even professionals and the educated middle class tend to hold a strong belief that disability is a result of sin.

Jamaicans are firm believers in the power of God as a mediator between good and evil in their daily lives. God is seen as a force operating from a position of duality, at the same time forgiving and punishing. The nature of God is perceived to include a great capacity for a long-term vindictive memory. Those who sin or commit wrongful acts will always be punished. If the perpetrator escapes punishment, their offspring are certain to reap the negative effects of past wrongs. Jamaicans frequently cite the biblical verse, "The sins of the father shall visit the third and fourth generations." Thus the cause of accidents or congenital deformities may be attributed to punishment deserved.

Acceptance of certain types of disabilities are affected by the views held about these disabilities. Physical disabilities are more readily accepted than mental or cognitive ones.

Personal perceptions can have an impact on whether a parent will accept a child with a disability. Parents who experience intense shame because of giving birth to a disabled child may reject that child.

In contrast to parents who abandon their children, there are those who provide very loving and nurturing environments for their children with disabilities. Overprotection of children with disabilities is another way in which parents may react. The tendency is to behave as if the child is incapacitated and totally dependent on others even when he or she might be quite capable of engaging in a variety of activities.

Some parents keep their children indoors away from public view and the disability is kept as a secret within the family for years. Residents in the community may be aware of the child, but would be unable to describe the nature of the disability. Keeping the child hidden can be attributed less to cruelty than to lack of information and education about the management of chronic disabilities. Parents are unaware of what a child with a disability can achieve given the proper accommodations and resources.
Korea (CIRRIE 2001)

Concepts of Disability Within Korean Culture

Some Koreans believe that disability can be caused by supernatural agents such as punishment from God or the curse of the devil for their sins or those of their parents or even their ancestors. Others think that the mother did something wrong during pregnancy such as creating an imbalance of metaphysical forces (Ŭmyang in Korean), failing to follow prescribed dietary and nutritional practices or violating certain taboos. For example, even a bad thought or an accidental killing of an animal or insect by a pregnant mother can harm the natural development of the fetus according to the Buddhist belief in karma, which holds that no living things should be killed.

Modern Koreans with education in biology and medicine believe that genetic defects or diseases cause disability. It is common to observe Koreans with a complex mixture of the belief systems described above, depending mainly on their education, religion, and family backgrounds.

Korean professionals working in rehabilitation categorize disabilities as: (a) impairments of the human body and internal organs, (b) disabilities in intelligence, behavior or emotion and (c) handicaps created by the society, which include limitations that stem from environmental factors such as negative perception and attitudes toward people with disabilities, poverty and malnutrition, barriers in architectural and the media (Special Education and Rehabilitation Center for Excellence, 2001). It is noteworthy that environmental factors are included as a cause of disability in addition to functional limitations.

Koreans are generally homogenous and conservative in terms of values and customs. People tend to stare at or gossip about those people whose dress code and behavior deviate from the social norms. For this reason, people with disabilities are likely to be isolated. The general public tends to avoid people with disabilities because of uneasiness associated with not knowing what to do. When helping a person with disabilities, Koreans usually overprotect or overcompensate, which only serves to frustrate those they are trying to help.

Some Koreans believe that lifelong disability is a kind of payback for something they did wrong in the past. As a result, many Koreans with disabilities and their families often suffer from shame, helplessness, denial, withdrawal and depression. Many view acquired disability as the result of some sort of bad luck or misfortune. People generally accept illness and disability due to aging as a fact of life, however.

If a disability is acquired through a work-related accident or military service, a glimpse of pride may be observed in the client and his family along with overwhelming distress.
**Mexico (CIRRIE 2001)**

**Cultural Concept of Disability**

In general, disability in the Mexican culture is viewed as either an act of God or as punishment for something one has done. Physical disability is more accepted than a mental disability, probably because the parents, especially the mother, blame themselves if their child is not "normal." In general, a physical disability is viewed as "normal." There appears to be a complete naturalness with which the people with physical disabilities are treated.

In the U.S. disability is viewed as a limitation on the person's impaired ability to take part in economic and social life. The goal in rehabilitation is to enable the individual to be as independent as possible so that he or she can have a "normal" life.

This is in great contrast with the view in Mexico. In Yucatan, Mexico, the native language of Zapotec, does not even have a word for "disability" (Holzer, 1999), since persons with disability contribute as much to society as anyone else. People in Yucatan do not need to work with the sole aim of making money in order to be valued by family and society. There is a broad range of activities that earn recognition and are considered as important as work at the market, the economic center of the town. The activities include giving each other time and attention, massaging one another, paying mutual visits, taking part in festivities, helping neighbors, and simply sitting with others and exchanging views. Those who need support are supervised and cared for by the family. In Yucatan, there are no "retirement" homes, nursing homes or homes for the persons with disability (Holzer, 1999).

The difference between the Western and Yucatan society is summarized best by Holzer (1999). She says that Western societies, in a global sense, are patriarchal in that work is correlated with money and the economy. In the Yucatan culture, and others in Mexico, the society is more matriarchal. In other words, what is most important is the mother's work - preservation and creation of life. Money and a commodity-based economy are viewed as ideals that remove one from what is most essential in life.

In the matriarchal world, being dependent and cared for is part of life. In addition, the women's production and distribution of food is considered "work" and "economy." Therefore someone with a disability in Yucatan is viewed as someone who contributes to society, not only because of his/her sheer existence but also because the activities in which they can participate are valued. Persons with disability view themselves as part of a community. In addition, being dependent is not viewed as a negative attribute, but as a way of life.

In summary, [...] the pressure is not for [those with disabilities] to become more independent; it is for them to be more functional within the family.
Philippines (CIRRIE 2002)

Cultural Concept of Disability

When families learn about the disability, their initial reactions are shock and disbelief. As reality sinks in, parents immediately seek assistance from relatives, friends and professionals. When financial and moral resources dwindle, the family turns to its religion and faith as a reservoir of hope and strength. The families cope with the help of acceptance, problem-solving, seeking help from friends and professionals, and religion (Arcadio, 1997).

After overcoming their initial grief, parents adjust to their roles and make the child with disability or sickness the priority. Some ask the siblings to stop going to school to assist in taking care of the child. All of the family members feel obligated to give their attention and effort to the child in need. Arcadio adds that the family adjusts its lifestyle and prioritizes the needs of the child in terms of time, finance, and effort. Eventually, the parents learn to accept the child's condition and relate to the child with deliberate patience, tolerance, and understanding (Arcadio, 1997). Parents are instrumental in facilitating the child's educational therapy and rehabilitation. They discover ways to teach the child at home. At the same time, the family members learn how to cope with guilt or responses of pity or rejection from others in relation to the family member's handicap.

Trinidad Baldo (personal communication, February 2001), a University of the Philippines SPED professor, adds that Filipinos' attitude toward the disabled has a spiritual component. Talking about her research on the gifted, she found that Pinoys hold the same beliefs as westerners on the cause of giftedness, but have added a spiritual dimension. They believe the gifted child is a gift from God. On the other hand, Carandang (1987) wrote that Filipino families view children with mental handicaps as "bringers of luck" especially in business. Regrettably, other families think that they are being punished if they are given a disabled or sick member. McBride (2001) mentions that some Filipinos think that sickness is caused by "mystical, personalistic and naturalistic causes."

An example of mystical cause is retribution from ancestors because of unfulfilled obligations. Personalistic causes include punishment by evil spirits. Naturalistic causes are more scientific: the cause of the disability is the environment or genetic susceptibility. But whatever the cause, because of the Filipinos' strong sense of family obligation they usually wholeheartedly accept and fight for their disabled family member. Also, they sacrifice time, effort, career, and sometimes, marriage, in order to take care of a sibling or parent.
Vietnam (CIRRIE 2002)

Cultural Concept of Disability

There are two general perspectives on disability in Vietnamese society. Until scientific evidence surfaced linking Agent Orange to many forms of congenital disability, Vietnamese ascribed disability to a more traditional belief that is strongly influenced by its cultural and religious practices. The modern perspective on disability attributes almost all forms of disabilities to Agent Orange and injuries from the war. Both of these views have consequences for how society treats people with disabilities.

The traditional view of disability is that it is a punishment for the sins committed by one's ancestors. Within this context, disability, whether acquired or congenital, is associated with shame and pity. Because of the fear of public humiliation, family members usually take extraordinary measures to keep the person with disabilities out of the public eye.

People with mental disabilities are regarded differently from those with physical disabilities. Due to the influence of Buddhism and Animism, mental illness is believed to represent possession by evil spirits and exorcism is considered the remedy. Affluent families usually hire monks or fortunetellers to conduct elaborate exorcisms in the hope of driving the evil spirit out of the inflicted. Those whose family cannot afford such treatment often end up homeless on the street.

One form of congenital disability is given special social status; however. People who are blind at birth are, in certain social circles, revered as psychics and fortunetellers. It is believed that these folks have special vision and power that can see beyond the present life into the past and the future and so they often work at a temple, in their own shop, or in the open market. For a small fee, these "psychics" can reveal to clients their past and future and what the present life will hold.

The newer perspective regards people with disabilities as victims of the war. Society in general pities yet sympathizes with these "victims." Since Agent Orange is believed to cause both acquired and congenital disabilities, there is no differential treatment between these two categories, especially in the postwar generation. They are all regarded as victims of the war.

Vietnamese cultural values are based on the teachings of Confucius, which emphasizes the importance of family cohesiveness and social harmony. Confucianism also stresses the importance of reverence for the elderly and caring for the vulnerable. Vietnamese elders live among their immediate family until their death and are cared for and well respected. After death, shrines will be built at home to continue to honor them.

Similarly, people with disabilities are deemed vulnerable, and it is the immediate family's responsibility to care for them. To expect an elderly person or a person with disabilities to live alone and to be independent is considered cruel by the Vietnamese.
Resources

http://www.sunyit.edu/library/html/culturedmed/
The Peter J. Cayan Library at SUNY Institute of Technology is the home of "CulturedMed", a web site promoting culturally-competent health care for refugees and immigrants. The library also houses a research center containing relevant print materials.

http://www11.georgetown.edu/research/gucchd/nccc/resources/publicationstype.html
Self-Assessment Checklist for Personnel Providing Services and Supports to Children and Youth with Special Health Needs and their Families

Awareness Activities
http://www.edchange.org/multicultural/activityarch.html

Culture and Disability - Providing Culturally Competent Services
Edited by: John H. Stone, University at Buffalo (08/2004) Sage Publications, Inc

The Rehabilitation Provider’s Guide to Cultures of the Foreign-Born
Center for International Rehabilitation Research Information and Exchange (CIRRIE)
http://cirrie.buffalo.edu/monographs/index.html#series
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Teaching Suggestions

These lessons were designed for use in personal study and/or a class environment.

If done in a class setting, the lessons should take from 45 minutes to an hour depending on the discussion time.

The exercises are meant to stimulate thought. There is no right or wrong answer. The suggestions in italics are for guidance only. Some are for general discussion and suggestions may not be listed. Depending on you and your group, you may want to add questions or interactive exercises.

Exercises - Lesson One

1. Think about the church you grew up in or knew the most about growing up. Was there a culturally diverse group of worshippers?
   (a) If not, in your opinion, why not?
   (b) If so, what bond(s) existed in addition to Christian love?

   In days gone by, most churches were attended by persons living near them. In larger cities, communities were generally separated along ethnic or economic lines. Some people attended a “family” church where their relatives were historically members. Encourage participation in discussion by offering an example based on your own experiences or that of someone you know about.

2. Have you participated in a charitable or civic project? Was there an opportunity to extend a hand of genuine friendship to someone served by the project?
   (a) If not, in your opinion why not?
   (b) If so, what did you do?

   As Christians we are eager to minister with those in need. Often, as we go about our mission, we benefit from the joy of giving of our time, talent and resources but, we fail to act upon the overarching goal of bringing others to know Christ or keeping them in fellowship with believers. Reflections should center on personal connections, how they were made and the outcome.

3. Paul actually traveled to many places spreading the gospel. Whether we make a physical journey or initiate a local outreach effort our goal is to help others know Christ. Which of Paul’s writings best personify his unifying spirit?

   Some possible examples:
   I Corinthians 12:12-14 NIV
   The body is a unit, though it is made up of many parts; and though all its parts are many, they form one body. So it is with Christ. For we
were all baptized by one Spirit into one body—whether Jews or Greeks, slave or free—and we were all given the one Spirit to drink. Now the body is not made up of one part but of many.

Ephesians 3:6 NIV
This mystery is that through the gospel the Gentiles are heirs together with Israel, members together of one body, and sharers together in the promise in Christ Jesus.

Philippians 1:7 NIV
It is right for me to feel this way about all of you, since I have you in my heart; for whether I am in chains or defending and confirming the gospel, all of you share in God's grace with me.

**Exercises - Lesson Two**

Which of the listed reactions would you choose in the following situations?

1. You approach a person, hand extended, to offer a friendly greeting and the person makes no attempt to reach out and shake your hand.
   a. Reach down and grab the person's hand.
   b. Pat them on the shoulder instead.
   c. Withdraw your hand and walk away without speaking further.
   d. Put down your hand and greet him verbally without contact.

   The best alternative is d: a is too pushy; b is condescending; c is unfriendly.

2. While engaged in an animated conversation with a new acquaintance, you sense that you may have said or done something to make the other person feel ill at ease.
   a. Continue what you are saying in the same manner and wonder, “what is their problem?”
   b. Change the subject and ignore their perceived discomfort.
   c. Say you forgot you had to be somewhere else and leave.
   d. Stop and gently inquire about their reaction.

   The best alternative is d: a, b and c make no attempt to ascertain if there is a problem that needs to be addressed.

3. A woman is introduced to you as Mrs. Ellen Jones. You greet her and ask her to call you by your first name. She does not state any preference as to how you should address her.
   a. Immediately begin addressing her as Ellen.
b. Avoid using her name at all.
c. Ask her if you may call her Ellen.
d. Call her Mrs. Jones unless she invites you to do otherwise.

The best alternatives are c and d: a assumes she has given permission to use her first name; b is awkward and impersonal.

4. Your teen Sunday school class has a new member. He appears shy and avoids eye contact and personal touch.

a. Give him a big hug to put him at ease and make him feel welcome.
b. While class is in session, ask him if he is paying attention.
c. Assume he will change eventually and ignore him.
d. Discreetly talk to the student’s parents or guardians about your observations.

The best alternative is d: a may make him even more uncomfortable; b will unnecessarily direct the notice of others in the class to the student; c does not address any potential challenges.

Exercises – Lesson Three

1. A newly immigrated family attends your church. They have two children, ages nine and eleven. You notice that the nine year old attends Sunday school and has made friends with other students. The eleven year old however does not attend Sunday school and seems unresponsive during worship. What should be your approach to the parents?

Speak with the parents privately. Tell them you want to make sure all members of their family are included in the worship experience. Let them know you have a special needs class or accommodations available that offer teaching about Jesus on different cognitive levels.

2. What is the most diverse cultural experience you have had? What did you bring away from it that made you a better person?

Lead the discussion to interactions that occurred either while traveling or simply outside a “comfort zone.”

3. A mission worker is invited to attend a social gathering of an unfamiliar cultural group. What potential problems do you see with the actions below?

a. The men are on one side of the room and the women are on the other. He or she tries to interact with both groups.

Separating by gender may be the norm in the group’s culture.
b. Everyone is standing but the mission worker sits without invitation.

There may be a hierarchy for seating in the group’s culture.

c. The worker has learned a few words of the group’s native language for this gathering and declines the offer of an interpreter.

Being able to converse in a different language takes time. The worker may not be able to enter into intelligible conversations with other gathering attendees.

**Exercises - Lesson Four**

1. “Declare His glory among the nations, His wonders among all peoples.”
Psalm 96:3 NKJV.

What separate “nations” exist within your local community?

Discuss those in your community who may not be full participants in the religious community due to age, economic status, disability, language, culture, etc.

2. Role play: One individual is a formerly active member of your congregation who has not attended for some time. The other is a ministry visitation worker. Scenario: The ministry worker seeing no apparent barrier to church participation gently probes for reasons for lack of attendance and suggests possible accommodations.

Some possible barriers are transportation, visual or hearing acuity, health concerns, emotional challenges, etc.

3. Discuss some words or phrases that may differ in meaning from region to region in the United States. (Example: soda, soda pop, pop, drink.)

The point of this exercise is to show that even among people from the same country who speak the same language, differences in meanings are common.
Exercises - Lesson Five

1. What is the primary step to understanding others?

   We must first understand ourselves.

2. What are some things we must do to make all cultures feel welcome in our congregation?

   • Learn as much as we can about an individual's or family's culture, while recognizing the influence of their own background on their responses to cultural differences.
   • Work within each person's family structure, which may include grandparents, other relatives, and friends.
   • Honor undamaging traditions relating to gender and age that may play a part in certain cultures. We must be aware of the manner in which different groups show respect, so that we can properly interpret the various ways people communicate.

3. How can we act as advocates for those in need of assistance?

   • For many people, additional tangible services—such as assistance in obtaining housing, clothing, and transportation or resolving a problem with a child's school—are expected. Be an advocate with community agencies to make sure these services are provided.
   • Study health disparities and the role they play in the lives of those we seek to include.
   • Promote health literacy in the lives of those we serve and in our own lives as well.

4. Think of a time when if we “ask three questions” it would have eased a situation for you. What benefit(s) do you think result from understanding the answers to these questions

   The three questions are:

   1. What is my main problem?
   2. What do I need to do?
   3. Why is it important for me to do this?