Show Notes

Episode 31: Balancing Stressors with Solutions: Integrating a Culturally Responsive Practice and LPAA values, a Conversation with Maria Munoz

Today, Dr. Katie Strong (Assistant Professor at Central Michigan University Department of Communication Sciences & Disorders) will be presenting another segment on "A-ha!" Moments in Aphasia Care as she speaks with Dr. Maria Muñoz about providing culturally responsive aphasia care.

Maria L. Muñoz, Ph.D, CCC-SLP is a Professor at University of Redlands. She received her doctorate from the University of Texas as a participant in the Multicultural Leadership Training Program and completed a post-doctoral fellowship in aphasia at the University of Arizona. She conducts research, teaches, and publishes in the areas of treatment outcomes and aphasia, and the manifestation of aphasia in Spanish/English bilinguals.

In this episode you will:

1. hear a story that provided an aha moment in making treatment culturally relevant.
2. learn about how cultural adaptation applies to LPAA philosophy and challenges clinicians to see a different world view.
3. discover some 'lessons learned' on facilitating a bilingual aphasia support groups.
4. learn a few tips in working with clients who are bilingual and have aphasia.

Some of your latest work highlights the challenges that SLPs face in using an evidence-based approach to assessing and treating cultural and linguistically diverse populations. Could you share your aha moment about this?

I'd like to start with one of my aha moments that came late in my career. I've been focused on client-centered intervention. I was surprised by a situation with a client I was working with. We spent quite a bit of time on getting his Spanish back. We worked with that diligently to the point he was fluent in Spanish. But he was bilingual and needed to use English at his work. We were working to restore the English he had prior to his stroke. We started building his vocabulary. We targeted concrete nouns. We tried different evidence-based (EB) approaches, cueing hierarchies, featured analyses, but we were getting nowhere. He was getting frustrated. I was getting frustrated. He wasn't doing his homework which was unusual. So, I sat down with him to ask what was going on. He told me that "You know, I just want to go to Starbucks and order coffee."

- And I thought oh my, what have we been doing? Yes, we'd been engaged in evidence-based practice (EBP), but it hadn't been meaningful to that client. He didn't need to restore every English word, he needed to be able to go to Starbuck and order coffee.
- So, we revamped our focus, still using evidence-based practice, to support his needs including key phrases like, "I'd like a latte." or 'Where is the restroom?".
- That literally was an aha moment! We have been doing this wrong! We need to make our interventions not only EB but relevant and meaningful in a cultural context to each client.
- This applies directly to the Life Participation Approach to Aphasia (LPAA) in that it involves listening to our clients, their families, and knowing what matters to them. This got me thinking about how we engage in both EB and culturally competent practice.

There are challenges in engaging in both EBP and culturally competent practice. I'd like to remind us about the EB triangle, scientific evidence, clinical expertise, and client perspective. And I'd like to focus on the science part of that triangle.

- When we look at the science, most of that work has been done with English speaking, Anglo participants in the United States. Or they don't identify who the participants are or information about the language of intervention.
- When we think about generalizing treatments to individuals who are culturally and linguistically diverse (CLD), that raises some issues. Are the treatment results or efficacy data generalizable to clients from CLD backgrounds? We don't know. We assume that it is, but we don't know.
- If those interventions are not addressing the needs of a cultural or linguistic group, what you have is ineffective clinic engagement. So, participants don't do their homework, because they don't care about the outcome. Or family doesn't participate because they don't understand or value the goals that are being targeted.
- Another issue is unique symptoms of the disorder. For example, my interest is in Spanish. There are aspects of Spanish, such as syntax which are complex. For example, subjunctive tense doesn't exist in English. So, if all of the interventions have been designed for English, they don't address aspects of other languages such as subjunctive tense or tonal issues. And so, clients don't receive the intervention they need for those features of their language that differ from English.
- Because we can't fully rely on the science when working with individuals who are culturally and linguistically diverse, we must rely on the other aspects of the EB triangle, the clinical expertise and the client perspective.

Maria, could you share with our listeners what the term 'cultural adaptation' is and where it comes from?

Cultural adaptation research is something I stumbled when I was navigating how to both engage in EBP and culturally responsive practice. Cultural adaptation research comes from psychology and education. Cultural adaptation research helps guide clinicians through questions of how to apply EB treatments to culturally and linguistically diverse clients.

- This field of study proposes and tests models for EB intervention to account for cultural and linguistic differences. What does it mean to engage in culturally and clinically relevant practice? How do we operationalize that? How do we move beyond just cultural sensitivity (being aware of these differences)?
- Cultural adaptation models provide a way to think about an intervention in a systematic way. Listen to hear Dr. Muñoz provide an example of using cultural adaptation with Anagram Copy Recall Therapy for a Spanish speaking client with aphasia.
- For more information on cultural adaptation, check out show notes for the citation for Dr. Muñoz's article.

How does cultural adaptation fit into LPAA philosophy?

LPAA is a philosophy. It's not an intervention per se where you have to follow certain steps. It's a way of thinking about intervention. I think that opens itself up to being responsive culturally responsive.

- Within the heuristic cultural adaptation model there are four steps; 1) Gather information, 2) Make preliminary adaptations, 3) Test adaptations, and 4) Refine adaptations.
- LPAA is fundamentally a client-centered approach to aphasia management. The emphasis is on re-engagement of life and meaningful goals. The focus is on pragmatics and social engagement. It emphasizes life participation, the rights of people with aphasia, enhancing quality of life, and considers both the individual and the environment.
- When I think about that, LPAA allows for a lot of cultural flexibility. When we think about adapting or applying LPAA across cultures the main challenge is to the clinician to be open to seeing a different world view. SLPs much recognize that what a patient and family values, may be different than what they value. And be responsive to that. Listen in to hear the story of the importance of not tossing out the fourth pig!

Would you share your experience in starting and facilitating a bilingual aphasia support group?

We had a monthly support group that met for about an hour. But people usually showed up early and stayed a little late. We started the bilingual support group as a response to provide services to clients that we couldn't necessarily get into the university clinic right away. It also provided community and support for people who had not spoken to Spanish speakers with aphasia. It was structured to be a bilingual group and anyone was welcome. Everything was done in English and Spanish to enhance participation.

- Providing a support group to Latino community can be challenging. If we keep in mind the cultural adaptation concept, what is it that we had to do differently with groups to be successful? We had to do a number of things differently. There are understandably trust issues when it comes to CLD individuals participating in going to an unfamiliar environment to participate in a group.
    - Recruitment: We had to think about how to announce the group and recruit individuals to the group. To do this we worked on establishing a relationship with the SLPs and physicians who could then refer their clients to the group. The invitation needed to come through someone they trusted.
    - Time of Group: We offered the group in the evening to allow the group to be open to family members.
    - Participants: The age range of participants ranged from 5 to 75! Participants included spouses, children, grandchildren, visiting family. When we surveyed to ask if they wanted a separate group for family members vs. persons with aphasia they said, 'absolutely not!' They wanted everybody together.
    - Student Training: The group was also a learning opportunity for students. Bilingual students in speech-language pathology helped to facilitate the group for a semester. Second year students led the group, first year students participated as observers and notetakers. Then led the group in the following year. I, as the faculty member, provided coaching when necessary.
- When you look at literature in what Latinos value in groups, there is an interesting balance of what they call *personalismo* or this idea of relating and trusting people. They want to see you as someone they can trust and someone who is a part of the group. But there is also a strong importance on structure. This idea of having a leader and being a leader. Being someone they can depend on. So, we had to find a way to balance that. We provided structure with agendas and topics. We addressed questions that they had. We found ways to share about our experiences that provided companionship between leaders and group members to make the leaders part of the group, while still leading the group.

- Latinos value community. So, we would have celebrations. We celebrated when students graduated each May. We celebrated one of our leaders becoming a U.S. citizen. Latinos also value *confianza* or mutual generosity. Many group members drove an hour to come to group. They were thrilled to participate as it gave them a way to tangibly celebrate the moment, express their gratitude, and be generous. This generosity extended to new group members who needed to learn about aphasia and share their experiences.

Would you share a few lessons you've learned from this group with our listeners?

Some things I've learned about how to run a group like this:

- One size doesn't fit all: The group was open to anyone, so we did have some monolingual English speakers come, but they usually didn't come back. I think it came down to people who speak more than one language are used to dealing with interpreters. They are used to that back and forth. People who are monolingual English speakers aren't. So, I think it linguistically was overwhelming. I decided that was okay. We can't be all things to all people.
    - We had members whose first language was Spanish. But also had members whose first language was English who had learned Spanish later in life. That tended to be who the group members were.
- Balancing stressors with solutions: I learned we needed to balance a discussion of stressors with solutions. Some people are more comfortable focusing on the challenges, what's hard. And other people found that to be too much. We needed to make sure we weren't just emotional all of the time. We always wanted to end on a hopeful note.
- Seek input from members: I also learned to routinely seek input from the group members. We routinely did short surveys. For example, surveys included what topics were important to group members.
- Go with the flow: I also learned to be flexible. If we need to toss out the agenda, we did that. If we needed to deal with a particular concern someone had, we did that. We wanted to make sure we heard what group members needed to say.

Could share a few tips for our listeners in working with cultural and linguistically diverse populations (or in working with people with aphasia who are bilingual)?

Bringing this back to LPAA. I really love the values and I think if we use those as a guide that is really important.

- Keeping in mind that our clients may interpret what is important differently than we do.

- Familiarize yourself with the CLAS standards. National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care. This is a list of required and recommended practices for improving health care for CLD patients. The standards fall in four themes. One of these themes is communication and language assistance. As SLPs it's our job to advocate for our clients. CLAS standards can be a way to advocate for making sure we have the language resources necessary for our non-English speaking clients.
- The language of intervention needs to be based on the linguistic needs of the client and not on the language skills of the clinician. Unfortunately, we still hear a lot of, "Oh, I can't work with that client because I don't speak the language." or, "Well, I'll just treat in English as that's what I know." Ethically, we are still required to provide services. That is where interpreters come in. Ideally you would work with a trained interpreter. When you think about the language of intervention, think about who this client is and what they are going to do with that language.

If you had to pick only one thing we need to achieve urgently, as a community of providers and professionals who support LPAA, what would that ONE thing be?

We need to engage with our clients in meaningful ways by always asking 'How is this intervention going to improve their quality of life?' Because if we can't answer that question, we need to be doing something else. Whether the intervention is functional or restorative. What are we doing and why? What is the functional outcome that we are looking for?

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References and Links

Muñoz, M. (2017). Cultural adaptation of evidence-based treatments: An example from aphasia. Perspectives of the ASHA Special Interest Groups SIG 14, Vol. 2(Part 1), 5-14.

National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care https://www.thinkculturalhealth.hhs.gov/clas