Core Curricula Content on Cultural Competence for UCEDDs

INDIVIDUAL LEVEL

The Embedding Matrix series is designed to establish a national standard for curricula and training activities on cultural diversity and cultural and linguistic competence for the network of University Centers for Excellence in Developmental Disabilities (UCEDDs). This matrix offers cultural competence frameworks, definitions, and areas of knowledge and skills for the UCEDD core function of interdisciplinary pre-service training and continuing education. It addresses cultural competence at both the individual and organizational levels. The Embedding Matrix series also provides individual behavioral or organizational change theories to facilitate systemic change in training and professional development activities for this core function.

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<th>Five Elements of Cultural Competence</th>
<th>Interdisciplinary Pre-Service Training and Continuing Education</th>
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<tr>
<td><strong>INDIVIDUAL LEVEL</strong></td>
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<tr>
<td><strong>Acknowledge Cultural Differences</strong></td>
<td>Include subject matter, theory, literature, themes, and first person narratives or lived experience</td>
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<td>• Various conceptual models of culture</td>
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<td></td>
<td>• Culture is multi-dimensional and is not synonymous with race or ethnicity</td>
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<td></td>
<td>• Language and culture are inextricably linked. The relationship between the language and culture is dynamic and changes over time and across settings.</td>
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<td>• Meanings, beliefs, and practices about disability in general and developmental disabilities in particular are influenced by culture</td>
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<td>• The concepts and practices of independence, productivity, inclusion, self-determination, and self-advocacy have different meanings to different cultural groups</td>
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<td>• Conceptualizations of intersectionality and multiple cultural identities within the context of race, ethnicity, and disability</td>
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<td>• Influence of stereotyping and implicit and explicit biases on how cultural groups are perceived and described</td>
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<td>• Disparities in services, supports, education, health, and employment experienced by individuals with developmental disabilities and their families based on such factors as race, ethnicity, culture, languages spoken other than English, gender, LGBTQ identity, socioeconomic status, geographic locale</td>
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<td>• Effects of historical trauma on individuals and groups including those at the intersection of race, ethnicity, and disability</td>
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<tr>
<td><strong>Understand Your Own Culture</strong></td>
<td>Include subject matter, theory, literature, themes, and first person narratives or lived experience</td>
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<td>• World view or mental model influences the perception of culture—including one’s own and the cultures of others</td>
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<td>• Approaches to explore and identify one’s own multiple cultural identities</td>
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<td>• Professional and organizational culture influences both policy and practices within programs concerned with developmental disabilities</td>
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<td></td>
<td>• Cultural influences on communication styles—(how one communicates with others verbally, non-verbally, using interpreters, augmentative means and technologies)</td>
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### Five Elements of Cultural Competence

#### Interdisciplinary Pre-Service Training and Continuing Education

#### INDIVIDUAL LEVEL

**Engage in Self-assessment**

- Approaches to reflect upon one's own cultural belief systems, (including the culture of one's professional discipline), and how they influence interactions with others including and not limited to:
  - Individuals with developmental disabilities and their families
  - Colleagues, co-workers, and staff
  - Community partners and collaborators
  - Students and trainees (long- and short-term)
- Processes to gauge one's comfort level in discussing: 1) racial and ethnic disparities in developmental disabilities services and supports; and 2) disproportionality in special education, behavioral health, and justice systems at the intersection of race, ethnicity, and developmental and other disabilities
- Instruments, strategies, and processes to engage in self-assessment of cultural competence, implicit and explicit biases, and the “Isms”

**Acquire Cultural Knowledge and Skills**

- Include subject matter, theory, literature, themes, and first person narratives or lived experience
  - Multiple dimensions of culture and their expression among individuals with developmental disabilities, their families, and the communities in which they live
  - Diverse populations that reside in region, state, territory, tribal nation, jurisdiction, or other geographic locale
  - Socio-cultural, economic, and political environments that affect individuals with developmental disabilities, their families, and the communities in which they live
  - Culturally-defined beliefs and practices among individuals and families that receive services and supports related to the key developmental disabilities values of independence, productivity, inclusion, self-determination, and self-advocacy
  - Applying concepts of intersectionality and multiple cultural identities in developmental disabilities services and supports
  - Recognition of and interventions to combat explicit and implicit biases and other “Isms” in services and supports including early intervention, education, health care, behavioral health care, and employment of individuals with developmental disabilities
  - Models and frameworks for effective cross-cultural communication
  - The role of cultural competence in one's discipline or field of study (including those articulated by professional associations and societies)
  - Approaches to use self-assessment results to develop personal learning goals and objectives that enhances cultural competence
  - Evidence-based practices that are normed on racially, ethnically, and culturally diverse populations
  - Effective approaches to engage culturally diverse communities including those affected by historical trauma, discrimination, and marginalization

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1 The "Isms" is an umbrella term used by the Georgetown University National Center for Cultural Competence (NCCC) to refer to a range of attitudes and behaviors that involve perceived superiority, oppression, prejudice, and discrimination based on such factors as race, national origin, ethnicity, language, class, disability, sexual orientation, and gender identity and expression.
### Five Elements of Cultural Competence

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<th>Individual Behavioral Change Theories and Frameworks</th>
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<td>Frequently those who teach or provide training on cultural competence focus on increasing areas of awareness, knowledge, or skills for the intended audience. Often this instruction relies primarily upon cultural competence subject matter and does not draw upon the behavioral change literature and models. Cultural competence requires not only organizational change, it also requires individual or personal change. Heifitz (1994) puts forth two types of challenges encountered in processes of change—technical and adaptive. Typically, in the case of technical change, the solution is clear and change can be accomplished by those in leadership roles or knowledgeable experts that provide the solution. In contrast, adaptive change requires new learning, the solution may not be clear cut or is complex, and responsibility for change rests with the individual—not leadership or authority figures. It is helpful to ask the question: Does understanding and practicing cultural competence require changes in a person’s values, attitudes, and behaviors? The answer is a resounding yes for myriad reasons. Cultural competence involves issues associated with race, ethnicity, cultural diversity, inequities, and the “isms” and for many are difficult to admit, discuss, confront, and address.</td>
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The following is a list of individual behavior change theories and frameworks, quite prevalent in the social and health sciences. They were selected because of their relevance and applicability to interdisciplinary pre-service training and continuing education for audiences learning to advance and sustain cultural competence. While each is different, these theories and frameworks have cross-cutting constructs: how the individual views the world, behavior change as a process, multiple levels of influence, motivation versus intention versus action, and changing behavior versus maintaining behavior change.3

**Diffusion of Innovation Theory**

Diffusion of Innovation Theory was developed by Rogers and defines an innovation as an idea or practice is perceived as new by an individual or other unit of adoption and how it can diffuse or spread within a social system (e.g., program, organization, department). Adoption means that a person does something different—such as embraces or adopts a new idea or acquires and performs a new behavior.4

Roger delineates five main factors that influence adoption of innovations.

1. **Relative Advantage**—The degree to which an innovation is seen as better than the idea, program, or product it replaces.
2. **Compatibility**—How consistent the innovation is with the values, experiences, and needs of the potential adopters.
3. **Complexity**—How difficult the innovation is to understand and/or use.
4. **Trialability**—The extent to which the innovation can be tested or experimented with before a commitment to adopt is made.
5. **Observability**—The extent to which the innovation provides tangible results.

**Practical implications for cultural competence.** Consider cultural competence as an innovation using this theory. The stages of adoption and diffusion would entail: awareness of the need for the cultural competence as an innovation in developmental disabilities; decisions to adopt or reject cultural competence as an innovation by those participating in interdisciplinary pre-service training and continuing education; testing cultural competence as an innovation in day-to-day practice, activities, and responsibilities; continuing to use cultural competence as an innovation in developmental disabilities. This Diffusion of Innovation Theory offers a multidimensional model for curricula and experiential learning activities in order to effect individual behavioral change to advance and sustain cultural competence.


**Integrated Behavior Model**

The Integrated Behavior Model draws from Social Cognitive Theory and the Theory of Planned Behavior. It includes constructs from both models and adds components of knowledge and skills, salience, environmental constraints, and habit. This model still defines behavioral intention as the most salient factor driving behavior. However, the model recognizes that even with an intent to perform a behavior there are other factors (i.e., environmental constraints or salience) that could prevent individuals from following through on their intent. Similarly, without adequate knowledge and skills, the behavior may neither be realistic nor feasible, or existing habits may encourage or inhibit the behavior.

**Practical implications for cultural competence.** The important contribution of the Integrated Behavior Model, as considered within the context of cultural competence and developmental disabilities, is that in the absence of adequate knowledge and skills, the desired behavior may not be obtainable. This is commensurate with one of the elements of the cultural competence model used in this matrix series—acquire cultural knowledge and skills. Behavioral change in and of itself is not the formula to advance and sustain cultural competence at the individual level. The combination of knowledge, skills, and using theories of behavioral change to affect attitudes, values, mental models, and practice is essential to embedding cultural competence in UCEDD curricula and training activities.


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Prochaska Stages of Change or Transtheoretical Model

Prochaska Stages of Change Model, also known as Stages of Change and Transtheoretical Model (TTM), conceptualizes the process of an individual's intentional behavior change and has two primary components: stages of change and processes of change. The stages of change are comprised of five distinct steps (not necessarily linear) that individuals undergo when adopting a change:

1. Precontemplation—no intention to take action in the foreseeable future; unaware of under-aware of the need for change
2. Contemplation—aware that a problem exists and seriously thinking about overcoming it; but has not yet made a commitment
3. Preparation—combines intention and behavioral criteria; initiation of “small steps”
4. Action—modification of behavior, experiences, and environment; short-term changes in place and planning long-term change
5. Maintenance—consolidates the gains attained during action phase and works to prevent any regression or lapses

Prochaska Stages of Change or the TTM provides a lens by which to view where students/trainees are in the process of learning about cultural competence within the context of developmental disabilities. Some are unaware, some are cognizant of the need of diverse populations, and still others are at early stages of behavioral adaptation and change. Prochaska describes termination as a sixth stage of change. This stage is incompatible with the cultural competence framework used in this matrix series. Cultural competence is a developmental process that an individual does not terminate. Culture is defined as constantly changing and evolving over time. It is important to stress the principle that cultural competence requires lifelong learning in preservice training and continuing education training.

References:

Social Cognitive Theory

Social Cognitive Theory (SCT) considers the unique way in which individuals acquire and maintain behavior, while also considering the social environment in which individuals perform the behavior. The theory takes into account a person's past experiences, which factor into whether behavioral action will occur. These past experiences influence reinforcements and expectations—all of which shape whether a person will engage in a specific behavior and the reasons why a person engages in that behavior.5

Practical implications for cultural competence. The dynamic interaction between the learner, the socio-cultural environment, and behavior are complex and multifaceted when considering the broad array of factors that affect cultural competence. SCT has many implications for cultural competence curricula and training activities both for faculty and staff conducting training activities and for students or those participating in such activities. While the constructs presented in 1-6 use a public health framework they are universally applicable to UCEDD interdisciplinary pre-service training and continuing education activities devoted to or that integrate cultural competence.

SCT posits six key constructs.
1. Reciprocal Determinism—This is the central concept of SCT. This refers to the dynamic and reciprocal interaction of person (individual with a set of learned experiences), environment (external social context), and behavior (responses to stimuli to achieve goals).
2. Behavioral Capability—This refers to a person's actual ability to perform a behavior through essential knowledge and skills. In order to successfully perform a behavior, a person must know what to do and how to do it. People learn from the consequences of their behavior, which also affects the environment in which they live.


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3. Observational Learning—This asserts that people can witness and observe a behavior conducted by others, and then reproduce those actions. This is often exhibited through “modeling” of behaviors. If individuals see successful demonstration of a behavior, they can also complete the behavior successfully.

4. Reinforcements—This refers to the internal or external responses to a person's behavior that affect the likelihood of continuing or discontinuing the behavior. Reinforcements can be self-initiated or in the environment, and reinforcements can be positive or negative. This is the construct of SCT that most closely ties to the reciprocal relationship between behavior and environment.

5. Expectations—This refers to the anticipated consequences of a person's behavior. Outcome expectations can be health-related or not health-related. People anticipate the consequences of their actions before engaging in the behavior, and these anticipated consequences can influence successful completion of the behavior. Expectations derive largely from previous experience. While expectancies also derive from previous experience, expectancies focus on the value that is placed on the outcome and are subjective to the individual.

6. Self-efficacy—This refers to the level of a person's confidence in his or her ability to successfully perform a behavior. Self-efficacy is unique to SCT although other theories have added this construct at later dates, such as the Theory of Planned Behavior. Self-efficacy is influenced by a person’s specific capabilities and other individual factors, as well as by environmental factors (barriers and facilitators).^6


Theory of Reasoned Action and Theory of Planned Behavior

The Theory of Reasoned Action is based on the premise that individual performance of a given behavior is primarily determined by a person’s intention to perform that behavior. The Theory of Planned Behavior adds to this theory that perceived control over the opportunities, resources, and skills necessary to perform a behavior is a critical aspect of the behavioral change process. Both theories seek to explain the relationship between behavior and attitudes, intentions, and beliefs (inclusive of both individual and socially perceived/experienced beliefs); and both assert behavioral intention is the primary determinant of behavior. The theories posit that behavioral intention is influenced by an individual’s attitude toward the behavior as well as perception of how those important to the person feel about the behavior (subjective norm).

Practical implications for cultural competence. These two theories emphasize the need to ensure curricula and training activities include subject matter that considers students’ or trainees’ individual experiences and offers experiential learning that addresses individual and socially perceived attitudes and beliefs about cultural competence in developmental disabilities.


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Critical Consciousness

Critical Consciousness is not a traditional theory of change, however it is highly relevant to cultural competence curricula and training activities. Critical consciousness is a concept developed by a Brazilian educator, Paolo Freire, in two of his seminal works—Pedagogy of the Oppressed (1968) translated from Portuguese into English in 1970, and Education for Critical Consciousness (1974). Freire stressed the role of education in raising critical consciousness among those populations that were marginalized and oppressed as a means of taking action against such conditions within society. The concept of critical consciousness has evolved and has been adapted to social-political contexts of education in the United States. Critical consciousness has been used to engage individuals and groups in dialogue to probe the contexts and root causes of inequities. The process of dialogue can spur critical thinking to delve deeply into causation and to take action to create a different reality. Several key concepts espoused by critical consciousness are: 1) the capacity to view reality as alterable can inspire motivation to change that reality; 2) that literacy includes awareness of one’s culture and situation; and that dialogue is indispensable to learning.

Practical implications for cultural competence. Critical consciousness posits education as the most important vehicle for change. Within the context of cultural competence curricula and training activities, the concept of critical consciousness can be employed to: 1) gain insight and knowledge about the conditions experienced by individuals with developmental disabilities and their families from underserved racial, ethnic, and cultural groups; 2) engage in self-reflection and discussion of disparities that have a deleterious effect on individuals at the intersection of race, ethnicity, and disability; 3) listen, participate, and learn from dialogues with underserved and marginalized populations and join them in advocacy and other actions to affect change in their communities; and 4) gauge the effectiveness of such dialogues in raising “critical consciousness” of disparities and disproportionality in systems serving individuals with developmental disabilities and their families.