The Rehabilitation Service Provider as Culture Broker:

Providing Culturally Competent Services to Foreign Bom Persons

Mary Ann Jezewski and
Paula Sotnik

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Mary Ann Jezewski, PhD
And
Paula Sotnik

CIRRIE
Center for International Rehabilitation Research Information and Exchange

University at Buffalo
The State University of New York

Center for International Rehabilitation Research Information and Exchange
(CIRRIE)
515 Kimball Tower
State University of New York, University at Buffalo
Buffalo, NY 14214
Phone: (716) 829-3141 x 169
Fax: (716) 829-3217
E-mail: ub-cirrie@buffalo.edu
Web: http://cirrie.buffalo.edu

This publication of the Center for International Rehabilitation Research Information and Exchange is supported by funds received from the National Institute on Disability and Rehabilitation Research of the U.S. Department of Education under grant number H133A990010. The opinions contained in this publication are those of the authors and do not necessarily reflect those of CIRRIE or the Department of Education.

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CULTURE BROKERING: PROVIDING CULTURALLY COMPETENT REHABILITATION SERVICES TO FOREIGN-BORN PERSONS

Preface

Since the early 1980s, approximately 850,000 persons have come to the United States every year from other countries. Thirty years ago, approximately one in twenty Americans was born outside the USA. Today, the ratio is closer to one in ten. Many of us can remember a time when contact with other cultures was considered the domain of diplomats, missionaries and Peace Corps Volunteers. Today, nearly everyone in the U.S. has a cross-cultural story to tell and rehabilitation service providers are no exception.

Disability can be a challenge no matter where one is born. For a recent immigrant, the challenge is often magnified. In addition to difficulties with language, housing and employment, the person may also have difficulty understanding and accessing rehabilitation services. Most service providers recognize this, but often experience frustration that arises from miscommunication and differing cultural perspectives. Providers can mitigate such problems, however, by recognizing obstacles that pose difficulties for the foreign-born consumer and identifying ways to overcome them.

Leavitt (1999) points out that, while ethnic minorities comprise approximately 25-30 percent of the U.S. population, they make up less than eight percent of the population of health and rehabilitation professionals. Although efforts are being made to recruit more service providers from other cultures, within the foreseeable future most foreign-born consumers will be served by professionals whose cultural backgrounds are very different from their own.

Therefore, it is critical that all service providers understand how such differences can affect their services.

According to Groce (1999, page 38),

> "Understanding sociocultural models of disability is of more than academic interest. Unless programs for individuals with disabilities are designed in a culturally appropriate way, the opportunity to make real and effective change is often lost. [The intent is not] to catalogue every known variation in disability beliefs, but rather to alert the practitioners to the fact that the ways in which disability and rehabilitation are conceptualized will have an impact on the manner in which rehabilitation professionals are received, regarded and able to serve their patients."

There are two types of understanding that are useful in providing effective services to persons from other cultures. One is knowledge about the specific culture of the persons with whom we are working. To assist practitioners with this, CIRRIE - The Center for International Rehabilitation Research Information and Exchange - is developing a series of monographs on the cultures of ten of the countries from which most immigrants to the U.S. originate, as determined by data from the U.S. Census Bureau. These include: Mexico, China, India, Vietnam, the Philippines, Korea, the Dominican Republic, El Salvador, Cuba and Jamaica.

The second kind of understanding useful to those working in cross-cultural rehabilitation settings relates not to specific cultures, but to the general process of working with persons from different cultures, whatever those cultures may be. The purpose of this monograph is to offer insights and meanings that expand the reader's understanding of this process and help develop stronger and more effective cross-cultural skills. While the focus of this monograph is on persons who are *foreign born*, many of the concepts also apply to persons who were born in the U.S. but are from a culture that is different than the dominant culture.

Included in the term *rehabilitation service providers* are physical, occupational and speech language therapists, vocational rehabilitation personnel, rehabilitation technology specialists, rehabilitation physicians and nurses, special educators, staff of centers for independent living and community service providers. While providing examples from several fields, the authors have attempted to avoid technical terminology specific to any one of them.

Throughout this monograph, the authors have used the term *consumer* to describe a person with a disability who uses the rehabilitation service system. We recognize that the term "*patient*" is commonly used in the context of medical rehabilitation and that *client* is commonly used in other rehabilitation fields. *Consumer*, however, besides being the term preferred within the disability community, expresses the notion that the person is a user of rehabilitation services and therefore is empowered to make the same kinds of choices and decisions as those who use other kinds of services.

The authors of this monograph are uniquely prepared to write on this subject. Mary Ann Jezewski, Ph.D. is an anthropologist at the University at Buffalo, State University of New York, who developed a model of *culture brokering* and adapted it for rehabilitation service providers. She defines culture brokering as the process of facilitating and mediating between the culture of the foreign-born person and the culture of the host country, as well as the culture of the rehabilitation service system itself.

Paula Sotnik of the Institute for Community Inclusion in Boston has worked for many years with foreign-born persons from diverse cultures in the context of rehabilitation services. She has developed and implemented eight demonstration, training and technical assistance projects designed to help un-served populations access disability services. Ms. Sotnik is the lead trainer in the CIRRIE workshop series that uses Jezewski's culture brokering model as its organizing theme.

The authors join me in acknowledging and thanking Nora Groce, Ph.D. of Yale University, Paul Preston, Ph.D., of Through the Looking Glass, Berkley, California, and Ricardo Contreras of the Louis de la Parte Florida Mental Health Institute at the University of South Florida, who reviewed the manuscript and provided valuable suggestions for strengthening it.

This monograph series was developed by CIRRIE, a center whose mission is to assist rehabilitation researchers and practitioners to access international expertise. CIRRIE is supported by a grant from the National Institute on Disability and Rehabilitation Research of the U.S. Department of Education.

We hope that this monograph will be useful to you in your work with individuals who are foreign-born. We welcome your comments that will enable us to deepen our understanding of ways to increase the effectiveness of rehabilitation services for persons born in other countries.

We are becoming an increasingly global community. It is our hope that the concepts presented in this monograph will help make all of us better citizens of that community, particularly in our ability to apply rehabilitation to the needs of foreign-born persons with disabilities.

John H. Stone, Ph.D., Director
Center for International Rehabilitation Research Information & Exchange (CIRRIE)
Series Editor

INTRODUCTION

This monograph consists of several sections to present the reader with basic information about key concepts related to cultural diversity among foreign-born persons. Examples are provided in each section relevant to the practice of rehabilitation service providers.

The first section provides a discussion of concepts that form the foundation for the remaining sections of the monograph. The concepts chosen for discussion in this section assist the reader in understanding the culture-brokering model presented later in the monograph. Also included in this section is a discussion of concepts related to foreign-born consumers and rehabilitation services from within a cultural perspective.

The second section focuses on the role of the rehabilitation service provider using Jezewski's culture-brokering model. The model is adapted to serve as a framework for the rehabilitation service provider's professional interactions with foreign-born consumers. The rehabilitation service provider-as-culture broker bridges or mediates between individuals or groups of differing cultural backgrounds for the purpose of reducing conflict or producing change in the service arena. The stages of the brokering process, as well as the intervening variables that affect brokering are presented in detail. A case study is provided to illustrate how the service provider might perform the role of culture broker.

The next section of this monograph focuses on a procedure that is useful for the culture broker to consider when brokering services for foreign-born consumers. The test consists of a series of questions that encourage consumers to discuss their explanation for their disability including causes, management and physical and social adaptation. This is referred to as explanatory models of disability. The way this procedure, eliciting explanatory models, can be used by rehabilitation service providers is explained in detail later in the monograph.

Another section of the monograph presents some variables that are important for the service provider-as-culture broker to consider when interacting with culturally diverse consumers. We have titled this section, Caveats. The section includes an in-depth discussion of cross-cultural communication and the importance of culturally appropriate communication with foreign-born consumers. The monograph provides examples and recommendations to providers related to cross-cultural communication techniques.

The last section of this monograph provides additional resources to supplement the content provided in the monograph.

This monograph should be viewed as a starting point to understanding and providing culturally sensitive care to foreign-born consumers. It is beyond the scope of this monograph to include all the information necessary to provide services to persons from different cultures, but it does provide the basic information necessary to move toward that goal. This monograph also serves as background information for the CIRRIE monographs that focus on individual foreign-born groups.

PART I: DISCUSSION OF KEY CONCEPTS

There are several key concepts that are important to understand when providing services to consumers whose culture is different from that of the provider. Knowing the meaning of the following concepts helps service providers reflect on their values and their role in providing services to their consumers. A discussion of key concepts also provides the basis for understanding the culture-brokering role and the role of rehabilitation service providers as culture brokers. The terms *disability*, *rehabilitation*, and *activities of daily living* will be discussed within a cross-cultural context. The key concepts in understanding cultural diversity in rehabilitation are listed below.

Culture
Cultural Competence
Stereotyping
Acculturation
Worldview
Diversity
Foreign Born
Disability
Rehabilitation
Activities of Daily Living

Culture

Although hundreds of definitions of culture can be found in the anthropology literature alone, for this monograph, culture is broadly defined as a system of learned and shared standards for perceiving, interpreting, and behaving in interactions with others and with the environment (Jezewski, 1990). Two key components in this definition are that culture is learned and shared. Human beings learn culture from those with whom they interact from the moment of birth (some would say before birth). Family, and those who cared for us as young children, are the formidable teachers of cultural values, beliefs and behaviors. Values are ideas about what is normal and abnormal, proper and improper, desirable and undesirable, right and wrong. Values form the basis for our beliefs and behaviors. Some of the values held by the majority of Caucasian, middle class Americans, often referred to as dominant U.S. values are:

Democracy
Individualism
Privacy
Change
Progress
Optimal health
Informality
Achieving, doing
Working
Materialism
Cleanliness
Time
Directness/Assertiveness

For example, many Americans believe it is important to work hard because they value achieving and doing, that is, it is important to accomplish tasks. This is not a universal value; not all cultures value doing to this degree. In some cultures who you are in relation to your family or community is valued more than what you do as an individual.

Culture should be viewed as a system. That is, culture is made up of discrete but interconnected components. The elements of a culture system consist of:

- normative codes (ways of behaving) such as:
  - food practices
  - religion, religious practices
  - child rearing practices
- communication codes (both verbal and nonverbal)
  - common language
- a body of knowledge
  (information necessary to function as a member of a culture group)
- problem solving strategies (how everyday problems are resolved)
- a set of relationships (family and social)
- methods of transmitting culture to the young, or new members of the culture group

Underlying and shaping these elements are the basic values and beliefs of the group. These elements function as a whole. A change in one component, or the introduction of new or unfamiliar elements, can affect other components as well as the system as a whole. For example, a recently immigrated elderly Vietnamese woman who develops a disability, and for whom an assisted living environment has been recommended, may have a difficult time adjusting to this environment because she is no longer a part of her family's household. Feelings of abandonment may be strong. The traditional Vietnamese is highly family oriented. Two or three generations may be living in the same household. Elders are highly respected, and adults within the family are expected to assume full responsibility for them. Traditionally, elders with disabilities are cared for at home. Being institutionalized is believed to be disrespectful to the elder member of the family. The Vietnamese family may feel that they are abandoning their family member and not fulfilling their role as a good and loyal family if they institutionalize a family member. This disruption (a family member in an assisted living environment) changes the configuration of the family and in turn violates many of the values of Vietnamese culture. In all likelihood, this recently immigrated Vietnamese family will not easily resolve the value conflict that has arisen as a result of their family member's disability. In turn, the life of the person with disabilities is vastly disrupted because of changes in her cultural system. The changes may involve

inability to continue some religious practices or the loss of ability to communicate with others. Communication (because of the inability to speak English) and disruption of dietary practices are some of the components of the cultural system that could be affected by moving the member with disabilities out of the Vietnamese family. Our cultural values and beliefs are continually changing, but at the same time, resist change because they serve the purpose of defining who we are within a group.

It is useful to distinguish between the terms *culture*, *ethnicity* and *race*. Although these terms are sometimes used interchangeably in the literature, they are not the same, and should not be used interchangeably. Culture was defined above 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.

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 situations 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.

Culture Competence and Sensitivity

Culture sensitivity is the awareness by one person of the differences in values, beliefs, and behaviors of another, and the understanding that these values, beliefs and behaviors are the basis for the way people interact with each other. Culture sensitivity precedes cultural competence, but it is not considered enough for providers to be culturally sensitive to the diversity in others. Culturally competent service is responsive to issues related to culture, race, gender and sexual orientation. Culturally competent service is provided within the cultural context of the consumer (AAN Expert Panel Report, 1993). Randall-David (1989) defines cultural competence as a set of behaviors, attitudes and policies that enable a system, agency or individual to function effectively with culturally

diverse consumers and communities. In the content of providing rehabilitation services, cultural competency requires recognizing and understanding how economic conditions, race, culture, ethnicity, the social context and environment define health, disability and the provision of services (Rorie, Paine & Barger, 1996).

Rorie and colleagues (1996) provide a useful framework describing a continuum from incompetence to competence. On the incompetent end of the continuum is cultural destructiveness (attitudes, policies and practices are exhibited that can be destructive to a culture). The continuum moves along to cultural incapacity (biased, authoritarian system that lacks capacity to facilitate growth in culturally diverse groups), and then onto culture blindness ("we're all human" approach is used where it is thought that culture, ethnicity and race make no difference in how services are provided). Next on the continuum is cultural pre-competence (cultural sensitivity wherein there is a decision made and attempts are made to deliver services in a manner respectful of cultural diversity). Following along the continuum is cultural competence (an acceptance of and respect for cultural norms, patterns, beliefs, differences, and self assessment regarding cultural competence), and lastly, cultural proficiency (motivation toward adding to the knowledge base of culturally competent service provision, and developing a culturally therapeutic approach). It should be noted that each time a service provider encounters a consumer from an ethnic group that the provider is not familiar with, the provider may have to move through all or part of the competence continuum. Developing competency takes time with each new culture encounter.

In 1993, an American Academy of Nursing panel of experts on culturally competent health care was convened to outline the major components of providing culturally competent care to diverse groups of patients. Although the panel concluded that there are no well-tested and tried models that can facilitate the provision of culturally competent care, the panel did identify a number of useful and effective models that have been used to enhance cultural sensitivity, and the delivery of culturally competent services. Jezewski's culture-brokering model was identified as one practice model that offered guidance for the delivery of culturally competent care. The culture-brokering model is described later in this monograph. Although iwas originally developed in the context of health care, it has applications in many fields, including rehabilitation services.

Diversity

There are many different types of diversity within a society - culture, gender, age, and economic. Each social group consists of different types of diversity. Although the focus of this monograph is cultural diversity, the different types of diversity within a society are integral to understanding cultural diversity and will be discussed in a later section in relation to the role of rehabilitation service providers as culture brokers.

Specific values, beliefs and behaviors are not universal across groups, but all human groups have a set of values and beliefs that guide their behaviors. When we are learning about specific ethnic or culture groups, it is important to keep in mind that there is as much diversity within groups as there is between ethnic or culture groups. For example, when we talk about Native Americans, we are talking about more than 400 different tribal groups. Historically, most of these tribes had little contact with each other, spoke different languages, and did not have the same values and beliefs, and therefore could not be considered in the same culture group. It is inappropriate to consider Native Americans as one culture and to assume that all Native Americans have the same values and beliefs. This is a form of stereotyping. Native Americans may have some of the same values but there is diversity among tribes as well as between members of the same tribe.

Stereotyping

Very often, when we first begin to learn about different culture groups, the tendency is to take the facts we learn and apply them to everyone who is a member of the group. We do this without evaluating the extent to which the individual members adhere to the dominant values and beliefs. This is a form of stereotyping. Stereotyping refers to action that is based on theassumption that all members of a group share the same characteristics, values and beliefs, and basing one's actions on this premise. For example, a service provider may have read that in Mexican families, the man is the decision maker and that women in the family will not make service decisions by themselves. Based on this information, the service provider will not spend the time discussing service decisions with a Mexican woman without her husband or father present. This is a form of stereotyping. In some Mexican families, the man may be the primary decision-maker, but in other families of Mexican origin, women assume autonomy in making decisions that affect them personally. By assuming the woman will not make decisions about the services she needs, the provider may be raising a barrier to effective intercultural communication and may be undermining a positive service outcome for this consumer. People within a culture group adhere to the basic values and beliefs of the group to varying degrees. The degree of adherence depends on variables such as gender, age and exposure to other culture groups.

In another example of stereotyping using the situation just described, a service provider may read about Mexican families and assume that every Hispanic group adheres to the same values as those of Mexican descent. Again *Hispanic* is an umbrella term, which encompasses people from Mexico, Puerto Rico, some parts of Central and South America as well as Spain. These varied culture groups have a common language, but have been separated culturally for many centuries. In addition, even though their common language is Spanish, the nuances of the language have evolved differently over the centuries.

One way to avoid stereotyping is to look at new knowledge about an ethnic group as a generalization, which is a beginning point, knowledge that indicates common trends for beliefs and behaviors that are shared by a group. Stereotyping is viewed as an end point, that is, no attempt is made to learn whether the individual in question fits what is known about the group.

Stereotyping assumes that every member of the group possesses certain characteristics, adheres to the same beliefs, and behaves in the same manner in any given situation. Generalization, as a beginning point, acknowledges that additional information is needed to determine whether the information known about the group applies to a particular individual within the group. For example you might read that most Mexican people are members of the Roman Catholic religion or that most people from the Middle East are Moslem. For the rehabilitation service provider to assume that every Middle Eastern consumer adheres to the Moslem religion and therefore prays five times a day is stereotyping. It could lead the provider to anticipate behaviors that do not exist and make inappropriate scheduling of activities.

Possessing knowledge about the Moslem religion may increase the service provider's ability to give culturally competent care to the Middle Eastern consumer. If consumers practice the Moslem religion, asking questions about their preferences, providing them the opportunity to pray at certain times of the day, and avoiding serving them pork or pork products will reflect service that is both culturally sensitive and competent. Galanti (1991) provides a useful discussion of stereotyping versus generalizing as well as discussions of many other basic concepts related to cultural diversity.

Acculturation

The degree to which one assumes the values and beliefs of a new culture is referred to as the degree of acculturation. Acculturation is influenced by language, length of time spent interacting with people in the new culture, and the intensity of contact with the new culture. Acculturation is an especially important concept when immigrants or refugees enter the U.S. and are exposed daily to the U.S. culture. To some extent the immigrant/refugee is influenced by the U.S. culture, and their values, beliefs and behaviors change based on frequency and intensity of contact. For some, this change will occur rapidly, and in others, the change will be slow or not at all. Acculturation essentially becomes a melding of a person's primary culture with that of the new culture. We can never assume that someone who has immigrated to the U.S. from another culture will assume the values and beliefs of the dominant U.S. society. Acculturation is also influenced by education, economic status, gender and personal choice.

The following example serves as an illustration of how acculturation evolves in the various members of a newly immigrated family. Young children who come to the U.S. from another culture and who attend public school, tend to acculturate faster and more completely than their parents. Daily exposure to U.S. values through the classroom environment, the pressure to learn English, along with peer pressure and the desire for peer friendships, all contribute to acculturation in the child. In contrast, the child's mother may be in the home most of the time, especially if there are preschool children in the family, and she is not working outside the home. Her closest friends may be women who have immigrated from the same geographic location. This woman may not be under any social pressure to learn the ways of the U.S. culture and thus not under pressure to become fluent in English. Her social world may revolve around her ethnic community where her primary language, rather than English, is spoken. The child's father and other family members acculturate depending, in part, on their work outside the home and the need to speak English in their work environments. Their degree of acculturation also depends on their need to attend to activities of daily living, such as shopping, accessing transportation and interacting with various immigration and social service agencies. The more acculturated children in the family become, the greater the chance they will be the ones who interpret for their parents in the service arena.

Worldview

A fundamental component of culture is an individual's worldview, which includes beliefs about religion, humanity, nature and one's existence. Worldview relates to the philosophical ideas of being (Jandt, 1995). In order to effectively support individuals with disabilities who are foreign-born, rehabilitation service providers should have an appreciation of the varied perceptions of existence in the world.

Samovar, Porter, & Jain (1981) defined three components of worldview. Differing interpretations are paired with these components in the following framework (Table 1):

One's worldview takes into account many beliefs that guide our behavior and may have particular implications for the perception of disability and related services by some foreign-born groups. One facet of worldview perspective is an individual's relationship to science and technology (Samovar, et al., 1981). People who abide by mainstream U.S. culture believe that a scientific strategy can solve problems and technology can help in this effort. Applying this concept to rehabilitation, an individual with a disability could successfully use a communication device that was developed based on rigorous research. This example is considered commonplace in our rehabilitation service world and culture. However, in some cultures, challenges posed by a disability are conditions that should not be altered. An individual's disability is predetermined by fate and thus cannot be

Table 1: Samovar's components of worldview

Component	Different Views
Individual and Nature	human life is more important than nature OR humans are part of nature; nature cannot be modified
Science and Technology	individuals can discover an explanation and solution to problems by scientific methods OR problems are predetermined by fate and cannot be altered
Materialism	the acquisition of material goods is important OR self sacrifice is valued; tangible assets are not

Table 2: Collectivist and individualistic value systems

Cultural Concepts	Personal Characteristics	Behavioral Indicators
Individualism	•Self expression •Assertiveness •Self-advocacy •Self-realization	•communicating dissatisfaction with services· •holding a different view of services than family unit or community •focus on the individual's unique set of talents and potential
Collectivism	•Individual's existence is inseparable from the family and community •Self-interests are sacrificed for those of the family or larger group •Group activities are dominant	•individual may not accept transportation and work outside his/her community • supports to achieve self sufficiency not welcomed

modified. Some religions are said to be fatalistic because they require submission to the will of God, which some would argue contradicts practices for preventing or remediating disabilities (Miles, 1995).

Another major dimension to the manner in which people perceive their world and behave, is an adherence to a collectivist or individualistic value system. The following framework (Table 2) indicates several examples of diverse cultural values and potential implications for understanding disability and accepting disability-related supports.

Implicit in the U.S. rehabilitation system are *individualistic* values that including self-sufficiency, technology or other adaptations to complete daily living tasks independently. Rehabilitation policies and practices including assessments, programs, supports and success criteria are based on meeting these standards of independence.

For some individuals who embrace strong family interdependence rather than individual independence, these standards will most likely pose conflict in the theory and practice of rehabilitation supports. Many persons with disabilities want assistive technology, vocational rehabilitation and other rehabilitation services, but, depending on their cultural values, they may want them for different reasons. For example, persons with an individualistic worldview may want assistive technology so that they will be able to live independently in their own dwelling and be economically self-supporting. Persons that abide by collectivist values may want assistive technology in order to be able to continue living with their family and participate in family tasks and recreation. Thus, diverse views guide one's choice of values and goals. Before discussing possible interventions with consumers, the service provider should be aware of their values and goals so that whatever interventions are discussed may be presented in the context of strategies to meet those goals. Consider the following scenario:

A middle-aged Chinese man, Mr. Chen, attended a demonstration of assistive technology products with his wife and two adolescent children. Mr. Chen became blind due to illness about five years ago. Following Mr. Chen's acquired visual disability, his wife shaved him daily. However, being assisted by a female in completing such a personal, masculine task was perceived as devaluing according to his cultural beliefs. Throughout the demonstration, he appeared to disregard the description of products to assist individuals with disabilities. However, he became interested as the presenter explained the functions of a buzzing shaver that beeped when it touched facial stubble. This product enabled effective shaving without needing to see his facial hair. He anticipated an opportunity to once again shave himself and became very interested in this particular device. Although many assistive technology products designed to increase overall independence may not be highly valued, this device was appealing because it supported Mr. Chen's cultural values and beliefs about personal care tasks and masculinity.

Foreign-Born Individuals

The estimated foreign-born population of the United States in March 1997 was 25.8 million based on data collected in the Current Population Survey (Schmidley and Campbell, 1999). This is the largest number of foreign-born persons in U.S. history and represents an increase of 6.0 million, or 30%, over the 1990 census total. An estimated 9.7 % of the U.S. population was foreign-born in 1997. This is the highest proportion since 1930. In 1970, persons who were foreign-born were only 4.7% of the U.S. population. The rapid growth in the foreign born population in the past generation has been due primarily to large-scale immigration from Latin America and Asia. Persons from Central/South America and the Caribbean accounted for 51% of the foreign-born population in 1997, while persons from Asia represented 27%. This rapid increase in the foreign-born population has had an impact on all sectors of U.S. society, including rehabilitation services.

Persons who are foreign-born include 1) "immigrants", a nonresident alien admitted for permanent residence, 2) "refugees" admitted to the U.S. outside of normal quota restrictions based on a well-founded fear of persecution, 3) "asylum-seekers" applying to the U.S. for refugee status, and 4) "undocumented persons" entering the U.S. without the documents to reside legally in the U.S. (Lipson, 1996).

According to the 1997 U.S. census (Schmidley and Campbell, 1999), the largest foreign-born groups by country of birth include persons from Mexico, China, India, Philippines, Cuba, Vietnam, Dominican Republic, El Salvador, Korea and Jamaica.

A high proportion of foreign-born individuals are employed in labor, farming and service jobs rather than technical or professional specialties. These individuals often fall beneath the poverty line and speak a language other than English. More than half of those who speak Spanish or an Asian and Pacific Islander language at home, do not speak English very well (U.S. Census Bureau, 1993).

Estimating the number of foreign-born individuals with disabilities is an extremely difficult task. There are many different definitions of disability, both within and between cultures and groups. Smart and Smart (1997) point out that there is no uniform definition of disability in the U.S. since government agencies define disability differently. Disability Statistics (1993) compared the three national surveys sponsored by three different Federal agencies: the National Center on Health Statistics, the Bureau of the Census and the Bureau of Labor Statistics. The report shows that each agency uses definitions that address its specific purpose, such as employment, health care or social security benefits. Particular agencies define the term according to the limited concerns of that agency. Disability rights advocates often use broader definitions.

Individuals, families and communities perceive and respond to disabilities differently. A person with a hearing loss may not consider it to be a disability. One of the authors of this monograph found through her work with Cambodians in Massachusetts that some Southeast Asian groups view a person with blindness as one who possesses a certain valued insight, not a disability. This great variance in the definition of disability poses a difficult task in measuring the rate of disability in a group. Additionally, changes in terms over time may affect these rates. The American Association on Mental Deficiency revised the IQ point from 85 to 70 to define individuals with mental retardation. As a result, this population decreased by 13 percent. (Harry, 1992).

"Due to a disturbing lack of hard data on minority populations with disabilities, it is not certain precisely how many members of minority groups have disabilities or how fast this population is growing." (National Council on Disability, 1993, page 3). Furthermore, the National Council on Disability (1999) indicates that virtually every federal estimate of the incidence of disability among people from diverse cultures in the U.S. is likely to be low. This report further indicates that these low estimates appear to have substantially impacted the effectiveness of service delivery. There are many reasons for lack of data on the disability rates in certain groups. Culturally and linguistically inappropriate assessment tools and stigma associated in identifying oneself as a person with a disability are among them. Because disability involves not only medical considerations, but also social, economic, and cultural factors, the prevalence of disability can vary significantly from one segment of society to another. Data compiled by the U.S. Census Bureau have revealed significant differences in disability rates among Americans belonging to various racial and ethnic groups. According to the 1992 Census Bureau's Survey of Income and Program Participation (SIPP), the overall rate of disability in the U.S. population is 19.4 %. The rate is highest for Native Americans (21.9%), followed closely by blacks (20.0%) and whites (19.7%), while those of Hispanic origin have a significantly lower rate (15.3%). For Asians and Pacific Islanders, the disability rate (9.9%) is only half that for whites and blacks. Unfortunately, this report does not identify the specific subsets of foreign-born individuals who have disabilities within a larger ethnic population, e.g. Vietnamese subgroup within the Southeast Asian population. For this reason, it is nearly impossible to extrapolate the number of individuals with disabilities from specific foreign-born groups.

Refugees and Immigrants

Refugees and immigrants arrive in the United States for many reasons, some come voluntarily while other individuals are forced to migrate due to political volatility or persecution in their homelands. The need or choice to immigrate is often influenced by a number of complex interwoven political, social and economic reasons that can change over time. Immigrants, as defined by the Immigration and Naturalization Service, are persons admitted to the United States for lawful permanent residence. The general term *immigrant* can refer to individuals who are granted permission to reside permanently in the United States for a variety of reasons. For example, many immigrants who came voluntarily to the U.S. between 1820 and 1960 were Europeans wanting to attain the *American dream*. Conversely, *forced immigrants* who migrate to the U.S. because of persecution or fear of death are termed refugees. *Refugees* are defined as persons outside their own countries who are unwilling or unable to return because of persecution or a well-founded fear of persecution based on religion, nationality, social group membership or political opinion, according to U.S. and international law. To illustrate, groups of special concern include the Bosnians who were given priority for refugee status by the U.S. in 1997 because they were being persecuted by their government because of ethnicity or political opinion. Since 1975, over two million refugees have been offered permanent resettlement in the U.S. (U.S. Department of State, 2000).

As mentioned, some immigrant groups who were motivated by the hope of freedom and economic opportunity have voluntarily relocated to the U.S. The impetus to move was based on an intention to become a citizen and have access to education, good wages, property ownership and financial assets. Thus, some individuals decide that a new country is a better option for them than their native country, anticipate a move, and plan accordingly. One can surmise that this group and others that share similar migration characteristics might embrace adjustment and acceptance of mainstream America more readily than individuals fleeing their countries, not because they choose to do so, but because of force.

Refugees typically abandon their countries and existence to relocate to a very different, sometimes unwelcoming, new world in which language, culture, social structures and community resources may be totally unfamiliar. This type of move, referred to as *displacement*, can be characterized by the loss of most of one's belongings, lack of personal, emotional and physical preparation and no choice in ones next destination. Frequently this move, although necessary to escape harm or death, is not a planned or chosen option for refugees. Acceptance and adjustment can be quite difficult for these refugee groups more so than other immigrants. This is particularly true for older refugees who leave rooted memories, achievements and, oftentimes, love for their abandoned homeland. It is not unusual for elders to cling to traditions and beliefs because of a strong desire to someday return to the old country.

To illustrate the plight of one refugee group, consider the recent migration of the Somalis to the United States. Somalis are mostly Sunni Muslims with traditional Islamic values including a strong family (usually extended base), respect for the elderly, caring for children, the indigent and individuals in poor health. Many recent arrivals are widows with children who lost their husbands to war.

They are both mother and father without the support of an extended family. Many women have no prior academic or employment skills. The language difference is a major barrier and their situation can be further deteriorated by illiteracy in their own language. Children will serve as interpreters, which results in a role reversal that diminishes the mother's influence as a revered parent.

Of special significance for the rehabilitation worker is understanding the challenge that accessing institutions and services, including those designed for individuals with disabilities, can pose to refugees and immigrants. This challenge, coupled with the sometimes unfavorable perception of disability held by newcomer refugees and immigrants (described in the next section) exacerbates the lack of access to needed supports. In addition to language and cultural barriers, many individuals are not familiar with the existence, range and purpose of services for individuals with disabilities. Even if these groups are made aware of relevant programs, the red tape, documentation and processes required by bureaucracies further impede an individual's access to services. Additionally, some groups who fled countries that were ruled by brutal systems might be fearful of any services that might even be indirectly associated with government, particularly those that request the identification of a physical or emotional disability. Finally, traditional therapies and services might be contrary to the values and beliefs of some groups. Consider our system's advocacy of independence through the use of assistive technology when a family believes its role is to provide total care for an individual. Consider a mainstream culture that directs an individual to comfortably and proudly divulge his or her disability contrasted with cultures that believe disability represents dishonor because it is caused by ancestral sins. This snapshot of refugees and immigrants is intended to provide the reader with the perspective of recent arrivals and potential implications for their understanding and acceptance of our service systems. It is highly recommended that the reader become more acquainted with our refugee and immigrant populations by additional resources located at the end of this monograph. Moreover, getting to know newcomer populations by researching and visiting community refugee and immigrant organizations, e.g., Mutual Assistance Associations, is a valuable approach to understand the past and current experiences of these groups.

Disability

To understand how other cultures understand and define disability, one should begin by examining how disability is seen and understood in the United States. Legislation signed into law to provide equal access for individuals with disabilities in the U.S. demonstrates an ideal example of how disability is interpreted by Western culture. For example, the Americans with Disabilities Act (ADA) defines the term *disability* as the following:

> With respect to an individual, the term 'disability' means (A) a physical or mental impairment that substantially limits one or more of the major life activities of such individual; (B) a record of such an impairment; or (C) being regarded as having such an impairment. A person must meet the requirements of at least one of these three criteria to be an individual with a disability under the Act (Equal Employment Opportunity Commission and the U.S. Department of Justice, 1991).

The ADA stipulates various modalities of supports and accommodations including products and environmental. Self-sufficiency is often based on non-human assistance, for example, assistive technology or environmental interventions, although personal care assistants are also part of the equation.

Analyzing the language and intent of the law, there are significant underlying characteristics that frame the Western definition of disability. Beth Harry (1992 page 22) describes these suppositions." First, it is assumed that the occurrence of the condition is located within the individual, and only in certain cases of clear genetic or biological etiology would other family members be implicated. Second, it is assumed that the condition should be treated by objectively verifiable interventions, conceived within the parameters of the scientific method. Third, the Western faith in science has tended to result in the belief that, wherever possible, biological anomalies should be corrected; there is little tolerance for deviation from the norm."

What constitutes having a disability in the United States often varies considerably among government agencies, public and private institutions and consumer groups. Thus, the definition and significance of disability is contingent on the differing perception of individuals, communities and institutions.

The National Institute for Disability and Rehabilitation Research (1999 page 68578) has identified a new paradigm of disability that "maintains that disability is a product of an interaction between characteristics (e.g., conditions or impairments, functional status, or personal and social qualities) of the individual and characteristics of the natural, built, cultural and social environments. The construct of disability is located on a continuum from enablement to disablement. Personal characteristics, as well as environmental ones, may be enabling or disabling, and the relative degree fluctuates, depending on condition, time and setting. Disability is a contextual variable, dynamic over time and circumstance."

The meaning of disability is influenced by the cultural beliefs and values of consumers and service providers. Euro-American values of equality and individual ability as a source of social identity shape a concept of disability that may not be applicable in other groups (Ingstad & Whyte, 1995). Foreign-born populations may view a disabling condition, causal factors and related services differently

than does mainstream America. For Euro-Americans, causation may be attributed to factors such as disease or genetic disorders. Acknowledgment of a having a disability is acceptable and outside intervention is thought to be desirable in American mainstream culture. Individuals who are foreign-born may not hold these opinions about disability. Descriptions of traditional beliefs between some Latino and Asian groups have shown how differential interpretations of the meanings of a disability can become a source of dissonance between professionals and culturally different families (Chan, 1986; Harry, 1992; Leung, 1988; Sotnik & Hasnain, 1998).

For example, Southeast Asian beliefs related to disability and its causation range from those that focus on the behavior of the parents and/or mother during pregnancy to sins committed by extended family members and reincarnation. Disability is sometimes attributed to the sins of the parents or ancestors. A Southeast Asian individual with a disability may be segregated from the community since the disability represents a wrongdoing by the parents or ancestors and is considered a source of disgrace. Generally, disability from birth, particularly developmental, physical, sensory and psychological disability, is stigmatizing for the individual and family due to these traditional beliefs (Sotnik & Hasnain, 1998).

The experience of an assistive technology public awareness project illustrates the miscommunication surrounding the term "disability" when used with persons from other cultures. The project disseminated multiple copies of a flyer that publicized the availability of products for people with disabilities. The project's efforts to attract individuals from diverse linguistic, ethnic and cultural backgrounds to inquire about assistive device strategy proved unsuccessful. Project staff inquired about the lack of interest and discovered significant findings. Most individuals did not define themselves as a person with a disability because they did not know what the word implied, or disability was considered as a condition that rendered a person helpless. Thus, a person who could not hear was not considered an individual with a disability because he could otherwise function very well at activities that did not require auditory ability. Better success was achieved when outreach materials deleted the term *disability* and described specific conditions, e.g. "if you have difficulty walking, hearing, seeing etc."

A collectivist view, inherent in many foreign-born cultures, prescribes that disability reflects the totality of the family rather than just the member with the disability. Beth Harry (1992) also indicates that families who believe that the source of a disability lies in spiritual rather than physical phenomena may be committed to spiritual rather than medical interventions. Harry further states that this finding has been documented among Mexican-Americans (Adkins & Young, 1976), Native Americans (Locust, 1988), and some Southeast Asian groups (Chan, 1986).

In the Southeast Asian community, Buddhism is the predominant religion. The principle of Buddhism stipulates that each person is responsible for his or her actions. A belief in Buddhism may establish a precedent wherein Southeast Asians adhere to *karma*, a belief that one's present life is determined by what one has done, right or wrong, in a previous existence. Thus, followers will accept a perceived misfortune, such as a disability, as predestined.

Rehabilitation

Rehabilitation service systems can be considered entities that, similar to a country or ethnic enclave, embodies a philosophy, values, policies and practices. The United States Vocational Rehabilitation (VR) system is one example. Although each state and region's VR will reflect some divergence in practices, the system shares similar dominant cultural aspects. A brief review of the origin of VR will enable an understanding of the system's cultural foundation. The VR system was created in 1918 with the passage of the Soldier Rehabilitation Smith-Sears Act to enable veterans with war-related disabilities to become self-sufficient through employment. Amendments to the 1973 Rehabilitation Act launched a growing increase in consumer self-sufficiency and advocacy by initiating Individual Written Rehabilitation Plans, the independent living program concept, consumer involvement in state agency policy and increased access by consumers to federally funded programs. A review of contemporary VR legislative content, funding processes, policies and programmatic practices confirm the incorporation of individualism and independence. Within the last two decades, vocational rehabilitation legislation (P.L. 95-607 and P.L. 102-569) reflects the increased emphasis on consumer empowerment and overall independence. Recall our earlier discussion of individualism and collectivism. Below are some examples of the effect that the values of individualism have on vocational rehabilitation principles.

Individualism	**Concepts of VR**
Self-determination: individuals control personal situations	Consumers set their own rehabilitation goals and are self-advocates
Success is defined in terms of professional achievement of the individual	Employment is successful rehabilitation
Person is unique and independent	Self-sufficiency is an ideal outcome

In a focus group conducted by one of the authors', vocational rehabilitation counselors were asked about the culture of the rehabilitation system. The participants characterized the rehabilitation system as institutionalized and linear. They pointed out that vocational rehabilitation is regulated by legislation, so services are more regulated by rules and statutes. The system is outcome and

placement driven. Success is defined as the quickest route to being placed. Services are great for a certain segment of the population that fits into the prescribed model. This segment is typically individuals who believe in the same values, can be readily employed and are English speaking. Furthermore, because of large caseloads, it is usually impossible to develop relationships with an individual and family members. This is directly opposite to the provision of culturally responsive services to people from some diverse backgrounds.

Another focus group was conducted with families of persons with disabilities from the Dominican Republic. Many of these families felt that it would be shameful and exploitative for them to allow their family members with disabilities to work because it is the responsibility of the family to care for its members with disabilities. Clearly, this runs counter to the philosophy of the vocational rehabilitation system and the independent living movement. Working with families that hold such values does not mean accepting such values, nor does it mean scorning them. A culture broker will use strategies that involve peer families and community organizations in showing newly arrived families the possibilities that exist in the U.S. for personwith disabilities to improve the quality of their lives. We will discuss such strategies in more detail in Section III of this monograph.

Activities of Daily Living

Activities of daily (ADL) living can be defined as those tasks necessary to maintain physical well being, personal appearance, hygiene and safety and general functioning in one's home and community. These tasks span many domains of living and might include bathing, dressing, eating, household chores, financial management and cooking. There are three important questions to address about ADL routines implemented by individuals with disabilities who are also members of foreign-born groups:

1. Are there differences in ADL activities in the person's country of origin in comparison to how they are performed in the U.S.? For example, persons in rural India usually eat with their hands, sitting on the ground, while in the U.S. eating is usually done at a table using silverware.
2. How are ADLs performed by persons with disabilities in that culture?
3. How might individuals from another culture respond to assistance in performing these activities?

The importance, type, variety and frequency of ADL routines may differ considerably from one group to another and, moreover, between generations within the same ethnic group.

The following table illustrates a sampling of several groups and some selected differing ADL practices:

Table 3: Examples of ADLs in selected cultures.

Ethnic Group	ADL Related Practices
Cambodian	Men keep the nail of right little finger longer than other nails. Young unmarried women wear an article around the waist to prevent "love magic" which should not be removed
Russian	Gender of personal assistance provider is not an issue. Personal care can be provided by a nurse or aide
Vietnamese	Hair should not be wet at night because it causes headaches. Only a family member of the same sex helps with personal care.

The value of specific daily living tasks can differ contingent upon a group's perception of one's role in life. For example, an individual with a cognitive disability cannot budget or read important documents but can serve as a family member and employee. If the latter roles are perceived as more important, conducting financial management activities by this individual may be insignificant.

It is important to keep in mind that not all members of an ethnic group will demonstrate identical daily living activities. Any information describing cultural aspects of personal care is intended to serve as a cue to then learn the unique characteristics of an individual and family.

Some individuals with disabilities may need the assistance of another person or a product to complete these tasks. Moreover, individuals with disabilities sometimes have added unique activities that the nondisabled population will not experience, e.g. accessing other forms of transportation, housing and care of adaptive equipment.

The nature of assistance with daily living skills for persons with disabilities can be affected by many individual characteristics including geographical, religious, socio-economic and the type of disability. For example, many Muslim women do not expose any skin, except for hands and part of the face, to any man, except for her husband (Family Education Program, 1997). Issues such as this example are particularly important for personal care assistance by other individuals.

Worldview, or how we perceive our world and related personal roles, can also affect the nature of how daily living skills are achieved. As described in a previous section, people who adhere to traditional mainstream United States culture of individualism might uphold assertiveness and self-advocacy as admirable characteristics. Behavioral indicators might be manifested when an individual with a disability disagrees with family members regarding types of daily living supports. These individuals may prefer the help of paid employees as personal assistance service providers because this relationship promotes independence and self-advocacy. Thus, individuals might not want to rely on family members for personal assistance. Findings indicate that family providers are generally not the ones consumers find the most satisfactory for many reasons including encouraging continued dependency (Nosek, Fuhrer, Rintala and Hart, 1990).

Not everyone holds this opinion, particularly groups that abide by other worldviews, for example, the collectivistic. Several groups, e.g., Southeast Asians, Ethiopians and Haitians, feel strongly that only family members are appropriate personal care assistants. Because other family members often assist an individual with a disability to complete daily routines, the family becomes the assistive technology. The suggestion that a device replace traditional family functions may not be regarded positively (Sotnik & Hasnain, 1998).

If culture is such an important influence on human behavior, how can the rehabilitation service provider work *through*, rather than *against* the culture of foreign-born consumers? In the next section, we will examine the role of the rehabilitation provider as a culture broker.

PART II: ROLE OF REHABILITATION SERVICE PROVIDERS - CULTURE BROKERING

The concept of culture brokering may be new to rehabilitation service providers but various components of the role of culture broker may already be part of the service provider's practice. In this section of the monograph the culture-brokering model will be explained (Figure 1). In addition, the relevance of the model for rehabilitation service providers will be discussed. Examples of ways that culture brokering may be used in specific situations will also be included.

Culture brokering is defined as the act of bridging, linking or mediating between groups or persons of differing cultural backgrounds for the purpose of reducing conflict or producing change (Jezewski, 1990). In other words, the culture broker acts as a go-between, one who advocates or intervenes on behalf of another individual or group.

The term *culture brokering* was first coined in anthropology when anthropologists observed that certain individuals in the communities they were studying acted as middlemen or brokers between colonial governments and the peasant societies that were ruled by the colonial powers. Very often, these middlemen brokered to resolve conflicts between the local people and the government, or brokered to acquire favors for the peasant population. In the 1960s, health care researchers began to explore the idea of brokering within health care delivery system. In this situation, the broker was, very often, a member of the consumer's community who also was knowledgeable about the health care system. At the same time, other health care researchers looked at the ways that health service professionals acted as brokers between their clients and the health service system, and between clients and other service providers. Today there is a body of literature on the concept of culture brokering, as well as the model discussed in this monograph, that can inform service providers on how to broker for consumers. A selected bibliography of the culture brokering literature is provided in Appendix II. The culture-brokering model presented in this section of the monograph is based on theory constructed through a series of studies that used a methodology specifically for theory generation (Jezewski, 1995).

Knowledge, skills, sensitivity and awareness of cross-cultural variables are needed to be an effective culture broker. This monograph provides the rehabilitation service provider with an introduction to culture brokering. Perfecting the role of culture broker takes time and practice, as is true of any role within a profession. The culture-brokering model is illustrated in Figure 1.

The culture-brokering model has relevance for rehabilitation service providers in a variety of settings, even in areas where service providers may not recognize the presence of cultural diversity between consumers and the rehabilitation service system as a cultural system. Earlier in this monograph, the term *culture* was discussed. These explanations, along with the discussions of worldview, acculturation, and diversity, form the basis of understanding the culture-brokering role. It is also important to remember that the rehabilitation service system is a cultural system itself, and, as a cultural system, it has a set of values and beliefs that strongly influence the behaviors and beliefs of the providers within it. In some instances, rehabilitation service providers are professional members of the U.S. health service system and thus adhere to many of the values of that system. It is also important to keep in mind that consumers who enter rehabilitation services, come into rehabilitation with their own cultural values, beliefs and behaviors. The differences in the beliefs and values of the lay culture of the consumer compared with the rehabilitation services cultural system need to be understood in order for effective and relevant service to take place. If cultural differences lead to conflict between the consumers and the rehabilitation system, there needs to be someone who can resolve the conflict. The rehabilitation service provider can act as a culture broker to resolve conflict or produce a change that will prevent further conflict from occurring.

Jezewski's Culture-Brokering Model

Culture brokering is essentially a conflict resolution and problem-solving model. The culture broker is a problem solver. Certainly this role is not a new role for rehabilitation service providers. However, looking at the problem-solving role from a cultural diversity perspective may be new. Referring to Figure 1 (the model) may help to understand the description of culture brokering that follows. Culture brokering has a set of intervening conditions that affect, either negatively or positively, the three stages. In some situations, an intervening condition facilitates brokering; at other times, the same condition hampers the brokering process. For example, bureaucracy can supply funding for services while at the same time place barriers and red tape in the way of easy access to funds. In any case, rehabilitation service providers must consider intervening conditions as they move through the three stages of culture brokering. The brokering model also directs the broker to return to previous stages if the problem is not resolved.

Stage 1 of the culture-brokering model is the recognition that there is a problem or potential problem in the consumer's encounter with the rehabilitation system. The service provider-as-culture-broker looks at the problem from a cultural perspective. As the service provider becomes more proficient at culture brokering, potential problems will be anticipated and prevented or minimized before they occur. Conflict in the rehabilitation environment can occur because of problems in access and/or use of services. Different views about the rehabilitation plan, breakdown in communication between providers and consumers and differences in beliefs about what are appropriate services are also examples of problems that can be resolved by using the culture-brokering model as a guide. These problems are very often based on differences between the culture of the consumer and the rehabilitation system as a cultural system, and result in conflict and breakdown in the encounter between consumers and the rehabilitation delivery system. In Stage 1, the rehabilitation service provider determines that there is a problem and assesses the problem by attempting to understand the causes. Reviewing and identifying which of the intervening conditions may be the basis for the problem also helps the culture broker to identify the problem and potential solutions. Knowledge of the meaning, scope and diversity of culture, and sensitivity to the importance of the components of culture in shaping the human view of disability, provide the skills necessary to identify how cultural variables influence provision of rehabilitation services. Later in this monograph, there are resources and references to assist rehabilitation service providers increase their knowledge, sensitivity and skills as culture brokers. Some of the resources provide information on the culture of specific groups of foreign-born persons.

After the problem has been clarified, the broker moves on to Stage 2 of the culture-brokering model, the intervention phase. In this stage, strategies are put into practice in order to resolve the identified problem or problems. These

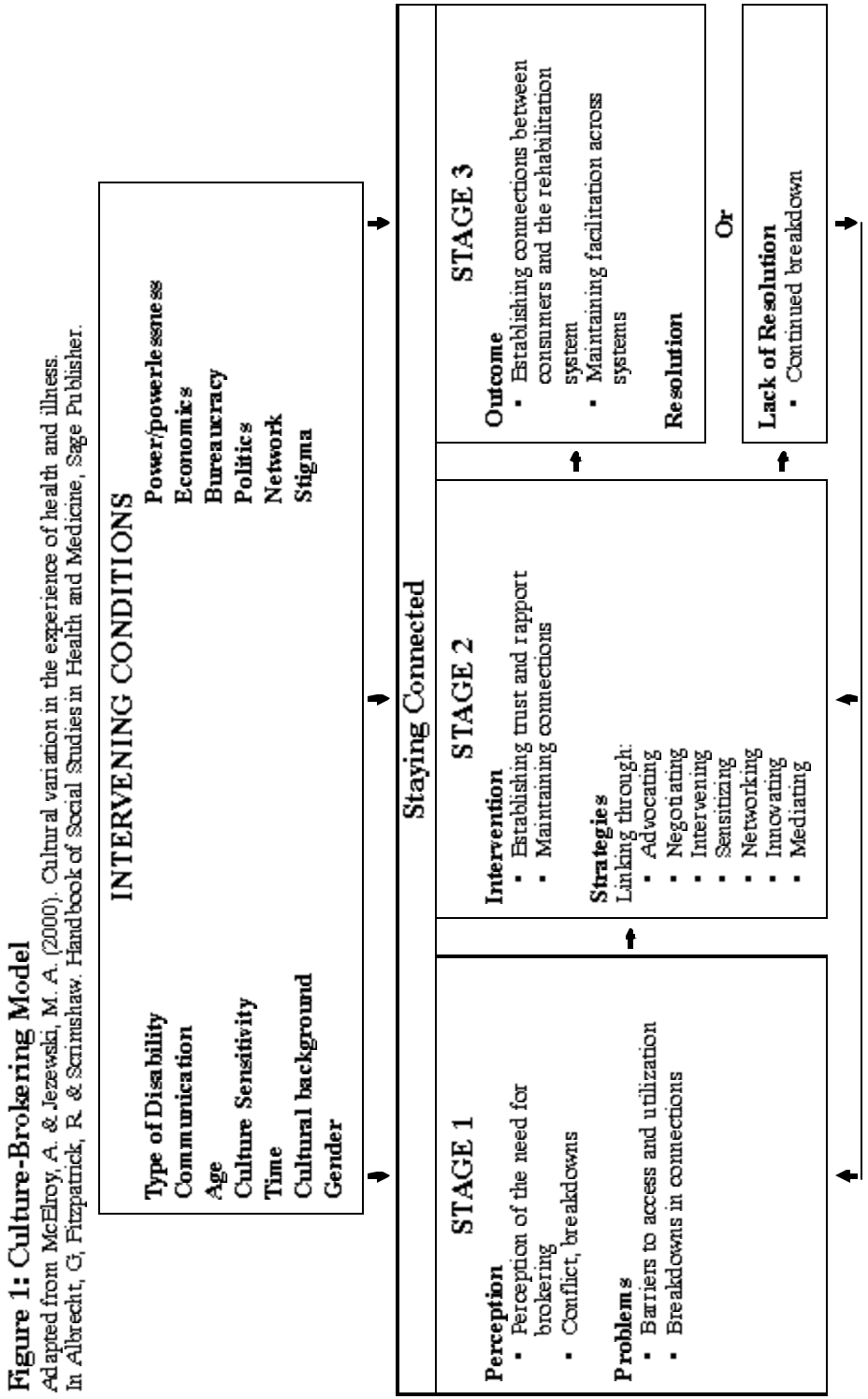


Figure 1: Culture-Brokering Model
Adapted from McElroy, A. & Jezewski, M. A. (2000). Cultural variation in the experience of health and illness. In Albrecht, G, Fitzpatrick, R. & Scrimshaw. Handbook of Social Studies in Health and Medicine, Sage Publisher.

strategies are used to prevent or minimizconflict situations, facilitate links between consumers and rehabilitation services, and assist consumers to stay connected to the rehabilitation system. The strategies used in brokering are varied and overlap. Two strategies have been observed most frequently in the studies used to develop the brokering model. They are *mediating* and *negotiating*. Although difficult to separate, there are certain aspects in these two strategies that are different. *Mediating* seems to be a more appropriate label for the strategy culture brokers use when conflict occurs and a go-between, an intermediary, is needed to resolve or minimize, and, in some instances, prevent conflicts between consumers and the rehabilitation service delivery system. Mediation is used to prevent conflict from occurring between service providers and consumers, or family members and consumers/providers. Mediation can be used whenever there is an element of conflict in the delivery of services.

Negotiating is a more appropriate label for a brokering needed to reach an agreement. Negotiating involves conferring with the consumer in order to come to terms with the consumer's perception of the need for specific services. An example of this would be the service provider who needs to negotiate a particular service for a consumer that is not provided to the consumer currently, and one that is necessary to optimize the rehabilitation environment, from the consumer's perspective. Perhaps this would include providing transportation to religious services, or negotiating additional hours for an interpreter when a consumer, who does not speak English, must interact with a variety of English-speaking service providers. Negotiating by the broker can empower the consumer. In order to negotiate, the provider has to understand the consumer's perspective, as well as possess knowledge of the rehabilitation system, and thereby function as a true middle-person.

Advocating is another strategy that is closely aligned with both negotiating and mediating. The advocate's role is one that defines and pleads the cause of, promotes the rights of, or changes the system on behalf of an individual or group. Advocacy involves activities that are aimed at the redistribution of power and resources to the individual or group that has demonstrated a need. The strategy of advocating is also closely integrated with the intervening conditions of power and economics, and the broker who is advocating must consider these intervening conditions in the brokering model. In rehabilitation services, advocacy can be further delineated as the act of informing and supporting consumers so that they can make decisions that serve their needs. Advocating can also encompass the responsibility to take appropriate action regarding instances of incompetence, unethical or illegal practices by a member of the service provider team. This would include a readiness to prevent any action on the part of others that is stigmatizing to consumers or prejudicial to their best interest.

Networking is another culture brokering strategy by which the rehabilitation provider-as-culture broker establishes links with other professionals who can provide services to consumers. These networks serve as a source of power for the service provider in facilitating rehabilitation services to culturally diverse consumers, especially because culturally diverse consumers may have problems with access and use of services.

The brokering strategies cannot be effective without understanding how, and considering why, the intervening conditions impact the consumer's situation. As the service provider is defining the strategies to resolve the identified problem, it is necessary to consider the intervening conditions.

Stage 3 of culture brokering focuses on outcome. The broker evaluates the degree to which the problem has been resolved. If resolution did not take place or the problem was not resolved satisfactorily, the culture broker reverts back to Stage 1 or 2 to either reassess the problem (Stage 1) or use additional strategies to intervene (Stage 2). This reassessment, again, involves re-evaluating the role of the intervening conditions.

The *intervening conditions* are integral to the stages of culture brokering and because of this, they will be discussed first. Table 5 in Appendix I provides a very detailed explanation of each of the intervening conditions as well as assessment questions for the culture broker to consider for each condition. In some situations where brokering is used, the intervening conditions influence each other. For example, two very important intervening conditions in the culture-brokering model are cultural background (which includes ethnicity) and culture sensitivity (competency). The consumer may be stigmatized based on his cultural background. This stigma or bias can affect the consumer's access to and use of services. Particular disabilities may also have a stigmatizing effect. In turn, the economic and political conditions present in rehabilitation service delivery may limit development of an adequate number of service facilities.

Stigmatizing conditions and low access to services may further decrease their use of services. This situation can complicate the service provider/culture broker's ability to negotiate access for the culturally diverse consumer. The intervening conditions can become a complex maze through which culture brokers need to weave their way in order to obtain optimal services for the consumer. The objective of Table 5 is to help the broker consider the conditions that affect the brokering process and to use this information to broker services for the consumer of rehabilitation services.

Several issues impact on culture brokering. If brokers are people who function as go-betweens, with whom do they align themselves? Does the broker represent one of the two parties, or is the broker acting on behalf of both parties?

Historically, in less complex brokering situations (peasant societies), the broker was a member of the community. The broker was able to function in both the community and the colonial government environment. The broker needs to have knowledge of both culture systems (the foreign culture of the consumer as well as the culture of the U.S. rehabilitation system) and be able to function in both systems. Because rehabilitation systems are often complex, in many cases it may be difficult for persons who are not part of the system to function as culture brokers; they may not always have the knowledge necessary to "work" the rehabilitation system. Today, in a complex rehabilitation system, the broker most often will be a member of the rehabilitation services delivery system, because the delivery system may be far too complex for the layperson to negotiate and mediate in most conflict/problem situations. It is not impossible for laypersons to be culture brokers in the rehabilitation system, but it is extremely difficult.

The above discussion does not imply that the culture broker needs to be a rehabilitation professional or a non-consumer. Organizations run by and for persons with disabilities for self-help and advocacy, such as Centers for Independent Living (CILs), play an important role in helping persons with disabilities become more independent. Because of activities such as peer counseling and individual advocacy, the staff of Centers for Independent Living (CILs) and other community-based service organizations have been included in this monograph as part of the rehabilitation service system. These persons usually have an understanding of how the rehabilitation service system works. Moreover, their understanding of the consumer perspective may make them particularly effective as culture brokers.

The brokering role is central to CILs. While they provide some direct services to consumers, the majority of their activity is referral and advocating for service on behalf of the consumer. CILs assess, discuss, explore, arrange, advocate, design and work with the consumer to see that the needed services are obtained. For the staff of CILs, culture brokering should be regarded not only as a skill in helping persons to receive services within the CILs themselves, but, more importantly, to broker for persons as they seek services outside the CIL. In fact, CILs and the Client Assistance Programs (CAPs) were developed precisely to provide a third party to broker the interaction between the consumer and the service system.

The rehabilitation provider-as-culture broker raises another question: if the broker is an employee of the system, might there not be a tendency to represent the interests of the system more than those of the consumer? The answer is yes in some respects, but there are also attributes that are inherent in the successful broker. If these attributes are not present, the service provider will have difficulty functioning in the role of culture broker. Attributes necessary to be an effective culture broker include a willingness to be a risk taker, the ability to tolerate ambiguous roles and a degree of comfort functioning at the margins of various systems (the consumer's cultural system and the rehabilitation service

delivery system). Additional attributes of an effective broker include good communication skills, the ability to network, effective problem solving skills, flexibility and a willingness to learn and perfect the culture-brokering role. Rehabilitation service providers possess many of these attributes already, and, if they do not, they can be learned and cultivated.

—*Alvernia: A Case Example of the Culture Brokering Model*—

A case study may illustrate some aspects of the brokering role in rehabilitation services.

Alvernia R., a 20 year old woman, moved from Puerto Rico with her mother, Mrs. R., two years ago. Alvernia was diagnosed with cerebral palsy as a young child. She has difficulty walking, moving her arms and engaging in fine motor activities. Currently, she is assisted by her mother and is using poorly fitted crutches to move about and complete daily living skills. She attended school sporadically in Puerto Rico and received some clinical services. Alvernia enjoyed school and being with other children. Mrs. R. became frustrated with the disability service limitations in San Juan for Alvernia, and left a professional, well paying position to move to New York.

At the time of Alvernia's diagnosis, her parents were told to place her in a mental institution because she would always be a burden. Close relatives agreed with this determination and described Alvernia's disability as a punishment from God. Mrs. R. felt particularly responsible for her daughter's condition and constantly relived her activities during her pregnancy. Due to this belief, Mrs. R. vowed that she would care for her daughter to the exclusion of her own or other family members' needs. She was convinced that she would find the best services elsewhere in the U.S. and left Puerto Rico.

Alvernia's extended family still resides in Puerto Rico. Although they maintain contact through phone, letters and vacations, Mrs. R. and Alvernia miss them greatly. Prior to their move, the family maintained almost daily personal contact. Mr. R. has no intention of moving and will not divorce Mrs. R. because of strong religious beliefs. Mr. R. is embarrassed by his daughter's condition. He feels guilty because of this emotion and by not being able to help her.

Alvernia attended special education classes in her high school and is now eager to get a job. Mrs. R. is uncertain of her daughter's education and had difficulty understanding information pertaining to her daughter's disability. She tried to participate in school meetings but felt stupid and helpless at not understanding the jargon and necessary action steps. Alvernia wants to be a hairdresser, but her mother strongly discourages this preference because of her mobility and fine motor difficulties. Mrs. R. is also afraid that others would tease her.

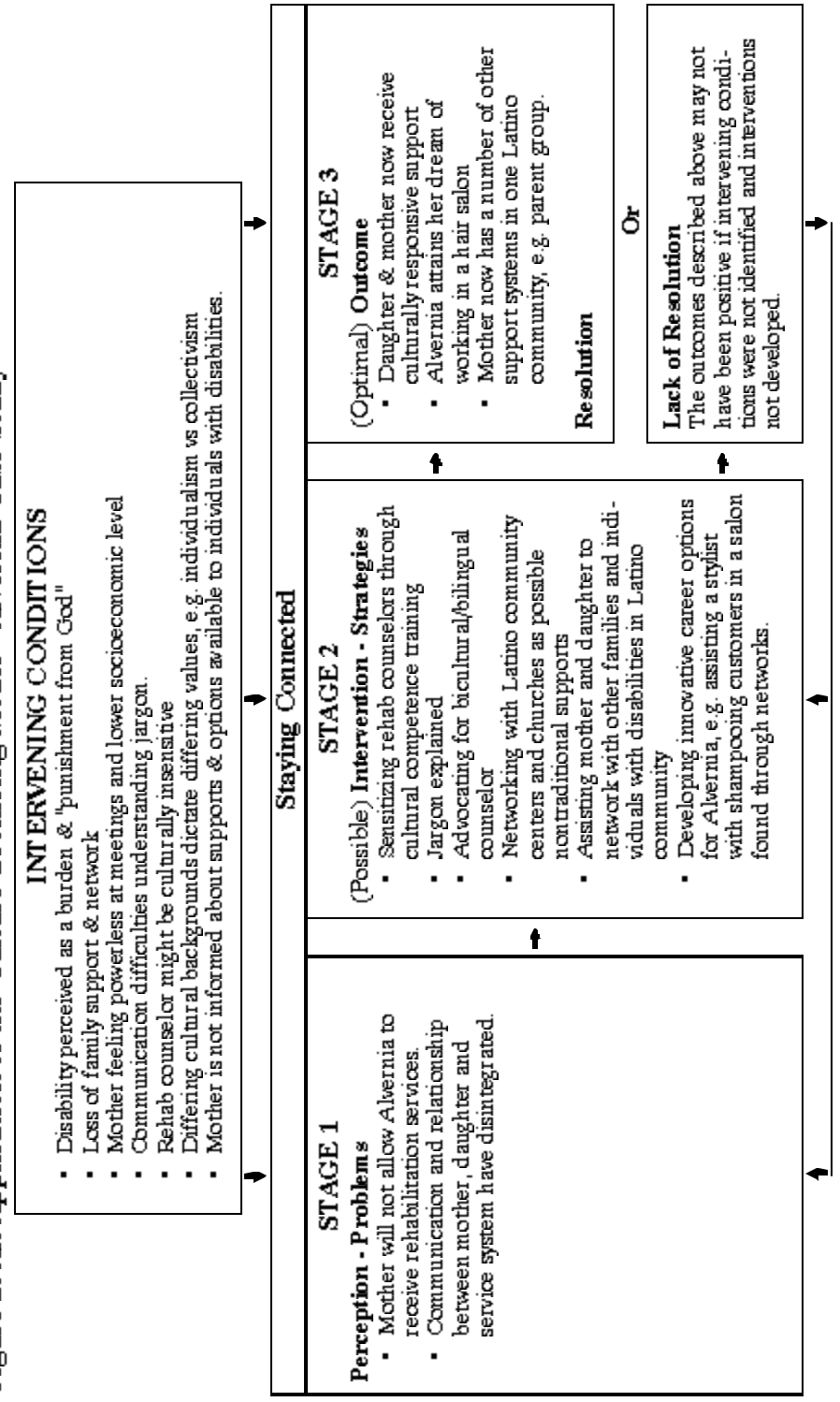
Alvernia and her mother met with a vocational rehabilitation counselor through school, but Mrs. R. felt that the counselor was discounting her role as a mother. The counselor encouraged Alvernia to follow her dream job despite what other people felt about her capabilities. Alvernia became hopeful of attaining a career choice following her meeting. However, Mrs. R. did not want her daughter to have contact with the counselor again and became suspicious of the vocational rehabilitation service system. This difference in opinion caused a conflict within the family. Alvernia and her mother continue to argue about pursuing a job and receiving vocational rehabilitation services. Mrs. R. has become increasingly depressed because of her daughter's increasing assertiveness and great distance from her husband and family. Alvernia now talks about becoming independent by getting her own apartment and dating. Mrs. R. still feels that her priority must focus on the protection and care of her daughter.

In using the culture-brokering model to analyze this case, a service provider would do well to focus on several of the following considerations:

- Puerto Rican culture
  - Worldview (values, beliefs)
  - Religion
  - Family
    - Role within the family
    - Other family member roles
  - Time Orientation
  - Degree of acculturation
- Communication
- Beliefs about:
  - What it means to be healthy and independent
  - What the disability means to different members of the family
- Explanatory model of disability and beliefs about the role of rehabilitation
- Financial status
- Education level
- Stigmatization

Figure 2 shows a partial analysis of this case using the culture-brokering model. This example identifies some of the principal factors in this case and some possible strategies that one might consider as starting points. However, alternative interpretations and solutions are possible.

Figure 2: An Application of the Culture-Brokering Model - Alvernia Case Study



Part III: Tools for Culture Brokers

Cultural assessment of consumers with disabilities is an important skill for those who wish to provide culturally competent rehabilitation services. A complete cultural assessment of the consumer is a complex task and involves obtaining information about all aspects of the consumer's culture. In most instances, a comprehensive assessment is not necessary even when the consumer's culture and the rehabilitation service provider's culture are vastly different. It is important for the provider to understand how the consumer perceives and lives with disability. Understanding the consumer's perspective will alert the provider to cultural components that need further exploration.

Consumers construct their own explanation of their disabilities. Service providers are not always aware of these explanations. The assumption frequently made by the provider is that consumers understand the causes of their disabilities and the types of services they need in the same way as the providers. This is frequently not true in a cross-cultural environment.

Over 20 years ago, Dr. Arthur Kleinman, a psychiatrist and medical anthropologist at Harvard Medical School, realized that the medical students and residents he was teaching did not understand how their patients perceived their illnesses. He also noticed that patients did not always agree with the treatment that was prescribed. Kleinman developed a useful tool for providers that help them to elicit from patients their understanding of their condition (Kleinman, Eisenberg & Good, 1978). Eliciting and understanding patients' explanatory models of their illnesses has proven to be a useful tool for health providers in a cross-cultural environment. Eliciting consumers' explanatory models, regarding their disabilities and the services they think they need, can be a useful tool for rehabilitation service providers as well.

The approach developed by Kleinman consists of a series of questions that require the respondents to express their understanding of their condition. The following list contains some questions that might be used by rehabilitation service providers to elicit consumers' explanatory models. The questions have been modified from Kleinman's questions to make them more relevant to rehabilitation contexts. Instead of the term disability, the provider may make the questions more specific to the individual by using the terms like mobility impairment, vision impairment, hearing impairment or others.

Explanatory Model Assessment Questions

The next few questions will enable me as a service provider to understand your ideas about your disability, how it effects your life, and the types of services you think will best meet your needs.

- Do you consider yourself well or ill?
- What do you think caused your condition?
- How does disability affect your everyday life?
- How severe do you consider your disability to be?
- What have you or others done about it?
- What kind of services do you think you should receive?
- What is the most important result you hope to receive from the services at ___?
- What are the chief problems caused by this disability?
- What does your family think about this disability?
- How does this disability affect your family? Your friends?
- What do you fear most about disability?

These questions attempt to elicit the consumer's understanding of etiology, symptoms, treatment, and the interaction of their disability on their social and cultural environment. Most importantly, eliciting the consumers' perceptions of their disabilities assists service providers in providing culturally competent care.

First, it is important to know whether the consumers view themselves as ill or well, as these terms are subjective and in fact may change from time to time. In all probability, we would assume that consumers consider themselves essentially well, but the provider should not assume to know the answer to the first question.

The remaining questions help the provider understand the consumers' perceptions of the cause of their disability, what they do to adapt to the disability, what they expect of the service provider, their friends and family, and most importantly, what rehabilitation services they think should be available to them.

The experiences of Kleinman and others demonstrate that the explanatory models of providers very often conflict with those of culturally diverse consumers. When these conflicts in understanding persist, poor provision of services also persists. Kleinman suggests that in order to provide culturally competent service, providers should negotiate shared explanatory models. First, the providers must assess their explanatory model of the consumer's disability and then compare their model with the consumer's. Any differences, particularly discrepancies or conflicting explanations, need to be discussed with the consumer and differences negotiated. Without this negotiation of differing explanatory models, culturally competent services are in jeopardy, and in all likelihood, will not occur effectively.

For example, a service provider asking the consumer the fifth question, finds out that the consumer regularly uses alternative medical practices including a variety of herbal remedies and religious healing ceremonies. This information should alert the provider to probe further into the consumer's response. For example, how do the religious ceremonies help the consumer? What specific herbal remedies is the consumer taking? There are resources available to providers to

research different herbs to understand their chemical and medicinal properties as well as their potential interactions with over-the-counter and prescription medications. Most herbal remedies are not harmful and some may have some medicinal properties. Nevertheless, it is the responsibility of the consumer's service providers to be proactive to resolve potential contraindications in consuming both herbal remedies and prescribed medications.

Part IV: Caveats for Rehabilitation Service Provider as Culture Broker

Communication

Communication is of primary importance in providing rehabilitation services. Communicating cross-culturally presents unique challenges to service providers. The challenges of cross-cultural communication need to be understood, and strategies to overcome barriers need to be addressed by providers of rehabilitation services.

The primary challenge in effective cross-cultural communication is to be aware and sensitive to differences in both verbal and non-verbal ways of communicating. Verbal and non-verbal communication approaches vary cross-culturally. Awareness, sensitivity and knowledge are three necessary prerequisites to developing effective strategies to communicate cross-culturally. This section of the monograph will explore both non-verbal and verbal communication patterns from a culturally diverse perspective.

Verbal Communication

Obviously, when the service provider speaks one language and the consumer speaks another, an interpreter will be needed in order to communicate. The role of translation and use of interpreters will be discussed later in this section. Culture influences how we use language to communicate. There are culturally determined nuances in the way that people communicate.

First, we will explore the dominant American style of verbal communication. Americans place a heavy emphasis on the preciseness of the words used, that the words be exact and technical. Meaning is conveyed in the words apart from situations and events. Americans are taught early in their development to "say what you mean." American conversation is dependent on what is said more than what is not said. During conversations, Americans are expected to make their point with a minimal amount of elaboration. When description is lengthy, the American listener often becomes restless and impatient. Additionally, Americans

generally do not value emotions in conversation. Often, they are embarrassed when communication becomes emotional. Americans emphasize factual, logical communication; emotions assume a secondary role to logic and facts. American conversation is categorized as low context communication, that is, Americans do not rely on the situation to inform their understanding as much as they rely on the spoken word.

In contrast, many culture groups depend on a style of communication that relies on context (situation dependent). Communication is less direct and is dependent on the common experiences of the communicators. For example, the status of the communicators is known and understood. What is said and how information is conveyed is highly dependent on the status of each of the communicators. Conclusions may not be stated explicitly. Listeners are left to draw their own conclusions. In such a high context situation, saving face (how you are viewed in the eyes of another and how you protect the feelings of another) is very important. Direct confrontation is considered rude because it does not take into consideration the feelings of others. Communication may be in a form to conceal feelings in order to avoid embarrassment for both speaker and listener (Stewart & Bennett, 1991). For example, there are as many as 16 ways to say no in Japanese, many of which are ways that will not embarrass the one to whom the reply is directed. American service providers may simply state to the consumer, "No, I can't" or "No, you can't receive services tomorrow." To a recently immigrated Japanese consumer, this logical, factual statement may be interpreted as rude, uncaring and lacking concern for the feelings of the consumer. Repeated interactions, such as this, could lead to the Japanese consumer losing trust and faith in the intentions of the service provider.

Another variable in cross-cultural communication is also related to the dominant high or low context communication patterns. It is the importance placed on greeting and leave-taking rituals. In American culture, greetings are short and the matter at hand is usually approached immediately after the greeting. Conversations are very often started, "I want to talk to you about…" (getting down to business). In many cultures (Middle Eastern, Asian) an elaborate greeting is expected. These include inquiries about one's family, health, etc. The greeting may also entail an offer of food or drink. In these circumstances, it is considered rude to refuse or to "get down to business" too soon. The prolonged greeting serves to set the context for the conversation and far exceeds the dictates of American conversational greeting (Stewart & Bennett, 1991). Americans generally become very frustrated with this extended preliminary formality. People from cultures where this is the norm find the American way as brusque and lacking concern for the welfare of others. Again, this points out the importance of service providers understanding the context in which information is optimally provided to culturally diverse consumers. Taking the time to properly greet consumers who value the contextual importance of a more elaborate greeting will improve communication between providers and consumers.

Another important aspect of intercultural communication is the degree of conversational formality that is considered appropriate to the individual speakers. Americans tend to value informality in conversation. This stems from the value of equality and is reflected by treating everyone the same, especially in conversation. Americans frequently engage in conversations with strangers they meet in their everyday life (waiters, clerks, cab drivers, etc.) This equality carries over in the frequent use of first names, even with relative strangers or those recognized as having higher and lower status. In the American value system, treating everyone the same is considered respectful. This is in contrast to other cultures where respect is demonstrated by acknowledging status by a more formal approach and the use of specific titles. To do otherwise is a sign of disrespect and reflects a fault in one's character. For the service provider, it is always better to err on the side of formality when talking with immigrants, until a time when the provider understands the culture of the consumer. As the provider gets to know consumers and their culture, it may be appropriate to move toward a more informal conversational pattern.

This contrast in high and low context communication can result in breakdowns in communication between American service providers and recently immigrated consumers. It is impossible within the context of this monograph to go into a detailed discussion of the implications of communicating between persons in high and low context cultures but there are many excellent resources that elaborate further on this rather complex aspect of cross-cultural communication. Some valuable resources are Stewart and Bennett's (1991) book, *American Cultural Patterns*, Kavanagh and Kennedy's (1992), *Promoting Cultural Diversity* and Jandt's (1995) *Intercultural Communication*.

Non-Verbal Communication

Another form of cross-cultural communication that is important for the rehabilitation service provider to be aware of is nonverbal communication. This is an integral component of everyday communication and has added importance in cultures where high context communication patterns prevail. Misinterpreting nonverbal cues or giving inappropriate nonverbal cues can be a major barrier to effective cross-cultural communication.

Cross-culturally, personal space can vary. In communication, personal space is the amount of distance individuals want between themselves and others at any given time. Socially, we feel uncomfortable when someone else invades this personal space by standing or sitting too close to us. In conversation, there is a range of space in which individuals feel most comfortable. The amount of space during communication depends on our relationship with the other person. The distance Americans feel most comfortable talking with colleagues, co-workers or providers is approximately three to four feet. Eighteen inches is handshake

distance (Hall, 1959). Usually, after shaking hands, Americans move apart to the comfortable conversation zone. This comfort zone is culturally determined. For instance, Arabs stand closer for conversation with colleagues than Americans do. When members of the two groups are conversing, very often each tries to maintain their comfort zone with the American stepping away and the Arab stepping closer. Unconsciously, we tend to move away when someone invades our personal space. In a provider/consumer situation, Middle Eastern consumers may interpret the distance that the American provider stands when talking with the consumer as cold or uncaring. There could be the tendency for the consumer not to take the provider seriously because of the nonverbal communication that is conveyed simply by the distance the provider stands from the consumer. Once the provider is aware that distance between communicators is important, the provider can allow the consumer to set the distance. This will facilitate communication and their role as provider.

The gestures we use are also culturally prescribed and affect our communication cross-culturally. These include hand gestures, body movements, facial expressions and eye contact. Communication includes the actions and movements of our bodies. Initial greetings between people differ among ethnic groups: from a firm handshake (U.S.) to an embrace (South America) to kissing both cheeks (France) to a bow (Japan).

Hand gestures can be misinterpreted. For example, 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 use of a thumbs up sign varies in meaning from "that's great!" (U. S. and Brazil) to "get stuffed" (Greece). The "OK" sign with thumb and forefinger that we use in the U.S. has a vulgar, insulting connotation in Brazil.

The amount of eye contact during conversation varies cross-culturally. Maintaining contact while speaking to another in American culture signals that the listener is interested in what the speaker is saying. Maintaining eye contact in other cultures may be a sign of disrespect. Lowering the eyes can be a sign of respect especially when the speaker is of higher status or is perceived to have greater knowledge as in the case of a service provider. Americans often perceive lack of eye contact as disinterest in the conversation or preoccupation. The service provider should not assume the meaning of lack of eye contact in a culturally diverse consumer until the provider understands the consumer's cultural norms.

The use of silence varies across cultures also. In the U. S., very little silence is tolerated during a conversation. Americans usually become very uncomfortable when there is a lull in the conversation. Eastern cultures of Asia value silence.

In these societies, silence can be a sign of thoughtful respect, affirmation or cooperation. Service providers should not view silence as indicative that the consumer did not hear or did not understand what the provider said. It is important to understand the meaning of silence for the culturally diverse consumer.

Words, Meanings and Translations

Words that rehabilitation service providers often take for granted may have different connotations in other cultures. Mr. Sam K., director of a Cambodian Mutual Assistance Association, listened to the interviewer carefully as she asked questions about the population with disabilities that might be served by his center. He was sure that his community did not include people with disabilities. Some individuals who came to the Center did not have arms or legs because of land mines and others had nightmares from terrible conditions experienced during Pol Pot's regime. However, these individuals were able to cook, clean their homes, go to temple and work. None of these individuals were crazy or violent and did not act like some people he knew of in Cambodia. He remembered some individuals that were hidden and not allowed out of a room in their house. The talk in his Cambodian village was that evil spirits made these individuals scream all day and night. These poor souls did not migrate to the U.S. so he was certain there were no people with disabilities in the Cambodian cultural enclave.

As the interviewer described what having a disability means and asserted that individuals with disabilities can perform many activities, Mr. K. could think of several young and middle-aged individuals that were different from most other people in the community. He considered one young girl who, at age three, could hardly walk or talk. Her parents describe her as a lazy child and hope that she will overcome this obstinate conduct as she gets older. Other family members and neighbors speculated the parents were not capable of properly disciplining their child. Although health care clinicians recommended a developmental assessment for the child, the parents have not yet followed through. Mr. K. also recalled that the young girl did not interact with other children her age during the Center's recreation activities.

The interpreter used the term disability to denote varied characteristics determined by the U.S. mainstream culture. Mr. K.'s original interpretation of this word was different and more narrowly defined. When he heard the word *disability*, Mr. K. visualized people who were threatening, violent and with a limited capacity. The meaning of the word disability and other related labels differ between cultures, populations, generations and service systems. Coming from a background where daily affairs can be managed by a healthy body, common sense and elementary skills, the label *mentally retarded* would apply to someone whose competence is severely impaired (Harry, 1992).

Many terms used by rehabilitation service providers on a daily basis may have no meaning in other languages and may be difficult or impossible to translate. Assistive technology terms exemplify how a lack of certain words in a vocabulary and related meanings can affect one's understanding of rehabilitation supports for individuals with disabilities. Outside of traditional disability services, the word *reacher* or *sound activated light* might be difficult to depict. Further, many terms and words naming adaptive products cannot be translated to any other language. The words *reacher* and *assistive* were contrived in the disability field within the last two decades and cannot be found in generic dictionaries or a thesaurus.

Service providers should be aware that persons who accompany the consumer for the purpose of translation may vary in their background and ability to communicate the meanings of the service provider to the consumer for many reasons. First, family members may themselves not have a full command of English. Second, if children or younger persons play the role of translator, this may introduce a demeaning element for the older consumer. Third, many persons who are brought along for the purpose of translation may not have a very good understanding of disability terminology in either language, and this may make it difficult for them to translate certain ideas.

Service providers should make an effort to speak slowly and use simple terminology, without speaking in a condescending way to either the consumer or the translator. The service provider should make an effort to speak to the consumer, even when a translator is involved in the communications. Finally, the translator's task will be made easier if the speakers pause after a few sentences to allow the translator the opportunity to translate at short intervals, rather than requiring that the translator remember a long, detailed explanation.

Time

In mainstream U.S. culture, schedules, clocks and watches regulate us. From infancy, medical professionals recommend feeding and sleeping schedules to ensure a well adjusted baby. Upon entering school, we initially learn how the day is organized into periods of learning and playing. As adults, we wear watches and are guided by calendars. As a culture, we value punctuality and effective time management. We are concerned about being late and equate tardiness with irresponsibility. Perception of time is culturally derived. In many other cultures, time is viewed and treated differently than in U.S. culture. Generally, life may be more relaxed and less hectic. Priority might be placed on personal interaction, rather than being on time for the next appointment. For example, a director of a small agency serving Latinos, herself a Latina, would usually arrive late for committee meetings with directors of other community organizations. Some of the participants from mainstream agencies, frustrated and feeling insulted by the consistent delays, confronted the latecomer. Surprised by the frustration of her

colleagues, this director described sessions with families conducted prior to her committee meetings. She could not imagine asking families to leave in order to be on time for a committee meeting. One way of understanding how cultures use time is described by Edward Hall (1983). Hall conjectured that Northern Europeans and Americans plan the order of their use of time, doing one thing at a time and labeled this monochronic time. Polychronic time, characteristic of Latin Americans and Middle Easterners, stresses the involvement of people and completion of transactions over adherence to schedules (Jandt, 1995). The following table provides a brief overview of the different time concepts:

Table 4: Monochronic and Polychronic Culture

Monochronic	Polychronic
Interpersonal relations	
Are subordinate to preset schedule	Preset schedule is subordinate to interpersonal relations
Activity coordination	
Schedule co-ordinates activity Appointment time is rigid	Interpersonal relations coordinate activity Appointment time is flexible
Task Performance	
One task at a time	Many tasks are performed simultaneously
Breaks and Personal Time	
Breaks and personal time are sacrosanct, regardless of personal ties	Breaks and personal time are subordinate to personal ties
Temporal Structure	
Time is inflexible and tangible	Time is flexible and fluid
Work/Personal Time Separation	
Work time is clearly separable from personal time	Work time is not clearly separable from personal time
Organizational Perception	
Activities are isolated from organization as a whole; tasks are measured by output in time activity per hour or minute	Activities are integrated into organization as a whole; tasks are measured as part of overall organizational goal

(Adapted from Intermundo, s/d)

Cultures also vary in their perception about the future, present or past. Some cultures have a strong connection to their past which determines such beliefs as the role of the dead in everyday life and the extent to which the living are affected by the behaviors of their ancestors or heirs. For example, many Southeast Asian cultures believe strongly in the influence of ancestors as described in *The Spirit Catches You and You Fall Down*, (Fadiman, 1998). The Hmong believe that illness can be caused by a variety of sources-- being punished for one's ancestors' transgressions. This belief can also be generalized to explain the incidence of disability in families. Southeast Asian causal beliefs of disability range from those that focus on the behavior of parents to sins committed by ancestors, and reincarnation (Sotnik, P. & Hasnain, R., 1998).

Conclusion

Although culture brokering may appear at first glance to be a new set of skills for rehabilitation service providers, in reality, it is an extension of skills that providers already practice. Assessment, problem solving and communication are important skills for all rehabilitation service providers. Through culture brokering, providers may add a new dimension to these skills. It is our hope that the concepts presented in this monograph will be useful to you in strengthening these skills.

PART V: RESOURCES FOR THE CULTURE BROKER

While many books and articles have been cited in this monograph, we present the following annotated list of resources that may be particularly useful to rehabilitation service providers, because of their concise summaries of cultures or their direct relevance to rehabilitation.

Administration on Aging. (2000). Culturally competent service delivery: An overview. Washington, DC: U.S. Department of Health and Human Services/Administration on Aging.

This information brief and attachments analyzes the nature of culturally competent service delivery and suggests techniques and programs to serve diverse aging populations.

David Kennedy Center for International Studies. Culturegrams. Provo, UT: Brigham Young University.

This series, up-dated annually, provides information on the cultures of most countries of the world. Although the Culturegrams describe the culture without reference to any specific focus, such as rehabilitation, they provide a comprehensive resource.

Driedger, D., Feika, I., & Batres, E. (Eds.) (1996). Across borders: Women with disabilities working together. Charlottetown, PEI: Gynergy Books.

This book, written almost entirely by women with disabilities, describes the issues facing women with disabilities and the experiences of the women's disability movement in many countries, with chapters written by authors from Canada, Jamaica, El Salvador, Guatemala, Trinidad and Tobago, Barbados, Kenya, the United States, South Korea, India, Malaysia, Yemen, Zimbabwee, Uganda and Lesotho.

Family Education Program. (1997). Multicultural Information Resources. Boston: Children's Hospital.

The Multicultural Information Resources are a series of information sheets to assist health care providers working with families from various cultural backgrounds. Some sheets describe specific cultures, while others discuss topics such as religion or use of interpreters.

Harry, B., Kalyanpur & Day, M. (1999). Building cultural reciprocity with families: Case studies in special education. Baltimore: Paul H. Brooks Publishing Co.

This book consists of eight in-depth case studies that illustrate the practice of cultural reciprocity between special education professionals and the families of children with special needs. The case studies include families from the following cultures: Salvadoran, African American, Trinidadian, Palestinian, Chinese and Dominican.

Hernandez, M. & Isaacs, M. (Eds.). (1998). Promoting cultural competence in children's mental health. Baltimore: Brookes Publishing.

The seventeen chapters of this book are organized into four sections: 1) organizational infrastructure development, 2) neighborhoods and communities as partners in mental health services, 3) special issues in serving culturally diverse populations, and 4) evaluation and research issues facing the development of culturally competent services.

Holzer, B., Vreede, A., & Wiegt, G. (Eds.). (1999). Disability in different cultures: reflections on local concepts. Bielefeld, Germany: Transcript Verlag.

The thirty one chapters in this book are organized into five sections: 1) concepts and beliefs about disability in various local contexts, 2) concepts of disability with regard to migrants, 3) disability and knowledge transfer in the field of development cooperation, 4) "Nothing about us without us." Case studies of self-help

movements, and 5) towards new approaches in the study of disability in an intercultural framework. Specific cultures and countries that are the subject of chapters include: Andean, Mexico, Benin, Jordan, Angola, Jamaica and Germany.

Kalyanpur, M. & Harry, B. (1999). Culture in special education: Building reciprocal family-professional relationships. Baltimore: Paul Brooks Publishing Co.

This book explores cultural factors in special education. It describes the steps and key features in the process of cultural reciprocity in which professionals and family members recognize the cultural factors that underlie their beliefs and actions and adapt professional recommendations to the value system of the family.

Leavitt, R. L. (Ed.). (1999). Cross-cultural rehabilitation: An international perspective. Philadelphia: W.B. Saunders.

The thirty two chapters of this book are organized into five sections: 1) the theoretical basis for developing cultural competence, 2) professional issues, 3) the practice of rehabilitation and international environments: case examples, 4) cross-cultural research and 5) the practice of cultural competence in the 21st century. Many chapters focus on specific countries or parts of the world, such as Guyana, Nicaragua, Botswana, South Africa, Mexico, Romania, Palestine, Vietnam, Zimbabwe and Jamaica.

Lipson, J., Dibble, S. & Minarik, P. (Eds.) (1996). Culture & nursing care: A pocket guide. San Francisco: UCSF Nursing Press.

This handbook provides succinct descriptions of certain aspects of many cultures related to health care. Among the cultures included are Native American, African American, Arab, Brazilian, Cambodian, Central American, Chinese, Colombian, Cuban, Ethiopian, Filipino, Gypsy, Haitian, Hmong, Iranian, Japanese, Korean, Mexican, Puerto Rican, Russian, Samoan, South Asian, Vietnamese, and West Indian.

Luckman, J. (2000). Transcultural communication in health care. Canada: Delmar.

The focus of this book is on health care rather than rehabilitation and all transcultural communication rather than a specific focus on the cultures of foreign born persons. The style and organization of the book makes it suitable for training and instructional purposes. Each of the five units opens and closes with self-assessment sections. Additionally, each chapter closes with a Testing Your Knowledge section. The five units are: 1) exploring trans-cultural communication, 2) developing trans-cultural communication skills, 3) using trans-cultural

communication to elicit assessment data, 4) using trans-cultural communication skills to plan and implement care, and 5) trans-cultural communication skills between health care professionals.

National Long Term Care Ombudsman Resource Center. (2000). Tried and true methods for reaching under-served populations. Washington, DC: National Association of State Units on Aging.

This information brief contains suggestions on how to provide services to older persons from multicultural groups.

Ong, W. A. (1993). Asian American cultural dimensions in rehabilitation counseling. Stillwater, Oklahoma: National Clearinghouse of Rehabilitation Training Materials.

This paper explores the cultural backgrounds of Asian Americans and their relationship to rehabilitation counseling services. The focus is mainly on Chinese, Japanese and Southeast Asians.

Salimbene, S. (2000). What language does your patient hurt in? A practical guide to culturally competent health care. St. Paul, MN: Paradigm Publishing, Inc.

This book presents chapters on the cultures of African Americans, Native Americans, Asians, Hispanics, persons from the Middle East, especially Arabs, Egyptians and Iranians, and Emigres from the Former Soviet Bloc Countries, especially Russians, Bosnians and Poles. Another chapter presents Tips for Successful Caregiver/Patient Interaction Across Cultures, comprising 33 practical tips. Each chapter concludes with a set of questions that could be used for the purpose of reflection and discussion.

A bibliography on Culture Brokering is found in Appendix II.

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APPENDIX I -INTERVENING CONDITIONS

Intervening conditions are the key to problem identification and selection of strategies within the culture-brokering model. Table 5 provides a detailed explanation of each of the intervening conditions and suggests some of the questions that the culture broker might ask about each of them in specific cases.

Table 5: Operationalizing the Intervening Conditions (ICs) in the Culture Brokering Theory

Table 5-A

Understanding of Disability

Type of disability and its cause

Explanation	Assessment Questions	Discussion
Consumers' understanding of the cause and nature of the disability sometimes creates breakdowns in facilitating service. Diagnoses may be explained in ways consumers and families do not understand.	What impact does the consumer's disability have on access or maintenance of rehabilitation services? Do consumers, providers and family understand the disability in the same way? Is the understanding of the disability creating a barrier to open communication?	Disability can become an economic liability. Rehabilitation for some disabilities may be very expensive and institutions may limit rehabilitation based on the economic liability to consumers who do not have a means to pay for it. In some instances, consumers may be given fewer rehabilitation options if their insurance does not cover the options.

Table 5-B

Communication

Interpersonal communication (verbal and nonverbal) that takes place between consumers, families, and service providers.

Explanation	Assessment Questions	Discussion
When rehabilitation service providers act as brokers of information, consumers and families are better informed and better able to understand what is communicated. The broker of information uses language in a way that is sensitive to the consumer or family's level of comprehension. Extra time and care needs to be taken when consumers or families do not speak English. Communication breakdowns are sometimes just as severe when consumers and families do not speak the language of rehabilitation.	Is there open communication between all participants? What factors may be hindering open communication? What does the service provider have to do to encourage communication if there is a deficit? Do consumers and family members speak the same language as the providers? Do consumers and family members understand the language of rehabilitation? What is the language of rehabilitation?	Rehabilitation service providers need to act as information brokers between consumers and the rehabilitation system. This includes interpreting the language of rehabilitation to the consumer as well as interpreting and clarifying explanations communicated to consumers. The role of the culture broker becomes one of advocate and innovator when consumers and families do not speak the same language as the providers.

Table 5-C

Age

Ageism. Age impacts on quality of life issues and rehabilitation options made available to the consumer.

Explanation	Assessment Questions	Discussion
When there are limited resources in rehabilitation service settings, preference is sometimes given to particular populations.Value judgments may be made regarding the consumer's age and rehabilitation services.	How does the consumer's age affect the service he receives?- What are the values and beliefs of rehabilitation service providers toward the consumer, related to the consumer's age? Does ageism affect the way the consumer's care is facilitated? Is the consumer labeled negatively (stigmatized) because of age?	Age is a subtle intervening condition in the brokering process. Ageism can be a potential form of stigmatization that can negatively impact on rehabilitation services. It can also be a positive influence on the brokering process. If providers positively value the age of the consumer, it may be easier for the consumer to obtain optimal service.

Table 5-D

Culture Sensitivity/Competence

Awareness by one person of the differences in values, beliefs and behaviors of another and the awareness that these are an integral part of the person's world-view. The ability to function competently is an important component.

Explanation	Assessment Questions	Discussion
The values and beliefs about disability may be very different for providers and consumers.Culture sensitivity does not have to do solely with ethnicity. It has to do with the similarities and differences in the values, beliefs and behaviors between the cultural systems of the consumers and the rehabilitation service providers.	Do the providers know the consumer's views of disability? What are the consumer's explanatory models of disability? Are the service expectations of the consumer similar to or different from the providers? Is culture sensitivity present in providers who are interacting with the consumer?	The rehabilitation service system is a cultural and social system with a set of values, beliefs and behaviors particular to that system. Culture sensitivity is a positive force in the brokering process. Culture insensitivity has a negative impact on the stages of brokering and leads to cultural incompetence. Culture sensitivity also increases awareness of stigmatizing behavior.

Table 5-E

Time/Timing

1. The time orientation (past, present and/or future) of consumers and providers.
2. The time it takes to broker.
3. In some cases, there are right and wrong times to initiate certain rehabilitation service interactions.

Explanation	Assessment Questions	Discussion
Brokering strategies are affected when the time orientation of the consumer differs from the provider's, especially when the provider is future-oriented, emphasizing preventive, goal oriented behaviors, and the consumer is present- oriented, emphasizing, "survival is living life one day at a time."Brokering takes time and can't be rushed. The power of the broker evolves over time, especially the establishment of complex service provider networks.	What is the time orientation of the consumer and the providers? Do they differ? Are differences in time orientations between provider and consumer creating breakdowns in the rehabilitation service interaction? Is it creating conflict between consumer and provider in their perception of appropriate service? Does the service provider see the value of taking time to broker for the consumer? How does a service provider make time to broker?	Awareness of differing concepts of time/timing informs the assessment of conflict and the strategies to resolve conflict, especially sensitizing others to the presence of this IC.Rehabilitation service providers may need to increase their own sensitivity to the concept of time orientation.There is a need to consider the timing of discussions with consumers in situations that require complex decisions.

Table 5-F

Cultural Background

Similar to cultural sensitivity, but narrower in scope. This IC implies that the cultures of the consumer and provider are imbedded in their ethnicity and in turnethnicity influences values, beliefs and behaviors.

Explanation	Assessment Questions	Discussion
Differences in cultural background influence interactions.Cultural backgrounds affect communication patterns, time orientation, and beliefs about disability.Differences in cultural background impact negatively on the brokering process if providers are not sensitive to the influence of culture.	What are the cultural backgrounds of the provider and consumer? Are they different? In what ways are they different? Do provider and consumer cultures impact positively or negatively on the rehabilitation service interactions? Is the potential for conflict increased as a result of cultural differences? How do consumer/ provider cultural backgrounds affect the other ICs?	Cultural background impacts on most of the other ICs. Culture is the framework by which the meanings of the other ICs are formed and interpreted by the consumer and provider.The broker needs knowledge of the meaning of culture.

Table 5-G

Stigma

Refers to the negative beliefs and values one person has for another based solely on a label ascribed to the person. The values and beliefs about the label are usually determined by the dominant culture. The stigmatizing label provides a discrediting attribute, which is likely to bring about social exclusion.

Explanation	Assessment Questions	Discussion
Stigma has a negative impact on access and utilization. The labels migrant farm worker and homeless may stigmatize because of the perceived differences and stereotyping on the part of providers. One type of stigma is linked to age. Elderly consumers are sometimes circumvented in favor of their family members' decisions. This occurs even though the elderly consumer is competent to make decisions.	Is the consumer labeled in a stigmatizing way that results in a negative view of the consumer or family member? What is the source of the stigma? What information or educational processes are necessary to reduce the stigma associated with a particular derogatory label?	When stigma, associated with the label disabled overlaps with stigma due to racial or ethnic affiliation, the stigmatizing effect may be increased. The effects of stigma are compounded when consumers' disabilities have a stigmatizing effect; such as mental retardation or impaired speech. Disability itself is sometimes stigmatized, regardless of the type of disability.Disabilities associated with accidents or war may sometimes be less stigmatizing than life long disabilities.

Table 5-H

Power/Powerlessness

Power is defined as the ability or capacity to act or function effectively in interactive situations, to control one's own actions and/or exercise control over the actions of others.

Explanation	Assessment Questions	Discussion
Power versus powerlessness was ever present in the studies that formed the basis for the culture brokering theory. The consumer is usually less powerful than providers.The potential for abuse of power is present, especially in the provision of services to those persons who are relatively powerless socially, economically and politically in our society, for example mentally ill persons.	Is there asymmetry of power in the rehabilitation service encounter? Is the provider using his power to influence consumer decisions? Are rehabilitation service professionals exercising power to control the consumer's access or use of services? Are providers withholding service they have the power to offer to consumers? Why is the service not offered? How can the consumer be empowered in the rehabilitation service interaction?	Powerlessness is often present when lack of health insurance is a factor in access or use of rehabilitation service.In some conflict situations providers withhold information from competent consumers under the guise that it is in the best interests of the consumer, despite the fact that consumers and/or family members want the information.Additionally, policy and protocols are influenced by those with the most power.

Table 5-I

Bureaucracy

An administrative system in which there is the need to follow complex procedures based in policy and/or legislation. Bureaucracy can impede the provision of rehabilitation services. Bureaucracy entrenches policy in a system.

Explanation	Assessment Questions	Discussion
Bureaucracy is the paper chase and red tape that can impede the brokering process.Bureaucracy in the form of complex protocols impedes brokering in interactions and mandates the need for an intermediary.In rehabilitation service settings there is the red tape of social service programs. The regulations of Medicaid create barriers rather than facilitate coverage for groups who economically are eligible for this rehabilitation service coverage but who may not meet all the regulations for eligibility.	Does the administrative paperwork impact on the consumer's autonomy? Are there forms that consumers must fill out/sign? Does the consumer understand what he/she is signing and why? Are the forms necessary? Are there committees that periodically review forms and policies that consumers must deal with directly? What aspects of providing rehabilitation service and resolving conflict are entrenched in the bureaucracy? How do bureaucratic mandates affect service?	Consumers have difficulty understanding the jargon present in the bureaucratic paperwork and protocols. Differences in cultural values may make it difficult for some consumers to understand the forms they must sign or the necessity of signing such forms. Consumers may not have knowledge of the politics of regulations imposed by local, state or federal governmental agencies on rehabilitation service agencies. Rehabilitation service providers act as intermediaries between the bureaucracy and the consumer.

Table 5-J

Politics

Defined in the context of culture brokering as conducting and engaging in activities that are designed to influence and determine decisions that affect rehabilitation service delivery.

Explanation	Assessment Questions	Discussion
Politics is, "what is possible", more dynamic and changing than the bureaucracy. Policy development through politics impacts on the bureaucracy.Rehabilitation service providers may not be involved in the politics of their institutions. Politics in the institutions control, to some extent, who will and will not receive service.	Is there a role for the service provider in changing policy to prevent conflict in particular situations in rehabilitation service interactions? Does the service provider have the ability to change protocols to reduce the possibility of conflict in rehabilitation service interactions? Do rehabilitation service providers sit on committees that are active in changing policy?	It is difficult to prevent political decisions from becoming immutable bureaucracy.Rehabilitation service providers who are active in policy decisions have more power to prevent or resolve conflict in rehabilitation service encounters. Politics affect economic conditions. Politics and legislation affect insurance coverage under the Medicaid program.

Table 5-K

Networks

Networks are established links between the culture broker (service provider) and others in rehabilitation services. Others may have the power and know-how to assist the broker. The broker needs to know who the others are to facilitate brokering.

Explanation	Assessment Questions	Discussion
Networks facilitate the power of the broker to effect conflict resolution. Networks are either formal (administrative, contractual) or informal (personal, social).Referrals can be an important part of brokering rehabilitation services. Referrals are facilitated by networks. Referrals may be made to outside agencies for follow-up. Referrals may also be made within agencies.	Rehabilitation service providers can ask themselves: "Whom do I know and what do they know that can help me facilitate service for consumers?" Are there formal networks in place to facilitate consumer services? What are the informal networks in place? Are there potential access problems for the consumers within agencies?	Networks provide power for the rehabilitation service providers practicing in a variety of settings within the community.

Appendix II - Culture Brokering - A Selected Bibliography

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