9

Special Interest and Priority Areas

In this chapter, *Special Interest and Priority Areas,* we explore areas that warrant special interest in the U.S., including maternal and child health, chronic and infectious disease, substance abuse, mental health, disability and aging. This chapter focuses on just some of the current major health issues faced in the U.S. and the potential role of professionals in addressing these in a culturally safe manner. It offers rationales for giving attention to certain groups and issues and asks readers to consider what issues are relevant in their local settings. It is not possible to look at all major health concerns, so we will review a selection of the key national priorities.

Chapter Objectives

After completing this chapter, you should be able to:

- identify some of the major health issues affecting our nation today
- describe leading health indicators and objectives that inform public health initiatives

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- describe major health issues from a social determinants perspective
- identify cultural safety considerations among special interest and priority health concerns.

What Are Our Priorities?

For a book for use in health psychology and human services, how could we not cover topics such as diabetes, cardiovascular disease, or cancer? Aren't these the health issues and conditions that warrant our attention? Or should we discuss gun violence, militarism, police brutality, and incarceration? There are so many topics that we could cover, but our main goal is to show *how* cultural safety analysis and practice can be implemented through a small selection of topics.

Similarly, we could explore in more depth the health of various populations, such as the top concerning health issues among Black Americans, Indigenous Peoples, veterans, etc.… but, as discussed earlier in this book, we can't possibly learn everything we would need to know about any group. With a cultural safety approach, we need to look at ourselves and our own cultures and identities. We also know the potential to inadvertently stereotype groups and individuals that can do more harm than good. Having an understanding of various groups of people, at the same time, is critical for the effective and appropriate delivery of health and human services, as the previous chapter indicated.

We might know that overall, in the U.S., heart disease, cancers, and accidents are the top three leading causes of death. But these are not the same when you start to disaggregate the data by various variables, such as rural versus urban, race or ethnicity, sexuality, veteran status, disability, etc. So, if we were to completely base our resources for health priorities on these aggregate outcomes, some groups would be underserved as their own health priorities don't make the cut. What do we do, as professionals, when the priority, as we see it, does not align with those of clients in our care?

In the determinants of health chapter, we explored the social and economic contexts that lead to various health and social conditions and inequities. In this chapter, we consider some areas of special interest,

keeping in mind that these health and social conditions are *produced* by the pervasive social and economic conditions. That is, put another way, they are *symptoms* of systematic oppression, the inequitable distribution of resources and power, and structural discrimination.

Statistically speaking, professionals will work with a diversity of clients regardless of intent or preferences. The fact that we have the health concerns that we do, within a very wealthy nation, should be cause for greater attention from health and human service professions. Health is not only the domain of health and human service workforces. In the determinants of health chapter, we identified the need for a more cohesive and collaborative approach to health and well-being that spans disciplines and sectors such as education, housing, employment, and justice.

Despite being one of the wealthiest nations in the world, the U.S. experiences some very poor health outcomes. These health concerns impact some populations and communities disproportionately. While it would be easier to attribute these health disparities to biological or behavioral differences, there is ample evidence to refute such simple explanations.

Critical Thinking

- What are the current health priorities in your state or region? Are there differing health priorities for different population groups? What might be some of the factors contributing to these differing health priorities and outcomes?

Healthy People: U.S. Priorities

In 1979, Surgeon General Julius Richmond issued a report 'Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention', which began the *Healthy People* initiative. Every ten years since 1980, the U.S. Department of Health and Human Services develops and reports on health promotion and disease prevention goals

and objectives. *Healthy People 2020* was launched in December of 2010, which included four overarching goals:

- Attain high-quality, longer lives free of preventable disease, disability, injury, and premature death.
- Achieve health equity, eliminate disparities, and improve the health of all groups.
- Create social and physical environments that promote good health for all; and
- Promote quality of life, healthy development, and healthy behaviors across all life stages.

Healthy People 2020 included 42 Topic Areas and 1,300 Objectives. These are further broken down into 12 Leading Health Indicators with 26 Objectives. Table 9.1 shows the objectives for each of the 12 Leading Health Indicators. For example, Environmental Quality is measured through the objectives of an Air Quality Index greater than 100 and reducing the numbers of children exposed to secondhand smoke. In 2017, *The Midcourse Review* report was released which provides data and information on the progress toward the *Healthy People 2020* goals and objectives.

The learnings from *Healthy People 2020* informed the new initiative, *Healthy People 2030*. The Framework of *Healthy People 2030* includes a Vision, Mission, Foundational Principles, Overarching Goals and a Plan of Action. The number of objectives has been reduced with objectives falling into topic areas that include health conditions, health behaviors, populations, settings and systems, and the social determinants of health. Importantly, for the first time, *Healthy People 2030* will also include personal and organizational health literacy.

The criteria for the Leading Health Indicators for *Healthy People 2030* will:

- Focus on upstream measures, like risk factors and behaviors, instead of disease outcomes (remember the story of the river of health we discussed earlier)
- Address issues of national importance

Table 9.1 *Healthy People 2020* leading health indicators and objectives

Leading Health Indicators	Objectives
Access to health services	Persons with medical insurance
	Persons with a usual primary care provider
Clinical preventive services	Adults receiving colorectal cancer screening based on the most recent guidelines
	Adults with hypertension whose blood pressure is under control
	Persons with diagnosed diabetes whose A1c value is greater than 9%
	Children receiving the recommended vaccines
Environmental quality	Air Quality Index > 100
	Children exposed to secondhand smoke
Injury and violence	Injury deaths
	Homicides
Maternal, infant, and child health	All infant deaths
	Total preterm live births
Mental health	Suicide
	Adolescents with major depression
Nutrition physical activity and obesity	Adults meeting aerobic physical activity and muscle-strengthening objectives
	Obesity among adults
	Obesity among children and adolescents
	Mean daily intake of total vegetables
Oral health	Children, adolescents and adults who visited the dentist in the past year
Reproductive and sexual health	Sexually active females receiving reproductive health services
	Knowledge of serostatus among HIV-positive persons
Social determinants	Students graduating from high school 4 years after starting 9th grade

(continued)

Table 9.1 (continued)

Leading Health Indicators	Objectives
Substance abuse	Adolescents using alcohol or illicit drugs in the past 30 days
Tobacco	Adult cigarette smoking
	Adolescent cigarette smoking in the past 30 days

- Address high-priority public health issues
- Be modifiable in the short-term (through evidence-based interventions and strategies to motivate action at the national, state, local, and community levels)
- Address social determinants of health, health disparities, and health equity

Critical Thinking

- What looks different in *Healthy People 2030* compared with *Healthy People 2020*?
- Recall the discussion in earlier chapters about evidence. How might this focus benefit some while disadvantaging others?
- What ways could the issues of 'national importance' or 'high priority public health issues' become inequitable? Can you think of ways that these can be culturally safe and inclusive so as to not inadvertently lead to further inequalities?

Health disparities are differences that exist among specific population groups in the U.S. in the attainment of full health potential that can be measured by differences in incidence, prevalence, mortality, burden of disease, and other adverse health conditions (NIH, 2014). Health disparities can stem from health inequities—systematic differences in the health

of groups and communities occupying unequal positions in society that are avoidable and unjust (Graham, 2004).

Activity
Find definitions for the following terms: morbidity, mortality, epidemic, pandemic, incidence, prevalence, burden of disease, or disease burden. Give an example for each term from national data sources.

Chronic Diseases

Chronic diseases are a national priority for everyone in the U.S. However, the predisposing factors and approaches for managing various health problems need to be put into context. Management and prevention approaches that may work for some people do not always work for everyone when the specific needs of individuals, groups, communities and their unique contexts are disregarded.

The major chronic diseases in the U.S. include diabetes, arthritis, cancer, epilepsy, heart disease, and stroke. It is believed that by targeting maternal health, there can be significant improvement in infant birth weight. This is underpinned by three main determinants: maternal and childhood education, the alleviation of poverty, and promoting a 'sense of control' and mental well-being.

Reading
For a comprehensive overview of the current state of chronic diseases, review the following reading.

National Center for Chronic Disease Prevention and Health Promotion.

https://www.cdc.gov/chronicdisease/resources/infographic/chronic-diseases.htm.

Chronic diseases have sometimes been referred to as 'lifestyle diseases', implying that the person with the chronic disease knowingly engaged in risk-taking behaviors that contributed to the development of the disease. This way of thinking emerges from biomedical and behavioral views of health that pay little attention to the socio-environmental and historical factors implicated in chronic disease profiles.

The discourse (or the ways we talk about) of chronic illness often shows the underlying attitudes and assumptions about causes and responses. 'Lifestyle diseases' implies blame or a conscious choice on the part of the client. For many health professionals, the view that 'They just need to be educated…' is repeated with frequency throughout healthcare settings. Education is undoubtedly a powerful contributor to enhancing health outcomes. However, the question might also be asked, 'Who else needs to be "educated"'?

Suggesting that chronic diseases such as diabetes or renal failure are *lifestyle* in origin denies the role of colonization in creating the environments that produce these health issues and in transforming lives to predispose people to such health problems. Colonization, like culture, is broadly defined here. Any one or group who are oppressed or disempowered can experience what it is to be 'colonized' by a more powerful group. Certainly, there are aspects within the control of individuals to manage or change and we are not suggesting that simply an awareness of our colonizing history is sufficient to change the outcomes toward better health. But it is important for professionals to examine their own beliefs about *why* people are at risk, in order to provide a relevant and meaningful support within their practice. For example, a belief statement about why someone might have a specific illness from a health professional's perspective may go:

You have chronic heart disease, because…

a. you don't exercise.

b. you don't understand the link between diet and ill-health.
c. you don't comply with your preventative treatments.
d. you don't care about your health.

A belief statement about why someone has chronic heart disease from another person's perspective may, depending on context and worldview, go something like:

I have chronic heart disease because…

a. It's a punishment for something I've done.
b. It's fate.
c. I live in a bad neighborhood.
d. I didn't believe I needed medication, because I felt OK.

Clients often have their own explanation of their problem or situation, and it may not match yours. Rather than try to convince or 'educate' the client about your beliefs, the client's explanations should be explored so that realistic solutions might be sought collaboratively. People of course may not offer a cultural or personal explanation, if a trust relationship hasn't first been established. Hopefully, through the preceding chapters, it has become abundantly clear that poor health today is not 'caused' by being whatever identity someone is. It is caused by a myriad of contextual influences; personal behavior is only one element of many.

This awareness requires professionals to monitor their responses in regard to clients, to avoid 'blaming the victim' and placing unrealistic and unworkable expectations on people who may have all the desire to become and stay healthy, but less of the control and opportunity. For many children born today, the reality is that a predisposition to chronic diseases starts in utero. Chronic diseases are much more prevalent in conditions of poverty, unemployment, and poor-quality education and housing. Health and human service professionals need to be alert to the possible co-morbidities and the implications this has for care.

Western approaches to chronic disease can tend to compartmentalize diseases and management. There is a focus on diabetes that is often separate from a focus on skin infections, which is often separate from a focus

on cardiovascular disease, which is separate again from renal failure, and so on. However, providing holistic care is not simply a nice idea, it is good practice.

Infectious and Parasitic Diseases

Infectious diseases are illnesses that can be spread from one person to another that are caused by organisms like viruses and bacteria. The COVID-19 pandemic has demonstrated clearly that such a virus does not discriminate, but disparities among specific populations can increase risk. Other infectious diseases include HIV/Aids and other sexually transmitted diseases (STDs), the flu (influenza), tuberculosis (TB), and hepatitis.

When HIV first emerged in the U.S. we saw people vilified and discriminated against not only within public spaces, but within the very healthcare settings intended to provide care. People were labelled by the way they acquired HIV which can be sexually transmitted or through blood transfusions. Those that acquired the disease through blood tranfsusions were treated with empathy and compassion while those who acquired HIV through so-called 'lifestyle choices' were demeaned and subject to victim-blaming. The movie *Philadelphia* depicted a little of the discrimination faced by people affected by HIV.

Infectious disease rates have decreased dramatically within mainstream populations. Poverty, environmental conditions and lifestyle changes, however, have seen infectious disease rates rise. Many of the issues still being confronted in some regions relate to the lack of appropriate infrastructure and resources to maintain public health. This was demonstrated particularly clearly with the COVID-19 pandemic.

Think about what pre-public health New York or Los Angeles must have been like. What happened to garbage and water supply before the introduction of sanitation and garbage disposal services? While precontact lifestyles would have been less hazardous for Indigenous populations in terms of potential for infection, contemporary lifestyles are fraught with risks that require adequate education and resources to manage.

Reflection

Read this: '91,757 deaths from diseases of the heart, 84,443 from cancer, 28,831 from chronic lower respiratory diseases, 16,973 from cerebrovascular diseases (stroke), and 36,836 from unintentional injuries *potentially could be prevented each year*' (Yoon et al., 2014, emphasis added).

What might your role as a professional be in effecting a change to this information? How could these deaths be prevented? It is all very well to advise people about health, hygiene, nutrition, and exercise but if the facilities and infrastructure are not present or not functioning, there is little value in the advice. Often, health and human service professionals, depending upon their disciplinary area, do not have an adequate picture of the home environment to be able to provide realistic advice. It is important therefore to get to know the communities with which you work. Establish positive relationships that allow you to work outside the clinical or community health centers and really get to know your clients' contexts in a way that is not reminiscent of the 'surveillance and intrusive' approaches of the past.

Handwashing is one simple but effective strategy to reduce the risk of infectious diseases. Although health professionals may often think this message should be well entrenched and understood, look at the number of hospital-related infections that are linked to less than adequate handwashing practices among health professionals.

What are parasitic diseases? 'The major neglected parasitic infections in the U.S. include Chagas disease, cysticercosis, toxocariasis, toxoplasmosis, and trichomoniasis. These five parasitic infections are considered "neglected" based on their high prevalence, chronic and disabling features, and their strong links with poverty' (Hotez, 2014). Of these 'neglected' infections, cysticercosis (tapeworm), toxocariasis (worms), and toxoplasmosis (parasite) can all be prevented by washing hands. But teaching people that washing their hands will have health benefits doesn't usually result in people washing their hands more!

At the start of the COVID-19 pandemic in early 2020, mass attempts were made to influence handwashing through social media, news, and

throughout businesses and organizations around the world. Hand sanitizing stations were installed at entrances to stores, businesses and restaurants and throughout schools. Research found significant increases in handwashing behaviors from October 2019 to June of 2020, during the COVID-19 pandemic, with particular increases in handwashing after coughing, sneezing, or blowing the nose (Haston et al., 2020). Interestingly, those most unlikely to wash their hands were White adults, men, and young adults aged 18–24, suggesting the need to target handwashing to those groups.

Website
See the Global Handwashing Partnership website for some interesting information and resources: https://globalhandwashing.org/.

Infant and Maternal Health

For the wealthiest country in the world, one might expect various health statistics in the U.S. to be among the best, yet our infant mortality doesn't even rank in the top 50 countries. The U.S. ranks at only 55 globally with a rate of 5.80 deaths per 1,000 live births (CIA, World FactBook, 2017 data). Infant mortality varies substantially by state and by race and ethnicity in the U.S.

These infant mortality rates are certainly unacceptable within such a wealthy nation. While some improvements have occurred, the rates of morbidity have increased for those who do survive beyond the first year of life. Most children today have a better chance of survival at birth, but many will suffer greater levels of illness that are largely preventable. There are a number of national programs targeting infant and maternal health. Increasing access to antenatal services, and initiatives such as home visitations from childcare nurses, are a few strategies aimed at reducing disparities in this area.

Maternal health has been identified as possibly the most significant factor in the health of whole families. Family structures and child rearing practices are culturally determined. From a cultural safety perspective, it is important that health and human services professionals examine their preexisting views of what maternal roles and responsibilities should be, to enable culturally safe engagement with families.

Activity

- Find out how services in your region access the most vulnerable women and infants. What programs are available to this group?
- Conduct a review of the literature to examine the responses of various states to infant and maternal health. What are the local policies and priorities?
- What does the research say about health and social outcomes for families when health education is provided to mothers? Look globally as well.

Risky and High-Risk Substance Use

Risk behaviors are another area to consider when thinking about the range of factors contributing to the health disparities between groups. This area, however, can be somewhat contentious because people's behaviors are often believed to be within the *complete* power and control of the person engaging in those behaviors. For example, some people might say that the reason someone smokes cigarettes is 'because they want to'. But human behavior, as already discussed, is influenced by a range of factors. It is overly simplistic to suggest that someone engages in certain behaviors 'by choice' or 'because they want to'. It discounts other factors, including social conditions (such as friends and family), cultural, financial, environmental (e.g., not exercising because a neighborhood is not safe or conducive to exercise), and historical factors. Overall, information about health-risk behaviors needs to be considered within this broader context. Correspondingly, interventions need to be developed and delivered that take these wider contextual details into consideration.

Some of the health-risk behaviors that are disparate between groups include smoking and drinking alcohol at risky levels. There is no doubt that one of the most destructive influences to affect so many Americans has been substances of addiction.

Readings

National Institute on Alcohol Abuse and Alcoholism, Alcohol Facts and Statistics. https://www.niaaa.nih.gov/publications/brochures-and-fact-sheets/alcohol-facts-and-statistics.

Moody, L., Satterwhite, E., & Bickel, W. K. (2017). Substance use in rural central Appalachia: Current status and treatment considerations. *Rural Mental Health*, *41*(2), 123–135. https://doi.org/10.1037/rmh0000064. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5648074/.

Scenario

Kelly is a social worker for a home hospice care agency. Two years ago, her 19-year-old son died suddenly after a long battle with mental illness. She was consumed with guilt over his death and distraught that she should have been able to prevent his death. She was prescribed opioids by her family doctor for back pain related to heavy lifting at work. She started taking more of them because they helped calm her and she wouldn't think as much about her son's death. But she needed more and more to cope. She made some friends who could help her get heroin, and spiraled even further into dysfunction. She was struggling to take care of her other younger children and her marriage was falling apart. Every day the goal was to figure out how to get the money and the drugs to get her through the day. She went to a drug rehab, promising herself and her family that she would do better. But it was already too late. Kelly had contracted an infection from using dirty needles. She refused the needed intravenous antibiotics and hospitalization and died. She was just 46 years old.

- Where were the points of intervention that may have avoided this outcome?

- How might Kelly's cultural identity have contributed to a lack of support from services, i.e., a college-educated, health professional, married with children.
- How did Kelly's issues go undetected for so long?
- How might it have helped to have family involved in health appointments or assessments?
- What role did the friends play in Kelly's outcome?
- Why might Kelly have refused treatment in the end?
- Have you made any previously unexamined assumptions about Kelly in terms of her social class, ethnicity, or character?
- Did you think that Kelly's story started with her son's issues—and possibly even further back? People can be high functioning and falling apart at the same time. Some health professionals overlook family input, concerned about their patient's confidentiality, but it is often valuable to encourage patients to bring a support person who they are happy to have with them.

Opioid Epidemic in the U.S.

The opioid epidemic in the U.S. is one example of how our medical system can gradually cause harm. While opioids are incredibly useful for patients in extreme pain, their use (and misuse) created a national crisis that hit its peak in 2017 with 47,600 deaths involving any opioid. Opioids are highly addictive.

One of the large pharmaceutical companies that makes OxyContin, an opioid that was an early driver of the opioid epidemic, has been involved in lawsuits and pled guity to criminal wrongdoing for aggressively marketing opioids. As a result, they have paid billions of dollars toward drug treatment and dealing with other effects of the opioid epidemic.

Asking clients about changing behaviors such as quitting smoking, or quitting drinking, can sometimes seem like a pointless or unwelcome exercise, but it can be helpful to remember that people trying to break an addiction often make several attempts before they are successful. Even if

a client seems disinterested or unappreciative of the conversation, don't give up on raising the issue. This might be the one time that they are ready to go.

Making It Local

Review the newspapers and other media for issues relating to alcohol and drug use among various population groups? What is the nature of the items presented?

How balanced is the representation? What drug and alcohol programs are available in your region?

Look up your local chapters of 12-step recovery meetings such as Alcoholics Anonymous or Narcotics Anonymous. How many meetings are held in your area? These 12-step recovery meetings have Open meetings, which are open for anyone to attend who has an interest. As a health or human service professional, chances are, you will have clients (or friends and family, or even yourself) who are in recovery or who would benefit from attending 12-step recovery meetings. Attending an open meeting, whether or not you identify as an addict or alcoholic, can be very valuable in your work with your clients. Search for an open meeting in your area and attend. Introduce yourself to someone when you get there and let them know that you are there to observe. If someone calls on you to talk, you can introduce yourself as an observer and pass on talking. Make sure to connect with people after the meeting.

Mental Health and Social and Emotional Well-Being

Mental health issues, like other health issues, are embedded in a larger set of questions relating to culture and cultural differences, historical events, social and cultural change and coping. Who defines mental health and ill-health and whose worldview is used to do this are important considerations. For example, how would you respond if a client told you they knew of a man who was hung on a cross and came back from the dead

three days later? If you were familiar with Christian ideas about the resurrection of Jesus, you would probably accept this as being part of the person's belief system and not even think about calling for mental health assessment. If another person told you that the reason they were sick was due to snakes in their chest, how would you respond? Does it depend upon your worldview?

Paying attention to differing worldviews is a relatively recent phenomenon in health, and some disciplines are more attentive than others. There is a growing body of literature focusing on the challenges of cross-cultural mental health assessment and counseling. An important consideration of cross-cultural mental health assessment is being able to ascertain whether someone's behaviors, thoughts or expressions are appropriate within their cultural context or not.

Scenario

Read the following example of culturally unsafe mental health assessment that had a disastrous impact for the individual concerned:

> …Rita Quintero, a Mexican native who was found wandering the streets of a Kansas town. She seemed to be dressed oddly, seemed not to have bathed recently, and was not able to communicate except for a few Spanish words. She was involuntarily committed and remained hospitalized for 12 years. During her commitment she was treated against her will with psychotropic drugs. It was eventually determined that she was a member of the Tarahumara Indian tribe of Mexico. Her appearance, dress, and behaviors, which had been described as odd and indicative of mental illness, were actually traditional aspects of her culture. She had only a limited grasp of Spanish because she was a native speaker of Ramuri, a tribal language. After a Ramuri interpreter was located, she was released and allowed to return to her home.

- What strategies could have been employed to ensure this person's cultural, psychological, and physical safety?
- What does the experience suggest about the preparation of professionals to work in a culturally safe way?

This case study is presented in a cultural competence resource, *Quintero v. Encarnacion.* https://aspph-wp-production.s3.us-east-1.amazonaws.com/app/uploads/2014/04/11-278-CulturCompet-Interactive-final.pdf.

Resources

Mad In America is a fabulous website with lots of resources relevant to mental health and well-being. The website includes blogs, videos, continuing education programs, current news, and research. https://www.madinamerica.com/.

Snyder, S. N., Pitt, K., Shanouda, F., Voronka, J., Reid, J., & Landry, D. (2019). Unlearning through Mad Studies: Disruptive pedagogical praxis. *Curriculum Inquiry, 49*(4), 485–502. https://doi.org/10.1080/03626784.2019.1664254.

https://www.tandfonline.com/doi/abs/10.1080/03626784.2019.1664254?journalCode=rcui20.

Making It Local

- How do people think about mental health and illness in your area? What about within your family—are there any strongly expressed views about mental health issues?
- How would you determine your client's and their family's cultural understandings of mental health and illness?
- In your opinion, how important is it for your clients to understand the Western medical explanation of mental illness?
- From your own professional standpoint (e.g., nurse, doctor, social worker, psychologist), what are the important facts about mental illness (as understood by Western medicine) that would need to be communicated to families?

As students and future professionals, it is essential that you conduct your own analyses of what is presented to you about health and well-being and the variations among different populations and groups. Actively interrogate how reports and other sources are presenting information about groups and populations. Reflect on how materials might cause further harm by contributing to stigma and stereotypes that perpetuate harm.

When confronted with information that shows disparities between groups, always ask what created these situations? How did it come to be this way? Health and human service professionals can continue to treat the symptoms, but they also need to consider the causes. Causes, as we learned in the chapter about the social determinants of health, are complicated and rarely simple. Causes can be like the layers of an onion. Once you pull back one layer, there is another beneath it. Keep pulling back the layers and embrace the complexity and resist the urge to reduce causes to simplistic or singular events.

Aging

We learned earlier that Indigenous, Black, and Hispanic populations may be younger in terms of demographic profiling, but diseases and other health problems related to aging are experienced much earlier than in White and Asian populations. The different population profiles may at least partially explain why so little attention has been given to the issues of aging for many in the U.S. It is increasingly apparent that the costs—personal, social, and economic—are substantial.

Furthermore, given the acute and chronic disease profiles, the diseases normally associated with aging are experienced much earlier. Students and professionals are often shocked to encounter people in their thirties and forties in the hospital and community health systems with chronic lung disease, cognitive impairments, as well as cardiac, renal and a range of other health issues normally associated with people in their sixties and beyond.

What makes for a positive aging experience can be subjective, but it can, like most aspects of health, also be culturally determined. Think about your own picture of healthy aging. For some readers, that may be a distant picture, for others it may be quite close. For many cultural and racial groups globally, there is generally a strong reverence for the elders of society who are viewed as holders of knowledge, experience, and authority. Physical indicators of aging in some cultures, far from being perceived negatively, can be valued. Think about your own cultural values toward grey or white hair, for example. The signs of the first grey

hairs in the authors' cultures are often met with trips to the hairdresser to cover up an obvious indicator of aging. Yet, in other cultures, it is when someone has grey or white hair that they are really regarded with respect and authority. Recent years have seen trends in young people intentionally coloring their hair grey, silver, or white.

While traditional values may place great importance on the elderly in society, today there are considerable pressures impacting on communities generally, which can result in a loss of respect and valuing of the elderly. What might this mean in contexts where the role of the elderly is so crucial? Think about the impact of losing significant sections of a society prematurely. Statistically speaking, many groups are likely to die earlier than White or Asian Americans. For those who do attain what is considered old age, it is important to think about what a culturally safe, healthy aging might be. How will you judge this as a practitioner?

Reading
National Institute on Aging. (n.d.). The National Institute on Aging: Strategic Directions for Research, 2020–2025, Goal F: Understand health disparities related to aging and develop strategies to improve the health status of older adults in diverse populations. Accessed from: https://www.nia.nih.gov/about/aging-strategic-directions-research/goal-health-disparities-adults.

Assessments

Whether for pain, cognitive, or other issues, there is a need to evaluate the validity of health assessment tools for the diversity of clients who may require care. Assessment tools made for a particular cultural group may not be appropriate for assessing the needs of someone from outside of the target group.

From a cultural safety perspective, this is critical to ensuring that care is determined on the basis of screenings and assessments that do not have

a cultural bias to them. Please note this is referring to tools of assessment, such as pain scores that use faces or numbers. Remember the reference earlier to the academic text that published stereotyped views of pain behaviors based on ethnicity. There is no cultural group that does not experience pain but assessing people's pain behaviors based on preconceived ideas is not only culturally unsafe, it's clinically unsafe, leading some to be under or over medicated and not be listened to in response to their experience of pain.

Ouldred (2004) points out the cultural bias that renders most standardized tests ineffective or inappropriate for use with people of differing cultural backgrounds. That is, people from non-Western cultures may have difficulty with some of the concepts and words used in the tests. A lower score may be misinterpreted to indicate cognitive impairment (or depression, depending on the test), but is actually only reflecting cultural misunderstanding or lack of exposure to culturally dependent concepts.

Activity

- Have a look at various assessment tools available for pain, cognitive, or other assessments. Reflect on their usefulness for intercultural assessment. Who has been involved in their development?
- Can you see any cultural bias in the tools?
- Can you find tools developed for specific cultural groups?
- What might be the consequences of using culturally biased or inappropriate tools?

(Dis)abilities

Disability is often measured by considering the limitations of a person to perform their daily core activities. Profound or severe core activity limitation means that a person always or sometimes needs help with at least one core activity of daily living. Core activities of daily living include eating, sleeping, and hygiene. Disabilities can be any impairment that prevents someone from easily participating in an activity such as walking, talking, seeing, hearing, thinking, etc. Disabilities are not deficits. Some language

groups don't even have words for disabilities suggesting an inclusivity rather than othering.

Overall, attitudes toward people with disabilities have changed over time with increased awareness, support, and systemic and structural changes that make society more inclusive and accessible for people with diverse abilities. Think about how buildings and spaces are or are not accessible for various abilities. Even though we have policies against discrimination toward people with various abilities, it would not be difficult to find examples of stigmatizing and exclusion that continue today.

An important cultural safety consideration here is to examine your own possible biases and assumptions regarding abilities. The idea that everyone with a disability will necessarily want to 'fix' their particular issue if they could, has the potential to diminish someone who does not see their disability as problematic.

Critical Thinking

- How would you respond to a client who refused a cochlear implant that might allow them to hear? What if the decision was being made for a child?
- By insisting that such a choice would improve their quality of life, what message are you giving about how you perceive the individual?
- How would you engage in such a conversation in a culturally safe way?

Social media has provided increased virtual support for people with a variety of abilities such that people no longer need to be in close geographic proximity to get support in community with others sharing similar experiences.

Hearing loss is a health issue that has far reaching impacts. With around 1 in 7 people experiencing some level of hearing loss, it's certainly important to be aware of the possibility of hearing loss and how it can affect individuals, their families, and extend into community. Hearing loss among young children can impact early language development, as

well as relationships and behavior. Educational experiences and opportunities can be significantly impacted among school-aged children with hearing loss. As hearing loss increases with age, family relationships can become strained and people experiencing hearing loss may become increasingly isolated. For those who experience complete hearing loss, inclusion in family and social life is facilitated by the existence of hand language or signing but for some, hearing impairment added to other physical challenges can lead to social exclusion and isolation for the elderly, along with diminished roles and responsibilities.

Reading
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Poem
Taking account of all the various health issues discussed in this chapter, read the following poem while keeping in mind our interactions with so many people as health and human services providers and how our care processes and interactions can inadvertently dehumanize the very people we aim to help.

She Hate Her Body, by Whisper Young

She hate her body
But she can't tell nobody
'Cause other's eyes don't believe their ears even after they've seen what she say
For this they press fingers to her lips
Denying her thighs and hips
So she hate her body
With all its smears and smudges
From all those touches
See she's tried bleaches and accents
But none of them be erasin' the stench
Of all those hand and eye prints
And she hate they smell
So she hate her shell
She hate her body
'Cause it's called her's but it don't belong to her

It belongs to the others
With their stares and uninvited...touches
So she prays and waits for heaven
As she play invisible as hell
Swallowing her tongue so her lips won't tell
What her soul yellllllll
That she hate to breathe so free
And speak so full and loud
That she hate being denied yet passed around
That she hate her crown
It's too easy to grip for those attempting to pull her down
So she covers that shit to blend in
To blend in and be loved
'Cause her body want things it has needs
Needs that leave her cursed when she heeds them
But they call her worse when she don't meet them
She hate this body because everyone but her is allowed to decide where it goes, what it does, what it needs
Yet they deny her screams
They even deny her bandages when it bleeds
It's her's, her's, her's but they've confiscated it
They possess it for hatred and pleasure
So caught in their label making, boxing, shipping, pattern clipping while unique fabric stripping
That no one sees…..her
So she hate her body
And every day when she looks in the mirror she attempts to make up where she falls short till she hate her
And NOTHING can make her see invisible beauty
Trapped in bodies....who hate....themselves

Critical Thinking

- In what ways can healthcare and human services work lead to someone feeling like their body is not their own? What other reasons might the writer be alluding to for feeling their body was not their own?
- What actual legislation can you find in which the government dictates control of people's bodies?
- Can you come up with examples of how healthcare and human services work can lead to someone feeling like they cannot speak up to ask for what they need or if they do not agree with something?
- How can professional work do better? Can you come up with some examples?

Conclusion

This chapter examined only a few of the numerous health issues of concern in the U.S. Many of you will have areas of interest that you will hopefully pursue independently. Other topics such as gender and health, growth and nutrition, palliative care, and so on, could all just as easily have been discussed. However, as professionals, the onus is very much on you to seek out the information and learning necessary to make your professional practice culturally safe in any setting.

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