

From a Clinician's perspective...

A cultural competency tool as applied to a 15-year-old with dyslexia

(The following article was originally published in the newsletter Focus in the Spring of 2004, and was recently updated)

Human beings share an interwoven fabric comprised of many threads. Among these are honor, respect, generosity and trust. But for many reasons-socioeconomic status, ethnicity, age, gender, disabilities-we may not always feel honorable, important or empowered to share our feelings-both negative and positive-about who we are.

Carina, a 15-year-old high school Honors Student, has written courageously over the years about being dyslexic. This article will examine some of Carina's writings and identify the main threads that run through her accounts of her struggle with dyslexia. Then, the author will introduce a cultural competency model, The Four Character Values, as an assessment and intervention tool.

When we discuss "threads" in this article, we are referring to core values. When interwoven, our many threads create "layers" of culture. All of us, as individuals, carry many layers of culture. There are layers of the "inner circle," which include our age, race, culture, ethnicity, religion, socioeconomic background, language, disabilities, and immigration status. The layers of our "outer circle" relate to how we feel we are perceived by institutions and individuals. The outer circle is influenced by expectations and normative functioning based on the values of a majority group.

"My mother and I stand in the middle of the pool. We are surrounded in an island of light and the only thing in my world is her. I am like a monkey clinging to her body, she holds me above the water, above all shame and fear. We stand together completely alone, a mixture of chlorine with a hint of safety hanging in the air like a blanket. My cheek which is resting against her throat sends the vibration of her voice down my neck.

"The family friend that she is talking to nods his head in understanding, his white face made almost iridescent by the pool's light. My mother is telling him about the latest subject in my life. Something that makes me feel special. Something that makes me feel like I could fly.

"Later that night, in the same pool my mother goes over what she had told me months ago. "Carina," she says, "you know that you are different. You are special; you have something that makes you shine like no one else."

"That night the sky had been so black, it was like someone used a magic marker to color out the stars. The only light I had was my mother.

"Sometimes when people are dyslexic it takes them a longer time to learn things, because you see the world differently from most. Sometimes seeing the world in a different way is going to be difficult for you, but it's going to be something that makes you special. Something that makes you, you.

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ALL OF US, AS INDIVIDUALS,
CARRY MANY LAYERS OF
CULTURE.



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A cultural competency tool as applied to a 15-year-old with dyslexia

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"My Mother was telling me that I was dyslexic. She was telling me that I was born different, that life was going to be harder for me, because my brain and my eyes don't always agree on what direction a letter is pointing. But on that night in Florida, my mother tells me that I am not stupid or lacking what I should have, but that I am special. I am something amazing, different and unique, because of my "disability."

"The way that my mother handled telling me about my dyslexia changed my life. Growing up, I was aware that I had a learning disability, but to me I never viewed it as if I was lacking something that I should have had. My mother made me feel like I had a magic power. She taught me that even though I was going to struggle with dyslexia for the rest of my life, it was going to be something that ultimately gave me strength and insight that others could not achieve. I am forever grateful for that."

Two main threads in Carina's stories are those of loneliness and shame:

"We are surrounded in an island of light and the only thing in my world is her. I am like a monkey clinging to her body, she holds me above the water, above all shame and fear."

But at the same time, Carina carries a sense of inner strength: *"But on that night in Florida, my mother tells me that I am not stupid or lacking what I should have, but that I am special. I am something amazing, different and unique, because of my "disability."*

Carina's sense of inner strength may have been fortified by the core values of her family culture. Her parents, both human service providers, adopted a family policy of "no secrets." They felt that they owed it to their children to be open about Carina's dyslexia, and they continuously reassured her that although she at times feel "alone," she has family and friends who know about her disability and support her:

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Anne Fadiman, in her book, *The Spirit Catches You and You Fall Down*, relates a conflict between the California health care system and a Hmong family. The family perceived their daughter's seizure disorder as the result of a divine force that made her a very special person. On the other hand, medical providers saw the disorder as a horrible illness needing treatment. Two very differ-

ent takes on a disorder: is it a "blessing from God" or a "curse"?

A similar conflict occurred between Carina's parents and kindergarten principal in regard to her dyslexia. At first, Carina's parents felt a certain shame. They wondered if they had done something wrong (who passed the "bad" genes to her?) But they knew that their daughter was a very special little girl.

By the age of five, Carina would come home and tell her parents that her teachers were not showing how they really felt about her. On many occasions, she told her parents that the teachers confused her, because "they say nice words but their mouths are not smiling." Carina's parents were amazed at her ability to read facial expressions and capture the feeling of a moment.

While in pre-school, Carina would have trouble with the letters of the alphabet when she was expected to follow a sequence with other children. When her turn came, she would blurt out a random letter, and her teachers would say, "Carina, you're trying to trick me!" Little did the teachers realize that Carina was beginning to experience her learning disability.

A year later, when she entered kindergarten, she was extremely anxious and under pressure to perform. She loved to listen to stories and to look at the pictures, but she could not correctly read most of the words. There was a pattern to her reading that her parents noticed: she inverted words and she mixed the letters "b" and "p". She also had a hard time with words that were not representative of objects.

Carina was bright, sensitive and extremely caring towards others, but she was lonely and felt terrible about her learning progress. Most schools will tell parents to wait until first or second grade for testing for dyslexia, but Carina's parents requested an immediate evaluation.

Carina had all the symptoms of a child who was dyslexic. But the school was reluctant to call her dyslexic and in fact the principal tried to convince her parents that it would be better if Carina and her classmates were not aware of her disability. He believed that this would cause her unnecessary distress. Her parents disagreed with his recommendation and decided to validate her "anxiety" by telling her the truth.

When Carina seemed extremely nervous about going to school, her parents listened to her feelings and helped her express herself by narrowing them down until she was able to identify the one that was the most worrisome. One summer night before starting first grade, she expressed great anxiety about going back to school and how she was going to handle the fact that she still could not read. Her parents walked her through these feelings

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and she cried. She was scared of how she would be perceived by teachers and fellow students. Her mother asked her how she perceived herself and suggested that she give a speech to the class about her dyslexia. Carina asked her older sister to type the following speech as she recited it:

“It all began when I was a little baby. When I saw my mother’s elbow, a picture of my mother’s head would come to my head. Or, if I saw a kitten curled up in a ball- regular people would see a ball, but I would see a kitten. Some people who have dyslexia are very famous. In fact, they include, Whoopi Goldberg, Albert Einstein, Jay Leno and even Walt Disney. Albert Einstein had it the worst.

“The reason why it is so hard for me to learn how to read is that because when my brain sees a letter, it sees lots and lots of letters; upside down, sideways and even apart. Dyslexia is a condition that different brains have. It doesn’t really matter if it runs in your family, it just happens.

“The best way that dyslexics can learn how to read is probably memorizing the words and recognizing them by memory. The dyslexic’s brain works like anyone else’s brain, it’s just harder for them to learn how to read.”

Thus, Carina set the tone for the new school year-she was not hiding something that would be a part of her life from now on. She was free to learn! Carina and her family had added another layer to their fabrics: the culture of living with dyslexia.

Where did Carina get the ideas for her speech? Many were passed on by her parents as they read *The Gift of Dyslexia*, a book by Dr. Ronald Davis. In it, he asserts that “dyslexia is a thought process that results from an individual’s reaction to a feeling of confusion.” He further develops this concept by explaining that there are two main forms of thought:

1. Verbal thought, where an individual makes meaning of sounds and words by using a step-by-step process to formulate mental sentences. There is order and predictability as conceptualization is maintained at a speed of 2.5 words per second. Language is then broken down into three main categories of symbols: sound, meaning and what it looks like. With verbal thought, we “think with the sounds of the language.”
2. Nonverbal thought, which seems to occur in three dimensional images that grow into other images at a higher speed than speech. Because of its speed, this process occurs in the subconscious and can create a sense of confusion and anxiety.

Most people use both verbal and non-verbal thought. Dyslexic individuals, however, experience an evolution of mental images in

a way that makes it difficult for them to use words for which they do not have a picture image. For example, many dyslexic patients have trouble connecting the words “a” and “the,” as there are no mental images with which to associate them. Dyslexics do better with words that describe objects, like cat, ball, fireplace, house, bedroom, and beach.

In Dr. Davis’ description, a dyslexic would read the sentence, “the ball and the cat were not at the house” like this:

_____ ball _____ cat were not _____ house.

These blanks create a feeling of confusion and disconnect between images, making reading and writing difficult or even impossible in some cases.

At home, to help Carina cope with the dyslexia that would so heavily impact her life, her parents used story telling to share personal experiences of feeling different or of feeling a sense of loss. Their stories were genuine and were a great way for the family members to connect with each other’s inner and outer circles. Two years ago Carina wrote about one of these stories:

“My mother grew up in the Azores, a group of nine islands in the North Atlantic that are part of Portugal. When she was my age eleven, the Portuguese were having a civil war with the African colonies. The colonies wanted to become their own country. At night my mother would dream of losing her family. “What will happen to me if they die or get hurt?” Every day she thanked God that she didn’t have any brothers, so they would not take place in the bloodshed. The very thought of war filled her with sorrow and pain. It hurt her to think how many lives were being lost.

“With these feelings, you could just imagine how she felt when one sunny morning, she woke up to find the American navy infested on the beach of her childhood, where many summer days were spent laying on her back letting the sun’s warmth engulf her. Men in camouflage crawled in the sand with guns in their muscular hands, while amphibious boats painted in menacing green, parked on the sloping ground, looking awkward, as if wondering why they would be needed in such a beautiful place. The Americans were fighting in the Vietnam War. My mother knew this because she had read many articles about how they had burned villages, and killed many people.

“At that dreadful moment my mother thought the worst, that the mighty army that wore red, white and blue, had come to crush and destroy what and who she loved most. Luckily the American men had only come to her island for a drill. She recalled how at the end of their practice they threw out green army blankets and chocolates in the sand, instead of giving the children the treats from their

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hands, as if in some way the soldiers were greater than her friends and family. Also, the Americans were cocky and arrogant. "How dare they come to our shores and act as if we were below them!" From then on, during my mother's childhood America was not her favorite country!

"As she grew older she began to see that not all of the Americans were like the soldiers that she saw on the beach. "I think what happened" said my mother, now forty-four, "was that when I was younger I only saw one side of things, but as I got older I began to realize that there are always two sides of a conflict and that you have to see both of them."

In consideration of the many layers of Carina's cultural fabric, we recall a cultural competency model created years ago by the author of this article. This model, The Four Character Values, is a valuable tool for application as a clinician, a parent, a professional, and in everyday interactions with others.

The Four Character Values is based on the premise that all human beings have an inner "tree," with roots (honor), branches (respect), leaves (generosity) and a canopy of trust.

How we grow our trees and how we expose our roots will differ from individual to individual (inner circle) or from country to country (outer circle). But we all know that a tree with damaged or missing roots will die.

Honor is a sense of worth or dignity that is defined by a person's traditions, rituals, beliefs or history. In general they are buried, at a subconscious level. A person acts a certain way based on a value that has been passed on from generation to generation. A person or a family may also grow a value into a root so as to balance other values based on their ethnicity that for some reason did not work well.

New roots can be added to the tree as an individual is able to integrate information from the inner and the outer circle. In Carina's story, we see the family tradition of "no secrets" and open communication. These values were passed on by her parents through positive reinforcement and story telling as their attempt to add new beliefs to their original roots. Which in some ways went against her mother's upbringing values where secrets were ok when faced with a taboo issue and one needed to protect the child or the family's name from the forces of the outer circle. A root similar to the one of the principal in Carina's school.

Another root was being Portuguese, and her mother's account of not picking up the candy thrown on the ground by American soldiers conveyed a sense of honor. Carina's religious values were instilled by her parents and her Reform Jewish background, through rituals such as preparation for her Bat Mitzvah. Another

of Carina's "roots" or values, is the understanding that as a dyslexic person, she would better manage three dimensional objects and facial expressions than letters and numbers.

Respect is the acknowledgement of a person's roots. Respect can be broken because one does not always know other's roots or values. The good thing is that it can be fixed as long as the person who broke the branch does not justify his/her action by imposing their own roots or values. Respect can be manifested by listening to a person, and accepting their information as valid, even if you don't agree with it. In Carina's story, her parents showed her respect by listening to her stories about school and to her anxieties and fears. Rather than allow Carina time to describe the teachers' faces, other parents might have just said, "I just don't see it, honey. I'm sure your teachers like you a lot!" Carina's parents, by respecting her values, helped her to find solutions to the challenges of dyslexia.

Generosity is the willingness to do something out of the ordinary that creates a sense of common ground. Storytelling itself is a form of generosity, and when parents or therapists take time to genuinely echo their children or patient's fears in story form, the result is often a growing dynamic of trust, or as Carina put it, "a hint of safety hanging in the air like a blanket."

As a therapist or a parent, it may not always be easy to show respect through the acknowledgement of a patient or family member's roots, especially if they are different from your own, or if the person in question doesn't fit your preconceived notion of what is normal or acceptable for the group of which you perceive the person to be a part. For example, as you were reading the introduction to this article, you may have found it difficult to identify with Carina as an Honors Student, especially if your experience with dyslexic individuals has been limited to those whose cognitive and emotional levels have not reached those of Carina as this stage in her life. Or you may have found it difficult to reconcile Carina's Jewish religion with her Portuguese ethnicity.

Two strategies that may help you to a more "culturally competent" path are to identify and understand your own cultural triggers and to find common ground with your patients or coworkers, which is a form of generosity. Cultural triggers are any action that hurts your roots as an individual. These triggers are shaped by your own layers of culture, which as considered above, reach far beyond language and ethnicity into your cumulative life experience. Your cultural triggers are like "hot potatoes." When you know what makes you tick, you can then learn to better manage your reactions to certain situations and to pass those "hot potatoes" along so that no one gets "burned."

A way to establish common ground with your patients or colleagues and thus exercise professional generosity is to approach

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matters by first echoing the thinking of the person in question. Phrases like, "It seems to me that..."; "Is it true that...?"; "Can you tell me more about...?" and "Am I hearing you correctly when...?", all serve to open a culturally sensitive dialogue around delicate issues.

A culturally sensitive approach to the assessment and treatment of learning disabilities worked for Carina. Her parents were able to work at home and among themselves on their and Carina's inner and outer circles and did not seek therapy. With many of the Portuguese families that I treated, one of the first issues to be addressed is how they were going to handle their own outer-circles. We worked around the stigma of seeking help from an outsider. This value is felt less as the family's socioeconomic background changes.

This story is a personal story. As I was going to write about my clinical work I read my daughter Carina's work from when she was 5 years old, and I decided to share with you her story, her challenges and how our family coped with dyslexia. Also I wanted to share and illustrate the Four Character Value model that I use in my personal and professional life.

Carina's parents and later on, her teachers, helped her to express, understand and manage the challenges of dyslexia. Carina now is thriving as a student, a writer and a captivating young person!

Then, just like that, I had it. It was a poem about bears, honey, and rainbows, something that any satisfied six year old would have thought up, but I scribbled it down on piece of paper and showed it to my mother.

"Carina," she exclaimed after reading it, "that's beautiful, you're a writer!"

And just like that I was. My mother showed my masterpiece to my father who praised it, his voice glowing, then she showed it to my first grade teacher, who typed it up for me on a piece of paper decorated with rainbows. I can still remember thinking that my rainbow- decorated poem was the prettiest thing I had ever seen. To this day I love to write, and know that no matter what I end up doing, my skill of writing will be with me.

Sometimes I wonder if I love writing because I was destined to love it, or because my mother told me I was good at it. I wonder that if she had reacted differently about that poem, if she had laughed at it, or gone back to reading her newspaper after viewing it, if I would have still found my passion in words. Thanks to the reaction I received when I first showed my writing to my mother, I have had the confidence and the drive to expand my writing ability. No matter whether I'm writing an essay for history, short story for English, or a regular homework for science,

TWO STRATEGIES THAT MAY HELP YOU TO A MORE "CULTURALLY COMPETENT" PATH ARE TO IDENTIFY AND UNDERSTAND YOUR OWN CULTURAL TRIGGERS AND TO FIND COMMON GROUND WITH YOUR PATIENTS OR COWORKERS, WHICH IS A FORM OF GENEROSITY.

I find joy in putting my thoughts in words. That is the unique gift my mother has given me. She has showed me something that makes me happy, something that will be a tool for me no matter what I choose to do in my life.

In conclusion: find common ground with the individuals or families you treat. When one feels so apart, so distant, so "disgusted by a value or an action, take a deep breath and seen in your inner circle what does that feeling real means or tells about you. I recommend that you do not start a relationship not based on the differences, start by finding something in common, and connect around it. Recently Carina went to her nurse at the school and nicely the nurse told her that her name was the same as her daughter's maid. Perhaps this is not where one should start!

Another common mistake is: "I hear an accent, where are you from?" This is a very personal question that one needs to earn. Stay with "Can you tell me about how you feel about being here?" And if the conversation leads to the pressures (stigma) of the outer circle than lead the conversation, or tell a story that acknowledges the issues and provides some open ended tools.

There were times where I met with patients outside the clinic at first, so that the community did not see them enter a mental health setting, and part of the initial treatment was how to bring them into the clinic. With any other subject we therapists are good about meeting our patients where they are, but when it has to do with another type of difficulty, often we meet them where we are, but not where they are!

I find story telling a great way to learn about one's tree. As you are listening, draw a tree and begin to write the different values and behaviors in the right parts on the tree. Another option is that you can write all of them on a paper and then you and the patient place them on the right parts of the tree. I created the inner and outer circles concepts, but it may also be helpful to you as a therapist to use these concepts by drawing the circles, and you and the patient would then begin to fill them as you find it appropriate.

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Mental Health-Vocabulary

- Dyslexia** Dislexia is manifested by a difficulty in reading, but often is also expressed through deficiencies relating to spelling, pronunciation, and math, despite routine instruction, normal intelligence, and adequate opportunity to read.¹
- Generosity** The willingness to do something out of the ordinary that creates a sense of common ground. Storytelling is itself a form of generosity.
- Honor** A sense of worth or dignity that is defined by a person's tradition rituals, beliefs or history.
- IEP** IEP stand for an Individualized Education Program, which is an individualized plan designed to meet the specialized educational needs of a child. This program should set out specific goals for the student to reach and at the same time clearly define to all those that will be assisting the student, of any limitations that they may have.
- Learning Disorders** They are characterized by inadequate development of specific academic skills (i.e., reading, mathematics and written expression) that are not due to demonstrable physical or neurological disorders, Mental Retardation, or Pervasive Developmental Disorders.²
- Nonverbal Thought** Nonverbal thought, which seems to occur in three dimensional images that grow into other images at a higher speed than speech. Because of its speed, this process occurs in the subconscious and can create a sense of confusion and anxiety.
- Respect** The acknowledgement of a person's roots or values. Respect can be broken because one does not always know one's roots or values. Respect can be manifested by listening to a person, and accepting their information as valid, even if you don't agree with it.
- Threads** An individual's core values
- Triggers** Words, images, or smells that induce the individual into a specific action or bring back memories. An example may be that when an alcoholic sees liquor then s/he is tempted to drink.
- Values** Beliefs that are considered to be of high importance
- Verbal Thought** Verbal thought is where an individual makes meaning of sounds and words by using a step-by-step process to formulate mental sentences.

¹ Fauman, Michael Ph. D., M. D. Study Guide to DSM-IV-TR. American Psychiatric Publishing, Inc. 2002. pg. 24. [adapted from this source]

² Fauman, Michael Ph. D., M. D. Study Guide to DSM-IV-TR. American Psychiatric Publishing, Inc. 2002. pgs. 28-29.





PRESIDENT'S CORNER

CCCS' customer base continues to expand each and every day because our services are appreciated and respected, and because our prices are reasonable. We also have invested in establishing infrastructures that can help assure our customers that we are ready for The Joint Commission's Roadmap guiding standards and expectations for hospitals.

On October 18, CCCS attended a wonderful workshop at the Diversity RX Conference in Baltimore, with a panel that included many members who were instrumental in the making of the new The Joint Commission Cultural Competence Standards which will be effective in 2011. Essentially the Standards are divided into three major components that address the patient's needs regarding: 1. effective communication, 2. the collection and use of data, 3. and non-discriminative provision of care that meets the patient's needs.

EFFECTIVE
COMMUNICATION IS THE
DUAL UNDERSTANDING,
MEANING THAT ONE
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COMMUNICATION.

As I was listening to the presenters, I was reflecting on the role of the interpreter and was pleased with the decision by The Joint Commission that acknowledged that the interpreter plays an important role as a member of a treatment team. All along we have been training interpreters to be effective communicators, by impartially representing the voice of both the provider and the patient and his or her family. In the interpreting world, effective communication is understanding meaning and accurately conveying it into another language by not omitting, adding or distorting the original message.

According to The Joint Commission's definition of effective communication, it is the dual understanding of a message, meaning that one needs to develop tools so as to assess how much the patient understood from the communication and assure that the provider or caregiver also understood the patient. This patient centered approach to medicine assures that both parties understand messages that could be "ambiguous," so that medical attention can be provided in a caring, respectful and responsible way.

With all the mixed emotions one may have about interpreting services, I am so proud that in fact we, the interpreters often encourage the usage of one of the patient centered tools by using the teaching back technique. We do this by letting the provider know that perhaps one should check if the patient understood the information conveyed, or if the patient just seemed to have not been able to digest all the information received. Often, providers alerted by the interpreter regarding this concern over potential miscommunication, ask the patient to repeat the information. When this is done we are opening the doors to effective communication!

This two way process involves a negotiated dialogue, which involves the understanding and the integration of the information and the interpreter indirectly plays an important role by making the provider aware of a potential misunderstanding.

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However, LEP populations are only one of the populations addressed in the Standards. In this month's main article we tried to provide you with a bit of the clinical insight on how one's learning disability such as dyslexia, has its challenges and strengths. And in some ways it is as if one spoke another language. Often, interpreters speaking with an accent are considered less qualified and at times not as smart as the ones who have no accent. Carina in the article, in fact faced some of the downs with her dyslexia, where she worked hard to see this new language as an asset with its challenges because it made her feel different.

In Carina's case she survived being different because she was loved, was given the opportunity to be part of the dialogue around her learning disability and was given the tools to be able to handle her challenges and her gifts. She then was able to develop a greater understanding of herself in a world where the majority of the population does not have to decode their written language or have to wait and take a deep breath reorganizing their thoughts so they come out in a logical manner.

I am sharing this article with you because all of us at some point need to build bridges to close the gap between the perceived differences by checking in, and by providing an opportunity for a negotiated dialogue. As members of a care giving team, we need to be aware of the different ways a person may communicate, no matter who they are! Together as a team we can educate ourselves and integrate new behaviors, thus helping the people we care most about, and at the same time we can be faithful to those that pay our salaries and who put their trust in us!

I hope that at one level or the other, that our interpreters and our customers have had the opportunity to feel that our communication is in fact a part of a dual understanding, where we represent you and voice of the LEP consumers.

Thank you for all your support

Zarita Araujo-Lane, LICSW
President



Dr. Lane

What is the difference between cataracts and glaucoma?

It's funny you should ask, because until around 1705, the words cataract and glaucoma were not distinguished from each other. Cataract is from the ancient Greek word "katarhaktes" which means waterfall. It is a deposit of protein on the lens in the eye which makes the world look blurry, as if you were looking at the world from behind a sheet of flowing water. Glaucoma is a disease of the eye in which there is an increase in the pressure inside the globe of the eye. This pressure can be painless, but can lead to damage of the optic nerve, which can lead to blindness. Originally in the 1640's, glaucoma meant "cataract opacity of the lens." Glaucoma later had a color connotation, usually like "gleaming silvery," or later with a sense of "bluish-green" gray. The Greek word for owl is glauk from its bright staring eyes.

Glaucoma is a disease in which the fluid pressure inside the eye increases to the point that the optic nerve is damaged. Often, this increased pressure is painless and it can rise up to injure the optic nerve and eventually cause blindness. There are two kinds of glaucoma. One is open angle which simply means the way of draining the fluid from the eye, the trabecular meshwork, is shut down. This is the most common kind of glaucoma. The second kind is closed angle glaucoma. It can cause a sudden increase in pressure. Both kinds can be inherited, or can occur with injury. This disease is treated with medicine that can lower pressure in the eyes. This medicine is given in the form of eye drops.

Cataract is a clouding of the lens of the eye. It can occur with age; it can occur at birth; it can occur with an eye injury. Vision becomes cloudy and blurry. Cataracts can cause difficulty with glare at night and also during the day. Sometimes this can be corrected with contact lenses or glasses. However most require a surgical procedure removing the old lens with cataract, and replacing the lens with a new man-made lens. There are 1.5 million such cataract surgeries in the US each year, and nine out of ten of them result in vision improvement. It is not known what causes cataracts. There are some who think life long exposure to the sun's ultraviolet rays are the culprits, and if this is the case then wearing sun glasses from early childhood can help prevent cataracts.

Both cataracts and glaucoma can be cured if caught at early stages. And both, can be painless, especially true for incipient glaucoma. It is recommended that people 40 to 64 have a comprehensive eye exam every 2-4 years. If they are 65 or older, they should have a comprehensive eye exam every 1-2 years. If patients have diseases affecting their eyes, such as diabetes, it is recommended to have yearly exams.

1. www.etymonline.com
2. <http://www.webmd.com/eye-health/glaucoma-eyes>
3. <http://www.webmd.com/eye-health/ataracts/health-cataracts-eyes>



NH Corner

Documentary “UPROOTED: Heartache and Hope in New Hampshire” – Free and Open to All



*©IStockphoto.com/WilliamWalsh

The UNH Center for the Humanities has produced a documentary that focused on the relocation of five refugees as they resettle in the Granite State, New Hampshire. The five refugees open their hearts and allow us to explore their past as they speak about war, refugee camps, and being persecuted. All five refugees, Umija and Rasim Gusinac, Zahara Mahitula, Manuf Mahmood, and Udai Baskota come from different areas and different backgrounds, but are similar in so many ways. Below you will find the times and dates for the screenings. There will be a panel discussion after each presentation.

UPROOTED: Heartache and Hope in New Hampshire

Free and Open to All

PREMIERE SCREENINGS

October 23, 2010 at 2 p.m.

Red River Theatres, 11 S. Main St., Concord, NH

November 16, 2010 at 7 p.m.

Laconia Middle School, 150 McGrath St., Laconia, NH

November 18, 2010 at 7 p.m.

New Hampshire Institute of Art
French Building, 148 Concord St., Manchester, NH

For more information please consult the following webpage:
www.unh.edu/humanities-center

New Website

We all need a new look from time to time and CCCS, Inc. is no different. No doubt many of you have noticed that in the past few months we have updated our logo and even switched some of our colors up. Our purple is still there, but we have also added a few other colors to the mix. At CCCS, Inc. we have always strived to stay as current as possible in this ever changing environment. In an effort to do so, we updated our logo, colors and even completely revamped our website. You will find that it has a modern, efficient feel, and yet conveys the warmth that CCCS, Inc. is known for. Some of the new and updated features include retooled request forms that will make it much easier for new and current users to place their request. Some of these requests even include vendor codes that will allow returning customers to save time, as many of the fields will self-populate. Another feature includes a fully functional calendar page that will allow the user to quickly see the upcoming courses, and workshops along with an overview for each one. These are just some of the new features, and we encourage you to take a look as soon as it goes online towards the end of November, 2010.



Embracing Culture

www.EmbracingCulture.com

Upcoming Trainings

The Art of Medical Interpretation-60 hour course

Woburn, MA

The program targets interpreters at all levels and fosters an environment that gives each individual a measure of control over the learning process. Training sessions focus on interpreting technique, cultural competency, interpreting ethics, mastering medical terminology through the Samurai! method, developing specialized glossaries and increasing memory power. Learning is measured through role-play and interpreter evaluation tools. Class size is limited to 30 students and features spoken languages only. Language coaches will assist students develop target language glossaries through role-playing exercises. Language coaches will be provided to groups of 3 or more interpreters working in each target language.

The classroom work is supported by a new training manual; The Art of Medical Interpretation was designed to accompany this course and includes over 875 pages of interpreter practice guidelines, medical terminology, disease information, exercises, diagrams, quizzes and over 90 role-plays. It serves as a resource guide to best practices and terminology for interpreting and is also an essential tool for developing professionals after they complete the classroom course work.

The American Translators Association has approved the Art of Medical Interpretation 60-hour training program for 10 Continuing Education Points.

November 8-13, 15, 16, 2010 (Daily 9am-5:00pm)

November 16, 2010-January 20, 2010 (Tuesdays and Thursdays 6:00pm-10:00pm)

For more information please call Linda at 781-497-5066



Interpreter Award of Excellence

Ly Pham is a very responsible and likable interpreter and goes above and beyond to help CCCS, Inc. to accomplish its mission of providing the best services for our clients and their respective patients. CCCS, Inc. is proud to have interpreters like Ly in its pool of interpreters.

Upcoming Conferences

American Translators Association (ATA) 51st Annual Conference October 27-30 Denver, CO.

Zarita Araujo-Lane, LICSW, President of CCCS, Inc. will be one of the co-presenters for "Introduction to Medical Terminology," along with Maria Rosdolsky, Patricia M. Thickstun, and Armando Ezquerra Hasbun. (Wednesday, 9:00am-12:00pm)
www.atanet.org





LEAD-FREE KIDS FOR A HEALTHY FUTURE—NATIONAL LEAD POISONING PREVENTION WEEK

(The following article has been provided by the CDC as part of a campaign for "National Lead Poisoning Prevention Week" October 24-30, 2010.)

Nearly a quarter of a million children living in the United States have blood lead levels high enough to cause significant damage to their health, estimates the Centers for Disease Control and Prevention, based on data from a 2003–2004 national survey. If high blood lead levels are not detected early, children with such high levels of lead in their bodies can suffer from damage to the brain and nervous system. They can develop behavior and learning problems (such as hyperactivity), slowed growth, hearing problems, and aggressive patterns of behavior.

To raise awareness of the consequences of lead poisoning among parents and pregnant women who live in homes built before 1978, the Massachusetts Department of Public Health is participating in National Lead Poisoning Prevention Week (NLPPW) October 24–30th. The Massachusetts Department of Public Health joins CDC, the U.S. Environmental Protection Agency, and the U.S. Department of Housing and Urban Development in encouraging parents to learn more about how to prevent lead poisoning.

This year's NLPPW theme, "Lead-Free Kids for a Healthy Future," underscores the importance of testing your home, testing your child, and learning how to prevent lead poisoning's serious health effects.

Established in 1999 by the US Senate, National Lead Poisoning Prevention Week occurs every year during the last week in October. During this week, many states and communities offer free blood-lead testing and conduct various education and awareness events. For more information about NLPPW activities in your area, contact the Massachusetts Department of Public Health at 617-624-5585, or by email, paul.hunter@state.ma.us.



National Perspective: CLAS Standards Enhancement Initiative: Honoring it's 10th year.

In recognition of the 10th year of the National Standards on Culturally and Linguistically Appropriate Services (CLAS Standards), the Health and Human Services Office of Minority Health has sent out a call across the country for input from both the professional and public sectors on the current standards. Your comments and input to the *CLAS Standards Enhancement Initiative* call can be presented through their website, <https://classenhancements.thinkculturalhealth.org>, or in person during several public meetings scheduled across the country; i.e., October 22, 2010 in Baltimore, Maryland, November 4, 2010 in San Francisco, California and November 15, 2010 in Chicago Illinois. For more information as well as comments, visit the *CLAS Standards Enhancement* information on their website <https://classenhancements.thinkculturalhealth.org>.ⁱ

The CLAS standards have provided a wealth of information to healthcare organizations, providers, administrators, providing guidelines in the evaluation, planning and implementation of cultural and linguistic policies to healthcare organizations. These standards are ever more relevant today as the nation as a whole, according to the 2000 census, has become much more demographically diverse. Although the standards are non-regulatory in nature, they are intended to help health care organizations and providers develop effective communication policies to ensure "meaningful access to services"ⁱⁱ for LEP patients/consumers by supporting patients cultural and linguistic needs. The standards provide a significant and useful framework and are organized by topics and stringency of requirements; i.e., mandates guidelines and recommendations:

- Culturally Competent Care (Standards 1-3)
- Language Access Services (Standards 4-7)
- Organizational Supports for Cultural Competence (Standards 8-14)

For example, *Standards 4-7*, have been developed as a result of federal mandates for healthcare providers and provide a guide to organizations receiving federal funds and are based on Title VI accommodation of "natural origin discrimination."

- Standard 4: "Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency

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at all points of contact, in a timely manner during all hours of operation."

- Standard 5: "Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services."

Other standards or guidelines are "recommended by OMH for adoption as mandates by Federal, State and national accrediting agencies."ⁱⁱⁱ They are Standards 1, 2, 3, 8, 9, 10, 11, 12 and 13. For example,

- Standard 1 guideline states: "Health care organizations should ensure that patients/consumers receive from all staff member's effective, understandable and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred languages."

The CLAS standards in essence provide a discernible roadmap to health care organizations and providers, as well as providing fundamental steps to improving the quality of health care services to patients/consumers within their communities. The end result of providing guidance is to improve the standard of care for the patients/consumers that they serve in their communities. In essence, developing partnerships with the community can be achieved through the collection of good "demographics, cultural and epidemiological profiles." Standards 10-11 provide just such guidance. For example,

- Standard 10: "Health care organizations should ensure that data on the individual patient's/consumer's race, ethnicity, and spoken and written language are collected in health records, integrated into the organizations' management information systems and periodically updated."^{iv}

Collecting public health data to address equal access to health-care disparities is an issue that has been addressed locally, statewide and nationally. By having the language, culture and health information of a particular segment in the community, health information can be made available in various languages, and language access programs and culturally sensitive best practices can be implemented. For more information on this topic see the report "A New Way to Talk About The Social Determinants of Health" by Robert Wood Johnson Foundation. This report summarizes the social determinants of health which includes discussions on "The Use of Data and Information to Support-Not Make-Your Case."^{vi}

Several government organizations, including The Office of

Management and Business (OMB) have posted a summary of their revised standards for the "Classification of Federal Data on Race and Ethnicity." These revisions are available to assist organizations in the collection of race and ethnicity data. A summary and the entire standards can be found on the following website: <http://www.whitehouse.gov/omb/rewrite/fedreg/omb-dir15.html>.^{vii}

A summary of the OMB revised standards is as follows:



*©IStockphotos.com/CatherineYeulet

OFFICE OF MANAGEMENT AND BUDGET: Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity.

AGENCY: Executive Office of the President, Office of Management and Budget (OMB), Office of Information and Regulatory Affairs

ACTION: Notice of decision.

SUMMARY: By this Notice, OMB is announcing its decision concerning the revision of Statistical Policy Directive No. 15, Race and Ethnic Standards for Federal Statistics and Administrative Reporting. OMB is accepting the recommendations of the Interagency Committee for the Review of the Racial and Ethnic Standards with the following two modifications: (1) the Asian or Pacific Islander category will be separated into two categories -- "Asian" and "Native Hawaiian or Other Pacific Islander," and (2) the term "Hispanic" will be changed to "Hispanic or Latino."

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The revised standards will have five minimum categories for data on race: American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or Other Pacific Islander, and White. There will be two categories for data on ethnicity: "Hispanic or Latino" and "Not Hispanic or Latino."^{viii}

Various states have made data collection a priority such as the 2007 mandate in Massachusetts which ensures that the Human and Health Services (HHS) collect data on ethnicity and language. In New Hampshire, a recently completed report, funded by the New Hampshire Endowment for Health and prepared by Justin Schreiber and Amy Costello of the University of new Hampshire NH Institute for Health Policy and Practice was released. It is entitled "Assessment of Race, Ethnicity and Language Data Collection in New Hampshire Public Health Data Sets", and it provides readers with a research document detailing the importance of collecting data to close the gap in healthcare disparities amongst vulnerable populations.^{ix}

In addition to the CLAS documents, the Health and Human Services (HHS) Office of Minority health (OMH) offers a guide entitled "Implementing Language Access Services in Healthcare Organizations: A Patient- Centered Guide to Implementing Language Access Services in Healthcare Organizations." A Web-based version of the guide is also available. The guide provides information to healthcare organization when "planning, implementing and evaluating language access services to better serve their limited English proficiency patient population and [help decrease] disparities in access to healthcare."^x

The Joint Commission's work is another important resource addressing culturally and linguistically appropriate services for LEP patients. Their most recent report is a guide for healthcare organizations entitled, "A Roadmap for Hospitals: Advancing Effective communication, Cultural Competence, and Patient-and Family-Centered Care." The Roadmap is a helpful tool relating to language and culture that focuses on measures and practices for improving the quality of care. This document is organized into chapters, and here is a sample of a few of them: Admission, Assessment, Treatment, End-of-Life Care, Discharge and Transfer and Organizational Readiness. Recommendations and examples addressing data collection (race, ethnicity, and language) are addressed in the Organizational Readiness chapter. As recommended, data collection can be a powerful tool in assessing quality improvement activities supporting cultural and linguistic services in the community.^{xi}

We hope that you can participate in the CLAS Standards Enhancement Initiative currently underway.

Disclaimer: The information provided in this article is for general information only and should not be used as a source when making decisions. We always recommend that the reader become fully informed by visiting the websites recommended as well as any other reference that may be of relevance. Information has been copied, quoted or provided by the following organizations:

- ⁱ CLAS Standards Enhancement Initiative; <https://clasenhancements.thinkculturalhealth.org>.
- ⁱⁱ National Standards on Culturally and Linguistically Appropriate Services (CLAS); <http://minority-health.hhs.gov/tempaltes>
- ⁱⁱⁱ National Standards on Culturally and Linguistically Appropriate Services (CLAS); <http://minority-health.hhs.gov/tempaltes>
- ^{iv} National Standards on Culturally and Linguistically Appropriate Services (CLAS); <http://minority-health.hhs.gov/tempaltes>
- ^v United States Department of Health and Human Services Office of Minority Health: Implementing Language Access Services in Healthcare; <http://minorityhealth.hhs.gov/tempaltes>
- ^{vi} Robert Wood Johnson Foundation, Vulnerable Populations Portfolio, "A New Way to Talk About The Social Determinants of Health" report; <http://www.rwjf.org/vulnerablepopulations>
- ^{vii} To view the entire standards as well as the revisions, visit <http://www.whitehouse.gov/omb/rewrite/fedreg/ombdir15.html>.
- ^{viii} OMB Federal Register Notice dated October 30, 1997, revisions were implemented to OMB Standards to classify "Federal Data on Race and Ethnicity" <http://www.whitehouse.gov/omb/rewrite/fedreg/ombdir15.html>.
- ^{ix} University of NH Institute for Health Policy and Practice, prepared by Justin Schreiber and Amy Costello, funded by Endowment for Health, "Assessment of Race, Ethnicity and Language Data Collection in New Hampshire Public Health Data Set"; September 15, 2010. <http://www.dhhs.nh.gov/omh/documents/stateplan>
- ^x (HHS) Office of Minority health (OMH) guide "Implementing Language Access Services in Healthcare Organizations: A Patient- Centered Guide to Implementing Language Access Services in Healthcare Organizations." <http://minorityhealth.hhs.gov>
- ^{xi} The Joint Commission, A Roadmap for Hospitals: Advancing Effective Communication, Cultural Competence and Patient-and Family-Centered Care; c2010.

13	Dyslexia
12	CLAS
11	Values
9	Lead Poisoning
5	Tree
4	WebSite
2	Glaucoma
1	Learning Disability
Down	
10	IEP
8	Unrooted
7	Honor
6	Roadmap
3	Cataracts
2	Generosit

Answers to the CCCS Crossword-October



Embracing Culture

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