

Prescription 4: Cultural Sensitivity

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Cultural Sensitivity is a set of skills that enables you to learn about and get to know people who are different from you, thereby coming to understand how to serve them better within their own communities.



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Lesson A: *Understanding Your Own Cultures*

After completing this lesson, Members will be able to:

- Define *culture*.
- Describe 3 cultural attitudes, beliefs, and/or practices related to health and health care.
- List 2 ways that his/her own cultures influence his/her thoughts, actions, attitudes, and beliefs toward health and health care.
- Identify 5-10 cultures and subcultures represented in your center's patient population.

Lesson B: *Whom Do We Serve?*

After completing this Lesson, members will be able to:

- Name 2 attitudes / beliefs / practices related to health and health care for each of 4 cultures / subcultures served by the health center.

Lesson C: *Cultural Sensitive Continuum*

After completing this Lesson, members will be able to:

- Define *cultural sensitivity*.
- Draw the *cultural sensitive continuum*.

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HealthCorps Reader

Part One: Why Cultural Sensitivity Is Important

Culture shapes how people experience the world, yet it is not an easy term to define. Culture is a set of values, social practices, and forms of expression held in common by a group of people. People within the group usually identify themselves and are identified by outsiders according to ancestry, language, and traditions. Although culture is often determined in this way — by ethnicity— it can also involve geography, religion, and socio-economic status. In fact, some people identify themselves as a group because they have similar gender status, sexual orientation, physical or mental ability, academic or professional experience.

To further illustrate the complexity of this subject, there are many people who have been raised within one culture but then choose to blend in with another. In the United States, many natives and immigrants have blended into the dominant European-American culture of the last 250 years or more, leaving their original language, values, and practices behind. This is called *assimilation* and has led to the U.S. being called a “melting pot.” Centuries of experience with assimilation have shown that it sometimes causes great pain within families and communities and other times causes great success and development.

Acculturation is a more recent idea, defined as the modification of the culture of a group or individual as a result of contact with a different culture (American Heritage Dictionary), in this case a dominant culture. Through acculturation, people hold onto their original culture while also learning enough of the dominant language, values, and practices to move comfortably through daily life. With larger non-European populations than before and with more people encouraged to acculturate rather than assimilate, the U.S. has now come to be called a “salad bowl.”

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Service in community health care may involve a single culture that is new to the HealthCorps member or a number of diverse cultures. HealthCorps members develop effective skills for working with clients, their families, and communities whatever their backgrounds and identities.

Cultural Sensitivity

The term *cultural sensitivity* embodies the knowledge, understanding, skills, and protocols that allow an individual or system to provide services across cultural lines in the best possible way. Cultural Sensitivity permits us to respond with respect and empathy to people of all nationalities, classes, races, religions, ethnic backgrounds and other groups in a manner that recognizes, affirms, and values their worth.

In the health care setting, cultural sensitivity is important for several additional reasons. Cultures vary in their beliefs about the cause, prevention, and treatment of illness. These beliefs may dictate the practices that people use to maintain their health. Cultural attitudes can also affect the relationship with providers. Too often, we interpret the behavior of others as negative because we don't understand the underlying value system of their culture.

The natural tendency is to assume that our *own* values or customs are more sensible or correct – “more normal” – than someone else's. To provide quality care for any client, it is important to acknowledge that client's different beliefs and behaviors, adapting health care delivery to a cultural framework that is acceptable to the client. After all, we want to develop the full range of skills required to work successfully with people – whatever their background and self-identification.

Additionally, cultural Sensitivity is championed by the Bureau of Primary Health Care, within the federal Department of Health and Human Services, which provides funding for all Federally Qualified Health Centers. In recent years, the Bureau has placed a high priority on the development of sensitivity, knowledge, and skills around cultural issues. In their 1999 curriculum, *National Health Service Corps Educational Program for Clinical and Community Issues in Primary Care*, is the statement, “The practice of

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culturally appropriate medicine can ease health care delivery, improve patient adherence to therapeutic regimens, and minimize confusing communication.”

Diversity within a Group

Diversity within a group is often greater than it is between groups! Think of all of the ways that you differ from various other people within your own culture. For each of these characteristics, are you in the majority or a minority within your culture?

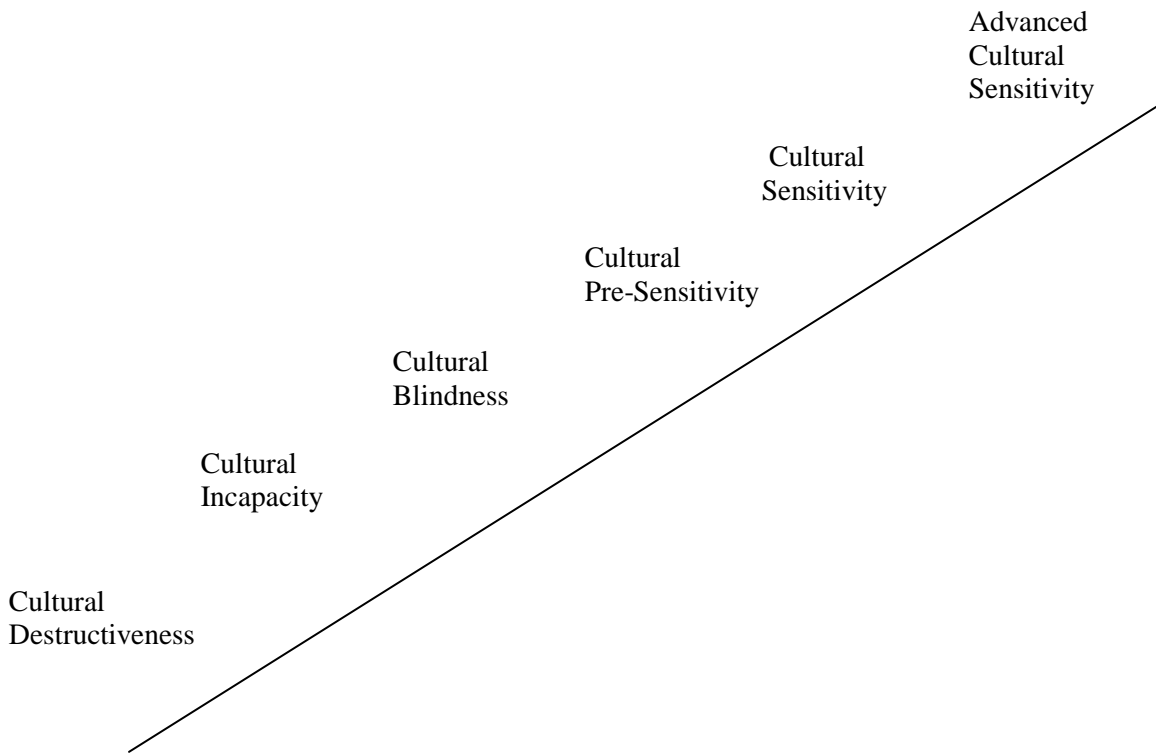
- Gender
- Age
- Length of time in the U.S. or your current region, county, city
- Religion
- Education
- Degree of assimilation (if any) from your family’s original culture
- Occupation choice
- Income prospects
- Familiarity or contact with your culture’s elders or other leaders

The Cultural Sensitive Continuum

Cultural Sensitivity may be viewed as a goal toward which we can all strive.

Accordingly, becoming culturally competent is a developmental process: there will always be room for growth. To understand better where each of us currently stands in the process of becoming more culturally competent, it is useful to think of the possible ways of responding to cultural differences. As delineated by Terry L. Cross, M.S.W., there is a continuum or spectrum that ranges from *cultural destructiveness* to *cultural proficiency*, that is, from negative attitudes and behaviors about diversity to positive ones. There are a variety of possibilities between these two extremes. Below is a diagram of the continuum followed by a description of the stages along the continuum.

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<i>Term & Definition</i>	Primary Characteristics
<p>Cultural Destructiveness. The most negative end of the continuum is represented by attitudes, policies and practices which are <i>destructive to cultures</i> and consequently to the individuals within the cultures.</p>	<ul style="list-style-type: none"> • Regarding others who are culturally different with prejudice; • Using power to control, exploit, or destroy others; and • Designing programs that specifically limit access to certain populations (by selection of location and service hours, physical inaccessibility, etc.).
<p>Cultural Incapacity. The next position on the continuum is where individuals do not intentionally seek to be culturally destructive but rather <i>lack the capacity to help</i> diverse clients or communities. The individual remains extremely biased, believes in the racial superiority of the dominant group, and assumes a paternal</p>	<ul style="list-style-type: none"> • Creating or promoting negative stereotypes; and • Having unrealistic fears of people who look, act, or believe differently.

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<p>posture toward "lesser" groups.</p>	
<p><i>Term & Definition</i></p>	<p>Primary Characteristics</p>
<p>Cultural Blindness. At the midpoint on the continuum, individuals <i>think they are unbiased</i>. They function with the belief that culture makes no difference and we are all the same. Such attitudes ignore cultural strengths and blame the clients for their own problems.</p>	<ul style="list-style-type: none"> • Assume everyone can access services in the same way; • Do not see the need even to adapt their oral and written communication; • Encourage people from other cultures to assimilate into the dominant culture, thus letting go of their own language, traditions, and values; • Believe that helping approaches traditionally used by their own culture and/or the dominant culture are universally applicable; and • Believe that, if the system worked as it should, all people — regardless of culture, language, race, sexual orientation, ability status, or anything else — would be served with equal effectiveness.
<p>Cultural Pre-Sensitivity. The next position up the continuum is where people <i>realize on their own</i> any weakness in their service to culturally diverse clients and <i>attempt to improve</i> their service.</p>	<ul style="list-style-type: none"> • Acceptance of and respect for difference; • Pleasure in recognizing and exploring differences, <i>for example</i>: asking a patient whether she has tried any cultural remedies recently for her condition and, if so, discussing politely any which are known to be either effective or dangerous; • Willingness to experiment and try new things, <i>for example</i>: asking to be taught a few words of the client’s language; • Continuous self-assessment about one’s own culture and its relation to others; • Careful attention to the dynamics of difference; • Continuous expansion of cultural knowledge and resources; and • Comfort in knowing there is no one right answer.

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<i>Term & Definition</i>	Primary Characteristics
<p>Cultural Sensitivity. Culturally competent individuals are <i>open</i> to the cultural experiences of others and to new information about cultures.</p>	<ul style="list-style-type: none"> • Treating people as individuals, not as stereotypes; • Examining one’s assumptions about difference; • Being open to the challenge of learning through others’ points of view; • Building empowered and interdependent relationships with people one regards as different; and • Demonstrating the willingness and ability to adapt the <u>organization’s</u> practice of health care to many different cultural situations.
<p>Advanced Cultural Sensitivity. This is the most positive end of the spectrum and represents the willingness and ability to adapt the organization’s practice of health care to many different cultural situations. Providers at this level seek to <i>add to their knowledge base</i> through culturally relevant research, then <i>develop new approaches</i> based on that research.</p>	<ul style="list-style-type: none"> • Hold cultural diversity in high esteem – understanding that it adds strength to a community; • Advocate for cultural sensitivity throughout the service system; • Include local census and other demographic data in their decision making about what services are needed and how best to provide them; • Analyze their particular organization’s way of “doing business” by evaluating location, hours, transportation, policies, procedures, and physical structure through the lens of the cultures in the community they serve; • Implement cultural training for both administrative and clinical staff; • Include cultural competency indicators in job descriptions; and • Ensure that terminology used is understood by patients; providing interpreters and translated materials for people who are hearing / speech impaired and those with limited English proficiency.

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Part Two: Cultural Sensitivity in Our Health Centers

Health centers strive to create programs that are culturally competent and address the needs of the individual client or the patient population. HealthCorps members should be attuned to issues of language, ethnicity, gender identity, sexual orientation, ability status, educational experience, and economic background (that is, their culture).

Now is the time to begin developing the key understanding, skills, and knowledge that will enhance *your* activities in the health center's community!

An interesting way to learn how to observe and evaluate relationships within a culture is to think about the framework of expectations, codes of behavior, and set of values within an organization. Yes — AmeriCorps, Community HealthCorps, and the health center each has its own *organizational culture*. We can analyze each of these cultures with a series of questions:

- What is expected of most or all people in the organization?
- How do they choose to communicate?
- Do they share belief in a mission or cause?
- Is some conduct discouraged or banned?
- Do we like some aspects of the culture and dislike others?
- Do people coming in contact with the organization have stereotypes about it?

Looking at organizational culture can make it more comfortable to ask and learn about such questions, because issues that sometimes divide people and make discussion uncomfortable — such as religious or political beliefs — are less involved in the daily life of this type of culture.

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Another interesting question is whether there are subgroups or minority groups inside the organization. Within the health center we tend to see people in different types of job as subgroups: *for example*: administrative, clinical, social work, and building maintenance. From this fact springs other important questions: Do the subgroups have stereotypes about each other? And do all groups have an equal responsibility to become culturally competent regarding the others?

Groups Are Made up of Individuals

Working with clients from diverse backgrounds takes a commitment to learning not only about the client's culture but also about the client as an individual. No culture or group is absolutely the same throughout (i.e., monolithic). *For example*: All people who must use wheelchairs to be mobile do not have the same medical condition. All people with brown skin are not from the same part of the world. All people from China do not understand one another when they speak. If we assume that the opposite is true, then we do not understand *either* the group or the individuals who belong to it.

There is a fairly straightforward way to assess our own attitudes and beliefs about another culture and the people who identify themselves as a part of that culture. It is recognizing the difference between *stereotypes* and *generalizations*:

A stereotype is an ending point. It is a standardized mental picture that represents an oversimplified opinion, a prejudiced attitude, and/or an uncritical judgment. Furthermore, the mental picture is shared by people within a group *about members of another group*. It is an ending, because no attempt is made to learn whether the statement fits the individual of that group or not. In fact, the mental picture is *so* firm that those who believe it might never think of checking it for accuracy.

For example: I meet Rosa, and I am told she is from Mexico. I say to myself, "Rosa is Mexican; she must have a large family." I am stereotyping. I do not ask Rosa if she has a large family nor I do not test my assumption in any other way.

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Stereotyping limits the way we serve members of the other group. *For example:* If all Mexicans have large families, then health educators should always talk to all Mexican women clients about contraception. Without the stereotype, we would instead adapt our approach to the individual and situation. We might decide to talk about it only if the client said she already had many children and it was causing a problem for her.

A generalization is a starting point. It is a vague or incomplete thought about another group and members of the group; the person having the thought is willing to incorporate further information to complete it or test its accuracy. Generalizations can come from what we read or see on TV or hear others talking about. We start thinking something like, “I guess such-and-such people are generally...”

For example: If, instead of thinking that all Mexicans have large families and therefore Rosa must have a large family, I think, “I’ve heard that many Mexican families are large. I wonder if Rosa has a lot of children”
— I am generalizing.

Generalizing is an opportunity to learn more about other people and their cultures. When we follow through and seek out more information, then generalizing has been helpful. However, if we don’t test our incomplete thought and instead repeat it to others, it may become a stereotype.



Bridging the Gap between Cultures

What can health center providers do to ensure that they are providing the best possible care to all clients?

- Treat each person as an individual and celebrate diversity among individuals;

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- Reflect on their own cultural background and values (what they learned growing up) so they can more easily find parallels between their own lives and the clients’;
- Build trust;
- Learn about various cultures, especially those in the community served;
- Explore factors that influence decision making in those cultures;
- Confront their own misconceptions about various cultures. Challenge themselves to identify when they are acting as if *their* cultural norms should be *everyone’s* norms;
- Develop face-to-face communication styles and written communication formats that are successful with most patients most of the time; and
- Keep in mind the particular psychosocial stressors relevant to certain groups. These include war trauma, living in refugee camps, migration, acculturation stress, and socioeconomic status.

What can health center management do to increase the usefulness of their services to the community?

- Assess and evaluate any current services targeted to specific populations for acceptance within the community and for effectiveness in health outcomes. Work to improve the comfort level and success rate;
- Make informed decisions on what the organization can and cannot provide, *for example*: Senior staff recognize the high value of providing medical interpreters for patients with little or no English skills, however there may be no money to offer that service;
- Advertise and offer their services through natural channels within the community, *for example*: newspapers put out by that community for its members, other newspapers and local radio stations in the language of the community served; and

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- Use terminology that is understood by the members of the community. Ensure that health center staff learn words and phrases used in the other language(s) to describe certain critical symptoms and events.

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Part Three: A Variety of Culturally Defined Behaviors

This part of the HealthCorps Reader on cultural sensitivity provides information about some culturally defined behaviors – and their underlying values – which can affect the level of communication and understanding in a health care setting.

The value of time. Our sense of time is a learned characteristic, like all of culture. Groups that have less experience with formal schooling and hierarchical employment structures, commuting to work or using public transportation, are less likely to employ strict time measurement in daily life. Some groups place other things ahead of “being on time” and “not wasting time.” We can see the clash between health centers booking all examinations, tests, and classes strictly by time and community members who tend to present for their appointments 30, 60, 90 minutes later than scheduled.

This is not a moral issue; that is, neither “side” is morally right or wrong. However, the patient *does* want to be helped and the center *does* want to be of help. While the patient bears some responsibility for learning the health center’s way of working, the center bears the larger share of the effort to bridge the gap.

The cultural issue of time is not to be confused with other reasons a patient is late, such as poorly run public transportation or lack of a clock or watch.

Literacy and language. Oral communication is frequently the best way to provide information, at least initially. Whether the client speaks English comfortably or another language, they may not be able to read in *any* language. When providers sense that this is the case, they can probe gently, *for example*: “Would you like me to say that again?” “I can repeat the information while we go over the pictures, would that be helpful?” “We have a brochure on pregnancy in both English and Spanish. Do you have someone at home who can read it to you?”

When asking patients to complete medical history forms, providers should keep in mind not only predominant language and level of literacy – but also that patients may be

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unfamiliar with standardized forms with check-boxes, multiple-response options, rating scales, and “skip-to” directions.

Personal identity. Within some cultures, people are not defined or named individually. Instead, their names and behaviors relate solely or primarily to their parents, their extended family, or their spouse.

Decision making. Decisions regarding medical screening and intervention may not be decided by the individual in a particular culture, but by the family as a whole. This means that the patient may not be in a position to give consent while in the doctor’s office, instead returning home, discussing the matter, and calling back another day.

How people treat and talk about their bodies and bodily functions tend to be strictly determined by cultural and religious beliefs. Even for individuals who have chosen to leave their culture/religion, these behaviors are learned so early in life that they can be difficult to change. The health care provider must be ready to observe and learn what makes people uncomfortable. Patience will be needed when a client finds it embarrassing to describe symptoms or says firmly that they are not allowed to follow a particular treatment.

Meanwhile, some cultures put a high degree of trust in the personal physician regarding all health matters and will follow his/her directions conscientiously.

Respect for authority. For some ethnic groups, their public etiquette may prevent a person from raising questions because to do so implies doubt in the doctor’s opinion or knowledge. Thus the patient may make an effort to please the health care provider rather than explore the medical situation as the provider’s partner in the treatment.

Comfort level with the individual service provider. Community members arrive with their own stereotypes and generalizations. A given client may be uncomfortable with a provider’s age, gender, sexual orientation, educational level, or race. When this occurs, it is **not** about the provider personally, but it can affect how well a provider’s, health

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educator's or outreach worker's ideas, suggestions, materials, and programs are accepted in the community.

Appropriate vs. inappropriate questions. Culture, religion, and direct personal experience tend to determine the types of questions that an individual feels are prying, too personal, and even unsafe. *For example:* To discuss income may be considered boasting and therefore impolite; for other people, it may be shameful if they are poor. Religion may place strict limits on discussion of sexual practices; perhaps it is only permissible woman-to-woman and man-to-man. And those who have lived for any length of time under dictatorship may worry that the health center will know too much about them, something that was very risky in their past.

Consider the many different ways there are to ask a question. In face-to-face interviewing, some clients respond comfortably to very direct questions. For others, it works best to ask a series of more subtle and indirect questions that ultimately lead to the same type and amount of information.

Experience with medical research. Members of several racial and cultural groups (around the world and in the U.S.) have been used as subjects in medical research without their informed consent. People have heard of instances when the confidentiality of medical records was not protected. At the same time, some U.S. communities have been studied over and over by doctoral students and others for the same health issue or neighborhood condition without anyone coming back to take action and improve the situation.

All of these can cause community members to be skeptical or even afraid of sharing any personal information.

Bad luck. Members of some cultures choose not to behave or speak in certain ways because they believe that to do so will bring on "the evil eye." *For example:* Some do not speak in positive terms about their spouse, children, or possessions because they feel it brings attention which in turn can cause bad luck.

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Self-identification. People self-identify in many different ways. *For example*, on the west coast of the U.S., the term *Hispanic* is often considered derogatory and *Latino/Latina* is more politically correct. But on the east coast it is acceptable to use the term *Hispanic*. Similarly, some individuals prefer the term *African-American* while others prefer *Black*. It doesn't take much time to find out from a client what he or she prefers.

Another issue is not so much about terminology as it is about being grouped with others solely or primarily due to one's looks. *For example*: A person who is generally considered to look Asian actually prefers to be identified as Pacific Islander. The health center may also have clients who physically look male but self-identify as female.

Culturally Related Styles of Communication

Communication is so important in establishing a good relationship between yourself and the community member that the subject should be looked at in great detail. Think how important communication is to making the correct diagnosis and ensuring that the patient follows through correctly on health education sessions.

Nonverbal Communication

- **Silence.** Some cultures view silence as awkward, however others are quite comfortable with periods of silence.
- **Distance.** The most comfortable physical distance between two people varies according to culture.
- **Eye contact.** The amount of eye contact that is comfortable varies with each culture. Some are comfortable with looking people straight in the eye; others have been taught not to make eye contact. Staring is considered impolite in some groups. However, if we avoid eye contact or break eye contact too frequently, it the client may misinterpret it as disinterest. If a provider is unsure, how can s/he show s/he cares — without being intimidating? S/he can sit *next* to the person rather than directly across, thus reducing the need for eye contact.

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- **Facial expression.** Showing emotion varies by culture from very expressive to very passive.
- **Body language.** The position, gestures, and motion of the body can be interpreted differently depending on culture. The use of hands is a common vehicle for nonverbal expression. A firm handshake may be a positive gesture of goodwill in some cultures while others prefer only a light touch or no handshake at all. Standing with hands on hips may imply anger to some clients and dominance to others. Pointing or beckoning with a finger may appear disrespectful.

How can you set people at ease? Conservative use of body language is wise when you are uncertain as to what is appropriate within a cultural group or with an individual. Observing the client's actions and interactions can give you clues. Being open with clients and asking general questions about body language can also help.

Verbal Communication. *How* we speak is always as important as *what* we say.

- **Making yourself understood.** Many of us have found ourselves speaking louder to a person who has little understanding of English, as if volume will solve the problem. We probably do this unwittingly, making things very uncomfortable for the other person!
- **Formality.** Seniors and people from certain cultures view being addressed by their first name as too familiar and inferring disrespect. Asking how someone prefers to be addressed is the easiest solution. When in doubt, we can start with the more formal address (“Mrs. Hampstead”) until the client asks us to use the more familiar form (“Oh, please call me Sandy.”)
- **Slang and technical jargon.** Although people sometimes use slang to make their communication seem “friendlier,” it can be very confusing to those without a strong English vocabulary. Medical and other technical terms increase efficiency between trained professionals but will not help most community members.

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Cultural sensitivity is a useful tool to build effective relationships with clients so that they receive the best care possible. It is also a dynamic tool: we can always learn more about *other* cultures, their value systems, beliefs, and behaviors — as well as *our own*.

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Lesson A: *Understanding Your Own Cultures*

Worksheet: *Self-Identification Diagram*

Instructions:

1. *On the center of this page, draw a circle large enough to write your full name inside.*
2. *Write your full name in the circle.*
3. *Draw a straight line out from the circle like a spoke from the hub of a wheel.*
4. *At the end of the spoke, write a fact about yourself. It could be your age, gender, ethnicity, nationality, occupation, or anything else.*
5. *Continue making spokes and writing a different fact about yourself at the end of each.*

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Lesson B: *Whom Do We Serve?*



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Lesson C: *Cultural Sensitive Continuum*

Worksheet: *Definition of Cultural Sensitivity*

Instructions:

- 1. Cut up this sheet so each of the 13 words and phrases is separate.*
- 2. Rearrange the words to make a definition of cultural sensitivity.*
- 3. Glue the words in place on the back of the previous page in the Participant Guide.*

THOSE PROFESSIONALS

IN CROSS-CULTURAL SITUATIONS

IN A SYSTEM **AND**

AMONG PROFESSIONALS

CONGRUENT BEHAVIORS

TO WORK EFFECTIVELY

OR **AND**

POLICIES THAT COME TOGETHER

ATTITUDES **OR**

ENABLE THAT SYSTEM

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Lesson C: *Cultural Sensitive Continuum*

Worksheet:

Scenes along the Continuum of Cultural Sensitivity

Instructions: Your facilitator will assign you one of the following scenarios.

#1: “I can’t see why all of these immigrants can’t learn to speak English — I did!”

#2: “I am who I am because of the culture into which I was born.”

#3: “All cultures essentially treat all people the same — why do it any differently?”

#4: “Arranged marriages are acceptable in my culture.”

#5: The health center produced health education materials in six languages to address the needs of families.

#6: “It’s okay that Mr. Goldstein cannot come to the parent group on Saturday, because that is his Sabbath.”

#7: “I was raised in a family that values education.”

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#8: “While on a home visit with a newly immigrated family, I asked them why they decided to come to the United States, so I can learn more about their cultural values.”

#9: “My friend Kim Yu eats different types of food and speaks a different language because of her racial and ethnic background.”

#10: “I think it’s just wonderful that we have so many different cultures all blending into one!”

#11: The local hospital does not have an interpreter available when a Vietnamese-speaking family, of which there are many in our area, arrives seeking services.

#12: During their Pre-Service Orientation, the HealthCorps Team meets with community residents to learn more about the cultures whose members they will serve.

#13: “I think it is completely unacceptable that people have pre-marital sex.”

#14: “The USA is a salad bowl where cultures are intermixed and yet maintain their own identities.”

#15: HealthCorps members conducting health outreach to a Buddhist community speak with the community’s elders before implementing their outreach activities.

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#16: “I think it is truly great to have so many different cultures and languages in the US.”