Section 2: What is Cultural Aptitude?

Cultural Aptitude
Cultural aptitude is a tendency, capacity, or predisposition to learn or understand another’s culture. It is a continuous transformational process that allows an individual to improve cognizance of another’s cultural knowledge, skills, attitudes, beliefs, and values. Cultural aptitude is a pertinent component of patient-centered care. Employing cultural aptitude equips the nurse to proficiently interact with the client(s) to provide culturally sensitive care and improve the health outcomes of individuals, families, communities, and aggregates. Cultural aptitude incorporates individual and group culture, cultural competence, cultural humility, and cultural safety.

Culture, Cultural Competence, Humility, and Safety

Culture
Leininger defines culture as the learned, shared, and transmitted values, beliefs, norms, and lifeways to a specific individual or group that guide their thinking, decisions, actions, and patterned ways of living and is passed from generation to generation (Leininger, 2002, p. 47). Hall (1975) paralleled culture to an iceberg. He proposed that, like an iceberg, only 10% is visible on the surface and that 90% of culture is not readily seen or identified. The 10% that can be seen is described as surface culture and include behaviors, traditions, and customs that are easily observable with touch, taste, smell, and sound. The 90% of the iceberg that is not seen or easily identified is described as deep culture. Deep culture is an individual or group’s worldview that includes core values, beliefs, attitudes, assumptions, and perceptions. Gaining an understanding of deep culture broadens the interpretation of culture beyond race and ethnicity and expands the understanding of views such as religious beliefs, interpretation of body language, notions of self, beauty, friendship, modesty, and cleanliness, views on marriage, raising children, gender roles, etiquette, attitudes towards social status and age, and the importance of time and space. Employing cultural aptitude aids us in learning more about the deep culture that makes up their worldview and influences decision-making. When individuals from different cultures meet, they are often unfamiliar with the 90% of culture that exists below the surface. If deep culture is not explored, it can contribute to assumptions, stereotypes, and biases.

Cultural Competence
Cultural competence refers to a set of culturally congruent practices, behaviors, and policies that allow nursing professionals to deliver high-quality services in a variety of cross-cultural scenarios. Cultural competence is an essential requirement in nursing (Albougami, 2016). Cultural competence is having the knowledge, understanding, and skills to respond respectfully and effectively to people of all cultures, languages, classes, races, ethnic backgrounds, religions, ages, abilities, spiritual traditions, immigration status, sexual identity, and other factors in a manner that recognizes, affirms, values, and preserves dignity (Danso, 2018; Loftin et al., 2013). Culturally competent providers value diversity and respect individual differences; however, cultural humility must be incorporated to interact effectively with culturally diverse populations. A critique of employing cultural competence alone is that it suggests there is a categorical knowledge that can lead to bias and discrimination and that it donates an endpoint to becoming fully culturally competent (Khan, 2021).
Cultural Humility
Cultural humility involves understanding the complexity of identities, that even in sameness, there is a difference, and that one will never be fully competent about the evolving and dynamic nature of an individual’s experiences (Khan, 2021). Therefore, cultural humility is a lifelong process of self-reflection and self-critique whereby the individual not only learns about another’s culture but starts with an examination of our own beliefs and cultural identities (Yeager, 2013). Cultural humility does not focus on competence or confidence and recognizes the more an individual is exposed to cultures different than their own, they often realize how much they do not know about other cultures (Yeager, 2013).

Campinha-Bacote (2018) coined the term ‘cultural competemility’ to describe this synergistic relationship between cultural competence and cultural humility. The origin of cultural competemility is the deliberate blending of the terms cultural competence (compete) and cultural humility (mility). Campinha-Bacote asserts cultural competemility requires healthcare providers to maintain both an attitude and a lens of cultural competence and cultural humility as they engage in cultural encounters, obtain cultural knowledge, demonstrate the cultural skill of conducting a culturally sensitive cultural assessment, and become culturally aware of both their own biases and the presence of “isms” (e.g., racism, sexism, ableism, classism, ageism, anti-Semitism, heterosexism, colorism, ethnocentrism).

Cultural competence and cultural humility: apposition rather than opposition. Both process (cultural humility) and product (cultural competence) are needed to interact effectively with culturally diverse populations. When cultural competence and cultural humility are authentically exercised, cultural safety occurs in healthcare delivery, decreasing health disparities and improving health outcomes.

Cultural Safety
A social justice framework underpins cultural safety and requires individuals to undertake a process of personal reflection. Cultural safety is a holistic and shared approach and creates an environment that is safe for people where there is no assault, challenge, or denial of their identity, who they are, and what they need. It is about shared respect, shared meaning, shared knowledge, and experience of learning, living, and working together with dignity and purposeful listening (Williams, 1999).

Cultural safety advocates that professionals and institutions work to establish a safe place for clients that is sensitive and responsive to their social, political, linguistic, economic, and spiritual concerns. Cultural safety is more than an understanding of a client’s ethnic background; it requires healthcare providers to examine themselves and the potential impact of their own culture on clinical interactions.

Culture Care
Culture care incorporates cultural aptitude and emphasizes considerations of a client's beliefs and heritage when developing a healthcare plan. Culture care requires healthcare providers to acknowledge that individuals belong to different cultures, therefore, necessitate treatments that respect the uniqueness of each individual.

Culture care emphasizes consideration of a client’s worldview when developing a healthcare plan that respects the uniqueness of each individual and their culture. Culture care recognizes when an individual meets another person(s) from a different culture, assumptions are made literally from the tip of the iceberg (surface culture). To ensure clients adhere to their healthcare plan, the healthcare provider must apply cultural aptitude to understand deep culture and provide culturally congruent care. Table 2.1 outlines definitions and characteristics of cultural competence, cultural humility, and cultural safety.
<table>
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<th>Definitions</th>
<th>Characteristics</th>
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<tr>
<td><strong>Cultural Competence</strong></td>
<td>Having the knowledge, understanding, and skills to respond respectfully and effectively to all people in a manner that recognizes, affirms, values, and preserves dignity.</td>
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<td><strong>Cultural Humility</strong></td>
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<td><strong>Cultural Safety</strong></td>
<td>Ongoing self-reflection and self-awareness and holding themselves accountable for providing culturally safe care, as defined by the client/individual and their communities. Is measured through progress towards achieving health equity.</td>
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### Implicit Bias

Implicit bias is attitudes, stereotypes, or opinions that we possess and unconsciously affect our understanding, actions, and decisions. Implicit bias contributes to health disparities through its effect on communication patterns and clinical decision-making. Implicit biases are mental associations individuals make about various social groups that can impact understanding and actions. They differ from explicit biases, which are opinions about various social groups that are conscious and purposeful (Rodriquez, 2021).

Implicit bias contributes to health disparities through its effect on communication and clinical decision-making (Rodriquez, 2021) and deteriorates client-provider trust and the client’s adherence to the plan of care. Implicit bias refers to the unconscious, unintentional assumptions one has about others. Whereas explicit bias is the conscious, intentional opinions one forms about others. Often, implicit and explicit biases are based on factors associated with SDOH, such as socioeconomic level, societal positioning, education, occupation, geographic residence, weight, gender, race, ability, clothing, and other assumptions. Cultural aptitude requires health providers to evaluate their own biases, attitudes, assumptions, stereotypes, and prejudices that may be contributing to a lower quality of healthcare.

### Changing the Paradigm

Employing effective community actions (upstream factors) requires cultural aptitude of the individual and community. Cultural aptitude, consideration of deep culture, and engaging community members in decision-making processes will positively influence individual actions (midstream factors) and decrease the number of individuals requiring service actions and tertiary care (downstream factors). With awareness of culture, intervention strategies, and their relationship to SDOH, nurses can decrease health inequities. Employing the concepts of cultural aptitude and being conscious of implicit bias will help to decrease the marginalization, prejudice, and discrimination that still exist with individual aggregates related to race, ethnicity, sexual orientation, gender identity, age, disability, socioeconomic status, and geographic location, poverty status, and employment. Changing the paradigm of how we approach health care and employing cultural aptitude can help reduce the health disparities associated with SDOH.