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How to Integrate DEIB Into the Curriculum and Clinical Training

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A principle of patient- and family-centered care is honoring a shared vocabulary which supports mutual respect and inclusivity among patients, families, and health care providers. Clinicians who practice patient-centered care are encouraged to dedicate time to listening attentively to clients' lived experiences, thereby fostering deeper understanding and connection. A key aspect of connecting with patients and families is recognizing and acknowledging diversity, equity, inclusion, and belonging (DEIB) through the words we use.

The personal stories shared by two different caregivers this semester further clarified this concept of word choices. During a presentation, one caregiver explained that it was traumatic for her to hear the preschool evaluation team label her child as nonverbal. She prefers the term preverbal. Another caregiver titled her daughter's presentation "Nonverbal Communication is my Superpower." These perspectives strengthened students' understanding that the same word can significantly affect feelings of inclusion and belonging.

In didactic classes and clinical rotations, faculty and clinical instructors discuss that inclusive vocabulary may evolve for various reasons; however, the most essential terms are those preferred by clients and caregivers themselves. This principle is grounded in the Universal Design for Learning, underscoring the importance of proactively including individuals rather than reacting after exclusion has occurred. Intentional language is a simple yet powerful gesture that aligns with trauma-informed care. Patient-informed and trauma-informed care are intricately linked, each serving as a relationship-based approach to create a safe environment. These models focus on reducing stress, anxiety, and cultural biases while simultaneously empowering clients and validating their autonomy (American Academy of Pediatrics, 2025).

What additional strategies are we using to promote a shared, respected experience or DEIB in the curriculum and clinical training? In our programs, students complete ASHA's Cultural Competence Check-In: Self-Reflection tool (2021). Small group discussions are facilitated to identify areas where students may feel less comfortable and to collaboratively develop strategies for personal and professional growth. In clinical settings, graduate clinicians provide teacher education in the teacher's preferred language and learn greetings and closings in that language to reciprocate the warm welcome extended by our community partners. Service learning projects are designed with careful consideration of clients' diverse needs, including race, gender, ability, age, access, interests, and preferences. By doing so, graduate clinicians created switch-adapted items that were relevant and equitable for all participants.

Adopting new perspectives and methodologies can provide valuable insights to guide curriculum and clinical training. During the recent CAPCSD Conference, Dr. Kimberly Green introduced the cultural compass. The south arm of the compass features a mirror for self reflection, encouraging educators and students to examine their biases and refine how principles of diversity, equity, inclusion, and belonging are addressed in both coursework and clinical practice.

Young et al. (2021) developed an anti-oppression curriculum that teaches students to reflect on their power, privilege, and positionality; identify and remove racial, gender, and language biases from treatment materials; explore strategies for increasing awareness of and reducing social determinants of health while improving access to services; and thoughtfully consider their communication with and about clients. Additionally, students are encouraged to actively engage with individuals with varying abilities. Other Communication Sciences and Disorders (CSD) programs have developed diversity-focused mentorship initiatives and launched community engagement projects aimed at underserved populations (Steward & Mishra, 2022).

Recent literature highlights the value of a three-tiered approach to culturally responsive education that encompasses awareness, knowledge, and skills (Robinson et al., 2023). Instructors can facilitate student development by helping them critically examine their values and biases, expand their understanding of social and health disparities, and build practical skills through clinical practice and partnerships with community organizations supporting diverse groups.

Wainscott (2025) describes a Framework of Inclusive Dispositions that teaches cultural humility by identifying personal beliefs, reviewing case studies with coached role-plays, sharing missteps, and responding to shared vulnerabilities. The Framework also teaches a person-centered perspective through intentional language, which reinforces the lesson learned from my guest presenters this semester: “language ascribes value; contributes to access and identity" (p. 77).

The integration of DEIB into the curriculum emphasizes that culturally responsive education is not an isolated topic. It is an ongoing framework woven throughout academic and clinical experiences. Faculty, students, clients, and caregivers each contribute valuable perspectives that shape how future clinicians develop cultural humility, inclusive communication practices, and patient-centered care. Integrating DEIB into coursework, clinical supervision, service-learning, and reflective practice encourages students to recognize how language, bias, privilege, and access affect therapeutic relationships and outcomes. Collectively, these approaches cultivate an educational environment that values belonging, respects lived experiences, and prepares clinicians to provide equitable and compassionate care across diverse communities.

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