# A Guide to Cultural Competence in the Curriculum

## *Occupational Therapy*

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# A GUIDE TO CULTURAL COMPETENCE IN THE CURRICULUM: Occupational Therapy

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# Preface

## Purpose of this Guide

This curriculum guide has been prepared by the Center for International Rehabilitation Research Information and Exchange (CIRRIE) under a grant from the National Institute for Disability and Rehabilitation Research. Its purpose is to provide a resource that will assist faculty in occupational therapy programs to integrate cultural competency education throughout their curriculum.

CIRRIE's current work with pre-service university training, complements previous CIRRIE publications designed primarily for in-service training, most notably a 12-volume monograph series, *The Rehabilitation Service Provider's Guide to the Cultures of the Foreign Born* (CIRRIE, 2001-2003), and *Culture and Disability: Providing Culturally Competent Services,* a book that summarized the series (Stone, 2005). Because of CIRRIE's funding mandate from the National Institute for Disability and Rehabilitation Research, its focus in the area of cultural competency is on the cultures of persons who have come to the US from other countries. Consequently, the primary focus of this guide is on the cultures of recent immigrant groups, rather than US-born persons. Cultural competency education should certainly address issues related to US-born minorities and Dr. Nochajski addresses her activities to both recent immigrants and US-born persons from a variety of cultural backgrounds.

## Philosophy and Approach

This Guide is a curriculum guide. Its objective is to provide a resource to faculty who wish to include or strengthen cultural competency education in their program and courses. Certain limitations are inherent in all curriculum guides. While there are certain common elements or competencies in most professional programs, there are also variations among different institutions in how these are organized into specific courses. Moreover, even courses that have similar objectives may use different titles. We have attempted to provide material that could be included in most occupational therapy programs, regardless of their specific curriculum structure. Its purpose is to enhance existing curricula by making available to instructors resources, case studies, and activities. This material can be adapted by the instructor as needed, in courses that are specific to cultural competence, or infused into other courses in the curriculum.

At the university level the CIRRIE approach to cultural competency education includes four main principles.

*1. Integration of cultural competency into existing courses, rather than creation of new courses*

Although the academic credentialing standards for programs in the rehabilitation professions now require cultural competence, the curricula of most programs are already overloaded. This makes it difficult to add new courses and as a consequence, content involving cultural competence usually becomes incorporated into existing courses retrospectively and in small doses. More importantly, a separate course on cultural competence can make the topic appear to students as isolated from the "real" set of professional skills that they are required to master.

Students may consider it an interesting topic but one of little practical importance. Moreover, by separating cultural competence from courses that develop practice skills, it becomes abstract and difficult to relate to practice.

Another reason for integrating cultural competence into existing courses is that students have an opportunity to see its implications and apply its principles in a variety of contexts. They also see that it is not just a special interest of one faculty member but an integral part of many aspects of their future practice that is supported and embraced by all faculty. When it reappears in their coursework each semester, their knowledge, attitudes, and skills in this area develop and deepen. The CIRRIE curriculum development effort has identified specific types of courses in the occupational therapy curriculum where cultural competence may be most relevant, and we have identified or developed activities and materials that are appropriate across the curriculum.

*2. Development of cultural competence education that is profession-specific, rather than generic*

CIRRIE's prior experience with providing cultural competency workshops for in-service training strongly suggests that an off-the-shelf generic approach is less effective than training that is specific to the profession in which the competence is to be applied. Generic training must be understandable by all rehabilitation professions, so examples, terminology, and concepts that are specific to one profession must be avoided. As a result, cultural competence becomes more abstract. With profession-specific training, students are better able to see the relevance and applicability to their profession, not as something outside its mainstream. Consequently, CIRRIE's approach is to work with faculty from each profession to analyze their curriculum and incorporate cultural competence into it in ways that seem most relevant to that profession.

*3. Multi-disciplinary case studies*

Although CIRRIE's general approach is profession-specific, we have found that studies developed in one program can sometimes be adapted for use in other programs. For example, a case scenario developed for a course in occupational therapy may be useful in courses in physical therapy, speech therapy, or rehabilitation counseling. The general facts of the case may be presented to students from each program, but many of the problems, questions and assignments related to the case may be different for each of the professions. The use of common case studies provides an opportunity to analyze cultural factors from a multi-disciplinary perspective, which is often the type of setting in which rehabilitation is practiced.

4. *Making materials available to instructors*

Most instructors realize the need for the infusion of culture into their curricula, but they may be reticent to incorporate culture into their courses if the burden of creating new materials is added to their normal course preparation. CIRRIE has approached this dilemma through specific strategies to allow instructors easy access to cultural content. Hence this guide was written. These materials are also available online at http://cirrie.buffalo.edu/curriculum/. The website was created to organize cultural materials into inter-disciplinary and discipline-specific assignments, case studies, lectures, reference materials, and classroom activities. This information will be expanded and revised based on feedback from users in universities nation-wide.

## How to Use this Guide

Curriculum committees and other faculty groups may wish to consult this guide to examine the ways that cultural competency can be infused across a curriculum and identify ways in which this approach may be adapted to the specific context of their program.

Individual course instructors can identify the sections of this guide that relate most closely to the courses they teach. They can then see how others have included cultural competency in such courses. The resources that are suggested in the guide may be seen as a menu from which instructors can select those that fit their course and their teaching style.

Prior to the main portion of this guide that pertains specifically to occupational therapy, we have included a section that presents suggestions and resources that are generic in nature and could be used in any of the rehabilitation professions.

We hope that this guide will be useful to those who are committed to strengthening this aspect of our professional programs in rehabilitation. We also understand that many institutions have created or identified resources that are not found in this guide. We welcome your comments and suggestions to increase the usefulness of future versions of this guide.

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## References

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## About the Authors

**Dr. Susan M. Nochajski** is a Clinical Associate Professor at the University at Buffalo, Department of Rehabilitation Science. She holds BS and MS degrees in Occupational Therapy and a Ph.D. in Special Education from the University at Buffalo. She has over twenty years of clinical experience in occupational therapy working primarily with persons of all ages with developmental disabilities. Dr. Nochajski teaches graduate level courses on the impact of the social and physical environments on the function, independence, and participation of persons with disabilities as well as an undergraduate course on human growth and development. Her current research interests focus on school to work transition for students with disabilities. She has previously conducted research on the effectiveness of assistive technology and environmental modifications in maintaining function in persons with developmental and cognitive disabilities.

**Mary Matteliano**, MS, OTR/L, has over 20 years of rehabilitation experience in the area of adult physical disabilities. She has been a clinical assistant professor in the Department of Rehabilitation Science at the University at Buffalo since 1999. In addition, she is the project director for "Cultural Competence in the Curriculum" for four rehabilitation programs. This is a NIDDR funded project through the Center for International Rehabilitation Research Information and Exchange (CIRRIE). Ms. Matteliano has also participated in and co-directed the study abroad program, Health in Brazil, in 2004 and again in 2006. She is currently pursuing her PhD in Sociology; her research explores the provision of culturally competent health care services to those who are from underserved groups.

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# Part I: Transdisciplinary Instruction for Cultural Competence

*Mary A Matteliano, MS, OTR/L, Project Director of Culture in the Curriculum, CIRRIE*

## Introduction

Rehabilitation services for persons with disabilities are provided in a variety of settings including medical facilities, schools, and the community. The recipients of these services are referred to as patients, students, clients, and consumers, depending on the setting. Henceforth, for the purpose of this guide, we will refer to the recipients of services as clients and students. In all settings, the team approach is valued, and the client or student benefits when each discipline is able to focus on its area of expertise in a collaborative manner. It is not unusual for clients or students to receive therapy from a variety of professionals during their course of treatment. In fact, a client or student may receive some combination of occupational therapy, physical therapy, rehabilitation counseling, and speech-language therapy simultaneously. Additionally, rehabilitation professionals frequently request consultations from other professionals and ask for another discipline's involvement in a case. As a result of these frequent interactions among rehabilitation professionals, a team approach develops in which each provider recognizes and often supplements the unique role of other professionals. Likewise, rehabilitation professionals learn from each other in these settings and are provided with opportunities to appreciate their commonalities. Therefore, it seems fitting that CIRRIE create not only guides that are discipline specific, but also transdisciplinary, containing foundational information for use in all four programs. By providing general content, the expressed needs for cultural competence education can be transferred across rehabilitation programs and serve to unify this intent. With this in mind, the transdisciplinary section of this guide was written to provide an introduction to cultural competence instruction for occupational therapy, physical therapy, rehabilitation counseling, and speech-language therapy programs.

Rehabilitation disciplines use various frameworks and models of service provision that are specific to their practice. A conceptual framework that shows utility for all rehabilitation programs is the International Classification of Functioning, Disability and Health (ICF) (World Health Organization [WHO], 2001). The ICF can be used by rehabilitation professionals to organize and identify relevant domains for assessment, treatment, and evaluation of outcomes (Reed et al., 2005; Rentsch et al., 2003). It also provides a common language for health care providers, thereby enhancing communication among disciplines (Rentsch et al., 2003). By examining the ICF and its classification system, we can further understand the areas of concern that impact the provision of culturally competent rehabilitation services. The ICF guides rehabilitation specialists in the assessment process by providing a framework that addresses client or student needs beyond the impairment level, thus establishing their capacity to perform within the natural environment (American Occupational Therapy Association, 2002). Contextual considerations, the external or internal influences on the client or student, impact the rehabilitation process and must be addressed. For example, external contextual influences may include the individual's immediate environment as well as cultural and societal influences. Internal influences are more personal in nature and include the individual's gender, race, ethnicity, and educational level, among others (WHO, 2001). It is useful for us to use the ICF as

a framework that addresses individuals' performance capacity within the context of their personal and external environment. By understanding this, rehabilitation professionals will improve their ability to address the influence of culture on client or student performance. In the next section we will examine a model that will be used to specifically guide the infusion of cultural competence into the curriculum for rehabilitation programs.

Although there are several models to choose from that can be used to guide curriculum planning, we have chosen the *Campinha-Bacote* model as a guide for teaching cultural competency to students who are enrolled in rehabilitation programs (Campinha-Bacote, 2002). According to this model, achieving cultural competence is a developmental process, not a onetime event. The *Campinha-Bacote* model (2002) consists of five constructs: (1) cultural awareness, (2) cultural knowledge, (3) cultural skill, (4) cultural encounters, and (5) cultural desire. These constructs are intertwined; cultural desire is the foundation of this process and provides the energy that is needed to persevere on this journey (Campinha-Bacote, 2002). Cultural awareness, the ability to understand one's own culture and perspective as well as stereotypes and misconceptions regarding other cultures, is a first step (Campinha-Bacote, 2002; Hunt & Swiggum, 2007). The development of cultural knowledge can be introduced and explored throughout the curriculum, both in courses that are general as well as courses that teach specific therapeutic skills. Cultural skills, the ability to evaluate a client or student and develop a treatment plan, build on the foundations of cultural awareness and knowledge. Courses that emphasize clinical and educational skills can be used to help students develop a skill set that will address the unique needs of the individual. Cultural encounters can be dispersed throughout the curriculum, with the emphasis on the application of practice skills, as the student advances in the program.

## Implementation of the Campina-Bacote Model into Curriculum Design

The next section of the guide is organized into five objectives that reflect the Campinha-Bacote model for achieving cultural competency. The objectives are further divided into specific goals along with suggestions, activities, and resources to achieve the stated objective.

**Objective 1: Students will Improve their Cultural Awareness**

*1a. Students will demonstrate the ability to examine and explore one's own culture (including family background and professional program).*

*1b. Students will identify stereotypes, biases, and belief and value systems that are representative of the dominant culture in the United States.*

*1c. Students will demonstrate an understanding of how one's own biases and belief system may subtly influence the provision of rehabilitation or educational services and lead to cultural imposition.*

In our experience, we have found that courses that emphasize communication and therapeutic interaction offer opportunities for exploration and understanding of one's own culture. These courses are usually taught to students prior to acceptance into a professional program or during the first year. These introductory courses will sensitize students by providing information that promotes cultural awareness and knowledge, although a comprehensive program should

emphasize a continuum of cultural competence that is threaded throughout the curriculum (Campinha-Bacote, 2002; Kripaiani, Bussey-Jones, Katz, & Genao, 2006). Assignments that are specific to cultural awareness may include a class exercise in which students write about their own ethnicity/racial background. This leads to a class discussion about cultural awareness, stereotyping, and variations among cultures. Several exercises may be used within and outside of the classroom to assist students in improving their cultural awareness. They may be worked on independently or in small groups. Examples of classroom activities that may be adapted depending on the program are included in Appendix A.

Students may benefit from taking the "Implicit Association Tests" online and discussing the results in class. Project Implicit is a collaborative research effort among researchers from Harvard University, University of Virginia, and the University of Washington. There are several exercises offered on this website, and the general purpose is to elicit thoughts and feelings that are outside of our conscious control. Those who participate in these exercises are provided with a safe and secure virtual environment in which to explore their feelings, attitudes, and preferences toward ethnic groups, race, and religion. The outcome of this exercise is for students to understand that they may have an unconscious preference for a specific race, skin tone, religious group, or ethnic group. Students are provided with the opportunity to understand innate and unconscious attitudes that might influence their decision making ability in a rehabilitation setting. Refer to Appendix B for the Project Implicit (2007) website.

The Village of 100 activity takes about 10 minutes to complete and will also lead into some good classroom discussion (Meadows, 2005). Students must imagine that if the Earth's population was shrunk to 100 persons what the representation of certain racial/ethnic groups would be like in areas that include religious representation, sexual orientation, literacy, wealth, education, and living conditions. Many students are not aware of the privilege they have experienced by living in the US and are enlightened once they examine the rates of poverty and general deprivation that are experienced by the global community. Again see Appendix B for the Village of 100 website.

Many readers may already be familiar with the body ritual among the Nacirema vignette, but we have found that it continues to facilitate self-reflection among students (American Anthropological Association, 1956). Nacirema is American spelled backwards, and this narrative describes the daily rituals of American life from an outsider's perspective. Many of our commonly accepted practices seem very strange when seen through an outsider's lens. The purpose of this exercise is to help students understand that although the customs and rituals of persons from other cultures may seem strange, our customs and rituals may also appear odd. Bonder, Martin and Miracle (2002) have concluded that an ethnographic approach, such as the one used in the Nacirema vignette, helps students to gain a different perspective on their culture. Appendix B details information on the Nacirema website.

Self-assessment questionnaires and surveys encourage student self-reflection and lead to group discussions and the development of cultural awareness, cultural sensitivity, and appreciation for diversity (Spence-Cagle, 2006). Several activities that enhance student self-awareness include the *Self-test Questionnaire*: *Assessing Transcultural Communication Goals*, the *Cultural Values Questionnaire* (Luckman, 2000) and the *Multicultural Sensitivity Scale*

(MSS) (Jibaia, Sebastian, Kingery, & Holcomb, 2000) (Appendix C). *The Self-test Questionnaire*, *Assessing Transcultural Communication Goals*, was developed to help students understand their knowledge and comfort level with various individuals and groups that reside in the US. Some examples of groups that are represented on this self-test are: Native Americans, Mexican Americans, prostitutes, the elderly, and persons with cancer. The objective of the self-test is to facilitate discussion and develop insight among students on their preferences and knowledge about persons who are different from themselves.

The *Cultural Values Questionnaire* asks students to rate their agreement with a series of statements. Some of the statements demonstrate values that reflect mainstream society in the US including timeliness, stoicism, individuality, while other statements reflect values that might be preferred by societies that value interdependence over independence. This exercise can be used to facilitate discussion among students on values that may be preferred by the rehabilitation provider. Students can develop strategies that tailor rehabilitation programs for persons whose values are different from the provider or the institutions that provide services.

The *Multicultural Sensitivity Scale* consists of 21 statements, and students rate their agreement with the statements on a scale of one to six. The statements ask students to rate their comfort level and willingness to accept various cultures that are different from their own. This scale can be taken on an individual basis and then used to enhance classroom discussion on students' ability to accept, interact, and feel comfortable with clients or students who are from diverse backgrounds.

**Objective 2: Improve Student Knowledge of Diverse Cultures and Practices**

*2a. Students will understand various health, education, and disability belief systems and practices.*

*2b. Students will familiarize themselves with disability prevalence and risk factors among different racial/ethnic groups.*

*2c. Students will understand and identify racial and ethnic disparities in rehabilitation and educational services in the United States.*

*2d. Students will recognize and understand various cultural worldviews and disability beliefs and explanatory models.*

*2e. Students will identify instances when religious or traditional views may influence the client's participation in rehabilitation and educational regimens.*

After general and self-awareness exercises, students can progress to the development of knowledge about other cultures. Encounters in non-traditional settings offer opportunities for students to try out new skills with clients from diverse cultures with guidance and feedback from their instructors (Luckman, 2000; Parnell & Paulanka, 2003). Students may increase their knowledge about different cultures by visiting ethnically diverse neighborhoods, exploring ethnic supermarkets and restaurants, attending religious services that are different from their own religious backgrounds, and observing programs in ethnically and racially diverse neighborhood

community centers (Jeffreys, 2006; Luckman, 2000; Hunt & Swiggum, 2007). These introductory observational opportunities should be set-up as non-threatening encounters that lead to self-reflection through written assignments and group discussions (Hunt & Swiggum, 2007). A by-product of this self-reflective process is the development of an appreciation for ethnic diversity, religious practices, food preferences, family values, health beliefs, and neighborhood community programs (Griswold, Zayas, Kernan, & Wagner, 2007). Furthermore, encounters in ethnically and racially diverse settings allow students to develop confidence when encountering clients from diverse backgrounds (Hunt & Swiggum, 2007). However, both the instructor and students must keep in mind that one or two visits to a "different" neighborhood merely introduces students to the most obvious aspects of a cultural community. Only living and interacting with members of a community on a daily or long term basis truly opens students to a culture.

The acquisition of knowledge about specific cultures can be approached in several ways. Students can access the Center for International Rehabilitation Research Information and Exchange (CIRRIE) on-line monograph series (CIRRIE, 2003). The monographs focus on the top eleven countries of origin of the foreign-born population in the US, according to the US Census Bureau: Mexico, China, Philippines, India, Vietnam, Dominican Republic, Korea, El Salvador, Jamaica, Haiti, and Cuba. There is an additional monograph on the Muslim perspective. Assignments can be provided using a case study format with the monograph series as a resource.

Prior to clinical encounters, the use of case studies is also helpful in developing clinical decision making, self-reflection, and examining ethical dilemmas (Spence-Cagle, 2006). The case study format has been used to help students process, problem-solve, and apply strategies that will enhance their knowledge of culturally competent service (Lattanzi & Purnell, 2006). Therefore, case studies encourage the examination of the professional's explanatory model and clients' explanation of their illness experience. Explanatory models are the perceptions and beliefs that rehabilitation providers, clients, students, and their families construct about illness and disability (Kleinman, 1988; McElroy & Jezewski, 2000). They are cognitive and emotional responses based on cultural experiences (Kleinman, 1988). Therefore, explanatory models are not always transparently logical, and if the rehabilitation provider's communication skills are based on their own perspective, the client or student may experience discrimination. In addition, through the case study format, students can be encouraged to develop *culture-brokering* skills that further expand their appreciation of various belief systems (Kleinman, 1988; Jezewski & Sotnik, 2005). Examples of case studies and case scenario assignments, that are applicable across disciplines, are found in Appendix D.

We refer to the *culture-brokering* model in this guide because it has been shown to be useful in training rehabilitation personnel in identifying and devising solutions for culturally related problems. The *culture-brokering* model was adapted by CIRRIE for rehabilitation systems, and a training workshop was designed based on the model (Jezewski & Sotnick, 2005). The model has three stages: (1) problem identification, (2) intervention strategies, and (3) outcomes. *Problem identification* includes a perception of a conflict or breakdown in communication. *Intervention strategies* include establishing trust and rapport and maintaining connections. Stage three is *evaluating outcomes*, both successful or unsuccessful. Success is achieved if connections are

established between consumers and the rehabilitation system, as well as across systems. What makes this brokering model a *culture-brokering* model is a fourth component, *Intervening Conditions.* These are culturally based factors that must be considered at all three stages: analyzing the problem, devising appropriate strategies, and evaluating outcomes. The intervening conditions include a variety of factors including type of disability, communication, age of the client or student, cultural sensitivity, time, cultural background, power or powerlessness, economics, bureaucracy, politics, network, and stigma. The model is not a set of rules or steps to follow. Rather, it is a conceptual framework that can guide the service provider in analyzing problems and devising culturally appropriate solutions. For a more detailed description of this *culture-brokering* model, including its applications to case studies, see Jezewski and Sotnick (2005).

When implementing the *culture-brokering* model, students must understand that health and education seeking behaviors are shaped by the individual's cultural context, and most cultural groups are heterogeneous (Rorie, Pain & Barger, 1996; Menjívar, 2006). Caution within training programs should be exercised. Knowledge of various cultures and their practices, if not considered within the context of individuals and their unique circumstances, can result in destructive stereotyping. Stereotypes that are associated with particular cultures may affect the provision of rehabilitation services in adverse ways. Therefore, although knowledge of cultures is important, students must refrain from stereotyping and be aware constantly of the heterogeneity of persons within cultural groups (Campinha-Bacote, 2002; Juckett, 2005). There are many reasons for intra-cultural variations including the individual's level of education, socioeconomic status, reasons for immigration, and regional and local differences within the country of origin. In addition, the process of immigration is complex. Immigration may be voluntary, or it may be a decision based on persecution or economic hardship. This affects the immigrant's ability to improve social status and assimilate into a new culture. Assimilation is also affected by the human, cultural, social, and economic capital that accompanies the immigrant into the destination country (Alba & Nee, 2003).

**Objective 3: Improve the Student's Skill in the Assessment of Clients from Diverse Cultures and Practices**

*3a. The student will learn to determine client and student needs within the context of their culture.*

*3b. The student will become familiar with and demonstrate the use of assessments that respect and explore client and student culture and the impact it has on their disability.*

*3c. The student will identify culturally biased assessments and demonstrate the ability to modify or adapt the assessment to fit client and student needs.*

*3d. The student will utilize the client's family and/or extended family in the assessment process, if designated by the client or student.*

*3e. The student will demonstrate the ability to use a professional interpreter in the evaluation process.*

Students' ability to develop cultural skill depends on the first two constructs that were explored, awareness and knowledge. Skill development overlaps with practice and cultural encounters. Students in rehabilitation professions must understand how to use the interview process to formulate relevant treatment options for their client. Students must then be provided with clinical encounters that allow for the development of skill when working with clients or students from diverse cultures (Campinha-Bacote, 2002). Neighborhood community centers, schools, and adult day care facilities are several examples of potential sites that may offer diversity and contribute to students' fieldwork experiences (Griswold et al., 2007; Hunt & Swiggum, 2007). Through observations and clinical encounters, students develop and expand on their interviewing techniques, including the use of interpreters, the ability to become flexible with traditional assessment procedures, and an appreciation for the client's narrative (Hunt & Swiggum, 2007). The personal narrative, listening to clients or students tell their story, is best learned through clinical encounters (Griswold et al., 2007; Kripaiani et al., 2006). Students must learn when to leave aside traditional assessment procedures and encourage interviewees to describe their illness experience in their own words (Griswold et al., 2007; Kleinman, 1997). The person's view of disability does not necessarily surface when using standardized assessments that are popular among professionals (Ayonrinde, 2003; Becker, Beyene, Newsom, & Rodgers, 1998). Another approach is to adapt current assessment/evaluation methods and identify culturally relevant assessments within each rehabilitation field.

To understand the participant's perception of disability, interviewers can use a semi-structured format that incorporates the ethnographic principles of open ended questions (Babbie, 2004). Changes and adaptations can be made to the interview questions, according to the interviewee's responses. This format may facilitate the emergence of the interviewee's personal story. Students may also use a modified version of Kleinman's eight questions and incorporate this into their interview schedule. The questions may help providers understand clients by asking for a description of what their disability means to them (Kleinman, Eisenberg & Good, 1978). Caution should be used when incorporating these questions into the interview schedule since some individuals may not choose to discuss their disability experience in this manner. See Appendix E for Kleinman's eight questions.

There are many factors that should be considered by rehabilitation providers in culturally diverse settings, and a number of these should be elaborated on and examined in depth in the academic setting. Examples are:

- Cultures vary on their expectation of formality in clinical situations. For example, Asian Americans may be more formal, especially elders (Liu, 2005; Wells & Black, 2000). Thus, clinical encounters should reflect this style of interaction.

- Some cultural groups communicate in ways that are different from the direct style of communication favored by Americans. For example, some cultures communicate in a less direct manner and rely on the context and subtleties in style to get their message across (Jezewski & Sotnik, 2005).

- Many Latin and Middle Eastern cultures do not value time in the same way as Americans. They may prioritize personal commitments over time commitments in business encounters or in adherence to clinical appointments (Sotnik & Jezewski, 2005).

- Some cultures, for example those of the Middle East, expect long greetings and inquiries about family members and their states of health. They may also expect offerings of food and drink (Ahmad, Alsharif, & Royeen, 2006).

- The assistance of an interpreter should be used to facilitate communication; however, family members should not be used in this role, if possible. The dual role of family member and interpreter may cause conflict, and valuable information may be omitted (Dyck, 1992). Clinicians must become familiar with techniques on how to use an interpreter and seek interpreters who are well-trained and artful in the subtle negotiation process between client and provider (Ayonrinde, 2003).

- In some cultures, such as the Hmong, a husband or oldest son will make decisions for all members of the clan. The individual's wishes are deferred to a designated member in the clan (Leonard & Plotnikoff, 2000). Thus, it is important to ascertain who is the primary decision maker in the family and enlist his or her help in the diagnostic and rehabilitation process.

- All clients have a history prior to their disability. Providers must balance clients' history, present condition, and potential for the future. This process is best accomplished through the dual contributions of provider and client (Fleming, 1991).

- Certain occupations and daily activities may be defined in ways that are not familiar to the provider. For example, some cultures prioritize certain daily activities (e.g. hygiene, dressing, and eating) whereas others do not (Zemke & Clark, 1996).

- Assessment tools that evaluate individual differences and preferences, including the personal narrative, should be included in the rehabilitation process (Clark, 1993).

**Objective 4: Improve the Student's Ability to Develop Treatment Plans for Clients and Students from Diverse Cultures**

*4a. Students will apply previously learned knowledge and skills to develop culturally competent treatment plans in medical, educational, and neighborhood community settings.*

*4b. Students will utilize the "Culture Brokering Model" to recognize and identify conflict that is a result of cultural beliefs and values.*

*4c. Students will demonstrate the ability to use strategies that result in better rehabilitation and educational services for clients and students.*

*4d. Students will demonstrate advocacy skills for those groups that are underrepresented in the rehabilitation and educational systems and will negotiate and network among providers to assist clients and students in achieving adequate services.*

Cultural encounters allow students to apply classroom knowledge and techniques into real world settings. Students gain knowledge about different cultural backgrounds and achieve skill by learning verbal and non-verbal communication techniques. Effective learning is developed through experiences that help students become self-aware and appreciate cultural differences, thus developing acceptance and advocacy (Jeffreys, 2006). Just as students in health related curricula must fulfill fieldwork requirements to ensure that they are competent practitioners, they should also be provided with opportunities to demonstrate competence with culturally specific interactions. Provision of opportunities to gain exposure to various cultural and ethnic groups can be dispersed throughout the curriculum, at many different levels (Kripaiani et al., 2006). The progression may start with encounters that are mostly observational and progress to interactions that require formulating a plan of action, a treatment plan, or a community-based intervention. Our students have performed service work and implemented programs at refugee centers, neighborhood youth programs, international institutions, and community after school programs. As students progress through the curriculum, their cultural encounters will reflect their acquisition of cultural competence skills (Campinha-Bacote, 2002; Griswold et al., 2007; Hunt & Swiggum, 2007).

Contextual considerations that include the individual's process of immigration and assimilation should be incorporated into the assessment process. Several situations that are a result of immigration may impede rehabilitation. Therefore, students should pay attention to such factors as the disruption of family support systems and social networks, post-traumatic disorders experienced by asylum seekers and refugees, and the withholding of information that characterizes undocumented immigrants' worry about deportation (Ayonrinde, 2003). The *Culture-brokering* model (Jezewski & Sotnik, 2005) can be used to demonstrate to students that treatment planning is a process of negotiation. This problem solving model will help students recognize and identify problems related to cultural preferences or beliefs, facilitate conflict resolution through the process of negotiation and mediation, and better prepare them to advocate and network on the client's behalf.

**Objective 5: Students will Develop the Desire for Cultural Competency and Understand that It is a Life-Long Process**

*5a. Students will develop and demonstrate the ability to empathize and care for clients and students from diverse racial/ethnic groups.*

*5b. Students will demonstrate flexibility, responsiveness with others, and the willingness to learn from others.*

*5c. Students will exhibit "cultural humility," the ability to regard clients and students as cultural informants.*

By using the Campinha-Bacote Model, it is hoped that students will develop the final construct of this model, Cultural Desire. "It has been said that people don't care how much you know, until they first know how much you care" (Campinha-Bacote, 2002, p. 182-183). Cultural desire is a result of successful cultural encounters. Successful cultural encounters are the result of good preparation and the support and guidance offered to the student throughout the process. The student should understand that this is a life-long pursuit for the professional who has a true desire to practice in a culturally responsive manner.

Griswold et al. (2007) discuss the development of empathy and cultural humility among medical students who have participated in refugee clinics. During an encounter with an elderly Vietnamese woman, a medical student tossed his checklist aside as the patient began to cry and tell him about the loss of her family members. The student discusses a transformation in his approach: "…I was going through the checklist…as she started to cry it shook me…I stopped the interview…as the empathy kicked in, the checklist started to fall out of my head" (Griswold et al., 2007, p.59). Students may find interviews particularly challenging with persons who have suffered grave personal loss or who have been victims of torture. They may at first meet failure because they are unable to show openness and flexibility during the initial assessment. Since these encounters may be difficult, they will need to be provided with opportunities to debrief and discuss their cases with instructors and other students. Opportunities for self-reflection regarding their feelings, as well as the needs of their clients, should be encouraged by their instructors (Griswold et al., 2007). Self efficacy, the belief that one can achieve competence in areas of practice, motivates students to overcome obstacles and embrace the learning experience (Jeffreys, 2006). It is our goal that the outgrowth of these exercises will provide students with positive cultural experiences that improve their confidence, engage their interest, develop their ability to empathize, and result in the desire to provide culturally responsive rehabilitation services across settings.

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# Appendix A: Cultural Competence Classroom Activities

Many of these activities involve encouraging students to meet and interact with individuals from diverse backgrounds. While the experience is important, it is the opportunity to reflect upon the interactions and perceptions that will heighten cultural awareness. Reflection can be encouraged through journal writing, class discussion and debates, and role playing.

**Activities**

a**. Who Am I?** Students begin the process of cultural awareness by exploring their own backgrounds. **Student Assignment:** Investigate your own cultural background. Try going back three generations. Make a genealogical map of your ancestors including their country of origin, family, language(s) spoken, religion, education, occupation, and beliefs regarding health/disease, disability, and education. Be prepared to discuss how you obtained your biographies, from whom, and the information that was omitted or obscure. Other areas that define the culture may be included such as family roles and rules, family support networks, music, food preferences and eating styles, entertainment, clothing, child rearing practices. Think about and be prepared to discuss how cultural influences have been maintained, changed, or have disappeared across generations.

b**. Story Teller.** Ask students to interview someone in their own family who is an especially good story teller about family life. **Student Assignment:** Interview an individual in your family who has a repertoire of family stories. Record the story(ies) he or she tells about your family's history. What is the story about, and what does it reveal about your cultural, ethnic, linguistic, religious, and racial background? What did you learn from this interview that you did or did not know about your history? Ideally, this story telling activity should be audio/video taped so that it can be presented to the class.

c**. Pix Share**. Visual history helps students understand their cultural background. Ask students to share pictures of their family and the area in which they have lived most of their life. **Student Assignment:** Find family pictures across generations, if possible. Discuss how these pictures reveal your cultural, ethnic, linguistic, religious, racial background, and living environments. What did you learn from these pictures that you did not know about your family? To whom did you go for the pictures and information about their content? Discuss how the pictures are similar or different across class members.

d**. Family Differences.** Have students discuss how their own views on cultural issues such as family, religion, health, education, and disability differ from that of their parents or grandparents. **Student Assignment:** What are your family's views on family, religion, health, education, and disability? Compare your views on these topics with that of your parents and grandparents. Also discuss family perceptions of disability especially if there is a family member who has a disability. What rehabilitation services did the family and individual access and to what success? How does your the family view disability and rehabilitation services?

e**. I See My Community.** Ask students to make a video tape of what they think best represents their individual cultural background in their home community. **Student Assignment:** Prepare a video and audio presentation that illustrates what you think is important about your community. Topics might include description of your physical and social neighborhood, education and health care options, transportation, language(s) spoken, icons that represent the community, arts, schools, and assets and problems. Compare and contrast the presentations across students.

f**. New Arrival.** Have students interview someone who has recently immigrated to the US from another country. If the individual does not speak or has limited ability in English, students should use an interpreter. Keep in mind that these are sensitive topics and not all recent immigrants may want to discuss them. Only students who are especially sensitive and grounded in cultural issues should do this assignment. **Student Assignment:** Interview a recent immigrant to the US on topics related to why the individual came to the US, the process and problems in coming, similarities and differences between the old and new communities in which the individual lives, and views on healthcare, education, and disability. Another important topic is the meaning and structure of family in the culture. If the immigrant does not speak English, you may need to work with an interpreter. Class discussion should also focus on several issues including (a) how the interviewer felt working with an interpreter, (b) problems in doing the interview, and (c) belief systems that emerged regarding health, education, and disability. This interview might be repeated with someone who immigrated 10+ years ago to determine how time in the US influenced perceptions of health, education, and disability.

g. **Exchange.** Discuss the experiences students have had to open them to other cultures; e.g. travel, having an exchange student in their home or high school, and living or working with students from other countries. **Student Assignment:** Through what experiences have you opened yourself to other cultures? Describe these. What did you personally gain from traveling throughout the US or other countries or interacting with an exchange student? What issues did you face when you spent time in another country and culture? How did these issues change over time? How do you maintain contact with persons you met from another country? Compare your perceptions from before the cultural exchange, during, and now. How have your perceptions changed?

h. **Getting to Know You.** Encourage students to "get to know" someone from a different culture during the semester and keep a journal about the experience. Remember that visiting another community for a shopping experience will not fulfill the goal of this assignment. **Student Assignment:** Ask a fellow student from another culture if you might spend some time with him or her at home. Immerse yourself in another culture by participating in family and community activities, shopping in the community, and attending church, celebration, or other activities that represent the culture. You might also tutor or mentor a student from a diverse background and discuss this experience. What did you learn about the culture? What experiences were most revealing to you? How do you think you were perceived as a visitor to the community? What will you do to maintain contact with the individuals you met for this assignment?

i. **Cultural Conflict**. Another topic for discussion is cultural conflict. Ask students what cultural conflicts occur in their community and why. **Student Assignment:** What can be done to diminish or erase cultural conflicts? Discuss how media such as television, radio, and other

entertainment venues reflect general American culture and how this is interpreted in various cultures in the US as well as around the world.

j. **Community Visits.** Have students visit a school and a hospital that are comprised primarily of those from diverse backgrounds. **Student Assignment:** Visit a school, hospital, or other agency that delivers rehabilitation services to children and/or adults who are from diverse backgrounds. Discuss how the facility reflects various cultural backgrounds – e.g. staff, language, type and style of delivery of services or classes, inclusion of family, programming, architecture and design, etc. What differences in quality of health care and educational services are apparent?

k. **Continuing Education Possibilities.** Rehabilitation students need to realize that cultural competence is a "profession-long" process. **Student Assignment:** How can rehabilitation specialists increase or improve their cultural competency once they have completed their professional degrees? What types of continuing education programs are available through local, state, or national professional organizations? What other venues are available for continuing education regarding multicultural issues?

l. **Multicultural Preparation.** Caseloads in all types of rehabilitation settings reflect an increase in clients from diverse backgrounds **Student Assignment:** Interview a variety of rehabilitation professionals who work with multicultural populations on their caseloads regarding their academic and clinical preparation for this type of client. How well prepared were they and what have they done post graduation to improve their cultural competency? What suggestions on cultural diversity do they have for clinicians entering today's profession?

## Appendix B: Website Resources

Center for International Rehabilitation Research and Information Exchange (CIRRIE) website:
http://cirrie.buffalo.edu/monographs/index.html

The Project Implicit (2007) website:
https://implicit.harvard.edu/implicit/demo/selectatest.jsp

State of the Village Report website:
http://www.sustainer.org/dhm_archive/index.php?display_article=vn338villageed

Nacirema website:
http://en.wikisource.org/wiki/Body_Ritual_among_the_Nacirema

# Appendix C: Self -Tests and Questionnaires

The reader may refer to the CIRRIE Cultural Competence Website http://cirrie.buffalo.edu/curriculum/activities/index.html for information on the following questionnaires and resources:

- *Self-test Questionnaire: Assessing your Transcultural Communication Goals and Basic Knowledge*
  Reprinted with permission from: Randall-David , E., (1989). *Strategies for working with culturally diverse communities and clients*. Association for the Care of Children's Health (ACCH), Bethesda MD.

- *Cultural Values Questionnaire*
  Thiederman, S. B. (1986). Ethnocentrism: A barrier to effective health care. *Nurse Practitioner*, *11*(8), 52-59.

- *Muticultural Sensitivity Scale*
  Reprinted with permission from: Jibaja, M. L., Sebastian, R., Kingery, P., & Holcomb, J. D. (2000). The multicultural sensitivity of physician assistant students. *Journal of Allied Health, 29*(2), 79-85.

- Classroom Activities: *Cultural Visit, Observation Visit, and Participant Observation Visit.* Adapted with permission from: Luckman, J. (2000). *Transcultural communication in healthcare*. Albany: Delmar Thompson Learning.

# Appendix D: Case Studies

The following case studies are designed for students and readers across disciplines. One is specific to one or two professions (Study 1), some are designed for all disciplines (Study 2 and 4), and one is specific to speech-language pathology (Study 3). The case studies also differ in their design; some providing more detailed backgrounds (Study 2 and 3), others more study questions and cultural information (Study 2 and 4). Pseudonyms are used in all cases.

**Case Study #1 for PT and OT: Middle Eastern Low Back Pain Patient**

*Background*

Farideh Daei (*pseudonym*) is a 25 year old woman from Iran. Her physician has recommended a consult for physical therapy for low back pain. During the initial evaluation, Mr. Daei, her husband, answered all the questions directed to Farideh. When asked to rate her pain on a scale of one to ten, the husband answered, "I really don't think her pain is that bad, you can give her a three." The wife compliantly allowed her husband to answer all questions. The PT attempted a physical assessment of the back but had to limit her examination due to Farideh's reluctance to disrobe. The PT was upset after the initial evaluation and was not sure how to go about helping her client's back pain because she was unable to conduct a standard evaluation.

The physical therapist recommended a home assessment by an occupational therapist because Farideh has two children that she picks up and carries, a 2 year old and a 5 month old baby. The OT scheduled a visit to observe Farideh carry out her daily routine and made some suggestions for modifying her child care activities to protect her back. When the OT arrived at the house, she was surprised to find Mr. Daei home. He did not allow the OT any time alone with his wife and answered all questions. The OT found the situation disconcerting since she had to go through a third party in order to understand her client's daily routine. She did not feel she was able to truly assess her client's situation although she was able to show Farideh how to wrap the baby in a sling close to her body when carrying the infant. Farideh and Mr. Daei seemed agreeable to this modification.

*Student Reading*

Ahmad, O. S., Alsharif, N. Z., & Royeen, M. (2006). Arab Americans. In M. Royeen & J. L. Crabtree (Eds.), *Culture in rehabilitation* (pp. 181-202). Upper Saddle River, NJ: Pearson Education Inc.

Hasnain, R., Shaikh, L., & Shanawani, H. (2008) Disability and Islam: An introduction for rehabilitation and healthcare providers. *Monograph series for the Center for International Rehabilitation Research Information and Exchange (CIRRIE)*, Buffalo, NY: CIRRIE.

*Discussion Questions*

1. What can both therapists do to gain Mr. and Mrs. Daei's trust?

2. Do you feel angry at Mr. Daei for not allowing his wife to participate in the evaluation procedure? Why?
3. What are some other examples of how gender can have a strong influence on communication between the client and clinician?

## Case Study #2 for SLP, OT, and PT: Hispanic TBI Client

*Background*

Hernando Gonzales (*pseudonym*), age 63, incurred a traumatic brain injury (TBI) to the left and right frontal lobes and the left temporal lobe and a broken right shoulder and leg during a car accident on March 15th of this year. Mr. Gonzales was born and resides in Mexico and was visiting his sister, Maria, for a two month vacation when the accident occurred. This was his first visit to Buffalo, NY, though he has visited Miami, Florida, and San Antonio, Texas, several times in the past 20 years. Mr. Gonzales has been a widower for 6 months and has four adult children who reside in Mexico. Mr. Gonzales completed 9th grade in Mexico and works as a security guard at an industrial site. He speaks fluent Spanish and reads and writes Spanish at about a 6th grade level. Although he has taken English emersion classes for several years and his auditory comprehension of English is good, his spoken English is limited. Reading and writing English are basic and inconsistent. He is an ardent soccer fan, enjoys Mariachi music, and attends church on a regular basis.

According to his sister, Mr. Gonzales has a history of hypertension, prostate cancer, and osteo-arthritis. He had a partial knee replacement to the right knee three years ago. He wears corrective lenses that were broken during the car accident, and during the optometric evaluation to replace his lenses, early stage bilateral cataracts were noted. Three years ago Mr. Gonzales was diagnosed with a mild bilateral sensori-neural hearing loss during an employment hearing evaluation but refused amplification.

Following the TBI, Mr. Gonzales made good physical recovery. He received intensive occupational and physical therapy for four weeks in a medical rehabilitation unit. Therapies focused on gaining independence in activities of daily living (ADLs). Although Mr. Gonzales made marked improvement in ADLs, he continued to need prompting and reinforcement to initiate and complete activities such as dressing, grooming, and bathing. He still has some difficulties with walking and balance. Cognitive-communicative therapy was also implemented and stressed word retrieval strategies, sentence production related to ADLs, auditory comprehension and verbal expression, and executive skills such as planning, problem solving, and self-evaluation. All therapy stressed the use of English language. Each therapist commented that Mr. Gonzales had difficulty following simple commands given in English and preferred to communicate in Spanish even though only the speech-language pathologist was somewhat fluent in Spanish. He switched between Spanish and English during most informal conversations.

Mr. Gonzales enjoyed inpatient therapies but seemed to want to socialize with other patients and clinicians more than do therapy. Other patients did not understand his overtures spoken in Spanish. Mr. Gonzales became increasingly distracted and uncooperative when tasks involved speaking or understanding English. The female clinicians also noted that Mr. Gonzales infrequently made direct eye contact with them during therapy activities. They were also concerned about some of what they considered inappropriate comments about female patients

and therapists. Continued home-care based PT, OT, and SLP therapies were recommended at time of discharge. Mr. Gonzales stated that he would like to return to his job on a part-time basis when he returns home in several months.

Mr. Gonzales's sister, Maria Lopez (*pseudonym*) age 70, is a widow and resides in an apartment with her adult daughter Rose, age 36, who works as an accountant for a national hotel chain. Rose travels frequently for her employment and relies on friends and neighbors from their church to help her mother. Mrs. Lopez speaks only limited English and prefers to communicate in Spanish. Her daughter says that her mother actually understands English relatively well but is "insecure" about her spoken English skills with those outside the home. Mrs. Lopez indicated through her daughter that she does not want her brother sent to a nursing home and will provide care for him on an extended basis. Mrs. Lopez visited her brother almost daily while he was in medical rehabilitation, often bringing him herbal drinks, sweets, and prayer cards. Therapists noted that Mr. Gonzales became more passive when his sister visited, and he expected her to meet his needs. Thus, Mr. Gonzales will reside with his sister for the next three to four months to receive home care therapy before returning to Mexico. His adult children will visit intermittently to help with care but will be available on an irregular basis. Only two speak English fluently.

You are the speech-language pathologist, physical therapist, or occupational therapist assigned to do home care with this patient. You do not speak Spanish fluently but know some social Spanish. Consider the following questions as you prepare to work with this client in his sister's home.

*Questions to Consider*

1. In reviewing the background information, what cultural, physical, cognitive, communication, and environmental factors would you need to take into consideration in working with this client in a home care situation?

2. How might cultural differences be confused with or compounded by other physical, cognitive, communicative, or environmental characteristics in this case? Why is it important to differentiate cultural differences from those related to the client's other characteristics?

3. What adjustments might you make in both your assessment and intervention based on this client's cultural and linguistic background and his traumatic brain injury?

4. How would you enlist the help of this client's family, particularly his sister, to facilitate therapy? What problems might you have in working with them to enhance therapy effectiveness?

*Resources for Working with Hispanic Clients*

American Speech-Language-Hearing Association. (1985). Clinical management of communicatively handicapped minority language populations. *ASHA*, 27, 29-32.

Battle, D. (1993). *Communication disorders in multicultural populations*. Boston: Andover Medical Publishers.

Brice, A. et al. (1998). Serving the Hispanic population: Creative solutions for therapy. *Annual Convention of the American Speech-Language-Hearing Association.* Available at http://www.asha.ucf.edu/ashasic98.html.

Centeno, J. (2005). Working with bilingual individuals with aphasia. The case of a Spanish English bilingual client. *Newsletter of the ASHA Special Interest Division 14: Communication Disorders and Sciences in Culturally and Linguistically Diverse Populations.* 12, 2-7.

Cheng, L. (1989). Intervention strategies: A multicultural approach. *Topics in Language Disorders*, *9*, 84-93.

Goldstein, B. (2000). *Cultural and linguistic diversity resource guide for speech-language pathologists.* San Diego: Singular Publishing Group.

Kohnert, K. (2005). Cognitive-linguistic interactions in bilingual aphasia: Implications for intervention. *Newsletter of the ASHA Special Interest Division 2: Neurophysiology and Neurogenic Speech and Language Disorders, 15*, 9-24.

Langdon, H. (1992). The Hispanic population: Facts and figures. In H. Langdon and L. Cheng (Eds), *Hispanic children and adults with communication disorders: Assessment and intervention*. Gaithersburg, MD: Aspen Publishers.

Marrero, M., Golden C., & Espe-Pfiefer, P. (2002). Bilingualism, brain injury and recovery. Implications for understanding the bilingual and for therapy. *Clinical Psychological Review, 22*, 463-478.

Morgenstery, L., Steffen-Batey, L. et al. (2001). Barriers to acute stroke therapy and stroke prevention in Mexican Americans. *Stroke, 32*, 1360-1364.

Ruoff, J. (2002). Cultural-linguistic considerations for speech-language pathologists in serving individuals with traumatic brain injury. *Newsletter of the ASHA Special Interest Division 14: Communication Disorders and Sciences in Culturally and Linguistically Diverse Populations. 8*, 2-5.

Santana-Martin, S., & Santana, F. (2005). An introduction to Mexican culture for service providers. In J.H. Stone (Ed.). *Culture and disability: Providing culturally competent services* (pp.161-186). Thousand Oaks, CA: Sage Publications.

**Case Study #3 for SLP: Korean Child with Asperger's Syndrome**

*Background*

David Lee (*pseudonym*), age five years ten months, was diagnosed recently with Asperger's syndrome. His parents, Lisa and Adam Lee, followed the recommendation of their pediatrician, Dr. Su, to have David evaluated by the Child Study Team at Children's Hospital four months

after his fifth birthday. Dr. Su was concerned about David's lack of interactive communication skills and his preoccupation with cars. The Lees believed that David's lack of age appropriate socialization was due to being an only child who was cared for by Mr. Lee's mother on a daily basis. Mrs. Soon Young Lee (*pseudonym)*, a widow, immigrated to the US from Korea three years ago to help care for her grandson while her son and daughter-in-law completed their doctoral and post doctoral programs in chemical engineering at a local university. Adam Lee, the eldest child and only son in his family, was born in Korea and came to the US for his undergraduate education at age 19 where he met and married Lisa seven years ago. Adam has no interest in returning to Korea to live and is presently negotiating a research and development position for a chemical company in the US. Lisa was born in the US shortly after her parents emigrated from Korea. Lisa is not fluent in Korean. Lisa's parents now reside in California and visit several times per year but cannot provide daily help to Adam and Lisa. Both parents are 30 years old, and Mrs. Lee is pregnant with their second child. The Lees are practicing Christians, and Mr. Lee's mother is a Buddhist.

David received a complete neurological, cognitive, and communicative evaluation at Children's Hospital several months ago. Results indicated that David verbally interacted only when spoken to and that he had difficulty with turn taking and coherence in conversations. Although David used complete sentences and a sophisticated vocabulary about his favorite topic of cars, his speech lacked inflection and sounded "robot-like." David responded to his name inconsistently, and showed little interest in play activities offered to him by either the clinicians or parents. His use of nonverbal communication, such as gaze and gestures, was also inappropriate for a child his age. The Lees stated that they believed that David's communication style in Korean is similar to what he exhibited on the day of the evaluation. David demonstrated some repetitive routines such as stacking and restacking papers and books. David has a special interest in cars and can identify cars by maker and year with precision. He brought several books on cars with him to the Child Study Team evaluation and focused on them even when his parents tried to engage him in conversation. The Lees also commented that David had advanced ability in mathematics and performed at a 5$^{th}$ grade level. David is expected to enroll in kindergarten this fall where he can receive speech-language therapy on a daily basis if the parents agree to the recommendations provided at by the Child Study Team. He has not attended preschool and has little socialization opportunities with peers other than when he attends church activities.

The Lees are concerned about their son's lack of interaction skills and the recent diagnosis of Asperger's syndrome. They are also concerned because Adam's mother, who provides most of David's daily care, denies that there is any type of problem. Mrs. Soon Young Lee, a former middle school mathematics teacher in Seoul, speaks Korean to her grandson and believes that he is a gifted child, not one with a communication difficulty. She encourages David's interest in both mathematics and cars and praises his precociousness to family in Korea. She told her son and daughter-in-law that they should be glad that their child is "quiet and smart; he does not talk back to adults, and that is good." She admonished them for "even thinking" that there was something wrong with their first son. Adam also indicated that there is friction with his mother because of his conversion to Christianity and what she considers his "disrespect" for her as the elder in the family.

The Lees are dependent on Mrs. Soon Young Lee for financial aid, help in the home, and child care. Mrs. Soon Young Lee has recently lent her son money for a down payment on a home. They are also concerned that Mrs. Soon Young Lee's criticism of and unwillingness to participate in therapy programs for their son will be detrimental. She has indicated that David should be placed in a school for gifted children and not labeled with Asperger's syndrome or receive any therapies. Mr. Lee states that he wants to do the best by his son, but that his mother's influence in his home is great and that to disregard her wishes will cause greater tension within the family. Mrs. Soon Young Lee has no plans to return to Korea in the near future as she will provide child care for the new baby and David.

*Discussion Questions*

1. What problems might a multi-generational and multi-cultural family such as this have in understanding Asperger's syndrome?

2. Why do you think the grandmother is so averse to her grandson being labeled with Asperger's syndrome and receiving therapy? How much of her perception is cultural? Related to her personality?

3. Suppose you were the clinician working with this child in kindergarten in a public school, how important would it be to work with the grandmother regarding the nature of and treatment for Asperger's syndrome? What are the advantages and disadvantages of enlisting her help or providing information to her?

4. What referral(s) might be useful in this case? To whom would you refer, and how would you convince the Lees to follow through on the referral?

5. What other issues other than cultural differences toward disability emerge in this case?

6. What resources can you find on Korean culture that might help you to understand the grandmother's perspectives on Asperger's syndrome? Compile a reference list.

**Case Study #4 for OT, PT, SLP and RC: Hispanic Physical and Communication Disability**

The following case scenario is an example of a culture bound syndrome that is a health belief among some Hispanics. Answer the questions that follow, relying on the *culture-brokering model* and Kleinman's eight questions to assist you with your approach.

*Background*

Carlos Garcia (*pseudonym*), a 50 year old Mexican man, is the foreman of a construction crew. He was experiencing chest pain one day at work but did not tell anyone until the pain became so unbearable that he collapsed. An ambulance was called, and Mr. Garcia was taken to the local county hospital. Although he speaks some English, he was not able to provide his medical history due to his severe pain. Mrs. Garcia, who speaks very little English, arrived at the hospital extremely distraught. The Garcias do not have medical insurance and usually rely on the local *curandero* for health advice.

Mr. Garcia was stabilized, and he eventually underwent an angioplasty of the Left Anterior Descending coronary artery with the insertion of a stent. Although the procedure was successful, Mr. Garcia suffered a minor stroke while on the operating table. He presents with mild to moderate slurring of his speech (dysarthria) and a clumsy hand. Upon discharge from the hospital, his physician recommended cardiac rehabilitation, occupational therapy, and speech therapy, but since Mr. Garcia does not have health insurance, he refused. While Mr. Garcia was recovering at home, his wife would not allow him to do anything around the house, even his normal household chores. His wife was clearly close to exhaustion herself since she also cares for her two small grandchildren.

Mr. Garcia has been very depressed. He is worried about working again and if he will be able to continue to earn a living. He is also very scared about having another heart attack. Mr. Garcia is having trouble sleeping, has nightmares, and is losing weight. Mr. Garcia complains, "I no longer feel like a man."

Mrs. Garcia is taking her husband to a local *curandero*, who is treating him for *susto*, "soul loss." She is using various herbal remedies and a change in diet, which relies on the hot and cold model. Because heart conditions are considered hot illnesses, the *cuandero* is recommending whole milk and coconut.

Upon his follow-up visit, the physician assistant, who speaks Spanish, referred Mr. Garcia to the clinic's insurance facilitator. He was qualified for a health maintenance Medicaid insurance program. He will be attending a cardiac rehabilitation program that is run by a physical therapist. Occupational and speech-language therapists will see him in the home setting, and a referral has been generated for rehabilitation counseling to evaluate his potential to return to work.

*Questions for Students*

1. How would you approach this case and what are your primary concerns?

Students should be concerned first and foremost for Mr. Garcia's health. This can only be accomplished if students understand Mr. Garcia's explanatory model for what has happened. This model may be different from the health care provider, and communication may involve a process of negotiation and strategies to overcome conflict and advocate for Mr. Garcia's well being. The provider must realize that Mr. Garcia is mourning the strength he once had and his role as the provider of his family. Through education and monitored involvement in activity, Mr. Garcia may gain confidence and realize that he is not as fragile as he thought and that he can once again regain his role as the breadwinner of the household. His resumption of work may depend on work modifications and the practice of energy conservation techniques. Contact with his employer may be helpful if Mr. Garcia is willing to adjust his work load as needed.

2. Who are the major players, and what would you do to gain their trust?

Students should realize that Mrs. Garcia and the *curandero* play an important role in Mr. Garcia's health and should be included in the treatment negotiations. Treatments can be discussed with the *curandero,* and suggestions and adaptations to the regime may be negotiated. For instance, skim milk or 1 percent can replace whole milk, and defatted coconut milk is available. Mrs.

Garcia's role as caregiver should also be considered. She may be concerned that her husband will die, and that fear motivates her to assume his chores around the house. Work simulations with careful monitoring might help Mr. Garcia to gain confidence and help his wife to realize that he is not an invalid. Her role should not be diminished but redirected to facilitate the therapy goals.

*Assigned Readings*

CIRRIE Monograph Series: http://cirrie.buffalo.edu/monographs/

Jezewski, M.A., & Sotnik, P. (2005). Disability service providers as culture brokers, In J. H. Stone (Ed.), *Culture and disability: Providing culturally competent services*. Thousand Oaks, CA: Sage Publications.

Santana–Martin, S., & Santana, F. O. (2005). An introduction to Mexican culture for service providers. In J. H. Stone (Ed.), *Culture and disability: Providing culturally competent services*. Thousand Oaks, CA: Sage Publications.

Thompson, T., & Blasquex, E. (2006). The smorgasbord of the Hispanic cultures. In M. Royeen & J. L. Crabtree (Ed.), *Culture in rehabilitation: From competency to proficiency*. Upper Saddle River, NJ: Pearson Education Inc.

*Learn More about the Client*

As you are reading background information on Mexican and Hispanic cultures, pay attention to several outstanding themes that will affect delivery of services to persons from this particular background. Under each heading, write several examples of the Hispanic view regarding the topics. Note contrasts and similarities between the dominant white culture in the US and Hispanic beliefs and values. Note: Realize that Hispanic culture is heterogeneous and that the examples in the readings are general and they are subject to individual variations and community influences. An individual's level of acculturation is affected by a variety of factors including but not limited to education, migration patterns, family influence, and socioeconomic status.

Concepts of Disability and Illness

Persons from Mexico and other Hispanic cultures may not differentiate between physical and mental illness. The balance between a person and his or her environment is considered important to one’s health. Health is a balance of one's emotional well being, spirituality, physical health, and God's will. Genetic problems or developmental disabilities may be viewed with shame and guilt, blamed on the parents, and looked upon as some type of divine retribution. Mental disability carries more stigma than physical illness. The family and community also feel a joint responsibility for the person with a disability, and institutionalization is rare.

Independence versus Interdependence

Nurturing those who have disabilities is considered an important role. Conflicts may result if rehabilitation personnel are working toward independence, but the family does not want to give up the role of caregivers. Independence may not be valued; relationships and roles may be based on interdependence. Evaluation tools that measure the level of caregiver assistance may not truly reflect rehabilitation potential or the ability to assume a role in the family and society. For example, the Functional Independence Measure (FIM™) is a measurement of Independence in

Activities of Daily Living. Scores are based on the amount of assistance that is needed from the caregiver.

### Machismo and Marianismo

Machismo is sometimes seen as having a negative connotation. It can also be positive in that a man protects and provides for his family and defends them. In Hispanic families, the man assumes the responsibility for providing for his household. Role conflicts may emerge when families are separated because of job opportunities in the US or when there is a disability or illness. When Hispanic women assume the breadwinner role, there may be conflict with traditional values within the home. Traditionally, boys are given greater freedom than girls, and men are expected to be strong.

A woman's role may be viewed according to the concept of marianismo. Marianismo is based on the Catholic interpretation of the Virgin Mary, who is both virgin and mother. Women are considered spiritually superior to men and capable of enduring suffering.

### Personalismo

Personalismo refers to the Hispanic custom of making small talk before getting down to business. Showing an interest in the other person is considered polite before approaching matters at hand. This may result in misunderstandings and poor communication of vital information in busy hospitals, clinics, and agency settings where a person is expected to provide important medical or personal information upon request. Hispanic persons may also inquire about the service provider's personal life. This reflects a desire to understand something about the person who is providing the care. Health care providers who do not understand this may avoid answering questions about themselves. In the US, provision of personal information about oneself to a client is considered unprofessional.

## *Alternative Health*

### Curandereos and Espiritualistas

*Curanderos* are traditional Mexican healers; *Yerbalistas* are herbalists; and *Espiritualistas* are spiritualists. One may first procure the services of a traditional healer before utilizing Western Medicine. Physicians and health care providers have been known to work with *Curanderos* and spiritual healers and negotiate positive results for the client.

### Beliefs Regarding Hot and Cold Remedies

The hot-cold model refers to a Hispanic belief that diseases and disorders can be classified into hot or cold groups. A hot condition must be treated with a cold food or medicine, and a cold condition must be treated with a hot food or medicine.

The following conditions are considered hot illnesses: skin aliments, pregnancy, ulcers, and heart problems. Some cold foods are milk, bananas, coconuts, and beer. Cold ailments may include those that are invisible or that result in immobility such as painful conditions, arthritis, menstrual problems, and colds. Hot foods are evaporated milk, chocolate, onions, and liquors. Penicillin is considered a hot medicine. An example of a conflict that might arise because of this hot-cold

belief is when a physician advises a cardiac patient to avoid high cholesterol foods such as whole milk or coconuts.

Health Risks for Hispanics

- Diabetes is two times more prevalent among Hispanics
- Hypertension is common
- Obesity
- Cervical cancer is double among Hispanic women
- Higher mortality rates from cancer

*Questions for Students about Hispanic Cultures*

1. Identify the variety of cultures that fall under the umbrella of "Hispanic." Note the variation in their migration practices. Discuss the problems that have accompanied various Hispanic groups in the US.

   Students should discuss the various waves of Hispanic immigration from Castro's Cuba (first wave and recent), refugees from El Salvador, Guatemala and Nicaragua, and Mexican immigrants, both legal and illegal. They should be aware of the problems that are encountered due to language, poor socioeconomic status, access to health care, and the problems that are unique to illegal immigrants.

2. Compare concepts of work and activities of daily living among Mexican or Hispanic persons to the values generally purported by the US. How does this affect those who are disabled?

   Those who are disabled, including members of society who are not able to work or earn money, may still be valued and serve other purposes in the community. Visiting, planning community events, helping others, and talking with others are valued roles within a community.

3. The commodity based society in the US differs drastically from the matriarchal society. Explain the differences and the impact this has on disabled persons.

   The student should note that in a matriarchal society the roles of the mother, for example caring for others, are valued. In contrast, a patriarchal society values earning money. An elderly person, or one who is disabled, may still feel valued in a matriarchal society and fulfill a role. For example, cooking for others is valued and fulfills a role. In a commodity based system, if one does not earn money, their "work" may not be valued.

4. Discuss the barriers that Hispanic immigrants face when they are disabled or ill (structural and cultural barriers). What health risks affect Hispanic immigrants, and why are these risks more common among this group?

Students should be aware of the structural and cultural barriers that play a role in access to health care. Structural barriers include language, transportation, insurance, and the ability to pay for medical services. Cultural barriers may include mistrust of the medical system, the practice of seeking native healers first, and different explanatory models regarding illness, and disability.

Some of the health risks, such as diabetes, have an evolutionary and genetic component. It is thought that high blood sugar was an evolutionary survival adaptation among native persons. Many of the risks may be due to lack of preventative care secondary to lack of resources and insurance.

*Activities to Improve Knowledge about Hispanic Cultures*

- Visit a market in a Hispanic neighborhood. Ask the store personnel about different foods that are unfamiliar to you and how to prepare them.
- Visit a *Botanica*, a market where natural remedies and herbs are sold. Discuss healing rituals and practices with the store personnel.
- Visit a *cuandero* or folk healer and learn about the different healing modalities that are used.

## Appendix E: Kleinman's Eight Questions to Assess the Patient's Perspectives (Kleinman, 1978)

Note: Rehabilitation professionals provide services to clients who not only have experienced illness, but long and short term disabilities that may be a result of developmental disorders, illness, or an accident. The following questions were modified in order to include those who are experiencing a disability.

1. What do you think caused your problem (disability)? Remember that in some cultures it is inappropriate to question why something occurred.
2. Why do you think your problem (disability) started when it did?
3. What do you think your sickness (disability) does to you? How does it work?
4. How severe is your sickness (disability)? Will it have a short or long course?
5. What kind of treatment do you think you should receive?
6. What are the most important results you hope to obtain from this treatment?
7. What are the chief problems your sickness (disability) has caused you?
8. What do you fear most about your sickness (disability)?

# Part II: Cultural Competence in the Occupational Therapy Curriculum

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## Introduction

Demographics in the United States are changing and as a result of these changes occupational therapy practitioners will increasingly be working with a growing number of patients, clients, or students from diverse cultural backgrounds. It is likely that these individuals will have different belief systems and values about health and wellness, illness and disability, and activities and participation than those of the occupational therapist (Wells, 2005a). In order to understand these differences and to be able to provide appropriate services to individuals from different cultural backgrounds, occupational therapists need to be culturally competent.

Cultural competency is a journey rather than an end. It refers to the process of actively developing and practicing appropriate, relevant, and sensitive strategies and skills in interacting with culturally different persons (American Occupational Therapy Association, 1995). Cultural competence involves "understanding the importance of social and cultural influences on patients' health beliefs and behaviors; considering how these factors interact at multiple levels of the health care delivery system; and finally, devising interventions that take these issues into account to assure quality health care delivery to diverse patient populations" (Betacourt et al., 2003, p.297). While this is a rather abstract explanation of cultural competence, there are specific clinical implications for occupational therapists and other health care service providers. From a clinical perspective, cultural competence means that the therapist has the self-awareness, knowledge, and skills to make ethical and culturally appropriate decisions (Davis & Donald, 1997).

Cultural competence is an important key to effective therapeutic interactions and outcomes. In practice, cultural competence involves the occupational therapy practitioner learning new patterns of behavior and effectively using these behaviors as relevant and appropriate. Depending on the particulars of a patient's or client's culture, Wells and Black (2000) suggest that the occupational therapist may want to consider the following:

(1) involve the extended family in the intervention process;
(2) address elderly persons more formally (by their surname and title) than younger persons;
(3) acknowledge and work with traditional healers or faith healers;
(4) be cautious about the use of touch and personal space;
(5) recognize that "small talk" at the beginning of a therapy session will be considered good manners and keeps from appearing too rushed;
(6) conduct the therapy session in the preferred language of the client or arrange for a professional interpreter; and
(7) add culturally related questions during the evaluation process.

The American Occupational Therapy Association (AOTA) recognizes the need for occupational therapists to provide culturally competent services as indicated in the profession's *Philosophy of Professional Education*, the *Occupational Therapy Practice Framework*, the *Occupational Therapy Code of Ethics*, and the *Standards for the Accreditation of Occupational Therapy Education Programs*. AOTA's statement on the philosophy of professional education indicates that "the occupational therapy education process emphasizes continuing critical inquiry in order that occupational therapists be well prepared to function and thrive in the dynamic environments of a diverse and multi-cultural society…." (Haynes & Jones, 2007). As such, the development of cultural competence can be infused at all levels of occupational therapy professional education.

*The Occupational Therapy Practice Framework* (OTPF) broadly states that the domain of occupational therapy focuses on engagement in occupation to support participation of individuals in a specific context or contexts. The term context refers to several interrelated conditions within and surrounding the client or patient that influence occupational performance. Contexts referred to in the occupational therapy practice framework include cultural, physical, social, personal, spiritual, temporal and virtual domains (American Occupational Therapy Association, 2002). The cultural and spiritual contexts might be most closely related to the concept of cultural competence.

The cultural context is defined as the "customs, beliefs, activity patterns, behavior standards, and expectations accepted by the society of which the individual is a member. (It) includes political aspects, such as laws that affect access to resources and affirm personal rights. (It) also includes opportunities for education, employment, and economic support" (American Occupational Therapy Association, 2002, p. 623). Spirituality may be culturally based as well. The occupational therapy practice framework defines the spiritual context as the "fundamental orientation of a person's life; that which inspires and motivates that individual" (American Occupational Therapy Association, 2002, p. 623).

*The Occupational Therapy Code of Ethics* (AOTA, 2000) recognizes that culture may influence how individuals cope with problems and interact with each other and health care providers. The manner in which occupational therapy services are designed and implemented must be culturally sensitive in order to be culturally effective. Cultural competence builds upon the profession's ethical concepts of beneficence, nonmaleficence, autonomy, justice, veracity, fidelity, and duty (Wells, 2005a).

The standards for an accredited occupational therapy education program mandate that a graduate from an Accreditation Council for Occupational Therapy Education (ACOTE, 2006) accredited master's degree level occupational therapy program must have an understanding of issues related to diversity. The guidelines for screening, evaluation, referral, and formulating and implementing an intervention plan indicate that these processes, as related to occupational performance and participation, must be culturally relevant. Several of the specific standards relate to cultural competence. For example, the standards mandate (standard number is in parentheses) that students will be able to:

- Demonstrate knowledge and appreciation of the role of **sociocultural,** socioeconomic, and **diversity factors** and lifestyle choices in contemporary society (B.1.7)

- Articulate the influence of social conditions and the **ethical contexts** in which humans choose and engage in occupations (B.1.8)
- Demonstrate knowledge of **global social issues** and prevailing health and welfare needs (B. 1.9)
- Analyze the effects of physical and mental health, heritable diseases and predisposing genetic conditions, disability, disease processes, and traumatic injury to the individual **within the cultural context of family and society** on occupational performance (B.2.6)
- Express support for the quality of life, well-being, and occupation of the individual, group or population to promote physical and mental health and prevention of injury and disease **considering the context** (e.g. **cultural**, physical, social, personal, **spiritual**, temporal, virtual) (B.2.9)
- Select appropriate assessment tools based on client needs, **contextual factors**, and psychometric properties of tests. These must be….**culturally relevant**….(B.4.2)
- ….Intervention plans and strategies must be **culturally relevant**….(B.5.1)

The curriculum design in many occupational therapy programs consists of themes, one of which may be understanding occupational therapy in a broader institutional and societal context. Cultural competence is an extremely important component of this theme. Cultural content may be immersed throughout the curriculum at three levels: Level 1 - Introduction and Foundation, Level 2 - Application, and Level 3 - In-depth Analysis. Level I activities are typically used in the "pre-professional" phase of an occupational therapy program (defined as the first two years in a BS/MS program or the undergraduate program leading to admittance in a MS or MOT program) or the first year of the professional component of the program which we are defining as year three of the program. Many of the Level I activities may be viewed as being generic in nature and might also be used by other health related professional programs. Level II application activities are typically used during the psychosocial, pediatric, and physical disability applied practice courses during the fourth year of the program. Level III in-depth analysis activities are used in the graduate year of the program. The following table depicts the levels and purpose of activities.

Table 1 Levels of Activities

| Level | Intended Audience | Purpose |
|---|---|---|
| I | Students taking courses that are pre-requisites for occupational therapy programs | Helping students to develop a self-awareness of their own cultural identity and values; helping students to begin to develop an awareness of cultures other than their own |
| II | Students taking occupational therapy practice courses that focus on assessment, treatment planning, and treatment implementation | Helping students to use culturally relevant practices in assessment, treatment planning, and treatment implementation |
| III | Students taking advanced occupational therapy practice courses that focus on | Helping students to reflect on cultural issues in occupational |

| | | |
|---|---|---|
| | assessment, treatment planning, and treatment implementation | therapy in greater detail and depth |

The next section describes activities that occupational therapy instructors may use at these different levels. They supplement the general activities listed in Part I, the Transdisciplinary Guide.

## Activities

Note to the Instructor: Resources on specific cultures are available in the resource section at the end of this guide. Although knowledge on specific cultural groups is helpful when working on the following case studies and activities, students should keep in mind that persons from various ethnic backgrounds are more heterogeneous than case typical. Students should use the cultural resources that are offered in this guide with discretion.

**Level I: Introduction and Foundation**

Many of the Level I activities focus of self-awareness, that is, students' beliefs, values, attitudes, and perceptions about their culture and the culture of others with whom they will be interacting with as occupational therapists.

*Activity One: Cultural Identity Paper*

This activity relates to a class discussion on cultural identity. As an out of class assignment, students are to write a paper on their cultural identity that addresses the following questions:

- How would you describe your own cultural identity?
- What part of your cultural identity has the greatest influence on your interactions with others? How so?
- Are there any conflicting aspects of your cultural identity?
- Think about someone you know from a different culture than your own and describe the similarities and differences between the two cultures. What conflicts could you see arising in a helping relationship involving members of these two cultures?

*Activity Two*: Self-Assessment from Brislin & Yoshida (1994, pp. 173-174). *Improving intercultural interactions*. Reproduced with permission, Sage Publications.

This activity is designed to help students focus on experiences or situations in which they may find themselves when providing occupational therapy services to clients or patients from a cultural background that is different than their own.

Students should read each statement carefully and respond in relation to their perception of the extent to which the statement is true for them. If the statement is true sometimes, students should place a "+" in Column 1 opposite the particular statement; if it is almost always true for them, they should place a "+" in Column 2; if never true, a "+" in Column 3; if it depends on the situation, a "+" in Column 4. Students should be aware that this is not a test and that there are no correct or incorrect answers.

When I am providing occupational therapy services to clients or patients from a cultural background that is different from my own, I am able to identify when:

| Sometimes (1), Always (2), Never (3), Depends (4) | 1 | 2 | 3 | 4 |
|---|---|---|---|---|
| 1. their concept of the inner structure of the body may be different from mine | | | | |
| 2. their ideas about the way the body works may be different from mine | | | | |
| 3. the intervention I use to improve their health/functional ability/participation may not be consistent with what they believe will improve their condition | | | | |
| 4. their ideas about their role as a sick person or a person with a disability may be different from mine | | | | |
| 5. problems that arise are not culturally based | | | | |
| 6. problems that do occur do have a cultural basis | | | | |
| 7. misunderstanding is due to intercultural communication breakdown | | | | |

This activity, or a similar one, can be used with students in each year of the program, to measure their "progress" in their self-awareness in regard to cultural issues.

*Activity Three: Cultural Self-analysis and Examination of Personal Culture.* Reproduced with permission from *Vace, DeVanney, & Wittmer (1995). Experiencing and counseling multicultural and diverse populations,* Taylor and Francis.

Working individually, students are to examine their own cultural heritage in terms of the questions listed below. Students can reflect "on their own" or, depending on the willingness of class members to share personal information and reflections, share with other class members.
Reflection Questions:

1. What is your national background, racial group, or membership in a diverse population or group?
2. What was your religious affiliation during your childhood?
3. What is your religious affiliation now?
4. What is your gender?
5. What is your age?
6. Based on your income and job, what is your current socioeconomic status?
7. In what geographic region were you reared?
8. In what geographic region do you currently reside?
9. What is one thing you are proud of regarding your culture?
10. What is one thing that embarrasses you about your culture?
11. What is a trait, practice, or tradition that you admire about a culture other than your own?

12. Describe a time when you were hurt by someone's prejudice in words or actions? Describe feelings involved.
13. Describe a time you hurt someone because of your prejudice in words or action? Describe feelings involved.

*Activity Four: What is Your Worldview?*

A worldview is a framework through which a person sees the world and is used to guide behavior. Worldviews can be looked upon in many different ways. For example, Vace, DeVanney, and Wittmer (1995) discuss differences between cultures in eight general categories: family, the arts, environmental concerns, legal institutions, health care, education, politics, and religious institutions. Similarly, Sotnik and Jezewski (2005) suggest that different cultural groups have different cultural orientations related to the needs of the person (individualism) and the needs of the group (collectivism).

In this activity, the student is asked to reflect upon and briefly describe how he or she views family, self-expression, assertiveness, self-advocacy, self-realization, health care, education, and political and religious institutions from the standpoint of his or her present cultural group context. What potential conflicts might occur if a patient or client had a different worldview than the occupational therapist?

*Activity Five: Proverbs*

After a class discussion on the role of proverbs in culture (i.e. teaching and sharing the values of a particular culture), the students are provided with a list of proverbs. They are asked to reflect about the possible meaning of proverbs or sayings from different cultures. In a small group, students are asked to discuss how the values portrayed by these proverbs differ from those in our culture and how might these differences in values affect occupational therapy practice and interactions with individuals from different cultures. Some examples of proverbs to be used in the activity are listed below (Baer, 2001).

Proverbs

- Women have but two residences – the house and the tomb.
- One does not make the wind but is blown by it.
- Empty cans clatter the loudest.
- The mouth maintains silence in order to hear the heart talk.
- He who speaks has no knowledge and he who has knowledge does not speak.
- Even if it is a stone bridge, make sure it is safe.
- A man's tongue is his sword.
- A zebra does not despise its stripes.
- Loud thunder brings little rain.
- A single arrow is easily broken, but not a bunch.
- He who stirs another's porridge often burns his own.

*Activity Six: BaFa'BaFa'®*

The goal of BaFa'BaFa'® is to introduce students to what it is like to be from a different culture or to be in a strange place. Students are divided into two groups, the alphas and the betas; each

group has a "culture" very dissimilar and unknown to the other group. Each group is taught the "culture" of their own group and the language that they should use. For example, the alpha society can be a patriarchal society where members frequently discuss each other's paternal relatives and where women would only approach women. Members of the alpha society speak English. Conversely, the beta society uses a different language. They are a utilitarian culture, and communicate using hand language and a simple language using the members' last names. Both groups are assigned a task to be completed following the rules and norms of their particular culture. After the students play the game, the instructor facilitates a discussion with the students to process what has occurred. A more detailed description of BaFa'BaFa'® and instructions for ordering can be found at Simulation Training Systems (Simulation Training System, 2008).

*Activity Seven: Vignettes*

The use of vignettes offers several unique advantages and can be used to discuss issues related to cultural competence at all levels of occupational therapy education but are particularly useful at the "application" level. Information can be elicited from the student in a relaxed and non-threatening format. For example, topics that are prohibitive or sensitive may become less threatening when presented as a story (Barter & Renold, 1999; Hughes, 1998). Specific variables or dimensions are introduced in order to help the students understand their beliefs, values, and intended behaviors (Alexander & Becker, 1978). The following two vignettes are from Wells (2005b): *On cultural competency and ethical practice.* Reproduced with permission, American Occupational Therapy Association.

Vignette One

Joan (*pseudonym*), a pediatric occupational therapist, is asked to make a home visit to a Vietnamese child who was recently burned. On examination of the child, she notes red, round, coin-sized marks over the child's back. The mother is never asked about the marks. After leaving the home, Joan wonders if the mother is using a traditional healing treatment.

Discussion Questions:

- Can Joan give the child ethical and quality care while allowing the mother to continue with this harmful practice?
- What is the responsibility of the therapist in such a situation?

Vignette Two

Mrs. Vega (*pseudonym*) is in her mid 60s and of Hispanic ethnicity. She is dependent on food stamps and Supplemental Social Security Income benefits. Somewhat hard of hearing, she has a slight tremor in her voice and arthritis in her hands. The three bedroom house in which she lives is in poor condition. The house is unkempt. For meals, she relies on her neighbors and "junk food."

Mrs. Vega was admitted to the rehabilitation unit after experiencing a mild stroke that left her impaired on the right side. Her treatment sessions consist of transfer training, learning one-handed cooking, and dressing with adaptive equipment. A variety of equipment and devices are recommended and ordered for her. At the discharge planning session, the occupational therapist states, "Mrs. Vega has refused all the equipment even though she is able to use them safely and properly."

Discussion Questions:

- What issues does the occupational therapist need to discuss with Mrs. Vega?
- What cultural issues or concerns may need to be addressed?

*Activity Eight: Children at Play (Wells, 1994)*

Observe a group of typically developing children from diverse cultural backgrounds at play. A day care center in an urban area is a particularly good place for this observation. Note similarities and differences in the children's behavioral patterns, social interactions, and use of toys and other objects in the environment. Are these differences cultural in nature? How might culture influence a child's play? Observations and findings are discussed with the class.

**Level II: Application**

The majority of the Level II activities focus on developing a student's understanding of a patients' or clients' cultural background and the implications of culture on assessment, treatment planning, and treatment implementation.

*Activity One: Case Studies*

The following case studies are divided into categories: general issues, physical disabilities practice, pediatric practice, and psychosocial practice.

General Issues: Case Study I: from Kavanaugh and Kennedy, 1992. *Promoting cultural diversity: Strategies for health care professionals.* Adapted with permission, Sage Publications.

Shivani *(pseudonym)* is an occupational therapist, originally from India, who is working in a private rehabilitation clinic. With a (European-American) occupational therapy student, Shivani entered a patient's room and introduced herself. After a few minutes, both women left the room. Later Shivani returned to the patient to discuss a therapy program. Referring to the occupational therapy student, the patient asked Shivani to "go get the real OT so that I have the right activities."

Discussion Questions:

- What assumptions are being made by the patient in this situation?
- How would you feel, or have you felt, in a similar situation?
- How could Shivani effectively manage this situation with minimal risk to the patient-provider relationship and to personal integrity?

General Issues: Case Study II: from Kavanaugh and Kennedy, 1992. *Promoting cultural diversity: Strategies for health care professionals.* Adapted with permission, Sage Publications.

The setting for this case study is a hospital which has a large OT rehabilitation clinic. The OTs provide therapy to several patients and daily scheduling is "tight". Two weeks ago, a well-liked and experienced OT aide left her position because her husband was transferred, and they were moving out of town. An advertisement was posted, and a new aide was hired. One of the duties for this position is to transport patients to therapy. In the morning, the aide should assist patients

with dressing if they have not finished and help them use the toilet, if needed, before she takes them to therapy.

The new aide is a quiet and unobtrusive woman from Saudi Arabia. She practices the Muslim faith and wears a traditional headscarf at all times. An OT who works in the clinic comes to you, the Department Manager, to complain after working a week with her. Several male patients have been very late in arriving for therapy because the aide refuses to help them finish dressing or use the toilet. This "backs-up" the schedule all day causing patients to have to wait longer for their treatments. The OT spoke to her about it and told her that she needed to start assisting the patients in their ADLs so that they can arrive for OT as scheduled. The aide nodded but has not changed her behavior or given any reason for it. The OT also complains that the aide smells and doesn't seem to be too quick to catch on. She comments that some of the other therapists make comments about her clothing and head scarf. You observe that the new aide eats lunch alone and does not socialize with the other therapists.

1. Identify:
    a. How the manager might be feeling in this situation.
    b. How the OT might be feeling in this situation.
    c. How the aide might be feeling in this situation.
2. As manager, what will you do now? What resources will you/could you use?
3. Answer the following:
    a. How do you think the aide will respond to your solution?
    b. How do you think the OT will respond to your solution?
4. How could this situation have been avoided?

General Issues: Case Study III: from Kavanaugh and Kennedy, 1992. *Promoting cultural diversity: Strategies for health care professionals.* Adapted with permission, Sage Publications.

Several patients from the oncology clinic were having coffee in the cafeteria while they waited for the clinic to open for their group session. Conversations ranged from personal ailments and progress to exercise techniques and diet among the African-American, two European-Americans, Korean, and Puerto Rican members of the group who were present. When one of the European-Americans mentioned a dream she had the night before, the Korean quickly stopped her with an explanation that the listeners would have "bad things" happen to them if they heard a dream recounted during daylight hours. He continued, if the contents of the dream were positive and it was shared during daylight hours, it might be only the dreamer who would have bad luck and the listeners might have good luck. But if the contents of the dream were bad, they were ensured that all would have bad luck. On the other hand, if the dream was shared during nighttime hours, both the dreamer and the listeners would be protected.

There were several puzzled faces around the table. Finally the African-American, a retired professor, remarked, "That sounds pretty far-fetched to us today, Mr. Park. Where did you get that?" Mr. Park replied, "From my grandmother. She knows many things. Very real things." The European-American woman with the dream that had prompted this interaction asked if Mr. Park's grandmother knew about palm reading. It was asserted that she had and that she had imparted the rudiments of that knowledge to her grandson, who then offered to read the palms of

the group present. Despite several comments about the "ridiculousness" of the situation, all consented.

Discussion Questions:

- How do beliefs affect behavior?
- What is the likelihood that traditional beliefs will have a negative impact on health outcomes?
- Are there are similar situations that might relate more specifically to occupational therapy?

Physical Disabilities Practice: Case Study I: from Kavanaugh and Kennedy, 1992. *Promoting cultural diversity: Strategies for health care professionals.* Adapted with permission, Sage Publications.

An elderly Vietnamese man was admitted to a hospital after having a stroke. Several family members were at his bedside day and night. One grown daughter of about 35 years of age was very demanding and in constant conflict with the staff. She made one request after another; frequently wanted a doctor called, and wanted a nurse always present in her father's room. Her requests were actually demands, and there was considerable anger as well as anxious facial expressions.

The nurses reported making every possible effort to meet the needs of the patient and to satisfy the daughter, but to no avail. Increasingly defensive, a member of the staff reminded the daughter that her father was not the only patient on the unit. They also began to enforce visitors' hours and went out of their way to avoid the daughter.

Finally the staff decided to have a meeting to discuss the family's needs, to verbalize their feelings, to set limits to prevent manipulation of the staff, and to promote respect for the staff. At the meeting it became clear that there were mixed feelings among the staff. These varied from excusing the Vietnamese woman's behavior because of her presumed lack of familiarity with American hospital etiquette and protocol, to deep resentment that "those foreigners are telling us how to do our jobs." The unit personnel decided that they needed to be consistent and to work with the family to resolve conflicts. The head nurse met with the family to inform them of the care that was being given and to explore their feelings. The behavior on the part of the family did not change. Mary Smith, *(pseudonym),* an occupational therapist with cross-cultural training, was asked to consult with the staff and family.

Mary knew that cultural transition for East Asian immigrant families can be very difficult. Language, customs, beliefs, family organization, and family process within the context of a specific culture (in this case Vietnamese of Chinese ethnicity) have impact on the situation. She met and talked with the patient's family, learning that the unmarried daughters were very concerned about their father's health and that their only brother was dead.

Mary explained to the unit staff about strong group ties and that women in Confucian philosophy and tradition are expected to follow their fathers, spouses, or eldest sons. Having immigrated with only their widowed father, he is looked to for authority and leadership. The daughters have

prescribed sets of paternal obligations, both spoken and unspoken, because it is parents who bring children into the world and care for them. They are more fluent in English than is their parent, so the eldest daughter feels it is her role to be her father's advocate and spokesperson.

Discussion Questions:

- How might this situation be handled or managed effectively?
- How might communication problems be effectively bridged?
- What is the problem from the client's (clients') point(s) of view?
- What is the problem from the staff's point of view?
- What role can health care providers play in supporting this family?

Physical Disabilities Practice: Case Study II: from Brislin and Yoshida, 1994. *Improving intercultural interactions*. Adapted with permission, Sage Publications.

Background: This case study was reported by Kate Lewis, an occupational therapist who provided home care therapy to patients after discharge from the hospital.

Jose Rodriquez *(pseudonym)* is a 65-year old man who had a cerebrovascular accident (CVA) and as a result has a left hemiplegia. Jose immigrated to America from Mexico when he was 25. He established a small but successful delicatessen business with a cousin. After 5 years he returned to his village for a short visit and to marry Mary, a woman from his village. They returned to America and worked to build an even bigger and more successful business. Jose has gone back to Mexico every two years for a holiday, sometimes with Mary, sometimes alone. They have five children, all of whom are married, and nine grandchildren. Their oldest son and his wife live with Jose and Mary in a comfortable two-story apartment behind the delicatessen. They are directly involved in running the business with Jose and Mary. The other children live close by with their families, and are involved in related businesses, for example, importing, wholesale foods, shop fittings, and accounting. They are a very close-knit family in which Jose is clearly the patriarch.

Jose is a well-known identity in the local community and an active member of the local Mexican Social Club. Prior to the CVA, he enjoyed arguing about politics, playing cards, entertaining family and friends, and going to the movies. Jose has been overweight for some time and has high blood pressure. He takes tablets to control the blood pressure, has a diet plan to follow, and has a light exercise program.

After one week in the hospital to stabilize his condition, Jose was transferred to a rehabilitation center where he was very unhappy. He insisted that he must go home to his family, so he was discharged early on a home rehabilitation program. At discharge, Jose had good return in his left arm and hand but was experiencing some residual problems associated with grasp and release. He was able to attend to his personal care needs but required some assistance with tasks requiring fine motor coordination. His ambulation was functional, he was able to do transfers with minimal supervision, and his cognitive and perceptual functions were intact. However, the family noticed a big difference in his mood. His son Paolo commented that his father was "a changed man since the stroke. It is as if he has given up on living."

Two days after Jose was discharged from the rehabilitation center, the home care occupational therapist visited him. The purpose of the visit was to assess what might be required to help him function independently at home and to start a home therapy program. The OT's duties also included checking that Jose was continuing to take his medication and adhering to his diet and exercise program.

When she arrived, Kate was greeted by a woman nursing a young baby who introduced herself as Anna, Mr. Rodriguez's daughter-in-law. Anna explained that her husband and mother-in-law were serving in the shop, but that she was available to assist and answer any questions. Anna led Kate through to the sitting room, where Jose was lying in bed propped up by pillows. Before they entered the room, Anna told Kate that her father-in-law refused to get out of bed and insisted that since his life was over; he had best just lie there and wait to die.

"He refuses to get dressed and insists that Mama take him to the toilet and bathe him. Paolo has to shave him. I am worried about Mama; she has not been well and is working so hard. While the baby is small, I try to give her a break from attending to him during the day. But he insists that she must take him to the toilet."

She explained that the bed was in the sitting room because Papa could not manage the stairs to go to the bedroom. She added, "Besides, Papa always likes to be in the center of things, so he knows what is going on and can tell us all what to do."

Anna introduced Kate to her father-in-law, and Kate quickly explained the reason for her visit. Jose's answer was to shake his head and tell her that there was no point in her coming to see him. He was a sick, old man, who was no good to anyone and must be looked after by his wife and family until he died. Kate reminded him that only a few days ago when he was discharged he was able to dress himself and could walk quite well using a cane.

Jose replied loudly, "I would rather be dead than let people see me, Jose Rodriguez, using a walking stick!" He added, "So, and what is the point of walking when any time I might be struck down again and die, eh? You think I should get up? I think it is better to stay in bed and wait to see if this arm gets better."

Kate asked Jose if any of his friends or customers had been to visit him since he had been home. Jose replied that he was ashamed to let any of his old friends see what a weak apology for a man he now was. He would wait to see if he got better before seeing anyone. Meantime he would rest in bed. If he did not get better, then the family must all pray that God would be merciful and take him.

He continued to resist any attempts Kate made to persuade him to get up and dress. However, he showed some interest when she asked to test the strength and movement in his arm. He allowed her to test grip and release in his left hand but complained that it was very painful when she moved his arm and hand. He agreed to her visiting him again next week, to work on his arm and to make it strong again.

When Kate reminded him that he would have also have to do some work to make the arm stronger, Joe replied, "What do you mean? I am a sick man. I will let you work on this arm to make it better. I must bear the pain while you exercise my arm. That is enough."

Discussion Questions:

- What are some of the cultural beliefs that underpin Jose's response to his illness and disability?
- What effect might these beliefs have on the home therapy program? What issues will need to be resolved?
- What issues will Kate need to approach with great sensitivity?
- Given the cultural background of the family, do you see any way of reducing the stress and demands on Mary?
- Jose complained about the pain in his arm when Kate was testing for grasp and release. What advice do you have for Kate about how she might deal with this while she is treating him?

Pediatric Practice: Case Study I

Sam (*pseudonym*), a 7 year old boy with multiple disabilities, needs an assessment by an occupational therapist in his home. He is too medically fragile to attend school, so he must receive all services in the home. Sam receives 24 hour nursing care and spends most of the day supine in his bed. Unfortunately, there is little sensory stimulation in his bedroom. The television is left on for most of the day, but often the nurse watches talk shows or the news. Additionally, the television is not in a position where Sam can easily see it from his position of comfort, so he spends most of his day looking at a blank wall.

The family consists of his mother, grandmother, and grandfather. They are a Spanish-speaking family from Puerto Rico. The mother does not work because she has to stay home to care for Sam since the nurses often call to cancel. The family lives in a second floor apartment in the Bronx, and the elevator in the building is often broken. Sam does not have an appropriate wheelchair, and the family does not have a car. Therefore, Sam rarely leaves the apartment. When he does need to leave (i.e. for a doctor's appointment), the family and Sam take a cab, and his mother holds him on her lap. The mother does not know how to get any equipment that they may need or what resources might be available to provide equipment, so she just adapts the best she is able.

Discussion Questions:

- What priority areas would an occupational therapy treatment plan address?
- What would be included in a treatment plan?
- What is the role of the occupational therapist in helping the family obtain the necessary equipment for Sam?
- In what ways can the occupational therapist involve the family in Sam's care and treatment plan? What might help them follow-through with the occupational therapist's recommendation?
- What cultural issues/factors might the occupational therapist need to take into consideration?

Pediatric Practice: Case Study II

Lucy (*pseudonym*) is a 3 year old girl who attends a half-day preschool program and receives OT, PT, and speech therapy in her home. Lucy does not have a specific diagnosis and is classified as a preschooler with a disability. She does, however, exhibit behaviors that are consistent with an Autism Spectrum Disorder. In particular, Lucy has difficulty with sensory processing and modulation, eye contact, and gross and fine motor development. The family immigrated to the United States from Vietnam and includes Lucy, her parents, her grandmother, a 1 ½ year old sister, and a newborn brother. They currently live in a very small apartment that consists of two small bedrooms, a living room, a small kitchenette, and a bathroom. The family has few material goods, and the children do not have many toys. The father works, and the mother stays at home with the children and provides care for her elderly mother-in-law. The family acts somewhat ashamed of Lucy's problems, and it is difficult to communicate with them since their English is limited.

Discussion Questions

- What priority areas would an occupational therapy treatment plan address?
- What would be included in a treatment plan?
- In what ways can the occupational therapist involve the family in Lucy's care and treatment plan? What might help them follow-through with the occupational therapist's recommendation?
- What cultural issues/factors might the occupational therapist need to take into consideration?

Psychosocial Practice Case Studies: Level II

The following two case scenarios are Level II practice case studies that can be used and modified for treatment planning in an OT psychosocial practice class. The instructor may use a general treatment planning format that includes the practice of creating long term goals, short term goals, and methods to achieve these goals. In addition, several questions regarding cultural issues can be discussed in the classroom and incorporated into the treatment planning session. Examples of cultural questions follow each case study.

Psychosocial Practice: Case Study I

Beatriz (*pseudonym*) is a 17 year old female student attending Richardson Day Treatment Program (RDTP). She has been diagnosed with Borderline Personality Disorder (DSM- IV-TR code: 301.83) due to her conduct at home, in school and in the community. Beatriz lives with her mother and 7 year-old sister, Isabella, and attended Lavern High School, Buffalo, NY, prior to admission to RDTP. Beatriz's mother emigrated from the Dominican Republic when Beatriz was 2 years old. Her father lives in New York City and has not been in contact with Beatriz since her $11^{th}$ birthday. Beatriz's mother works full time as a nursing assistant on the 3-11 shift and sends remittances to her mother, who still lives in the Dominican Republic.

Beatriz is in an ungraded Option III classroom at RDTP. She participates in work-study at school and attends a Board of Cooperative Educational Services (BOCES) program at Parkside Center 3 mornings weekly. She is currently sampling training options in food service and health care. Additionally, Beatriz works at a fast food restaurant 10 hours weekly, a job she has had for the

past 5 weeks. Beatriz has had 4 other jobs at fast food restaurants during the past year and was fired from 3 of them for failure to comply with supervisors' requests.

Beatriz's academic skills are limited. Reading level is 6th grade; math level is 5th grade. Beatriz is frustrated by her poor school performance and resists reading and problem solving tasks. She enjoys work-for-pay activity and practicing learning to drive. She wants to own a car; Beatriz views driving as freedom to socialize with friends.

Beatriz lives in a Hispanic community that has high rates of unemployment and gang activity. Beatriz "hangs out" with gang members and admits to experimenting with crack cocaine and smoking marijuana when she "can get it." Beatriz has had no history of legal entanglements, though she freely describes the illegal activities of her friends. She boasts about the times she hasn't been caught or arrested. Beatriz struggles in her relationship with her mother, whom she finds to be "too old fashioned." Beatriz's mother does not approve of her provocative style of dressing and her experimentation with drugs, alcohol, and sexual activity. She emphasizes to Beatriz that women must be pure, get married, and be good mothers. Beatriz feels that this mind-set did not help her mother, who has had to work and support Beatriz and her sister since her father left. Beatriz states, "Being a good wife and mother didn't help my mom." She uses her mother's situation to justify her experimentation.

Currently, Beatriz's future plans include graduating from Lavern High School with an IEP diploma at age 18, working in a restaurant, getting an apartment, buying a car, and marrying her boyfriend, Hernando, whom she has known for 2 months.

Details to consider when writing Beatriz's treatment plan:

(1) Students will develop a treatment plan that includes a list of strengths and problems/needs based on the above scenario. Students will follow the instructor's format.
(2) Students should also discuss and incorporate into their methods section Beatriz's cultural influences and how they impact her decisions and behavior. In particular, students should discuss and identify the following situations regarding Beatriz and her family:
    - Identify the conflicts that Beatriz has with her mother and the source of these conflicts, for example, Beatriz's rejection of her mother's traditional culture. How can this source of tension be remedied?
    - What role does the community in which she lives affect Beatriz's behavior, and what can be done to remediate its influence?
    - Examine the influence that immigration has on Beatriz, the loss of the extended family, disruption of the nuclear family, and the adaptations that must be made by all players.
(3) What approaches might an occupational therapist consider when working with a person who has a Hispanic background?

Psychosocial Practice: Case Study II

Mrs. Amina Nawafleh (*pseudonym*) is a 35 year old woman referred to Brookside Continuing Treatment Program at the Brookside Psychiatric Center through the department of social services after her aunt, Mrs. Mouammar, brought her to the emergency room in a severely delusional

state. Amina and her family are originally from Iran; they immigrated to the United States 20 years ago. Amina speaks fluent English.

Amina has had a history of mental illness over a period of 9 years. She was admitted to a psychiatric hospital for severe post-partum depression after the birth of her son. She was then transferred to a community mental health center. There she had received individual psychotherapy and medication to manage her illness. Also, she participated in the day treatment program activities 4x's weekly. This continued for approximately one year, and then Amina stopped attending sessions. She was re-admitted to a psychiatric hospital after the death of her mother and once again participated in treatment on an outpatient basis for approximately one year. She held a job as a sales clerk in a retail store for 6 months when her symptoms were in remission. In treatment, she had been considered for vocational exploration but had not followed through on this plan.

Amina completed high school in Buffalo, NY, where she lived with her family in a small Muslim community. Although she had above average grades, she did not participate in extracurricular activities or school clubs. Amina helped her father and mother in their small store. Amina attended community college for one year, taking courses in liberal arts and early childhood education. However, by the middle of her second semester she became more reclusive, had difficulty sleeping, and began missing classes more often than she attended them. As a result, Amina was on academic probation by the end of her second semester and discontinued her schooling at that time. During the past 9 years, Amina worked in her parents' store until her father died in 2000. Amina was able to remain somewhat mentally stable during this period of time although the community in which she lived viewed her as somewhat "odd."

Amina was married in 2001 for 18 months; this was an "arranged" marriage. Her somewhat odd and reclusive behavior was kept secret from the perspective husband and his family. Amina has a 7 year-old son, Adil, who lives with his paternal grandparents and father in Cleveland. Amina moved to Cleveland with her new husband upon marriage. After Adil was born, Amina began demonstrating erratic and unpredictable behavior. Amina was unable to sleep, she reported hearing voices, and she neglected caring for herself and her child. This behavior was largely ignored, and Amina's mother moved to Cleveland to help her to care for the child. Amina's instability escalated until one day she attempted to jump out of a third story apartment window. The neighbors called the police, and Amina was admitted to a psychiatric hospital. Mr. Nawafleh divorced Amina and obtained legal custody of their son. Amina returned to Buffalo, lived with her mother, and received treatment at a day treatment program for approximately one year. Amina gradually stopped attending day treatment and neglected to take her medications.

A few years later, Amina's mother became ill and died. Amina moved in with her maternal aunt, Mrs. Mouammar. Shortly after her mother's death, Amina was taken to the emergency room by Mrs. Mouammar, after she was found by a neighbor walking the streets in her nightgown, disoriented and delusional. After Amina was released from the hospital, she was assigned a social worker who recommended a community residence program. The aunt refused to allow Amina to move and insisted on taking care of her. The aunt feels that to allow Amina to live apart from her will bring shame on the family. Mrs. Mouammar does not trust doctors, especially psychiatrists.

Details to consider when writing Amina's treatment plan

(1) Students will develop a treatment plan that includes a list of strengths and problems/needs based on the above scenario. Students will follow the instructor's format.
(2) Students should also discuss and incorporate into their methods section, Amina's family, their cultural influences, and how they impact family decisions and behavior. In particular, students should discuss and identify the following situations regarding Amina and her family:
    - Mrs. Mouammar's distrust for the medical system and psychiatrists. What explanation might be offered for this viewpoint? Discuss the possible differences between Mrs. Mouammar's interpretations of mental illness compared with the social worker's perspective.
    - Potential cultural conflicts that may exist between the medical system and Amina's family and their belief system. For example: Amina has not consistently been treated for her illness; she improves and then stops taking her medications and attending treatment sessions. Discuss how preventative medicine may be an unfamiliar concept in some cultures. Is knowledge of health care options a cultural barrier in this situation? How can this be addressed?
    - Amina's husband divorced her and obtained custody of her son shortly after she became ill. Discuss how gender roles affect this decision. If the situations were reversed, and Mr. Nawafleh was mentally ill, would Amina be expected to care for Mr. Nawafleh? Discuss the traditional roles of Muslim women and the influence their religious beliefs may have on marriage, illness, and the family.
(3) What approaches might an occupational therapist consider when working with a person from a Muslim background?

*Activity Two: A Variety of Case Scenarios*

A pair of students is presented with a case scenario (listed below). One student becomes the patient and the other student, the therapist. The student dyads research the background of their patient and develop solutions to the issues presented in the case scenario based on the patient's cultural background. Students should be cognizant that persons who are from a particular culture vary in belief systems and attitudes depending on many factors such as: the number of years lived in a particular country, years of education, ability to speak the language of their new country, circumstances involving immigration, economics, and willingness to assimilate to a different culture. Students should keep in mind the following questions:

- In a particular culture, are formal greetings or introductions important?
- How is time regarded?
- What are the attitudes toward disability in a particular culture?
- What is the person's explanatory model for a particular illness? In other words, how do they interpret illness or disability based on their belief systems?
- How are elderly persons regarded? How are males and females regarded? How are children regarded? What are the role expectations for each of these groups?
- What religious beliefs are common in that particular culture and how might this affect rehabilitation?

The student pairs are expected to fill in the details that would realistically accompany their patient's particular scenario (e.g. a person with a stroke might be expected to have residual weakness) and develop a problem list based on these deficits.

The student pairs will also describe how the therapist can be a "culture broker" for the other members of the health care team. A culture broker negotiates with the patient to come up with a satisfactory solution for a problem. The culture broker establishes trust and rapport with the patient and mediates conflicts the patient may have with other health professionals. Readers should refer back to the Transdisciplinary Guide, in the first section of this guide, for more information on the *culture-brokering* model.

Each pair of students will submit one case study that will provide information on the cultural background of the patient, their explanatory models, and information on conflicts that might develop. In addition, students will develop one long term goal, two short term goals, and specific examples of treatment strategies that are culturally relevant. Finally, students will role play their particular scenario using culturally relevant interviewing techniques.

Case Scenarios

1. Mr. Wong (*pseudonym*) is an 80 year old man from mainland China who recently underwent a right hip replacement and is in a sub-acute care clinic for approximately 10 days. He is not interested in lower extremity adaptive equipment since his wife will help him when he goes home. His wife is 10 years younger than he is and is in good health. His family brings in his favorite foods daily, and the nursing staff is complaining about the large number of family members gathering in his room and eating "strange food." Mr. Wong does not speak English very well nor does his wife. His oldest son usually interprets.

2. Kim (*pseudonym*) is a 43 year old Korean college professor with multiple sclerosis. She is experiencing an acute exacerbation that has left her with residual weakness throughout her left side (she is left-handed) and with poor balance. She wants to return to work as soon as possible. She is married, and her husband is a physician with a thriving practice. Her mother-in-law, who is 81 years old, also lives with the couple. Until this last exacerbation, Kim has helped care for her mother-in-law who has occasional memory lapses. Kim also needs to resume driving and improve her mobility since she takes her mother-in-law to her doctor's appointments, does the food shopping, and is generally responsible for the household chores. Kim and her husband are religious, and her church members are praying for her full recovery. She has just attended a healing service and is contemplating discontinuing her medication as an "act of faith."

3. Danny (*pseudonym*) is a 19 year old male of Jamaican descent who lives with his mother and was recently injured in a motorcycle accident. He sustained a fractured pelvis, has external fixators on both lower extremities, and has a fractured left wrist. He is non-weight bearing on both lower extremities and his left upper extremity. He has one month of rehabilitation before college starts, and it is important that he is able to perform his own activities of daily living (ADLs) in order to get to class on time. He is not coping well with his situation, and the nursing staff describes him as "uncooperative." He will

4. Benny (*pseudonym*) is a 43 year old man from Puerto Rico with two children. He sustained a traumatic brain injury after being hit by a car. Prior to his accident he worked in a factory and played in a band on weekends. He makes sexually inappropriate comments to the nurses and does not seem to understand the full impact of his disabilities. He has very poor attention, and his balance is unsteady at times. His wife is supportive, but she also works and is worried about leaving Benny alone during the day. His fine and gross motor abilities are good, but he has trouble remembering how to use objects (ideational apraxia). Benny has trouble dressing and bathing himself; he recently put a sock on his hand and tried to brush his teeth with a comb.

5. Mrs. Garcia (*pseudonym*) is a 78 year old Mexican-American woman who has diabetes. She is overweight and prefers to eat her traditional diet rather than the diet prescribed by her physician. She has just sustained a mild stroke. She is in a sub-acute rehabilitation unit to try to regain strength and balance before returning home. She lives with her daughter, son-in-law, and three grandchildren. Until her stroke, she did all the cooking and watched her grandchildren while her daughter worked. She is right-handed and has some residual weakness in her left hand. She enjoys knitting and wants to regain strength in her hand so she can again participate in this activity. Mrs. Garcia is unsteady on her feet and needs assistance to get out of bed and go to the toilet. She cries a lot and lacks motivation in therapy. The therapists think she is depressed, but she states that she is fine and has faith in God to help her.

6. True (*pseudonym*) is a 40 year old, educated, Vietnamese immigrant who arrived in the United States less than two years ago. Formerly a teacher, True is fluent in English. He worked as a delivery person due to his lack of professional credentials in this country. True was struck by a car and sustained a spinal cord injury. He has paraplegia and is able to maneuver his wheelchair with both upper extremities. He is being discharged from rehabilitation in one week and will be living with his wife and three children. His mother-in-law lives with them and helps with the care of the children. True's wife works long hours during the day and has not been able to meet with the nurses and learn how to assist True with his daily care needs (catherization and bowel regime). True is not able to provide his own hygiene and care in these areas and seems content to allow the nursing staff to care for him. The therapists are concerned about skin breakdown because True is not independent with his pressure relief program.

7. Dr. Rene Patel (*pseudonym*) is a 54 year old Indian psychiatrist who is married with four grown children. She has recently undergone open heart surgery and desires to return to work after her out-patient rehabilitation program. She presents with poor endurance for most daily activities resulting in fatigue and shortness of breath. Her husband is used to having his meals prepared and the household tasks attended to by his wife. Dr. Patel is very distressed, feeling that her roles as a psychiatrist and a wife have been disrupted. Two children live out of town, and her only daughter is attending college and is trying to

8. Che (*pseudonym*) is a 49 year old male from the Dominican Republic who works as a data entry specialist. He had severe carpal tunnel syndrome in both his hands. He has undergone bilateral carpal tunnel surgery two weeks ago and has been referred to out-patient therapy. He is worried about supporting his family during his recovery period because he receives minimal worker's compensation. His wife is not currently working outside the home and is the primary care provider for the children. Che has difficulty getting to therapy because of transportation issues. Currently, his grip strength is weak, and he continues to experience numbness and tingling in both hands. The scheduler is becoming very frustrated with Che because he is usually late for therapy or misses his appointments altogether.

9. Trinidad (*pseudonym*) is a 29 year old computer programmer from the Philippines who sustained a head injury while riding his motorcycle. He now has seizures and short term memory loss. He has impulsivity and judgment deficits. Recently, he took the family car out for a drive and hit a parked car. He is being seen in an outpatient clinic and desires to return to work. He lives with his parents who accompany him to every therapy session and loudly encourage him during the sessions, much to the distraction of the therapist and other patients. His parents think he is doing very well although the therapist has concerns about his ability to return to work. Although the therapist shows the parents the results of his testing and emphasizes his need for supervision, they just nod and continue to discuss his plans for returning to work with him.

10. Carlos (*pseudonym*) is a 50 year old Mexican-American man who passed out while operating machinery at the local Ford plant. He sustained a below the elbow amputation of his left upper extremity (he is right handed) and has been very depressed throughout his rehabilitation. He is now being seen as an outpatient, and his wife explained to the therapist that he is being treated by a healer for "Susto" (soul loss - a culture bound syndrome). He is having trouble sleeping, has frequent nightmares, and is unable to focus and gain skill using his new prosthesis.

*Activity Three: Culturally Relevant Assessment*

Students are asked to review references on occupational therapy assessment, catalogs, and websites and compile a list of assessments used by occupational therapists that are available in languages other than English. A "master list" is compiled for physical disability practice, pediatric/school-based practice, and psychosocial practice and shared with the class.

*Activity Four: Cultural Differences or "Non-compliance"*

In health care and treatment services, actions of individuals and their families who are "different from the norm" are often misunderstood. The need for cultural sensitivity and cultural competence is important in interactions with all our patients or clients. This is particularly true when an individual is not able to advocate for him or herself, such as individuals with developmental disabilities, and when the health care professional is unaware of cultural preferences.

In each of the following situations, the individual or family member has been labeled "non-compliant" by the OT. What else might be going on? What are the cultural implications of these situations? What other similar situations have you encountered?

- Faina (*pseudonym*) is a 45 year old woman who has been diagnosed with an intellectual disability. Her family is of Lebanese descent. She is able to complete most activities of daily living (i.e. showering, dressing, grooming) independently. However, during the summer months, personal care aides at her residence insist that she shave hair from her legs and under her arms. Faina refuses to do so and becomes very angry when staff continues to prompt her to do so.
- Mrs. Chen (*pseudonym*) is a 78 year-old mother of a 38 year old daughter with Down syndrome. After the death of her husband ten years ago, Mrs. Chen and her daughter, Ming, immigrated to the United States from China to be closer to family members. Ming lives at home with her mother. Both mother and daughter are showing some physical signs of aging. After an assessment, the OT suggests several pieces of adaptive equipment that will help Ming to become independent in ADLs. Her mother says no, she can help her. In addition, at a meeting with the OT and other day program staff, a recommendation was made that Ming move to a group home. Mrs. Chen became very agitated and was adamant in her refusal to move Ming to a group home.

**Level III: In-Depth Analysis**

*Activity One: Conceptual Models*

Students should review the literature related to models of cultural competence (i.e. *Kawa Model*, *Culture-Brokering Model*, *Campinha-Bacote Model*) and compare and contrast each in regard to their perceived relevance to occupational therapy practice. Students should submit a written paper and present information in class. The *Culture-Brokering Model* and the *Campinha-Bacote Model* are described in the first section of this guide, the Transdisciplinary Guide. The *Kawa (river) Model* uses a metaphor, the river, to describe occupational therapy services to clients. This model, based on Japanese social context, offers a naturalistic view of individuals as rooted in their environment. Although this model incorporates the use of Eastern philosophical ideologies, it has been found to be easily adaptable and relevant for many different cultures. Through the use of this model client are encouraged to view themselves, their personal attributes and problems, within the context of their environment. When obstacles create a reduction of the "life flow," occupational therapy is needed to help redirect their energy. The occupational therapist and the client collaborate on methods of intervention in order to find what is meaningful for clients within their personal environment and the community in which they live (Iwama, 2005).

*Activity Two: Development of an Occupation-based Intervention*

Based on a needs assessment of the agency, students develop and implement an occupation-based intervention at a community agency not currently providing occupational therapy services. Depending on the agency and clientele, specific cultural considerations must be incorporated into the intervention. The details of this assignment are that students must first interact with staff members at a particular site and review the mission of the facility. They are then required to

gradually increase their interaction at the site by first documenting their general observations and then progressing to the role of a participant in the site's regular programs. Students are asked to conduct a needs assessment by interviewing staff members and clients. Based on interviews and observations, they must develop a program that is relevant and meets the occupational needs of both the staff and clients at the site. They are expected to understand and incorporate cultural considerations into their intervention plan. Students develop this plan over the course of a semester with guidance from their instructors and feedback from fellow students. In-class time provides an opportunity for students to debrief and discuss their experiences in non-traditional and diverse settings. The final graded project at the end of the semester is the implementation of a program that was developed to meet the occupational needs of the site's clientele.

*Activity Three: Provider Interview (Wells, 1994)*

Students interview health professionals or agency staff who work with individuals from diverse cultural backgrounds. The focus of the interview relates to the problems, issues, and cultural conflicts that are encountered most frequently. Prior to the interview, the students develop a series of open-ended questions based on the interview topic. The method for the intensive interview is face-to-face. Small groups of students may interview the provider. If possible, the students should ask permission to audiotape the interview so that they can, at a later date, transcribe the interview verbatim. Students should meet after their interview and write down their observations while they are still fresh in their mind. They should conduct a thorough analysis of the data based on the transcribed interview and their observations, considering both verbal and non-verbal responses. During the preliminary analysis of the data, students should categorize the data into topics that are relevant to the students' questions; further analysis of the data should lead to the expression of recurring themes. The students should submit a 3-4 page double spaced discussion of the interview experience and present the results of preliminary data analysis.

*Activity Four: Create a Presentation for a Conference*

For this activity students are to assume that they have been asked by their local or state occupational therapy association to plan a presentation on Cultural Competency in Occupational Therapy.

In groups of three, students will prepare a program proposal and presentation that identifies cultural barriers in a specific area of OT practice. Student groups will choose an area of OT practice that they are interested in (e.g. school-based practice, early intervention, developmental disabilities, physical disabilities, psychosocial practice, or geriatrics). Each group will review the literature on their chosen area of practice and discuss possible cultural barriers or conflicts that can arise between practitioner and client/student in these situations. For example, many pediatric assessments do not account for linguistic barriers or differences in childhood socialization experiences. Likewise, elders from culturally diverse backgrounds may have a unique relationship with family members as caregivers and independence is not an achievable goal. Cultural barriers in various aspects of practice should be identified and strategies for resolving conflict can be discussed. Additionally, students who have encountered cultural barriers during their fieldwork experiences can share them with the group.

Student groups will then develop strategies that the practitioner can use to overcome cultural barriers within their chosen area of practice. Some strategies that can be utilized include the practitioner applying the *Culture-Brokering Model,* asking questions that are culturally sensitive such as *Kleinman's eight questions to assess the patient's perspective,* and/or discussing an individual's worldview, their explanatory model for the interpretation of illness and disability. Information on these approaches can be found in Part I, the Transdisciplinary Guide.

Student groups will prepare a brief abstract on their topic, including the identified cultural barriers and strategies that will aid the practitioner in overcoming cultural conflict. They will review the abstract with their instructor and the other students in the class, in order to refine their ideas. Each group will then prepare a brief power point presentation, 10 slides, on their topic and present this to the class. Student groups will be graded on the abstract, learning objectives, identification and rationale for cultural barriers, references, and final presentation.

A sample rubric is given below (Lubinski, 2008).

| | **Superior** | **Good** | **Needs Improvement** |
|---|---|---|---|
| **Content** | Expresses in depth knowledge of multicultural issues. Exceeds expectations in presentation of facts. Presents perceptions clearly and convincingly. | Content is accurate but does not go beyond expectations. Perceptions are credible. | Content is limited, not presented in a logical manner |
| **Clinical Application** | Highly creative and appropriate clinical suggestions. Applies cultural knowledge to solve diagnostic and intervention clinical issues with accuracy | Clinical suggestions are standard and reflect sensitivity to issues. | Clinical suggestions are not well-based, do not reflect sensitivity to cultural issues and are limited in number. |
| **Presentation** | Visual aids are appropriate, captivating and extend oral presentation. Speaking is clear. | Presentation and visual aids are adequate but not exemplary. Speaking style is clear. | Presentation and visual aids do not enhance the overall presentation. Poorly prepared. Speaking style is not clear to average listener. |
| **Resources** | Uses plentiful, high quality and current research based references to support content. | Uses a limited number of good quality research based references. | Uses few references, most of which are of questionable quality. |

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## Resources

There are numerous resources available that are related to occupational therapy and cultural competency; listed in the sections below are a select few of the many excellent resources available, primarily for occupational therapists but of interest to other health and social service professionals as well.

**Books and Book Chapters**

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