Culturally responsive caring in occupational therapy

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ABSTRACT: The present study examined how practitioners conceptualized culture and used their understanding of a client’s culture to provide culturally responsive caring. Descriptions of practice were elicited from experienced practitioners serving culturally diverse clients. Twelve practitioners completed a written questionnaire and participated in a telephone interview. Half of these same participants also participated in a follow-up interview, which was confirmatory in nature. Grounded theory methodologies were used to identify and conceptualize key processes inherent in these practitioners’ descriptions of providing culturally competent care. Practitioners’ perceptions of providing culturally responsive care were categorized into five interrelated constructs: building cultural awareness; generating cultural knowledge; applying cultural skills; engaging culturally diverse others; and exploring multiculturalism. One environmental construct, the diversity context was also defined in the data. Culturally responsive caring is described as a process of actively developing a synergistic relationship grounded in mutuality and an intentional respect for a person’s cultures. The findings add to the discourse on cultural competency in occupational therapy and may help to examine conceptual models of cultural competency for the profession. Possible implications for culturally responsive professional development, education, practice and research are presented. Copyright © 2007 John Wiley & Sons, Ltd.

Key words: cultural competency, grounded theory, qualitative research

Introduction

Culture is profoundly and inextricably tied to matters of health and healthcare. People learn from their own cultures how to be healthy, how to define illness, what to do to get better and when and from whom to seek help. Culture permeates every clinical encounter in occupational therapy. The practitioner and the person seeking care each bring their own personal and familial cultures, whereas the context where care is provided adds yet another layer of culture. In the USA the traditional, biomedical perspectives on care, including the definition and
categorization of illness and the various systems developed for providing and paying for care, represent a broader cultural context. Like many countries, the USA is considered to be a multiracial, multiethnic, multiclass society (US Census Bureau, 2006). This pluralism is manifest in healthcare settings in the broad cultural, linguistic and religious diversity of clients seeking care (Eck, 2002). A growing body of research is demonstrating that levels of healthcare, healthcare outcomes and general health status are typically poorer for racial and ethnic minorities and economically disadvantaged populations (Institute of Medicine, 2003). Given this evidence of cultural pluralism, and continued disparities in the health status of people from diverse cultural backgrounds, it is essential that practitioners be capable of providing care that is sensitive to a person’s beliefs, priorities and preferences for managing health, illness and disability. The capacity to provide such care is often defined as cultural competence (Bonder et al., 2002).

Cultural competency
There is no universally accepted definition of cultural competence (Bonder et al., 2002). Some definitions of cultural competence seek to broadly classify a practitioner’s abilities to understand and address a person’s needs within socio-cultural context (Lynch and Hanson, 1998). Others attempt to specifically delineate the skill sets that connote multicultural competence at personal, professional and institutional levels (Arredondo et al., 1996). Collectively, these definitions suggest that cultural competence is a complex, multidimensional construct that integrates cognitive, affective and behavioural components.

Multiple models of cultural competence have been proposed in the psychological (Cross et al., 1989; Sue et al., 1992), nursing (Campinha-Bacote, 1999; Leininger, 2002; Purnell and Paulanka, 2002) and occupational therapy literature (Wells and Black, 2000; Bonder et al., 2002). Models of cultural competency in the counselling psychology and in nursing disciplines are particularly well developed. For example, Sue et al. (1992) propose a framework organized around three critical dimensions: the capacity to be aware of one’s own assumptions, values and biases; knowledge and understanding of the world-views of culturally different clients; and the ability to develop appropriate intervention strategies. This model has been continually refined and has lead to the development of multicultural education and practice standards and the definition of a multicultural research agenda in counselling psychology.

In the nursing field, Madeline Leininger spearheaded the development of the field of transcultural nursing nearly 60 years ago (Leininger, 2002). A major assumption in Leininger’s model of culturally congruent care is that culture care concepts vary transculturally, but that diversities (differences) and universalities (similarities) can be established across cultures. Specific cultural and social components of this model include economic, educational, legal and political factors, cultural values, beliefs, and life-ways, kinship and social patterns, and
religious, philosophical and technological factors (Leininger, 2002). Leininger’s model is only one of several well-developed models of cultural competency in nursing (Purnell, 2002; Campinha-Bacote, 2003; Giger and Davidhizar, 2004). It is quite likely that the assumptions and concepts inherent in these counselling psychology and nursing models may also apply within occupational therapy, but as a profession, occupational therapy has not critically questioned whether models of cultural competence imported from these disciplines fit the realities of occupational therapy practice.

Models of cultural competency in occupational therapy

The development of cultural competency models within occupational therapy is a more recent phenomenon. Wells and Black (2000) proposed a cultural competency education model grounded in multicultural education and concepts drawn from sociological perspectives, including functional, conflict and interactional theories. This model identifies self-awareness, knowledge and skills as three critical areas for cultural competency. Although practitioners are encouraged to use this model to self-reflect on their own cultural competence, the clear focus of these authors was to develop a framework that supported multicultural education.

Bonder and colleagues (2002) advocated an enquiry-centred approach to developing cultural competence. In their culture emergent model, culture is viewed as dynamic and constantly embedded in and influenced by the context. The focus of this approach is to develop a skill set for cross-cultural interactions and intervention which are grounded in anthropological and ethnographic methodology. In a similar vein, Iwama (2005) has introduced the kawa (river) model as a culturally relative approach to understanding the person in a socio-cultural context. Iwama’s model is grounded in an East Asian cosmology which challenges practitioners to consider how concepts typically found in occupational therapy practice models, such as autonomy, independence, self and temporality, translate when taken outside Western, middle-class, social and cultural norms.

More recently, Suarez-Balcazar has analysed 30 unique models of cultural competency her research team found in their literature review of health science journals and book chapters published between 1991 and 2006 (Suarez-Balcazar and Muñoz, 2007). One intention of this ongoing research is to develop a synthesis model of cultural competency. In preliminary analyses, Suarez-Balcazar reported that the most common components were cultural awareness, cultural knowledge, cultural skills and cultural encounters or practice (Suarez-Balcazar and Muñoz, 2007).

In summary, model development in the area of cultural competency is in its infancy in the occupational therapy profession. Conceptual models of cultural competency within occupational therapy have not been generated from empirical study of occupational therapy practice. Wells and Black (2000) drew heavily from multicultural education and sociology, whereas Bonder and colleagues (2002) integrated interdisciplinary perspectives from anthropology, public health
and counselling psychology. Iwama's (2005) model did evolve from the study of Japanese occupational therapists, however; the intent of his research was not to provide a framework for cultural competence per se. Instead, his model presents a culturally relative approach for understanding a person in a socio-cultural context. This model arose from practitioners’ frustrations in attempting to apply occupational therapy practice models that were grounded in Western perspectives and which did not always translate to the practice context in Japan.

Examination of cultural competency in occupational therapy

The vast majority of occupational therapy literature that addresses cultural competency is dated, descriptive and concludes by providing guidelines for clinical practice based on culture-specific descriptions of particular cultural groups. Cultural groups most frequently discussed are populations that have emigrated to the Australia, Canada, the UK or the USA (Barney, 1991; Blanche, 1996; Yuen and Yau, 1999) or indigenous people seeking occupational therapy in their own countries, for example Aborigine (Haig, 1993), Maori (Jungersen, 1992), Tongan (Guthrie et al., 1994) and Yanomani (Moore, 1996) populations. These authors encouraged practitioners to recognize culturally valued activities, health and wellness rituals, the role of traditional healers and the need to understand explanatory models of health, illness and rehabilitation within original cultural contexts.

Some of the discourse related to addressing culture in occupational therapy demonstrates that occupational therapists are beginning to study cultural influences on activity choices, culturally based value differences affecting rehabilitation and culturally based explanations of health and illness. Almost all of this research has been pursued using qualitative methodology, including interpretive interviews, focus groups and ethnography. Although a person’s ethnicity or immigrant status are still in the foreground in most of these studies, researchers have also addressed other dimensions of culture, such as social and economic dislocation (Dyck, 1992) or the influence of refugee trauma and level of acculturation (Driver and Beltran, 1998).

There is a dearth of research that has attempted to specifically examine the process of providing culturally competent care in occupational therapy and much of the research that is available is dated. Phipps (1995) explored Australian therapists’ perceptions of barriers to caring for non-English speaking clients and strategies they used to overcome these barriers. In the Netherlands, Kinebanian and Stomph (1992) interviewed Dutch practitioners about approaches they used to treat immigrant clients. The research of Khamisha (1997a, 1997b) focused on British therapist’s cultural knowledge and service delivery to clients of Indian subcontinent origin. These studies all focused more on delineating barriers to the provision of culturally competent care than on defining the process of providing such care. These studies document that communication with immigrant populations is a primary barrier to providing effec-
tive care. Practices based on Western, middle-class values, such as an emphasis on activism as a response to disability, routinely working towards autonomy in activities of daily living and predating intervention on a future-oriented time perspective, often disregarded non-Western cultural mores (Kinébanian and Stomph, 1992; Iwama, 2005).

Very few studies have directly examined the process of delivering culturally competent care. Blanche (1996) used a reflective ethnographic approach to examine her own work with one Central American immigrant woman frustrated in her attempts to secure care for her child with special needs. Scott (1997) used a phenomenological framework to interview occupational therapy practitioners working with culturally diverse clients in and around London in the UK. Practitioners in Scott’s (1997) study defined the most significant challenges to effective care: errors made in interpreting client behaviour; language and communication barriers; and difficulties establishing reciprocal therapeutic relationships. These studies, although more focused on the process of delivering culturally competent care, tended to identify the challenges of providing such care rather than descriptions of the day-to-day actions of practitioners as they worked with culturally diverse clientele.

The present study sought to specifically examine the process of delivering culturally competent care by eliciting descriptions of culturally competent care from experienced practitioners serving culturally diverse clients. Grounded theory methodology was used to identify and conceptualize key processes inherent in the clinicians’ descriptions of their provision of culturally competent care.

An examination of culturally competent care

A qualitative research design using grounded theory methodology was chosen as the best approach for eliciting and analysing occupational therapists’ perceptions about their provision of culturally competent care. Occupational therapy is inherently an interpersonal process. Grounded theory methodology appears to be favourable in situations where little is known about a phenomenon and when processes being studied occur within a social situation (Munhall and Boyd, 1993; Denzin and Lincoln, 2000). Grounded theory methodology provides systematic processes to inductively collect and analyse data to produce conceptual frameworks that can be used to explain social processes (Glasser and Strauss, 1967; Strauss and Corbin, 1998).

The researcher

It is essential that qualitative researchers locate themselves transparently within the research processes they use to develop, collect and interpret data (Patton, 2001). Some of the author’s cultural identities include being male, heterosexual, raised in the Catholic religion, North American of Mexican descent and from a
working class family. As a member of an ethnic minority living in a society when race matters the author has experienced racism. Practice experiences have provided many opportunities to work with people from diverse backgrounds and many examples of being acutely aware of how culture influenced the clinical encounter. Every person has multiple cultural identities and, for each of us, one part of our life journey is a multicultural journey. The author is committed to multicultural training, believing that a significant component of cross-cultural conflict is based in a lack of knowledge of and limited interactions with culturally diverse others. As an initial step in reflexivity the author documented personal views and theoretical perspectives on culture and cultural competency within an electronic researcher's journal. The intent here was not to eliminate subjective reasoning, assumptions, knowledge or expectations about cultural competency, but, rather, to illuminate and make explicit presuppositions and to situate analyses. These are merely features that the author is conscious of and the existence of subconscious factors and influences that remain invisible are acknowledged.

The participants

Participants were recruited using a network sampling technique (Burns and Grove, 1995). North American leadership groups within the profession (American Occupational Therapy Association (AOTA) Executive Board, AOTA Diversity Task Force, Commission on Education, and the Committee of State Association Presidents) and leaders of multicultural networks (Association of Asian/Pacific Occupational Therapists in America, Black Occupational Therapy Caucus, Network for Gay, Lesbian and Transgender Concerns in Occupational Therapy, Network of Native American Practitioners, Network of Occupational Therapy Practitioners with Disabilities and their Supporters and TODOS Network of Hispanic Practitioners) were sent a covering letter providing a brief description of the study, inclusion criteria for participation and a request to recommend culturally competent practitioners.

A description of the study was also posted on each (11) of the AOTA Special Interest Section Listservers (Administration and Management, Developmental Disabilities, Education, Gerontology, Home and Community Health, Mental Health, Physical Disabilities, School System, Sensory Integration, Technology, Work Programs). Individuals who responded to the letters or listserver about inclusion in the study (n = 189) were sent a covering letter inviting participation in the study and a demographic questionnaire. A total of 87 questionnaires were returned from all sources and a pool of 35 full-time practitioners who had at least five years' experience, a master's degree or higher, treated a diverse clientele and had attended multicultural training (e.g. coursework, conference workshops, continuing education) were defined. From this pool, 20 potential participants were identified. Each was very experienced at providing services for culturally diverse populations, self-reported high levels of cultural competency, consistently pursued multicultural education and was recognized by others as cultur-
ally competent. The selection process was purposive with the intent of identifying a pool of practitioners who were very proficient in providing culturally competent care.

Twelve female participants were interviewed before the data from newly collected and analysed data became redundant (Strauss and Corbin, 1998). The participants were seasoned (mean age 48.3 years), educated practitioners (eight held MSc degrees and four PhDs) who were considerably experienced (mean experience 22.3 years) at providing services for culturally diverse populations. All were English-speaking and six were also conversant in other languages, such as Creole, Edo, French, German, Hebrew, Spanish or Yiddish. Seven of the 12 participants had each delivered more than four presentations on cultural aspects of care at local or national conferences, and three others had each delivered two such presentations. Collectively, they were diverse in terms of race, ethnicity, sexual orientation, religious background and practice setting (Table 1).

Data generation tools

Four tools were created to generate data:

- a demographic questionnaire
- an interview guide
- contact notes
- a researcher’s journal.

Personal data about a participant’s multicultural education, clinical practice, clinical training and work experiences with culturally diverse clients were generated by use of a demographic questionnaire. This questionnaire included open-ended and self-rating items examining level of cultural competency, frequency of multicultural training experiences and the degree to which the participant discussed and participated in social action relative to culturally competent healthcare. Items for this tool were developed based on a review of previous research that suggested educational experiences, heritage consistency and personal experience with diversity were correlated with levels of cultural competency (Pope-Davis et al., 1993; Phipps, 1995; Khamisha, 1997a).

Telephone interviews were the primary method of data generation. Twelve participants were interviewed once (average 76 minutes) and six of them participated in a follow-up interviews that were confirmatory in nature (average 58 minutes). An interview guide with statements, such as ‘Describe for me, so that I can know as if I were there, a clinical encounter where you felt culture played a critical role in how therapy unfolded’ and ‘Tell me about techniques you use to get clients to tell you their perspective of their problem’, was used to structure the interview. The guide helped direct and ensure some consistency among interviews; however, it was refined with each phase of data analysis. For example, after an initial set of interview questions were completed, questions that might be more effective in eliciting specific descriptions of culturally competent...
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*Not fluent.
interventions were added. These additions included, ‘Can you describe a clinical encounter where you felt you got “stuck” in therapy and where you felt being “stuck” was related to a cultural issue?’ and ‘Can you give me an example of how attention to culture is part of your assessment process?’

Follow-up interviews were confirmatory in nature and focused on verifying initial interpretations of the data. A file containing an image depicting a preliminary conceptualization of the data and written definitions of the primary categories and subcategories was sent electronically to the participants before secondary interviews. Participants were asked to comment on the structure and organization of concepts depicted in the image and whether the definitions of primary categories and their subcategories resonated with their own experiences of providing culturally competent care. Follow-up interviews were discontinued after the sixth interview as confirmation analyses had become redundant with no new findings emerging from the process (Strauss and Corbin, 1988).

Contact notes were made at each point of data generation. These brief summations were used to contextualize the data (Munhall and Boyd, 1993). For example, who was spoken to, when, reactions and points to consider in subsequent interviews were consistently documented in the contact notes. A researcher’s journal served as a repository for memoranda throughout the data-generation and analysis procedures. The journal provided a clear auditable record of decision points in the study, rationales for conceptualization of the data (including how concepts were developed) and when or why questions were adjusted in the interview guide (Denzin and Lincoln, 2000). The following excerpt documents some reasoning in the early stages of concept formation, which eventually led to asking clarifying questions about experiences with discrimination and institutional racism.

12-8: I added a new free code in my analysis today: ‘discrimination’. I am not sure whether this [reference to discrimination] is part of the clinical encounter or of the participant’s personal experience. Is the participant’s own cultural identity or past experiences with discrimination sensitizing them to other people’s experiences? I’m thinking about Cross’s Black, racial identity and Helm’s White racial identity models, which both include stages where the individual is more aware of oppression of racial minorities and stages where the person actively works against such institutional racism. I am not sure how to think about this yet. I get the sense that participants are talking about their own lived experience of discrimination even though I am not asking about it directly? Should I? I need to come up with a good way to ask about this.

Analysing the data

The use of grounded theory procedures data analysis proceeded in four phases: concept formation; concept development; selective coding; and definition of a core variable (Strauss and Corbin, 1998). These phases are presented here in a
linear fashion, but analysis was an iterative process with considerable interplay between the phases.

Concept formation employed a process of open coding to name any concept in the data that appeared to describe culturally competent caring (Strauss and Corbin, 1998). Interviews were transcribed and checked for accuracy by the researcher. The essence of what practitioners were describing was labelled in line-by-line examination of the data. Particular attention was directed at action words ending in ‘-ing’ that described what was happening (listening for, watching if), context words that connoted where action occurred (home, clinic and so on) and temporal descriptions that ordered action as a sequence of events (when the client first comes in, after the session).

In the concept development phase connections were made between codes so that categories and subcategories were defined (Miles and Huberman, 1994). For example, during concept formation ‘knowing where I came from’, ‘knowing myself’ and ‘reflecting on my culture’ were defined. These codes were grouped under the category ‘cultural awareness’ as they all described practitioner self-awareness.

Selective coding involved specifying the range of properties in each category and seeking evidence that captured the variability in these categorizations. This phase was supported by the use of NU*DIST, a qualitative computer program (Scolari, 1997). For example, a code which appeared in all 18 interviews was ‘cultural assessment’. More than 650 text units (a text unit can be anything from a sentence to a paragraph) were initially coded as ‘cultural assessment’. Using the NUD*IST program, a report was generated that retrieved all text coded as ‘cultural assessment’. Selective coding was then used to define specifically the properties and dimensions of cultural assessment. During this phase, memoranda from the researcher’s journal and stored within the NUD*IST software were integrated into the interpretation of the data.

The final phase involved defining the core variable. A core variable is invariably present in a grounded theory study (Glaser, 1978). It is a guiding principle that serves to link the data together and to explain variations in behaviour (Chenitz and Swanson, 1986). Through an iterative process of defining and reducing categories, culturally responsive caring was defined as the core variable that captured the essence of providing cultural competent care in occupational therapy. Constant comparative analysis was used to expand, modify, delimit and integrate this core variable (Stern and Pyles, 1985). These processes helped to refine the central components and the taxonomies created to understand and explain the grounded theory. Data from secondary interviews were integrated into each phase of analysis, but most notably in the second and third phases.

Findings: the central categories

Culturally responsive caring is conceptualized as the interaction of five interdependent components which comprise processes of providing care and one
contextual component that illuminates environmental factors influencing the provision of culturally responsive caring (Figure 1). Each of these components is grounded in the data of this study. Generating cultural knowledge is a process whereby practitioners develop and seek to expand a knowledge base that helps them to understand the world-views of culturally diverse clients. It involves viewing clients as inherently multicultural, constructing a broad definition of culture that encompasses attributes beyond race and ethnicity, and acknowledging the differences that exist within any cultural group. Building cultural awareness is a process whereby practitioners recognize their own cultural heritage, their biases and their capacities and limitations for treating culturally diverse clients. Active reflection directed at understanding themselves and others as cultural beings is a key aspect of building cultural awareness.

Applying cultural skills is manifest in strategies used in assessment and intervention. These skills are also embedded in descriptions of efforts to forge an interpersonal connection with culturally diverse clients. Specific skills include maintaining an open and welcoming stance, reading and responding to the dynamics of the clinical encounter and engaging each client with a purposeful intent to identify and honour their cultural life-ways. Engaging culturally diverse

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FIGURE 1: The central categories of culturally responsive caring.

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others involves having direct encounters with culturally diverse populations in both professional and personal contexts. These encounters provide opportunities for practitioners to test the depths and recognize the limits of their cultural knowledge and to practise skills for connecting and responding. Encounters are not always harmonious and sometimes result in clashes between the practitioners’ and clients’ cultural values.

Exploring multiculturalism is a reflective process whereby practitioners demonstrate an intentional drive to continually broaden their cultural understanding and pursue a personal journey of multiculturalism. Exploring multiculturalism is a purposeful act grounded in a commitment to address culture in clinical practice as a means of providing best practice.

Diversity context is a contextual component acknowledging environmental factors influencing practitioners’ experience of providing culturally responsive caring. Primary factors influencing the diversity context include the presence of diverse healthcare personnel and the nature of institutional support (or lack thereof) for providing culturally competent healthcare.

Support for the organization of data into categories of culturally responsive caring is grounded in data of the present study, the participants’ descriptions of culturally competent practice. In the present analysis, individual participants are not identified even by pseudonym. This decision was deliberate as the focus in grounded theory is to amplify the common voice that grounds the conceptual organization of the data. When illustrative quotes are included, excerpts that reflect data from the broadest possible range of participants have been used.

Generating cultural knowledge

All the practitioners in the present study described both attitudes and actions that focused on developing and expanding a broad knowledge base that helped them understand the world-views of clients from different cultural groups. Practitioners actively constructed a personal knowledge base of culture-specific information through a variety of methods, including directing specific questions about culture to the people they worked with:

I think I look for information and I think about it [culture] all the time. I try to find out about the rhythms of life within different groups, and what makes up the rhythm of life . . . What do people do? How do they do it? How do they go about it? How does their cultural group do things? How do they deal with sickness and health and things like this? And even the mundane things of eating, sitting, toileting and such? . . . I find out some of this by reading, but a lot more by asking the people I treat.

I try to build up my knowledge about people, the groups that they come from, what it means to them to be a member of that group, what patterns,
activities, tasks, occupations are part of the expectations of members of that cultural group.

Practitioners generated a broad definition of culture that transcended race and ethnicity. They described judiciously using culture-specific knowledge, acknowledging within-group variations in cultural groups and conscious efforts to determine whether culture-specific information was applicable to the client being treated. These practitioners generated knowledge that helped them reason about a client’s cultural identity:

Culture is not only ethnic, racial or religious, so I also consider gender, age, regional and national. I see culture more from an anthropological point of view than a biological one. I try to read about and pay attention to these things.

Building cultural awareness

A central category in the data was building cultural awareness. This category is grounded in practitioners’ descriptions of self-reflection. Each of the participants provided multiple examples of reflection strategies for understanding their own cultural identity and their prejudices and biases. Practitioners often connected the need to learn about themselves as cultural beings to culturally competent care with their clients. The following quote captures this description of active reflection on personal cultural heritage:

To see others as cultural beings, I’ve learned that I have to examine my own cultural identity. I see myself as having evolved from eight cultures into what I consider my cultural identity. So basically I have in my background Native American roots, I have ties to Western Europe. I have some roots within Great Britain. I have some Welsh roots. I have some English roots. My last name happens to be of Saxon origin, which is German. I have ancestors that were French.

Practitioners built cultural awareness through a conscious process of examining their own biases. The participants described concerted efforts to recognize how stereotypes and racism affected the healthcare experience of culturally diverse clients. The perspectives they voiced suggested that reflective self-awareness was a strategy for checking assumptions and guarding against preconceptions and biases. The participants described a willingness to examine their own prejudices and to remain open to the experience of diversity and multiculturalism:

I think you have to be willing to do that self-examination [of prejudices and assumptions]. You have to be open to getting there and being OK with what
you find. And dealing with your own prejudices and your own biases, because we all have them, regardless of whether we want them or not.

Applying cultural skills

In the present study, practitioners were not actually observed. The structure of this category is abstracted from practitioners’ descriptions of strategies they used when working with culturally diverse clients. For example, they reported completing cultural assessments, creating cultural narratives for their clients and using interpersonal skills to demonstrate intentional respect for clients’ culture. Cultural assessment included asking questions, clarifying values and probing to understand clients’ cultural life-ways and perspectives. These practitioners did not report the use of any specific cultural assessments. Cultural data were gathered by intentionally considering culture in the assessment process and generating interview questions that elucidated cultural aspects of clients’ identity. Practitioners tested their hypotheses about clients’ culture and adjusted their practices based on data gathered through interview and observation. A common description of specific therapy practices included directly asking clients about their culture. Every participant gave examples such as the following:

So you just, I just ask . . . So I ask, what is your background, where did your family come from, how long have you been here. Do you speak Spanish dada da da da. And people, I’ve never had anyone have a problem with my asking those questions.

I’ve actually stopped and asked something more direct like, ‘As we are working in therapy, you need to let me know if we are doing anything that doesn’t feel right for you or goes against your culture’.

Cultural assessment informed these practitioners’ reasoning processes as they constructed stories of their clients as cultural beings. Making culture a central feature of clinical story-telling helped practitioners to generate cultural narratives:

It [thinking about culture] is part of being an OT [occupational therapist] and the whole process of trying to reason narratively . . . I try to frame the story relative to the person I am working with and their outcomes. You just can’t deny the cultural aspects of the story.

I use occupational story-telling as a tool for that [learning about clients’ cultural identity]. It’s asking questions. It’s the qualitative aspect of being an occupational therapist.

One of the most prominent skills practitioners discussed was the capacity to create an interpersonal connection. Practitioners emphasized the need to estab-
lish a sense of mutuality with clients, by paying careful attention to the client’s verbal and non-verbal communication. When practitioners described this interpersonal skill set they often described their skills by reflecting on the interpersonal processes that occur within the cross-cultural encounter:

You form each relationship in a different way. You kind of gauge, you can tell when you’re overstepping and you’re making them uncomfortable versus what they’re comfortable telling you at the moment. So I read body signals, read facial expressions, their eye contact, their responses.

Culturally responsive intervention was described as treatment that held cultural meaning for clients. Practitioners shared the reasoning behind the selection of treatment interventions that recognized and celebrated clients’ cultural identity. Interventions offered clients opportunities to express their cultural heritage, to learn about the cultural identities of others or to celebrate diversity within the peer group. The following quotes provide specific examples of using activity that held cultural meaning with clients.

We had to problem-solve a lot, but in the end we came up with three different way of preparing the tortillas. At the end of it [therapy], she was like, ‘I’m not tired. [when] I started out, I thought I was going to be really tired. I don’t hurt. I enjoyed this activity.’ . . . Choosing activities that are culturally appropriate is part of being a good OT.

One of the things I try to do for my group at various times is to give them an opportunity to talk about their heritage, and talk about their lifestyles and things that are different from and similar to the general population. That’s one way of acknowledging them.

Engaging culturally diverse others

These practitioners engaged culturally diverse people in both their personal and professional lives. These encounters provided a context for them to develop their cultural awareness, hone their cultural skills and add to their cultural knowledge:

I think actually having had these encounters makes me more competent. I’ve worked with people who are different from me, and my private life is one where I go out and learn about other people . . . In the absence of encounter, you can have a lot of knowledge. You can actually have some good skills, you can be aware of yourself. But if you don’t have the encounter, its [cultural competency] not going to happen.

Engaging culturally diverse clients sometimes resulted in a clash of cultural values. Almost all the practitioners shared incidents where they failed to

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interpret or misinterpreted cultural information or where they found themselves facing a difficult clinical choice brought on by differences in cultural perceptions, attitudes or behaviours between them and the client or their families. These stories of cultural clashes often emphasized lessons learnt from the encounter. Culturally responsive caring is supported by this reflective process.

So I was teaching her some one-handed or minimal bilateral kitchen skills. And thinking like a Californian I had lots of fresh vegetables and salad and all that sort of thing and I figured she could make a green salad. And she got kind of a kick out of that because she said, ‘You know, where I live we don’t get that many fresh vegetables for most of the year. So I don’t mind making a salad, but this isn’t a regular part of what my diet would be.’ It was like boiiiing! She really brought it home to me that I had been thinking in my own cultural context.

Exploring multiculturalism

Participants described the process of becoming culturally competent as a journey and a lifelong process. Each participant, without being asked, shared their own cultural biography. In most cases these stories were in response to initial interview questions aimed at simply getting to know the person and their practice context. The term ‘exploring’ is employed to capture a sense of discovery described by these participants. Practitioners’ cultural biographies often highlighted experiences which they felt influenced their journey towards multiculturalism. These stories were often intensely reflective:

My culture is richly infused with a life that has brought me from the fields of Mississippi, the small-town living of East St Louis, the racial polarity of St Louis, and now to the diversity of California. My own culture is about community and strong family ties, punctuated by regular family reunions that include multiple ethnic groups, generations of families worshiping at the same church and family mobilization in times of crisis.

Growing up in the South, I experienced the effects of racial tensions and racism as well as the prejudices of others who were not from the South. Coming out also shaped my experiences –it affected all aspects of my life and relationships with others.

These stories also emphasized a sense of commitment towards multiculturalism that was manifest in a desire and obligation to learn and experience cultural diversity. For some, this commitment paralleled efforts to become proficient in other aspects of their profession:

You have to be motivated not only to learn the language, but to learn the meaning, to learn about people and to continue to work and work on refi-
ing it. So there has to be motivation and that’s what, if you think about it, that’s what you have to do if you are going to be a good therapist too, you constantly have to be motivated. You have to have desire and motivation, and the only way you are going to develop those skills is to read about it, to do it, to talk to people, like any other skill and you have to be motivated.

A theme of cultural curiosity also permeated practitioners’ stories. Many described being genuinely intrigued by cultural difference and this fascination fuelled their motivation to explore other cultures. Some described an inner drive to learn about other cultures and a desire to become a more multicultural person:

I guess it kind of goes to an inner motivation of myself to succeed in reaching the best outcome for that person that I can. Which kind of goes back to the idea that what I do in the job is I step into someone’s life. I try to make a little bit of a difference and then I step out. Well, when I am in that person’s life I want to make the biggest difference that I can that will be helpful to them. So it’s a challenge to try and do that and the way that I can achieve that is by delving as much as possible into all the aspects of that person so that involves looking at their culture.

Diversity context

The critical role of institutional context was a consistent theme in these participants’ stories of their practice. Participants felt most supported in facilities where the diversity context included a critical mass of practitioners who respected the influence of culture on healthcare and where their workplace made multicultural resources available to staff:

We have a cultural diversity department. It used to be affirmative action, and now its cultural diversity . . . like there’s all kinds of information they put up on our website or they have all kinds of activities to focus on different cultures or different ethnic groups, different celebrations.

Supportive settings were described as having objects that conveyed a sense of hospitality for diversity, such as signs, forms, a patient’s bill of rights in languages other than English or having the waiting room television tuned to a Spanish language channel. In such settings, clients in occupational therapy could expect to work with plantains, tortillas and other traditional foods. Paediatric centres had toys that were familiar to children from diverse cultural backgrounds and their families and traditional storybooks were reading options on the bookshelves:

[So] that when they come in we make sure that they see things they can relate to, like the pictures on the wall and toys in the room. You try to make those things as welcoming and as familiar to them as possible.
Providing culturally responsive care sometimes meant circumventing biomedically oriented rehabilitation practices. Practitioners described conscious attempts to modify or discard traditional rehabilitation practices to develop a stronger sense of mutuality with culturally diverse clients. These modifications required a clear recognition that the rehabilitation context had its own rules and cultural norms, and that a culturally competent practitioner needed to demonstrate a willingness to break or at least bend these rules:

At some level you have to, you have to abandon, or at least set aside some cultural assumptions that come with the territory of rehabilitation, that in rehab, we do it this way. You have to be willing to suspend that – to be able to accept that this person maybe doesn’t want to do it that way.

Like picking out clothing for a patient to wear or making clothing suggestions in rehabilitation where people need easier clothing to get dressed. For some elderly, and I have found it more with immigrant elderly, the idea of switching to sweaters was just horrible. Just very, very rude because that just was not the type of clothing that is worn in proper environments kind of thing. And yet for the therapist it could make it much easier to develop some of those basic skills. . . . The difference between a therapist who is culturally competent and a therapist who is less so, is that the one who is less so may easily adopt the prevailing cultural norm of rehabilitation and the culturally competent therapist will consider that option but also make a conscious attempt to match or consider whether there is a match between the client from a cultural perspective and the activity or the equipment that’s being offered. So it’s either carte blanche acceptance of the status quo culture of rehabilitation or a conscious attempt to reconsider.

Situating the findings

The data in the present study were organized to describe the process of culturally responsive caring as resulting from the synergistic interaction of five components. These components, in varying combinations, can be influenced by the supports available within the practice environment. Generating cultural knowledge and building cultural awareness involves understanding and respecting the cultural identities of oneself and others. Applying cultural skills and engaging culturally diverse others requires the application of cultural knowledge and is manifest in skills employed in cross-cultural encounters. Exploring multiculturalism is conceptualized as a personal multicultural journey and a transformative process reflected in one’s commitment to develop as a multicultural being. The diversity context in the practice settings where occupational therapists engage their clients can vary in their ability to support culturally competent healthcare. The results of the present study offer a vantage point for examining the concept
of cultural competency in occupational therapy practice. The findings may also offer a comparative framework from which existing models of cultural competency can be assessed for their relevance to occupational therapy. Practitioners may find the structure and organization of the findings provide a mechanism that supports reflection on their own culturally competent practices.

Reconsidering cultural competency

Webster's New Collegiate Dictionary (1975, p. 230) defines competence as a 'state of being' using examples of 'legal capacity' and 'certified qualification' to describe this state. One component of cultural competence often discussed in the literature is the need to have a solid base of culture-specific information about different cultures (Purnell and Paulanka, 2002). Sue and Zane (1987) described this type of knowledge as cultural literacy. Cultural literacy is reflected in the way that a practitioner studies the available scholarship about a client’s culture. On the other hand, the findings of the present study conceptualize cultural competency more as a process of becoming rather than a state of being (Campinha-Bacote, 1998, 2001). This process-oriented vision sees cultural competency as far more than knowing culture-specific information about various groups. Participants in the present study described their conscious efforts to build a knowledge base of culture-specific information but also reported a willingness to intentionally consider whether what they knew about a cultural group applied to the client they were currently treating.

The use of the term 'culturally responsive' rather than 'culturally competent' in the interpretation of these data was intentional. Responsiveness conveys the give and take and the adjustments and reactions that occur when exploring and reacting to cultural aspects of care. Responsiveness also communicates a state of being open to the process of building mutuality with a client and to accepting that the cultural-specific knowledge one has about a group may or may not apply to the person you are treating.

This approach to reasoning is similar to the process of dynamic sizing described by Sue (1998). When a practitioner uses dynamic sizing skills they recognize when to generalize and when to individualize culture-specific knowledge. In fact, practitioners in the present study maintained a stance of informed not-knowing to help them remain open to cultural understanding. Anderson and Goolishian (1992) described informed not-knowing as an advanced level of therapeutic artistry manifest in an interpersonal approach featuring active listening, intentional respect and questioning processes that conscientiously recognize the client as the expert of their own experience. Participants in the present study, though very proficient and experienced at working with culturally diverse clientele, all gave examples of suspending what they thought they knew about a person’s culture until they found out how the person expressed their cultural identity. Similar processes have been described as cultural empathy (Dyche and Zayas, 2001) and cultural humility (Tervalon and Murray-Garcia,
Culturally responsive caring (1998). Cultural competency is a standard byword in the lexicon of the health professions. Study results suggest that competency may be a misnomer if practitioners believe it is a state of being that can be achieved.

**Linkages with current models of cultural competency**

Wells and Black (2000) have presented a cultural competency education model featuring a tripartite mix of knowledge, skills and awareness, which is proposed as a framework for self-monitoring cultural competency and for designing multicultural training. Bonder and colleagues (2002) have proposed the culture emergent model as a way of thinking about culturally competent assessment and intervention by applying strategies grounded in anthropological and communication studies. The constructs of culturally responsive caring complements both these models and provides a framework for comparative analysis that is grounded in the reported clinical experiences of occupational therapy practitioners. As stated previously, Iwama's (2005) *kawa* model was not specifically designed as a model to address cultural competency. Nonetheless, the *kawa* model offers conceptual structure that is consistent with the conceptual structure of cultural responsive caring reported in the present study. In particular, the strategies Iwama (2005) suggests for applying the river metaphor as a means of exploring a client in socio-cultural context offers practitioners additional tools for generating cultural knowledge and applying cultural skills.

Although the structure of the components in this description of culturally responsive caring parallel those in some of the most popular nursing and counselling psychology models, most of these models place more emphasis on delineating the specific characteristics of a client’s culture to attend to (Andrews and Boyle, 2002; Leininger, 2002; Purnell, 2002) or on defining the specific skill sets for culturally competent care (Sue et al., 1992, 1998). Many nursing models have defined specific cultural domains (e.g. communication, family roles, nutrition, death rituals, fertility and so forth) for organizing cultural assessment and interventions. Although some of these domains may also serve occupational therapists as they strive to provide culturally responsive care, others may be less useful. Further, none of the nursing models includes occupation, activities of daily living or leisure as cultural domains to prioritize in assessment and intervention.

Models of cultural competency in the health professions are, for the most part, untested (Canales and Bowers, 2001; Narayanasamy, 2002). Though occupational therapists often regard their profession to be distinct and unique when it comes to providing culturally responsive care, it is likely that cultural competency models developed in other disciplines may be modified or synthesized with current occupational therapy models to develop frameworks that effectively fit practice needs in occupational therapy.
Linkages to multicultural practice and education

The components of culturally responsive caring may provide a language for discourse about multicultural education and practice in occupational therapy; however, the discussion that follows relative to education should be considered an extrapolation from the data as multicultural training was not a focus of data-generation. Nonetheless, some of the strategies employed by these practitioners who self-identified and were nominated by peers as proficient, culturally competent practitioners may provide suggestions that inform both practice and education.

The results suggest that practitioners may want to evaluate their knowledge and skills for cultural assessment and intervention, and review communication strategies employed with culturally diverse clients, such as processes used to elicit cultural narratives. Bonder and colleagues (2002) and Iwama (2005) both specifically address strategies that may help practitioners to interview clients effectively in a manner that privileges their socio-cultural context.

The finding that the participants in the present study actively sought continually to generate a knowledge base of cultural data suggests that practitioners may also want to reflect on their current fund of cultural knowledge and their awareness of their own cultural beliefs and biases. Descriptions of culturally responsive caring provided by practitioners in the present study also highlighted the necessity of centralizing culture as a key component in the evaluation process. The results of the present study may encourage occupational therapists to consider whether the tools they employ in their current evaluation processes address culture. None of the practitioners in the present study employed a specific cultural assessment, but did include direct questions about cultural identity and cultural practices within their interview processes. The findings related to diversity context support researchers who have advocated for the healthcare context to reflect to an inclusive, multicultural environment (Brach and Fraser, 2000; Howard et al., 2001) and suggest that practitioners advocate ensuring that the healthcare systems where they work provide institutional support to foster culturally responsive caring. These supports might include having trained translators, providing multicultural training or having therapy materials on hand which respect the cultural preferences of the clientele seen.

A consistent finding in the few studies investigating cultural competency in occupational therapy is that respondents describe their multicultural training as insufficient (Pope-Davis et al., 1993; Khamisha, 1997b; Scott, 1997). Students are known to struggle with the concept of culture (Fitzgerald and Mullavey-O’Byrne, 1996) and several authors have discussed the need to critique multicultural training in occupational therapy (Wells and Black, 2000; Forwell et al., 2001; Bonder et al., 2002). Nursing has criticized academia for not better integrating multiculturalism across the curriculum (Gary et al., 1998; Gerrish, 1998) and has suggested that faculty cannot teach what they do not know (Doyle et al., 1996). They also criticize educational programmes for not being clear.
about their outcomes relative to multiculturalism (Anderson, 1995; Culley, 1997). Educational programmes in occupational therapy have not received a similar level of scrutiny. Curricular content and educational processes might be examined using the key components of culturally responsive caring to assess the content and delivery of multicultural training in occupational therapy programmes.

The finding of the present study provide a conceptualization of cultural responsive caring that when added to the current discourse on this topic may help provide continued examination of multicultural research, education and practice. Further research and development of this framework will need to occur if it is to have any lasting value and significance for the profession. In particular, direct observation of culturally responsive caring would be a logical next step for researching culturally responsive caring. The present study focused on well-educated, very experienced practitioners who were already accomplished at providing culturally responsive caring. A study which targets new practitioners or which employs sampling strategies that seek to establish maximum variation in the level of cultural skills and training would probably contribute to our understanding of culturally responsive caring in occupational therapy. Future research might also explore how cultural beliefs influence and shape occupational values and choices over the lifespan.

Further, enquiry into occupation as a complex, culture-bound phenomenon may expand the profession’s conceptualization of culture as dynamic and emergent. The present research framed culturally responsive caring from the vantage-point of the practitioner. Research which explores clients’ perspectives of culturally responsive care is virtually absent in the occupational therapy and healthcare literature. Research from the client’s perspective can provide insights into the quality of culturally responsive care and may be able to address issues concerning the effectiveness of multicultural training and coursework.

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References


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