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**CULTURAL CONSIDERATIONS IN CLINICAL REASONING:
AN OCCUPATIONAL THERAPY CASE STUDY**

by

Sandra M. Winter

**A Thesis
Submitted to the
Faculty of The Graduate College
in partial fulfillment of the
requirements for the
Degree of Master of Science
Department of Occupational Therapy**

**Western Michigan University
Kalamazoo, Michigan
December 1997**

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Sandra M. Winter

CULTURAL CONSIDERATIONS IN CLINICAL REASONING: AN OCCUPATIONAL THERAPY CASE STUDY

Sandra M. Winter, M.S.

Western Michigan University, 1997

This study looked at an occupational therapist's work with clients from varied cultural backgrounds. Qualitative research strategies and a phenomenological approach were used to gather data through interviews with a single respondent and observation of treatment. This methodology was used to examine the process utilized to acquire cultural knowledge and integrate that knowledge into treatment planning. Research focused on: (a) how the cultural background of a client influenced an occupational therapist as she planned and implemented treatment, (b) how the treatment process was influenced by cultural differences between the therapist and the client, and (c) how training or education helped the occupational therapist better serve cross-cultural clients.

This case illustrated the relationship between consideration of culture and clinical reasoning. It explored the client's cultural background and how it impacted development of the therapist-client relationship. This impact included communication with the clients and the therapist's treatment approach. Cultural differences were apparent in the assessment process and effected treatment outcomes. Results of this study support education focused on skills for providing culturally relevant and individualized care and the development of clinical reasoning skills.

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CHAPTER I

INTRODUCTION

Purpose of the Study

The purpose of this thesis is to explore the concept of culture and its relationship to clinical reasoning in occupational therapy. This information is intended to aid therapists in understanding the importance of integrating cultural considerations into clinical reasoning. A review of the literature supports the belief that consideration of culture in treatment planning leads to more effective treatment and positive treatment outcomes. Dillard, et al. (1992) state in their study of mental health treatment for diverse clients that knowledge of culture can aid the therapist in developing insight into clients from the non-dominant culture and in the selection of appropriate treatment activities. Understanding differences between the philosophies, values, and norms of occupational therapy and the cultural norms and values of the client can help eliminate barriers to effective treatment (Kinébanian & Stomph, 1992).

Influences on Study Design

This research is based on two studies. Kinébanian & Stomph (1992) conducted a qualitative study of cross-cultural care in the Netherlands. Occupational therapists were interviewed on the importance of cultural competency, problems

encountered in cross-cultural care, and how they were trained to treat cross-cultural clients. The second study was a qualitative study of clinical reasoning that analyzed the reasoning process occupational therapists use in everyday practice (Cohn, 1991; Mattingly & Fleming, 1994). Viewing the client as a person dealing with a disability in a broader cultural and societal context is a form of clinical reasoning (Mattingly & Fleming).

Cultural and clinical reasoning in occupational therapy has been studied in regard to values underlying clinical reasoning (Fondiller, Rosage, & Neuhaus, 1990), narrative reasoning and consideration of culturally based meanings and motivations (Mattingly, 1989), and the influence of culturally based pre-theoretical assumptions on clinical reasoning (Hooper, 1997).

Design of the Study

This thesis focused on the experience and clinical reasoning of one therapist whose practice included a high percentage of cross-cultural clients, in order to examine the process used to acquire cultural knowledge and integrate that knowledge into treatment planning. Research questions for this study were:

1. How does the cultural background of a client influence an occupational therapist as he or she plans and implements treatment?
2. How is the treatment process influenced by cultural differences between the therapist and the client?

3. What training or education could help the occupational therapist better serve cross-cultural clients?

The Study of Culture in Occupational Therapy

Culture has been defined as “the sum of beliefs, practices, habits, likes, dislikes, norms, customs, rituals, and so forth that we have learned from our families during the years of socialization” (Spector, 1991, p. 50), and a way people make sense of the world around them which includes the nature of health, illness, and appropriate forms of care (Kavanagh & Kennedy). Culture includes beliefs, norms, values, institutions, traditions, and behaviors. Cultural differences which may impact the provision of health services include language, religious beliefs, socio-economic status, age, and gender. Cross-cultural interactions occur when significant differences exist between the involved persons with regard to culturally based communication styles, beliefs, and practices (Kavanagh & Kennedy). Sanchez (1964) was an early proponent of examining the cultural values underlying occupational therapy and the impact on clients. He outlined the value orientations of middle-class culture in the U. S., how these value orientations influenced treatment, and potential difficulties cross-cultural clients may experience with therapy due to conflicts in value orientations. As the percentage of minorities in the U.S. increases, occupational therapists will be treating larger numbers of clients from diverse cultural backgrounds (Dillard et al., 1992). In order to provide effective and ethical treatment, it is important for therapists to gain skills in working with consumers from diverse cultural backgrounds (Taughner, 1996).

Cultural Competency

Cultural competency is defined as having cultural awareness, as well as skills to facilitate effective interaction, communication, and cooperation with consumers from a variety of cultures (Campinha-Bacote, 1994). In addition to developing a knowledge base about other cultures, to be effective a therapist must be aware of the cultural values and attitudes held as a result of his or her own cultural heritage. Cultural competency allows the therapist to address the special needs of clients from diverse cultural backgrounds. Needs may include altering communication strategies to meet a client's cultural norms for verbal and non-verbal communication, use of open-ended interview questions, receiving treatment from a therapist of a particular gender or age, use of culturally sensitive assessment or evaluation tools, and awareness of a client's model of health, including the cause and meaning of symptoms and appropriate forms of treatment.

Educating Practitioners for Cultural Competency

Several models have been proposed to aid in educating health care practitioners for cultural competency. Most of the models focus on developing cultural awareness and sensitivity, enhancing critical skills for the provision of cross-cultural care such as interviewing and negotiation, inclusion of the social sciences, and providing a method for the acquisition of knowledge about specific cultures (through academic and experiential learning). Models to be discussed include the culturally

competent model of care developed by Campinha-Bacote (1994), a model for the training of transcultural nurses (Leininger, 1989), a program for occupational therapists providing cross-cultural care (Kinébanian & Stomph, 1992), and the health belief model proposed by Becker (1974). Additional topics to be discussed include the use of narrative as a tool for learning about culture and methods for integrating social science and medical knowledge.

Clinical Reasoning in Occupational Therapy

Joan Rogers, in her 1983 Eleanor Clark Slagle lecture, encouraged research of clinical reasoning or “the process of knowing and understanding that underlies practice” (p. 602). The American Occupational Therapy Association (AOTA) and the American Occupational Therapy Foundation (AOTF) co-sponsored the clinical reasoning study in 1986 with the goal of developing an increased awareness of the types of thinking used by therapists in the practice of occupational therapy (Mattingly & Fleming, 1994). Four forms of clinical reasoning will be discussed in regard to consideration of culture: (1) conditional reasoning, (2) interactive reasoning, (3) narrative reasoning, and (4) procedural reasoning. Clinical reasoning in occupational therapy will be contrasted with clinical reasoning used in the bio-mechanical framework.

CHAPTER II

REVIEW OF RELATED LITERATURE

Cultural Base and Values Orientation of Western Medicine

Kleinman (1980) depicts the health care system, including the bio-medical model, as a cultural system. Medicine as a cultural system includes “a system of symbolic meanings anchored in particular arrangements of social institutions and patterns of interpersonal interactions” (p. 24). Cultural components of the health care system include patterns of belief about the etiology of disease, norms for treatment options and how they are considered, and social sanctioned roles, power relationships, status, interaction settings, and institutions (Kleinman). Western medicine as a cultural system is based on white, middle-class values and priorities. Values that influence Western medicine include a focus on disease, an emphasis on a scientifically based (physical) understanding of symptoms, and a high regard for technological cures. Practitioners of Western medicine have been viewed as ethnocentric, based on the fact that historically they have rejected methods of prevention or healing outside of those researched and promoted under the bio-mechanical model (Spector, 1991).

The Study of Culture in Occupational Therapy

The theoretical and philosophical bases of occupational therapy support the study of culture and its impact on practice. Purposeful activity was established as the core of occupational therapy by the Representative Assembly of AOTA in 1979. The philosophical base of occupational therapy defines purposeful activity as having “both an intrinsic and a therapeutic purpose” (Hopkins, 1993). The term “purposeful” as used here implies that the values of the client, as well as the therapist, are involved in a determination of activities that have meaning and are appropriate to be used in treatment.

The model of human occupation and Allen’s work on cognitive levels each provide an illustration of culture as a component of occupational therapy theory. In the model of human occupation, culture is described as influencing occupation in terms of the nature of work and play, where and when occupations take place, and how knowledge and values regarding work and play are transmitted to each individual (Barris, Kielhofner, Levine, & Neville, 1985). Allen (1987) illustrated the cultural influences on adjustment to disability. Rehabilitation and psychological adjustment to disability must be approached in relation to “the available social conditions” (p. 571). Allen encouraged the selection of activities which aid the person in developing a sense of his or her disability, the impact of the disability, and the meaning of the disability in social terms. As a result of disability, the options for activities which are both

desirable to the client and socially accepted may be limited. A primary role of the occupational therapist is to find activities to meet these needs.

Cultural Base and Values Orientation of Occupational Therapy

Sanchez (1964) stated that the values of the white, middle-class culture in the U.S. underlie the practice of occupational therapy. These middle-class values included an orientation to individualism, emphasis on a future time orientation, belief that one can conquer nature through use of his or her skill and resources, an orientation toward activity or doing, and a view of people as beings who have human failings but are capable of achieving perfection. Sanchez pointed out that clients from other socio-economic or cultural groups are likely to hold values in conflict with middle-class values. Sanchez recommended adapting therapeutic approaches according to the value orientation of the client.

In 1993, the Standards and Ethics Commission of the American Occupational Therapy Association published the core values and attitudes of occupational therapy practice. Values were defined as “a belief or an ideal to which an individual is committed” (p. 1085) and viewed as a fundamental part of the profession of occupational therapy. Values influence practice through the attitudes and actions of clinicians as they provide service to clients. Seven core values were identified from a review of AOTA documents: (1) altruism, (2) equality, (3) freedom, (4) justice, (5) dignity, (6) truth, and (7) prudence. These values were then defined in terms of occupational therapy practice and desired actions and attitudes of therapists. Being

“committed to a set of common values” was promoted as a method for building trust and clarifying expectations between therapists and clients (p. 1086).

A study by Fondiller, Rosage, and Neuhaus (1990) focused on values which influence the clinical reasoning of occupational therapists, including emphasis on a holistic approach, intellectual flexibility, the role of teaching, the importance of the therapeutic relationship, and the delivery of client-centered treatment utilizing purposeful activity. The therapists studied thought it was important to consider the client’s cultural background, life routines, roles, interests, and motivations as part of developing client-centered treatment and selecting purposeful activity.

Hooper (1997) studied clinical reasoning in relation to the world-view of an occupational therapist and the influence of world-view on that therapist’s practice of occupational therapy. World-view was considered to encompass “an individual’s perspective of the nature of reality, their assumptions about human nature, and their assumptions about the relationship of occupation to human nature” (p. 2). The therapist’s world-view was perceived as influencing her style of interacting with clients, choice of goals, selection of treatment methods, and overall approach to treatment.

Need for Culturally Competent Health Care Practitioners

America is experiencing a radical change in demographics with greatly increasing populations of certain minority and ethnic groups, including Hispanics, Asians, and African Americans (Campinha-Bacote, 1994; Dillard, et al., 1992;

Friedman, 1992). These changes in the population create a demand for health care services which address the needs of the various cultural subgroups (Anderson, 1990; Andrews, 1992; Leininger, 1989; Pope-Davis, Prieto, Whitaker, & Pope-Davis, 1993). Greater numbers of culturally and ethnically diverse clients will impact all areas of service provision, including assessment, treatment, evaluation of services, reimbursement, and marketing (Friedman). Additional demands for culturally sensitive care will come from older adult clients who are accustomed to a particular way of living (Barney, 1991). In order to provide the highest quality of health care service and remain true to the nature of occupational therapy, we need to ensure that the cultural values of our clients and related needs are addressed (Barney, 1991; Schwartz, 1990).

Components of Cultural Competency

Cultural competence is a process in which the health care provider continuously works to develop an ability to provide effective health care by working within the cultural context of the client (Campinha-Bacote, 1994). Other authors have emphasized aspects of cultural competency including self-awareness of cultural values and biases, awareness of cultural influences on the provision of care, development of a knowledge base concerning various cultural and ethnic groups, awareness of differences between practitioners and clients that may influence treatment, and the ability to respond to these differences with a variety of treatment approaches which are culturally sensitive (Dillard, et al., 1992; Pope-Davis, et al., 1993). Discussion of

cultural competency in occupational therapy has included both the means for considering culture in practice as well as the desired outcomes. Means for consideration of culture in practice include education on cultural diversity, the use of assessments that elicit cultural beliefs and values, individualization of treatment based on a client's unique culture, increasing the number of occupational therapists from diverse backgrounds, and developing skills of listening and observation. Desired outcomes include a more effective and efficient practice, increased ability of therapists to identify and resolve potential conflicts in treatment which are culturally based, improved communication between the therapist and client, increased collaboration on treatment, increased ability of a therapist to positively impact a client's health through treatment and education, and prevention of frustration that can develop after unsuccessful interactions with clients or families and improved client satisfaction (Barney, 1991; Krefting, 1991; Mattingly & Beer, 1993; Paul, 1995). Mattingly & Beer described "good therapy" as including consideration of culture in order to facilitate a collaborative relationship with the client and to aid in the individualization of therapy.

Randall-David (1994) characterized a culturally competent practitioner as someone who:

1. Is sensitive to and aware of his or her own cultural heritage.
2. Has a knowledge of his or her own values and biases and their influence on clients from other cultures.

3. Is comfortable with cultural differences that exist between himself or herself and clients.

4. Gains specific knowledge about the cultural group(s) treated.

5. Understands the negative impact historical events have had on a particular cultural group.

6. Realizes that clients from diverse communities have special needs.

7. Understands the importance of cultural diversity within, as well as between, cultural groups.

8. Strives to educate himself or herself about cultural groups through client interactions, cultural diversity seminars, community events, reading about cultural diversity, and use of cultural informants from the community.

9. Is committed to understanding the viewpoints of individuals from diverse cultures.

10. Demonstrates flexible thinking and an ability to tolerate ambiguity.

11. Employs a sense of humor when interacting with clients.

12. Demonstrates a willingness to relinquish control in clinical encounters.

13. Can risk failure and will reflect on how he or she has contributed to the development of frustration, anger, and resistance in clinical interactions.

14. Places equal importance on the process and the product.

Cultural competence can also be viewed in terms of the system providing care, as is the case with the “cultural competence continuum” described by Rorie, Paine, & Barger (1996). The six levels of competence range from cultural destructiveness to

cultural proficiency. The first level, cultural destructiveness, is present when attitudes, policies, and practices of the health care facility and practitioners prevent the recognition and acceptance of the client's culture, negatively impacting treatment outcomes. The second level, cultural incapacity, is characterized by a biased, authoritarian system of care which places its goals, needs, and values above those of the health care consumer. The third level, cultural blindness, is demonstrated by a culturally relativistic approach emphasizing the equality of all clients (in terms of values and needs) and providing treatment which is not sensitive to race, ethnicity, or cultural background of the client. The fourth level, cultural precompetence, is demonstrated by cultural sensitivity and efforts to provide culturally relevant care and respect diversity. Level five, cultural competence, is practiced through self-assessment of cultural competence, the adaptation and acculturation of service models, and a relationship between policy and practice. The sixth level, cultural proficiency, is characterized by contributions to the knowledge base of culturally competent practice, creation of therapeutic approaches for specific cultures, and the recruitment of staff with specialty training in cultural competence. The authors encourage all facilities and practitioners to evaluate their level of cultural competence, commit to increasing their cultural knowledge and skill, and continually seek to improve the level of care provided for minority clients.

Impact of Culture on Symptomology and the Illness Experience

Disease is defined as “a malfunctioning of biological and/or psychological processes,” while illness is defined as “the psychosocial experience and meaning of perceived disease” (Kleinman, 1980, p. 72). Disease can be defined in biological terms, but illness is a social construction. In illness, there are psychological and cultural factors that create meaning and significance from the symptoms. The care which is sought for an illness is directly based on the meaning and significance that a client gives to the illness. The cultural construction of illness provides a basis for acceptable patterns of behavior and a guide for seeking health. It also dictates which forms of treatment will be viewed as effective.

Cultural differences can influence the client’s perspective regarding the origin of symptoms, how to express illness, appropriate methods of treatment, and potential consequences of not treating the symptoms. Kleinman (1980) described an explanatory model for illness and has used the model in illustrating illness beliefs from several different cultures. The description of an illness usually includes the etiology, timing of onset and presentation of symptoms, physical changes seen, course of the illness, and types of treatment. Each person’s explanatory model is based on his or her cultural background. Clinicians and clients each have explanatory models which often differ greatly and create conflicts in the process of medical care.

Impact of Cultural Considerations on Assessment

The idea of cultural bias in standardized assessments has been well researched. Many of the standardized assessments used today were developed and normed to a white, middle-class culture and have not been updated to reflect the current population, which is increasingly multi-cultural and bilingual (Paul, 1995; Sedlacek, 1994). These assessments contain items which measure cultural knowledge (versus intelligence or functioning potential), and for this reason minorities receive lower scores. There is a need for non-discriminatory assessments which are selected and administered in a manner that prevents discrimination based on racial or cultural differences. Even when using non-standardized interviews and observations, a clinician may misdiagnose a client by perceiving normative behavior from another culture as pathological and indicative of mental illness (Westermeyer, 1987).

Cultural bias in assessment impacts the practice of occupational therapy as well as the conceptions (or misconceptions) that are formed regarding the capacity and functioning of cross-cultural clients (Paul, 1995). An individual from a different culture is often classified as having a disability (or mental health diagnosis) without consideration for the impact the diagnosis will have on the person and his or her social interactions. These clients have to bear additional stigma of being labeled disabled on top of the challenges they already face as a cultural minority. Practitioners, counselors, and others who use culturally biased tests contribute to discrimination and harm those persons they purport to serve. Persons responsible for testing and labeling clients must be ethically responsible for using assessments which are sensitive to

cultural differences (Westermeyer, 1987). Professionals must aggressively point out biased tests and demand alternatives. Many well-known tests have been identified as culturally biased but continue to be used due to a lack of alternatives or clinician initiative. Use of biased assessments is justified with the excuse that the tests are well recognized and accepted. The impact of cultural bias is often perceived as negligible when, in fact, it is profoundly serious. With any assessment or evaluation tool, care should be taken to understand how the norms for the assessment were developed and how this might impact the results of the assessment when it is administered to a client from a non-dominant cultural group (Paul).

Impact of Cultural Considerations on Treatment

In treatment, failure to consider cultural aspects of an illness or disability can result in poor compliance with the treatment program, discontinuation of therapy, decreased effectiveness of interventions, and diminished rapport with the client (Krefting & Krefting, 1991; Robinson, 1987; Rodriguez-Wargo, 1993). Poor compliance may be a result of language barriers, inadequate environmental conditions or resources, conflicts in the family, treatment programs which are complicated or seem unnatural to the client, or a client's desire to avoid pain (Robinson). A client may discontinue therapy if he or she feels that the treatment offered violates cultural norms, if the social structure of the health care provider places too many demands on him or her, or if the treatment offered does not address the problems for which the client is seeking help. Treatment planned without considering cultural differences is

often less effective because the client is not motivated to fully engage in the treatment and may not perceive the treatment as having a benefit. Diminished rapport is perhaps the most critical impact of failing to consider cultural differences. In order for practitioners and clients to work together in addressing a health problem, they must first arrive at a shared understanding of the problem at hand and the factors to consider in the solution of that problem. When the client does not trust the practitioner (or vice versa), two-way communication of beliefs regarding the illness and treatment will not occur (Anderson, 1996).

Consideration of culture can have positive influences, including greater consumer satisfaction with care, increased follow-through with the treatment regimen, and decreased stress of the client, family, and health care staff. Tailoring treatment to account for cultural differences will result in a higher acceptability of care and better outcomes. Dillard, et al. (1992) described how knowledge of culture can aid the therapist in developing insight into clients from the non-dominant culture. Knowledge of culture also assists a therapist in planning treatment activities which are uniquely suitable to a client from a different cultural background. Through evaluation of the client's cultural background, options for treatment interventions are expanded (Barney, 1991). Occupational therapy requires the active involvement of the client. Therefore, the therapist must form a holistic view which facilitates understanding of the values and motivations that would encourage a client to engage himself or herself in the treatment process (Mattingly, 1989).

In order to appropriately address cultural aspects of medicine, a provider must look at his or her own cultural background, the culture of the institution through which care is provided, and the culture of his or her profession, in addition to considering the culture of the client. Many barriers to the delivery of effective health care to diverse clients originate with the culture of the health care system, institution, or provider. Medical research has also been biased because of a failure to adequately include racial and ethnic minorities in the subject pool.

Educating Practitioners to Develop Cultural Competency

Training for therapists must go beyond promoting cultural sensitivity and provide strategies for communication, interviewing to elicit health beliefs, collaborating on acceptable treatment, and implementation of treatment (Kavanagh & Kennedy, 1992).

Kleinman, Eisenberg, & Good (1978) suggest the creation of a “clinical social science” in order to educate practitioners on the cultural aspect of clinical reality and to enhance understanding of health beliefs and practices of other cultures. Clinical social science would involve case-based instruction that demonstrates how anthropological and sociological concepts apply to the provision of health care. In clinical social science, the study of medicine is expanded to include popular health care (care received within the family and community) and folk health care (care received from non-professional healers). Understanding relationships between professional medicine (the formal health care system), popular, and folk medicine allows clinicians

and policy makers to make decisions and provide care which is more attuned to the needs and expectations of their clients. Clinicians are taught to consider illness (the human experience of sickness, including changes in functional ability and roles) as well as disease (pathophysiology). The failure of clinicians operating under the bio-mechanical model to attend to illness problems contributes to noncompliance with the treatment regimen, decreased consumer satisfaction with professional health care, and the provision of inadequate medical care. Practitioners who study clinical social science are trained to elicit the beliefs of their clients regarding illness, to share their view of the illness in a culturally sensitive manner, and to negotiate with the client a medical reality. Kleinman, Eisenberg, & Good refer to this process as the “cultural construction of clinical reality” (p. 254). They proposed that training clinicians to deal with both disease and illness concerns will improve the management of care, increase compliance with recommended treatment, increase client satisfaction, and improve treatment outcomes.

Leininger (1989) pushed for specialty training in transcultural nursing because caring--the essence of nursing--is culturally based. She attributed the high job stress and burnout rate among nurses to their inability to work effectively with diverse clients. Professionals unprepared to provide culturally competent care experience conflicts with their clients, impose their culture on clients, and communicate (through words and actions) in ways that are often misunderstood by the clients they are trying to help. Education for transcultural nurses includes anthropology and sociology courses to prepare nurses to provide care which incorporates the cultural background

and beliefs of clients. This type of education includes focused study of the values, beliefs, and life ways of selected cultures and the complex relationships between care, health, and environmental factors. Transcultural nurses develop skills in interviewing, communicating, negotiating, and designing treatments which blend the healing traditions of the client with those of Western medicine. Qualitative research methodology is taught so that transcultural nurses will have the tools to study the provision of care across cultures. A field experience is an essential part of the education for transcultural nurses. It provides a direct means of learning about a specific culture and an opportunity to conduct qualitative research..

Kinébanian & Stomph (1992) looked at improving the ability of occupational therapists in the Netherlands to provide treatment for immigrants and other minority clients. They proposed an educational program which included a study of the value base of occupational therapy, guidelines for the treatment of clients from various cultures, a selection of case studies on cross-cultural occupational therapy, and clinical experiences with clients from diverse cultural backgrounds. Therapists were trained to alter their treatment approach based on the values and cultural background of the client. Assessment of the client in the home and work environment was utilized as a tool to observe the performance of individuals in their daily roles and tasks. The therapists learned how to organize the physical structure of the treatment clinic (decor, equipment used) and the non-physical structure (timing of appointments, interaction with clients, etc.) to create a more welcoming and comfortable atmosphere for cross-

cultural clients. The authors emphasized the importance of policy development which sets standards for care provided to cross-cultural clients.

The health belief model (Becker, 1974) proposed evaluation of four aspects of culture as it relates to the provision of health care: (1) health risks of a cultural or ethnic group for developing a given illness; (2) how a cultural group perceives the severity of a disease or health condition in terms of clinical, medical, and social consequences; (3) the benefits of a given treatment plan or therapeutic course of action and whether it fits with the client's culture; and (4) consideration of barriers which may exist and interfere with treatment, including financial constraints and geographic accessibility of health care facilities. The health belief model has been discussed primarily in relation to health education and preventative health efforts (Radley, 1994). The model also has potential for contributing to the development of cultural competency. Practitioners can be trained to use the health belief model as a framework when questioning clients about their health beliefs. Interviews based on the health belief model provide relevant information regarding the client's motivations and values in regard to health behaviors. This information is critical to the clinician's effort to find a common ground from which to collaborate on treatment.

The culturally competent model of care developed by Campinha-Bacote(1994) addressed four areas of cultural competence: (1) cultural awareness, (2) cultural knowledge, (3) cultural skills, and (4) cultural encounters. Cultural awareness is defined as increased sensitivity to cultural differences. As part of cultural awareness, a practitioner examines the values and assumptions held as a result of his or her cultural

background and socialization to a health profession. Interaction styles of both the practitioner and the client are studied. Practitioners are encouraged to develop a culturally liberated style of interpersonal communication which expresses understanding and acceptance of cultural differences and promotes cultural sharing from the client. Cultural knowledge is developed through a study of the social sciences and specialty medical fields such as transcultural psychiatry. The goal of culturalogic knowledge is understanding the relationship between culture, health beliefs, and health practices. In the area of cultural skill, practitioners learn how to conduct a culturalogic assessment to ascertain the client's perception of the illness and what treatment is needed. Cultural encounters are the last part of developing competency. Cultural encounters involve experiential learning through hands-on work with cross-cultural clients. Through cultural encounters, a practitioner can integrate academic knowledge of culture with the practical knowledge of the clinical setting. Caring for clients, including clients from diverse cultures, helps a clinician see the uniqueness of individuals and avoid stereotyping clients according to an ethnic or racial identity.

The use of narrative in the education of health care practitioners has been recommended as a way to develop sensitivity to cultural differences and understand how these differences influence the provision of care. The validity of medical decisions, including assessment, treatment, and ethical judgments, are increased when the unique characteristics of a case are considered. Medical decision making does not occur in a social or cultural vacuum. Practitioners must be provided with a model for problem solving which includes consideration of social and cultural factors.

Hunter (1996) discussed narrative as an important part of clinical judgment.

Narrative is a tool for transmitting knowledge between a client and practitioner.

Narrative knowledge aids the practitioner in matching the particular needs of a client with the general rules of medical practice and allows a practitioner to make sense of a particular client. The skills of taking a history from the client and developing the information from an examination of the client into a medical narrative require perception and skill. The experienced practitioner with exceptional clinical judgment is actually drawing from a resource of narrative stored from the cases that the practitioner has treated. Hunter encouraged the use of narrative in education to train practitioners to focus on the client's history, teach construction and indexing of the medical case (medical narrative), and show practitioners how to include client narratives in the resources they use to make decisions.

Clinical Reasoning in Occupational Therapy

Clinical reasoning in occupational therapy is primarily directed toward understanding the illness experience or the meaning the disability has for a particular client (Mattingly, 1991). An occupational therapist uses a phenomenological perspective in order to understand disability from a client's point of view. In order to better understand cultural aspects of a client, a therapist engages in several types of reasoning, including procedural reasoning, conditional reasoning, interactive reasoning, and narrative reasoning (Fleming, 1991). Procedural reasoning is used when considering a client's disease or disability and planning treatment. Conditional

reasoning is used to form a holistic view that includes the client, the family, the disability, the meaning the disability holds for the client, and the physical and social environment in which the client functions. Interactive reasoning is utilized in face-to-face encounters with the client in order to understand a client as a unique individual. Narrative reasoning is used when therapists use stories as a way of making sense of information.

Cultural Considerations in Clinical Reasoning

The clinical reasoning study conducted by AOTA and AOTF in 1986 raised questions regarding the type of clinical reasoning necessary to practice phenomenologically and the knowledge base needed to support this type of practice. Occupational therapy philosophy commits therapists to “viewing the patient as a whole person--not as someone with an injured part--and as one whose life should be considered in the context of a satisfying living environment” (Gillette & Mattingly, 1987, p. 400). Using naturalistic modes of inquiry, a therapist must develop an understanding of a client’s motivation, behavior, lifestyle, values, and roles. The interests, abilities, and motivations of the client should be considered in treatment planning.

Conditional Reasoning

Fleming (1991) described conditional reasoning as reasoning holistically about the person and his or her disability, imagining potential changes in the condition, and

developing methods to engage the client in treatment. When using conditional reasoning, a therapist “interprets the meaning of therapy in terms of a possible future for the person” (p. 1012). The therapist develops a mental image of the person prior to the disability or illness and uses this image to determine future possibilities.

Through conditional reasoning, a therapist can develop a treatment plan that is individualized to the client’s interests, capacities, and goals. Clients participate in conditional reasoning when they provide information about their previous life to help construct the future vision and when they collaborate with the therapist on establishing treatment goals.

Interactive Reasoning

Interactive reasoning is utilized “during face-to-face encounters between the therapist and the patient” (Fleming, 1991, p. 1010). Interactive reasoning is used to develop a better understanding of a client. Knowledge about the client can be used to understand a client’s reaction to treatment and to individualize treatment. Interactive reasoning is used to find out the client’s perspective on his or her disability.

Narrative Reasoning

Narrative reasoning involves using knowledge gained in therapy to form a picture of the client where he or she is now, where he or she could be in the future, and the use of this picture to structure therapy (Mattingly & Fleming, 1994).

Mattingly (1989) studied the clinical reasoning of occupational therapists, focusing on

their use of narrative. Occupational therapists used stories in several forms, including stories told to colleagues, stories told to and by clients, and the process of therapy framed as a story in progress. Occupational therapists tell stories to colleagues in order to orient themselves and as a way of making sense of a particular case. Through the process of constructing a medical narrative, a therapist gains understanding of the client's perspective and the psychological, moral, and social influences on the person's illness experience (Hunter, 1996). Stories are told to clients in order to motivate clients to see themselves as actors within the therapeutic process. When clients tell stories, they tell about events which occurred in relation to their disability or illness and also what these events mean. Through clients' stories, a therapist can gain insight regarding the influence of culture on a person's perception and response to disability and treatment. Lastly, therapists create a story from clinical actions in order to impose structure and meaning on the therapeutic process and as a means of connecting a series of actions into a comprehensible whole. Stories created from therapeutic interactions with clients allow therapists to place events in a context from which action decisions can be made (Mattingly & Fleming). Through narrative, cause and effect relationships are stated, and a picture of human character and motivation is developed. Narrative provides rich details of the human experience, and through these details meaning is constructed (Hunter).

One form of narrative used in occupational therapy is the life history interview. Life history interviews can illustrate the process of adaptation to disability (Larson, 1996), aid in eliciting the client's perspective (Price-Lackey & Cashman, 1996), and

show the metaphors a client uses to frame his or her life problems and consider potential solutions (Mallinson, Kielhofner, & Mattingly, 1996). According to Frank (1996), “clinical practice, implicitly or explicitly, involves constructing and interpreting the patient’s life history, a chronological narrative that identifies and makes sense of important events in the patient’s life” (p. 251).

Procedural Reasoning

Procedural reasoning occurs when a therapist analyzes the client’s disability and plans activities to address problems in functional performance. Procedural reasoning is oriented toward identification and interpretation of cues to aid in the tasks of problem identification, goal setting, and treatment planning. The development and evaluation of competing hypotheses regarding treatment is part of procedural reasoning. The reasoning of therapists most resembled the reasoning displayed by physicians when procedural reasoning was used (Fleming, 1991).

Competing Frameworks--Phenomenological Practice and the Bio-mechanical Model

The occupational therapists studied as part of the AOTA clinical reasoning study worked in a hospital setting oriented to the bio-mechanical model. These therapists expressed concern for the influences that the practice atmosphere had on their ability to practice phenomenologically. Pressure came from trying to fit into the hospital culture and gain acceptance from other medical professionals who were oriented to treat the client and disability as separate entities. Formal communication at

the hospital was based on diagnostic and treatment plan information. In team meetings, discussion of a client's perspective--if it occurred--only happened after the diagnostic and treatment information had been communicated (Mattingly, 1989).

In a study of values underlying clinical reasoning, a conclusion was reached that "therapists who emphasized the therapeutic relationship, being wholistic in approach and taking the time to obtain a thorough history, find themselves working in a health care system that does not support their values and priorities" (Fondiller, Rosage, & Neuhaus, 1990, p. 51). Gillette and Mattingly (1987) saw a need to develop an educational base and theories which would promote a therapist's ability to deal with the conflicts and demands created by competition between the phenomenological and mechanistic paradigms.

CHAPTER III

METHODOLOGY

Phenomenological Approach and Ethnographic Methods

This qualitative study utilized ethnographic research methods to research cultural influences on treatment approach, treatment outcomes, development of cultural competency, and clinical reasoning. Methods included observation with field notes and audiotaped interviews. The use of naturalistic methods has been recommended for research in occupational therapy that focuses on phenomenological aspects of practice (Mattingly & Gillette, 1991; Schmid, 1981; Yerxa, 1991). Aspects of the phenomenological approach include a focus on the knowledge, subjective meanings, and interpretations people use when they interact with other people and objects in their “life-world.” The concept of “life-world” and the phenomenological approach to the study of social interactions originated with Schutz (1970) who stressed that social science should orient its study to how the “life-world” is created and experienced by people as a result of perceptions, interpretations, and meanings given to otherwise neutral objects and situations.

Development of a Proposal

A proposal was written to conduct a qualitative case study with an occupational therapist exploring cultural considerations in clinical reasoning. This proposal was submitted to Western Michigan University's Human Subjects Institutional Review Board (HSIRB) and was approved (see Appendix A). Following HSIRB approval, a purposive sampling of regional occupational therapists was conducted in order to select an appropriate respondent. Selection of an exemplar respondent was recommended by Stake (1994) because an exemplar case provides the best potential for learning about the phenomena under study.

Subject Selection

The rural health education office at a midwestern university provided a list of occupational therapists and other health professionals who worked with culturally diverse populations. The individuals were contacted by phone and given information about the study according to an approved script. Each person was asked if they would like to participate in the study and/or asked to recommend a therapist who might be interested in participating as a subject. Purposive sampling was utilized to select a respondent according to the following factors: (a) experience with cross-cultural clients, (b) education, and (c) reputation for providing culturally sensitive care. Based on an above-average level of experience, education, and knowledge of structuring treatment for cross-cultural clients, the selected therapist was qualified as an exemplar

respondent. After selection of the respondent, the research proposal was reviewed by the respondent and the research committee of the home health agency where she was employed. The proposal was approved by the research committee of the home health agency. The nature of the research and the procedures to be followed for data collection were reviewed with the respondent prior to obtaining her consent (see Appendix B).

Data Gathering

The respondent was interviewed over six sessions, each lasting one to one and one-half hours. The interviews were scheduled once a week over a six-week time period. The semi-structured interviews were based on a prepared list of questions; additional topics and questions were pursued as they developed. The interview format, suggested by Bogdan & Taylor (1975), allowed a balance between collection of information based on specific questions and opportunities for the respondent to describe her thoughts, feelings, and perceptions. The respondent was also observed over seven treatment sessions, providing care to six clients. Observations were scheduled after the second and fourth interview with the respondent. The research project was described to each client by the respondent, and an informed consent was obtained (see Appendix C). Five clients were observed for one treatment session, and one client was observed for two treatment sessions. Clients were initially selected for observation based on significant cultural differences with the respondent in the areas of ethnicity and race. The respondent's view of significant cultural differences included

gender, religious background, age, socio-economic level, work history, type of family and geographic location, as well as ethnicity and race. For this reason, observations of the respondent with clients were expanded to more accurately reflect the continuum of cultural difference and similarity represented in the respondent's caseload. Ethnic cultures represented by the clients observed included African-American, Latvian-American, and Dutch-American. The therapist was observed treating clients in urban as well as rural homes.

Questions in the initial interview dealt with the respondent's education and experience in treating cross-cultural clients, her perception of cross-cultural care, and how cultural differences influenced her treatment approach (see Appendix D). In the interviews which followed, questions were asked to further explore concepts regarding culture and clinical reasoning in occupational therapy, to assist in analysis of observation sessions, and to clarify information from previous interviews. The goal of the interviews was to determine how cultural differences between the respondent and clients influenced the respondent's treatment approach and clinical reasoning process. According to qualitative research design, the respondent was given structured opportunities to review the data collected and the written interpretations of the data.

Analysis of the Data

The constant comparative method of data analysis, as described by Maykut & Morehouse (1994), was utilized to provide a structure which promoted rigor and trustworthiness. Prolonged engagement was utilized by scheduling six sessions of at

least an hour in length over a six-week period with the respondent. Each interview session was audiotaped and then transcribed. An audit trail was created by having the audiotapes transcribed, development of a list of concepts represented, and by categorizing the data cards according to conceptual label after the initial interpretation. During data collection, transcripts from previous interviews with the respondent, field notes from observation sessions, and a review of relevant literature were used to generate questions for interviews. Upon completion of data collection, the transcript data were analyzed, labeled, and sorted into categories based on the concepts represented. A review of the transcripts generated a tentative list of concepts and concept definitions were formed. This list was typed and codes were assigned for each concept. Each transcript was broken down into units of text representing a specific concept. These units of text were put on 5 x 8 index cards, and the cards were filed by conceptual category. The coded data were then used to provide a description and interpretation of the phenomena studied as presented by the respondent. During the process of data analysis and the development of the thesis manuscript, the faculty advisor for the project reviewed the interview transcriptions, the list of themes and concepts related to the data, and the thesis manuscript in a peer review process. The research proposal and thesis manuscript were also reviewed by two additional faculty readers and the director of a regional rural health grant program. The purpose of the peer review process was to insure the inclusion of important information and the accuracy of data interpretation. Through member-checking, the data in the study were reviewed with the respondent for accuracy and to allow for sensitive information to be

removed from the results of the study (Denzin & Lincoln, 1994). The transcripts and thesis manuscript were reviewed by the respondent for verification of the data interpretation. It also provided a means for her to have input on the written portrayal of her thoughts and ideas.

CHAPTER IV

RESULTS

Summary

Through the series of observations and interviews, the respondent shared her perspective on the provision of occupational therapy with clients from diverse cultural backgrounds. She described how cultural differences impacted treatment with respect to the development of a therapeutic relationship, communication, assessment, treatment planning, and treatment outcomes.

Background of the Respondent

The respondent had practiced as an occupational therapist for five years in the areas of mental health and physical disabilities. For two years prior to the study, she worked in home health care serving both urban and rural areas with a diverse client population in terms of race, ethnic background, and socio-economic status. The respondent's decision to become a home health therapist was primarily motivated by a desire to work with clients in the actual environment where performance of skills was needed. Her educational experience in a program for training health care workers to serve rural areas was also cited as a major influence on her decision to be a home health therapist. This program was part of her undergraduate studies and included one

semester of field work in a rural area, as well as seminars and projects designed to increase cultural awareness and develop skills to meet the health needs of diverse populations. The rural health program gave her an opportunity to work with cross-cultural clients and drew her attention to the possibility of working in a rural setting versus working in a “big hospital.” She felt it was important to “fill the gap” for people who were not able to get the health care they needed and perceived herself as having the capability to provide that care and establish relationships with clients in the home setting. In addition, her undergraduate studies included several anthropology classes, taken as electives because of her interest in culture. These classes increased her knowledge and awareness of culture and contributed to the development of a culturally sensitive mind-set.

The respondent’s philosophy of occupational therapy focused on promoting “maximum independence” according to the needs of the client. The respondent’s caseload included clients with a physical disability diagnosis, as well as clients with a mental health diagnosis. She described using a holistic approach in which both the physical and mental concerns of each client were considered.

R: If the need leans more towards a physical disability, you still care for that mental aspect in terms of . . . if they’re having a bad day or if they’re getting depressed over whatever the physical disability is. You treat that whole person . . . but your focus tends to be more on the concrete, how can you facilitate that independence (G4:4-8).

Her treatment approach included use of therapeutic exercises, crafts, modalities, muscle re-education and ADL training. The respondent enjoyed using crafts, but tended to use them only with clients being treated for a mental health

diagnosis, as she saw a greater acceptance of crafts as a treatment modality for this population. She based her treatment as much as possible on practical activities and disliked using “rote exercise.” She viewed the goal of occupational therapy as progressing a client to the next level on a continuum, of independence.

R: When you’re working with a child, when you’re working with an adult, you’re setting goals for levels of independence. And I say independence on a continuum because if the person is able to put the toothpaste on their toothbrush, that’s one more level of dependence. . . . That’s what I like. . . . You can find examples to give a patient showing that, “Hey, you’re making progress. This is good and you are okay. . . .” Whereas sometimes when I find I go in there and I just give exercises, it’s important, but the person has a lot harder time seeing that they’re making improvements. You need to say, “Hey, look. Last week you couldn’t even begin to hold onto your shirt.” Or, “You got so short of breath when you were doing it.” It’s that independence continuum [which] allows you to show positives where it might not be seen (G4:31-43).

The respondent was raised in a suburban area of southwest Michigan in a Dutch-American family. She described herself as a conservative individual for whom religion and spirituality were important concerns. She thought the easy-going, tolerant, and compassionate aspects of her nature contributed to her ability to work successfully with clients from diverse cultural backgrounds.

Respondent’s Perception of Cross-cultural Health Care

The respondent had a broad view of cultural differences. She tended to see and appreciate the individual attributes of each client. This perspective was evident in her response to a question regarding the percentage of cross-cultural clients treated.

R: Any two patients I’ve had . . . would be coming from different backgrounds most likely, whether it be because of their age or their

environment. So in that aspect . . . you could almost say the majority of your caseload is going to be cross-cultural. And particularly because of the areas that I worked . . . I might get a migrant worker . . . a factory worker . . . a housewife . . . so they're all different (R1:172-178).

According to the respondent, home health care is an area of practice that requires consideration of the client's culture. She described consideration of the client's culture as "a necessity" and further explained the impact of culture on home health care.

R: In my line of work, going into someone's home, you are going into their domain. You are going into their culture. You are going into their family. You can't avoid it. Sometimes it makes treatment difficult because I come with my own concept of how they should respond or how they should behave or how they should act . . . and timeliness or promptness or how fast they move to do something is very different. And so that sometimes is frustrating to me, but it's something that I have to back off and work through (R1:87-93).

She was asked if there are greater stresses involved in treating cross-cultural clients.

R: That's not fair, because we've talked about how cross-cultural comes into all of your patients' lives. . . . If there are cultural communication barriers, definitely it increases the difficulty and stress of that case . . . because communication is so crucial. But other than that, I think more often it's the disabilities where the difficulties and the stresses come, rather than the culture. . . . Once in a while you run into frustrations because you can't think of a culturally appropriate activity that the patient would enjoy and give meaning to. Then you sit there and beat your brains trying to find something. So that's small stresses every once in a while, but for the most part it's more communication . . . that runs into being the stress (V6:231-240).

Development of the Therapeutic Relationship

The nature of the therapeutic relationship between the respondent, client, family members, and caregivers was a common thread discussed throughout the interview sessions. Aspects of the therapeutic relationship included rapport,

credibility, authority, and power. The therapeutic relationship influenced communication, assessment, the treatment approach of the respondent, and treatment outcomes.

Rapport

The respondent named several factors contributing to rapport: (a) ability to engage the client in conversation, (b) cultural similarity, (c) professional credibility, (d) openness of the client and family, and (e) similarities between the client's and respondent's perception of the problems at hand. The purposes served by rapport building were to aid in establishing credibility, to put herself, the client, and the family at ease, to facilitate instruction of clients, and to increase acceptance of treatment recommendations.

Conversation was the main method for establishing rapport. Efforts to create rapport were complicated when language barriers existed or when treating a non-verbal client. In such instances, the respondent described asking questions about a physical cue in the home and having to "broach supposed answers" which may or may not elicit a response from the client. In these cases, she made a greater effort to converse with family members. Credibility was cited by the respondent as a factor which enabled her to gain the acceptance and trust of the client in cases where a strong personal rapport did not develop.

The respondent discussed two cases where a high level of rapport had developed. The first client was an African-American male whom the respondent had

treated for a stroke for the past three months. She attributed the strong rapport in that case to the length of time in treatment and to their common religious background. The second client was a Latvian-American woman being treated for cardiac and mental health diagnoses. In this case, the respondent attributed the rapport to her efforts in getting the client's questions answered and making some phone calls. The respondent remarked, "Because I had followed through on things she had questions about, I became family almost. . . . She treats me like a granddaughter almost at times, which is good and bad" (Y3:71-73). She went on to describe how this family-type rapport contributed to her ability to provide treatment.

R: It's . . . easier to slip things in, in education, and not be offensive . . . [such as] equipment recommendations. It's been easier to bring those to light and explain to her how they would help her and how . . . I use them with my own grandmother. . . . That rapport then has facilitated me being able to present it and her accepting it . . . whereas sometimes when I present it, if that type of rapport isn't there, it's not accepted very well (Y3:73-80).

The development of family-type rapport also increased social expectations on the therapist, such as requests from a client for the therapist to visit in a non-work capacity.

Rapport building was enhanced by the presence of cultural similarities between the therapist and the client. A lack of cultural similarities made it difficult to establish communication and especially impacted the informal conversation that builds rapport. The respondent was asked if it was difficult to build rapport with clients from other cultures.

R: Yes . . . you always search for a common ground to make both of you at ease and for making presentation of information easier because so much of what I do is teaching and instructing. You're constantly teaching the

patient . . . teaching the caregiver, and if you can't find a common ground that's comfortable, it makes it very hard to tell them, "Hey, this loved one is not functioning where they're supposed to be and you gotta be making changes." And . . . even when you do have the rapport, their own belief system about the person's role in the family or how their role previous was and how they perceive it to be now interferes. So you try and find the rapport that's . . . [going to] provide you that ability, but even sometimes when you have the rapport, you don't have the ability.

I: The rapport makes it easier?

R: . . . if you can establish a rapport, you can establish your credibility. And credibility is important to the patient, I find. "Why are you coming? What's your purpose in being here?" If you can start to establish a rapport in some personal area, then it's easier to interject your credibility into that conversation, as well as they're more open to listening to it (Y3:146-160).

Rapport with family and caregivers was strengthened when their perception of the client was close to the respondent's perception. The respondent discussed both situations, when a shared perception existed and when difficulties arose from differing perceptions. In the first situation, the family member with whom the respondent established rapport came from out of state and was able to see the deficits of the family member as the therapist saw them. In the latter situation, the respondent described family members or friends who had been involved with day-to-day caregiving as having a perception that could not be changed because of their frequent contact with the client and lack of fresh perspective. In these cases, it was important to her to build rapport and establish credibility so her interventions would be accepted.

The respondent felt there was a balance to be maintained between development of rapport and promotion of a client's independence. She saw rapport as having a negative impact on treatment if it encouraged a client to be more dependent on the

therapist. The respondent was questioned about two cases, both where a strong rapport was observed.

I: What do you see as making the difference in the two cases, wherein on the one hand the really strong relationship is facilitating therapy, and in the other it's a concern that you're trying to manage?

R: Dependency is the issue. With the one that it's really strong and it's facilitory, that's the point. It's facilitory. It's still working him towards independence. . . . It's motivating him to go on and to progress to a point where . . . as a therapist, he won't need me. He'll be able to exist without me. . . . In the other [case] . . . I perceive her bond [is] higher from her side [the client's] than my side. And with her issues being more what I perceive as psych-related, I see a very great likelihood for dependency, that she just can't get along if she doesn't have her OT (Y3:132-141).

Authority

The respondent discussed her authority as a home health therapist in relation to working with clients and dealing with family and other caregivers. The degree to which the respondent was authoritarian in her approach with clients varied greatly. Her typical approach was observed as casual, informal, and friendly. In cases where this approach did not gain compliance, she would move to a more straightforward approach. The power and authority of the respondent influenced her efforts to educate clients, family members, and caregivers and gain compliance with the treatment regimen. In the following situation, the respondent felt a family member was not complying with the treatment goal of facilitating the client's independence in bathing. She was asked how she would approach the situation if the family was resistant to her input.

R: If they're resistive and hedgy because they want to do it, then I might be a little more firm about . . . "He's at a point where he needs to do it. This is why. This is what he's . . . [going to] to get out of it, and we're working for his independence, right?" And confirm that that is still the foremost goal . . . and sometimes you just . . . [need to] be tough. And other times you literally just let it go. Okay, [the] caregiver's . . . [going to] take over this role. Unfortunately it's not the patient's maximum potential. But at that point you take on that -- "I am a guest in their home. It is their home, and they have the right to say no" (Y3:452-460).

Communication

The respondent discussed two forms of communication used in treatment.

Formal communication occurred when the therapist was interviewing, assessing, evaluating, giving feedback on treatment, and conducting client education. Formal communication was referred to as "the business approach" in which the therapist communicated with a serious tone and made primarily factual statements related to treatment issues. Informal communication was characterized as conversation that occurred during treatment which was not about the treatment but about the background, life, or interests of either the therapist or the client. Information about the client's interests, values, and beliefs was most often elicited as part of informal communication. The respondent's style of conversing and interacting with clients was influenced by her outgoing nature, interest in others, curiosity about people, and her sense of humor. She described asking questions about a client's interests, activities, items in the home, and family. This information was used to give her an idea of who the client was and was used in determining her treatment approach.

The respondent saw informal communication and the related sharing of interests, values, and beliefs as being significantly decreased by the presence of language barriers or by the failure to establish rapport. In cases where rapport was not established, she tended to stick with formal patterns of communication in order to make the purpose of treatment understood and to perform the treatment as described below.

I: How do you go about finding common ground?

R: Conversation. . . . You walk into a patient's house. You take note of something. You ask about something. If there's a pet running around, "Oh, what's the pet's name?" . . . It's the clinical observation heart of occupational therapy which is your grounding for coming up with questions. And you know right away if they're . . . [going to] be open to it or not. Are they the type of person where you . . . aren't . . . [going to] get a rapport in the sense of easy conversation. Are you . . . [going to] walk in the door and say, "I'm an OT, this is my purpose here. This is the business I need to attend to. This is what we're . . . [going to] do. What do you think? Is this something that you're interested in?" I mean, you almost take a business attitude towards it. And that makes it really difficult for treatment, too, then because . . . there's no laxity, there's no easy-going. There's nothing to make the mood light if it's a difficult task to encourage (Y3:161-173).

Treatment in this type of situation was complicated by a lack of feedback from the client indicating an understanding or acceptance of the treatment. The respondent's reaction to this situation included increased questioning of the client to get feedback and a tendency to stick to the basic treatment.

The respondent cited cases where the verbal response of the client conflicted with the client's behavior or intentions. When asked whether they could perform certain activities of daily living (ADL's), clients would say, "Yes, I can do that." In order to gain a more accurate response, the respondent would ask clients how they

performed various ADL's. She would question clients about the occurrence of symptoms, such as pain or shortness of breath during the performance of ADL's. These questions elicited more accurate and detailed information on difficulties the client experienced in ADL performance. Another example occurred in treatment when clients expressed verbal support for selected treatment goals, yet did not work toward these goals in the home program. If the respondent noticed this, she would ask if the client still desired to pursue the goal(s). If so, she would ask what was preventing him or her from working on the goal in the home program.

During observation sessions, clients were observed telling stories to the respondent about their life prior to the accident, illness, or disability that created the need for treatment. The respondent illustrated the influence of stories on her perception of an elderly female client whom she treated for an arm fracture. According to the respondent, the client was being treated at home because she had not been able to meet her self-care needs well enough to manage outpatient therapy. The client appeared very motivated to engage in treatment. She paid attention to the respondent as therapy was conducted and asked questions about specific aspects of the treatment. The client also recited in detail the exercises and repetitions she had completed in her home program.

I: What do you learn from the stories?

R: Just a different aspect of what they were like. You can tell from the stories that she's always been kind of a go-getter, so to speak. She has not been shy to try things out, almost in some ways aggressive. And the stories confirm . . . some of the observations you see. When you're talking with her about therapy, about her eagerness to comply and follow through, you can see that in

her case as a long-standing history, complying and following through, doing the best that she could (B5:224-230).

The stories told by the client also allowed the respondent to see how this client viewed her disability. This client contrasted the incapacitated state caused by her arm injury with what she had been capable of as a young woman working in a box shop and “how much she used to lift and move and push and carry . . . with this hand.” In the perception of this client, “she couldn’t do anything and there was . . . no in-between ground there--where she had been doing things at home after she retired or anything. . . . It was either the box shop or how we are now” (B5:186-189). This insight helped the respondent understand the client’s need to achieve a return of function in her injured hand before she would attempt self-care.

Importance of Cultural Understanding

According to the respondent, a knowledge of what tasks are valued and considered appropriate in the client’s culture is crucial to planning treatment. If a therapeutic activity is selected which creates conflicts based on the client’s culture, the client will not be motivated to comply with therapy. Selection of an inappropriate activity may also cause a disruption of family dynamics if a task given to a client is typically viewed as the work of another family member. If the family does not think the prescribed therapeutic activities are appropriate, they may discourage the client from following through with therapy. The respondent gave two examples where therapy was influenced by a family member’s perspective of appropriate roles and tasks.

R: I had a Dutch man who'd had a stroke. And his wife one minute would be complaining because he wasn't up and doing what he should be, which is very typical. The Dutch woman wants the man to be doing something around the house. But the next minute -- "Oh, I do that for him. . . . Oh, he doesn't need to do that. I take care of that" (R1:260-267).

The respondent went on to describe use of towel folding for upper-body endurance.

R: It's a good upper-body endurance task. . . . You're folding big towels, you're raising your arms, you're working the heart. . . . To someone who's . . . had a bout with congestive heart failure or something like that, that's . . . [going to] be work. But the woman says, "No, no. That's my job, that's my job." And oh, you go round and round . . . trying to explain, "No, it's exercise. It's good, it's okay to get him to the point where he can do something else" (R1:279-286).

A client's cultural perspective also influences the orientation of therapy to rehabilitation or compensation. The respondent discussed experiences with Latvian-American clients and described their viewpoint as, "If something's broken, it's okay. Don't worry about it." She perceived this as meaning deficits in physical performance or functioning are acknowledged but are not seen as problems. To the respondent, it was "not okay" and she was frustrated by the conflict. Treatment was impacted because problems or deficits which were acceptable to the clients the respondent saw as safety issues and areas to be targeted in treatment.

Developing an understanding of the client's cultural background, beliefs, and values can be difficult and involves direct questioning of the client or family, use of informal communication, observation of the client as he or she interacts with others, and the identification and interpretation of cues present in the client's home. The

respondent gave an example of a case where her efforts to learn about the client's culture and language provided an opportunity to build rapport.

I: I know you've treated some Hispanic patients, some other patients who might have difficulty with English as their primary language. What happens in those cases?

R: One [case] . . . her daughter was present at treatment. . . . It initially started out, "This is what I am. This is who I am. This is what I'm doing. . . ." . . . that was the first visit, very business approach. The second visit . . . we were able to take the language issue, and I was able to turn it into part of our rapport. I'd say to her, "How do you say socks?" I'd show her the sock, and she would tell me. And then I'd try and say it and we'd laugh over it. And we found . . . that rapport in the end was probably not as close as some of the others, but at least it was beyond that cold box, what I feel is this business box type of a rapport (Y3:177-187).

In this case, the respondent also questioned the client about the way things were done in the client's home country. The respondent's curiosity and willingness to learn in combination with the client's openness in sharing about her culture resulted in a positive therapeutic relationship despite the degree of cultural differences present.

In another case, the respondent noticed an unusual cloth tucked in the clothing of an African-American client she was treating. The client's family explained that the cloth was blessed and then worn as a reminder to have faith in healing. The respondent described how learning about the cloth influenced her perception of the client and his family.

R: It just enriched it. I wouldn't say that it changed it. . . . It [healing cloths] was just a component that I myself was not familiar with, so it broadened my perspective of what their belief system was and in some ways how they viewed recovery. That they acknowledged that they, by all means, do the most that they can within themselves to facilitate recovery, but yet they have the belief that there's a higher power, that there's a God that will facilitate that.

I: How did it change your interaction with them? You said it threw you for a loop.

R: Well it did . . . it's not every day you run across this wad of material in someone's clothing, and you begin in your medical mind running through, "Is this a dressing? What's the deal? . . . What's going on?" In that way it threw me for a loop.

I: Because it didn't fit with the medical?

R: Well no, it definitely is not your traditional medical perspective. . . . It goes back to that holistic concept of OT, dealing with the whole person. You can't deny a person's beliefs and just focus on the physical because the beliefs definitely impact the outcomes of the physical (B5:93-109).

The respondent indicated this experience had provided her with a greater awareness of how religious beliefs influenced the client's recovery and views about the healing process. The respondent believed that the knowledge from this situation would help her treat future clients from a similar background.

In one case, the respondent sought the help of a colleague to interpret during an evaluation session with a Latvian-American client. To aid in understanding Latvian culture, the respondent sought information from a colleague who was raised in a Latvian-American family. The colleague was able to share the perspective of Latvian culture and explain behaviors which were puzzling to the respondent. The respondent thought the use of the colleague as an interpreter impacted the delivery of the evaluation. The respondent felt unable to gauge the client's comfort level with the evaluation process due to her lack of knowledge about the client's culture, including verbal and non-verbal communication. Due to communication and cultural barriers, the respondent had difficulty developing an accurate picture of the client's cognition.

The client's performance on the evaluation was influenced by the manner of interpretation. Due to this, the respondent was unable to develop an accurate picture of the client's cognition. She felt for the purpose of "pure communication" needed for evaluation, a non-colleague interpreter would be preferred. The benefits of a colleague interpreter included getting "the scoop" on the family and cultural perspectives that would not have been provided by a non-colleague interpreter. The colleague interpreter was able to share with the respondent about the client's discomfort with the evaluation and the reason for that discomfort. This information aided the respondent in creating an appropriate treatment plan and gave her ideas for ways to approach treatment.

Assessment

Assessment included both the home health care agency's formal evaluation process and the respondent's informal evaluation of the client and home environment. Assessment included learning of the client's previous life roles and interests.

According to the respondent, the formal intake and initial evaluation did not include questions about cultural background or health beliefs. In some cases, the client would mention cultural information during the initial interview, but cultural information was primarily gained during informal conversation with the client and through observation of the client's home. Conversation provided the respondent with an awareness of the client's activities which she could then draw upon during treatment. The therapist also used conversation as a way to learn of the client's

culture, including language, customs, and unique features of the home environment. Through conversation, the respondent gained knowledge of the client's and family's perceptions of disability and recovery. The respondent was very aware of the home environment and would evaluate physical clues in the home to develop a sense of the client's or family's cultural background. She also evaluated the degree to which they held to the beliefs and participated in the customs associated with their cultural background.

Through the formal assessment, the informal conversation, and evaluation of the home environment, the respondent would develop an idea of the cultural similarities and differences between herself and the client. Cultural similarities and differences included being budget-minded, religious beliefs, commitment to going to church, perceptions regarding the roles of men and women, and values and perceptions regarding disability. Cultural differences in body language, preferences for body space, and physical privacy were noted by the respondent. When asked about client preferences for physical closeness or distance, she contrasted clients from three cultures.

R: Both Latvian homes . . . were very welcoming. Handshakes. One home it was hugs. That was their greeting. . . . African-American houses that I've been in, as a general rule, it's just . . . what I perceive as normal range for bodily closeness. . . . I'll get a handshake. If there's good rapport built up, I might get a hug . . . from the patient as a greeting. . . . I don't see either of that in Hispanic [homes]. You come in, you sit down, you do your job, and you go (G4:261-266).

The respondent also noted differences in the amount of eye contact and physical feedback from clients during treatment. The respondent looked for eye

contact and physical feedback to indicate that the client understood and approved of the treatment. The respondent most often noted decreased eye contact and physical feedback with Hispanic and African-American clients, while Latvian clients were more open in both verbal and physical expression. In some cases, if the respondent could not get physical or verbal feedback from the client or family, the respondent's decision regarding continuation of treatment was influenced.

R: Sometimes . . . the response determines how long you're there. If you weren't real sure if they're agreeing or if they're accepting what you're teaching, and if after a couple visits you're not seeing the fruit of what you've taught, then you have some choices or decisions as to -- is this really what they want and do I need to be here (G4:300-303).

Treatment

The respondent saw cultural differences on treatment in the areas of treatment approach, activity selection, type of treatment desired, client response to treatment, and family response to treatment. Cultural influences on treatment originated from the client, the family, the community, and the respondent.

The respondent's initial approach to treatment included communicating with the client and family about needs she perceived and how occupational therapy treatment could address those needs. The respondent collaborated with the client and family members when planning treatment goals in order to increase acceptance of treatment interventions. She felt an approach of providing options and encouraging the client and family to choose was respectful of the client's right to select or refuse treatment. The respondent's approach to treatment included finding out about the

client's routine for ADL's. She strove to be "more aware" and "more sensitive" to the client's feelings regarding personal hygiene and the impact of helping clients with these activities. For example, if she planned to work on bathing three times a week when a client was used to bathing once a week, she would alter the treatment plan to meet the client's need.

Selection of treatment activities was based as much as possible on the client's previous roles, interests, and goals for treatment. Limitations caused by disability or illness often created the need to find new activities for the client which were culturally acceptable. In one case described by the respondent, a Latvian-American client with dementia replicated the flags of Europe from an encyclopedia as a means of reality orientation. This client viewed the flags in the encyclopedia with the therapist and through this activity was able to appreciate and share his cultural background and interests. The respondent described another case where the treatment was designed to include the client's roles and interests.

R: I needed a fine motor task, and you can achieve that through theraputty, but I have a gentleman who's kind of a handyman . . . works for a veterinarian, and is involved in fixing and repairing things around barns and making sure the equipment is running. Well, I bet this guy has . . . nuts and bolts. So my fine motor task to get two-point and three-point pinch has been to have him hold the bolt with the right hand and screw the nut on with his affected CVA hand. . . . It was practical to him. He could see it . . . we had to deal with the issue of, "Oh, I know I can do this better" . . . but it also shows him as he's improving. "Yeah, I'm . . . [going to] make it. I'm . . . [going to] get back there again." And so that's how it changes. I still gave him theraputty exercises. . . . I think there's an aspect of strengthening there that's important. But it's not . . . another thing to do in his day. Whereas nuts and bolts, he knows it. If he can do nuts and bolts, he can get back to work. Practical (G4:62-73).

A client's preferences with respect to physical and verbal interaction also influenced treatment. Activities such as facilitation of shoulder movement, massage, and bathing were difficult for the respondent to initiate with clients who preferred less physical interaction. The respondent described her approach in a situation where the client or family showed a tendency to engage in a minimal amount of physical and verbal interaction during treatment.

R: You're just all business . . . to the point. You get it done with. You provide this information you need to provide. You may not perhaps be drawn to expound in areas that you might with someone that's more responsive . . . that's probably the biggest thing . . .

I: Does it influence the amount of hands-on teaching or hands-on work?

R: It can . . . if they aren't willing or accepting for you to be there and show them techniques and to help them dress or help them bathe and show them how they can gain independence in that . . . then obviously you're . . . [going to] be providing the information and that is all the further it's . . . [going to] go (G4:314-323).

Response to treatment included the client's comfort level with the type of treatment and presentation as well as the client's compliance with the treatment regimen. The client's comfort level with the treatment and therapeutic interactions was measured by the respondent through body language and verbal feedback during treatment. Based on the response of the client, the respondent would modify the treatment method and/or her style of interacting in order to gain a more positive response. The respondent discussed sessions with a client where a change in her interaction style was needed.

R: The perspective is almost . . . you're supposed to give me my bath. It's like . . . "No, I'm teaching you how to get back that skill again." . . . I try and

be very respectful with modesty . . . when we are doing that type of activity, but yet if there's an error when they're doing the shower . . . I try and keep a jovial [light-hearted] perspective on it rather than . . . coming in with a negative corrective attitude. And he [client] doesn't take that jovial attitude very well, so I've had to learn to be extremely business, very straight-faced. "This is what needs to be done" . . . and he does very well with that. If I make any jokes to try to create a comfort zone, it makes him uncomfortable (B5:311-321).

Compliance with treatment was influenced by several factors, including rapport between the therapist and client, the client's personality, the client's reasons for seeking treatment, the client's belief in the type of treatment offered, and the client's economic and other resources for achieving treatment goals. The respondent discussed building rapport and establishing a positive therapist-client relationship as key factors in achieving treatment goals. Rapport made it easier to broach difficult subjects during treatment, such as equipment recommendations, modification of clothing, or changing the client's ADL routine. The respondent described clients who were less defensive about making changes and more accepting of her suggestions because of a strong rapport. Some clients were compliant as part of their personality and demonstrated a high level of follow-through with treatment.

Patterns of non-compliance were usually indirect. The clients and family would express verbal agreement with treatment goals, but the therapist would not see actions taken by the client and family to reach the established goals. The respondent would try to read the verbal and physical response of the client and family to treatment and would modify treatment until a positive response was perceived. The respondent

was asked if she saw any difference in compliance with treatment related to the degree of cultural difference between herself and the client.

R: No. It's individualized based on the rapport . . . that you establish with the patient. It's more that issue than . . . a cultural issue. Because I've been in homes where we've come from a similar background, had a rapport, but follow-through [with] treatment has not been good. And that's the patient's choice (Y3:473-477).

Socio-economic status of the client and family influenced the degree of independence that was possible in many cases. A client's inability to afford recommended adaptive equipment reduced the client's ability to complete tasks without assistance. The respondent would try to coordinate family efforts and utilize community resources to meet the client's needs.

Characteristics of the family that were seen as influences on treatment included a matriarchal or patriarchal orientation, the presence of multiple generations in a household, and a family's perception of appropriate roles for the client. A matriarchal orientation was seen by the respondent as promoting caregiving for a client instead of facilitating independence. This was discussed in reference to a client who was receiving care from his wife (who was seen as having a patriarchal orientation) and a sister-in-law (who was seen as having a matriarchal orientation). The respondent described the matriarchal orientation as, "You take care of your family. You take care of your man . . . you hold him in high regard, but it's your job to make sure he's cared for" (Y3:303-305). The patriarchal orientation held by the wife included a perception of her husband as head of the household (prior to his stroke) and a desire to see him return to this role. In homes where multiple generations resided, the respondent noted

a reduced compliance from caregivers with recommendations for treatment. Family perception of appropriate roles for a client influenced the respondent's treatment approach and goals. In some cases, the spouse or other family member would want the client to return to his or her previous roles and responsibilities within the family. In other cases, the spouse and family desired to care for the client and placed less importance on the client's return to the previous level of functioning or maximum potential for recovery.

The cultural aspects of a community influenced treatment in several ways. In one case described by the respondent, attempts to increase the independence of a client were impacted by the client's status within the community.

R: The patient's role in the family had been one of leadership, and within that community . . . her health gradually deteriorated . . . [and] it was okay for her not to be well to some extent because then the people in the community would come to her to care for her because she had done so much for them. . . . She was still held in regard as the leader, but she no longer was a leader that led. She was a leader to be cared for now. And that really makes it hard, because then no matter what I do, it doesn't matter, because she was to be cared for, and I see that real strong . . . in that community (O2:134-145).

Traits and values of the respondent, such as a tolerance for cultural differences and a compassionate nature, also influenced treatment. She described how her perspective of the world influenced her provision of occupational therapy.

R: I tend to be . . . more compassionate, which can be good and it can be not so good, because I will go out of my way to do things for patients. If I know I'm going past an equipment place, I'll offer to pick it [piece of adaptive equipment] up for a patient. I would stop and pick something up because I know that being homebound, they're aren't . . . [going to] get out to get something, which is good and it's bad. . . . Sometimes that doesn't exactly help to foster their independence. They have a family member that can just as easily do it. However, half the time the family member doesn't understand what . . .

you're talking about, so it's just as easy to do it yourself. . . . Compassion is the big one, I think, something that impacts my treatments. I have a really hard time when I have to leave a house where . . . I know inside myself the patient could achieve more, but the family or the patient doesn't desire it. That's really hard for me (V6:123-133).

Clinical Reasoning of the Respondent Therapist

The respondent discussed skills in clinical reasoning as the primary source of her ability to make sense of the cultural information she acquired about a client and integrate that knowledge into her treatment approach. The respondent described the reasoning process she used to consider a client's culture in planning treatment.

I: How does knowledge of the patient's cultural background and beliefs influence the picture that is formed of them at their optimal ability and functioning?

R: The big thing for me is you take what you know that patient was before and the role that they played, the things that they did. You add that to the component that you have of . . . where they're at physically now, and you're striving to get them back to where they were before . . . as much as possible. So your picture comes more from . . . the roles and activities that they were participating in prior . . . You look at who they were and what they were before the illness or whatever. And then how can we get them back to being that person again. . . . Take the task of cooking. For a woman, in most cultures, that's a pretty significant task. And if that was her role to have the meals ready by five o'clock when her husband was finished working around the house . . . then you know that it's of importance to them in their cultural setting and so you're striving for that again. But you . . . [have to] know who they were and what they were (V6:196-209).

The respondent discussed the role of the occupational therapist in a case where the client could not return to former roles and interests.

R: Sometimes you have to start from ground zero . . . you know what they were before, but there is no way physically they're . . . [going] back to that or mentally that they're . . . [going to] be able to handle what they were before.

So then you're working with a patient on an ongoing basis . . . developing a new self.

I: Okay. And how do you see cultural background and beliefs as tying into that as you're helping the patient create a new self?

R: Sometimes it's hard because culturally they're supposed to be this [particular] male or female. However, they can't carry out that role, so you try and find the things that they can still do. . . . It may not be what they have typically done, but maybe there's another aspect in that culture . . . that they can take on and develop (V6:217-227).

Cultural Competency

The respondent rated her level of cultural competency at "mid-high" level due to her ability to use clinical observations skills for attending to and interpreting environmental and verbal cues from the client and the home environment. She elaborated on her strengths in working with cross-cultural clients.

R: I think that's a real strength if you can get past the clinical observation part of . . . range of motion and how their performance is, into who the person is. That helps to make a better treatment. I am a people person, and I think because of that I am able then to converse easily with others and to draw out their strengths, their interests, and their background through conversation. I guess those would be the strengths . . . because you need both of those entities in order to be able to gain an understanding of the person (V6:13-20).

The respondent saw her primary weakness as a lack of knowledge about specific cultures. The education provided at her work locations had been oriented "on how not to impose my beliefs, my thoughts, on someone else that I'm treating, rather than training me in how to handle . . . someone with a . . . different religious viewpoint on medical care, or a cultural difficulty (R1:144-147). She felt additional training on

perspectives regarding medicine and roles of males and females in a culture would aid in treating clients from diverse backgrounds.

CHAPTER V

DISCUSSION

Review

This thesis incorporated a phenomenological approach to qualitative research in an attempt to determine the influence of culture on the clinical reasoning and treatment approach of an occupational therapist. The study focused on three primary questions:

1. How does the background of a client influence an occupational therapist as he or she plans and implements treatment?
2. How is the treatment process influenced by cultural differences between the therapist and the client?
3. What training or education could help the occupational therapist better serve cross-cultural clients?

Influence of the Client's Background

The results of this study illustrated the influence of a client's cultural background on the selection of activities, methods used in treatment, and the orientation of treatment to compensation or rehabilitation. The client's culture impacted treatment including what goals were established, the timing or frequency of

treatment, presentation of treatment, and compliance with treatment regimen. The respondent selected treatment activities based on the client's cultural background, including ethnic identity (copying European flags), type of job (nuts and bolts for a handyman), and gender (meal preparation for a housewife). Cultural background influenced treatment methods utilized, including use of hands-on techniques, introduction of adaptive equipment, and approach to ADL retraining. Orientation of treatment to compensation or rehabilitation varied based on cultural perspectives of how to deal with illness. Treatment was more often geared toward rehabilitation and returning the client to their former level of ability, as well as previous roles and interests. Treatment of Latvian-American clients was often oriented to compensation because of their "It's not okay, but it's okay" philosophy. In other cases, the desire of the family to provide caregiving and accept a new role for the client shaped the orientation of therapy to compensation. The client's family and community influenced treatment, in part by determining the roles and occupations that were acceptable for the client. This was a factor in the respondent's treatment of the Dutch-American client whose wife did not want him folding towels as a treatment activity.

Influence of Cultural Differences

The respondent viewed each client as having significant cultural differences. Her assessment of culture attended to the individuality of each person. The respondent's consideration of a client's culture occurred in all the levels described by Krefting (1991): (a) individual, (b) family, (c) community, and (d) regional. In

consideration of the individual, she avoided stereotyping clients based on ethnic or racial identity. She adapted a style of communication and a treatment approach for each client based on their personality, previous roles, and interests. In consideration of the family, she looked at caregiving style, the family's view of the client, the family's needs for education, and the power structure within the family. At the community level, she considered community involvement in caregiving, social norms, and opportunity for social involvement. At the regional level, she considered regional resources and support, as well as geographic issues, including isolation and resource scarcity.

The initial interactions of the respondent and client were, in large part, oriented toward the development of a mutual understanding of backgrounds and viewpoints. During this time, cultural similarities and differences between the respondent and clients were discovered. The respondent compared the treatment-related problems and issues she identified with the problems and issues put forth by the client or family. The respondent introduced herself, explained her role as a therapist, and described her perception of the situation. She asked questions to elicit the client's perception of disability related problems. As a result of social conversation during the initial session, the respondent and clients had opportunities to share aspects of their cultural background, such as family connections, places they had lived, religious beliefs, and involvement in the community. Levine (1987) described an occupational therapist as a participant observer whose evaluation of the environment is "a small scale search for

the meaning of events and objects” (p. 736). This action was visible in the work of the respondent as she evaluated clients and their environments.

Therapists must be aware of the cultural basis of assessment and be trained to assess clients within a cultural context. Judgments made in the assessment process must take into account the client’s cultural background and its impact on assessment results. Therapists must consider culture in the interpretation of results or fail in truly understanding the results. The respondent realized the impact of culture on assessment and that assessment results were often not reliable due to cultural issues, including self-esteem, privacy, language, and trust. She tried to seek information from the client, family members, and colleagues in order to have as complete an understanding as possible of the client’s situation.

The treatment process was impacted by cultural differences between the respondent and clients at several levels. Cultural differences influenced the respondent’s style of interaction and communication. In cases where she perceived treatment barriers related to cultural differences, the respondent used an increased amount of questioning to develop knowledge of the client’s culture and to elicit feedback from the client regarding treatment. If the respondent was unable to develop a rapport, she tended to provide treatment and communicate with the client in a style she termed “the business approach.” The business approach was characterized by straightforward communication oriented to diagnostic information, treatment goals, and treatment activities. During the AOTA/AOTF clinical reasoning study, a similar tendency to rely on procedural reasoning was noted in cases where therapists were unable to establish a

rapport with a client (Mattingly, 1989). In some instances, the perception of cultural differences by either the respondent or client led to a feeling of caution or mistrust which hindered the development of rapport and decreased opportunities for cultural sharing. The respondent discussed her use of a jovial approach with a serious-natured client and the barrier this created to her presentation of treatment.

Tailoring treatment to account for cultural differences will result in a higher acceptability of care, greater client satisfaction, and better outcomes. As a result of improved cultural competency, clinicians will receive greater satisfaction in their role as care provider, relationships with clients will be enhanced, quality of care will increase, and greater equity of care will be achieved as more minorities seek and continue treatment. The motivation to address issues of cultural difference may come from marketplace pressures (Friedman, 1992), poor treatment outcomes (Rorie, Paine, & Barger, 1996), a desire to provide a higher quality service (Schwartz, 1990), or professional philosophy (Levine, 1987). Marketplace pressures include an increase in the cultural diversity of clients, greater consumer advocacy, and outcomes studies. Poor treatment outcomes include decreased compliance, clients who discontinue treatment, errors in treatment due to miscommunication, and failure to meet goals which are important to the client. A desire to provide higher quality service includes improving communication, fostering the therapist-client relationship, and providing individualized treatment. Professional philosophy includes valuing the involvement of the client in the decision-making process and a focus on purposeful activity.

Education for Cultural Competency

The respondent thought that specific information on health beliefs and practices of cultural groups she served would help her provide culturally sensitive treatment. She wanted to learn about cultural perspectives on illness, disability, recovery, caregiving, gender roles, community involvement, family roles, communication styles, and acceptance of physical contact. She intended to use this knowledge to increase her awareness of clients' cultural backgrounds and culturally based perspectives. She would be careful not to "fit everyone into that stereotype that would be given."

The respondent's education in rural health and anthropology helped develop a style of interaction with clients and a treatment approach that were culturally sensitive. Education on rural health issues increased her knowledge of special needs that clients may have related to cultural background. The social science courses (mainly anthropology classes) formed a framework for her consideration of culture. The social science course work increased her awareness of culture and the degree of importance she gave culture in clinical reasoning.

It is important for any cultural competency training to provide clinicians with skills and strategies for integrating knowledge of culture into practice. Training for therapists must go beyond promoting cultural sensitivity and provide strategies for communication, interviewing to elicit health beliefs, collaborating on acceptable treatment, and implementation of treatment. AOTA requires that educational programs address the cultural sensitivity and awareness of practitioners. Occupational therapy

programs are encouraged to take the additional step of teaching skills for culturally based assessment and treatment planning. While formal tools are available to aid occupational therapists in consideration of culture, well-developed communication and clinical reasoning skills will provide the best resource for understanding culture.

Clinical Reasoning

Clinical reasoning skills were evident in the respondent's way of viewing cases. The respondent thought about clients phenomenologically as evidenced by her interest in all aspects of their lives. She sought to see beyond traits of the person or the diagnosis. Her innate curiosity motivated her to question clients about their cultural background, family, beliefs, and interests. She wanted to know how their life was altered and what difficulties and challenges their illness or disability presented. She considered the influence of a client's illness experience on interactions within the family and the community.

All four forms of clinical reasoning--conditional reasoning, interactive reasoning, narrative reasoning, and procedural reasoning-- could be identified in the respondent's actions and thought processes as she worked with clients. Conditional reasoning was demonstrated by the respondent's concern to know about the client's life prior to disability or illness. She considered whether a client would return to his or her previous way of life. In cases where the client would not be returning to his or her previous roles and interests due to the nature or severity of disability, she helped the client construct a new life and self-image. She worked with the client to develop a

vision of a future life to work toward in treatment which included occupations that would have meaning to the client and value within the larger community.

Interactive reasoning was shown through the respondent's reliance on feedback from the client. It was important for her to know how the client was responding physically as well as psychologically to the treatment process. When working with a client, she sought an "easy-going" level of rapport and interaction that would allow her to get honest feedback from the client through both verbal communication and body language. All types of communication served as a source of information about the client, the client's culture, and the client's response to treatment.

Narrative reasoning was utilized by the respondent as a way of gathering information about clients and as a way for her to express her thoughts, motivations, and choices when describing a particular case. Narrative, including stories told by clients, was used by the respondent to understand clients' perspectives on disability and the rehabilitation process.

Procedural reasoning was evidenced by her use of "the business approach" in which she focused on the physical issues of a client's disability and what she could offer in terms of equipment or training. Part of procedural reasoning is gauging a client's or family's reaction to treatment. The development of cultural understanding allowed the respondent to form preliminary ideas about how treatment would be viewed by the client or family. It also helped the respondent know why clients made certain choices regarding therapy or why they behaved in a certain way.

Similar to this study, Hooper (1997) showed the influence of culture on the clinical reasoning process. Hooper's study looked at the world-view of a therapist and how it influenced treatment. While this study focused on the cultural background of the client rather than that of the therapist, the cultural background and world-view of the respondent were shown to be important factors. The respondent in this study presented her treatment approach as unique, based on her family experiences, education, religious beliefs, philosophy, and personality. Cultural values which she noted as influencing treatment included compassion, tolerance, and curiosity. Other traits that influenced therapy included her outgoing personality, budget-minded nature, and conservative tendencies.

Cultural Competency

The respondent demonstrated cultural competency according to the characteristics outlined by Randall-David (1994). The respondent was aware of her cultural heritage and culturally related values which influenced her perceptions, opinions, and treatment approach. She sought to be comfortable with cultural and value differences between herself and clients, while recognizing internal conflicts and stresses related to these differences. She attempted to gain specific cultural knowledge through interactions with clients and colleagues, including how disability and illness were perceived and dealt with in a culture. She recognized the special needs experienced by her clients due to their cultural background, such as decreased affordability of or access to health care resources. She understood that clients are unique individuals who may or

may not hold to a given cultural identity. She sought to learn about cultures through interaction with clients and colleagues. She was committed to understanding the viewpoint and perspective of her clients. She demonstrated flexible thinking and used a trial-and-error approach in treatment. She was prepared to adapt treatment to better suit the unique needs of the client and family. A sense of humor was incorporated into her personal style when working with clients. She was willing to share control of a clinical situation with clients. She sought client input on goals for therapy and methods to reach these goals. She was willing to accept a less than optimal outcome of a clinical situation if concluding treatment was desired by the client. She analyzed her feelings and reactions in clinical situations where frustration, anger, or resistance developed and would try to be aware of situations where she needed to “let go.” The therapeutic relationship with clients and families was highly valued by the respondent. She saw it as a critical element which impacted her ability to present treatment and have it be accepted and viewed positively by clients. She valued the interaction with clients and their collaboration as much as she valued achieving treatment goals.

Occupational Therapy Education

The results of this study emphasize the value of education on the psychological aspects of occupational therapy. The respondent’s background in mental health was an important factor in her ability to practice occupational therapy holistically. Decreased occupational therapy education on psycho-social issues and decreased

mental health practice opportunities may impair the ability of therapists to engage in a phenomenological approach to practice.

This study supports education designed to develop clinical reasoning skills. Practitioners who increase their clinical reasoning skills will be better able to provide individualized care for a diverse client caseload. They will also experience greater ease in justifying this care in a practice environment which focuses on pathological aspects of disability rather than the life experiences and concerns of clients.

Limitations

Study limitations include the researcher's lack of experience in conducting qualitative research and lack of practical experience as an occupational therapist. A team approach to research, as suggested by Lincoln & Guba (1985), would have enhanced the depth of the study and the ability to analyze data. Recommendations for a replicative study include increasing the amount of time spent observing therapist-client interactions, interviewing clients, and audiotaping observation sessions.

This study explored the relationship between culture and clinical reasoning. The results provide a picture of the ways in which one therapist considered culture in the provision of occupational therapy. It adds to the body of knowledge on phenomenological thought and clinical reasoning in occupational therapy. While the results are not generalizable, they compare favorably with other studies on culture and clinical reasoning. Lastly, this study supports education for practitioners that emphasizes clinical reasoning and skills for working with culturally diverse clients.

Recommendations for Further Research

Providing identical care for all clients regardless of their cultural background is not an appropriate or effective response to the cultural diversity of health care clients. This form of care is not equally effective for all consumers and fails to take into account values, norms, and socially determined relationships that are part of the health care system. The current effort involves raising awareness of cultural differences and their impact on the provision of occupational therapy. Occupational therapy is based on the daily activities or occupations of clients. Because clients' occupations are culturally based, culture and ways of living must be understood in order to provide effective and relevant occupational therapy. If consideration of culture and individualization of treatment are to remain important parts of occupational therapy, they must be included in research in a way that is meaningful given the current and anticipated practice environment and guides future practice. Case studies on cultural aspects of care frequently focus on the client's cultural background, beliefs, and practices versus focusing on the interaction between the therapist, the client, and the setting in which care is provided. The people providing care and the setting in which care is provided are essential elements of the case. Therefore, they cannot be removed from the factors to be studied in a given situation. Cultural aspects of the client influence the care which is provided. There is no question that the decisions and overall approach of the therapist are also influenced by aspects of his or her cultural background and the cultural characteristics of the health care setting. Any therapist

can learn how to make treatment more acceptable and better understood by the client and family through the development of cultural understanding.

Clinical reasoning studies are valuable because therapist subjects gain improved clinical reasoning ability through examining the processes by which occupational therapy treatment is provided. The knowledge of how therapists practice is usually tacit (unspoken), but this knowledge can be made explicit through careful examination and analysis. By developing clinical reasoning, therapists develop an increased ability to analyze relevant characteristics of a case, plan individualized treatment, and justify this treatment to others on the treatment team (Mattingly & Gillette, 1991).

Care addressing the psycho-social aspects of disability is seen as harder to qualify, quantify, present, and justify. When undertaking a phenomenological approach to treatment, it is harder to justify what we are doing and why. This part of treatment with a client is more exploration. We cannot say what exactly will happen, but our education and experience have taught us that it is an important part of practice. Occupational therapists should not feel they have to sneak in holistic practices or interventions geared toward psychological adjustment to disability. Additional research will provide a foundation of support for care that is culturally relevant and individualized. It will support such care, not only as best practice by a philosophical viewpoint, but also as a factor in improving outcomes, quality of care, and customer satisfaction.

Appendix A
Human Subjects Institutional Review
Board Approval



WESTERN MICHIGAN UNIVERSITY

Date: 12 November 1996

To: JoAnne Wright

From: Richard Wright, Chair

Re: HSIRB Project Number 96-11-09

This letter will serve as confirmation that your research project entitled "Consideration of Culture in Clinical Reasoning: A Case Study" has been **approved** under the **expedited** category of review by the Human Subjects Institutional Review Board. The conditions and duration of this approval are specified in the Policies of Western Michigan University. You may now begin to implement the research as described in the application.

Please note that you must seek specific approval for any changes in this design. You must also seek reapproval if the project extends beyond the termination date. In addition if there are any unanticipated adverse reactions or unanticipated events associated with the conduct of this research, you should immediately suspend the project and contact the Chair of the HSIRB for consultation.

The Board wishes you success in the pursuit of your research goals.

Approval Termination: 9 November 1997

xc: Sandra Winter

Appendix B
Therapist Consent Form

Therapist Consent Form

Western Michigan University/Department of Occupational Therapy

Principal Investigator: JoAnne Wright, Ph.D., OTR
Research Associate: Sandra Winter, MS Candidate

Explanation of the Research Study

I have been invited to participate in a research project entitled "Consideration of Culture in Clinical Reasoning: A Case Study." I understand the nature of this research is to determine how a therapist takes culture into account when planning treatment for cross-cultural clients. I further understand that this project is Sandra Winter's thesis.

Procedures/Purpose

My consent to participate in this project indicates that I will be asked to participate in six sessions of interviews and three sessions of observation and/or videotaping with Sandra Winter. These sessions will take place at a location and time that I designate. I will be asked to provide information about myself, including work history and cultural background. I will assist the researcher in obtaining data about the number and type of clients I serve. For those clients who are part of observation or videotaping sessions, I will be asked to provide relevant data regarding the patient's background and treatment. The data provided will be used to construct a description of how a therapist considers culture in treatment planning.

Description of Risks/Invasion of Privacy

As in all research, there may be unforeseen risks to the participant. If an accidental injury occurs, appropriate emergency measures will be taken. However, no compensation or treatment will be made available except as otherwise specified on this consent form. Potential risks for this study include breach of confidentiality, disclosure of sensitive personal information, attrition of patients, and decreased productivity.

Potential Benefits/Development of New Knowledge

A potential benefit from participating in this study includes having an opportunity to analyze and enhance my clinical reasoning skills by reviewing the treatment data with the research investigators. I also understand that other therapists will benefit from the information on culture and clinical reasoning derived from this study.

Measures to Ensure Anonymity and Confidentiality

I understand that all information collected from me is confidential. My name will not appear on research materials. All written data and videotapes will be marked with a date only. Interviews will be audiotaped and transcribed. After transcription the audiotapes will be erased. Videotapes will be destroyed after data collection. All data related to the study will be kept for three years in a locked file in the principal investigator's office.

Voluntary Participation/Freedom to Withdraw Without Penalty/Contact Persons

I understand that my participation in this study is voluntary. I may refuse to participate or quit at any time during the study without prejudice or penalty. If I have questions or concerns about this study, I may contact either Dr. JoAnne Wright at 387-4311 or Sandra Winter at 349-6089. I may also contact the Chair of Human Subjects Institutional Review Board at 387-8293 or the Vice President for Research at 387-8298 with any concerns that I have. My signature below indicates that I understand the purpose and requirements of the study and that I agree to participate.

Signature

Date

Appendix C
Patient Consent Form

Consent for Observation

Western Michigan University/Department of Occupational Therapy

Principal Investigator: JoAnne Wright, Ph.D., OTR

Research Associate: Sandra Winter, MS Candidate

I have been invited to participate in a research project entitled "Consideration of Culture in Clinical Reasoning: A Case Study." I understand the nature of this research is to determine how a therapist takes culture into account when planning treatment for cross-cultural clients. I further understand that this project is Sandra Winter's thesis.

My consent to participate in this project indicates that I will be asked to participate in two to three sessions of observation and videotaping coordinated by Sandra Winter. The observation and videotaping will be focused on the therapist as she performs therapy, not on me as a client. These sessions will take place in my home during regularly scheduled treatment. The videotape and observation will be used to provide information on how the therapist carries out a planned treatment.

As in all research, there may be unforeseen risks to the participant. If an accidental injury occurs, appropriate emergency measures will be taken. However, no compensation or treatment will be made available except as otherwise specified on this consent form. Potential risks for this study include breach of confidentiality and disclosure of sensitive personal information

It is not expected that I will receive any direct benefits from participating in this study. I understand that therapists who work with patients from other cultures will benefit from the results of this study by being able to plan more effective and culturally relevant treatment.

I understand that all information collected from me is confidential. This means my name will not appear on any papers on which research data is collected. Videotapes from the study will only be viewed by the researchers and will be destroyed after data collection. All data related to the study will be kept for three years in a locked file in the principal investigator's office.

I understand that my participation in this study is voluntary. I may refuse to participate or quit at any time during the study without prejudice or penalty. If I have questions or concerns about this study, I may contact either Dr. JoAnne Wright at 387-4311 or Sandra Winter at 349-6089. I may also contact the Chair of Human Subjects Institutional Review Board at 387-8293 or the Vice President for Research at

387-8298 with any concerns that I have. My signature below indicates that I understand the purpose and requirements of the study and that I agree to participate.

Signature

Date

Appendix D

Guidelines for the First Interview

GUIDELINES FOR THE FIRST INTERVIEW

Therapist's Background/Philosophy

Tell me about your education and how it helped prepare you for working with cross-cultural patients.

Outline your work experiences since becoming an OTR.

What influenced your job choices?

Why did you choose to practice OT in a rural setting?

Work Experiences

What are the strengths and weaknesses of this type of practice?

What training was provided at these jobs to prepare you to work with patients from diverse cultural backgrounds?

What was the percentage of cross-cultural clients on your caseload at previous jobs?

What is the percentage of cross-cultural clients on your caseload at your current job?

What ethnic backgrounds do your patients represent?

Assessment and Treatment

How have cultural differences between you and your clients impacted therapy?

What methods do you use to consider cultural background when planning treatment?

How does your approach to treatment differ when treating a cross-cultural patient?

What are your sources of information about a patient's culture?

Cultural Competency

What is your perception or attitude about working with cross-cultural patients?

If the resources were available for additional training to address the needs of cross-cultural patients, what types of training would you seek and why?

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