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The Challenge of Cultural Competency in the Multicultural 21st Century: A Conceptual Model to Guide Occupational Therapy Practice

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The Challenge of Cultural Competency in the Multicultural 21st Century: A Conceptual Model to Guide Occupational Therapy Practice

Abstract

Background: Occupational therapists increasingly encounter clients from diverse cultural backgrounds and need to meet their professional obligation of delivering culturally competent practice. Yet the process of cultural competency is poorly understood in occupational therapy practice. There is a need for a clear understanding of the meaning and process of cultural competency as it is enacted in practice with a wide range of individuals from culturally diverse backgrounds.

Aim: To investigate the process, stages, characteristics, and requirements of cultural competency as practiced by experienced occupational therapists.

Method: Semi-structured interviews were carried out with 13 community occupational therapists experienced in delivering occupational therapy services in clients' homes in a culturally diverse area in London, England.

Findings: Interview data were analyzed and ordered into the format of a conceptual process model where cultural competency formed the core concept. The model of cultural competency that emerged from this study comprised six stages: cultural awareness, cultural preparedness, a cultural picture of the person, cultural responsiveness, cultural readiness, and cultural competence.

Conclusion: Cultural competency is a complex process that needs to be based on underpinning occupational theory and actualized at the level of practice. Further research is needed to test out the model and illuminate the process of cultural competency in different areas of occupational therapy practice.

Keywords

Cultural competency, occupational therapy, qualitative research, conceptual model.

Cover Page Footnote

A grateful thanks to Dr. Joanna Jackson who supervised my PhD research study. Thanks are extended to the occupational therapists who participated in this study and to their manager for allowing the study to take place.

Credentials Display

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Multicultural communities from diverse cultural and ethnic backgrounds exist across the contemporary world (Office for National Statistics [ONS], 2009; Thomas, 2013). Cultural diversity is expected to increase due to the ease of transportation, an increasing inflow of immigrants, and the effects of wars, such as the increasing numbers of refugees and asylum seekers (Lindsay, Tétrault, Desmaris, King, & Piérart, 2014; ONS, 2009). As a consequence, occupational therapists will continue to regularly encounter people from many different cultural orientations in their everyday practice. It is generally accepted that culture has a significant influence on health care practice (Santoso, 2013), and that culturally competent practice has become a professional obligation (Lindsay et al., 2014). However, there is inconsistency in the delivery of occupational therapy services to clients from different cultural backgrounds (Muñoz, 2007; Steed, 2014; Suarez-Balcazar & Rodakowski, 2007). Culturally competent practice is essential, regardless of cultural background, in order to meet the needs of clients and to avoid marginalization based on background, cultural needs, and characteristics (Capell, Dean, & Veenstra, 2008; Santoso, 2013; Steed, 2014).

Definition of Cultural Competency

Awaad (2003) states that cultural competency refers to the awareness among health care professionals of differences in cultures and the effect of these differences on professional practice. The problem is that there is a lack of consistency and agreement about the meaning of cultural competency (Muñoz, 2007). Suarez-Balcazar et al. (2009) describe cultural competency as a skill that can be acquired through practice. Others describe cultural competency as a complex, ongoing process that encompasses several skills and characteristics (Capell et al., 2008; Muñoz, 2007). Atchison (2009) states that cultural competency is a process that is built up gradually through experience, but presents it as something peripheral and specifically refers to home-based health care. Atchison goes on to say that cultural competency is rarely discussed in depth, especially in terms of the stages or the dynamics embedded in this process. In this study, the authors define cultural competency as a complex process of professional maturation that is reached when the unique cultural needs and idiosyncrasies of each individual person have been considered and met in the context of their occupational needs.

Strategies Used to Deliver Culturally Competent Practice

Occupational therapists are concerned with what people do and the way in which the doing is done, more specifically, the doing of occupations. Implicit in the "doing" are internalized cultural roles and expectations. Cultural competency, therefore, requires a great deal of effort and commitment on the part of occupational therapists. Moreover, there is a lack of understanding of the process involved in acquiring cultural competency as well as a need to offer strategies and guidance that will enable therapists to actualize cultural competency in their practice (Pooremamali, Persson, & Eklund, 2011). Current strategies that promote cultural competency tend to act as a set of recommendations without reference to the process of cultural competency itself. Some researchers stress that communication skills, language

proficiency, and the ability to understand clients is the essential element in actualizing cultural competency (Ghaddar, Ronnau, Saladin, & Martínez, 2013; Lindsay et al., 2014). Others stress that acquiring cultural knowledge together with an understanding of the inherent traditions, norms, proverbs, and ways of living is the best way to facilitate cultural competency through an understanding of others [clients] without misconception or prejudgment (Pooremamali, Östman, Persson, & Eklund, 2011). Lindsay et al. (2014) offer common sense elements that are required for the establishment of any therapeutic relationship as examples of strategies of cultural competency, such as promoting rapport and connecting with the client's social network.

Models of Cultural Competency

While many models of practice acknowledge the importance of culture, most do not sufficiently elucidate the process of culturally competent practice or the state of what this type of practice looks like (Suarez-Balcazar et al., 2009). An early model developed by Cross, Bazron, Dennis, and Isaacs (1989) suggested that cultural competency developed as a continuum over several stages beginning with cultural destructiveness and progressing through cultural incapacity, cultural blindness, cultural pre-competence, cultural competency, and finally, cultural proficiency. Such a model does not target the process and dynamics of cultural competency and thus neither illuminates the skills required to actualize cultural competency, show how cultural competency is achieved, or explain the dynamics embedded within the process. The model developed by Cross et al. elucidated an early classification and labeling system for therapists based on their attitudes or actions toward cultural differences. Thus, the potential of this type of model to support the development of cultural competency is questionable, and it is still used as a model on which to base and lead contemporary studies instead of being subjected to thorough scrutiny and revision. Velde, Wittman, and Bamberg (2003) utilized this model to evaluate and measure the practice of cultural competency among occupational therapy students. However, there are limitations associated with the findings reached by Velde et al. (2003). The practice of cultural competency cannot be evaluated in isolation from a thorough understanding of the process of cultural competency per se. In addition, the classification offered by Cross et al.'s model and used on its own by Velde et al.'s study is not a valid tool for evaluating the cultural competency of occupational therapists' practice.

Almost 10 years later, Purnell and Paulanka (1998) described 12 domains and areas of life that should be considered in the delivery of culturally competent practice. These included items such as nutrition, communication, pregnancy and childbearing practices, workforce, and spirituality, but again their model did not explicate the process or guide therapists in how to deliver culturally competent practice. Moreover, their model was based on a synthesis of knowledge from diverse fields such as anthropology, sociology, and psychology rather than using empirical finding from research conducted in the health care milieu. Wells and Black (2000) suggested that three elements were essential if cultural competency were to be actualized in practice: knowledge, skills, and awareness. While these three elements were

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discussed by Wells and Black, they did not explicate the process of how and when these elements are acquired or used in a culturally competent way. Acquiring cultural competency is clearly a complex process, as it contains an attitudinal element (Steed, 2010), but again, how this attitudinal element is developed or fits with the process of culturally competent practice is not explicated or made clear in the literature.

Muñoz's (2007) conceptual model of cultural competency described the requirements for occupational therapists, but did not describe or elucidate the interactions, stages, or dynamics that took place with clients during the process of culturally competent practice. Muñoz's model was based on the assumption that cultural competency, as a phenomenon, occurs "within a social situation" (p. 260). While this may be true, the literature has shown that cultural competency is a process of development within each individual therapist. It manifests itself in the therapeutic relationship between therapist and client, but it is driven by and based upon the feelings and attitudes of the therapist; these factors guide his or her actions and not the social situation per se (Steed, 2010). Cultural competency as a phenomenon and as it is enacted in a social context is different from that which occurs within a practice context. Thus, exploring the elements and/or skills of cultural competency within occupational therapy practice alone is insufficient, as it is a social phenomenon that occurs within an unfolding social process.

Pooremamali, Persson, et al. (2011) arrived at a model for developing cultural competency when working in mental health occupational therapy. They described a process defined by three interacting categories: dilemmas in clinical practice, feelings and thoughts, and building cultural bridges. They also identified a core category: "The challenges of the multicultural therapeutic journey – a journey on a winding road" (Pooremamali, Persson, et al., 2011, p. 112). Although this model acknowledged cultural competency as a process and recognized the therapists' feelings and thoughts, it did not identify the skills the therapists needed to develop during the process.

A model is needed that describes the process and dynamics of cultural competency and illuminates the skills developed by therapists as they actualize this process in their practice. Cultural competency is a complex process that encompasses multiple elements, such as the awareness, knowledge, skills, attitude, and an ability of individual therapists to adjust their practice to suit the unique cultural idiosyncrasies and needs of clients (Muñoz, 2007; Pooremamali, Östman, et al., 2011; Suarez-Balcazar & Rodakowski, 2007; Suarez-Balcazar et al., 2009). Although tangible methods, such as education and training to acquire knowledge can help (Suarez-Balcazar & Rodakowski, 2007), there is also an attitudinal aspect associated with this process and this relates to therapists' respect for, acceptance of, and ability to deal with cultural differences (Muñoz, 2007; Suarez-Balcazar & Rodakowski, 2007; Suarez-Balcazar et al., 2009). Delivering culturally competent practice requires more than knowledge and understanding of the elements and stages involved; it must also include the meaning of cultural issues to clients and an awareness of attitudes of those delivering health and social care. A model is needed that guides the process of

cultural competency within health and social care settings so that occupational therapists (and others) can be responsive to the unique cultural needs of each person with whom they work. Against this background, this study was developed with the aim of investigating the process, stages, and characteristics required for cultural competency and developing a model that described the process and stages used by occupational therapists in community-based practice.

Method

This research was qualitative in nature and its epistemological perspective was congruent with the principles of interpretivism. The ontological perspective adopted was that of critical realism, in which reality exists independently from subjective values, beliefs, and understandings (Ritchie & Lewis, 2007). Occupational therapists' practice of cultural competency was deemed to be a reality that needed to be explored by weaving together the multiple accounts of participants, which was congruent with the assumptions of critical realism.

The Type of Qualitative Approach

The epistemological and ontological principles guided the choice of the methodological approach. A critical realist ontological assumption and an interpretivist epistemological stance are congruent with the phenomenological approach adopted in this study (Finlay & Ballinger, 2006; Sim &Wright, 2002). In critical realism, there is a reality which is experienced and interpreted in a subjective and individual way (Ritchie & Lewis, 2007), and that renders reality as multiple rather than singular and makes it a relative concept (Sim & Wright, 2002). Interpretivism and critical realism do not focus on generating explanations or objective knowledge, but rather on understanding the multiple interpretations of the world (Finlay & Ballinger, 2006). These principles coincide with those of phenomenology (O'Leary, 2004; Sim & Wright, 2002), used in this study to denote a data-driven approach to data analysis.

A phenomenological approach was thus deemed appropriate for addressing the aim of this study, which was to explore what occupational therapists considered as culturally competent practice and how they experienced the process of developing such practice. Ethical approval was granted from the Research and Development office of the research site and from the local Research Ethics Committee (08/H0701/88).

Recruitment Strategy and Procedure

London has the highest proportion of multi-ethnicity in England (ONS, 2009). The community setting selected for this research was located in one of the most culturally diverse boroughs in London as shown by the Data Management and Analysis Group (DMAG, 2007). This implied that the participants would have encountered clients from diverse cultural backgrounds that would enable them to provide rich and pertinent data designed to address the research aim. This assumption was made without any preconceptions, generalizations, or judgments concerning the level of cultural competency of the participants. Accordingly, the selection strategy used was purposive sampling (Sim & Wright, 2002) to obtain information-rich participants.

There were 55 occupational therapists within the research site, distributed across seven teams: four in the Learning Disabilities Team, 15

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in the Children's Team, four in the Mental Health Team, one in the Adult HIV Service Team, three within the Community Disability Service Team, one within the Home Rehabilitation Service Team, and 27 within the Adult/Elderly Service Team. They comprised the accessible population or the sampling frame from which the sample for this study was derived.

Inclusion and exclusion criteria. The inclusion criteria was that participants had to have been working as an occupational therapist for at least 3 years or more at the research site, or have a total of 3 years of experience working at other sites and in other countries, in addition to working at the research site. A certain level of proficiency or expertise was required in this study. The literature shows that the curricula and the theoretical knowledge transferred to students is lacking in cultural sensitivity (Kale & Hong, 2007). Accordingly, it was anticipated that novice therapists and advanced beginners would not have established a level of experience that would enable them to inform this research project.

The research question required participants to demonstrate creativity in reflecting on their experiences along with flexibility in thinking about cultural competency, the values and principles that influence it, and ways to actualize it. The high level of readiness required for participation in this research study is associated with a higher level of experience than simply being a competent practitioner. According to Benner (2001), a competent level of experience is associated with 2 to 3 years of experience in a particular field. Therefore, a proficient level is associated with at least 3 years or more of experience. Proficient and expert professionals tend to be more open and understanding toward new and alternative methods of practice than competent practitioners (Benner, 2001). They will have already encountered several novel approaches, strategies, and concepts that have formulated their conceptions and clinical reasoning when delivering their therapy (Benner, 2001).

General attributes of the participants. There were 13 participants who met the inclusion criteria and gave their consent to participate, and all of them were interviewed. The participants' experience in occupational therapy ranged between 3-and-a-half to 25 years. The participants were from diverse cultural backgrounds and were experienced in delivering occupational therapy services either in different areas in the UK (n = 5), or in other countries than the UK (n = 8), in addition to their experience in the research site. Three of the latter had also worked in the UK in areas other than the research site. Table 1 summarizes the work experiences of the participants.

Table 1

Participants' Experiences in the Research Site other Health Care Settings in the UK or other Countries

Experience in other countries	Experience in other health care setting within the UK	Experience in the research site	Experience as an OT	Interviewee
No	2-and-a-half years – With acute adult mental health, 18-65 years of age.	11 months – In the older adults' service > 60 years of age. Community team and hospital base. Mainly physical conditions but also with psychiatric conditions.	3-and-a-half years	P1
5 years	1-and-a-half years	About 3 years	9-and-a-half years – Mental health clients. – Stroke conditions. – Hand surgeries. – Rheumatology. – Palliative care. – Community work. – Care of older adults, conditions where the mental and physical conditions are combined.	P2
No	4 years and 3 months	3 months – Intermediate care with older adults.	4-and-a-half years – Neurological conditions. Rehabilitation (six months). – Pediatrics (year and a half). – Cardiac conditions (6 months). – Mental health (1 year).	P3
2 years and 4 months – With learning disabilities, psychiatric conditions, CP, physical and mental conditions. – Residential facility for older adults, school for learning disabled.	10 months	19 months –Children's team (7 months). –Adult medical surgical wards (3 months).	4 years	P4
2 years and 9 months – Mental health (1 month). – Vocational rehab (1 year and 3 months). – Vocational rehabilitation with a recruitment company doing occupational health and safety (1 year and 3 months).	No	9 months – Home Rehab Service (4 months). – Day hospital, inpatient orthopedics (5 months).	3-and-a-half years	P5
20 years with different conditions and in various countries	(Not mentioned)	More than 3 years	23 years	P6

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4 years – A community neurological service in south way of the capital city and in a rural community.	7 years and few months – Mental health predominantly elderly, orthopedics, plastic or hand therapy. – Worked in a neurological hospital, which is tertiary service, so people came from all over the country. – A stroke service.	4-and-a-half years – Community neuro services, the population 18-65 years of age.	16 years	P7
3-and-a-half years – Day center for children and young adults with learning disabilities, autism, and cerebral palsy. Not as an OT but as a volunteer.	No	2-and-a-half years (rotation) – Mental health (1 year) in a mental hospital and in community mental health. – Acute orthopedics, medical surgical work (6 months). 3 years – Children's team. 2-and-a-half years – Older adults' services.	12 years	P8
No	9 months – Physical rotation.	23 years and 9 months – Community mental health setting. – Older adults with physical and mental health issues. – The role of a manager. – Children service. – Non-disability service.	24 years	P9
9 years in different countries – Pediatrics (2 years). A school and residential home for children with developmental delays. – Pediatrics (5 years). A school and residential home for chronically disabled children, from autism to down syndrome and learning disabilities.	No	5-and-a-half years – Inpatient medical surgical wards, orthopedics and intermediate care with rehabilitation unit. – Mostly acute conditions. – Adult population and elderly adults.	5 years	P10
No	No	1-and-a-half years (band 5 rotation) – Elderly adults. – Inpatient and community settings. – In the mental health trust. The community rehabilitation team – Adults over the age of 16.	3-and-a-half years – Worked in the children's team as a student.	P11
5 years in different countries – In pediatrics with developmental delays	No	7 years – Adults above age 16 – Medical surgical conditions, e.g., fracture	12 years	P12

and cerebral palsy conditions.		of humerus, hip dislocations, and shoulder dislocations. – Diabetes, palliative care, and cancer.		
No	5-and-a-half years – Adult psychiatry/mental health, acute admission ward. – Elderly psychiatry/mental health, acute inpatient admission ward (2 years). – The elderly mental health in the day hospital (1 year). – Elderly mental health in the home support team. Rehabilitation of patients going home after the acute mental illness (1 year).	10 years – Elders physical health conditions, acute wards (2 years). – The elderly day hospital on the physical health setting (3 years). – Managing team (5 years).	15 years	P13

Data Collection

Data collection was based on in-depth semi-structured interviews, each lasting about one hour. The interview explored each therapist's knowledge and understanding in three areas: cultural competency, the role of occupational therapists in relation to culture, and how cultural competency is achieved. All interviews were tape-recorded and transcribed verbatim. A topic guide was used in order to guide the interviews. However, other pertinent topics that emerged were explored as well. The following are examples of questions asked in the interviews:

- Can you give an example of a perplexing experience where the difference in the cultural backgrounds between you and your client constituted a challenge for the delivery of services?
- What was the real element that caused the challenge in your opinion: was it the lack of knowledge, feeling of disparity, fear of the unknown?
- How did you encounter the situation? What did you need?
- How did that affect you: your practice, perception, or feeling for future experiences?
- What should be done and from where to start in order to achieve cultural competency in occupational therapy?

Data Analysis

Thematic content analysis was used for analyzing data. It is commonly incorporated in phenomenological studies in order to manage the thick descriptions attained from data and synthesize them into comprehensive and comprehensible interpretations (O'Leary, 2004). However, the focus of the analysis pursued did not only target the data content but also the authors' thoughts about the way the data were linked together and whether associations or interrelation between the chunks of data were present. Analysis focused on the purpose behind the data as well as the key message of the text. This was clearly evident in the coding, where the intention

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was not to reduce the data into manageable chunks using a preestablished code system, but rather to carry out the process of coding/indexing alongside the construction of the code system. The code system was developed based on the meaning suggested by the data and by incorporating rational and logical methods of thinking about them.

The initial versions of the code systems comprised the main themes pertinent to the topic of research. These included: cultural competency and current occupational therapy practice, cultural competency and occupational therapy theory, and culture and occupational therapy practice. Analysis was undertaken in tandem with the process of data collection. New themes emerged throughout the interviews and further details and sub-themes were identified, such as the stages of cultural competency and culture shock. This, in turn, resulted in a gradual development of the code systems until they reached their final format.

Findings and Discussion

The analysis of the interview narratives generated rich data of how the participants developed knowledge, skills, and experience in cultural competency. When data were examined with regard to the process of becoming culturally competent, two processes emerged: awareness or culture shock, and the process of cultural competency. Culture shock was seen as the process of becoming aware of oneself and one's own culture in relation to a wider multicultural context. This process as described by all of the participants can be found in Figure 1, starting with the presence of a preset picture of what is normal, and ending with the delivery of treatment and of a therapist being negatively affected.

Culture shock is described as a process of becoming aware. Some of the participants described passing through this before they could begin on their journey to becoming culturally competent practitioners. Several participants described examples from their own experience of situations where cultural difference had affected the way practice was delivered to clients, and resulted in the therapist experiencing discomfort. An example from Participant 4 (P4) is described and analyzed below. Excerpts of this example are interspersed throughout the following section so that the reader can follow the interpretation and analysis of these with the sources referenced.

Culture shock is discussed first, as it sets the context or the need for this initial awareness of self that is essential if cultural competency is to be achieved. Without this awareness of self and one's own cultural context, and a desire to make changes in the way one practices, a more culturally competent way of working is unlikely to develop. The process of developing cultural competency is discussed next as described by the participants with discourses from the literature that helped shaped the model of cultural competency that emerged.

Culture Shock

Culture instills expectations about the proper way of acting, behaving, and living in one's social group (Suarez-Balcazar et al., 2009). Therapists have an array of cultural views and behaviors, which are partly individual and partly professional, and which may cause them to have preconceived ideas and expectations about clients and how to behave prior to meeting them (Adams, 2009). Participant 8 (P8) stated, "I guess I have been trained as an OT and worked as an OT for

quite a long time, I have a culture of being an OT as well." Another commented that "I am just so used to in my own doing, walking in with your shoes, greeting with hand" (P4).

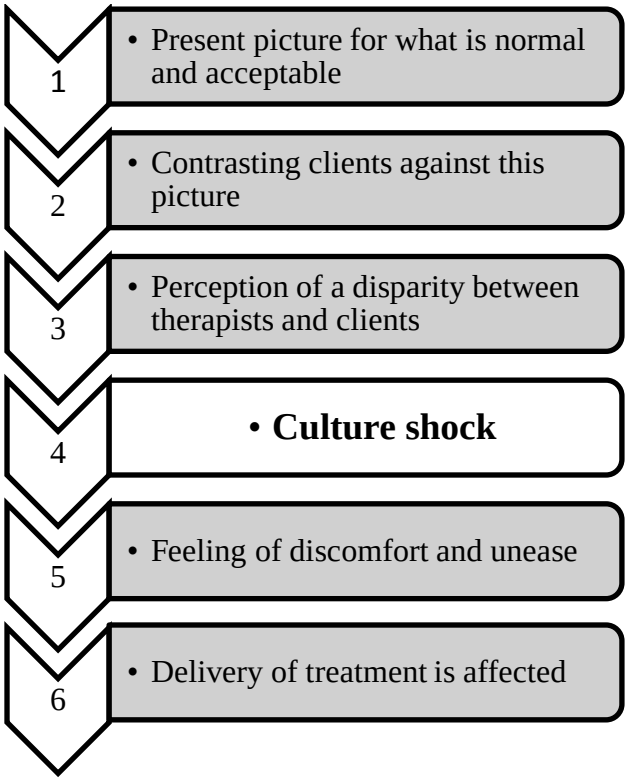

***Figure 1*. Culture shock.**

If culture shock arises from preconceptions of what is culturally acceptable and appropriate, then therapists need to become aware of and understand their own preconceived notions and assumptions first. Culture shock was part of this process and revealed differences to the participants about themselves and about the way that clients did things differently:

> I did a home visit for this child, it was for specialized seating and when I've got to the front door, the dad opened the door, turned around and walked away, didn't say a word. So, and I am used to . . . because in our culture we put out our hand and greet. So I followed you know, sort of looking where he was and, when I came to the living room, I saw there were no couches which is also something else, another culture, they believed just sitting on the floor. (P4)

Figure 1 shows that culture shock occurred when the participants perceived a disparity between themselves and the client (Stage Three) by contrasting their own cultural picture of what is acceptable against the client's cultural picture (Stage Two):

> Then I noticed everyone else is barefoot and I have my shoes on and then when I walked out I saw all the shoes lying at the front door and then I just realized I should've asked, I should have said, do you want me to take off my shoes? (P4)

Behaviors and expectations associated with their own culture were part of the therapists' work routine or usual way of practice (Stage One). These were the reference points for each when making judgments about what is usual or accepted but beginning to note differences with others (Stage Two). This was especially true when the participants worked in clients' homes and thus in clients' social and cultural contexts:

"I've never even thought of it, I am just so used to in my own doing, walking in with your shoes" (P4).

The participants described a gap between the cultural expectations of themselves and those of the client; this gap took them out of their comfort zone and into a state of halting and thinking of what may have gone wrong, or a state of "culture shock":

> Then the child came in and the sister brought the child in and then when the mother and father came again I said 'Hi I

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> am [name]' and the mother greeted me and the dad just said 'I don't do it' . . . I felt so uncomfortable. (P4)

Discomfort was associated with cultural shock but it was associated with an awareness of differences, which results in a state of being culturally aware. Thus, culture shock (Stage Four) can be described as a manifestation or even embodiment of a practice that is not culturally competent: "I was uncomfortable in the house and it was because of a cultural difference" (P4).

Perceptions of what were usually considered rational operations were translated into feelings and actions that resulted in negative feelings or discomfort or unease, even when the situation was neither unsafe nor posed any threat. This discomfort (Stage Five) was manifested in different ways along with an awareness that it could affect the delivery of care, such as providing care that was different, not relaxed, or not as effective (Stage Six). These differences, while unintentional, could be disadvantageous to the clients and became motivators for the participants to make changes.

> I felt so uncomfortable that I've just wanted to get it all done and when I left I realized, oh I didn't check the serial number of the seating so I had to call them again to check the number and it was just because I was uncomfortable in the house. (P4)

Process of Cultural Competency

The participants' narratives about their experiences in practice with clients from multiple cultural backgrounds suggested that they had undergone a process. There were narratives concerning the nature of their practice and how it progressed through encountering clients whose cultural backgrounds, in several instances, were different to them. From this data, the conceptual model of cultural competency delineated in this paper was constructed, based on the collectivist construction of the accounts of the participants.

The collectivist construction of the participants' accounts to illuminate the process of cultural competency implied an assumption that those participants may have undergone the process of cultural competency or a part of it. This assumption formulated the basis of inclusion and exclusion criteria of the participants in this study, that is, the participants should have been working in multicultural settings or have been exposed to various multicultural experiences with various clients. However, that assumption cannot be proved. It cannot be proved that the participants have definitely undergone the process of cultural competency or even part of it by being exposed to various multicultural experiences. However, the literature shows there is a limitation in understanding the process of cultural competency, i.e., how and when it happens. The authors created this study because they did not have anything against which to measure the participants' level of cultural competency. The generated model is not aimed to judge the participants nor any therapists based on the stages posited by it. Rather, the aim of the model is to gain further understanding of the process of cultural competency.

According to Muñoz (2007), cultural competency is a process of cultural maturity that comprises a series of stages where cultural competence represents the ultimate step at the pinnacle of the process. This paper presents

cultural competency as a process and posits a model of cultural competency based on the findings from the research study, with more detailed findings to be published elsewhere. The model posits six stages of the process of cultural competency: cultural awareness, cultural preparedness, cultural picture of the person, cultural responsiveness, cultural readiness, and cultural competence (see Figure 2). The model constructed in this paper was synthesized taking into account the literature as a source and a reference throughout the process of analysis by placing the findings of this study in context and endowing them with relevance and credibility (Bryman, 2008). Thus, in the next sections the words of the participants are interspersed in order to show the source of conclusions and interpretations, while at the same time using previous studies from literature to support such interpretations.

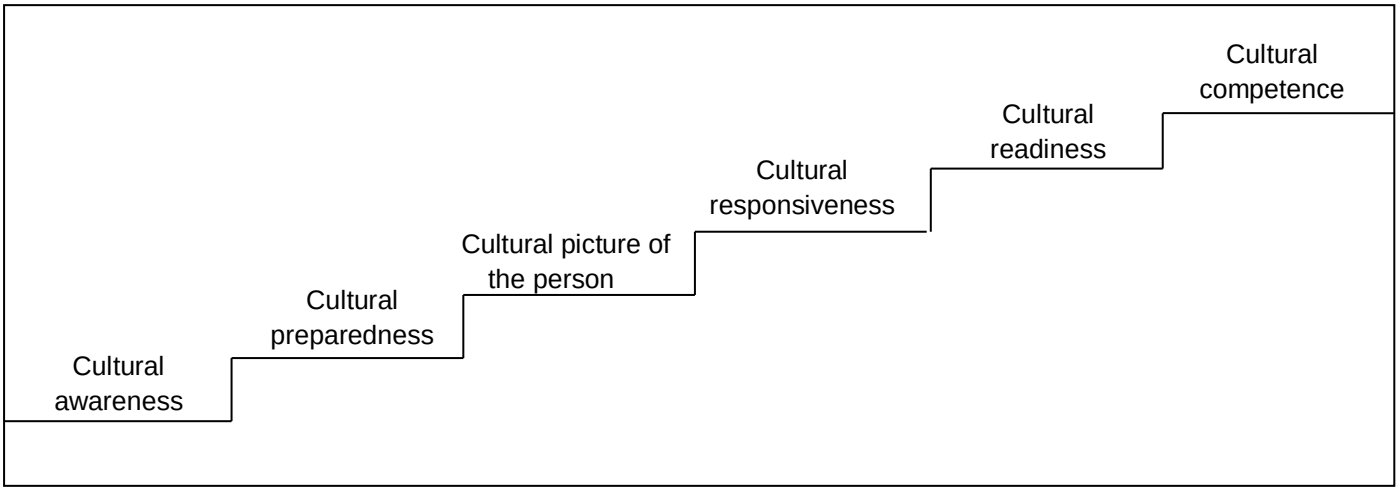

Figure 2. Process and stages of cultural competency.

First Stage: Cultural awareness. There is an overlap between culture shock and the first stage of becoming culturally competent. The process of culture shock can be viewed as an inauguration of cultural awareness or a precedent to it. The participants reported becoming more aware when they adopted an open stance, observing differences, and acknowledging these as a natural part of practice: "If your mind is open, you are ready to learn then to help, you will be culturally aware naturally" (Participant 12 [P12]).

The participants described a realization that there was no single point of reference for judging what is normal or acceptable or meaningful, only that there were differences among individuals as seen from the perspective of each therapist:

"I guess it's being open, I think everybody has got their own cultural kind of filter that they see the world through" (P8).

By acquiring this awareness of cultural differences, the participants became more aware of their own culture, actions, and behaviors and the ways in which these can affect their interactions with clients (Suarez-Balcazar & Rodakowski, 2007). The process of cultural competency began with an awareness of cultural differences and being open to adopting an ethnorelative stance rather than an ethnocentric one (Capell et al., 2008; Hammell, 2013). That is, what may be valued in one culture is not

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acceptable in another (Atchison, 2009). Ethnorelativism enabled the participants to expect cultural variations and to respect these differences when dealing with a wide variety of people (Hammell, 2013). Fear of not knowing what was appropriate and a lack of confidence were very typical of this stage:

> I didn't have a great deal of work experience in working with people from different cultural backgrounds. So it was like going into a situation where you're in a new clinical area . . . it's fear of the unknown I think. (Participant 1[P1])

In the literature, cultural awareness refers to an awareness of one's own culture as well as being able to recognize differences with other cultures (Atchison, 2009; Capell et al., 2008; Muñoz, 2007; Murden et al., 2008; Suarez-Balcazar & Rodakowski, 2007; Thomas, 2013).

Second Stage: Cultural preparedness. The participants who were culturally aware described feeling unprepared; thus, the more exposure they had with people from different cultures the more prepared they felt:

> I already worked with different religions and different cultures. So I think possibly I am already aware of most of the big issues or how to talk to them, how to agree on goals, how to work with them, how to have a rapport. Everything is different with different culture. (P12)

Being culturally prepared required the participants to acquire the experience and knowledge developed by continuously working with clients who are culturally different from them (Smith, Cornella, & Williams, 2014). By that, such an experience rendered them acutely aware of their own cultural identity and required them to reflect deeply on it (Muñoz, 2007; Thomas, 2013). Next, the participants acknowledged the cultural differences between themselves and others, including differences between one client and another (Suarez-Balcazar & Rodakowski, 2007). By acquiring more cultural knowledge and experience, the fear that the participants initially described was gradually replaced by confidence, making them more prepared to face the unexpected and making the unfamiliar less so (Thomas, 2013). Being culturally prepared is accompanied by an open, non-judgmental attitude and a respect for cultural differences (Atchison, 2009; Muñoz 2007; Murden et al., 2008; Suarez-Balcazar & Rodakowski, 2007). These first two stages are indispensable if cultural competency is to be achieved and actualized in practice.

Exposure to cultural differences by engaging in cross-cultural experiences may be a strategy for promoting cultural competency if that exposure leads to awareness about cultural differences and a preparedness to encounter them (Smith et al., 2014; Thomas, 2013). The need for such an exposure goal has been increasingly addressed in the curricula of occupational therapy programs by engaging the students in international fieldwork placements (Ghaddar et al., 2013; Haro et al., 2014). However, there is a need to recognize that cultural awareness and preparedness are only the first stages in the process of cultural competency. There are further requirements that need to be met to establish a culturally competent practice.

Third Stage: Cultural picture of the person. The participants described how clients saw events and the meanings of actions and

objects differently through their own particular cultural lens. The literature shows that therapists attempt to describe the client's unique cultural picture and understand the meaning of this in relation to their (the client's) world, objects, and actions (Suarez-Balcazar & Rodakowski, 2007). This stage is an important stage if therapists are to understand the individual needs of clients, including their cultural needs, and to practice in a client-centered way (Suarez-Balcazar et al., 2009): "So . . . ask them or ask their family, find out. Because with that knowledge you can then be client centered; you can gear your treatment around what's important for them" (Participant 13 [P13]).

The participants described that for mastering this stage, they need to go into the field without any preconceived notions of what is "normal," expected, or how things should be done. In fact, they had already recognized that normal did not exist, only differences. When the participants were able to interact with clients with this blank page mindset, they were more ready (prepared) for cultural differences and unknown situations, feeling confident to understand individual needs regardless of culture. Metaphorically, this stage required the participants to be equipped with the necessary skills and strategies to paint an individual portrait of each client. One stated, "You need to always take it on an individual basis because everybody is different" (P8), and another commented, "We can't make assumptions about anything really. They [clients] are very different and living in very different ways" (Participant 11 [P11]). Thus, in this stage, the participants not only recognized cultural differences among individuals from different cultures, but also differences among individuals from the same culture: "We're so different, I couldn't say to you a person with this faith group or this ethnic group will behave like this" (Participant 9 [P9]).

The skills required for this recognition included more than just obtaining the necessary and appropriate information about clients. It required active, culturally relevant enquiry so that assessments and observations focused on culturally relevant tasks and roles and being able to pick up on appropriate cues quickly (Muñoz, 2007). P12 stated, "I'll ask them as to what areas they are really bothered about, what areas they will want to work with me"; and participant 2 (P2) stated, "I see myself as . . . somebody who observes the person very well; what are they saying? What are they doing? How are they doing it?"

Fourth Stage: Cultural responsiveness. The participants who had reached the fourth stage were able to translate the client's cultural and functional goals and preferences in a culturally appropriate way. Muñoz (2007) uses the term "cultural responsiveness" in his model, as it refers to the need for therapists to design interventions that address the specific cultural needs and perspectives of clients. Being culturally responsive meant that the participants were finding ways of delivering therapy in a client-centered manner, based on a cultural picture that had been constructed in the previous stage (Stage Three in Figure 2). In addition, they were able to uphold their own integrity without breaching their own cultural values. The participants described a number of ways in which they did this: "I refer

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them to other services where I think I won't be able to provide services" (P12). And:

> If I didn't ever feel I will be able to work with male clients, well how am I going to deliver the code of ethics if that's the case? Now I might be able to but I would have to discuss that again with my colleagues. (P9)

The question that is posed here is whether practicing in a client-centered way will simultaneously allow therapists to practice in a way that is culturally competent. Findings from this study suggest that being client centered alone is not enough, as the excerpt of P9 above shows. The therapist might deliver client-centered practice while feeling uncomfortable with a situation with male clients, for example. In this case, the practice as P9 referred to might result in client-centered practice that addressed the client's needs. However, in this study, it was not necessarily being culturally competent as the participant was not feeling culturally ready to work with certain types of difference, i.e., gender difference. Therapists and the services that employ them need to have awareness of different cultural needs and preferences so that they can respond appropriately in a non-judgmental way and make provisions for these differing cultural needs and preferences.

Fifth Stage: Cultural readiness. By this stage, the participants were psychologically, behaviorally, and attitudinally ready to deal with clients from a wide variety of cultural and ethnic backgrounds and felt entirely at ease with these. They had reached a stage of readiness in their practice that gave them a sense of being able to cope with almost anything: "I'd say I'm so very comfortable with it now but to start with, I was probably a bit less confident in how it would turn out" (P1).

Cultural readiness requires a level of practice that is grounded in feeling confident and at ease when dealing with any kind of cultural situation. It implies that therapists have the potential to deliver practice that takes into consideration the cultural differences of clients, the tasks and roles they undertake, and the way in which these are carried out without harming their own cultural integrity:

> We must never pretend that we don't feel uncomfortable about something. I think we have to be aware of our own values, attitudes, and beliefs before we can then appropriately meet our clients' needs. So if I'm very uncomfortable about something the client wants to work on, then it's my responsibility to find a colleague to talk that through or a colleague to help me work through what it is I'm uncomfortable about. (P9)

When practice is delivered without a state of cultural readiness it may place the therapist's personal integrity at risk or harm their professional well-being:

> We want to be occupational therapists; that's our responsibility to come up with ways if we can't do that. But we wouldn't ever force a client to do something that they weren't comfortable with, that's the flipside of us being uncomfortable. (P9)

If therapists force themselves to act in accordance with the clients' preferences without feeling comfortable or acknowledging cultural differences, this cannot be described as being

culturally competent: "Ya . . . if it's against our own beliefs, then we need to identify what that might be" (P9).

Moreover, clients are unlikely to be offered a service or intervention if it is at odds with the therapist's values or preferences. Cultural readiness requires therapists not only to be fully aware of their own attitudes and preferences toward cultural differences, but to assess these constantly: "You can't look completely at the other side, but you need to recognize any potential biases that you have" (P8).

Therapists who are culturally ready are able to deal comfortably with clients who do not share the same cultural backgrounds as them (Steed, 2014). Cultural readiness does not imply that therapists have to accept all cultural differences in order to be culturally competent. The participants who demonstrated cultural readiness were aware of their own underlying attitudes toward culture and could recognize these appropriately (Steed, 2014). They had ways of working and strategies that enabled them to feel comfortable when dealing with all kinds of client situations and preferences: "So oh yo yo, I'm from [place] you are . . . that's great. You know and then they can have a chat and they can actually build a relationship just based on things they have in common" (Participant 5 [P5]). Thus, cultural readiness can be viewed as a measure for the delivery of practice that addresses clients' cultural needs while simultaneously preserving therapists' state of integrity and professional well-being (Murden et al., 2008).

Sixth Stage: Cultural competency. In light of the literature and the results of this study, cultural competency is shown to be a process whereby therapists have a clear appreciation of their own cultural identity and a deep understanding of cultural differences that enables them to respond effectively when working with those from cultural backgrounds the same as and different from their own (Capell et al., 2008; Muñoz, 2007; Suarez-Balcazar & Rodakowski, 2007):

> You being culturally competent if you have an understanding of how your clients' culture impacts on their daily living tasks and you then use that information to help make realistic goals with your patient about what you want to work towards. (P13)

It also requires therapists to realize that they are guests intruding on the cultural environment of clients (Iwama, 2007), and that they need to do so in a respectful manner (Iwama, 2007; Murden et al., 2008). Therapists need to recognize too, that when meeting clients' goals, they are the ones who should conform to the clients' rules because clients are the people who should be empowered (Iwama, 2007).

Cultural competency requires occupational therapists to use their unique knowledge and skills of meaningful occupation in a therapeutic way that acknowledges the specific cultural needs of clients and the special perceptions of disability, health, and meaningful occupation (Capell et al., 2008; Muñoz, 2007; Suarez-Balcazar & Rodakowski, 2007). It implies that therapists need to reach out to clients who are culturally different, assume the responsibility of gaining clients' co-operation throughout the process of intervention, win their trust, and ensure that clients feel comfortable and ready to receive

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interventions in the same way as occupational therapists (Iwama, 2007; Muñoz, 2007; Suarez-Balcazar & Rodakowski, 2007). It also requires them to recognize that they bring their cultural attributes into the cultural environment of clients and that they need to do so in a respectful manner (Iwama, 2007; Murden et al., 2008). The tendency for therapists to reach out to help clients who are culturally different, gaining their co-operation so that clients feel comfortable to receive interventions should be replaced with a process of empowerment. With empowerment comes a responsibility for both client and therapist to work together collaboratively finding culturally appropriate solutions that meet the client's needs and preferences (Iwama, 2007; Muñoz, 2007; Suarez-Balcazar & Rodakowski, 2007). Thus, the delivery of culturally competent practice entails the employment of special strategies and skills designed to include and integrate all clients within services, regardless of their cultural background, and tease out their compliance and comfort throughout the process of treatment (Lindsay et al., 2014).

Actualizing cultural competency in occupational therapy requires targeting efforts on multiple levels (Ghaddar et al., 2013; Iwama, 2007). It is not only an issue that is pertinent to practice, but it is also pertinent to the research and theory of occupational therapy (Hammell, 2009; Hammell, 2013; Iwama, 2007; Piven & Duran, 2014). Practice and research in occupational therapy need to be guided to actualize and promote cultural competency. There is a need to incorporate issues related to cultural diversity into constructing and applying theories of occupation (Hammell, 2013). The education of occupational therapy students needs to be targeted as well in order to equip students with the necessary skills and knowledge to acquire cultural preparedness (Haro et al., 2014; Matteliano & Stone, 2014). The requirements of cultural competency need to be acknowledged and incorporated into the theory, education, practice, and research in occupational therapy at all levels because the findings of this study suggest that the profession of occupational therapy is still at the early stages of addressing the topic of cultural competency and becoming alert to its requirements.

Limitations

This study did not incorporate other methods of data collection. Triangulation of any other additional forms of data, such as observations of therapists or reports from clients would have further addressed the complexities of the topic of this research. There is a need for further research to verify the model of cultural competency posited in this paper and identify strategies and approaches to actualize cultural competency in different settings and different services.

Implications of research

- Cultural competency is a process of professional development, yet the process of cultural competency is poorly explored.
- Actualizing cultural competency is a professional obligation on the part of the therapists, as they are the professionals providing a service to clients.
- Therapists need to be aware of their cultural tolerance and their own cultural values, beliefs, and attitudes toward cultural differences. They also need to find ways to deal with cultural differences.

- While this study has illuminated the process of cultural competency, there is a need to verify or contradict the findings of this study in a variety of practice settings.

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