

Educating for Cultural Competence: An Evidence-Based Approach

■ Jessica Scheer, PhD, and Pamalyn Kearney, MS, OTR/L

Patty is starting her first year as the academic coordinator of fieldwork education in an entry-level occupational therapy program at a Midwestern state university. The students in the program are generally from working- or middle-class families, and one third of them are the first person in their families to attend college. Almost all (87%) of the students are white, 8% are Hispanic, and 5% are African American. When compared with occupational therapy students nationwide, students in Patty's department are less racially and ethnically diverse (American Occupational Therapy Association, 2006).

At the end of September, Patty visited two of her students at their fieldwork sites. The first student had been placed in a Level I fieldwork site in an urban homeless shelter to work with mothers and children. This student is white, from a working-class rural family, and the first in her family to attend college. She expressed feelings of frustration because she did not believe that some of the mothers were taking "proper care" of their children. She described feeling confused about how many of her clients could afford to own and operate expensive cell phones yet still live in the shelter. The fieldwork supervisor reported that this student had not been able to establish an effective rapport with the mothers and appeared to blame the mothers for their circumstances, with little awareness of the variety of factors that can contribute to homelessness.

The second student had been placed in a subacute rehabilitation unit in a small town for his Level II fieldwork experience. This student is white and from a suburban area; both of his parents are professionals. The clients in the rehabilitation unit were primarily white adults with farming or working-class backgrounds; other clients were farm workers and laborers from Mexico. During their conversation, Patty asked this student, "Are you finding ways to incorporate issues of culture into your interactions with clients?" He described learning about traditional foods in meal preparation from his Mexican clients and his evolving comfort level in working with translators. Patty then inquired about examples related to his other clients: the white adults from rural farming or rural working-class backgrounds. The student seemed unsure about what Patty was asking, but finally said, "Culture wasn't really an issue with the other clients."

Several faculty members seemed surprised by the students' performance because, they reported, they did incorporate issues of cultural competence within their courses. The department chair asked Patty to explore and summarize the literature related to best practices in training health professional students to become culturally competent providers and to report back to the faculty the following month with evidence-based suggestions for curricular improvements.

Patty's first step was to turn to the bibliography of Black and Wells's (2007) "Research Evidence for Cultural Competence and Culturally Competent Care," where she found a systematic review on the topic of education and training effectiveness (Beach et al., 2005). Further investigation into its listed references led to another systematic review available as a report on the Internet (Fletcher, Crabtree, McKennitt, Landrie, & Magee, 2006). The availability of systematic reviews greatly streamlined Patty's assignment because these articles synthesize findings from multiple studies. Specifically, systematic reviews are developed around a clinically relevant, focused question and (a) identify studies that use specific inclusion and exclusion criteria, (b) select a group of the highest quality and most relevant articles ranked according to standardized criteria for rigor in study design and methods, (c) appraise critically the design and methods used in each article, (d) present the findings of key articles in relation to study limitations, and (e) synthesize the findings of the articles as a group in a balanced and impartial way.

Evidence From Two Systematic Reviews

The objectives of Beach et al. (2005) were to synthesize the findings of studies that evaluated interventions to improve the cultural competence of health care providers and identify strategies that have been shown to be effective. Studies selected for the review ($N = 34$) were relevant to the health of minorities, published between 1980 and 2003, had both a before- and an after-intervention evaluation, and had a control group for comparison. Two thirds of the study sample were of pre-professional groups ($n = 22$), and one third ($n = 12$) were with practicing professionals. The selected studies described interventions that were evaluated with either a written test or a scale, such as the Bernal and Frohman (1993) Cultural Self-Efficacy Scale, which evaluates learner confidence in knowledge about culture-specific issues for African American, Asian, Latino, and Native American populations.

The findings from Beach et al.'s (2005) review showed excellent to good evidence that cultural competence training has a beneficial effect on provider knowledge, attitudes, and skills. Interventions focusing on three areas had positive effects:

1. General cultural concepts, including inter- and intragroup diversities, ethnocentrism, power, and discrimination
2. Culture-specific characteristics, including culturally patterned variation in family organization; social roles; childcare practices; types of social support; use of traditional folk health practices and healers; and beliefs about health, illness, religion, and norms related to gender, authority, and modesty
3. Impact of cultural issues on provider-client communication and client-centered care, including cultural self-awareness and knowledge of health care as a cultural system with its own set of assumptions, beliefs, and practices

Weekly hands-on, experiential learning interventions for the period of one semester were effective in increasing knowledge and communication skills, such as cultural autobiographies, case scenario demonstrations, and videotaped communication skill practice. Nonexperiential learning interventions, such as lectures and small group discussions, also were shown to be effective. The review authors concluded that culturally competent health care professionals may affect client outcomes through improved communication in that they are more skillful in obtaining histories and, therefore, making diagnoses, and satisfied clients are more likely to adhere to recommended treatments.

Fletcher et al.'s (2006) systematic review defined two skill areas of culturally competent practice: cultural assessment, which is the process of investigating the client's cultural context, and cross-cultural communication, which is gaining rapport by listening and speaking in cultural context and the effective use of a translator, if necessary. Studies selected for this review ($N = 30$) were published between 1990 and 2005; had content relevant to increasing cultural awareness, knowledge, and skills among health professional students; and had an evaluation component with enough information for the reviewers to assess internal validity. Based on the results of their review, Fletcher et al. recommended the following best practices for training health professional students to become culturally competent providers:

1. Base program development on a model or theory of cultural competence.
2. Offer education over an extended period to allow students to implement what they have learned.
3. Engage students in active, experiential learning that combines didactic lectures and small group discussions with guided cross-cultural encounters.
4. Provide opportunities for students to become familiar with and practice cultural assessments.
5. Plan pretesting and posttesting so that the effectiveness of the curriculum and teaching strategies may be evaluated with existing assessments and measures of cultural competence as well as with modifications or other appropriate instruments.

A Cultural Competence Across-the-Curriculum Matrix

With the "big picture" from the results of the two systematic reviews in hand, Patty returned to evaluating her department's curriculum with a more critical eye. She found that half of the courses in both Year 1 and Year 2 contained learning objectives related to cultural competence. Specific Year 1 objectives were to describe the influence of cultural values and beliefs on the development and adaptation of self-care, play, and vocational and productive abilities; describe the influence of culture on the therapeutic teaching and learning process; recognize cultural bias in assessments; gather assessment data effectively about health beliefs and needs of indi-

viduals from diverse communities; and identify culture-specific beliefs about health, health care, and health behaviors. Year 2 objectives were to develop culturally relevant intervention plans; compare and contrast client-centered approaches within various cultural contexts; analyze the impact of discrimination and racism on occupational performance; demonstrate an understanding of how to use translators; and communicate with clients and families in a manner that is culturally appropriate.

Patty cross-checked the evidence-based topics from the reviews (e.g., culture-specific characteristics, cross-cultural communication) with the learning objectives and presented the information in a matrix. Most of the topics were included in the learning objectives, but notably missing were objectives related to cultural self-awareness and knowledge about health care as a cultural system—both identified as elements of effective cross-cultural communication in the systematic reviews. Additionally, based on the discussion that took place during the faculty meeting, neither an overarching model of the cultural competence process nor an overall evaluation of change in cultural knowledge, awareness and skills, or efficacy of teaching methods was used. From conversations with four faculty members, representing two thirds of the faculty, about cultural competence objectives in the courses they taught, Patty learned that there was a focus on didactic teaching and small group discussions of assigned reading, with few instances of guided cross-cultural encounters outside of the classroom or role playing within the classroom. Students did engage in one service learning experience during Year 1 with an emphasis on developing culturally appropriate health education materials for a community setting.

Patty provided faculty members with copies of the matrix and summaries of and electronic links to the two systematic reviews to review before the next faculty meeting. The chair and her colleagues were impressed with the evidence-based analysis and promptly voted to create a cultural competence curriculum subcommittee, with Patty as its chairperson. The committee was charged with three tasks for the remainder of the fall semester: (a) expand the matrix by examining each course syllabus for more specific information on topics, readings, and class activities and then interview each instructor to gather more details about assignments and activities; (b) use existing course content and new evidence-based content to develop two new curricular and active learning modules related to cultural self-awareness (including awareness of health care as a cultural system) and cross-cultural skills training; and (c) review current student assessments and scales and develop an evaluation process.

The committee selected the textbook by Black and Wells (2007) for student reference and adopted their evidence-based Cultural Competency Model (p. 60) as an organizing framework for the curriculum. The committee volunteered to develop the November faculty retreat around cultural self-awareness, asking each faculty member to write his or her own cultural autobiography (using a set of specific instructions) before the event. The retreat also inspired faculty to start brainstorming about ideas for students to practice cross-cultural communication skills with community volunteers. Patty was confident that the activities of the committee would prompt evidence-based changes in course content and teaching style and that new students would enter fieldwork with greater cultural knowledge, awareness, and cross-cultural communication skills. ■

References

- American Occupational Therapy Association. (2006). *2005–2006 OT program annual data sheets*, AOTA Accreditation Department. Retrieved April 1, 2008, from <http://www.aota.org/Educate/EdRes/OTEdData/Ethnicity/38371.aspx>
- Beach, M. C., Price, E. G., Gary, T. L., Robinson, K. A., Gozu, A., Palacio, A., et al. (2005). Cultural competence: A systematic review of health care provider educational interventions. *Medical Care*, *43*, 356–373.
- Bernal, H., & Froman, R. (1993). Influences on the cultural self-efficacy of community health nurses. *Journal of Transcultural Nursing*, *4*, 24–31.

Education

Special Interest Section
Quarterly

(ISSN 1093-7188)

Chairperson: Jyothi Gupta
Editor: Ann Burkhardt
Production Editor: Jennifer Hart

Published quarterly by The American Occupational Therapy Association, Inc., 4720 Montgomery Lane, Bethesda, MD 20814-3425; cjotsis@aota.org (e-mail). Application to mail at Periodicals postage rates is pending at Bethesda, MD. POSTMASTER: Send address changes to *Education Special Interest Section Quarterly*, AOTA, PO Box 31220, Bethesda, MD 20824-1220. Copyright © 2008 by The American Occupational Therapy Association, Inc. Annual membership dues are \$225 for OTs, \$131 for OTAs, \$75 for Student-Plus members, and \$53 for Standard Student members. All *SIS Quarterly*s are available to members at www.aota.org. The opinions and positions stated by the contributors are those of the authors and not necessarily those of the editor or AOTA.

Black, R. M., & Wells, S. A. (2007). *Culture and occupation: A model of empowerment in occupational therapy*. Bethesda, MD: AOTA Press.

Fletcher, F., Crabtree, A., McKennitt, D., Landrie, M., & Magee, P. (2006). *A systematic review of the academic literature related to the use and development of cultural competence in health promotion and community service professionals*. Edmonton, Alberta: Alberta Cancer Board and the University of Alberta. (Available from www.transculturalcare.net)

Jessica Scheer, PhD, is Applied Medical Anthropologist, Department of Health Care Sciences, George Washington University, 2150 Pennsylvania Avenue, Washington, DC 20036-2396; hcsjxs@gwumc.edu.

Pamalyne Kearney, MS, OTR/L, is Assistant Professor and Vice Chair, Department of Occupational Therapy, University of the Sciences in Philadelphia; p.kearne@usp.edu.

Scheer, J., & Kearney, P. (2008, September). Educating for cultural competence: An evidence-based approach. *Education Special Interest Section Quarterly*, 18(3), 1-3.

Reflections of One Educator on Teaching Cultural Competence

■ Jyothi Gupta, PhD, OTR/L, OT(C)

Given occupational therapy's commitment to eliminate health disparities (American Occupational Therapy Association [AOTA], 2006a) and to meet societal needs (AOTA, 2006b), careful attention must be given in educating our students to grow in the areas of cross-cultural interactions and personal and professional responsibility for social change.

Enabling students to become culturally competent is easier said than done. Black and Wells (2007) stressed that cultural competency is "a journey rather than an end...a lifelong process" (p. 31). Despite this assurance, use of the word *competence*, in my opinion, inadvertently implies that a hypothetical end-point exists that can be reached by acquiring the right knowledge and skills and attitudes needed to work with persons of different cultures. I also believe that it may lead our teaching on culture to focus more on the cognitive (knowledge) domain than on the behavioral (skills) domain, with very little by way of the affective (attitudes) domain. The latter is by far the most challenging domain to teach. How does one go about changing learned attitudes and beliefs about the "other"? My greatest challenge is in getting students to understand notions of power, privilege, prejudice, and "whiteness." I am deeply appreciative of Black and Wells (2007) for infusing these concepts into our professional dialogue. So what then are effective approaches to transform students' attitudes to enable authentic interactions with diverse individuals?

I have found it beneficial to use critical pedagogy (Friere, 1993; Wink, 2005). The primary attributes that I infuse in my teaching are creating safe democratic space for students to participate and contribute to the discourse, and valuing the knowledge that they bring from their life experiences. Critical pedagogy is clear about using teaching and learning for positive social change; it requires risk-taking, getting out of one's comfort zone, and transparency on the part of both students and instructor.

Guided reflection is key to transformational learning (Mezirow, 2000). It is instrumental in helping students explore their assumptions, beliefs, and values while mindfully and systematically understanding facets of their personal and professional lives that have shaped their worldview. Instilling the habit of lifelong, critical self-reflection to gain insights into one's behavior patterns—what Tervelon and Murray-Garcia (1998) labeled *cultural humility*—is a

valuable skill that must be taught and learned. Justice requires seeing the whole person in his or her social context, which is complex, multidimensional, and influenced by the past. Hence, of equal importance is using supportive reading materials that can inform students of historical legacies of colonization, slavery, patriarchy, and so forth. I find that students also need to be taught how to perform critical social analysis of the societal issue at hand in order to understand the root causes of the problem. A framework I use, conceived as an open-ended spiral, includes the following four steps: reflection, social analysis, judgment, and action. As students go through this process, they engage in critical internal and external dialogue that can potentially trigger a "crisis within" that may eventually lead to altered beliefs (Gupta & Howell, 2005). Using videos or novels on particular social issues, students can do a justice analysis: identify the stakeholders; who has the power; why it is a justice issue; and what action is needed for social change at the micro, meso, and macro levels of society.

Like many occupational therapy programs around the country, I include local and global service learning experiences to provide opportunities for students to interact with diverse groups. For a short time, students experience firsthand the day-to-day realities of persons who are marginalized. Students value these opportunities, which for some are truly transformative.

While working with marginalized individuals, many of my students are quick to harshly judge the poor in their local communities but are far more tolerant of and more easily show empathy for this same group in other countries. In my experience, students tend to struggle with the pervasiveness of the dominant culture on their home turf and find it difficult to comprehend how one's social location determines access and opportunities. This struggle is well illustrated by bell hooks's (1984) description of growing up in Kentucky, where the railroad tracks literally served as a reminder of the marginality of blacks. Being in the margin, she says, "We looked both from the outside in and from the inside out. We focused our attention on the center [where privilege resided] as well as on the margins. We understood both" (preface). How do I help my students to look "inside out"?

Cultural intelligence picks up where *emotional intelligence*, a term made popular by Golman (1995), leaves off. According to Golman, emotional intelligence—a form of social intelligence—allows one to monitor, discriminate, and interpret one's feelings and emotions and use them to guide behaviors. Furthermore, he makes clear that emotional intelligence is the basis for emotional competency, which includes personal and social skills rooted in self-awareness, motivation, self-regulation, empathy, and adeptness in relationships. If indeed emotional competency is grounded in emotional intelligence, I ask: Should cultural competency be grounded in cultural intelligence? Will tapping into this dimension of intelligence better prepare our students to develop high cultural intelligence that will enable them to engage in behaviors that are culturally attuned to the person or group with whom they are interacting? Will it tap into their affective domain more effectively? ■

References

- American Occupational Therapy Association. (2006a). *AOTA's societal statement on health disparities*. Retrieved May 7, 2008, from <http://www.aota.org/News/Media/Statements/39431.aspx>
- American Occupational Therapy Association. (2006b). *AOTA's Centennial Vision*. Retrieved September 11, 2007, from <http://www.aota.org/news/centennial.aspx>
- bell hooks. (1984). *Feminist theory: From margin to center*. Cambridge, MA: South End Press.
- Black, R. M., & Wells, S. A. (2007). *Culture and occupation: A model of empowerment in occupational therapy*. Bethesda, MD: AOTA Press.
- Friere, P. (1993). *Pedagogy of the oppressed* (M. B. Ramos, Trans.). New York: Continuum.

Golman, D. (1995). *Emotional intelligence: Why it can matter more than IQ*. New York: Bantam.

Gupta, J., & Howell, H. (2005, January). *A transformational approach to interdisciplinary community work and learning*. Proceedings of the 3rd Annual Hawaii International Conference on Education, Honolulu.

Mezirow, J. (2000). Learning to think like an adult: Core concepts of transformation theory. In J. Mezirow & Associates (Eds.), *Learning as transformation: Critical perspectives on a theory in progress* (pp. 3–34). San Francisco: Jossey-Bass.

Tervelon, M., & Murray-Garcia, J. (1998). Cultural humility versus cultural competence: A critical distinction in defining physician-training outcomes in multicultural education. *Journal of Health Care for the Poor and Underserved*, 17, 117–125.

Wink, J. (2005). *Critical pedagogy: Notes from the real world*. Boston: Pearson.

Jyothi Gupta, PhD, OTR/L, OT(C), is Associate Professor, Departments of Physical Therapy and Occupational Therapy, College of St. Catherine, 601 25th Avenue South, Minneapolis, Minnesota 55454; jgupta@stkate.edu.

Gupta, J. (2008, September). Reflections of one educator on teaching cultural competence. *Education Special Interest Section Quarterly*, 18(3), 3–4.

The Lebed Method, Focus on Healing

- Training sessions to certify and license Instructors
- Uses traditional Physiotherapy movements in dance and exercise
- Founded in 1980 by two surgeons and a dance movement specialist
- Medical references available on program

APPROVED PROVIDER of CONTINUING EDUCATION
by The American Occupational Therapy Association, Inc.

For free information and training workshop schedule: call us toll-free at 877.365.6014 or see us on the web at www.lebedmethod.com

SIS-1

ED

PERIODICALS
POSTAGE
PAID AT
BETHESDA
MD

The American Occupational
Therapy Association, Inc.
PO Box 31220
Bethesda, MD 20824-1220

OTA
®