Cultural Competence for the Physical Therapy Professional

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Physical therapy professionals need to develop culturally competent communication skills and understandings in order to interact effectively with clients of diverse cultures. In reality, all physical therapy clinical encounters carry a degree of cultural diversity when one considers that culture is composed of both primary characteristics, which are largely unchangeable, and secondary characteristics, which result from life experiences and circumstances. Even the physical therapy professional brings to the encounter a professional subculture, representing the US model of professional medical practice, beliefs regarding health and wellness, and attitudes about independence and rehabilitation. Purnell's cultural model has been recognized as a valuable cultural assessment tool within the nursing profession and has direct application for the physical therapy profession as well. The model consists of 12 cultural domains set within the influence of family, community, and global society. This article explores 3 of the cultural domains—communication, health care practices, and health care practitioners—as they apply to the physical therapy cultural encounter. Recent research demonstrates that the acquisition cultural competency has proven elusive to health care professionals. This article describes 4 steps in the development of cultural competency: (1) identification of personal cultural biases, (2) understanding general cultural differences, (3) accepting and respecting cultural differences, and (4) application of cultural understandings. The acquisition of cultural competence requires understanding, sensitivity, study, and practice. Purnell's cultural model offers a means by which physical therapy professionals may move forward in their development of the cultural competence needed for successful clinical encounters.

Key Words: Cultural competence, Cultural models.

INTRODUCTION

Physical therapy professionals need to possess excellent interpersonal and communication skills if they are to effectively treat clients. When the client comes from a cultural background different from that of the physical therapist, the potential for miscommunications and misunderstandings increase and may lead to cultural barriers. The myriad of cultural differences can be overwhelming to new students, and even many seasoned clinicians are simply unaware that these cultural barriers exist. The physical therapist attempting to meet the health and wellness needs of a client risks miscommunicating and potentially rendering ineffective care if the cultural misalignment is not acknowledged. For example, a client may not respond to the instruction and intervention of the physical therapist if he or she does not agree with the underlying rationale for the treatment. Some physical therapy interventions such as touch or manual contact might be perceived as inappropriate or even offensive in some cultures. The physical therapist needs to develop a sensitivity to potential cultural misalignments.

The problem of cultural misalignment is magnified when one compares the demographics of the physical therapy profession with the demographics of the US population. According to the 2000 US census, the Hispanic population in the United States grew 58%, the Native American population increased 25%, and the Asian population increased 48% since 1990.1 Experts predict that 50% of the US population will consist of nonwhite ethnic minorities by the year 2050.2 In contrast, physical therapy programs draw students and faculty of a more homogeneous nature. According to Johnette Meadows (written communication, April 2001), in 1997-98, 86.4% of physical therapy students were Caucasian, whereas only 13.6% were minorities (3.2% African American, 3.2% Hispanic, 5.8% Asian, and 0.4% American Indian), and faculty demographics traditionally approximate those of the student body. Thus, the ethnicities represented in the population of physical therapy students match poorly the growing diversity of the US population—the people students will encounter in the clinical setting.

This article will first explore concepts and terms related to culture and transcultural communication, followed by an exploration of a cultural model developed by Purnell.3 Purnell's model has been widely used in the field of nursing, and we believe it holds value for the practice of physical therapy as well. This article will emphasize 3 domains of culture within the model that most directly relate to physical therapy transcultural encounters. Lastly, the article will look at the development of cultural competency according to a pathway described by Purnell and Paulanka.4 The model and pathway offer direction to the physical therapist seeking to educate the client as well as the physical therapy educator seeking to educate the student within a diversity of cultures.

THE NATURE OF CULTURE

Before understanding how to address the potential conflicts and barriers present in a culturally diverse interaction, one must understand the meaning of culture. Culture defines and dictates much of human thought, views, and beliefs. Purnell and Paulanka defined culture as "the totality of socially transmitted behavioral patterns, arts, beliefs, values, customs, lifeways, and all other products of human work and thought characteristics of a population of people that guide their worldview and decision making."2(p10) They noted that one's cultural orientation is largely derived from one's family and community. According to Leininger, culture "refers to the learned, shared, and transmitted knowledge of values, beliefs, norms and lifeways of a particular
group that guides an individual or group in their thinking, decisions, and actions in patterned ways. MacEachlan stated that "culture presents us with a set of guidelines—a formula—for living in the world." Helman Padilla and Brown have identified culture as "a dynamic perceptual lens through which individuals view and interpret the world we inhabit." Culture is derived from one's social group, background, and life experiences. Culture provides the framework for our understandings, perspectives, decisions, and interactions with others and the environment.

According to Purnell and Paulanka, one's culture is composed of primary and secondary characteristics (Table 1). Primary characteristics consist of nationality, race, color, gender, age, and religious affiliation. One is born into a particular nationality, race, color, gender, and religious affiliation. Primary characteristics are largely unchangeable and shape one's cultural understandings from an early age. Secondary characteristics of culture include socioeconomic status, length of time away from country of origin, education, occupation, military status, urban versus rural residence, marital status, parental status, physical characteristics, sexual orientation, enclave identity, and gender issues. Secondary characteristics relate more to life's circumstances and experiences as one grows and may change throughout one's life. They are more circumstantial in nature and typically not as obvious, yet they contribute strongly to one's cultural worldview understandings. Both primary and secondary characteristics shape and mold one's thinking, behavior, and values, thus influencing one's actions, decisions, interactions, and worldview.

In almost every health care setting, health care professionals will interact with clients of different backgrounds, different primary and secondary characteristics from those of the health care professional. Certain primary characteristic differences are obvious; other secondary characteristics are hidden. People may wear the same style of clothes, speak the same language, and watch the same television shows but still possess dramatically different cultural backgrounds, which define their basic values and perspectives. Loveland referred to the visible characteristics of dress, activities, and language as "material culture" and the abstract aspects of culture such as values, attitudes, and beliefs as "nonmaterial culture." She noted that the nonmaterial culture can be understood only with lengthy and careful observation and communication, and yet poses the greater potential to contribute to misunderstanding and miscommunication.

Subcultures

Subcultures are specific cultures that exist within a larger culture. They are closely related to their dominant culture but do not necessarily hold to all of the same values. Differing primary and secondary cultural characteristics may differentiate the subculture from the dominant culture. For example, a second-generation female Puerto Rican American most likely will hold slightly different cultural values and beliefs than her first-generation father or mother. Both share the culture of their Puerto Rican heritage (a primary characteristic), but they differ in their birthplace and length of time away from the country of origin (secondary characteristics). A second example of a subculture might be an African American who practices the Catholic faith and another who embraces the Muslim religion. Both share the same African heritage and yet espouse different religions, thus identifying with different subcultures.

Subcultures may traverse larger cultural distinctions when unifying commonalities, life experiences, and secondary cultural characteristics link them. Homeless people, those who are victims of acquired immunodeficiency syndrome, and members of political and social groups are all examples of subcultures, which may cross dominant cultural lines. Shared secondary characteristics may unite a group that represents a wide array of primary cultural characteristics.

Similarly, health care professionals represent their own subculture. A socialization into the culture of the health care profession occurs as students acquire a new vocabulary and perspectives on health and illness. Helman called this a "professional subculture." Spector noted, "As students become more and more knowledgeable, they usually move farther and farther from their past belief systems and, indeed, farther from the population at large in terms of its understanding and beliefs regarding health and illness." Thus, health care professionals bring not only their own personal culture, but also the culture of their profession into the interaction. This may potentially complicate client and clinician interactions and communications.

Overall, therefore, individuals acquire certain aspects of their culture at birth, but other aspects develop as their life experiences, training, and illnesses serve to challenge and reshape their cultural understandings. The nature of culture is dynamic, with culture adapting and changing through a lifetime according to experiences and outside influences. MacEachlan noted, "Each person represents an amalgam of differing cultural experiences, to which he or she may give more or less credence than others do, and these experiences may relate to each individual's health and welfare to different extents." One's culture largely dictates one's response to the world and how he or she experiences the world as well as how people experience the world as well as their clients if they are to communicate effectively with the client.

Ethnocentrism

Worldview was defined by Purnell and Paulanka as "the way individuals or groups of people look at the universe to form values about their lives and the world around them." As noted previously, one's worldview is largely shaped by one's culture—both primary and secondary characteristics—and by changing life experiences within society, community, family, and person. By nature, one's worldview tends to be situational ethnocentrically. Purnell and Paulanka defined ethnocentrism as "the universal tendency of human beings to think that their ways of thinking, acting, and believing are the only right, proper, and natural ways...." Leininger concurred, stating, "Ethnocentrism is a universal phenomena in that most people tend to believe that their ways of living, believing, and acting are right, proper, and even morally correct." A common manifestation of ethnocentrism in health care may be seen in the labeling of a client as

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noncompliant when it is actually a case of conflicting belief systems. One might assume that the client did not comply with the instructions when, in reality, the client did not understand them or the instructions did not align with his or her understanding of the problem. For example, a Hmong mother might be labeled ‘noncompliant’ when she fails to administer the proper dose of medication for her child with epilepsy when she simply does not understand the dosage. Complicating matters, the mother understands an epileptic seizure to be a spiritual experience, and she feels that her child is blessed by the gods. A blind ethnocentric approach to this clinical scenario will not lead to an effective solution.

MacLachlan described the tendency toward ethnocentrism as our attempt to simplify a complex world. In order to manage diversity, we tend to identify similarities and commonalities and ignore the differences. Oversimplification leads to generalization, which may lead to stereotyping, an oversimplified conception, opinion, or belief about a group of people. Ethnocentrism, then, allows one to potentially mismanage the overwhelming complexities of diversity. What begins as a coping mechanism may become a major barrier to living effectively in a complex world.

Ethnocentrism may readily lead to cultural imposition. Leininger defined cultural imposition as "the tendency of an individual or group to impose their beliefs, values, and patterns of behavior upon another culture for varied reasons." Health care professionals are not immune to the practice of cultural imposition. Leininger warned that health care professionals may knowingly or unknowingly impose their cultural views and expectations on clients in efforts to accomplish the desired task. She noted that the power and authority discrepancy between professional staff and clients lends itself to such imposition. Health care professionals bear the responsibility of identifying the potential imposition and rectifying it.

**PURNELL'S MODEL FOR CULTURAL COMPETENCE**

Purnell’s Model for Cultural Competency (Figure) presents a schema for overcoming ethnocentrism and for identifying various cultural meanings essential for a culturally competent clinical encounter. The model leads the professional to consider the whole person, encompassing his or her culture and perspectives in all areas of life. Arranged within a circle, the outer layers represent global society, community, family, and person, respectively, and are considered macroaspects of the cultural model. Purnell and Paulanka described global society as encompassing world communication, politics, warfare, natural disasters, and advances in health sciences among other things. Community describes a group of people with a common interest or identity and living in a specified locality. Within our American culture, we are most aware of the personal component of culture. We stress the importance of the individual and tend to focus our understandings around self rather than family, community, or society.

Specific domains arranged in pie-shaped wedges within the circle comprise the microaspects (Figure). Purnell and Paulanka have identified 12 domains common to all cultures and listed concepts specific to each domain. As shown in the figure, these domains are arranged in a pie-shape within the circle. The center of the circle is dark and unmarked and represents unknown phenomena that contribute to one’s culture. The domains include overview and heritage, communication, family roles and organization, workforce issues, biocultural ecology, high-risk behaviors, nutrition, pregnancy, death rituals, spirituality, health care practices, and health care practitioners.

Although physical therapist interactions with clients encompass the whole person, and therefore all domains, this article will discuss 3 domains most pertinent to physical therapy: communication, health care practices, and health care practitioners. The domain of communication includes dominant language, dialects, contextual use of the language, volume and tone, spatial distancing, eye contact, facial expressions, greetings, temporality, time, format for names, and touch. The health care practice domain encompasses one’s focus on health care, traditional practices, magico-religious beliefs, responsibility for health, rehabilitation, self-medication, pain or sick role, mental health, and barriers. Lastly, the health care practitioner domain considers one’s perceptions of Western practitioners, folk practitioners, gender and health care, and status of health care providers. Information pertaining to these 3 domains of culture will provide...
the physical therapist with valuable information useful in developing and implementing a culturally appropriate physical therapy intervention.

ELEMENTS OF CULTURAL MISALIGNMENT RELATED TO CULTURAL DOMAINS

Communication Domain

MacLachlan noted that culture provides a means of communication with those around us with different styles of communication reflecting the culture of different people. The use of verbal and nonverbal communication varies and holds different meanings in different cultures. The volume of speech, spatial distancing, eye contact, and body language convey various messages in different cultures. MacLachlan stated, "Not only is culture a 'voice' through which we can communicate, it is also the eyes and ears through which we receive communications." The receiver brings his or her own cultural understandings and expectations to the interaction. The cultural perspective complicates the interaction and opens wide the potential for miscommunication and misunderstanding.

Problems in communication arise when the therapist and client bring 2 completely different worldviews, languages, or backgrounds to the interactions—a cultural misalignment. Cultural misalignments coupled with ethnocentrism and cultural imposition may result in cultural barriers, impeding effective patient care. Without an awareness of cultural misalignments and potential cultural barriers, the therapist risks miscommunicating and misunderstanding his client's expectations and needs. The culturally competent therapist is cognizant of possible cultural misalignments and potential communication barriers.

Differing social norms regarding eye contact provide an example of potential miscommunications. Purnell and Paulanka noted that many Mexican Americans and Navajo Indians consider sustained eye contact when speaking directly with someone rude and possibly confrontational, while avoiding eye contact is deemed a sign of respect. In contrast, the European-American tradition considers direct eye contact a sign of respect and attentiveness.

Another example of possible cultural misalignments and misunderstandings within the domain of communication pertains to conversational silence. Artihenbwa noted that Westerners are usually uncomfortable with periods of silence and tend to associate it with voicelessness or weakness. In contrast, African Americans value silence and nonverbal communication. Likewise, the Navajo Indians, undaunted by long periods of silence, understand an attentive, silent listener to communicate interest.

Differing values on punctuality or time pose another potential cultural barrier within the domain of communication. The dominant US medical culture places great value on timeliness and expects clients to arrive on time for their scheduled appointments. Interestingly, the American culture does not place such strict demands for timeliness on health care professionals. For example, the client is expected to arrive on time, while the health care professional is permitted to run at least slightly behind schedule. Most Hispanic cultures, however, do not place a high priority on punctuality. Meetings and scheduled appointments rarely begin on time; therefore, it is acceptable in the Latino culture to arrive a little late. A therapist from the United States working with a client who does not value punctuality runs the risk of misinterpreting the client's lateness as not caring about the appointment rather than a cultural misalignment over punctuality.

Format for names constitutes another consideration under the domain of communication. In some cultures, it is perfectly acceptable to address a client by his or her first name. In other cultures, such as Mexican culture, a personal reference is seen as offensive, and the more formal use of one's last name is preferred. The physical therapy professional needs to consider how best to address the client and should ask the client what he or she would prefer in order to avoid offending or showing disrespect for the client.

Physical touch communicates a diversity of meanings across cultures. It also can be a powerful communicator of respect or disrespect and holds the capacity to heal or to hurt. For example, homeless people may not have been physically touched in a long time, and when they were touched, it may have been a harmful touch rather than a loving or respectful touch, such as the homeless woman who fled an abusive home situation. Physical touch, therefore, may be foreign, painful, threatening, or undesirable. Because of the possible negative associations, the physical therapist should ask permission of clients and explain the necessity of touch before conducting a physical examination.

Physical touch across genders requires special consideration. Because the Arab-Muslim culture places a high value on female modesty, it would be inappropriate for a physical therapist to begin a physical examination without consulting with the client and taking special precautions for modesty. Sometimes, the client may request that another female or her husband remain in the room. Latin cultures, however, encourage physical touch as a communication of caring. Physical space requirements are less, as evidenced by the crowding of elevators and buses in many Latin-American countries. Physical touch is regarded as a powerful healer.

In general, the physical therapist would do well to remember 2 things with regard to physical touch. The first is to request permission of the client before proceeding with physical examination or manual techniques, allowing others to remain in the room if requested. The second is to proceed with respectful physical touch. Respectful touch is characterized by purposeful, nonthreatening contact such as a warm handshake or a firm hand on one's shoulder. In a recent study of physical therapy students serving in a homeless shelter clinic, Black (2000, unpublished dissertation) observed students interacting in respectful ways, with respectful physical touch, establishing excellent rapport with their clients.

As therapists interact with clients, their individual norms of communication may differ and clash. The kind of misalignment in social norms can lead the therapist to form inappropriate judgments about the client and can result in miscommunications and misunderstandings. Differing social norms regarding communication can create barriers to effective client care and are a result of cultural misalignments between client and therapist.

Domain of Health Care Practice

Culture powerfully influences one's interpretation and understanding of health and illness. Different cultures give different meanings to health, wellness, illness, and disease. Pain and suffering are regarded differently across various belief systems. The reality of working as health care practitioners in our society is that we are going to encounter understandings of illness and health that are quite different from our own.

In the United States, the biomedical model of health care prevails. Students are socialized into these understandings in their programs if they had not already come to embrace the scientific nature of medicine in their cultural upbringing. Overall, the US culture of health care holds beliefs that disease is biological in origin; that medications, surgery, or scientifically proven interventions are the best treatments; and that the use of unproven or alternative treatments such as homeopathy or folk medicine denotes denial or ignorance.

The biomedical concept is not the only concept of health and illness in existence. Many cultures hold different understandings of health and wellness. As MacLachlan noted, "Different understandings of how the human body works should, and do, lead logically to different ways of 'fixing it'". He noted that a model of health and illness that
crosses several cultures reflects the notion of balance and imbalance in the body. According to this conception, the various systems within a healthy body maintain a harmonious balance. Imbalance can result from physical, psychological, nutritional, environmental, or spiritual influences, which, in turn, results in illness or disease.4

The notion of balance and imbalance dates back to the time of Hippocrates when he identified 4 humors in the body—blood, phlegm, yellow bile, and black bile. An overabundance or scarcity of one of these humors would put the body "out of balance" and result in disease.4 Similar balance theories exist in Latin-American culture with the notion of hot and cold or wet and dry. For example, if an illness is classified as hot, it is treated with a cold substance; an illness classified as cold is treated with a hot substance. Food, beverages, animals, and people possess the characteristics of hot and cold to various degrees.6,8

Another example of the concept of balance is the Chinese ‘yin’ and ‘yang’ theory. ‘Yin’ and ‘yang’ represent the 2 major, opposing, and yet complementing powers that are believed to govern the universe. Yin possesses the attributes of darkness, moistness, and femininity, while yang is characterized as bright, hot, dry, and masculine.4 Different organs of the body possess properties of yin and yang in different proportions. Even different weather conditions and seasons of the year are identified with yin and yang energies. Illness results when an imbalance of yin and yang exists within the body.4,7,8

To understand illness in an individual client, the health care professional needs to appreciate the cultural context the client brings with the illness. Culture and notions of health are so completely interconnected that one cannot fully understand, let alone cure, the illness if one does not seek to understand the perceived origins of the illness. The health care professional needs to refrain from automatically accepting assumptions and understandings that are a product of the dominant cultural model of one's training.

Rehabilitation is an area under the health care practice domain that specifically relates to the physical therapy professional. Just like other aspects of health care practice, rehabilitation is laden with cultural interpretations and values. Failure on the part of the physical therapy professional to recognize these differences will result in frustration and ineffective care. Physical therapy professionals in the United States are socialized into the US value of individual autonomy, personal responsibility for wellbeing, and the importance of hard work to achieve goals.6 Not all cultures share these same values, however, and the client from another culture may resist and even resent having the physical therapy professional impose these principles upon him or her. Many other cultures place greater value on the group rather than the individual. Such societies are described as "collectivistic" rather than "individualistic" societies. With this in mind, the physical therapist must realize that the client is integrally linked to his or her larger society. Decisions about the goals and course of rehabilitation will not be made individually, they will involve the entire family and sometimes the entire community. Viewed in this manner, the goals that the therapist envisions for the client may actually be in conflict with the goals of the larger society. The therapist must be ready to negotiate and adapt the program if effective care is to be rendered.

Likewise, US culture values hard work and teaches personal responsibility for growth and achievement. The "be all that you can be" motto of the US Army depicts this cultural understanding. Rehabilitation from injury or disease is viewed in much the same manner. Physical therapists learn to promote independence, to establish goals, and to work hard to help their clients achieve these goals. They expect the client to work hard as well and to desire independence.

In contrast, many societies hold that one can do little to change one's destiny and that it is best to accept one's fate.6 No amount of work or effort will be able to change the course of destiny, so it is useless to fight. This attitude is not necessarily a negative resignation but may be a positive acceptance of life's events and experiences. Often, this view recognizes supernatural influences beyond human control that order and affect the course of one's life. To resist against the supernatural direction is foolish and pointless. We encountered this attitude in Belize when attempting to train a young woman in rehabilitative practice. She learned the range of motion and transfer training techniques quite readily but was very reluctant to put them into practice. When we questioned her regarding her reluctance, she responded that she did not see that it would alter the course of life and that the client did not really want it. The woman was of the Garifuna culture, a culture that is fatalistic in beliefs or worldview.

Acceptable pain and sick roles vary across cultures as well. As mentioned previously, the US culture values independence and personal responsibility for well-being. Other cultures value the family, the extended family, and the community. To be dependent upon family members is viewed as a healthy thing. Families and communities care for their infirm elderly and injured family members. Taking care of their every need brings great pleasure and is expected. Physical therapy professionals may find this very frustrating when they encounter a wife or mother feeding or dressing the client when the therapist is trying to have the client relearn to do the task independently. The primary author (JDB) conducts physical therapy mission trips to Mexico and became quickly frustrated with the dependent state of the clients and the families who seemed to keep them there. She had to learn to appreciate the value placed on family and care and negotiate ground whereby the client could make quality-of-life gains while nourishing within the dependent environment.

Grocott identified 3 cultural factors that influence effective rehabilitative practice. The first is to determine the cultural explanation the client has for why the disability occurred. Second, the physical therapy professional must identify which physical or intellectual attributes are valued or devalued in the client's culture. Lastly, one must identify the role an individual with a disability is expected to play as an adult in the community. Identification of these 3 factors will help bridge the gap of cultural understanding as it relates to physical rehabilitation.

Domain of Health Care Practitioners

Cultural considerations regarding the domain of health care practitioners are described here. Julia listed unfamiliarity and distrust of health care professionals or service models as a potential cultural barrier to effective health care. Not all cultures are familiar and comfortable with the Western hospital-based medical system. Spector noted that the American hospital is an alien place to the Chinese. Typically, they are uncomfortable with many aspects of the Western hospital-based medical system, ranging from the separation from their family to the type of food served. The Hispanic culture traditionally resents the separation from family as well. In many Latin-American countries, the family is permitted to stay in the room of a loved one day and night if they wish. Often, it is the family who is encouraged to wash and feed the patient. The culturally competent therapist will learn to make use of the visiting family, incorporating them in the care of the patient. It is also important for the therapist to be aware of the stress that the patient is feeling in a foreign environment. Perhaps the cultural misalignment is contributing to the patient's "poor motivation."

Many people in some cultures simply do not trust health care professionals. Sadly, African Americans have not always been treated well in the American health care system. At one time in US history, hospitals were thought to use African-American lives as studies for new treatments. This history
sometimes leads the African Americans of today to distrust their health care professionals.\textsuperscript{16} Even today, studies show a disparity in the treatment of African Americans and the dominant culture.\textsuperscript{17} This cultural misalignment may result in cultural barriers that run deeply and emotionally. The culturally competent therapist must be aware of these potential barriers and must seek to overcome them if treatment is to be effective.

**ARE HEALTH CARE PROFESSIONALS CULTURALLY COMPETENT?**

Recent literature suggests that health care professionals are grossly lacking in their ability to identify and address potential cultural barriers in their professional interactions. Babyar et al.\textsuperscript{18} surveyed the physical therapy programs of New York State to determine the inclusion of cultural and gender issues in physical therapy curricula. They noted the same disparity between the homogeneous student body and faculty and the diversity of the patient population in New York. Despite this disparity, they found that the physical therapy programs lacked specific courses or units in multiculturalism. They did find, however, that some faculty were sensitive to cultural and gender issues and made attempts to incorporate them into their classes.

Pope-Davis et al.\textsuperscript{19} measured the cultural competency of 120 nursing students in a midwestern university. The study showed that nursing students who had work experience with a diverse population scored higher on a scale of multicultural sensitivity and knowledge compared with nursing students without such work experience. Likewise, Pope-Davis et al.\textsuperscript{20} measured the cultural competencies of occupational therapists sampled in California, Illinois, and Iowa. They found that occupational therapists with higher cultural competency scores had higher levels of education, had taken course work or attended seminars regarding multiculturalism, or had work experience with diverse populations. The study by Babyar et al.\textsuperscript{18} points to the lack of a specific multicultural curriculum in physical therapy schools in New York, and the studies by Pope-Davis and colleagues\textsuperscript{19,20} illustrate the positive effects such a curriculum can have on health care professionals and clients.

Kraemer\textsuperscript{21} conducted a qualitative study among 12 physical therapy students to determine their perceptions and experiences regarding culturally congruent care in a clinical internship experience. She found that the students were ill-prepared for the cultural collisions they faced and often were unaware of the barriers encountered. When the students did identify the barriers, they were ill-equipped to handle them and lacked appropriate resources for assistance. The study points to the need for cultural competency training in the physical therapy curriculum and cultural assessment tools for the physical therapist that will assist in the administration of culturally congruent care.

Leavitt summarized the state of cultural competency among physical therapy professionals this way:

Historically, few practicing rehabilitation professionals have been suitably educated on the issues associated with the delivery of cross-cultural health care. Often, their education has ignored the influence of socioeconomic status, religion, race, or ethnicity, as well as the presence of differing explanatory models or differing verbal and non-verbal communication or learning styles. Strategies to overcome potential barriers resulting from misunderstandings have been sorely lacking, and, few schools or training programs provide adequate instruction about culture and health.\textsuperscript{22(p576)}

**THE DEVELOPMENT OF CULTURAL COMPETENCE**

How does one develop cultural competence to overcome potential cultural misalignments? Cultural competence is a skill and an understanding that evolves over time and study. Pedersen noted that one does not give up one's assumptions easily, stating, "We have a tendency to see evidence that supports our assumptions more clearly than evidence that challenges those assumptions."\textsuperscript{23(p66)} The development of cultural competence involves a major change of perspective. Pope-Davis et al. described culturally competent individuals as "persons who have moved from being culturally unaware to being sensitive to their own cultural issues and to how their values and biases affect racially and ethnically diverse patients."\textsuperscript{24(p639)} Leavitt\textsuperscript{22} described the culturally competent practitioner as one who has the capacity for cultural self-assessment; values diversity with an awareness, acceptance, and celebration of differences; is conscious of the possibility of misjudging those differences; and incorporates this cultural knowledge into clinical practice.

Purnell and Paulanka\textsuperscript{2} developed a pathway for cultural competency development. The pathway provides a direction for educational programs as well as individuals to pursue cultural competency development. The four steps in the progression toward cultural competency are shown in Table 2 and are discussed below.

**Identification of Personal Cultural Biases**

The first step in the process of attaining cultural competency is to examine oneself to identify one's own culture and background. Many people are truly unaware of their own strong attitudes and values. Without such introspection, it is nearly impossible to identify misconceptions or misinterpretations.\textsuperscript{15,24,25} The first step, then, involves the recognition of one's own ethnocentrism and the identification of personal values and beliefs that might contribute to a cultural misalignment. One must understand one's own values before attempting to adjust to the value system of another culture.\textsuperscript{25}

**Understanding General Cultural Differences**

In the second step, the student actively seeks knowledge regarding different cultures in order to be equipped to deal with diversity. To gain a thorough understanding of all cultures presents an almost impossible task, but a student can develop sensitivity to health care issues or to the communications that might be culturally related.\textsuperscript{15} When the student does identify a culturally related situation, he or she can refer to appropriate resources to address the situation positively and effectively. A study of general cultural differences and how they might affect the health and practices of a person will enable the practitioner to identify health care issues arising from diversity. Purnell's Model of Cultural Competence provides a systematic means of considering a client's culture.

**Accepting and Respecting Cultural Differences**

The third step is to come to value diversity. Kavanaugh and Kennedy\textsuperscript{26} identified the natural human tendency to respond to differences with discomfort, fear, and apprehension. They noted that

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**Table 2**

Steps Toward the Development of Cultural Competence

1. Developing an awareness of one's own existence, sensations, thoughts, and environment without letting it have an undue influence on those from other backgrounds.
2. Demonstrating knowledge and understanding of the client's culture.
3. Accepting and respecting cultural differences.
4. Adapting care to be congruent with the client's culture. Cultural competence is a conscious process and not necessarily linear.
students would handle diverse situations by avoiding or attempting to minimize the differences rather than acknowledging and responding to the differences. Many students, professionals, and educators learn to tolerate diversity, but not accept, respect, appreciate, and value it. Leavitt22 expounded on celebrating diversity, recognizing the ways one can learn and grow from the differences of others. Accepting, respecting, or even celebrating diversity, however, is not enough. Physical therapy professionals must be equipped to adapt physical therapy care to be culturally congruent if it is to be effective.

Application of Cultural Understandings

The implementation of culturally competent health care practices is step 4 in the process of attaining cultural competency. Once one has identified a personal culture and cultural biases, has recognized diversity as good, and has acquired an understanding of various cultural differences, he or she is ready to apply the cultural skills in practice. Pedersen defined cultural skills as "the ability to present a solution in the other culture's language and cultural framework."23(p28) Applications manifest themselves in many ways and begin with a sensitivity to diverse situations. Dillard et al22 recommended the client as a resource and emphasized the importance of an open-minded and accepting environment. Kavanagh and Kennedy26 discussed negotiating with the patient. They described the process of negotiation as "finding a place where you can feel confident in the exercise of your professional judgment, yet incorporate the beliefs and values of the patient into the treatment plan to achieve mutually desirable outcomes."26(p55)

In order to apply cultural understandings, the health care professional must be skilled in communicating cross-culturally. Skill in effectively communicating cross culturally requires practice and practice infers a risk of making mistakes. Kavanagh and Kennedy26 described 4 cross-cultural communication skill areas: the ability to articulate and present an issue or problem as it is perceived from another's perspective, recognizing defensiveness in the interaction, reducing defensiveness in the interaction, and acknowledging that we all make interactive mistakes and that taking the risk of making an error is preferable to not communicating.

CONCLUSION

The development of cultural competence is an ongoing learning process. One can always improve upon one's cultural competence and should be prepared to learn from mistakes. Purnell's cultural model provides a framework for the physical therapy student, professional, and educator to study, gain, and teach cultural competency. Additionally, the model holds relevance for physicians, nurses, social workers, and all other health care professionals. In today's era of teamwork and collaboration among health care professionals, this versatile cultural model provides an excellent resource by which health care professionals can develop greater cultural sensitivity. Health care professionals and clients will mutually benefit from more culturally competent interactions.

REFERENCES


