

A Guide to Cultural Competence in the Curriculum

Physical Therapy

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UB University at Buffalo
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A GUIDE TO CULTURAL COMPETENCE IN THE CURRICULUM: Physical Therapy

Table of Contents

Preface.....	i
Purpose of this Guide.....	i
Philosophy and Approach.....	i
How to Use this Guide.....	iii
References.....	iii
About the Authors.....	iv
Acknowledgements.....	v
Part I: Mary Matteliano	
Transdisciplinary Instruction for Cultural Competence	1
Introduction.....	1
Implementation of the Campina-Bacote Model into Curriculum Design.....	2
Objective 1: Students will Improve their Cultural Awareness	2
Objective 2: Improve Student Knowledge of Diverse Cultures and Practices	4
Objective 3: Improve the Student’s Skill in the Assessment of Clients from Diverse Cultures and Practices.....	6
Objective 4: Improve the Student’s Ability to Develop Treatment Plans for Clients and Students from Diverse Cultures	8
Objective 5: Students will Develop the Desire for Cultural Competency and Understand that it is a Life-Long Process	9
References.....	10
Appendix A: Cultural Competence Classroom Activities	14
Activities	14
Appendix B: Website Resources	17
Appendix C: Self -Tests and Questionnaires	18
Appendix D: Case Studies	19
Appendix E: Kleinman’s Eight Questions to Assess the Patient’s Perspectives	30
Part II: Karen J. Panzarella	
Cultural Competence in the Physical Therapy Curriculum.....	31
Introduction.....	31
Implementation of Cultural Competence into the Physical Therapy Curriculum	34
Teaching Material	35
Examination	38
Evaluation	40
Prognosis.....	42
Intervention.....	43
Service Learning/ Community Based Projects	44
A Day in the Life of... ..	44
Screening of Local Refugees	46

Outcomes	47
Clinical Experiences	48
Assessment of Cultural Competence	49
References.....	51
APPENDIX A: Reflective Paper	55
APPENDIX B: Health BELIEF™ Instrument Attitudes Survey.....	56
APPENDIX C: Communicating Between Cultures.....	57
APPENDIX D: DPT Clinical Case Outline.....	58
APPENDIX E: Case Presentation.....	59
APPENDIX F: Measuring Integration.....	60

Preface

Purpose of this Guide

This curriculum guide has been prepared by the Center for International Rehabilitation Research Information and Exchange (CIRRIE) under a grant from the National Institute for Disability and Rehabilitation Research. Its purpose is to provide a resource that will assist faculty in physical therapy programs to integrate cultural competency education throughout their curriculum.

CIRRIE's current work with pre-service university training, complements previous CIRRIE publications designed primarily for in-service training, most notably a 12-volume monograph series, *The Rehabilitation Service Provider's Guide to the Cultures of the Foreign Born* (CIRRIE, 2001-2003), and *Culture and Disability: Providing Culturally Competent Services*, a book that summarized the series (Stone, 2005). Because of CIRRIE's funding mandate from the National Institute for Disability and Rehabilitation Research, its focus in the area of cultural competency is on the cultures of persons who have come to the US from other countries. Consequently, the primary focus of this guide is on the cultures of recent immigrant groups, rather than US-born persons. Cultural competency education should certainly address issues related to US-born minorities and Dr. Panzarella addresses her activities to both recent immigrants and US-born persons from a variety of cultural backgrounds.

Philosophy and Approach

This Guide is a curriculum guide. Its objective is to provide a resource to faculty who wish to include or strengthen cultural competency education in their program and courses. Certain limitations are inherent in all curriculum guides. While there are certain common elements or competencies in most professional programs, there are also variations among different institutions in how these are organized into specific courses. Moreover, even courses that have similar objectives may use different titles. We have attempted to provide material that could be included in most physical therapy programs, regardless of their specific curriculum structure. Its purpose is to enhance existing curricula by making available to instructors resources, case studies, and activities. This material can be adapted by the instructor as needed, in courses that are specific to cultural competence, or infused into other courses in the curriculum.

At the university level the CIRRIE approach to cultural competency education includes four main principles.

1. Integration of cultural competency into existing courses, rather than creation of new courses

Although the academic credentialing standards for programs in the rehabilitation professions now require cultural competence, the curricula of most programs are already overloaded. This makes it difficult to add new courses and as a consequence, content involving cultural competence usually becomes incorporated into existing courses retrospectively and in small doses. More importantly, a separate course on cultural competence can make the topic appear to students as isolated from the "real" set of professional skills that they are required to master. Students may consider it an interesting topic but one of little practical importance. Moreover, by

separating cultural competence from courses that develop practice skills, it becomes abstract and difficult to relate to practice.

Another reason for integrating cultural competence into existing courses is that students have an opportunity to see its implications and apply its principles in a variety of contexts. They also see that it is not just a special interest of one faculty member but an integral part of many aspects of their future practice that is supported and embraced by all faculty. When it reappears in their coursework each semester, their knowledge, attitudes, and skills in this area develop and deepen. The CIRRIE curriculum development effort has identified specific types of courses in the physical therapy curriculum where cultural competence may be most relevant, and we have identified or developed activities and materials that are appropriate across the curriculum.

2. Development of cultural competence education that is profession-specific, rather than generic

CIRRIE's prior experience with providing cultural competency workshops for in-service training strongly suggests that an off-the-shelf generic approach is less effective than training that is specific to the profession in which the competence is to be applied. Generic training must be understandable by all rehabilitation professions, so examples, terminology, and concepts that are specific to one profession must be avoided. As a result, cultural competence becomes more abstract. With profession-specific training, students are better able to see the relevance and applicability to their profession, not as something outside its mainstream. Consequently, CIRRIE's approach is to work with faculty from each profession to analyze their curriculum and incorporate cultural competence into it in ways that seem most relevant to that profession.

3. Multi-disciplinary case studies

Although CIRRIE's general approach is profession-specific, we have found that studies developed in one program can sometimes be adapted for use in other programs. For example, a case scenario developed for a course in physical therapy may be useful in courses in occupational therapy, speech therapy, or rehabilitation counseling. The general facts of the case may be presented to students from each program, but many of the problems, questions and assignments related to the case may be different for each of the professions. The use of common case studies provides an opportunity to analyze cultural factors from a multi-disciplinary perspective, which is often the type of setting in which rehabilitation is practiced.

4. Making materials available to instructors

Most instructors realize the need for the infusion of culture into their curricula, but they may be reticent to incorporate culture into their courses if the burden of creating new materials is added to their normal course preparation. CIRRIE has approached this dilemma through specific strategies to allow instructors easy access to cultural content. Hence this guide was written. These materials are also available online at <http://cirrie.buffalo.edu/curriculum/>. The website was created to organize cultural materials into inter-disciplinary and discipline-specific assignments, case studies, lectures, reference materials, and classroom activities. This information will be expanded and revised based on feedback from users in universities nation-wide.

How to Use this Guide

Curriculum committees and other faculty groups may wish to consult this guide to examine the ways that cultural competency can be infused across a curriculum and identify ways in which this approach may be adapted to the specific context of their program.

Individual course instructors can identify the sections of this guide that relate most closely to the courses they teach. They can then see how others have included cultural competency in such courses. The resources that are suggested in the guide may be seen as a menu from which instructors can select those that fit their course and their teaching style.

Prior to the main portion of this guide that pertains specifically to physical therapy, we have included a section that presents suggestions and resources that are generic in nature and could be used in any of the rehabilitation professions.

We hope that this guide will be useful to those who are committed to strengthening this aspect of our professional programs in rehabilitation. We also understand that many institutions have created or identified resources that are not found in this guide. We welcome your comments and suggestions to increase the usefulness of future versions of this guide.

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About the Authors

Dr. Karen Panzarella holds a bachelor's degree in physical therapy, a master's degree in exercise science and a PhD in Educational Psychology all from the University at Buffalo where she is the Director of Clinical Education for the Doctor of Physical Therapy program. She instructs courses to physical therapy students in case management, professional development and pediatric physical therapy. She has twenty years experience as a clinician and over ten years as an educator. Her research focuses on assessing student's clinical competence through the use of standardized patients. She strives to facilitate the transition from the academic to clinic environment through clinical and cultural competence.

Mary Matteliano, MS, OTR/L, has over 20 years of rehabilitation experience in the area of adult physical disabilities. She has been a clinical assistant professor in the Department of Rehabilitation Science at the University at Buffalo since 1999. In addition, she is the project director for “Cultural Competence in the Curriculum” for four rehabilitation programs. This is a NIDDR funded project through the Center for International Rehabilitation Research Information and Exchange (CIRRIE). Ms. Matteliano has also participated in and co-directed the study abroad program, Health in Brazil, in 2004 and again in 2006. She is currently pursuing her PhD in Sociology; her research explores the provision of culturally competent health care services to those who are from underserved groups.

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Acknowledgements: Special thanks to Dr. Ronnie Leavitt who reviewed this curriculum guide and provided insightful comments and suggestions. Dr. Leavitt is a licensed physical therapist. Her advanced degrees in Public Health and Medical Anthropology have proved a focus for her interest. She has been involved in a variety of community and public health arenas both nationally and internationally. Her expertise is in cultural competence as well as the development of community based rehabilitation in developing nations. Additionally, we would like to thank Dr. Rosemary Lubinski and Marcia E. Daumen for their assistance with proofreading, editing, and overview of the general content of this guide.

Part I: Transdisciplinary Instruction for Cultural Competence

Mary A Matteliano, MS, OTR/L, Project Director of Culture in the Curriculum, CIRRIE

Introduction

Rehabilitation services for persons with disabilities are provided in a variety of settings including medical facilities, schools, and the community. The recipients of these services are referred to as patients, students, clients, and consumers, depending on the setting. Henceforth, for the purpose of this guide, we will refer to the recipients of services as clients and students. In all settings, the team approach is valued, and the client or student benefits when each discipline is able to focus on its area of expertise in a collaborative manner. It is not unusual for clients or students to receive therapy from a variety of professionals during their course of treatment. In fact, a client or student may receive some combination of occupational therapy, physical therapy, rehabilitation counseling, and speech-language therapy simultaneously. Additionally, rehabilitation professionals frequently request consults from other professionals and ask for another discipline's involvement in a case. As a result of these frequent interactions among rehabilitation professionals, a team approach develops in which each provider recognizes and often supplements the unique role of other professionals. Likewise, rehabilitation professionals learn from each other in these settings and are provided with opportunities to appreciate their commonalities. Therefore, it seems fitting that CIRRIE create not only guides that are discipline specific, but also transdisciplinary and foundational information for use in all four programs. By providing general content, the expressed needs for cultural competence education can be transferred across rehabilitation programs and serve to unify this intent. With this in mind, the transdisciplinary section of this guide was written to provide an introduction to cultural competence instruction for occupational therapy, physical therapy, rehabilitation counseling, and speech-language therapy programs.

Rehabilitation disciplines use various frameworks and models of service provision that are specific to their practice. A conceptual framework that shows utility for all rehabilitation programs is the International Classification of Functioning, Disability and Health (ICF) (World Health Organization [WHO], 2001). The ICF can be used by rehabilitation professionals to organize and identify relevant domains for assessment, treatment, and evaluation of outcomes (Reed et al., 2005; Rentsch et al., 2003). It also provides a common language for health care providers, thereby enhancing communication among disciplines (Rentsch et al., 2003). By examining the ICF and its classification system, we can further understand the areas of concern that impact the provision of culturally competent rehabilitation services. The ICF guides rehabilitation specialists in the assessment process by providing a framework that addresses client or student needs beyond the impairment level, thus establishing their capacity to perform within the natural environment (Occupational Therapy Practice Framework, 2002). Contextual considerations, the external or internal influences on the client or student, impact the rehabilitation process and must be addressed. For example, external contextual influences may include the individual's immediate environment as well as cultural and societal influences. Internal influences are more personal in nature and include the individual's gender, race, ethnicity, and educational level, among others (WHO, 2001). It is useful for us to use the ICF as

a framework that addresses individuals' performance capacity within the context of their personal and external environment. By understanding this, rehabilitation professionals will improve their ability to address the influence of culture on client or student performance. In the next section we will examine a model that will be used to specifically guide the infusion of cultural competence into the curriculum for rehabilitation programs.

Although there are several models to choose from that can be used to guide curriculum planning, we have chosen the *Campinha-Bacote* model as a guide for teaching cultural competency to students who are enrolled in rehabilitation programs (Campinha-Bacote, 2002). According to this model, achieving cultural competence is a developmental process, not a onetime event. The *Campinha-Bacote* model (2002) consists of five constructs: (1) cultural awareness, (2) cultural knowledge, (3) cultural skill, (4) cultural encounters, and (5) cultural desire. These constructs are intertwined; cultural desire is the foundation of this process and provides the energy that is needed to persevere on this journey (Campinha-Bacote, 2002). Cultural awareness, the ability to understand one's own culture and perspective as well as stereotypes and misconceptions regarding other cultures, is a first step (Campinha-Bacote, 2002; Hunt & Swiggum, 2007). The development of cultural knowledge can be introduced and explored throughout the curriculum, both in courses that are general as well as courses that teach specific therapeutic skills. Cultural skills, the ability to evaluate a client or student and develop a therapeutic treatment plan, build on the foundations of cultural awareness and knowledge. Courses that emphasize clinical and educational skills can be used to help students develop a skill set that will address the unique needs of the individual. Cultural encounters can be dispersed throughout the curriculum, with the emphasis on the application of practice skills, as the student advances in the program.

Implementation of the Campinha-Bacote Model into Curriculum Design

The next section of the guide is organized into five objectives that reflect the Campinha-Bacote model for achieving cultural competency. The objectives are further divided into specific goals along with suggestions, activities, and resources to achieve the stated objective.

Objective 1: Students will Improve their Cultural Awareness

- 1a. Students will demonstrate the ability to examine and explore one's own culture (including family background and professional program).*
- 1b. Students will identify stereotypes, biases, and belief and value systems that are representative of the dominant culture in the United States.*
- 1c. Students will demonstrate an understanding of how one's own biases and belief system may subtly influence the provision of rehabilitation or educational services and lead to cultural imposition.*

In our experience, we have found that courses that emphasize communication and therapeutic interaction offer opportunities for exploration and understanding of one's own culture. These courses are usually taught to students prior to acceptance into a professional program or during the first year. These introductory courses will sensitize students by providing information that promotes cultural awareness and knowledge, although a comprehensive program should

emphasize a continuum of cultural competence that is threaded throughout the curriculum (Campinha-Bacote, 2002; Kripaiani, Bussey-Jones, Katz, & Genao, 2006). Assignments that are specific to cultural awareness may include a class exercise in which students write about their own ethnicity/racial background. This leads to a class discussion about cultural awareness, stereotyping, and variations among cultures. Several exercises may be used within and outside of the classroom to assist students in improving their cultural awareness. They may be worked on independently or in small groups. Examples of classroom activities that may be adapted depending on the program are included in Appendix A.

Students may benefit from taking the “Implicit Association Tests” online and discussing the results in class. Project Implicit is a collaborative research effort among researchers from Harvard University, University of Virginia, and the University of Washington. There are several exercises offered on this website, and the general purpose is to elicit thoughts and feelings that are outside of our conscious control. Those who participate in these exercises are provided with a safe and secure virtual environment in which to explore their feelings, attitudes, and preferences toward ethnic groups, race, and religion. The outcome of this exercise is for students to understand that they may have an unconscious preference for a specific race, skin tone, religious group, or ethnic group. Students are provided with the opportunity to understand innate and unconscious attitudes that might influence their decision making ability in a rehabilitation setting. Refer to Appendix B for the Project Implicit (2007) website.

The Village of 100 activity takes about 10 minutes to complete and will also lead into some good classroom discussion (Meadows, 2005). Students must imagine that if the Earth’s population was shrunk to 100 persons what the representation of certain racial/ethnic groups would be like in areas that include religious representation, sexual orientation, literacy, wealth, education, and living conditions. Many students are not aware of the privilege they have experienced by living in the US and are enlightened once they examine the rates of poverty and general deprivation that are experienced by the global community. Again see Appendix B for the Village of 100 website.

Many readers may already be familiar with the body ritual among the Nacirema vignette, but we have found that it continues to facilitate self-reflection among students (American Anthropological Association, 1956). Nacirema is American spelled backwards, and this narrative describes the daily rituals of American life from an outsider’s perspective. Many of our commonly accepted practices seem very strange when seen through an outsider’s lens. The purpose of this exercise is to help students understand that although the customs and rituals of persons from other cultures may seem strange, our customs and rituals may also appear odd. Bonder, Martin and Miracle (2002) have concluded that an ethnographic approach, such as the one used in the Nacirema vignette, helps students to gain a different perspective on their culture. Appendix B details information on the Nacirema website.

Self-assessment questionnaires and surveys encourage student self-reflection and lead to group discussions and the development of cultural awareness, cultural sensitivity, and appreciation for diversity (Spence-Cagle, 2006). Several activities that enhance student self-awareness include the *Self-test Questionnaire: Assessing Transcultural Communication Goals*, the *Cultural Values Questionnaire* (Luckman, 2000) and the *Multicultural Sensitivity Scale*

(MSS) (Jibaia, Sebastian, Kingery, & Holcomb, 2000) (Appendix C). The *Self-test Questionnaire, Assessing Transcultural Communication Goals*, was developed to help students understand their knowledge and comfort level with various individuals and groups that reside in the US. Some examples of groups that are represented on this self-test are: Native Americans, Mexican Americans, prostitutes, the elderly, and persons with cancer. The objective of the self-test is to facilitate discussion and develop insight among students on their preferences and knowledge about persons who are different from themselves.

The *Cultural Values Questionnaire* asks students to rate their agreement with a series of statements. Some of the statements demonstrate values that reflect mainstream society in the US including timeliness, stoicism, individuality, while other statements reflect values that might be preferred by societies that value interdependence over independence. This exercise can be used to facilitate discussion among students on values that may be preferred by the rehabilitation provider. Students can develop strategies that tailor rehabilitation programs for persons whose values are different from the provider or the institutions that provide services.

The *Multicultural Sensitivity Scale* consists of 21 statements, and students rate their agreement with the statements on a scale of one to six. The statements ask students to rate their comfort level and willingness to accept various cultures that are different from their own. This scale can be taken on an individual basis and then used to enhance classroom discussion on students' ability to accept, interact, and feel comfortable with clients or students who are from diverse backgrounds.

Objective 2: Improve Student Knowledge of Diverse Cultures and Practices

2a. Students will understand various health, education, and disability belief systems and practices.

2b. Students will familiarize themselves with disability prevalence and risk factors among different racial/ethnic groups.

2c. Students will understand and identify racial and ethnic disparities in rehabilitation and educational services in the United States.

2d. Students will recognize and understand various cultural worldviews and disability beliefs and explanatory models.

2e. Students will identify instances when religious or traditional views may influence the client's participation in rehabilitation and educational regimens.

After general and self-awareness exercises, students can progress to the development of knowledge about other cultures. Encounters in non-traditional settings offer opportunities for students to try out new skills with clients from diverse cultures with guidance and feedback from their instructors (Luckman, 2000; Parnell & Paulanka, 2003). Students may increase their knowledge about different cultures by visiting ethnically diverse neighborhoods, exploring ethnic supermarkets and restaurants, attending religious services that are different from their own religious backgrounds, and observing programs in ethnically and racially diverse neighborhood

community centers (Jeffreys, 2006; Luckman, 2000; Hunt & Swiggum, 2007). These introductory observational opportunities should be set-up as non-threatening encounters that lead to self-reflection through written assignments and group discussions (Hunt & Swiggum, 2007). A by-product of this self-reflective process is the development of an appreciation for ethnic diversity, religious practices, food preferences, family values, health beliefs, and neighborhood community programs (Griswold, Zayas, Kernan, & Wagner, 2007). Furthermore, encounters in ethnically and racially diverse settings allow students to develop confidence when encountering clients from diverse backgrounds (Hunt & Swiggum, 2007). However, both the instructor and students must keep in mind that one or two visits to a “different” neighborhood merely introduces students to the most obvious aspects of a cultural community. Only living and interacting with members of a community on a daily or long term basis truly opens students to a culture.

The acquisition of knowledge about specific cultures can be approached in several ways. Students can access the Center for International Rehabilitation Research Information and Exchange (CIRRIE) on-line monograph series (CIRRIE, 2003). The monographs focus on the top ten countries of origin of the foreign-born population in the US, according to the US Census Bureau: Mexico, China, Philippines, India, Vietnam, Dominican Republic, Korea, El Salvador, Jamaica, Haiti, and Cuba. There is an additional monograph on the Muslim perspective. Assignments can be provided using a case study format with the monograph series as a resource.

Prior to clinical encounters, the use of case studies is also helpful in developing clinical decision making, self-reflection, and examining ethical dilemmas (Spence-Cagle, 2006). The case study format has been used to help students process, problem-solve, and apply strategies that will enhance their knowledge of culturally competent service (Lattanzi & Purnell, 2006). Therefore, case studies encourage the examination of the professional’s explanatory model and the client’s explanation of their illness experience. Explanatory models are the perceptions and beliefs that rehabilitation providers, clients, students, and their families construct about illness and disability (Kleinman, 1988; McElroy & Jezewski, 2000). They are cognitive and emotional responses based on cultural experiences (Kleinman, 1988). Therefore, explanatory models are not always transparently logical, and if the rehabilitation provider’s communication skills are based on their own perspective, the client or student may experience discrimination. In addition, through the case study format, students can be encouraged to develop *culture-brokering* skills that further expand their appreciation of various belief systems (Kleinman, 1988; Jezewski & Sotnik, 2005). Examples of case studies and case scenario assignments, that are applicable across disciplines, are found in Appendix D.

We refer to the *culture-brokering* model in this guide because it has been shown to be useful in training rehabilitation personnel in identifying and devising solutions for culturally related problems. The *culture-brokering* model was adapted by CIRRIE for rehabilitation systems, and a training workshop was designed based on the model (Jezewski & Sotnick, 2005). The model has three stages: (1) problem identification, (2) intervention strategies, and (3) outcomes. *Problem identification* includes a perception of a conflict or breakdown in communication. *Intervention strategies* include establishing trust and rapport and maintaining connections. Stage three is *evaluating outcomes*, both successful or unsuccessful. Success is achieved if connections are established between consumers and the rehabilitation system, as well as across systems. What

makes this brokering model a *culture-brokering* model is a fourth component, *Intervening Conditions*. These are culturally based factors that must be considered at all three stages: analyzing the problem, devising appropriate strategies, and evaluating outcomes. The intervening conditions include a variety of factors including type of disability, communication, age of the client or student, cultural sensitivity, time, cultural background, power or powerlessness, economics, bureaucracy, politics, network, and stigma. The model is not a set of rules or steps to follow. Rather, it is a conceptual framework that can guide the service provider in analyzing problems and devising culturally appropriate solutions. For a more detailed description of this *culture-brokering* model, including its applications to case studies, see Jezewski and Sotnick (2005).

When implementing the culture-brokering model, students must understand that health and education seeking behaviors are shaped by the individual's cultural context, and most cultural groups are heterogeneous (Rorie, Pain & Barger, 1996; Menjívar, 2006). Caution within training programs should be exercised. Knowledge of various cultures and their practices, if not considered within the context of individuals and their unique circumstances, can result in destructive stereotyping. Stereotypes that are associated with particular cultures may affect the provision of rehabilitation services in adverse ways. Therefore, although knowledge of cultures is important, students must refrain from stereotyping and be aware constantly of the heterogeneity of persons within cultural groups (Campinha-Bacote, 2002; Juckett, 2005). There are many reasons for intra-cultural variations including the individual's level of education, socioeconomic status, reasons for immigration, and regional and local differences within the country of origin. In addition, the process of immigration is complex. Immigration may be voluntary, or it may be a decision based on persecution or economic hardship. This affects the immigrant's ability to improve social status and assimilate into a new culture. Assimilation is also affected by the human, cultural, social, and economic capital that accompanies the immigrant into the destination country (Alba & Nee, 2003).

Objective 3: Improve the Student's Skill in the Assessment of Clients from Diverse Cultures and Practices

- 3a. The student will learn to determine client and student needs within the context of their culture.*
- 3b. The student will become familiar with and demonstrate the use of assessments that respect and explore client and student culture and the impact it has on their disability.*
- 3c. The student will identify culturally biased assessments and demonstrate the ability to modify or adapt the assessment to fit client and student needs.*
- 3d. The student will utilize the client's family and/or extended family in the assessment process, if designated by the client or student.*
- 3e. The student will demonstrate the ability to use a professional interpreter in the evaluation process.*

Students' ability to develop cultural skill depends on the first two constructs that were explored, awareness and knowledge. Skill development overlaps with practice and cultural encounters. Students in rehabilitation professions must understand how to use the interview process to formulate relevant treatment options for their client. Students must then be provided with clinical encounters that allow for the development of skill when working with clients or students from diverse cultures (Campinha-Bacote, 2002). Neighborhood community centers, schools, and adult day care facilities are several examples of potential sites that may offer diversity and contribute to students' fieldwork experiences (Griswold et al., 2007; Hunt & Swiggum, 2007). Through observations and clinical encounters, students develop and expand on their interviewing techniques, including the use of interpreters, the ability to become flexible with traditional assessment procedures, and an appreciation for the client's narrative (Hunt & Swiggum, 2007). The personal narrative, listening to clients or students tell their story, is best learned through clinical encounters (Griswold et al., 2007; Kripaiani et al., 2006). Students must learn when to leave aside traditional assessment procedures and encourage interviewees to describe their illness experience in their own words (Griswold et al., 2007; Kleinman, 1997). The person's view of disability does not necessarily surface when using standardized assessments that are popular among professionals (Ayonrinde, 2003; Becker, Beyene, Newsom, & Rodgers, 1998). Another approach is to adapt current assessment/ evaluation methods and identify culturally relevant assessments within each rehabilitation field.

To understand the participant's perception of disability, interviewers can use a semi-structured format that incorporates the ethnographic principles of open ended questions (Babbie, 2004). Changes and adaptations can be made to the interview questions, according to the interviewee's responses. This format may facilitate the emergence of the interviewee's personal story. Students may also use a modified version of Kleinman's eight questions and incorporate this into their interview schedule. The questions may help providers understand clients by asking for a description of what their disability means to them (Kleinman, Eisenberg & Good, 1978). Caution should be used when incorporating these questions into the interview schedule since some individuals may not choose to discuss their disability experience in this manner. See Appendix E for Kleinman's eight questions.

There are many factors that should be considered by rehabilitation providers in culturally diverse settings, and a number of these should be elaborated on and examined in depth in the academic setting. Examples are:

- Cultures vary on their expectation of formality in clinical situations. For example, Asian Americans may be more formal, especially elders (Liu, 2005; Wells & Black, 2000). Thus, clinical encounters should reflect this style of interaction.
- Some cultural groups communicate in ways that are different from the direct style of communication favored by Americans. For example, some cultures communicate in a less direct manner and rely on the context and subtleties in style to get their message across (Jezewski & Sotnik, 2005).

- Many Latin and Middle Eastern cultures do not value time in the same way as Americans. They may prioritize personal commitments over time commitments in business encounters or in adherence to clinical appointments (Sotnik & Jezewski, 2005).
- Some cultures, for example those of the Middle East, expect long greetings and inquiries about family members and their states of health. They may also expect offerings of food and drink (Ahmad, Alsharif, & Royeen, 2006).
- The assistance of an interpreter should be used to facilitate communication; however, family members should not be used in this role, if possible. The dual role of family member and interpreter may cause conflict, and valuable information may be omitted (Dyck, 1992). Clinicians must become familiar with techniques on how to use an interpreter and seek interpreters who are well-trained and artful in the subtle negotiation process between client and provider (Ayonrinde, 2003).
- In some cultures, such as the Hmong, a husband or oldest son will make decisions for all members of the clan. The individual's wishes are deferred to a designated member in the clan (Leonard & Plotnikoff, 2000). Thus, it is important to ascertain who is the primary decision maker in the family and enlist his or her help in the diagnostic and rehabilitation process.
- All clients have a history prior to their disability. Providers must balance clients' history, present condition, and potential for the future. This process is best accomplished through the dual contributions of provider and client (Fleming, 1991).
- Certain occupations and daily activities may be defined in ways that are not familiar to the provider. For example, some cultures prioritize certain daily activities (e.g. hygiene, dressing, and eating) whereas others do not (Zemke & Clark, 1996).
- Assessment tools that evaluate individual differences and preferences, including the personal narrative, should be included in the rehabilitation process (Clark, 1993).

Objective 4: Improve the Student's Ability to Develop Treatment Plans for Clients and Students from Diverse Cultures

- 4a. Students will apply previously learned knowledge and skills to develop culturally competent treatment plans in medical, educational, and neighborhood community settings.*
- 4b. Students will utilize the "Culture Brokering Model" to recognize and identify conflict that is a result of cultural beliefs and values.*
- 4c. Students will demonstrate the ability to use strategies that result in better rehabilitation and educational services for clients and students.*

4d. Students will demonstrate advocacy skills for those groups that are underrepresented in the rehabilitation and educational systems and will negotiate and network among providers to assist clients and students in achieving adequate services.

Cultural encounters allow students to apply classroom knowledge and techniques into real world settings. Students gain knowledge about different cultural backgrounds and achieve skill by learning verbal and non-verbal communication techniques. Effective learning is developed through experiences that help students become self-aware and appreciate cultural differences, thus developing acceptance and advocacy (Jeffreys, 2006). Just as students in health related curricula must fulfill fieldwork requirements to ensure that they are competent practitioners, they should also be provided with opportunities to demonstrate competence with culturally specific interactions. Provision of opportunities to gain exposure to various cultural and ethnic groups can be dispersed throughout the curriculum, at many different levels (Kripaiani et al., 2006). The progression may start with encounters that are mostly observational and progress to interactions that require formulating a plan of action, a treatment plan, or a community-based intervention. Our students have performed service work and implemented programs at refugee centers, neighborhood youth programs, international institutions, and community after school programs. As students progress through the curriculum, their cultural encounters will reflect their acquisition of cultural competence skills (Campinha-Bacote, 2002; Griswold et al., 2007; Hunt & Swiggum, 2007).

Contextual considerations that include the individual's process of immigration and assimilation should be incorporated into the assessment process. Several situations that are a result of immigration may impede rehabilitation. Therefore, students should pay attention to such factors as the disruption of family support systems and social networks, post-traumatic disorders experienced by asylum seekers and refugees, and the withholding of information that characterizes undocumented immigrants' worry about deportation (Ayonrinde, 2003). The *Culture-brokering* model (Jezewski & Sotnik, 2005) can be used to demonstrate to students that treatment planning is a process of negotiation. This problem solving model will help students recognize and identify problems related to cultural preferences or beliefs, facilitate conflict resolution through the process of negotiation and mediation, and better prepare them to advocate and network on the client's behalf.

Objective 5: Students will Develop the Desire for Cultural Competency and Understand that it is a Life-Long Process

5a. Students will develop and demonstrate the ability to empathize and care for clients and students from diverse racial/ethnic groups.

5b. Students will demonstrate flexibility, responsiveness with others, and the willingness to learn from others.

5c. Students will exhibit "cultural humility," the ability to regard clients and students as cultural informants.

By using the Campinha-Bacote Model, it is hoped that students will develop the final construct of this model, Cultural Desire. “It has been said that people don’t care how much you know, until they first know how much you care” (Campinha-Bacote, 2002, p. 182-183). Cultural desire is a result of successful cultural encounters. Successful cultural encounters are the result of good preparation and the support and guidance offered to the student throughout the process. The student should understand that this is a life-long pursuit for the professional who has a true desire to practice in a culturally responsive manner.

Griswold et al. (2007) discuss the development of empathy and cultural humility among medical students who have participated in refugee clinics. During an encounter with an elderly Vietnamese woman, a medical student tossed his checklist aside as the patient began to cry and tell him about the loss of her family members. The student discusses a transformation in his approach: “...I was going through the checklist...as she started to cry it shook me...I stopped the interview...as the empathy kicked in, the checklist started to fall out of my head” (Griswold et al., 2007, p.59). Students may find interviews particularly challenging with persons who have suffered grave personal loss or who have been victims of torture. They may at first meet failure because they are unable to show openness and flexibility during the initial assessment. Since these encounters may be difficult, they will need to be provided with opportunities to debrief and discuss their cases with instructors and other students. Opportunities for self-reflection regarding their feelings, as well as the needs of their clients, should be encouraged by their instructors (Griswold et al., 2007). Self efficacy, the belief that one can achieve competence in areas of practice, motivates students to overcome obstacles and embrace the learning experience (Jeffreys, 2006). It is our goal that the outgrowth of these exercises will provide students with positive cultural experiences that improve their confidence, engage their interest, develop their ability to empathize, and result in the desire to provide culturally responsive rehabilitation services across settings.

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Appendix A: Cultural Competence Classroom Activities

Many of these activities involve encouraging students to meet and interact with individuals from diverse backgrounds. While the experience is important, it is the opportunity to reflect upon the interactions and perceptions that will heighten cultural awareness. Reflection can be encouraged through journal writing, class discussion and debates, and role playing.

Activities

a. **Who Am I?** Students begin the process of cultural awareness by exploring their own backgrounds.

Student Assignment: Investigate your own cultural background. Try going back three generations. Make a genealogical map of your ancestors including their country of origin, family, language(s) spoken, religion, education, occupation, and beliefs regarding health/disease, disability, and education. Be prepared to discuss how you obtained your biographies, from whom, and the information that was omitted or obscure. Other areas that define the culture may be included such as family roles and rules, family support networks, music, food preferences and eating styles, entertainment, clothing, child rearing practices. Think about and be prepared to discuss how cultural influences have been maintained, changed, or have disappeared across generations.

b. **Story Teller.** Ask students to interview someone in their own family who is an especially good story teller about family life. **Student Assignment:** Interview an individual in your family who has a repertoire of family stories. Record the story(ies) he or she tells about your family's history. What is the story about, and what does it reveal about your cultural, ethnic, linguistic, religious, and racial background? What did you learn from this interview that you did or did not know about your history? Ideally, this story telling activity should be audio/video taped so that it can be presented to the class.

c. **Pix Share.** Visual history helps students understand their cultural background. Ask students to share pictures of their family and the area in which they have lived most of their life. **Student Assignment:** Find family pictures across generations, if possible. Discuss how these pictures reveal your cultural, ethnic, linguistic, religious, racial background, and living environments. What did you learn from these pictures that you did not know about your family? To whom did you go for the pictures and information about their content? Discuss how the pictures are similar or different across class members.

d. **Family Differences.** Have students discuss how their own views on cultural issues such as family, religion, health, education, and disability differ from that of their parents or grandparents. **Student Assignment:** What are your family's views on family, religion, health, education, and disability? Compare your views on these topics with that of your parents and grandparents. Also discuss family perceptions of disability especially if there is a family member who has a disability. What rehabilitation services did the family and individual access and to what success? How does your the family view disability and rehabilitation services?

e. **I See My Community.** Ask students to make a video tape of what they think best represents their individual cultural background in their home community. **Student Assignment:** Prepare a video and audio presentation that illustrates what you think is important about your community. Topics might include description of your physical and social neighborhood, education and health care options, transportation, language(s) spoken, icons that represent the community, arts, schools, and assets and problems. Compare and contrast the presentations across students.

f. **New Arrival.** Have students interview someone who has recently immigrated to the US from another country. If the individual does not speak or has limited ability in English, students should use an interpreter. Keep in mind that these are sensitive topics and not all recent immigrants may want to discuss them. Only students who are especially sensitive and grounded in cultural issues should do this assignment. **Student Assignment:** Interview a recent immigrant to the US on topics related to why the individual came to the US, the process and problems in coming, similarities and differences between the old and new communities in which the individual lives, and views on healthcare, education, and disability. Another important topic is the meaning and structure of family in the culture. If the immigrant does not speak English, you may need to work with an interpreter. Class discussion should also focus on several issues including (a) how the interviewer felt working with an interpreter, (b) problems in doing the interview, and (c) belief systems that emerged regarding health, education, and disability. This interview might be repeated with someone who immigrated 10+ years ago to determine how time in the US influenced perceptions of health, education, and disability.

g. **Exchange.** Discuss the experiences students have had to open them to other cultures; e.g. travel, having an exchange student in their home or high school, and living or working with students from other countries. **Student Assignment:** Through what experiences have you opened yourself to other cultures? Describe these. What did you personally gain from traveling throughout the US or other countries or interacting with an exchange student? What issues did you face when you spent time in another country and culture? How did these issues change over time? How do you maintain contact with persons you met from another country? Compare your perceptions from before the cultural exchange, during, and now. How have your perceptions changed?

h. **Getting to Know You.** Encourage students to “get to know” someone from a different culture during the semester and keep a journal about the experience. Remember that visiting another community for a shopping experience will not fulfill the goal of this assignment. **Student Assignment:** Ask a fellow student from another culture if you might spend some time with him or her at home. Immerse yourself in another culture by participating in family and community activities, shopping in the community, and attending church, celebration, or other activities that represent the culture. You might also tutor or mentor a student from a diverse background and discuss this experience. What did you learn about the culture? What experiences were most revealing to you? How do you think you were perceived as a visitor to the community? What will you do to maintain contact with the individuals you met for this assignment?

i. **Cultural Conflict.** Another topic for discussion is cultural conflict. Ask students what cultural conflicts occur in their community and why. **Student Assignment:** What can be done to diminish or erase cultural conflicts? Discuss how media such as television, radio, and other

entertainment venues reflect general American culture and how this is interpreted in various cultures in the US as well as around the world.

j. **Community Visits.** Have students visit a school and a hospital that are comprised primarily of those from diverse backgrounds. **Student Assignment:** Visit a school, hospital, or other agency that delivers rehabilitation services to children and/or adults who are from diverse backgrounds. Discuss how the facility reflects various cultural backgrounds – e.g. staff, language, type and style of delivery of services or classes, inclusion of family, programming, architecture and design, etc. What differences in quality of health care and educational services are apparent?

k. **Continuing Education Possibilities.** Rehabilitation students need to realize that cultural competence is a “profession-long” process. **Student Assignment:** How can rehabilitation specialists increase or improve their cultural competency once they have completed their professional degrees? What types of continuing education programs are available through local, state, or national professional organizations? What other venues are available for continuing education regarding multicultural issues?

l. **Multicultural Preparation.** Caseloads in all types of rehabilitation settings reflect an increase in clients from diverse backgrounds **Student Assignment:** Interview a variety of rehabilitation professionals who work with multicultural populations on their caseloads regarding their academic and clinical preparation for this type of client. How well prepared were they and what have they done post graduation to improve their cultural competency? What suggestions on cultural diversity do they have for clinicians entering today’s profession?

Appendix B: Website Resources

Center for International Rehabilitation Research and Information Exchange (CIRRIE) website:
<http://cirrie.buffalo.edu/monographs/index.html>

The Project Implicit (2007) website:
<https://implicit.harvard.edu/implicit/demo/selectatest.jsp>

State of the Village Report website:
http://www.sustainer.org/dhm_archive/index.php?display_article=vn338villageed

Nacirema website:
http://en.wikisource.org/wiki/Body_Ritual_among_the_Nacirema

Appendix C: Self -Tests and Questionnaires

The reader may refer to the CIRRIE Cultural Competence Website <http://cirrie.buffalo.edu/curriculum/activities/index.html> for information on the following questionnaires and resources:

- *Self-test Questionnaire: Assessing your Transcultural Communication Goals and Basic Knowledge*
Reprinted with permission from: Randall-David, E., (1989). *Strategies for working with culturally diverse communities and clients*. Association for the Care of Children's Health (ACCH), Bethesda MD.
- *Cultural Values Questionnaire*
Thiederman, S. B. (1986). Ethnocentrism: A barrier to effective health care. *Nurse Practitioner*, 11(8), 52-59.
- *Muticultural Sensitivity Scale*
Reprinted with permission from: Jibaja, M. L., Sebastian, R., Kingery, P., & Holcomb, J. D. (2000). The multicultural sensitivity of physician assistant students. *Journal of Allied Health*, 29(2), 79-85.
- Classroom Activities: *Cultural Visit, Observation Visit, and Participant Observation Visit*. Adapted with permission from: Luckman, J. (2000). *Transcultural communication in healthcare*. Albany, NY: Delmar Thompson Learning.

Appendix D: Case Studies

The following case studies are designed for students and readers across disciplines. One is specific to one or two professions (Study 1), some are designed for all disciplines (Study 2 and 4), and one is specific to speech-language pathology (Study 3). The case studies also differ in their design; some providing more detailed backgrounds (Study 2 and 3), others more study questions and cultural information (Study 2 and 4). Pseudonyms are used in all cases.

Case Study #1 for PT and OT: Middle Eastern Low Back Pain Patient

Background

Farideh Daei (*pseudonym*) is a 25 year old woman from Iran. Her physician has recommended a consult for physical therapy for low back pain. During the initial evaluation, Mr. Daei, her husband, answered all the questions directed to Farideh. When asked to rate her pain on a scale of one to ten, the husband answered, "I really don't think her pain is that bad, you can give her a three." The wife compliantly allowed her husband to answer all questions. The PT attempted a physical assessment of the back but had to limit her examination due to Farideh's reluctance to disrobe. The PT was upset after the initial evaluation and was not sure how to go about helping her client's back pain because she was unable to conduct a standard evaluation.

The physical therapist recommended a home assessment by an occupational therapist because Farideh has two children that she picks up and carries, a 2 year old and a 5 month old baby. The OT scheduled a visit to observe Farideh carry out her daily routine and made some suggestions for modifying her child care activities to protect her back. When the OT arrived at the house, she was surprised to find Mr. Daei home. He did not allow the OT any time alone with his wife and answered all questions. The OT found the situation disconcerting since she had to go through a third party in order to understand her client's daily routine. She did not feel she was able to truly assess her client's situation although she was able to show Farideh how to wrap the baby in a sling close to her body when carrying the infant. Farideh and Mr. Daei seemed agreeable to this modification.

Student Reading

Ahmad, O. S., Alsharif, N. Z., & Royeen, M. (2006). Arab Americans. In M. Royeen & J.L. Crabtree (Eds.), *Culture in rehabilitation* (pp. 181-202). Upper Saddle River, NJ: Pearson Education Inc.

Hasnain, R., Shaikh, L., & Shanawani, H. (2008) Disability and Islam: An introduction for rehabilitation and healthcare providers. *Monograph series for the Center for International Rehabilitation Research Information and Exchange (CIRRIE)*, Buffalo, NY: CIRRIE.

Discussion Questions

- What can both therapists do to gain Mr. and Mrs. Daei's trust?

- Do you feel angry at Mr. Daei for not allowing his wife to participate in the evaluation procedure? Why?
- What are some other examples of how gender can have a strong influence on communication between the client and clinician?

Case Study #2 for SLP, OT, and PT: Hispanic TBI Client

Background

Hernando Gonzales (*pseudonym*), age 63, incurred a traumatic brain injury (TBI) to the left and right frontal lobes and the left temporal lobe and broken right shoulder and leg during a car accident on March 15th of this year. Mr. Gonzales was born and resides in Mexico and was visiting his sister, Maria, for a two month vacation when the accident occurred. This was his first visit to Buffalo, NY, though he has visited Miami, Florida, and San Antonio, Texas, several times in the past 20 years. Mr. Gonzales has been a widower for 6 months and has four adult children who reside in Mexico. Mr. Gonzales completed 9th grade in Mexico and works as a security guard at an industrial site. He speaks fluent Spanish and reads and writes Spanish at about a 6th grade level. Although he has taken English immersion classes for several years and his auditory comprehension of English is good, his spoken English is limited. Reading and writing English are basic and inconsistent. He is an ardent soccer fan, enjoys Mariachi music, and attends church on a regular basis.

According to his sister, Mr. Gonzales has a history of hypertension, prostate cancer, and osteoarthritis. He had a partial knee replacement to the right knee three years ago. He wears corrective lenses that were broken during the car accident, and during the optometric evaluation to replace his lenses, early stage bilateral cataracts were noted. Three years ago Mr. Gonzales was diagnosed with a mild bilateral sensori-neural hearing loss during an employment hearing evaluation but refused amplification.

Following the TBI, Mr. Gonzales made good physical recovery. He received intensive occupational and physical therapy for four weeks in a medical rehabilitation unit. Therapies focused on gaining independence in activities of daily living (ADLs). Although Mr. Gonzales made marked improvement in ADLs, he continued to need prompting and reinforcement to initiate and complete activities such as dressing, grooming, and bathing. He still has some difficulties with walking and balance. Cognitive-communicative therapy was also implemented and stressed word retrieval strategies, sentence production related to ADLs, auditory comprehension and verbal expression, and executive skills such as planning, problem solving, and self-evaluation. All therapy stressed the use of English language. Each therapist commented that Mr. Gonzales had difficulty following simple commands given in English and preferred to communicate in Spanish even though only the speech-language pathologist was somewhat fluent in Spanish. He switched between Spanish and English during most informal conversations.

Mr. Gonzales enjoyed inpatient therapies but seemed to want to socialize with other patients and clinicians more than do therapy. Other patients did not understand his overtures spoken in Spanish. Mr. Gonzales became increasingly distracted and uncooperative when tasks involved speaking or understanding English. The female clinicians also noted that Mr. Gonzales infrequently made direct eye contact with them during therapy activities. They were also

concerned about some of what they considered inappropriate comments about female patients and therapists. Continued home-care based PT, OT, and SLP therapies were recommended at time of discharge. Mr. Gonzales stated that he would like to return to his job on a part-time basis when he returns home in several months.

Mr. Gonzales's sister, Maria Lopez (*pseudonym*) age 70, is a widow and resides in an apartment with her adult daughter Rose, age 36, who works as an accountant for a national hotel chain. Rose travels frequently for her employment and relies on friends and neighbors from their church to help her mother. Mrs. Lopez speaks only limited English and prefers to communicate in Spanish. Her daughter says that her mother actually understands English relatively well but is "insecure" about her spoken English skills with those outside the home. Mrs. Lopez indicated through her daughter that she does not want her brother sent to a nursing home and will provide care for him on an extended basis. Mrs. Lopez visited her brother almost daily while he was in medical rehabilitation, often bringing him herbal drinks, sweets, and prayer cards. Therapists noted that Mr. Gonzales became more passive when his sister visited, and he expected her to meet his needs. Thus, Mr. Gonzales will reside with his sister for the next three to four months to receive home care therapy before returning to Mexico. His adult children will visit intermittently to help with care but will be available on an irregular basis. Only two speak English fluently.

You are the speech-language pathologist, physical therapist, or occupational therapist assigned to do home care with this patient. You do not speak Spanish fluently but know some social Spanish. Consider the following questions as you prepare to work with this client in his sister's home.

Questions to Consider

1. In reviewing the background information, what cultural, physical, cognitive, communication, and environmental factors would you need to take into consideration in working with this client in a home care situation?
2. How might cultural differences be confused with or compounded by other physical, cognitive, communicative, or environmental characteristics in this case? Why is it important to differentiate cultural differences from those related to the client's other characteristics?
3. What adjustments might you make in both your assessment and intervention based on this client's cultural and linguistic background and his traumatic brain injury?

How would you enlist the help of this client's family, particularly his sister, to facilitate therapy? What problems might you have in working with them to enhance therapy effectiveness?

Resources for Working with Hispanic Clients

American Speech-Language-Hearing Association. (1985). Clinical management of communicatively handicapped minority language populations. *ASHA*, 27, 29-32.

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Case Study #3 for SLP: Korean Child with Asperger's Syndrome

Background

David Lee (*pseudonym*), age five years ten months, was diagnosed recently with Asperger's syndrome. His parents, Lisa and Adam Lee, followed the recommendation of their pediatrician, Dr. Su, to have David evaluated by the Child Study Team at Children's Hospital four months

after his fifth birthday. Dr. Su was concerned about David's lack of interactive communication skills and his preoccupation with cars. The Lees believed that David's lack of age appropriate socialization was due to being an only child who was cared for by Mr. Lee's mother on a daily basis. Mrs. Soon Young Lee (*pseudonym*), a widow, immigrated to the US from Korea three years ago to help care for her grandson while her son and daughter-in-law completed their doctoral and post doctoral programs in chemical engineering at a local university. Adam Lee, the eldest child and only son in his family, was born in Korea and came to the US for his undergraduate education at age 19 where he met and married Lisa seven years ago. Adam has no interest in returning to Korea to live and is presently negotiating a research and development position for a chemical company in the US. Lisa was born in the US shortly after her parents emigrated from Korea. Lisa is not fluent in Korean. Lisa's parents now reside in California and visit several times per year but cannot provide daily help to Adam and Lisa. Both parents are 30 years old, and Mrs. Lee is pregnant with their second child. The Lees are practicing Christians, and Mr. Lee's mother is a Buddhist.

David received a complete neurological, cognitive, and communicative evaluation at Children's Hospital several months ago. Results indicated that David verbally interacted only when spoken to and that he had difficulty with turn taking and coherence in conversations. Although David used complete sentences and a sophisticated vocabulary about his favorite topic of cars, his speech lacked inflection and sounded "robot-like." David responded to his name inconsistently, and showed little interest in play activities offered to him by either the clinicians or parents. His use of nonverbal communication, such as gaze and gestures, was also inappropriate for a child his age. The Lees stated that they believed that David's communication style in Korean is similar to what he exhibited on the day of the evaluation. David demonstrated some repetitive routines such as stacking and restacking papers and books. David has a special interest in cars and can identify cars by maker and year with precision. He brought several books on cars with him to the Child Study Team evaluation and focused on them even when his parents tried to engage him in conversation. The Lees also commented that David had advanced ability in mathematics and performed at a 5th grade level. David is expected to enroll in kindergarten this fall where he can receive speech-language therapy on a daily basis if the parents agree to the recommendations provided at by the Child Study Team. He has not attended preschool and has little socialization opportunities with peers other than when he attends church activities.

The Lees are concerned about their son's lack of interaction skills and the recent diagnosis of Asperger's syndrome. They are also concerned because Adam's mother, who provides most of David's daily care, denies that there is any type of problem. Mrs. Soon Young Lee, a former middle school mathematics teacher in Seoul, speaks Korean to her grandson and believes that he is a gifted child, not one with a communication difficulty. She encourages David's interest in both mathematics and cars and praises his precociousness to family in Korea. She told her son and daughter-in-law that they should be glad that their child is "quiet and smart; he does not talk back to adults, and that is good." She admonished them for "even thinking" that there was something wrong with their first son. Adam also indicated that there is friction with his mother because of his conversion to Christianity and what she considers his "disrespect" for her as the elder in the family.

The Lees are dependent on Mrs. Soon Young Lee for financial aid, help in the home, and child care. Mrs. Soon Young Lee has recently lent her son money for a down payment on a home. They are also concerned that Mrs. Soon Young Lee's criticism of and unwillingness to participate in therapy programs for their son will be detrimental. She has indicated that David should be placed in a school for gifted children and not labeled with Asperger's syndrome or receive any therapies. Mr. Lee states that he wants to do the best by his son, but that his mother's influence in his home is great and that to disregard her wishes will cause greater tension within the family. Mrs. Soon Young Lee has no plans to return to Korea in the near future as she will provide child care for the new baby and David.

Discussion Questions

1. What problems might a multi-generational and multi-cultural family such as this have in understanding Asperger's syndrome?
2. Why do you think the grandmother is so averse to her grandson being labeled with Asperger's syndrome and receiving therapy? How much of her perception is cultural? Related to her personality?
3. Suppose you were the clinician working with this child in kindergarten in a public school, how important would it be to work with the grandmother regarding the nature of and treatment for Asperger's syndrome? What are the advantages and disadvantages of enlisting her help or providing information to her?
4. What referral(s) might be useful in this case? To whom would you refer, and how would you convince the Lees to follow through on the referral?
5. What other issues other than cultural differences toward disability emerge in this case?
6. What resources can you find on Korean culture that might help you to understand the grandmother's perspectives on Asperger's syndrome? Compile a reference list.

Case Study #4 for OT, PT, SLP and RC: Hispanic Physical and Communication Disability

The following case scenario is an example of a culture bound syndrome that is a health belief among some Hispanics. Answer the questions that follow, relying on the *culture-brokering* model and Kleinman's eight questions to assist you with your approach.

Background

Carlos Garcia (*pseudonym*), a 50 year old Mexican man, is the foreman of a construction crew. He was experiencing chest pain one day at work but did not tell anyone until the pain became so unbearable that he collapsed. An ambulance was called, and Mr. Garcia was taken to the local county hospital. Although he speaks some English, he was not able to provide his medical history due to his severe pain. Mrs. Garcia, who speaks very little English, arrived at the hospital extremely distraught. The Garcias do not have medical insurance and usually rely on the local *curandero* for health advice.

Mr. Garcia was stabilized, and he eventually underwent an angioplasty of the Left Anterior Descending coronary artery with the insertion of a stent. Although the procedure was successful, Mr. Garcia suffered a minor stroke while on the operating table. He presents with mild to moderate slurring of his speech (dysarthria) and a clumsy hand. Upon discharge from the hospital, his physician recommended cardiac rehabilitation, occupational therapy, and speech therapy, but since Mr. Garcia does not have health insurance, he refused. While Mr. Garcia was recovering at home, his wife would not allow him to do anything around the house, even his normal household chores. His wife was clearly close to exhaustion herself since she also cares for her two small grandchildren.

Mr. Garcia has been very depressed. He is worried about working again and if he will be able to continue to earn a living. He is also very scared about having another heart attack. Mr. Garcia is having trouble sleeping, has nightmares, and is losing weight. Mr. Garcia complains, "I no longer feel like a man."

Mrs. Garcia is taking her husband to a local *curandero*, who is treating him for *susto*, "soul loss." She is using various herbal remedies and a change in diet, which relies on the hot and cold model. Because heart conditions are considered hot illnesses, the *cuandero* is recommending whole milk and coconut.

Upon his follow-up visit, the physician assistant, who speaks Spanish, referred Mr. Garcia to the clinic's insurance facilitator. He was qualified for a health maintenance Medicaid insurance program. He will be attending a cardiac rehabilitation program that is run by a physical therapist. Occupational and speech-language therapists will see him in the home setting, and a referral has been generated for rehabilitation counseling to evaluate his potential to return to work.

Questions for Students

1. How would you approach this case and what are your primary concerns?

Students should be concerned first and foremost for Mr. Garcia's health. This can only be accomplished if students understand Mr. Garcia's explanatory model for what has happened. This model may be different from the health care provider, and communication may involve a process of negotiation and strategies to overcome conflict and advocate for Mr. Garcia's well being. The provider must realize that Mr. Garcia is mourning the strength he once had and his role as the provider of his family. Through education and monitored involvement in activity, Mr. Garcia may gain confidence and realize that he is not as fragile as he thought and that he can once again regain his role as the breadwinner of the household. His resumption of work may depend on work modifications and the practice of energy conservation techniques. Contact with his employer may be helpful if Mr. Garcia is willing to adjust his work load as needed.

2. Who are the major players, and what would you do to gain their trust?

Students should realize that Mrs. Garcia and the *curandero* play an important role in Mr. Garcia's health and should be included in the treatment negotiations. Treatments can be discussed with the *curandero*, and suggestions and adaptations to the regime may be negotiated. For instance, skim milk or 1 percent can replace whole milk, and defatted coconut milk is available. Mrs.

Garcia's role as caregiver should also be considered. She may be concerned that her husband will die, and that fear motivates her to assume his chores around the house. Work simulations with careful monitoring might help Mr. Garcia to gain confidence and help his wife to realize that he is not an invalid. Her role should not be diminished but redirected to facilitate the therapy goals.

Assigned Readings

[CIRRIE Monograph Series](http://cirrie.buffalo.edu/monographs/): <http://cirrie.buffalo.edu/monographs/>

Jezewski, M.A., & Sotnik, P. (2005). Disability service providers as culture brokers, In J. Stone (Ed.), *Culture and Disability: Providing culturally competent services*. Thousand Oaks, CA: Sage Publications.

Santana–Martin, S., & Santana, F.O. (2005). An introduction to Mexican culture for service providers. In J. Stone (Ed.), *Culture and Disability: Providing culturally competent services*. Thousand Oaks, CA: Sage Publications.

Thompson, T., & Blasquex, E. (2006). The smorgasbord of the Hispanic cultures. In M. Royeen & J. L. Crabtree (Ed.), *Culture in rehabilitation: From competency to proficiency*. Upper Saddle River, NJ: Pearson Education Inc.

Learn More about the Client

As you are reading background information on Mexican and Hispanic cultures, pay attention to several outstanding themes that will affect delivery of services to persons from this particular background. Under each heading, write several examples of the Hispanic view regarding the topics. Note contrasts and similarities between the dominant white culture in the US and Hispanic beliefs and values. Note: Realize that Hispanic culture is heterogeneous and that the examples in the readings are general and they are subject to individual variations and community influences. An individual's level of acculturation is affected by a variety of factors including but not limited to education, migration patterns, family influence, and socioeconomic status.

Concepts of Disability and Illness

Persons from Mexico and other Hispanic cultures may not differentiate between physical and mental illness. The balance between a person and his or her environment is considered important to one's health. Health is a balance of one's emotional well being, spirituality, physical health, and God's will. Genetic problems or developmental disabilities may be viewed with shame and guilt, blamed on the parents, and looked upon as some type of divine retribution. Mental disability carries more stigma than physical illness. The family and community also feel a joint responsibility for the person with a disability, and institutionalization is rare.

Independence versus Interdependence

Nurturing those who have disabilities is considered an important role. Conflicts may result if rehabilitation personnel are working toward independence, but the family does not want to give up the role of caregivers. Independence may not be valued; relationships and roles may be based on interdependence. Evaluation tools that measure the level of caregiver assistance may not truly reflect rehabilitation potential or the ability to assume a role in the family and society. For example, the Functional Independence Measure (FIM™) is a measurement of Independence in

Activities of Daily Living. Scores are based on the amount of assistance that is needed from the caregiver.

Machismo and Marianismo

Machismo is sometimes seen as having a negative connotation. It can also be positive in that a man protects and provides for his family and defends them. In Hispanic families, the man assumes the responsibility for providing for his household. Role conflicts may emerge when families are separated because of job opportunities in the US or when there is a disability or illness. When Hispanic women assume the breadwinner role, there may be conflict with traditional values within the home. Traditionally, boys are given greater freedom than girls, and men are expected to be strong.

A woman's role may be viewed according to the concept of marianismo. Marianismo is based on the Catholic interpretation of the Virgin Mary, who is both virgin and mother. Women are considered spiritually superior to men and capable of enduring suffering.

Personalismo

Personalismo refers to the Hispanic custom of making small talk before getting down to business. Showing an interest in the other person is considered polite before approaching matters at hand. This may result in misunderstandings and poor communication of vital information in busy hospitals, clinics, and agency settings where a person is expected to provide important medical or personal information upon request. Hispanic persons may also inquire about the service provider's personal life. This reflects a desire to understand something about the person who is providing the care. Health care providers who do not understand this may avoid answering questions about themselves. In the US, provision of personal information about oneself to a client is considered unprofessional.

Alternative Health

Curanderos and Espiritualistas

Curanderos are traditional Mexican healers; *Yerbalistas* are herbalists; and *Espiritualistas* are spiritualists. One may first procure the services of a traditional healer before utilizing Western Medicine. Physicians and health care providers have been known to work with *Curanderos* and spiritual healers and negotiate positive results for the client.

Beliefs Regarding Hot and Cold Remedies

The hot-cold model refers to a Hispanic belief that diseases and disorders can be classified into hot or cold groups. A hot condition must be treated with a cold food or medicine, and a cold condition must be treated with a hot food or medicine.

The following conditions are considered hot illnesses: skin ailments, pregnancy, ulcers, and heart problems. Some cold foods are milk, bananas, coconuts, and beer. Cold ailments may include those that are invisible or that result in immobility such as painful conditions, arthritis, menstrual problems, and colds. Hot foods are evaporated milk, chocolate, onions, and liquors. Penicillin is considered a hot medicine. An example of a conflict that might arise because of this hot-cold

belief is when a physician advises a cardiac patient to avoid high cholesterol foods such as whole milk or coconuts.

Health Risks for Hispanics

- Diabetes is two times more prevalent among Hispanics
- Hypertension is common
- Obesity
- Cervical cancer is double among Hispanic women
- Higher mortality rates from cancer

Questions for Students about Hispanic Cultures

1. Identify the variety of cultures that fall under the umbrella of "Hispanic." Note the variation in their migration practices. Discuss the problems that have accompanied various Hispanic groups in the US.

Students should discuss the various waves of Hispanic immigration from Castro's Cuba (first wave and recent), refugees from El Salvador, Guatemala and Nicaragua, and Mexican immigrants, both legal and illegal. They should be aware of the problems that are encountered due to language, poor socioeconomic status, access to health care, and the problems that are unique to illegal immigrants.

2. Compare concepts of work and activities of daily living among Mexican or Hispanic persons to the values generally purported by the US. How does this affect those who are disabled?

Those who are disabled, including members of society who are not able to work or earn money, may still be valued and serve other purposes in the community. Visiting, planning community events, helping others, and talking with others are valued roles within a community.

3. The commodity based society in the US differs drastically from the matriarchal society. Explain the differences and the impact this has on disabled persons.

The student should note that in a matriarchal society the roles of the mother, for example caring for others, are valued. In contrast, a patriarchal society values earning money. An elderly person, or one who is disabled, may still feel valued in a matriarchal society and fulfill a role. For example, cooking for others is valued and fulfills a role. In a commodity based system, if one does not earn money, their "work" may not be valued.

4. Discuss the barriers that Hispanic immigrants face when they are disabled or ill (structural and cultural barriers). What health risks affect Hispanic immigrants, and why are these risks more common among this group?

Students should be aware of the structural and cultural barriers that play a role in access to health care. Structural barriers include language, transportation, insurance, and the

ability to pay for medical services. Cultural barriers may include mistrust of the medical system, the practice of seeking native healers first, and different explanatory models regarding illness, and disability.

Some of the health risks, such as diabetes, have an evolutionary and genetic component. It is thought that high blood sugar was an evolutionary survival adaptation among native persons. Many of the risks may be due to lack of preventative care secondary to lack of resources and insurance.

Activities to Improve Knowledge about Hispanic Cultures

- Visit a market in a Hispanic neighborhood. Ask the store personnel about different foods that are unfamiliar to you and how to prepare them.
- Visit a Botanica, a market where natural remedies and herbs are sold. Discuss healing rituals and practices with the store personnel.
- Visit a cuandero or folk healer and learn about the different healing modalities that are used.

Appendix E: Kleinman's Eight Questions to Assess the Patient's Perspectives (Kleinman, 1978)

Note: Rehabilitation professionals provide services to clients who not only have experienced illness, but long and short term disabilities that may be a result of developmental disorders, illness, or an accident. The following questions were modified in order to include those who are experiencing a disability.

1. What do you think caused your problem (disability)? Remember that in some cultures it is inappropriate to question why something occurred.
2. Why do you think your problem (disability) started when it did?
3. What do you think your sickness (disability) does to you? How does it work?
4. How severe is your sickness (disability)? Will it have a short or long course?
5. What kind of treatment do you think you should receive?
6. What are the most important results you hope to obtain from this treatment?
7. What are the chief problems your sickness (disability) has caused you?
8. What do you fear most about your sickness (disability)?

Part II: Cultural Competence in the Physical Therapy Curriculum

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Introduction

The education of physical therapists is rapidly moving toward the clinical Doctor of Physical Therapy (DPT) degree. This unyielding pace is in response to the Commission on Accreditation of Physical Therapy Education (CAPTE) narrowing the scope of its accrediting activity to include only post-baccalaureate programs after January 1, 2001 (American Physical Therapy Association, 2005). This response has resulted in numerous programs in physical therapy education adopting new curricula. Many of these curricula are integrated following a systems based approach, and emphasize evidence based practice, differential diagnosis, and cultural competence (American Physical Therapy Association, 2004).

The Guide to Physical Therapist Practice and a Normative Model of Physical Therapist Professional Education, Version 2004, provide the context for the doctoral level PT education. The Normative Model practice expectation defines cultural and linguistic competence as a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations (Office of Minority Health, 1999). The physical therapy profession advocates that graduates be prepared to provide physical therapy to all populations who can benefit from our services.

Physical therapy students are educated to be autonomous practitioners who have direct access to patient care in over 80% of states and practice privileges in all settings. Physical therapists practice in a broad range of inpatient, outpatient, and community-based settings. Physical therapists must have the ability to adapt and be flexible to the changing needs of health care while critically examining many possible choices in clinical decision-making. Specific to this role of the physical therapist is the focus on habilitation, rehabilitation, prevention, and wellness. Each of these roles requires effective communication with the patient/client. Physical therapists must have the ability to know when to refer and/or collaborate with other health care professionals and community agencies. Autonomous practice requires a conscious awareness of ethical, power, and socio-cultural dynamics in society and the health care system (Romanello, 2007). Academic institutions must determine that students are ready for practice and are deemed competent.

Competence is a statement of the relationship between ability (in the person) and a task (in the world). The dictionary definition of competence is: “qualified, capable, and adequate for a specified purpose” and uses synonyms such as suitable, sufficient, efficient, apt, and appreciate (Webster’s New Riverside Dictionary, 1984). Competence as stated in the normative model implies having the capacity to function effectively as an individual and an organization within

the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities. Competence is concerned with what people can do rather than what they know. A working definition of professional competence is the ability to use professional knowledge and skills to solve problems that arise in daily clinical practice (Kane, 1994).

The extent to which individuals can perform in various situations that arise in their area of practice defines competence within these encounters. The general public puts trust in professional practitioners and views them as competent to the extent that they can provide appropriate help to the client. Appropriate help is measured by the public based upon how well the professional is able to communicate with them about their problems, manage their problems, and answer their questions (Colliver, Swartz, Robbs, & Cohen, 1999). In this age of accountability, the professional (physical therapist) is assumed by society to be competent. Society trusts that academic institutions and accrediting and licensing agencies will produce only competent individuals. Physical therapists must be trained to intervene with patients from a variety of ethnic, religious, and other diverse backgrounds but must also be deemed competent (in their ability) in a clinical setting (the real world).

In 2007 the American Physical Therapy Association (APTA) reported that approximately 12% of its members are of color, with student membership slightly more diverse (American Physical Therapy Association, 2007b). In contrast, the US Census Bureau (2007) reports that approximately 25% of the US population are individuals whose ethnic background is Black, American Indian, Asian, Pacific Islanders, or Hispanic. Thus, physical therapy educators need to address how students will become competent in providing care to patients from diverse cultural backgrounds, most of which will differ from their own. As demographics of the United States become more diverse, educators need to adopt a contemporary view of cultural competence. Physical therapy practitioners must understand that cultural competence is an integral component of overall clinical competence.

All physical therapy (PT) programs are preparing to meet new accreditation standards for their DPT curriculum. The Commission for the Accreditation of Physical Therapy Education (CAPTE) has clearly outlined that the physical therapist professional curriculum includes content and learning experiences designed to prepare students for initial practice in the profession of physical therapy (American Physical Therapy Association, 2005). To achieve accreditation, physical therapy programs must identify where content is presented that meets the criteria. In addition, programs must provide examples/descriptions of the learning experiences that are designed to meet these practice expectations. They must also provide examples of course objectives that demonstrate the expected level of student performance.

In regards to cultural competence, CAPTE expects that students will identify, respect, and act with consideration for patients/clients' differences, values, preferences, and expressed needs in all professional activities. When students are working with patients, they need to problem solve issues that may present as cultural barriers to working toward the best possible rehabilitation outcome. Identifying social-cultural issues is a requirement for devising an appropriate patient plan of care. No matter what the role of the PT is at any given point in the rehabilitation process, cultural competence is an essential skill in providing effective health care. Patient participation in the rehabilitation process can be drastically affected by cultural collision as demonstrated in the

book, *The Spirit Catches You and You Fall Down*, the true story of a Hmong child, her American doctors, and the collision of two cultures (Fadiman, 1997). This story describes how miscommunication, as well as differing worldviews of disability, can affect how one views impairment and whether or not specific interventions will be valued. This book makes great required reading for preparing students for a cultural curriculum.

CAPTE also mandates that students effectively educate others with culturally appropriate teaching methods that are commensurate with the needs of the learner to determine a plan of care that is acceptable, realistic, *culturally competent*, and patient-centered to achieve goals and outcomes. Patient education is integral to the success of PT intervention, patient compliance and carry-over of home activities/exercise programs.

Students must also be able to select outcome measures to assess individual outcomes of patients/clients using valid and reliable measures. Such measures must consider the setting in which the patient/client receives services, *cultural issues*, and the effect of societal factors such as reimbursement. When students are involved in patient case activities in the classroom or clinic, they must identify cultural issues that present barriers to effective client care and then defend strategies to manage these issues. PT students must also be aware of other societal issues such as the ability to pay for rehabilitation services. There is a direct correlation between poverty and the ability to access medical care. Being among the working poor, where the employer does not offer health insurance, is a growing epidemic in the United States (Leavitt, 2002). Lack of medical coverage is a common problem in the US, and immigrants, both documented and undocumented, comprise a large portion of the underinsured (United States Bureau of the Census, 2007).

CAPTE also requires that PT students provide culturally competent services involved in prevention, health promotion, fitness, and wellness programs to individuals, groups, and communities. Thus, the curriculum must include activities that challenge students to promote culturally appropriate health and quality of life to diverse populations.

The Patient/Client Management Expectation for Management of Care Delivery (American Physical Therapy Association, 2004) states that students shall provide *culturally competent* first-contact care through direct access to patients/clients who have been determined through the screening and examination processes to need physical therapy care. This expectation is very important as the majority of states now have direct access to physical therapy services. In addition, students must be able to provide *culturally competent* care to patients/clients referred by other practitioners to ensure that care is continuous and reliable, as well as in tertiary care settings in collaboration with other practitioners.

As we head toward a more diverse society, we must begin to value diversity in many dimensions including ethnicity, class, gender, religion, sexual preference, physical ability, body habits, and more (Welch, 2003). Traditional PT education has focused upon a Western biomedical model of healthcare with limited regard for socio-cultural variables (e.g., visiting a faith healer) (Leavitt, 2002). Thus, new educational methods and materials are needed that emphasize culturally competent care. There is also a need for valid and reliable measures to assess the outcomes of these educational strategies.

Implementation of Cultural Competence into the Physical Therapy Curriculum

Faculty members' desire to educate culturally competent practitioners plays a prominent role in the curriculum change process (Romanello, 2007). The first step in this educational reform is the building of excitement, comfort, and cohesion among faculty about cultural competence. With only 12% of PT and PTA members of the APTA reporting minority status, it is safe to say most faculty (most of whom are APTA members) are also of a non-minority status or have little to no experience in providing care to clients of diverse backgrounds (American Physical Therapy Association, 2007a). Although it would be ideal for PTs to be proportionately representative of all ethnic groups, it is most important that all PTs, no matter what their ethnic background, to be culturally competent (Leavitt, 2002).

The faculty movement should be lead by individuals who have a strong educational and practice foundation in providing culturally competent care. Education may be obtained at the pre-professional level or through continuing education. Faculty with practical experience in working with diverse cultures can be especially valuable to students. It is important, moreover, that programs support faculty continued education and exploration of cultural curricular teaching. PT faculty might also use cultural teaching resources from other rehabilitation professions (e.g. occupational therapy and speech-language pathology) as well as education, medicine, and business. Faculty should share their educational and professional experiences that focus on cultural competence and encourage infusion of ideas across the curriculum.

Agreement upon the operational definition of cultural competence is indispensable to outline the plan for building a cultural curriculum. To start, it is usually easiest to begin with agreeing upon what cultural competence is not. Most authors agree that it is *not* abandoning your own culture for another, nor is it being familiar with all attitudes, values, and behaviors of all other cultures that exist. Rather, to be culturally competent, one should be able to acknowledge the influence of culture and appreciate ethnocentricity (e.g. believing that our own culture is the norm), reduce stereotyping and misperceptions, gain knowledge about patient's/client's culture and lifestyle, and be able to adapt interventions and the physical environment accordingly (Leavitt, 2002).

It is essential that faculty members are grounded firmly in their own cultural awareness. Such knowledge and skills enhance the inclusion of cultural issues throughout the curriculum. Faculty education might include the use of self-assessments of cultural awareness and the previewing of cultural audiovisual educational programs. Again, collaboration with other rehabilitation, medicine, and educational faculty provides excellent opportunities for continuing education and sharing of successful educational methods and materials.

When cultural competence is infused across coursework, faculty and students understand that it is essential, not elective, knowledge and skill. Cultural competence is an integral component of clinical competence and should be viewed as such by faculty. Purtillo (2000), in her address at a national APTA conference, called for cultural competence to be a non-negotiable skill, subject to rigorous testing similar to kinesiology or any other core component of the PT profession. Decisions about curriculum and instructional methods are often more political than educational, and the reality is that not all faculty will be passionate about this content. Conflict can arise when

faculty fear they are losing control over course content, and therefore themes that represent all faculty need to be tied together to gain cohesion. Integration of some key cultural concepts (e.g. communication, ethics, how people learn, etc.) throughout courses in the curriculum will ensure that methods begin to cross course boundaries. Faculty must arrive at consensus about what cultural competence knowledge and skills students should obtain and what educational and assessment methods best achieve these outcomes.

Relating the educational experience to Stephen Covey's *Seven Habits of Highly Effective People* (1989) can help to outline a general approach to embrace curriculum infusion of cultural competence. The second of these seven habits is "begin with the end in mind", and can be applied when faculty discuss cultural competence as a means to the end (Covey, 1989). It prompts the PT faculty to view cultural competence in terms of the integrated curriculum objectives and real life situations. It forces faculty to determine "what really matters" when we send our graduates out to practice in our health care community. How do we want our graduates to conduct themselves when they are practicing and what outcomes do we want for the patient/client?

Experts from the practicing community, such as clinical instructors (CI) who provide clinical education experiences, are an integral component in deciding how to infuse cultural activities and competencies throughout the program. Clinical instructors have a valued interest in educating students who will be entering their profession. A cooperative effort between college and externship faculty reinforces the value of cultural competence as an essential professional skill.

It seems appropriate in the PT curriculum to have one course that has primary responsibility for general cultural awareness training and that serves as a foundation throughout the curriculum. Courses that have been appropriate for this primary responsibility are usually either professional development or case management courses. Such courses highlight the overarching theme of the "science" and the "art" of PT. Other courses in the curriculum should infuse cultural related outcomes (e.g. how to inspect for skin infection on a Black patient, how to assist patients who do not have insurance coverage in accessing services, how to understand the different ages of developmental milestones secondary to cultural practices etc.) that build upon the agreed operational definition of culture competence. Problems may occur when faculty do not communicate and plan effectively to ensure that knowledge and skills are infused across courses in a systematic and sequential manner.

Teaching Material

The Commission on Accreditation of Physical Therapy Education and Normative Model of Physical Therapist Professional Education gives latitude in how cultural competence is built into the curriculum. It does, however, hold educational programs accountable so that students are able to demonstrate cultural competence through a combination of coursework and clinical education experiences. Camphina-Bacote (1991) suggests four factors that contribute to culturally competent care: cultural awareness/sensitivity, increasing cultural knowledge/worldviews, developing cultural skills and participating in cultural encounters. In order to integrate multicultural topics in the curriculum, it is advantageous to designate courses that will serve to:

(1) introduce cultural concepts of awareness/sensitivity (**Introductory** courses); (2) provide the primary information regarding culturally appropriate assessment and intervention skills (**Primary** courses); and (3) develop cultural skills through case studies or patient interactions (**Supplemental** courses). Table 1 outlines sample coursework where cultural topics may be typically found in many PT educational programs across the country. The course titles are taken from typical DPT curriculums that were randomly chosen from five programs in the states of New York, California, Florida, Ohio, and Texas. Although some of the course names differ, the content is similar within each box (Table 1).

Table 1: Sample Coursework for Cultural Topics

Introductory	Primary	Supplemental
Colloquium Introduction to PT (skills)	Foundations of PT Movement Science	Cardiopulmonary PT Medical Diagnosis
Professional Development Professional Practice	Case Management Integrated Patient Management Clinical Pathology	Musculoskeletal PT
Health Promotion and Wellness	Critical Analysis of Patient Care	Neuromuscular PT
	Professional Development Professional Practice Clinical Issues	Integumentary PT
	Psychosocial Aspects of Rehabilitation	Evidence Based Practice Critical Inquiry Pharmacology Leadership/Management
		Clinical Experiences Practicum Experiences

Utilizing the Patient/Client Management model from the *Guide to Physical Therapist Practice* will help to outline content areas to cover within introductory, primary, and supplemental courses (American Physical Therapy Association, 2001). These six areas of the model are outlined in Table 2.

Table 2: Infusion of Cultural Curriculum

Elements of Patient/Client Management		Areas to Infuse Cultural Curriculum
Examination	History, Systems Review, Tests and Measures	Own Cultural Awareness Recognizing Values/Priorities Accessing the patient's perspective Culturally sensitive communication Modesty Touch and exposure of body parts Gain Trust
Evaluation	Clinical Judgments	Power/Powerlessness Prejudice, Influence, Stereotyping Learned Helplessness Nonverbal Communication Invisibility of our own Culture
Diagnosis	Impact of a Condition on Function	Interpretation of Clinical Diagnosis Patient Education
Prognosis	Plan of Care	Provision of Care, whom will be involved? World Views Socio-economics Patient/family Goals
Intervention	Purposeful Interaction of PT with Client	Non-traditional modalities of Care Cultural Barriers to Care Use of Translators
Outcomes	Statistical Reports	Goal Achievement Patient Satisfaction Surveys

Examination

The examination element is performed for all patients/clients and is required prior to any intervention, treatment, or care. The initial examination is a comprehensive screening leading to specific selection of tests and measures (American Physical Therapy Association, 2001). The examination is comprised of the history, systems review, and selected tests and measures. The history includes a face to face interview with the patient/client, family, and caregivers and a review of pertinent records and charts. Types of data that may be collected through the history are general demographics, chief complaint, social, medical and surgical history, medications, employment, work or social activities, living environment, general health status, family history, current and pre-morbid functional activity, and results of other clinical tests.

Kleinman's "Eight questions to access patient perspective" (see Part I, Transdisciplinary Guide, Appendix E), is an excellent vehicle to teach students how to ask culturally appropriate questions during a patient interview, to gain further insight, and break down cultural barriers. Davis (2006), in her experiential manual for developing the art of health care topics, suggests activities that focus on appropriate communication styles with cultural sensitivity.

To become culturally competent in patient examinations, PT students need to first have an awareness of how they define their own culture. Several cultural self-assessment exercises are available for use with physical therapy students. An introductory exercise is to ask students, without prior discussion, to identify in writing their religion, social class, race, place born, ethnicity and place they spent the majority of their life. From this information create a "cultural statistics" chart for that cohort of students. Using the chart, the instructor can facilitate a discussion about the definitions of race, culture, and ethnicity. Formal education about key concepts such as culture, ethnicity, race, diversity, stereotyping, acculturation, and foreign born persons etc. can be found in the monograph series, *The Rehabilitation Provider's Guide to the Culture's of the Foreign-Born* (Center for International Rehabilitation Research Information & Exchange, 2001-2003). Another exercise has the students identify their primary cultural characteristics (nationality, race, sex, age, religious affiliation), and secondary cultural characteristics (education, socioeconomic status, occupation, military experience, political beliefs, physical characteristics, sexual orientation, married, children). This can be found in chapter one in the Lattanzi and Purnell text, *Developing Cultural Competence in Physical Therapy Practice* (2006). After students identify their primary and secondary characteristics of culture, they can explore how these have changed over their lifetime, if they remain similar to their family, and how their primary characteristics influence their view of the world, attitudes, and values.

Understanding our own personal values is integral to understanding how our values shape our choices. Having students engage in a values priority exercise will help them develop insight into the values they have learned unconsciously at home. Values priority exercises usually have people rate each value as not very important, important or very important. Examples of values include achievement, aesthetics, altruism, autonomy, creativity, emotional well being, health, honesty, justice, knowledge, love, loyalty, morality, physical appearance, pleasure, power, recognition, religious faith, skill, wealth, and wisdom (Davis, 2006). Students enjoy comparing their values with others and easily discuss how these values relate to therapeutic presence. In addition, they can discuss what to do when values differ from their patients.

Cultural exploration can culminate in a reflective paper to be shared in small groups within the class. This cultural awareness paper challenges students to use the values and priorities they have explored to explain how their traditions, religion, and cultural practices make them similar to or different from others. Within the paper students should create a plan for increasing their awareness of other cultures. This reflective paper can also be used to develop classroom panel discussions. Appendix A outlines student requirements for the paper.

Another exercise when beginning a cultural unit should include a survey of one's ideas about the beliefs and attitudes students have toward culturally sensitive care with patients. The Health BELIEF Attitudes Survey Instrument (IPC MS 1 Survey), created by Medrana and Dobbie of the University of Texas Health Science Center at San Antonio, was developed for medical students or practicing physicians (Appendix B). This survey asks the opinion of the health care provider about the patient-professional relationship surrounding culturally competent care, in particular about communication.

Students' initial orientation to clinical care or entrance colloquium offers an early forum to introduce the topic of multicultural sensitive patient care. In these learning experiences, students are trained in the importance of culturally competence care and how this important theme will be infused throughout their academic and clinical coursework and experiences. One innovative way to reinforce the importance of cultural competence is to have faculty role model a culturally competent examination with a patient (either real or simulated) in front of a new class of PT students. This exercise motivates students and lays a firm foundation of how we expect students to practice at the end of the program (beginning with the end in mind).

After completing a patient history, the PT will begin a hands-on systems review. For this portion of the examination, it is critical the PT chooses appropriate tests and measures to assess a patient and thus arrive at a clinical diagnosis. Careful planning will help create a positive first impression that the PT is culturally sensitive to the patient's needs. Such cultural competence helps generate patient cooperation and compliance. The hands-on portion of the examination should pay particular attention to gender issues, modesty, and family involvement. The necessity of the review should be explained and permission sought. The patient or family member must be involved in exploring alternative ways of performing the review, if desired. The systems review is a brief anatomical/physiological examination of the four systems: musculoskeletal, neuromuscular, cardiopulmonary, and integumentary systems. In reviewing the musculoskeletal system, PTs need to place their hands on various body parts and expose the spine to assess symmetry of the body (posture), gross range of motion, and strength of the joints.

For the neuromuscular review, the PT will assess coordinated movements of balance, ambulation, and transfers. Patient education is imperative before proceeding with the systems review as patients wonder why PTs are looking at their ability to ambulate when they have pain in their shoulder. For the cardiopulmonary review, the PT will take vital signs including heart rate, respiratory rate, blood pressure, and edema. For the integumentary review, the PT will assess skin integrity, skin color, and presence of scar formation. This portion of the review can require dialog about skin conditions not clearly visible due to skin coloring or skin scars/bruises from cultural practices such as coining. Coining is commonly practiced in Southeast Asia. It is

an alternative form of medicine involving rubbing heated oil on the skin and vigorously rubbing a coin over the area until a red mark is visible.

During a systems review, it is important to assess the patient's ability to communicate his or her needs. Areas to assess include the ability to communicate verbally and nonverbally, affect, cognition, languages spoken, and learning style. This communication assessment will alert the PT to anticipated emotional/behavioral responses as well as learning barriers/educational needs of the patient. All of the information gathered in the systems review will help PTs identify problems that can be handled within their scope of practice and those that require consultation with another provider.

The PT will use this information to decide which specific tests and measures to proceed with to most effectively complete the examination. The selected tests and measures are used to rule in or rule out causes of impairment and functional limitations, to establish a diagnosis and prognosis, and to form a plan of care. The tests and measures should be chosen to confirm or reject a hypothesis about the factors that contribute to the patient's current level of functioning and support clinical judgments about appropriate interventions, goals, and outcomes (American Physical Therapy Association, 2001).

Evaluation

The evaluation component of the patient/client management model is where the PT makes clinical judgments based upon the data gathered from the examination. The evaluation takes into account not only the clinical findings from the examination but also the chronicity or severity of the current problem, preexisting conditions and the stability of the condition. Other factors that weigh heavily in the evaluation are the patient's living environment, social support system, and cultural beliefs.

During the evaluation phase of patient care, the PT is called upon to make judgments about the patient's condition in order to arrive at an appropriate diagnosis. The patient-practitioner relationship puts the PT in the position of power, especially when decisions about rehabilitation and living arrangements are made. Many times patients feel powerless due to their conditions, and this can be amplified when cultural and or communication barriers are present. Clinical judgment needs to be made without prejudice or preconceived ideas. As the outcomes of patient care are dramatically affected, PT students need to recognize what it means to be powerful, what it feels like, and what behaviors are associated with powerlessness.

A dramatic, powerful way to introduce the topic of prejudice, influence, and stereotyping is to have students view *Eye of the Storm* with Jane Elliott (1970). In this dramatic documentary Jane Elliott divides her students into two groups: those with brown eyes and those with blue eyes. She does this in order to teach her third grade class what it feels like to be discriminated against based on a physical characteristic over which one has no control. This award winning experiment takes place in an all-white, all-Christian small town following the assassination of Dr. Martin Luther King, Jr.

On day one Elliott tells the divided class that brown-eyed people are stupid, dirty, lazy, etc., and gives advantages to the blue eyed children in class. In a matter of minutes, the blue-eyed students

assume the superior role and get the gleam of power in their eyes. The brown-eyed students sink in their chairs, and their school performance declines. On the second day Elliott tells the class that she made a mistake; blue-eyed people are the inferior ones. And hence, the cycle begins again. Following both groups being on the receiving end of discrimination, Elliott brings them together to talk about how they felt. She helps the children to draw connections between the experiment and racism in the world.

Following the viewing of the movie, class discussions could be lead on key points such as 1) the ease with which the students conformed to their teachers proposition of superior/inferior status, 2) the non-verbal responses of the students, 3) and the phenomenon of “learned helplessness.” Learned helplessness is an emotional, motivational, and cognitive disability that results from exposure to non-contingent, unavoidable punishing consequences (Gentile, 1997).

How these concepts relate to clinical examples of patient care can be the focus of discussions. In discussing the notion of superior/inferior status one can provide cultural examples of when patients feel they are in a subservient situation and may not question authority or be an active participant in their rehabilitation process. Regarding the nonverbal responses, it is helpful to talk about the powerful effects of our nonverbal communication when patients may tell us things that are different from our own beliefs and values and how this can impact the patient/practitioner relationship. The learned helplessness phenomenon should be explored in terms of patient compliance and motivation in response to our expectations for our patients/clients. Students should discuss the positive steps that they can take, as therapists, to avoid the barriers that are mentioned in the above key points. In addition, they should explore and develop an understanding of the underlying cultural components that influence these points.

In order for students to approach the evaluation with some aptitude, they should be given the opportunity to develop some basic knowledge of different cultures. It is unrealistic to expect a person to know the multitude of cultural values and differences in the world. While it is a daunting task to expect students to become familiar with all of the many types of cultures they may encounter, it is still worthwhile to expose them to a chosen few, if only to illustrate the necessity to gain some general skills. Faculty can direct students to explore the ethnic make-up and new immigrant groups in the geographical area of the campus or clinics and use this information to guide specific information gathering.

Some cultural givens can be so deeply imbedded in thought patterns that they are invisible to those who hold them. This is demonstrated in the video *Communicating between Cultures* in which people wear glasses of different shades to depict the dangers of stereotyping (Schrank & Diffenbach, 2004). This non-threatening video shows how to make some of these patterns visible and improve communication. It uses people of similar age to most college students and the situations are familiar to many of us in daily life. Following the video, class discussion can focus on the key points that have potential for patient interaction (Appendix C). The concept that cultural imposition is relatively unconscious in our culture is directly linked to previous discussions and exercises on self-assessment.

Diagnosis

Diagnostic labels can describe multiple dimensions of the patient/client from the cellular level to the highest level of functioning in society. Physical therapists use diagnostic labels to identify the impact of a condition on overall function of the person as a whole. The process of obtaining a diagnostic label involves integrating the data that were obtained during the examination to describe the patient/client condition. This information will help in determining the prognosis, plan of care, and intervention strategies. The diagnostic label will indicate the primary dysfunction toward which the physical therapist directs interventions (American Physical Therapy Association, 2001).

Making the diagnosis requires the student to sort data into categories using a scheme relevant to that patient/client. This sorting of data can be practiced with case studies where students are given various amounts of information along the way, and they then create appropriate classification schemes. This can also work well with examples of actual patients that students have interacted with during their clinical experiences. It is advantageous to have students collect and document (following HIPAA requirements) actual patient cases while they are on their clinical experiences. These can be used for further discussion in the classroom.

Examples of case assignments that students can collect during their clinical experiences and bring back to campus to share with their classmates are listed in Appendices D and E. Students should outline at least one case of a patient/client who has a culture different from their own. This assignment facilitates active discussion about culturally appropriate care. Primary and supplemental courses lend well to focusing on various systems involved in clinical cases while maintaining focus on culturally appropriate patient interaction.

Prognosis

The prognosis is the determination of the predicted optimal level of improvement in function and the amount of time that will be needed to achieve that level. The prognosis is in part based upon patients' socio-cultural life, particularly their economic position. Students typically have great difficulty with this element of patient/client management as it takes experience (hands-on clinical) to become proficient in making a prognosis. Prognosis may be best discussed after students have had some clinical experiences.

The plan of care, an integral component of the prognosis, should reflect goals (short-term and long-term goals), specific interventions to be used, and the duration and frequency of interventions needed to achieve the stated goals. Primary courses should focus upon writing culturally appropriate goals that include the family and support system. The supplemental courses should focus on introducing interventions that are typically used with patients/clients in a specific practice pattern and take into consideration the expectations of the patient/client and appropriate others (key for culturally appropriate care). Supplemental courses should enhance the introductory and primary course materials and continue to build upon experiences and knowledge in many practice contexts with client/patients from diverse backgrounds.

The anticipated goals and expected outcomes also address risk reduction, prevention, impact on societal resources, and patient/client satisfaction. Prognosis is key to determining what

patients/clients view as important to them for their rehabilitation. This area of the patient/client management model is most crucial for progression of cultural competence and should be enforced throughout the primary and supplemental courses targeted. Specific information that the PT student needs to consider is the impact of the patient's socio-economic status on ability to get care. The student should be comfortable and practiced seeking information from patients about their ability to pay for care, provide transportation if needed, carry out home exercise programs, and access family support.

Intervention

The intervention component of the patient/client management model is where the PT uses various physical therapy techniques to produce change or improvement in the condition consistent with the diagnosis and prognosis. Decisions about interventions are based upon evaluation results, patient/client response, and progress made. Students may choose interventions that fall into three categories: (1) coordination, communication, and documentation, (2) patient/client-related instruction, and (3) procedural interventions.

The coordination, communication, and documentation processes are intended to ensure that patients/clients receive efficient, appropriate care from initial visit to discharge. Working effectively with all parties involved in the patient/clients' care is essential. The verbal or written exchange of information must be culturally appropriate, in language and intent, to be successful. Patient related instruction can involve informing, educating, or training patients, care givers, or others to optimize the benefits of PT interventions. The exchange of information and instruction is pivotal in PT intervention in the US where face to face contact time with the patient/client is minimized due to reimbursement and job vacancies. Students often struggle with how to provide optimal instruction to patients who speak languages other than their own or who have different learning styles. Students should use technology for written translation into other languages and programs for patient instructions in pictorial form when appropriate.

The use of interpreters during the intervention phase of care can be extremely beneficial though many times overlooked. Although state laws require the use of interpreters in medical care when necessary, the reality is that most agencies do not have the funds or ability to provide them. Interpreter phones are often difficult to use and cumbersome when trying to develop rapport with patients. If a translator is provided many times it is just for the examination phase only. While helpful in obtaining information, it does not facilitate interaction during intervention with the patient. When possible, PTs should avoid the use of family members as interpreters.

At this point it is appropriate to challenge students to problem solve issues of cultural barriers that exist in the medical field. Real life cases such as those depicted in the *Worlds Apart* video modules can be used to accomplish this objective (Grainger-Monsen & Haslett, 2003). Award-winning physician/filmmaker Maren Grainger-Mosen and filmmaker Julia Haslett developed this documentary film and teaching vignettes to explore culturally diverse patients' and families' experiences with the American health care system. *Worlds Apart* captures many of the conflicts that arise when patients and health care professionals come together with different perspectives on health, illness, and medicine. The real patient vignettes shed light on how cross-cultural conflicts arise and can affect health care decisions and patient compliance. The video has an

accompanying facilitator's guide to help the instructor explore ideas about cross-cultural issues and learn from the actual experiences of patients, family members, and clinicians.

Reexamination is also an integral component of the intervention element of patient/client management. Decisions made during reexamination include determining whether predicted outcomes are reasonable and if modification is necessary. During reexamination, the PT may also identify the possible need for consultation with or referral to another provider. To be successful at reexamination the PT student must understand the roles of other health care providers. Primary courses could be used to introduce students to other health care professionals. Students should engage in case presentations of patients/clients that involve interdisciplinary teams.

Service Learning/ Community Based Projects

Primary Courses should give students opportunities to actually practice culturally sensitive patient care. Higher education programs for a variety of developing health care professionals have embraced service-learning as a method of instilling cultural competence in their students while teaching methods to meet the needs of their community. The literature available on service learning opportunities is limited for physical therapy, but vast in other health care professions such as nursing. A definition of service-learning commonly used in the literature is "structured learning experiences that combines community service with explicit learning objectives, preparation, and reflection" (Reams, 2003, p. 145). Potential benefits to involved students include increasing confidence in applying technical skills of their profession in a variety of settings, developing cultural competency, increasing awareness of disparities in health care, and developing professional and civic responsibility (Worrell-Carlisle, 2003). Some hallmarks of a successful service-learning relationship are that the needs of the group receiving services are met, those being served experience growth, and the group that is providing the service is involved in active learning. This is best achieved by establishing a recurring project with open communication between the community organization and the service program (Hamner, 2007).

Differing opinions exist about the time commitment necessary to make an impression on students, but shorter experiences can have a positive effect on students and may prevent negative feelings of increased stress in response to a demanding volunteer schedule. It is recommended that students are involved with the planning, execution, and evaluation of service-learning programs for maximum benefit. Completion of reflective exercises is almost universally considered an attribute of service-learning (Brown, 2007; Reising, 2006; Yoder, 2006).

Through participation in a structured program of community outreach, students will have opportunity to gain and practice skills in the areas of examination, evaluation, and intervention in culturally rich environments. Two examples of culturally rich learning activities such as "A Day in the Life of..." or a "Screening of Local Refugees" are outlined below and can be embedded in primary courses such as case management.

A Day in the Life of...

This learning experience requires students to spend a day long experience with a person with a disabling condition (minimum of 6-8 hours). This can be one day or broken up into various

components, i.e. medical/therapy visits, support group attendance, employment or social experiences, ADL's in home and community, other activities....(family get-togethers).

Students prepare a scripted interview, using Kleinman's eight questions to access patient perspective, to conduct with their chosen person. This interview includes conversation about a person's belief of etiology, coping mechanisms, impact of disability upon themselves and family, and cultural and spiritual background. Information about the person's career, education, social, and activity life should all be explored. This experience will give students an opportunity to practice interviewing while exploring sensitive issues of religion, culture, and socio-economic status. Upon obtaining this information students should analyze how cultural perspectives have impacted intervention and outcomes. In addition, they should explore what resources the person has used to cope with his or her disability. Based upon these resources or lack of, students should research and visit community organizations that could be advantageous for their person with a disability.

This community based project can contain some of the following requirements:

Table 3: A Day in the Life of....Project Requirements

Disabling condition overview	Definition, description, diagnosis, treatment, implications and impact
Interview with a person with the disabling condition or with a collateral service provider/health professional (other than a PT)	Medical condition, impact, services, issues, reactions, coping, accomplishments, challenges, cultural perspectives, beliefs, spirituality. How does society treat them?
Rehabilitation role & plan	What is your role as a PT? What are the roles of other health care professionals? Identify any potential cultural barriers to care and plans for improvement.
In-person contact with community organization or support group	That supports or educates about this disabling condition, agency structure, services, resources, and links, overall evaluation.
List of related support groups and community services.	Name, location, meetings, leadership etc.
Literature review	A minimum of 5 related articles that either support or contradict your interpretation throughout the paper. One article should relate to the coping mechanisms described.
Summary	What is it like to live life as a person with this disabling condition? Analyze the interventions of all health care professionals involved. Are they appropriate? Where can improvements be implemented?

Students can work in small groups of three, prepare a written report, and present their results. The groups have the option of having the person they met come to class to give his or her perspective on disability and coping mechanisms. These presentations have proven to be extremely powerful to the audience. When presenting from the patient's perspective, most focus on spiritual and cultural/family coping mechanisms to assist with the disabling condition. Feedback from students about this project has been extremely positive and rewarding. Students have expressed that the project gave them great insight into the barriers people face during the rehabilitation process and challenged them to seek alternative solutions based upon cultural beliefs and family values.

Screening of Local Refugees

Students may have difficulty relating to the life situations of the refugees they meet. Cultural mannerisms and phrases used by students may be misinterpreted as offensive or disrespectful by the refugees. For example, components of a physical examination, such as lifting a teenage girl's shirt to check for scoliosis, may be incompatible with a family's cultural beliefs, and adjustments to the screening plan will need to be made. Refugees have been traumatically displaced from their homes and are challenged to survive in a completely different culture with a new language. Separation from family members, loss of material possessions, malnutrition, and torture are several unfortunate common experiences. Ability to manage the nonverbal emotional reaction to stories of a patient's suffering can be difficult for a student but necessary for effective interaction.

Another example of a community outreach program is to provide physical therapy screenings for local refugee individuals and families. Expected benefits for refugee participants include increased comfort communicating with and being examined by American medical professionals, education about health risk factors, and improved access to physical therapy services. Expected benefits to student participants are increased cultural awareness, opportunity to practice screening skills, and an increased sense of social obligation and responsibility.

In preparation, students should attend an orientation session, receive informational handouts and a recommended reading list, and complete a short survey about their cultural views and expectations of the experience. On site, students meet with refugees, communicating through an interpreter, if necessary. This encounter focuses on obtaining a brief health history and completing a short physical examination of routine vital signs, anthropometric measurements, and observation of musculoskeletal alignment and active range of motion. The students then discuss the results of their screening with the participants and make recommendations for follow up care, if needed. Follow up surveys should be completed by student and refugee participants to identify areas for future improvements in the program. In addition, students have an opportunity to reflect on their experiences.

Language barriers have been identified as a significant source of miscommunication, dissatisfaction, and reduced patient compliance with recommended treatments. Most students participating in the refugee screening project will have no prior experience working with someone who does not speak English. Students report following this clinical experience that it is not necessary to be fluent in a patient's native language, but just speaking a few key words can encourage a patient and build a connection (Romanello, 2007). Supplemental courses also

provide an opportunity for role playing activities involved in communicating with non-English speaking patients/clients. Another way to emphasize the importance of communication is to use international students within the university who speak a language other than English for role playing activities. One PT student at the University at Buffalo developed a guide of Spanish terms for the physical therapist after completing a clinical experience at a setting where over 80% of the patient population spoke Spanish as their only language. This guide contains words and phrases that are commonly used in patient/client management in PT encounters. It can be accessed on the CIRRIE website, <http://cirrie.buffalo.edu/curriculum/resources/spanish.html>

A good preparatory exercise, prior to performing screens with refugees, is to have the students view and discuss a video such as, *Communicating Effectively through an Interpreter* (Roat, Braganza, & VanderHoof, 1998). This video helps providers to work effectively with a trained interpreter and also to guide an untrained interpreter. Many refugees will relate their health history through a story common to their culture. This will be particularly challenging for students who often rely on detailed checklists when taking a patient's medical history. Students will need to know the patient's spoken language and some details about their migration history. Some refugees will not be comfortable sharing their immigration history with relative strangers and students should be cautioned about being too intrusive.

Additionally, cultural beliefs regarding healthcare can make it difficult to communicate a rationale for treatment, even with a technically skilled interpreter. Also, family involvement should be included in this intervention process. Students will have to analyze and incorporate family roles in the decision making process.

Some of these challenges will be mediated by the many class activities that have been outlined above as well as the orientation session and a targeted reading list (geared to the culture or plight of the individuals with whom they will be interacting). Even in academic programs where cultural competence is a main mission of the PT program, students report they want more resources to deal with diverse patient situations they confront during their clinical experiences (Romanello, 2007). This refugee screening experience pulls together the cultural learning activities and gives them confidence for the challenge of providing culturally competent care while on clinical experiences and in future careers.

Outcomes

As the termination of PT services approaches, the PT is responsible for measuring the outcomes of the services provided. Students need to be able to quantify the impact of PT interventions on the patient/client condition, function, disability, prevention, societal resources, and satisfaction. Systems courses that supplement the cultural curriculum should provide information regarding specific outcome measures that are useful in measuring treatment effectiveness. Achievement of specific goals set with the patient during the prognosis phase of patient/client management will determine if outcomes were achieved. The outcome or construct identified as the target of the rehabilitation process needs to be important to the patient and his/her environment. In order to evaluate rehabilitation success, it is imperative that the student has written culturally appropriate goals that include the family and support system.

Outcome measures are classified as either performance or self-report. Performance measures indicate specific change in performance in a given environment and at a given point in time. Examples of performance changes in physical therapy are typically ambulation (quality and distance), transfers, endurance, balance, etc. There are several standardized tools available that can be used to assess specific functional performance with patients (i.e. Tinetti, Timed Up & Go, Gait Speed Index, Berg Balance Scales, Functional Reach Test...) (Kane, 1994). While these measures have been reported to provide more accurate data than self-report measures, they will not give a global impression of improvements in the patient's quality of life or overall functioning.

Self-report measures are particularly useful for measuring constructs that cannot be observed with performance (i.e. pain, satisfaction, energy level). They can also be used to gain information about how patients are functioning on a daily basis in their customary setting. One way to have students assess outcomes is by gauging the contentment of patients with physical therapy. Students can develop their own patient satisfaction survey as a requirement in appropriate courses such as critical analysis of patient care or case management. This survey should include questions about culturally appropriate care. This exercise is most fruitful when students individually develop the survey and then ask a peer to review and provide input on the assessment. Students may also implement their survey with a variety of patient/clients while on clinical experiences. The only explicit instructions for this assignment are for students to include questions about their ability to take into consideration the patient's needs, values, and priorities. If students attend a facility where a patient satisfaction survey is already being used, they may adopt it or revise as appropriate. Students should be cautioned about the influence of individuals giving assistance to patients in completing self-reported measures as a potential source of bias. Self-report measures should be designed for the patient to complete independently or through a neutral third party (interpreter, non family member, or non health care provider).

Clinical Experiences

The average length of time spent on clinical experiences in PT academic programs is 35 weeks with an average of four experiences. Most programs require a mixture of inpatient and outpatient experiences. Although clinical experiences are listed as a supplemental course in the culture curriculum, they provide opportunities to practice skills in all six elements of the patient/client management model (Tables 1 & 2).

Academic faculty should seek clinical sites that facilitate students' ability to interact with diverse societal groups. If these sites are not located close to the academic setting, students should be encouraged (required) to complete at least one experience outside of the geographical campus area. Surprisingly, culturally diverse populations are available in rural and small town settings, not only major metropolitan areas. With the current demand for health professionals, many rural clinical sites are offering housing and meal provisions for student experiences. While on clinical rotations, students should be given the opportunity to share their experiences working with diverse groups. The use of technology, e.g. the Internet, can facilitate the sharing of experiences with diverse patient cases. Course information on diversity is enhanced through weekly postings on diversity issues. Although students appreciate the opportunity to work in culturally diverse facilities, they also express the need for appropriate class time preparation for these experiences and more resources to deal with diverse patient situations (Romanello, 2007).

Assessment of Cultural Competence

The academic institution is charged with determining that students meet entry-level requirements for competent practice. If cultural competence is important enough to embed into the curriculum, it should also have an assessment portion that bears weight in measuring student performance. All assessment methods should be meaningful, applied consistently to all students, and linked to the intended learning outcomes.

The Commission on Accreditation of Physical Therapy Education (CAPTE) requires that program faculty utilize a variety of effective methods to assess student competence, safety, and readiness to progress through the curriculum. The validity of any competence must be based, at least in part, on the professional judgment of experienced physical therapy practitioners including those with an interest in education and culturally sensitive care. Since culturally rich learning activities should be infused across the curriculum, the assessment of cultural competence should be a collective faculty process. The involvement of the entire faculty in the assessment of cultural competence will lead to greater validation and integration of curricular content.

Assessment drives learning and has powerful effects on student outcomes, how they learn, and how they go about their studies (Frederiksen, 1984; McLachlan, 1997). How students are assessed will determine how they view the expectations and how they react to opportunities to learn and respond to feedback. If students are mainly assessed for their knowledge of facts, they tend to develop a learning strategy of rote memorization. When assessment focuses on the comprehension and integration of knowledge, students tend to develop a more deeply oriented learning strategy (Martenson, Hakan, & Kerstin, 1999). It seems the traditional approach of paper/pencil testing may not be the best for testing competence in culture.

A concept known as the “steering effect” means that students learn best those subjects in which they expect to be examined (Kemahli, 2001). Students tend to become more ‘mindful’ and conscientious if curricula or exercises will be observed or graded (Epstein & Hundert, 2002). Thus, course work or experiences that focus on becoming culturally competent should not be viewed as “fluff” in the curriculum or “soft” material but rather as an essential clinical skill. Students must be assessed on their skills in working with patients/clients different from themselves. An assessment that challenges them to apply what they know in a real or simulated work situation will likely improve their ability to generalize, integrate, synthesize, and interact effectively (May, Straker, & Foord-May, 2002). In turn, if assessment is focused on applying and doing, faculty will be inclined to teach how to apply and do, which is vital to becoming culturally competent.

Assessing clinical competence in physical therapy education is most commonly accomplished through the use of practical examinations (Nayer, 1995). Typically these examinations are generated from a single course and do not integrate concepts across the curriculum. Students generally perform techniques learned that semester on peers or faculty members. The encounter is usually scored by one examiner using an arbitrary standard. Reliability or validity of practical examinations is usually not known or tested (Panzarella & Manyon, 2007).

An alternative assessment tool, with demonstrated reliability and validity, is the use of a standardized patient (SP) examination. Standardized patient examinations use trained lay people who present a particular medical condition and have been used successfully in medical education for over three decades (Barrows, 1993). The elegance of the SP examination is its ability to portray patient concerns of depression, anger, silence, cultural barriers, bad diagnostic news, death and dying, signs of domestic violence, or other issues. Students may not always be exposed to each of these issues in their clinical education experiences, nor can faculty members or peers authentically role play them (Edinger, Roberston, Skeel, & Schoonmaker, 1999; Ladyshevsky, Baker, Jones, & Nelson, 2000). Standardized patients can be recruited from the new immigrant population who speak in their native language.

The use of SP examinations in physical therapy education is just beginning. Most programs have begun implementing them for teaching purposes or the effect they have on student confidence and attitudes (Black & Marcoux, 2002; Boissonnault, Morgan, & Buelow, 2006; Hale, Lewis, Eckert, Wilson, & Smith, 2006). To date, no studies in medicine or other health professions have examined the assessment of students' cultural competence through the use of an SP examination. This is an area that deserves further investigation as a reliable and valid way to assess students' competence in meeting the needs of culturally diverse patients. The integrated standardized patient examination (ISPE) is a newly created version of the SP exam that can be used to assess the student's clinical and cultural competence in a simulated clinical setting (Panzarella & Manyon, 2007). The ISPE requires students to perform a history, targeted tests, and measures and to respond to questions from a trained standardized patient. The entire encounter is recorded. The SP asks questions about his or her case that requires students to integrate material across the curriculum and communicate it effectively back to the SP. This integration component can also allow for assessment of cultural competence. In one such case encounter of a patient with a diagnosis of cervical radiculopathy, following the history and physical examination, the SP asks the student, "Members of my family have used spiritual healers when we lived in Puerto Rico, do you think I should try one?" The student responses are scored using a rubric by faculty, the SP, and a peer (Appendix F). Students also complete a self-assessment. Students take the feedback/scores from all sources and document the strengths/weaknesses of their encounter and a plan for improvement in a self-assessment paper placed in their academic portfolio.

The entire process of participating in the ISPE has been described by the students as an extremely valuable experience. Although it began as anxiety provoking, it challenged them to think on their feet like no other experience ever had. Anecdotal accounts from students who have participated in the ISPE are positive and perceived as closely reflective of real life clinical encounters (Panzarella & Manyon, 2007). The ISPE creates a cognitive challenge for students in that they must apply their knowledge in a real-life clinical situation. Self-assessment challenges students to analyze their performance, to distinguish and discriminate their behaviors, and to organize their patient encounters. The self-assessment paper stimulates students to think at the highest levels of the cognitive domains, and to synthesize and evaluate their abilities (Gentile, 1997).

Components of the curriculum only hold weight when students are expected to be tested; the same is true for cultural competence. When developing a cultural curriculum, it is best to think

with the end in mind. Faculty should first answer how they will be satisfied that students have a defined standard of competence in culturally appropriate care prior to graduation and then create the learning experiences and activities around this standard. Assessment of cultural competence should not be viewed as disconnected from clinical competence but rather an integral component of it.

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APPENDIX A: Reflective Paper

Reflective Paper: My Cultural Awareness

Scoring Guide:

Exceptional = 4

Strong = 3

Emerging = 2

Needs Work = 1

Content	Exceptional	Strong	Emerging	Needs Work
Opening paragraph clearly defines the topic and purpose of paper in relation to assignment.				
Purpose is clear, identifies personal cultural traditions and/or religious traditions.				
Identifies how they are like all human beings, like some human beings and like no other human being.				
Interpretation	Exceptional	Strong	Emerging	Needs Work
Ideas presented show complex reasoning, well thought out.				
The author's "culture" is clearly defined.				
Ideas presented show evidence of original thought from personal experiences.				
Ideas for ways to improve the author's awareness of cultural and religious beliefs of his or her patients are apparent.				
Ideas presented engage the reader.				
Organization	Exceptional	Strong	Emerging	Needs Work
Ideas and concepts show a logical development that reaches a conclusion in the final paragraph.				
There is a clear sense of sentence structure, transitions, and verbal clarity.				
Mechanics	Exceptional	Strong	Emerging	Needs Work
Spelling, grammar, and punctuation are appropriate.				
Paragraphs have an opening topic sentence and are well organized in length and structure.				

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APPENDIX B: Health BELIEF™ Instrument Attitudes Survey

IPC MS 1 Survey					
Give YOUR opinion for each item using the responses below. Bubble in your responses using the <u>SCANTRON</u> sheet provided.					
Strongly Disagree	Moderately Disagree	Mildly Disagree	Mildly Agree	Moderately Agree	Strongly Agree
1	2	3	4	5	6
1) Physicians should ask patients for their opinions about their illnesses or problems.					
2) It is important to know patients' points of view for the purpose of diagnosis.					
3) Patients may lose confidence in the physician if the physician asks their opinion about their illness or problem.					
4) Understanding patients' opinions about their illnesses helps physicians reach the correct diagnosis.					
5) A physician can give excellent care without knowing patients' opinions about their illnesses or problems.					
6) Understanding patients' opinions about their illnesses helps physicians provide better care.					
7) A physician can give excellent health care without knowing a patient's understanding of his or her illness.					
8) Physicians should ask their patients what they believe is the cause of their problem/illness.					
9) A physician should learn about their patients' <i>cultural</i> perspective.					
10) Physicians can learn from their patients' perspectives on their illnesses or problems.					
11) Physicians should ask their patients why they think their illness has occurred.					
12) Physicians should ask about how an illness is impacting a patient's life.					
13) Physicians should make empathic statements about their patients' illnesses or problems.					
14) Physicians should ask patients for their feelings about their illnesses or problems.					
15) Physicians do not need to ask about patients' personal lives or relationships to provide good health care.					

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APPENDIX C: Communicating Between Cultures

The point of this exercise is to appreciate cultural differences instead of hiding from them or fearing conflict. Have the class view the video *Communicating between Cultures* (Schrank & Diffenbach, 2004) together and then divide into small groups to respond to the following questions. The key to these discussions is to keep an open mind and to see the situation from the other person's point of view rather than to pass judgment on the culture. It is important to stress during discussion that it is unlikely that the average person would remember a long list of cultural differences. Instead we need to be aware that cultural differences exist and often explain what seems to be illogical or even rude behavior. It is unrealistic to expect a person to know the multitude of cultural values and differences in the world. For each of the vignettes on the video have students respond to these questions:

- Glassland
 1. What is the meaning of Glasslands?
 2. What is meant by the "built in eye glasses?"
 3. Imagine you are transported to Glasslands today with no built in eye glasses. How would you be received by Glasslanders if your message were that "it's time to remove your glasses and see the world as it really is?"
- Fred the Gardner
 1. Is Fred merely too quick to judge or is he prejudiced?
 2. Why does the video show BOTH Fred and Jose wearing sunglasses?
- Lee knows Chinese Food
 1. Is this situation an example of ethnic discrimination?
- Language
 1. How do you feel in the presence of a conversation you do not understand?
 2. Do you feel differently if you perceive that the conversation is ABOUT you?
 3. Comment on this statement: "...Americans think English, French, and Irish accents are cute and charming. But they don't find Asian accents as attractive." Is this prejudice or truth?
- Direct vs. Indirect
 1. Say what you mean, get right to the point, and speak your mind are American virtues. How is this different from other cultures that view social harmony as more important?
 2. How does this work when Jared asks Tabore for a ride?
 3. How could this affect patient care...or the clinical instructor/student relationship?
- Kim is offered help
 1. Is Mike giving Kim a brush off or is there a cultural misunderstanding here?
 2. Why does Kim seem hurt by the fact that Mike won't help now?
- Illya lands a job
 1. What cultural difference caused the confusion in this example?
 2. What is the assumption Brianna has made?
- Frishta and Alex
 1. Should Alex have known NOT to offer Frishta a high five?
 2. What is the best way to approach or respond to a similar situation (ever have a pt, who wants to hug and kiss you?)

(Schrank & Diffenbach, 2004)

APPENDIX D: DPT Clinical Case Outline

Using the Guide to Physical Therapist Practice

You must complete 3 cases. Please have them complete and ready to present at the start of the semester, following your prior clinical experience

One case should be a multi-system (at least 2 co-morbidities); one case should involve at least 2 health care team members (i.e. PT, OT, or SLP); and one case must involve a patient with a culture that is different from yours.

Student's Name:

Facility Attended:

Practice Pattern/System:

Pattern: ICD-9-CM Code:

I. EXAMINATION:

Patient/Client History
Systems Review
Tests and Measures

II. EVALUATION:

Clinical Judgment
Impairments/Problems

III. DIAGNOSIS:

Primary dysfunction
Secondary/tertiary dysfunction

IV. PROGNOSIS:

Amount of rehab time
Goals/objectives
Plan of Care

V. INTERVENTION:

Coordination, Communication, Documentation
Therapeutic Exercise
Functional Training
Manual Therapy
Devices and Equipment
Physical Agents

VI: OUTCOMES:

Re-evaluation

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APPENDIX E: Case Presentation

You are to pick two cases from either of your clinical experiences. You will have a total of 35-40 minutes to present each case. The presentation must consist of 2 parts: a small group presentation (lecture/information) and small group interaction. You may divide the allotted 35-40 minutes between the two parts as you see fit.

A. Small Group Presentation:

Part of the case will be presented to the entire group. This presentation will take place in your small group of three students. You should use handouts or other supportive material (pictures represent a 1,000 words!). This presentation will be assessed, by a randomly chosen classmate in your small group, based upon your presentation style, completeness, interest, educational content and your learning experience. Since you will probably only use 15 minutes to present, you must emphasize only a few points about the case that you think will be particularly interesting or helpful to your classmates. You should, however, include enough information for all to grasp the case. Be as creative as you wish.

B. Small Group Interaction:

The second part of the case is to be presented in your same small group of 3. The guidelines are wide-open. You may give a written copy of a case with some things left off and have groups fill in the blanks, or you can provide a case and have your peers answer different or same questions. Try to ask “good” questions that stimulate thought and discussion, such as, “How could the patient’s practice of visiting a faith healer affect his outcomes?” Avoid questions like, “What would the short term goals be?” You could have the group do written work to hand in or give your peers 5-7 minutes to work on several discussion points and then report back to entire group. Again, be as creative as you can and think deeply.

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APPENDIX F: Measuring Integration

Patient question	“Why does the pain feel different in my neck, shoulder, arm and hand?”		
Student response	Satisfactory 3	Marginal 1.5	Unsatisfactory 0
To explain normal physiologic or biomechanical mechanisms.	Good explanation, in a manner understood by the patient, uses model or visual image, talks about structures in the cervical spine referring the pain.	Explanation not clear or not supported by visuals, language does not match the patient’s level of understanding.	Disregards question, confusing explanation, language confuses the patient.
Patient question	“When you were doing testing, why does it hurt when I tilt my head to the (L) side?”		
Student response	Satisfactory 3	Marginal 1.5	Unsatisfactory 0
To explain abnormal physiological or biomechanical mechanism	Good explanation, talks about compression on nn root and spinal structures. May use model or visual image, in a manner likely understood by the patient.	Explanation not clear or not supported by visuals, language does not match the patient’s level of understanding.	Disregards question, Confusing explanation, language confuses the patient.
Patient question	“Members of my family have used spiritual healers in Puerto Rico; do you think I should try one?”		
Student response	Satisfactory 3	Marginal 1.5	Unsatisfactory 0
To discuss prognosis, the role of intervention/ Prevention or 2 complications	Explains that the PT can work with a spiritual healer and that they are interested in learning more about the practices so that it can be an adjunct to the PT program.	May show some support for pts beliefs but appears skeptical and attempts to sway patient away from using a spiritual healer.	Does not support patient’s beliefs or talk about other therapy interventions. Disregards patient’s question. States spiritual healing has no evidence to support its efficacy.

Panzarella, K., & Wylegala, J., 2007, University at Buffalo, Buffalo, NY