COMMENTARY

▲ Facilitating Culturally Integrated Behaviors Among Allied Health Students

Katherine Barrett, OTD, OTR/L

This article offers a perspective on why culturally integrated behaviors are important for allied health education and suggestions of methods to facilitate such behaviors. Literature and theory are used to support cultural integration in allied health curricula. Examples of learning experiences from students in cross-cultural environments and reflections on those experiences further elucidate facilitation methods. J Allied Health. 2002; 31:93–98.

"If you wish to help a community improve its health, you must learn to think like the people of that community."[1]

AS THE UNITED STATES becomes more diverse in race and ethnicity, allied health students increasingly are working in cross-cultural practice sites. Preparing students for practice sites in diverse cultural settings is a challenging and crucial process for allied health curricula to address. Academia no longer can afford to focus only on knowledge and skill levels of students; curricula need to be broadened to facilitate humanistic behaviors in students to foster positive interactions with others.

Today allied health professionals are more likely to encounter patients from different cultures that have varying beliefs regarding medicine and therapy. Increasingly, health care is recognizing the importance of culture in practice. Dilliard et al[2] stated that when patients perceive an environment of open-mindedness and acceptance from therapists, they may begin to share their own culture and suggest treatment ideas consistent with their culture. When patients' beliefs clash with dominant cultural beliefs underpinning U.S. health care, patients may be perceived as foreign, irrational, or simply wrong which may provide an obstacle to delivering care. Academic curricula can prepare students better with an understanding of their personal beliefs, their professional values, and tools to understand and use culturally integrated behaviors and to mitigate potential cross-cultural problems.

Dr. Barrett is a postdoctorate fellow, School of Pharmacy and Allied Health, Creighton University, Omaha, Nebraska.

Received November 16, 2000; revision received March 26, 2001; accepted July 5, 2001.

Address correspondence and reprint requests to: Katherine Barrett OTD,OTR/L, 6609 Parkwood Road, Edina, MN, 55436; telephone: (952) 936-0274; e-mail: <kbarrett17@hotmail.com>.

Culture and Health Care

When defining culture, one must be cautious. *Culture* has been used too often to describe only that which appears different in looks, behavior, or values.[3] Using the term *culture* in such a way would suggest that familiar looks, behaviors, and values do not qualify as culture. Everyone has culture, whether it appears familiar or foreign. Culture implies the integrated patterns of human behavior that include thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups.[4] It provides a road map or a lens from which one comprehends and gives meaning to the world. Culture is the *order* shaping meaningful action.[5]

Habits, behaviors, and beliefs regarding health all are influenced by one's culture.[6] Habits are actions that are performed spontaneously with little thought or difficulty.[7] Behaviors are people's observable actions performed under given environmental circumstances.[7] Beliefs include "conviction, opinion, confidence in the existence of something that is not immediately susceptible to rigorous proof, confidence, faith, or trust."[8] Most ideas about health and illness come from everyday experiences.[9]

There are many ways to define health or illness and to determine what they mean in people's daily lives. People learn from the time they are born *how* to be healthy, *how* to recognize illness, and *how* to be ill.[10] An example of a culturally influenced unhealthy habit is eating a high-fat, high-cholesterol diet. Food that is prepared for a sick family member is a behavior that often is influenced by culture, for example, whether to give someone cold or hot fluid. Culture often influences beliefs about why someone becomes sick. In some cultures, it is believed that sickness is a punishment for having done something wrong.

Many authors have referred to the importance of approaching culture in health care as a process that includes reflection. According to Padilla and Brown,[11] a willingness to acknowledge one's own culturally biased predisposition is key to integrating a cultural approach in health care. This willingness requires an active commitment to an ongoing practice of critical reflection. *Critical reflection* is a process that facilitates one to move beyond the acquisition of new knowledge and understanding into questioning existing assumptions, values, and perspectives.[12] When health care professionals identify their own cultural

biases, they are in a better position to understand how these biases influence their interactions with patients. Dilliard et al[2] posited that a necessary component of becoming culturally aware is the willingness to acknowledge and explore one's own feelings and biases regarding one's own culture. This is an ongoing process requiring self-reflection. Sue et al.[13] described culturally skilled therapists as persons who have transitioned from being culturally unaware to being sensitive to their own cultural issues and how their values and biases affect their treatment of others.

How do allied health curricula produce creative, compassionate, open-minded, patient, flexible, and empathetic therapists, leaders, advocates, team players, communicators, and educators? Such characteristics are required from new graduates as they enter into diverse cultural practice settings. Incorporating cultural integration tenets into a health care curriculum assists in preparing students for the demands of cross-cultural practice.

Cultural Integration

For the purpose of this article, the term *cultural integration* is used to refer to what other literature has called *cultural competency* or *cultural sensitivity*. The term *cultural integration* is different from *cultural competency* because it refers to an ongoing process, not a finite level of competency that one may achieve. Cultural integration implies a more active process than *cultural sensitivity*, which implies an awareness but not an action. Cultural integration is a process that permits one to function effectively in a variety of cultural contexts, not simply in one or two different cultures. It is shown in the everyday behaviors one displays toward each individual encounter. It is a process with a reflection component as its core.

Transformative Learning

Transformative learning emphasizes the structure and process of making and reorganizing meaning. *Transformative learning* is the "development of revised assumptions, premises, ways of interpreting experience, or perspectives on the world by means of critical self-reflection."[14] Transformative learning holds that meaning is making sense of or giving coherence to experience.[15] In other words, we use our established expectations to explain and construe what we perceive to be the nature of a novel experience that before had lacked clarity. It involves examining, questioning, validating, and revising perceptions.

A key component of transformative learning is critical reflection. Mezirow's[15] definition of critical reflection includes what the literature most often refers to as *self-reflection*. The role of self-reflection in the process of becoming culturally sensitive is documented thoroughly in the literature.[11,13,16] Through the process of self-reflection, an individual is able to define and understand better his or her values and beliefs and the reasons for them.

Mezirow[15] stated that we must be able to name our reality, to know it divorced from what has been taken for granted, to speak with our own voice. To be able to apply culturally integrated behaviors in practice, students and professionals need to examine their individual values and assumptions about others and those of the dominant culture. Reflection is used to assess critically one's interpretations of experience. Critical reflection can be used to assess content, process, and premise. A critical component in this process is learning to negotiate meanings, purposes, and values critically, reflectively, and rationally instead of passively accepting the social realities defined by others.

My Personal Reflection

Applying premises from cultural integration and transformative learning, I reflect on my own experiences with students in various learning environments to show how culturally integrated behaviors can be facilitated.

As an occupational therapist, I supervised and facilitated students in a variety of settings—traditional settings such as hospitals and school systems, and nontraditional settings, such as in other countries, urban community–based Latino clinics, and Native American reservations. Each site provided students with unique learning experiences with regard to content and skills and opportunities to apply different learning strategies.

It is my experience that when students are challenged in the nontraditional sites, they are more likely to explore, discuss, and problem solve on their own, with other students, or with me. In the more traditional settings, student learning is more focused on specific treatment skills and how to find the *correct* answer from a therapist or book. Both are valuable experiences because learning hands-on skills and learning to think for oneself are necessary for successful practice. Both types of learning may happen at the same site; however, in my experience, different learning styles are emphasized at different sites.

Following are examples of how I have seen students learn in nontraditional sites. Not all cross-cultural experiences have to be accomplished within a fieldwork model. They can be achieved through class assignments, volunteer opportunities, or short-term immersion experiences. After the examples, I explain what kind of learning I believe such cross-cultural sites facilitate and how this type of learning can be integrated into allied health curricula.

International

Dominican Republic. Creighton University has a program in which occupational or physical therapy students and professionals work together in six different sites for 1 month in the Dominican Republic. One site is an orphanage for abandoned, disabled children, many of whom have cerebral palsy or have had meningitis. Although the government funds the site, it remains quite poor. The staff is made up of a special

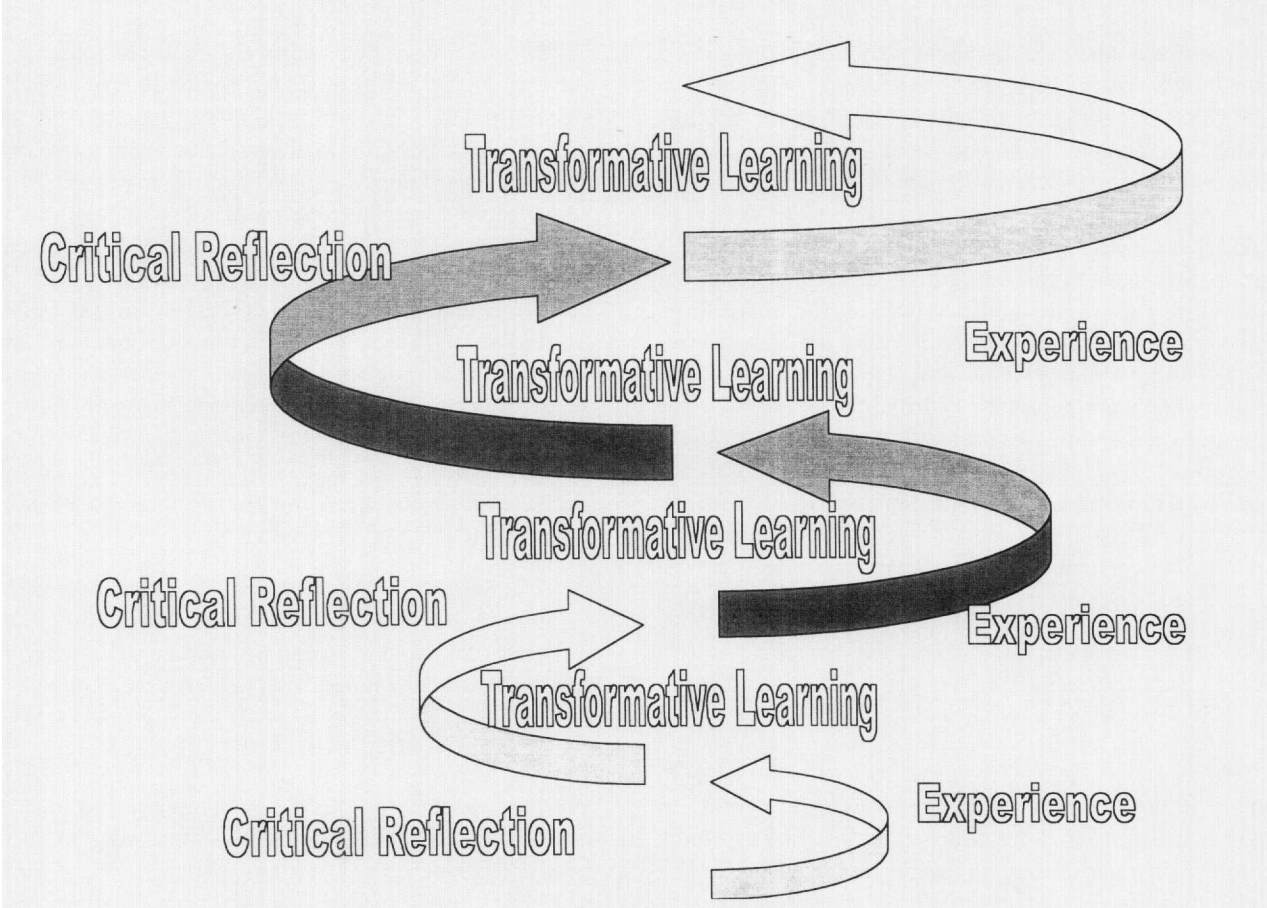

FIGURE 1. Culturally Integrated Behaviors

education teacher, a visiting physician, and personal care attendants (approximately 1 for every 10 children).

In the minds of students and professionals, the site could have benefited greatly from education on positioning, feeding, and handling. The students and professionals were frustrated, however. To them, the staff did not seem interested in learning anything new or in changing their system. Students feared that they could do more harm than benefit working with just the children and then leaving, having had little communication with the staff to facilitate long-term change. Nightly, small groups had endless conversations regarding this issue. Sometimes the conversations were organized and facilitated; other times, they occurred over dinner and after hours. This ethical dilemma was on everyone's mind.

After much brooding over the various individual perspectives and different ethical approaches, community-based development theories, and social justice literature, students and professionals came to their own conclusions. The group realized that blame should not lie with the individuals working at the site because they too were victims of the system, being overworked and underpaid in dire conditions. As a result of the discussions and the new perspective, individuals decided for themselves what action they would take. Some decided to stay and work with the children; others decided to write letters to the director with their questions; and others decided to spend some time with the staff, doing what they do, to understand their perspective better. This site provided everyone an opportunity to work through an ethical dilemma with a group of people, think for themselves, question, and reframe the same question many different times.

Ecuador. Creighton University has developed a program in Quito, Ecuador, similar to the program in the Dominican Republic. While a small group of students and professionals were working at a center for persons with amputations, a young woman walked in and asked a couple of us to come home with her to see her brother, Pedro, a 24-year-old with a spinal cord injury. A professional, a student, and I jumped at the opportunity to visit a person at home in Quito. The sister drove us to her home, along the way asking us about our family, our country, the weather, and our culture. She pointed out several differences and similarities between the countries. She learned to drive differently than people in my country. She learned to drive in mountains, high elevation, and clouds, whereas I learned to drive in snow. The people in our group learned later that the sister had not just been making conversation, but in her way, she was asking us to start thinking about how to return her brother to driving.

When we entered the home, extended family members greeted us. We were offered juice and cookies before we saw the brother. When we went upstairs to meet the brother, another social conversation ensued. We talked to Pedro for an hour or so before we began to talk about therapy and his injury. Although we were enjoying ourselves, we were concerned that we were not making the best use of our time. As a group, we discussed the similarities and differences in our approach to Pedro's therapy. In this discussion, many questions were asked: 1) Are we offering Pedro the most that we can? 2) Are we offering Pedro what is important to him? 3) Why is therapy different with Pedro? After several sessions and group discussions, we addressed what was most important to Pedro, his ability to drive with adapted steering controls. Pedro now has a car and the hand controls for the car. On reflection about this process, we came to understand that practicing client-centered, occupation-based therapy means that the therapy is driven by client, occupation, and context, not by the therapist.

INTRANATIONAL

Urban Latino Clinic. I have worked with students in home health for community-based urban Latino clinics in different cities. Generally the population served is the uninsured or underinsured, a culture in and of itself. The clients often have spent most of their lives in a different country and may speak English as a second language, speak little English, or not speak English at all. This type of rotation challenges students to become resourceful and creative in terms of accessing resources, especially durable medical equipment.

One student was working with a young man her age who had been shot eight times in the stomach and had survived with a spinal cord injury, among other complications. Javier, (pseudonym) who spoke little English, had no community mobility because he was without a proper-fitting wheelchair. Other barriers included no ramp to maneuver the wheelchair up and down the stairs into his home and dependency on public transportation that was not handicap accessible. These barriers are a lot for one student to address. Generally in addition to occupational therapy, there would be at least a social worker, nurse, and physical therapist working on this case. In response, the student reached out to community resources, made phone calls, and talked with agencies about how they could help and what they had to offer. A couple of months later, a ramp was built, a wheelchair ordered, and calls were made about public transportation. As a result, Javier now is beginning English classes and applying for jobs. In this situation, the student developed and used her advocacy skills. She also acted as a facilitator and gained support from various community agencies, consulting with each as they were able to provide resources and services for Javier. This was a unique role for a student to experience and gave her a new perspective on what her profession can offer.

Native American Reservation. As a result of a federal grant (D36 AH 10082-01, funded by Health Resources Services Administration), Creighton University has developed an occupational therapy and physical therapy practice on two different reservations and use them as learning sites for students. Having students observe the development of a practice in such a setting has been invaluable. Students participating in fieldwork on the reservations were asked: What skills or characteristics did you observe your supervisor use to be successful in cross-cultural practice? Students consistently identified personal qualities of their supervisors, such as creativity, flexibility, resourcefulness, compassion, and patience. Students also were amazed at the differences between a *white* hospital and one on a reservation. It is beneficial for students to see how these differences play out in practice, rather than just reading about it in class.

Considering the previous examples, how can curricula incorporate culturally integrated behaviors? The following section describes various methods that may be used to facilitate culturally integrated behaviors in a curriculum.

Curriculum Components

The purpose of the proposed curriculum is to facilitate allied health students' abilities to work effectively with persons from diverse cultures. The curriculum is based on transformative learning tenets and includes active learning, experiential learning, and critical reflection. The process cannot be achieved through lecture in the classroom alone. Although culture-specific information (most often transmitted by lecture) is valuable, it also is the most easily accessible. More challenging for students is the clarification of their own beliefs and values and their origins and how to approach others in an open, compassionate, and effective manner to work in collaboration with persons from other cultures.

In cultural training there is a danger in attempting to teach about cultures of particular ethnicities or races because it may lead to prejudices and misconceptions. Too often, cross-cultural care is presented in terms of "exotic encounters with patients newly immigrated from other countries or members of ethnic groups with whom professionals have little familiarity."[11] A culture-specific approach often may result in exoticism of culture by reducing it to a distant and mysterious construct. When differences and folk practices are emphasized, cross-cultural training may reinforce the concept that culture refers only to the unusual and exceptional practices of unsophisticated peoples.[17] Appreciation for enormous variations within different ethnic groups, such as age, gender, sexual orientation, religion, health, income, education, acculturation, and individual differences, may be lost.

Critical reflection, active learning, and experiential learning are methods that are crucial to facilitating culturally integrated behaviors in a curriculum. Following is a description of these methods and ideas of how to implement them.

Critical Reflection

Critical reflection is the vehicle that allows students to take new knowledge or experience and transform it to make and redefine meaning.[14] Reflection facilitates the student's ability to integrate his or her cross-cultural experience into learning to affect future learning and practice. Student critical reflection skills can be developed in the classroom and integrated into learning experiences outside the classroom such as fieldwork.

Critical reflection enhances didactic learning and experiential learning. Critical reflection can happen in a group, one on one, or in an individual setting. Group reflection can be facilitated by asking questions such as:

1. What is the issue?
2. Why is the issue important?
3. What about the issue is important?
4. What do we think about the issue?
5. Why do we think that?
6. What do others think about the issue?
7. Why do they think that?
8. Should we revise our thinking on the issue?
9. How should we revise our thinking?
10. Why should we revise our thinking?

These questions are adapted from Cranton's[14] chart on types of reflection and learning domains. The questions address reflection over content, process, and premise as they ask *what*, *how*, and *why* questions. Such questions can be adapted for almost any situation, whether it is in the classroom or in a cross-cultural learning environment. Students also can be asked to keep a journal answering such questions about various learning objectives.

Active Learning

Didactic learning most often consists of lecture for a variety of reasons, such as time constraints and large class sizes. Active learning often is seen as time-consuming and burdensome for professors. Lecturing on cross-cultural topics often leads, however, to making generalizations about different cultures and teaching stereotypical behaviors of certain cultures. When addressing cultural topics in the classroom, I recommend facilitating small group discussions. It is in this type of setting that individuals are able to voice opinions and explore other ideas.

Small groups can address a variety of learning objectives. Students can be asked to role-play different scenarios, asking them to step into the shoes of a different culture. Role play can be followed by a discussion of how each student could relate to the particular scenarios, what each individual might do differently in a particular situation, and what new meaning was created for the group as a result of the role play. Small groups also can be asked to problem solve together over various ethical situations. In these situations, students are asked to think through different scenarios and voice their processes and let others respond to their thinking immediately. Small groups open up an environment in which peers can challenge peers to reorganize and make meaning out of old assumptions and beliefs.

In addition to small group discussions, critical thinking and problem solving can be addressed in the didactic portion of the curriculum. How would one go about finding out a person's beliefs regarding health care? What questions would they ask in an interview? Where else can they go to find out about culture? When such thought processes are facilitated in the didactic portion of the curriculum, students feel less intimidated when faced with such dilemmas in cross-cultural situations.

As stated earlier, reflection should be facilitated in the didactic portion of the curriculum as well. Students can begin to ask themselves what it is they believe and why they believe what they believe. The better a student understands the *lens*[11] that he or she sees out of, the better the student is prepared to *clean the lens* and gain a clearer understanding of another culture's perspective.

Experiential Learning

The most important and impacting portion of this suggested curriculum is getting out of the classroom and becoming immersed in other cultures. The value of being immersed in a different culture is immeasurable. Sayles-Folks and People[18] advocated for students to work with persons who are from different cultures to enhance their professional practice.

By stepping out of one's *comfort zone*, one may begin to develop empathy for persons as individuals. One may begin to make fewer assumptions about individuals who look exotically different from themselves and individuals who are relatively similar looking to themselves.

By working among individuals with different cultures, one may learn more about his or her own culture by comparing and contrasting it to a different culture. Identifying a trait in one culture may raise an awareness about the nature of that same trait in one's own culture. Examples of such traits may include respect for elders, humor, poverty, and violence. Learning about different cultures teaches us more about our own culture.

When trying to gain an understanding of another person's perspective, it may be useful to consider Cox's[19] concepts that can be used to describe cultural similarities and differences. After observing someone in their culture, students can be asked to describe the similarities and differences between their own culture and the culture observed regarding time and space orientation, leadership style orientations, individualism versus collectivism, competitive versus cooperative behavior, locus of control, and communication styles.

Several examples were given earlier on how experiential learning can be accomplished and their benefits. Students can be immersed in another culture for a day,

month, or year. Experiential learning should incorporate the prior learning strategies of active problem solving and reflection.

Discussion

The purpose of this article is to suggest that a curriculum without such experiences integrated into it is not complete, and it does not prepare students at an adequate level for the current demands of practice. It is not to say that the only type of learning that takes place is transformative learning in cross-cultural settings.

Academia has a colossal responsibility to prepare students not only with the skills and knowledge they need in practice, but also with an ability to practice effectively across many cultures and with increasingly diverse populations. Diversity defines and makes the United States unique. It is our goal to facilitate in health care students the development of characteristics that integrate culture into their practice. To do this, we must examine our own biases, sensitivities, knowledge, and skills to affirm diversity in health care. Facilitating culturally integrated behaviors is more than simply teaching knowledge about specific cultures. It is a behavioral approach to practice. The challenge of allied health education is to facilitate students' behaviors and attitudes regarding culture and practice rather than just teach specific knowledge regarding culture. There are many ways to enter into cross-cultural experiences. It is not necessary to leave the country or the city in which one resides. There are many cultures within one geographic area.

The author thanks Charlotte Brasic Royeen, PhD, OTR, and Gail M. Jensen, PhD, PT, for their continued support, suggestions, and encouragement throughout the formation of this article. The author thanks Carol Peters for her technical support.

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