Exploring Multicultural Competencies of Occupational Therapists: Implications for Education and Training

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Key Words: education, occupational therapy

The purpose of this investigation was to explore the influence of demographic and educational variables on self-reported multicultural competencies of occupational therapists. A sample of 91 occupational therapists currently working in the field participated in this investigation. Multicultural coursework, seminars and workshops, percentage of minority patients worked with, and highest degree held were found to correlate significantly with self-reported multicultural competencies. Regression analyses found that highest degree held, percentage of minority patients worked with, multicultural coursework, and participation in multicultural seminars and workshops accounted for about half of the variance in multicultural awareness. These findings are discussed in terms of academic courses and continued professional training and education for occupational therapists.

Within the profession of occupational therapy, a mandate is taking shape for practitioners to attend to the needs of patients who are racially or ethnically different. This perspective is seen as paramount for the profession because of the growing diversity in the population of the United States and the desire to deliver equitable, quality care to all patients (McCormack, 1987). A multicultural perspective is advocated, not only for practitioners who are members of the majority group in the United States, but for all occupational therapists regardless of their race or cultural background. Current thought in multicultural education suggests that persons who are racially or ethnically different should not assume that they are multiculturally competent simply because they are not members of the majority culture (Pope-Davis, Reynolds, & Vazquez, 1992).

Historically, occupational therapists have been described as health providers following the western medical model, which views a patient’s disability or illness as a separate entity from the patient’s particular world view or culture (Barney, 1991). The result of this orientation has often been that the needs of the patient are assessed and treatment is delivered, with little or no attention paid to the effect that the patient’s cultural or racial background may have on the therapeutic encounter. Recent rehabilitation research has advocated the perspective that appropriate provision of services can only occur when the cultural diversity of patients, the interaction of patient culture with the culture of the provider, and the professional orientation of the western medical model are taken into consideration (Dillard et al., 1992; Fitzgerald, 1992).

Occupational therapy has been defined as a profession that assists people in competently performing occupational activities that involve their time, energy, skills, and values (Reed & Sanderson, 1983), and is viewed as a profession well suited to a holistic approach to patient care (Schkade & Schulz, 1992; Schulz & Schkade, 1992). Such a holistic approach would, by definition, encourage the incorporation of an understanding of patients’ cultural background and values in the provision of therapy (Vilaubi, 1990). To this end, occupational therapy literature has begun to identify issues of multiculturalism as central concerns in the development of a sound, effective therapeutic alliance with patients to aid in their receptivity toward occupational therapy (Dillard et al., 1992). For instance, it has been argued that the cornerstone therapeutic process of motivating patients to actively cooperate with and accomplish treatment goals is greatly assisted by culturally aware communication between provider and patient, as well as by increased patient investment in making therapeutic treatment meaningful within the patient’s unique cultural context (Dillard et al., 1992; Levine, 1987; Skawski, 1987). Barney (1991) has pointed out that taking an objective or noncultural approach toward occupational therapy is neither possible nor desirable.

The need for a multicultural approach toward patient care has also been supported by theory and research...
in other fields, such as counseling and psychology, where a strong therapeutic alliance is a major component in the provision of services (Atkinson, Morten, & Sue, 1989; Sue & Sue, 1990). In fact, multiculturalism has been identified as a “fourth force” in counseling, in addition to the philosophies of Freudianism, behaviorism, and humanism (D’Andrea, Daniels, & Heck, 1991; Pedersen, 1990, 1991), and is quickly becoming established as a major theoretical perspective. Further, a multicultural approach is viewed as appropriate for all patient or client activities, rather than as a special type of intervention or treatment (Atkinson et al., 1989; Speight, Myers, Chikako, & Highlen, 1991). Thus, a multicultural approach seems appropriate within any service provision system, such as occupational therapy, that involves a therapeutic relationship between provider and patient.

In a classic paper in the field of multiculturalism, Sue et al. (1982) outlined necessary competencies for culturally skilled persons, that is, persons who have moved from being culturally unaware to being sensitive to their own cultural issues and to how their values and biases affect racially or ethnically diverse patients. Multiculturally competent persons consider and evaluate factors such as the effect that the sociopolitical system has on people of color in the United States, have a knowledge base concerning cultural and racial groups, and are able to implement a wide range of appropriate responses to patient needs. Overall, they are aware of and comfortable with differences that exist between themselves and their patients in race and beliefs, and are sensitive to circumstances that may suggest referral of patients to members of their own race or culture for provision of services.

Multicultural competencies have been categorized into four areas: Beliefs and Attitudes, Knowledge, Skills (Sue et al., 1982), and Relationship (Sodowsky & Taffe, 1991). Sue, Arredondo, and McDavis (1992) provided a more detailed framework in which beliefs and attitudes, knowledge, and skills are defined. The Beliefs and Attitudes component, which is also referred to as Awareness, consists of the awareness of one’s own cultural heritage, values, and biases, and of the ways in which these affect one’s relations with persons of color (Sue et al., 1982).

The second component, Knowledge, pertains to an attempt to appreciate and respect differences found in other cultures. This goal is accomplished by acquiring information about specific cultures and groups. Culturally skilled persons also demonstrate knowledge by understanding the sociopolitical system treats and affects ethnically diverse groups. Skills are illustrated by behaviors demonstrated during interaction with culturally different patients. Culturally skilled persons are effective in demonstrating verbal and nonverbal behaviors and in using techniques appropriate to the patient’s cultural context. In addition, these persons are also sensitive to culturally bound behaviors, both verbal and nonverbal, elicited by patients of different cultural groups (Pedersen, 1990; Sue & Sue, 1990). Sodowsky and Taffe (1991) also identified an area of Relationship, which deals with a person’s ability to integrate knowledge, awareness, and skills and use these to build effective and positive therapeutic relationships with culturally diverse patients.

Sue and Sue (1990) asserted that the primary goals for culturally skilled persons are to become aware of their own assumptions about human behavior, to seek an understanding of patients’ assumptions about human behavior, and to become active in developing appropriate intervention strategies for culturally diverse patients. Thus, being multiculturally competent requires the ability to integrate awareness, knowledge, and skills while maintaining a positive relationship with the patient (Sodowsky & Taffe, 1991).

Within the field of occupational therapy, support has been given for similar processes as they pertain to training, employment, and practice. For instance, Fisher, Liu, Velozo, and Pan (1992) discussed the need for clinical assessment to contain a greater awareness of the cultural diversity of patients and the need for assessment measures to be validated on all populations encountered in treatment. Sayles-Folks and People (1990) have suggested that training and education of occupational therapists should include issues of multiculturalism to enable competent treatment for culturally diverse populations. This suggestion has also been posited by multicultural researchers who have demonstrated that multicultural course work and experience have greatly influenced self-reported multicultural competencies as measured by various instruments examining the aforementioned four areas of competency (Porterotto, Sanchez, & Magids, 1991; Pope-Davis, Ottavi, & Dings, 1993). Post (1990) and Lowery (1990) suggested that practitioners in the field need to examine their cultural biases and how these biases are likely to affect the provision of services to patients, as well as the recruitment of persons of color into the occupational therapy profession.

Such observations and research build a strong case for examining the multicultural competencies of occupational therapists and demonstrate a ground swell of concern within the field for ensuring the provision of holistic, sensitive, and effective health care to diverse populations. However, little empirical research is available that has examined the multicultural competencies of practicing occupational therapists, or the influence that various demographic or educational variables have on these competencies. The purpose of this investigation, therefore, was to explore the self-reported multicultural competencies of occupational therapists. Such research can assist in laying a foundation for further study and can help to point out ways in which occupational therapists may be able to increase their multicultural competencies when dealing with patients of color.
Method

Participants

Surveys were sent to a sample of occupational therapists in California, Illinois, and Iowa. Of 175 surveys mailed, 94 (54%) of the recipients agreed to participate in this investigation. The participants ranged in age from 21 to 68 years ($M = 34.04, SD = 8.79$). For women ($N = 90$), the mean age was 33.57 years ($SD = 8.44$), and for men ($N = 4$), the mean age was 44.75 years ($SD = 11.00$). There were 82 white Americans (87%), 7 Asian Americans (7%), 2 African Americans (2%), and 1 Hispanic (1%). The remaining 3% did not indicate race or ethnicity.

Sixty-eight percent of the participants held a bachelor's degree, 21% held master's degrees, and the remaining 11% held associate's degrees. The number of months of work experience in the field of occupational therapy ranged from 1 to 396, with a mean of 86.64 months ($SD = 77.10$).

Regarding multicultural training, 36% of the participants had completed a multicultural course and 30% had attended a multicultural seminar or workshop. Approximately 75% of the participants indicated that less than half of their work had been with patients of color. African-American patients were the minority with whom most occupational therapists worked (45%), followed by Hispanic patients (31%), and Asian-American patients (24%).

Instruments

The participants were asked to complete the Multicultural Counseling Inventory (MCI) (Sodowsky, Taffe, & Gutkin, 1991), adapted by the authors for use with the participants, and a demographic questionnaire that was developed for this investigation. The MCI was developed to measure multicultural competencies on the following four subscales:

- **Awareness**: Ten items measure multicultural sensitivity, interactions, and advocacy in general life experiences and professional activities. Sample items include “I am involved in advocacy efforts against institutional barriers in health services for minority patients” and “When working with international patients or immigrants, I have knowledge of legalities of visa, passport, green card, and naturalization.”

- **Knowledge**: Eleven items measure treatment planning, case conceptualization, and multicultural research. Sample items include “When working with minority patients, I keep in mind research findings about minority individual preference in health care,” and “When working with minority patients, I apply the sociopolitical histories of the patients' respective minority groups to understand them better.”

- **Skills**: Fourteen items measure general and specific multicultural skills. Sample items include “When working with minority patients, I monitor and correct my defensiveness” and “When working with all patients, I am able to be concise and to get to the point when reflecting, clarifying, and probing.”

- **Relationship**: Eight items measure the interaction process with the minority patient (e.g., comfort level, world view, and trustworthiness). Sample items include “When working with minority patients, I am confident that my conceptualization of individual problems does not consist of stereotypes and biases,” and “When working with minority patients, I perceive that my race causes the individual to mistrust me.”

The 43 self-report items of the MCI assess multicultural competencies on a 4-point Likert scale (1 = very inaccurate; 4 = very accurate). Scale scores are obtained by adding the items specific to each subscale. Higher subscale scores indicate greater multicultural competence in the respective subscale areas.

Alpha coefficients and intercorrelations of the MCI subscales for the current sample are presented in Table 1. The internal reliability estimates of the four MCI subscales were .77, .78, .78, and .65. These estimates approximate the reliabilities reported by Sodowsky et al. (1991). Inter-correlations of the four subscales of the MCI demonstrated consistency for use with this national sample of occupational therapists. Low to moderate correlations were found between the four subscales ranging from $r = .02$ to $r = .51$. These correlations approximate MCI subscale correlations found during instrument development and suggest that the inventory is measuring related but different constructs. These results suggest that the inventory has adequate subscale reliability and distinctiveness to encourage further use. A demographic sheet was used to obtain information about participants regarding racial and ethnic background, age, gender, highest degree held, months of work experience in the field, percentage of minority patients worked with, and multicultural course work or seminars and workshops taken.

Procedure

The instruments were mailed to participants arranged in the order of consent form, demographic questionnaire, and the MCI. Participants completed the instruments at their own pace and returned them by mail when finished.

<table>
<thead>
<tr>
<th>Table 1</th>
<th>Alpha Coefficients and Intercorrelations for MCI Subscales</th>
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<tbody>
<tr>
<td>Subscales</td>
<td>Skill</td>
</tr>
<tr>
<td>Skills</td>
<td>.77</td>
</tr>
<tr>
<td>Knowledge</td>
<td>.51</td>
</tr>
<tr>
<td>Awareness</td>
<td>.29</td>
</tr>
</tbody>
</table>

Note. Alpha coefficients appear in the diagonal of the matrix.

*Readers can contact the first author regarding the instrument used in this investigation.*
Results

Descriptive Statistics

MCI subscale means and standard deviations for occupational therapists were Awareness (M = 2.41, SD = 5.20); Knowledge (M = 3.20, SD = 4.82); Skills (M = 4.64, SD = 4.35); and Relationship (M = 2.52, SD = 3.50). For convenience, averages were computed so that scores could be interpreted with reference to the original 4-point Likert scale. Higher mean scores indicate more self-reported multicultural competency in the respective subscale. Because the scale midpoint is 2.0, it is evident that the participants reported reasonable levels of multicultural competencies, particularly concerning multicultural skills.

Correlational Analyses

Pearson product-moment correlations among educational, demographic, and multicultural competencies are presented in Table 2. The variables of age, months of experience in the occupational therapy field, and percentage of minority patients worked with were considered as separate variables in this study, despite a possible overlap of variance. This separation was done to evaluate the degree to which the observed difference related to age reflects genuine differences between older and younger therapists, or is attributable to the acquisition of multicultural competencies solely as a result of practical experience. Additionally, the authors wanted to assess the genuine differences that might exist between the amount of general practice experience held by therapists and the amount of practice experience garnered specifically with patients of color. The high correlation between age and months of experience suggests that they are closely related but not completely similar, perhaps reflecting the variety of ages at which therapists began their professional practice careers. The negative low correlations between these two variables and percentage of minority patients worked with suggest that younger and less experienced therapists had had greater opportunities to work with patients of color.

Correlations involving multicultural course work and multicultural seminars or workshop participation are dichotomous; therefore, the interpretation of relationships with these variables is somewhat complicated. For these two variables, responses were coded as integers 1 and 2 to reflect nonparticipation or participation, respectively, in either a multicultural course or a seminar or workshop. Correlations involving highest degree held were coded as integers 1, 2, or 3 to reflect the current possession of an associate’s degree, a bachelor’s degree, or a master’s degree. These data are best conceived of as ordinal rather than interval, and therefore must be interpreted with caution. This caution is especially necessary because participants may have completed most of the requirements for a higher degree than indicated but have not yet been awarded a higher degree, and because degree levels do not necessarily indicate comparative levels of knowledge or education. The remaining variables of age, months of experience, and percentage of minority patients worked with appear to constitute ratio data.

The variables of multicultural course work and highest degree held were found to correlate significantly with the multicultural Skill subscale. Those who had completed multicultural course work and those who held higher degrees scored higher on the MCI than those who had not taken a course or who held lower degrees. Similarly, the variables of multicultural course work and highest degree held correlated significantly with the subscale multicultural Knowledge. Age, months of experience, percentage of minority patients worked with, and attendance at a multicultural seminar or workshop were not significantly correlated with either the Skill or Knowledge subscales. The variables of percentage of minority patients worked with, multicultural course work taken, multicultural seminar or workshop taken, and highest degree held were found to correlate significantly with the multicultural Awareness subscale, yielding moderate to high correlations. Therapists who had worked with a higher percentage of minority patients, had taken multicultural course work, had attended a multicultural seminar or workshop, or held higher degrees scored higher on the MCI. Age and months of experience did not correlate significantly with the Awareness subscale. None of the variables of interest significantly correlated with the multicultural competency of Relationship.

Significant correlations were obtained between multicultural course work and multicultural seminar or workshop attendance, suggesting that those therapists who have had course work experience also tend to have participated in multicultural seminars or workshops. A significant correlation was also found between highest degree held and multicultural seminar or workshop; this indicates that therapists who possess higher degrees were more likely to have attended multicultural seminars or workshops.

Table 2

<table>
<thead>
<tr>
<th>Variables</th>
<th>Age</th>
<th>Months</th>
<th>Percent</th>
<th>Course</th>
<th>Seminar</th>
<th>Degree</th>
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<td>.05</td>
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<td>.45**</td>
<td>.35**</td>
<td>.30**</td>
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<td>.03</td>
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<td>-.06</td>
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<td>-.27**</td>
<td>-.11</td>
<td>-.04</td>
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<td>Months</td>
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<tr>
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</table>

*p Two-tailed tests significant at p < .05.
**Two-tailed tests significant at p < .01.
Regression Analyses

Multiple regression was employed to examine the extent to which linear combinations of the demographic and educational variables could account for differences in multicultural competencies above and beyond the correlation of these variables with scores on the Skill, Knowledge, Awareness, or Relationship competencies. Stepwise regression was selected as the best alternative to an examination of all possible regressions. A brief summary of results of the significant stepwise regressions carried out for the MC1 subscales, with a significance level of .05 for inclusion in the model and .10 for being dropped from the model, is presented in Table 3.

In the stepwise regression model, none of the examined variables was able to significantly account for the variance in Skill and Relationship scores for participants in this sample. As to the Knowledge subscale, highest degree held accounted for 10% of the variance. As the correlations indicated, therapists who possessed higher degrees self-reported higher levels of multicultural knowledge.

Percentage of minority patients worked with, multicultural course work, and participation in a multicultural seminar or workshop together accounted for 53% of the variance in multicultural Awareness. The variable of percentage of minority patients worked with accounts for 46% of the variance in multicultural Awareness; the variables of multicultural course work and attendance at a multicultural seminar or workshop account for an additional 13% of the variance. Working with a higher percentage of patients of color, having taken multicultural course work, and attending a multicultural seminar or workshop were associated with higher self-reported multicultural Awareness.

These multiple regression results indicate that, when the variance present in the current sample is used to its fullest reasonable statistical advantage, 53% of the variance in multicultural Awareness can be explained by demographic and educational variables. This is a substantial amount and suggests that there is value in considering demographic and educational variables together in attempting to understand what factors are related to multicultural Awareness, although these variables can by no means completely explain differences of multicultural competencies in occupational therapists.

Discussion

The purpose of this study was to explore the self-reported multicultural competencies of occupational therapists. Further, the influences of demographic and educational variables were examined for their contributions to self-reported multicultural competencies. Results suggest that there is a clear difference in perceived multicultural competencies among those therapists who have a higher level of education, have worked with patients of color, have taken multicultural course work, or have attended multicultural seminars or workshops. These findings support the contention that educational experiences directly dealing with multicultural issues and direct practical experience with patients of color play a part in the acquisition of perceived multicultural competencies by occupational therapists.

Working with patients of color appears to be the strongest contributor toward acquiring an Awareness competency, followed by taking multicultural course work and attending seminars or workshops. Although this study did not explore the influence of educational factors at different levels of professional experience, a logical suggestion would be that such educational experiences occur during formal professional training, rather than after clinical practice has begun. In that way, the foundation of positive influence that these factors possess may be established before clinical contact with patients is made. This point is consistent with the suggestions made by Sayles-Folks and People (1990), who advocated that the education of occupational therapists include issues of multiculturalism to increase the likelihood of competent treatment for diverse populations. Further, enabling students to gain experience in working with persons who are racially or ethnically different during their clinical training may also enhance their multicultural Awareness before they engage in professional practice.

The results of this investigation also suggest that...
exposure to course work and seminars or workshops dealing with multicultural issues seem to have a strong effect on the perceived acquisition of certain multicultural competencies. Thus, after occupational therapists have begun to develop a foundation of multicultural competencies through course work in their formal training, encouraging their exposure to further seminar or workshop hours on multicultural issues may enhance and fortify these competency bases. Sue and Sue (1990) noted that instructional tools are quickly becoming a highly used resource for the training and education of professionals. Training tools that deal with multicultural issues are now available (Pope-Davis, et al., 1992; Pope-Davis, Prieto, Reynolds, & Vazquez, 1993).

Noteworthy is the absence of any significant correlations between the Relationship subscale and educational and demographic variables. It may be that the current scale measuring Relationship competencies in the MCI may not accurately measure the multicultural Relationship competencies that occupational therapists acquire from their educational or clinical experiences. Additionally, perhaps current educational and clinical experiences are not imparting to occupational therapists those specific abilities within this domain. If this is the case, occupational therapy curricula and clinical training may need to expand their examination concerning multicultural relationship issues. These areas of multicultural competency seem to merit further study.

Also worth noting is that age and experience in months are totally uncorrelated with multicultural competencies, tending toward negative correlations with multicultural scales. This finding might imply a need for ongoing training in general, and particularly seminars or workshops for older or more experienced occupational therapists.

In interpreting these results and conducting future research, the limitations of this investigation should be considered. Because the MCI is a self-report measure, participants may have assessed anticipated rather than actual behaviors or attitudes; they may have responded in a socially desirable way; and their interpretations of the items may have differed from those intended by the authors. Further, because perceptions of multicultural competency may vary for occupational therapists from one region of the nation to another, replication of this study in other geographic areas of the country would heighten confidence in these findings.

Despite these limitations, the results of this study have demonstrated important implications for education and continued professional training of occupational therapists in multicultural issues to meet the goal of delivering holistic, culture-sensitive patient care. Multicultural research has yet to discover fully the nature of the interrelationship among the four established multicultural competencies, the acquisition of competencies, the factors that assist the maintenance of established competencies, and the exact criteria to be used in identifying the behavioral implementation of competent multicultural practice. However, research such as the present study may assist in uncovering important demographic or educational factors that appear to influence the development of multicultural competencies in occupational therapists. Further investigations are necessary to determine the relevant experiences that will increase an occupational therapist’s competency to deal with diverse clinical populations. This study underlines the importance of educational experiences such as multicultural course work and seminar or workshop participation in the development of multicultural competencies. Academic training programs in occupational therapy that incorporate multicultural course work into their curriculum and encourage or require students to participate in such courses are likely to better assist their students in becoming multiculturally skilled therapists. Additionally, training programs or employers who encourage and support their staff members to take advantage of seminars and workshops concerning multiculturalism will probably increase their staff members’ perception of themselves as multiculturally competent and subsequently will increase the likelihood of their delivering holistic and effective services to patients of color. Through enhancing the training and development of multiculturally competent occupational therapists, the profession may better meet its mandate to serve the needs of the increasingly diverse patient population in the United States.

References


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