Cultural Competency in Occupational Therapy: Beyond a Cross-Cultural View of Practice

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The purposes of this paper are two. The first purpose is to contribute to cultural competence in occupational therapy practice. The second is to contribute to occupational therapy literature about culture and cultural analysis related to practice. This paper introduces a cultural analysis of stories about the therapeutic process with two Japanese therapists and their Japanese patients. Two therapeutic situations, including therapists’ and their patients’ experiences, are interpreted by the author, a Japanese occupational therapist, as critical incidents for reflection to improve culture general competence. The stories illustrate the patients’ perception of life with illness and, particularly, the emergence of their cultural values within the therapy process. The analyses focus on how an understanding of the patients’ illness experience is integrated into the therapy process and how the therapeutic interventions reflect the culture. In one case, the therapeutic occupation of cooking links to the meaning found in the traditional Japanese woman’s role. In the second case, the therapist–patient relationship, based on local rather than western social relationships, promoted the patient’s engagement in meaningful occupations. Reflection on these stories, which illustrate an alternative cultural view of occupations and therapeutic relationships, may assist occupational therapists in the development of improved level of cultural competence.


Occupational therapy’s values come from social movements in the early 1900s, including Jane Addams’ work at Hull-House with immigrants from other cultures adapting to American society (Clark, Wood, & Larson, 1998). Occupational therapy’s most salient feature is its focus on assisting clients to engage in meaningful occupations in order to participate in their community (American Occupational Therapy Association, 2002). Therefore, understanding a patient’s sociocultural background is extremely important as the occupational therapist helps patients identify and engage in culturally meaningful occupational experiences.

The cultural analyses of therapeutic situations in this paper illustrate not only cultural values, customs, and lifestyles, but also the illness experience. Occupational therapists work with patients using their “double vision” (Mattingly & Fleming, 1994, p. 38), meaning the occupational therapist simultaneously considers both the medical aspects and the person’s illness experience. While working with a patient, a therapist may observe the patient’s hand movements to evaluate function. But, additionally, the therapist also listens to the patient complaining of pain and empathizes with how the patient is trying to deal with cooking at home. All of this occurs without therapists’ conscious awareness of their complex understanding of the patient’s life. Similarly, the therapists’ understanding of the diagnosis extends beyond the medical aspects to include the experience of the patient living with the disease process in a particular culture.

Illness experiences are the meanings associated with the disease by the affected persons and their families. Illness experiences are frequently spoken about or
written in narratives, not described in medical charts (Frank, 1995; Garro & Mattingly, 2000; Kleinman, 1988; Mattingly, 1998; Mattingly & Fleming, 1994). These illness experiences are seen as shifting back and forth on a continuum of suffering to healing in the treatment process. Occupational therapy, using culturally and personally meaningful occupations in treatment, can assist individuals in this movement toward healing. The illness experience is shaped by cultural local knowledge, expectations, preferences, and dislikes about appropriate standards for living life (Frank; Garro & Mattingly; Kleinman; Mattingly; Murphy, 1987). An illness experience perspective involves seeing ill persons in the world in which each one is living, that is, in context, not as separate from their environment. As such, an illness experience is dynamically social; it both occurs in the social setting and is changed by it (Frank; Garro & Mattingly; Mattingly; Murphy). As a social experience, the illness experience is shaped by the culture of which one is a part.

Historically, in Western societies where the profession started, the majority of occupational therapists have been white, middle-class women. They have encountered patients with diverse cultures (minorities or immigrants in Western societies) and have learned that their patients had different cultural values, customs, religion, and lifestyles from their own (Barney, 1991; Kinébania & Stomph, 1992; Levine, 1984). While struggling with the difference between therapists and their patients in therapeutic intervention, occupational therapists have acknowledged the need for awareness and sensitivity to cultural differences (Dillard et al., 1992; Mirkopoulos & Evert, 1994; Wittman & Velde, 2002). Occupational therapists began to develop cultural competency by striving to attain a cross-cultural view.

Cultural analyses conducted in the profession were cross-cultural studies in which therapists with Western cultural backgrounds analyzed their intervention with their patients from non-Western cultural backgrounds (Levine, 1984; Kinébania & Stomph, 1992). In such cross-cultural studies, therapists are often puzzled by the difference between their patients’ values, customs, and lifestyles and their own. These cross-cultural studies were a first step toward cultural competency. However, the real challenge is in seeing the world from the different view of their patients, stepping into their world, walking in their shoes. Without more experience gaining different viewpoints, therapists can't fully succeed in integrating the patient’s cultural values into therapeutic interventions (Bonder, Martin, & Miracle, 2004).

Cultural competency may be considered from three perspectives: culture specific, intercultural, and culture general competency (Fitzgerald, 2000). Culture specific competency is the ability to participate in the everyday life of a particular social group, as one does in one’s own culture, or as Japanese therapists and patients do within their culture. Intercultural competency emphasizes working across cultures with an awareness of and sensitivity to differences that might affect the clinical situation, for example as an Euro-American therapist with a Japanese-American or Japanese patient. However, with culture general competency, the professional “recognizes and values cultural differences and the potential implications of culture (as a general concept) on everyone’s illness and clinical experiences” (Fitzgerald, p. 187). In other words, cultural competency is not only developing the awareness that culture is an issue in health, illness, and health care, but also learning one's own cultural assumptions, values, and beliefs in order to interpret the therapeutic situation from multiple perspectives.

Reflective thinking appears to be an important part of developing culture general competency. Reflective practitioners can identify assumptions underlying their practice based on their own cultural community and the culture of occupational therapy, evaluate the validity of these assumptions relative to cultural variables from patients’ worlds and, as necessary, adjust their actions for these alternative assumptions about life, illness, and occupation.

One means of developing such reflectivity is to analyze stories of therapeutic experience as critical incidents. Critical incidents are occurrences or events between persons, positive or negative, which reflect their cultural assumptions or backgrounds (Fitzgerald, 2000).

The two narratives in this paper present critical incidents emerging from Japanese occupational therapy practice that provided culturally meaningful therapeutic experiences for the patients. As such they contribute to occupational therapists’ reflection on culture and its integration in practice, improving their culture general competency.

Methods

The critical incident approach to improving cultural competency is based on the idea that we try to understand, problem solve, and learn using stories (Fitzgerald, 2000). Stories that are critical incidents are social dramas, which, upon reflection, may allow us to see alternative assumptions, values, and perspectives from another culture. These stories require critical analysis and interpretation. Reflection on such stories can provoke therapists’ awareness of and insight into their own practice, using their accumulated knowledge and clinical and life experience (Hasselkus & Dickie, 1994).
In this paper, stories from two Japanese occupational therapists' practice are analyzed by the author, a Japanese occupational therapist, acting as a cultural interpreter. Therapists from other countries can use the stories as critical incidents in which cultural elements are seen emerging from cultural assumptions that might differ from their own. The analyses will illustrate the tacit cultural practice of Japanese occupational therapy.

The data in this paper, though collected “informally,” are part of a much larger, formal ethnographic research project that has involved participant observation and interviewing Japanese elderly and their occupational therapists. The stories, about events occurring in the 1980s, were written in Japanese and translated into English by the author. The author is also the therapist in the first story, which was later reflected upon for the purpose of a course assignment for graduate class in the late 1990s. The second story was by another Japanese therapist of good renown among local therapists in Japan, who was contacted for the same course assignment and asked to recall a story of a successful clinical experience. The therapist wrote a story, which the author expanded through follow-up phone conversations. Preliminary analysis was submitted for the class but further reflection and analysis, particularly with cultural concepts, occurred over several years. Interpretation of the therapeutic situations in the two stories focus on how the patient's illness experience is integrated into culturally meaningful occupation.

**Story 1: Backstage Work**

Occupational therapy intervention with Akari, a female Japanese patient with a diagnosis of rheumatoid arthritis illustrates the culturally embedded nature of the therapeutic process.

**Japanese Eldercare**

Traditionally, in Japan, it has been taken for granted that elderly persons will be taken care of at home by family when they got ill. However, Japanese society has encountered a profound structural change in industry (Fitzgerald, Mullavey-O’Byrne, & Clemson 2001), which consequently changed the younger generation’s patterns of employment and their lifestyles. At the same time, the society was experiencing a rapid increase in elderly persons. It is now difficult for Japanese families to take care of the elderly at home, especially those with disabilities such as the patient Akari, in the story which follows. In the 1980s, when these stories occurred in Japan, residential institutions for elderly persons were not available. Also, placing family elders in nursing homes was thought to be shameful and the Japanese family would lose face (Freed, 1990; Jenike, 1997; Lebra, 1984), as would, for example, Chinese, Greek, and Lebanese families in similar situations (Fitzgerald et al., 2001). Thus, when the therapist met Akari, many families wanted their elderly relatives to stay in hospitals as long as possible, where their stay and therapy was provided without cultural shame and was, in fact, covered by government insurance.

It was less than 2 years since I (the author) had become an occupational therapist. I was working in a private hospital surrounded by mountains far from the downtown area of a city.

Akari (pseudonym) was referred to occupational therapy. She was in her 60s and was diagnosed with severe rheumatoid arthritis. When I first met her, she had been in the hospital for several years. Her only brother had his own family, but visited her several times a year. She was going to stay in the hospital as long as possible because she had no family to live with.

Thus Akari’s situation was neither unusual nor inappropriate. The culture recognized the shortcomings of the system for eldercare, but had few options available at the time. There would be no pressure for Akari to leave the hospital.

**The Illness or Disability Experience**

Frank (1995) suggests there are four major aspects that illustrate the illness experience on a continuum of suffering to healing (recovering for a good life). These aspects are embodied in the following four questions: (1) Is one’s view of life contingent upon a random disease process or a process in which a predictable disease must be controlled? (2) Is one facing the changes in one’s body and taking care of it or hesitating to do so? (3) Is one open to others, including ill peers or isolated? That is, is one social and sharing one’s illness with others? and (4) Does one have desire in one’s life or not? These questions can be answered, describing the patients’ place on the illness experience continuum, as we follow their occupational therapy program.

Although Akari was independent with her self-care, joints all over her body had deformities and were painful. She needed a cane to walk inside the hospital and could not walk outside the hospital alone. She said that her typical day began first with a big effort to sit up in her bed despite pain and stiffness all over her body. Next, she would take a hot shower to move her body more easily. After hot packs and therapeutic exercise, she spent the day bedridden reading novels, newspapers, and magazines. Although she was not an unsociable person, she was spending more time reading than chatting or watching TV programs with other patients in the hall of the hospital.
In terms of the first aspect of the illness experience, Akari saw the amount of pain and limitations of her illness as more random from day to day than predictable. Second, although she had joint pain all over her body and her disabilities disturbed her everyday life, she did not avoid facing or detest her situation. Rather, she accepted it and spent time each day taking care of her body. Third, although she was enjoying some solitary occupations such as reading and listening to radio, which her disabilities allowed, she had little opportunity to share socially with others. Fourth, because she had lost social and other occupational opportunities due to her disabilities (Mattingly & Fleming, 1994; Sacks, 1984), she was not satisfied with her life and desired something more.

When we met for her evaluation, she told me that she wanted to make crafts with the other patients in the occupational therapy room, which, she said, looked like fun. I discussed with her how those crafts required stress on the joints of her fingers and might cause more deformities. I made suggestions and together we decided she would begin cooking. Cooking includes a wide range of activities from light work (making toast) to heavier (baking a cake). It also would have the possibility for social activities like sharing the food with others.

At first, it took her 20 minutes to peel an apple. After she finished peeling it, the apple had turned brown. She practiced peeling an apple three times a week. Two weeks later, she could peel an apple in 5 minutes. She progressed from peeling an apple to making a sandwich. After she had made a sandwich with me in therapy, she started making sandwiches in her room in the morning, using the bread, strawberry jam, butter, and fruit that were served for breakfast in the hospital. She delivered sandwiches to me and other occupational therapists when she came to her therapy. Although some of her sandwiches tasted weird, because the insides happened to be mismatched (strawberry jam and cucumbers), the sandwich delivery was her idea, and I loved it. Akari was surprised but glad that other therapists and I ate her peeled apples and sandwiches. She said modestly that she did not expect us to eat but that she was happy we did.

Therapy started with Akari’s voicing a desire for “fun,” which may have been inspired by the social interactions of patients and therapists in the occupational therapy clinic during activity participation. The therapist did not know exactly what Akari’s need was, but they began to search for “fun” together. Although the therapist was addressing Akari’s function by having her practice peeling an apple, she did not consciously realize she was also making clinical decisions based on her patient’s illness experience. The movement from an experience of suffering the constraints of her illness toward a healing ability to live a good life in spite of it began. Post hoc reflection stimulates therapists to become aware of the illness experience of the patients and consciously focus on transformation in therapy.

**Motivation in a Person With an Interdependent Self**

Markus and Kitayama (1991) state that people define themselves relative to others according to culture, which shapes their cognition, emotions, and motivations in their everyday lives. According to Markus and Kitayama people who have an independent view, as in many Western societies such as the United States, give priority to “expressing their own inner attributes and seeking information for being autonomous” (p. 240). In contrast, persons who have an interdependent view, as in many non-Western societies such as Japan, are “motivated to actions which enforce relatedness to others” (p. 240). Akari’s story demonstrates how therapy provided opportunity for her culturally shaped interdependent selfhood to motivate her occupational participation.

Akari’s therapy was now modified. Although I wanted her to try to cook different dishes, she took a long time to cook and got tired easily. The kitchen was, however, on a different floor from the therapy room, and I could not stay with her for more than 1 hour. I had an idea and asked her opinion about forming a cooking group. She was excited and proposed that two other patients, Toshi and Sumi (pseudonyms), join the group. Toshi was a patient with right hemiplegia and severe Broca’s aphasia. She was slightly depressed because she could not communicate as she wanted. Sumi had left hemiplegia and rheumatoid arthritis, but she also was very interested in cooking.

Once a week, the three patients planned a recipe and I did the grocery shopping. The three patients managed the cooking project and I merely assisted. They checked the ingredients in the fridge and showed me what I needed to buy for the next cooking exercise. They helped each other in the cooking group. Toshi could not use her right hand because of her right hemiplegia. While she was beating eggs in a bowl, Sumi held the bowl. Although Akari and Sumi could not cut a pumpkin, Toshi’s left hand was strong and she would cut it with her left hand. They were proud of themselves and each other.

Once, during the group cooking time, when I was in the therapy room and not in the kitchen, I got a phone call from Sumi in the kitchen. She told me that Akari had fallen down. Fortunately, Akari was not injured. The cooking group members seemed relatively relaxed. Sumi said to me that they would not have worried me by calling over the phone, but they needed help to stand Akari up. I was panicked in my mind, but I pretended to be calm. They were proud that they cooperated to cope with this accident.

Let’s now consider Akari’s motivation. Through exchanges with her patient, the therapist came to respond to Akari’s social needs and helped her to establish social
interactions through her occupation of cooking. Therapy unfolded with Akari’s attempt to create relatedness between herself and others. Responding to her motives for social interaction embedded in sandwich delivery, the therapist tried to shift Akari’s project. Here, the therapist’s ability to understand the cultural interdependence of his patient’s advanced the therapeutic process.

The therapist formed a cooking group using Akari’s motivation that was based on her assumption of an interdependent self. Agreeing with her therapist’s offer, Akari proposed to join with two patients she cared about. Her concern for her peers was based on sympathy and a desire to get closer to others, which guide interdependent persons to motivation and cooperation (Markus & Kitayama, 1991). The three women were attentive and sensitive to and open with each other.

Openness about one’s own illness experience emerges as the person with illness or disability shares with others in the process of healing (Frank, 1995). Akari showed empathy through caring about her peers and joining them, as well as through cooperating with them in the cooking. Her nonassertive style of openness to others is a feature of persons with interdependent selves, especially her consideration of and caring for them (and similarly, their care for her) (Markus & Kitayama, 1991).

Although this project was officially led by the therapist, the three patients showed initiative and great harmony in planning a menu, cooking, cleaning, checking the kitchen, and even in managing a risk event. The cooperation and reciprocity they showed in these occupations is representative of valued behaviors among persons with interdependent selves.

Cultural Meanings of Cooking

Hocking, Clair, & Bunrayong (2002) suggest that among different societies such as those of New Zealand and Thailand (Western and non-Western, respectively), older women share the belief that preparing, serving, and enjoying food appropriately, both in everyday meals and festive occasions, reflect women’s work and is a culturally valued way to spend time and effort. Many older members of both cultures find pleasure and appreciation in this women’s work. In most of these cultures, the older women enjoy sitting at the table together with their family, friends, and honored guests (Hocking et al., 2002). Although Japanese older women share the view that women’s work represents not only their obligation but also their pride, they have an occupational pattern called “backstage work,” on special event days in their household (Lebra, 1984).

Traditionally, when Japanese families invited their guests to a feast for a celebration or rite of passage, the women in the house usually cleaned and decorated the house and cooked seasonal vegetables, fish, and fruits for a couple days before. Japanese value spending elaborate amounts of time and work preparing attractive and delicious food for their guests. If the event was really big and there were a lot of guests (like a funeral), other women relatives or neighbors were called for help.

At the feast time, however, the women were usually still busy working in the kitchen, and moved back and forth between the living room and the kitchen to bring food and drinks to the guests and to the husband, who accompanied the guests. The women rarely ate or drank at the table with the guests.

This backstage work was the appropriate pattern of women’s work for special household events, like celebration ceremonies, annual events, and mourning ceremonies. The occupations not only express women’s celebration of the event, but convey gratitude to the guests for their help and friendship in everyday life as well, in the present as well as the past. When the dinner was over, the guests left for their homes. The women then cleaned dishes, pots and pans, and the house, and organized things. When the event was over, the women were tired but relieved and proud of themselves, as they accomplished their responsibility in the event.

The three patients cooked traditional Japanese home-style dishes, talking with cheerful and excited voices. They modestly, but at the same time proudly, served their dishes to the therapists or their doctors. I suggested that they eat with us, but they refused, smiling. They preferred serving us dishes to sitting at the table with us.

While cooking and serving, they seemed cheerful and happy. They were very glad to hear that the therapists and the doctor were satisfied with their nostalgic style of food that tasted “like mom used to make.” Akari told to me happily that her doctor appreciated their nice meal and admired their cooking performance.

The three older female Japanese patients’ cheerful and excited voices and cooperation in cooking and their enjoyment of appreciation from significant others showed the valued meaning cooking had for them. They shaped their occupation into a kind of Japanese women’s backstage work. Their refusal to sit at the table and modest but decisive attitudes were those of the Japanese tradition of women as backstage workers on special days in a Japanese household. The three patients looked similarly proud and modest in cooking and serving others, even though the occupational therapy kitchen in the hospital was not beautifully decorated with ornaments and their guests were not in well-tailored suits or nice kimonos. These were their therapists in white pants and blue hospital shirts and their doctors in white lab coats. But the women had experienced traditional women’s occupational roles in social situations throughout their lives.
in domestic ceremonies, events, and family reunions. Now, participation in these occupations gave Akari and her peers a chance to engage in backstage work once again as a treat for their guests. They were excited to display their performance abilities again in a subtle and modest way, and were proud of it. They were also satisfied; creating a celebration for themselves and greeting others in their present living context enlivened and empowered them.

When the session was over that day, Akari described a frequent experience. While she was lying in bed at night, she imagined she could do anything the next day. When she awoke in the morning, however, she could hardly sit up in her bed from pain in all her joints and morning stiffness. Still, she was smiling while she told her story, talking to me at the entrance of the kitchen about how happy and excited she was to be able to cook and serve her dishes to others. She had believed she would never be able to cook again, and she had given up cooking many years ago. She said that now she was happy to have met me, her occupational therapist, thanks to whom she was able to cook and then to serve her dishes to her doctors and the therapists, whom she appreciated for their care of her.

Summary

Beginning with Akari's desire to have "fun," occupational therapy assisted her to cook. Through this occupation, she showed positive change in the third and fourth aspects of the continuum of the illness experience. She became more open while she was sharing her illness with others, and she found a desire for future occupational participation. Through the cooking activities, Akari developed social interactions with other patients and was able to show her gratitude to significant persons in the hospital where she was living. A pattern of sharing her cooking emerged that reflected traditional societal roles, providing a culturally meaningful experience. Akari regained some of the occupational role she had lost due to rheumatoid arthritis.

Akari's comments documented her movement on the continuum of the illness experience (suffering to healing) as she recognized her need for future occupational participation. Her words communicated the desire she experienced before she fell asleep at night, even though pain was, once again, throughout her body the next morning.

Through the therapeutic process, Akari lived out her desires. While she developed her cooking project, her need was to be accepted by the therapist. When she was cheered by the therapists, she answered by expanding her social interactions. She and her peers finally presented their food in an appropriate pattern of social actions for traditional Japanese women, which embodied the meaning of cooking to them. Akari paid attention to her whole context and responded to appropriate therapeutic opportunities for the healing process to occur. Her illness experience was changed through occupational therapy.

Social interactions in this therapy process show characteristic Japanese behaviors and motives similar to those of others with interdependent selves (Markus & Kitayama, 1991). Such persons are assumed to be more attentive and sensitive to others and are motivated to create and maintain relatedness with others more than people in Western culture, who take autonomy for granted and are motivated to express their own abilities and attributes. A person with an interdependent self does not give up personal desires, but interweaves them with the social context. Throughout this process, Akari came to be more open to others; her interactions more intense, caring, and reciprocal. She increased opportunities to care for her body, not neglecting her illness, but integrating it into her experience of meaningful occupations.

Cultural competence in this therapeutic intervention allowed the therapist to recognize the culturally salient characteristic of Japanese people of the interdependent self and integrate it into therapeutic occupation in ways that motivated the patient to develop culturally meaningful occupations. This activity embodied the occupational patterns of traditional women's work in Japanese society. The next story also provides a social drama offering a critical incident for reflection on cultural competence of occupational therapists, linking the illness experience to culturally relevant assumptions about relationships.

Story 2: India Ink

This story describes a therapeutic intervention with Taro (pseudonym), a male Japanese patient with a stroke, told by Mari (pseudonym), his Japanese occupational therapist. The story is analyzed using the Japanese cultural concepts of *amae* and *uchi/soto* (inside/outside). There is no precise English equivalent for the concept of *amae*, but it is usually translated in English as dependence or indulgence. *Amae* and *uchi/soto* are social terms that are particularly relevant to the therapeutic process described in India ink.

*Amae*

*Amae* is a noun that originally meant sweetness or easiness. Although *amae* is found among people all over the world, no other language has a term that means *amae* in the exact same sense. When *amae* is used among Japanese in everyday conversations, it means the desire to be passively cared for (Doi, 1971). The Japanese usually use it as a verb, "amaeru," which means to seek *amae*, or "amayakasu," which means to give (fulfills) *amae*. The person who expresses *amae* is an "amae-seeker." The other party, who fulfills
the *amae*-seeker’s *amae* is the “*amae*-giver.” Between the two parties, *amae* emerges like this: The *amae*-seeker often expresses *amae* (desire) nonverbally; the *amae* giver, responding to the *amae* seeker, fulfills the desire; and both have an intimate sense of unity (Doi). The prototype of a relationship in which *amae* emerges is between a mother and her baby. The baby cries or weeps, seeking *amae*. Responding to it, the mother knows it is hungry or wants her to change its diapers, and she does so, fulfilling its desire. Afterwards, the two of them feel satisfied and intimate with each other. Later, the child learns that its success in seeking *amae* depends on context, including to whom he or she expresses desire (Doi). As they grow, through experience, the Japanese become expert at both *amae*-seeking and *amae*-giving in the *amae* relationships (Markus & Kitayama, 1991). They use this *amae*, especially when they initiate new relationships with others. Among the Japanese, *amae* is required to make relationships with others smooth and comfortable. It is required for a healthy life and for adapting to society (Doi).

**Uchi/Soto**

*Uchi* and *soto*’s original meanings are inside or outside. In Japanese society, however, *uchisoto* means not only location, like “inside the room” or “outside the hospital,” and orientations of actions, like “put the baby inside the cradle” or “look outside the window,” but also reflects the sociocultural position of the self-relating to others or to the society; it is the self in context (Backnik, 1994). The Japanese use the terms “*uchisoto*” and “*soto*” in daily conversation, and many other terms belong to the group of *uchisoto* or to the group of *soto*. The terms included in the group of *uchisoto* are “*I*,“ “we,” “my family,” “our company,” “our club,” and others. Examples of terms included in the group of *soto* are “he” and “others.” Using a habitually *uchisotost* distinction, verbally or otherwise, the Japanese represent the degree of distance between the self and others. That enables them to anchor the self in a social context. As stressed by Markus and Kitayama, persons with interdependent selves give higher priority to relations with significant others than to autonomy in society (1991). Interdependent persons are not fixed socioculturally in relation to the society, but are shifting on the continuum of *uchisoto* and *soto* depending on the context. Through social practice, *uchisoto* becomes an arena in which the self is anchored and continues to be; the self is intimate with other *uchisoto* members and engaged with them. In *uchisoto*, things, habits or values are shared. *Soto* often has the opposite characteristics. In social practice, *uchisoto* and *soto* have many characteristics that are inverts of each other: informality/formality, intimate/distant, engaged/detached, sharedness/nonsharedness, and unity/diversity (Backnik, 1994).

When the therapist, Mari, met the patient, Taro, she was in her late 20s and had worked in a rehabilitation hospital for 4 years.

I treated Taro when I was working in a rehabilitation hospital. At the hospital, almost all of the patients had had a stroke. At the time I met Taro he was 65 or 64 years old. He had a stroke almost immediately after retiring from his job as the principal of an elementary school and had severe Wernicke’s aphasia. In addition, he could not use his right hand. He could walk with a cane, but his gait was a little unstable.

At first Taro was quite irritated. He tried to communicate his complaints to his wife. However, due to his aphasia, she could not understand him. He was often frustrated and would hit her with his cane or shout loudly at her. He joined a speech training group with a medical doctor. Nobody in the group could understand Taro. Therefore, he quit speaking all together and began behaving unpleasantly. He began physical therapy in order to make his gait more stable for independent living. He was upset at his physical therapist many times. When he became upset, he would leave and go to his room in the middle of the therapy session because he felt that his physical therapist did not understand him. He was identified by the medical personnel as “an egoistic patient.”

Occupational therapy was prescribed for Taro. At the start of therapy he was not relaxed. It was hard to talk to him. I talked to him one day while he was sitting on the sidelines, looking unpleasantly at the other patients doing physical exercise in a group, and invited him to join in the activities in occupational therapy. I said to him, “Would you like to do something? You seem bored with watching them doing exercise.” I wanted to change Taro’s mood.

In response, Taro showed me his right hand. Although I thought that it would be impossible for his right hand to recover, I performed a passive range of motion exercise on his right arm for a few weeks, and turned to exercise for changing his hand dominance. Taro started to relax. In addition, he began to try to communicate with me. In the end, I knew that he desired to learn to communicate. I tried to shape therapy around his desires.

When I asked him if he would like to practice writing, he nodded very excitedly. Because he could not write anything voluntarily, his writing exercise began with copying his name, his address, his family’s name, and my name. He loved to practice writing. He spontaneously practiced in his free time in his room and showed me his work often. I treated him supportively, saying, “You did well.” and “Good for you.” Taro progressed from copying words to sentences. Then he began to identify pictured objects. For example, he would write “telephone” next to a picture of a telephone. He also drew pictures of objects and asked me their names. Although he had not tried to repeat aloud before, now he tried to say something in voice. I praised him, saying that talking was important.
Irritation was disappearing from his face. He seemed really happy and was willing to do walking exercises. Later, he created his own way of keeping a diary and took messages by writing the name of a person who called his wife while she was out and drawing a picture of a telephone next to the caller's name. When he was discharged from the hospital, he communicated by saying words or showing pictures he had drawn.

After his discharge from the rehabilitation center, Taro came to occupational therapy periodically and continued communication exercises at home. I suggested that he keep memos about his everyday life. I also listened to and advised his wife, who was suffering from Taro's emotional problems. She was annoyed because he got irritated or depressed often. I tried to comfort her and discussed coping strategies. She complained that Taro was different from what he had been. His temperament before the stroke was mild. I told her that it would take a long time for him to return to his old personality. I recommended that she go out and leave him at home. He could take care of himself. I stressed that she needed rest. I also recommended that she take him to an elderly day-care center. I stressed also it was important for him to have something in which he could be engaged.

After 3 years, I received a letter from Taro's wife with a drawing in India ink by Taro and a photo. In the photo, Taro was relaxed at home. His wife wrote in the letter that the pattern of life had settled down. Taro was now an India ink artist and asked his wife to mail the drawing to me. In the end of the letter, she explained that he was too shy to write to me himself. He started to draw in India ink, which he saw in the elderly day-care center and then went with his wife to buy the necessary tools. He decided to start drawing by himself.

Until his death several years later, he mailed me a New Year card every year with greetings in his handwriting. I am glad that I helped him change and reconstruct his life. I am happy that I developed and maintained a good relationship with Taro.

Illness Experience

In the beginning, Taro's illness experience was chaos. He could not predict recovery from the stroke, so his view of life was dependent upon the random process of the degree of spontaneous recovery. It was difficult for him to face the changes in his body and provide care for it with his right side severely affected. Taro was not open to others and able to share the feelings about his illness experience. His communication problem rendered his relations to others very frustrating and conflicting. His verbal approach to others was not acceptable to his wife or the medical staff. He could not get help from the medical staff because of his communication problem. To have a desire was initially too hard for him given his chaos. He was totally frustrated and disoriented by his new context, after the debilitating stroke had disrupted his life. His chaos illness experience was not understood and he was treated as an unsocial patient in the hospital. As a result of this illness experience, he failed to comply with the medical staff (Frank, 1995).

Therapeutic Relationship and Meaningful Occupation

The therapist, Mari, was attentive to his chaos and his failure to situate himself in the new context. From her previous experience with stroke patients with speech problems, especially those with Wernike's aphasia, she knew that it was really hard for them to be understood by others and thus hard to be social. Mari talked to Taro and invited him to join therapy with her. Responding to the therapist's offers, Taro showed his *amae* by asking her to treat his right hand. By evaluating Mari as kind, beneficial, and trustworthy, Taro would have judged from his experience that she would accept and fulfill his *amae* and that it would be worthwhile to establish *uchi* with this therapist. Taro sought *amae*, and the therapist gave *amae*. Mari read his mind (Bruner, 1990; Markus & Kitayama, 1991), that is, understood his need without a direct verbal statement, and so she began to treat his right hand, despite the fact that she thought it would be impossible for his hand to recover function. Here, *amae* produced a warm, healthy, comfortable, protective relationship from which they started establishing *uchi* as an arena for his new life. *Amae* made it possible for Taro to situate himself in a safe and supportive relationship, express his intentionality and let him get involved in occupations for self-reconstruction. After that, *amae* disappeared, but their intimate and trustful relationship remained in *uchi*.

Mari took a risk in the *amae* relationship. Although professional knowledge and experience rendered the occupational therapy goal and program realistic and necessary in order to help him return to a meaningful life in the real world, there was actually no guarantee that the occupational therapy process would succeed after she accepted Taro's *amae* seeking. Nevertheless, Mari was willing to take the risk because she knew how necessary Taro's intentionality was for the transformation of his self in the context of his illness experience. In an *amae* relationship, the occupational therapist can perceive the patient's intentionality and help him or her actualize it in occupations that bring about the transformation of the self or allow the recreation of their life.

Taro and his therapist established their *uchi* with the purpose of embodying his illness experience for healing or making a new life. After establishing that relationship, Taro began to anchor himself in the *uchi* arena. Among its characteristics, *uchi* includes intimacy and solidarity, but charges the member with active participation as an obligation in
order to continue its existence (Kondo, 1990). To belong to an *ie*, the Japanese traditional household, is a prototype of *uchibi*; it was demanded of a bride, a newcomer, that she participate actively in the household work. By the same token, to succeed in therapy, Taro was not only given *amae* but was required to participate actively in actualizing his intention to establish a new life and to hold himself in this context.

In this therapeutic intervention, the story becomes a critical incident in which therapists can recognize the integration of culturally salient phenomena (*amae* and *uchibi/soto*) into the therapeutic relationship. In contrast to a Western emphasis on independence and objectivity, the therapist allowed a dependent and close relationship to develop. In this relationship she assisted the patient to find and to engage in occupation meaningful to him and thus, to reestablish his life.

**Conclusion**

This paper analyzes patients’ experiences and therapists’ experiences in the therapeutic process as therapists assist patients to participate in meaningful occupations. As a health care profession in a multicultural society, it is important for occupational therapists to develop cultural competency. Beyond the first step of cross-cultural studies, it is time for therapists to further explore people’s experience as cultural beings. The two stories in this paper present examples of critical incidents, stories of social dramas within occupational therapy that illustrate unique cultural assumptions, beliefs, and concepts. This paper introduces the cultural analysis of concepts that are salient among Japanese communities to promote therapists’ understanding of insider’s non-Western view. The analyses show how the occupational therapists have created their own approaches toward their patients’ healing, using traditional local cultural concepts, shared by patients and therapists.

Such cultural analyses will help occupational therapists to develop cultural competence through reflection on their own cultural lenses. They can help therapists to understand patients from different cultural backgrounds from the therapist’s, to better integrate their patient’s cultural view into therapeutic interventions and to assist patients in finding culturally meaningful occupational experience. Within their own cultures, therapists can benefit from such analysis by increasing their understanding of the cultural nature of their own values, beliefs, and actions. This will improve their cultural competence with patients of their own cultural backgrounds, because people do not always understand the embedded values in their own cultures. The author believes that cultural analysis of stories of occupational therapy practice as critical incidents promotes cultural-general competence of therapists both for patients from different cultures and within one’s own. Therapists’ reflection of their own experience in the therapy process, both during and after therapy, will heighten their awareness of their own attitudes toward different cultural views and strengthen therapeutic attention to the patient’s cultural view. Occupational therapists must not only be aware of, sensitive to, and respectful of their patients’ cultures but we must make efforts to integrate the patient’s cultural view into therapeutic intervention to promote meaningful occupational experience.

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