Cross-Cultural Occupational Therapy: A Critical Reflection

Astrid Kinebanian, Marjan Stomph

Key Words: culture, sociology • values clarification

In the Netherlands, Dutch health care professionals, including occupational therapists, are confronted with a growing number of patients whose cultural backgrounds differ from theirs. Acknowledging this influx, the Dutch government allocated a grant for educating occupational therapy students on cross-cultural care. This paper summarizes the information we collected from a survey of Dutch occupational therapists on treatment of immigrants and briefly describes the eight educational tools we developed for the two occupational therapy curricula. Two of these tools are described fully—first, a critical essay on the white middle-class values and norms that underlie occupational therapy theory and practice, and second, the guidelines for developmental policies to use in the treatment of immigrant patients. Case studies illustrate how the values of our profession create obstacles to cross-cultural care.

Astrid Kinebanian, MA, REG OT, is Assistant Professor, School of Occupational Therapy, Hogeschool van Amsterdam, the Netherlands. (Mailing address: Meidendorf 457 1106 EN Amsterdam, the Netherlands)

Marjan Stomph, REG OT, is Assistant Professor, School of Occupational Therapy, Hogeschool van Amsterdam, the Netherlands.

This article was accepted for publication April 28, 1992

In many parts of the world there are various groups of immigrants, each with its own culture. Most live under marginal conditions: They are poorer and less educated than the dominant cultural group, and their values and life-style are seen as underdeveloped. Immigrants have come to the Netherlands from all over the world, but mainly from Indonesia, Vietnam, the Middle East, the Mediterranean, Suriname, the Caribbean, China, and Sri Lanka. The topic of this paper is the provision of health care, specifically, occupational therapy services, to these immigrants from a cross-cultural perspective. The issues we discuss are equally applicable to groups of people in other countries who for reasons of race, ethnicity, or social class are seen as distinct from the dominant group.

Unlike the system of individual health insurance in the United States, the national health insurance system in the Netherlands provides equal access to health care for all, but immigrants do not benefit equally from the treatment because treatment procedures are not geared to their particular needs. In fact, the philosophies of some professions, such as the norms and values underpinning occupational therapy and embedded in the concepts of independence and meaningful activity, may create obstacles to the care of immigrant patients.

We obtained a grant from the Dutch government to develop teaching materials that would provide occupational therapy students with the cultural skills they would need to respond to the cultural expectations of immigrant patients (Kinebanian & Stomph, 1991). We collected relevant literature from therapists in other countries, interviewed teachers in the two Dutch occupational therapy schools, and conducted a survey and interviews of occupational therapists in practice.

Collection of Information

We wrote to 25 occupational therapists in 10 countries (Australia, Austria, Belgium, France, Germany, Great Britain, Iceland, New Zealand, Switzerland, and the United States), all members of the World Federation of Occupational Therapists, and asked them for representative literature on the topic of cross-cultural care. Reviewing the articles we received from only 3 of the 10 countries, we learned that the dilemmas that occupational therapists encounter in the Netherlands in the care of immigrant patients are common throughout the Western world (Austin, 1988; Cromwell, 1987; Essame, 1990; Hume, 1984; Lightfoot, 1985; Mullaney-O'Byrne, 1990; Tebbutt & Wade, 1985; Wan Khoo & Renwick, 1989; Wieringa & McCall, 1987).

From interviews with the teachers in our two occupational therapy schools, all of whom have Dutch backgrounds, we found that students are taught to consider the patient's background but that little attention is given to specific difficulties encountered in the treatment of
people from other ethnic groups. The number of occupational therapy students from immigrant groups is less than 1% (Knébanian, 1990).

To learn more about the extent and content of the problems encountered in the treatment of immigrant patients, we sent a questionnaire to all 374 occupational therapy clinics in the Netherlands. One hundred and ninety-nine clinics (53%) returned the questionnaire. Of these clinics, 134 treated immigrant patients, and our findings are based on this group. None of the responding clinics kept a detailed record of ethnicity, but their estimates of immigrants as a percentage of total patient load are shown in Table 1. These estimates correspond broadly to national figures (Sociaal en Cultureel Planbureau, 1990).

Of the 134 clinics that treated immigrant patients, 25 were selected for interviews about their treatment facilities and their approaches to this population. All the therapists interviewed had a Western background and, regardless of the percentage of immigrant patients treated, only one of the clinics had a policy regarding treatment of these people. Most of the interviewees stressed the importance of being experienced in treating these patients to provide adequate care.

From a content analysis of the interviews (Knébanian & Stempf, 1991) we concluded that the problems encountered by these therapists are similar to those encountered by all professionals in the treatment of specific ethnic groups, namely problems of communication. However, certain dilemmas related to norms and values within occupational therapy itself were mentioned as obstacles to the treatment of immigrant patients. These dilemmas were an emphasis on the patient's independence, an emphasis on purposeful activity (e.g., the doing-it-yourself philosophy), a focus on the patient's home and work environments, and having to plan treatment in the context of administrative regulations with a focus on reimbursement.

Using this information, we developed eight educational tools for use within the schools, as follows:

- A critical essay on the white middle-class values of the profession, which serves as background information for students and teachers.
- Guidelines for the treatment of people with cultural backgrounds different from that of Dutch occupational therapists
- A manual for students containing five case studies and student tasks
- A manual for teachers
- A reading file containing articles on occupational therapy with immigrant patients
- A list of audiovisual materials and resource addresses
- An adaptation of clinical practice requirements
- A 2-day course for teachers.

We describe below the specific content of only the critical essay and the guidelines.

Dilemmas in the Treatment of Immigrant Patients

**Independence**

The major value guiding occupational therapy intervention is to help clients achieve independence (Council of the World Federation of Occupational Therapists, 1990; Frieden & Cole, 1985; Rogers, 1982). In technical, social, and emotional terms, this is a Western white middle-class value. It is associated with making one's own decisions, having freedom of choice, knowing what one wants to achieve in life, and accepting personal responsibility.

In most non-Western societies, such values as being part of the family, accepting other people's decisions, and honoring the family are more important than independence. In many non-Western cultures, dependency is a respectable choice. Subordination without loss of self-respect is a normal way of life. Patients from these cultures who are receiving occupational therapy may be better off focusing on a shift in the roles and tasks of the family than on personal independence. One of our respondents gave the following example:

A 60-year-old Hindu man was admitted to a rehabilitation center with hemiplegia. He is able to do quite a lot by himself, but he does not want to do a thing, because he is counting on God to make him better. The constant care that he needs is physically too demanding for his wife. His children are able to help him only during the evening and at night. In such a case it might be better to find a solution together with the family and his own ethnic organization and offer community care facilities so that this man can keep his self-respect and his wife can be relieved.

From the viewpoint of cross-cultural care, it might be advisable to define the aim of occupational therapy in terms of interdependence rather than independence.

**Purposeful Activity**

Cross-cultural care may require reconsideration of the core of occupational therapy: being engaged in purposeful activity. Although Katz and Sachs (1991) point out that occupational therapists ascribe different meanings to this concept, it is clear to all occupational therapists that get-
ting patients involved in an activity by facilitating their doing the activity themselves is the core of the profession.

Activities are the primary means and tools of the occupational therapist. The emphasis that occupational therapy places on engagement in purposeful activity by persons who are sick or disabled contrasts sharply with the way most non-Western cultures treat sick and disabled persons. Immigrant patients may expect the occupational therapist to do something to make them better. They believe that submitting to treatment is the right attitude. An occupational therapist working in a rehabilitation center stated the following:

If somebody with a Dutch background comes here with a hand injury, he is normally easily motivated to do as much as possible by himself to activate and train his hand. Most of the people from other cultures wait until they get better. You can hardly motivate them to do anything themselves to speed up their recovery. Most of these people don't have to do anything—they are taken care of. That is the custom.

As occupational therapists, we shall have to change our approach and philosophy regarding the active participation of patients in treatment. Respect for and recognition of patients' views on the way they want to participate are essential. Occupational therapists should adapt to the patients' life styles. Activities that enable patients to express their perceived social status and have it acknowledged might afford some opportunity for them to participate in their treatment. To choose such activities, the occupational therapist should analyze what is appropriate in the patient's culture and what purposeful means to the patient. The family plays an important role in this approach, as do representatives of the patient's cultural organizations. From them we can gain information about the meaning that certain activities have for the patient and the family.

Home and Work Environments

The occupational therapist is skilled in analyzing patients' living conditions and relating the analysis to what the patient can or cannot do. Because this analysis serves as a basis for treatment planning, the therapist might expect to conduct it the same way for immigrant patients as for other patients. However, Western occupational therapists analyzing the life-styles of non-Western patients are confronted with many problems. They do not recognize the symbolic and emotional meaning of objects and habits for these patients. The patient does not understand why the occupational therapist wants to know so much about issues that the patient sees as routine or private. An occupational therapist interviewed on this subject said the following:

Often I skip the training of ADL [activities of daily living] activities such as washing and dressing, because it is so difficult to know what to do in this sort of case. We hardly do any ADL activities with men.

To analyze the domestic and living conditions, the occupational therapist has to gather a lot of information about the way immigrants live. Finding information about a group's habits in the professional literature is difficult. Fictional works and documentaries give some insight into the life-styles of ethnic groups, but they express mainly how people think and feel. Although this is valuable information, as occupational therapists we are especially interested in how people perform certain activities and why they do them that way. Observing them in a real-life situation might be the best way to gather information. The wish of many members of ethnic groups to establish friendship with the therapists is useful: A therapist who visits for a friendly cup of tea can gather a lot of information in a natural way. An occupational therapist who treats children told us the following:

Very often I visit families of children from ethnic groups at home. I treat many Turkish and Moroccan children. I know that because of their cultural background, these people do not stimulate severely handicapped children. Because they are sick, the children are allowed to do nothing. I show the mothers what you can do with the child by putting it [sic] in a certain posture. Mostly I take a simple self-made toy with me as a present, not something from a store. For example, an empty plastic bottle with some little stones in it so it rattles nicely. I take the time to see what happens at home. Often mother is busy in the kitchen, then I show her that the child can roll a carrot, an onion, or some dough. So the mother sees that by doing this the child can have the same experiences as other kids have daily. Often the child enjoys doing such things, the mother sees the child's pleasure. I also show the mother how she can care for the child in an easy way. And of course I adjust myself to their customs, of course I take off my shoes in a Moroccan home, just as I would accept coffee with a biscuit in a Dutch home.

Another aspect that needs consideration is the role of religion and traditional healing methods (Essame, 1990). In Western society, medical care is almost completely separated from spiritual and religious concerns. Spiritual or religious problems are dealt with by a member of the clergy; these problems do not belong to the domain of medical professionals. For most immigrants, however, spiritual or religious matters dominate the perception of illness. As occupational therapists, we have to learn about the role of religion and traditional healing methods in these cultures, especially because we are so interested in the way people live and because religion is so much a part of daily life for these people.

Most immigrants belong to the working class, and many have problems concerning work. The unemployment rate among immigrants is high in the Netherlands as well as in other countries (Bennani, 1980; Reid & Trompf, 1990; Sociaal en Cultureel Planbureau, 1990; Tebbutt & Wade, 1985). Many of them emigrated hoping to work hard for money to support their families both here and back home. When they become disabled, their future in the Netherlands and in their own countries collapses. Occupational therapists often find that immigrants are able to do less and experience more pain than is strictly justified in medical terms. Assessing their capaci-
ity for work then becomes difficult. An occupational therapist working in a vocational rehabilitation setting stated the following.

Very often I notice that the way immigrants handle pain is very different. How it differs I do not know—that is the problem. The pain people express is not medically understandable. I think there are many psychosocial problems of which I do not know the origin. Very often people come here with chronic pain. They come here to get rid of their pain and they do not understand that they have to do practical activities that may cause pain.

Bennani (1980) pointed out that with their sickness of body, many Moroccan immigrants express their opposition to a society that only uses them as labor. They came here to work and sold their bodies for much too low a price. Often they became sick because of their work. The pain of the immigrant, according to Bennani, is a call for help with socioeconomic problems and recognition that he has for many years been used only as a working body, a body that was not allowed to express itself in its own way or to show sorrow or pleasure. Recognizing the essence of this suffering is necessary if we are to help immigrant patients. For example, understanding their feelings and acknowledging the socioeconomic factors by giving a decent disability allowance are prerequisites for treating immigrant patients. As long as modern medical care, including occupational therapy, separates body and mind, and every subjective complaint is seen as irrational or simulated, as long as medical science concentrates only on the pain, we will increase rather than decrease the suffering of the immigrant patient.

Treatment Planning

Treatment planning and assessment procedures as normally used in occupational therapy are often inadequate for immigrant patients. The division between the phases of assessing the problem, formulating the treatment goals, and treating the patient do not seem logical to immigrant patients. The direct approach, so normal within the Western medical model in which you must explain your problems and what you want done in 15 min, does not work with these patients. Of course the different phases of treatment normally overlap, but with immigrant patients we advise starting the actual treatment at an early stage. During the assessment, the therapist must establish a relationship with the family. As mentioned above, a friendly visit to the patient’s home is useful in this respect.

The treatment model that is chosen also needs consideration. Different authors (Wan Khoo & Renwick, 1989; Wieringa & McColl, 1987) have described how the Model of Human Occupation (Kielhofner, 1985) can be used to obtain information about the cultural background of the patient. However, as Wieringa and McColl pointed out, this model is also influenced by cultural biases. For example, it defines dysfunction as “the inability to effectively accomplish daily tasks and to enact occupational roles. The adjective 'daily' implies a cultural bias as to how activities are organized in time” (p. 78).

Time concepts and the use of time are specifically influenced by culture. Peloquin (1991) described how important it is for occupational therapists to have an understanding of how time concepts in the United States are formed by images that the media force on people. Western society values time as a commodity that can be bought and sold, wasted or saved. In other words, time is money. The whole administration of treatment planning, how long it will last, how often it will be carried out, and the exact hour, is based on this idea, especially because the current health care climate shows more interest in reimbursement than in fulfilling a person’s needs. For non-Western people, this is difficult to understand; for them it is not so important when something happens, as long as it happens. Often in these cultures it is impolite to be in a hurry. One must have a lot of time for friends, and a good therapeutic relationship is partly based on friendship.

The routines of an occupational therapy clinic strongly affect the treatment process. The strict time schedule and the implicit norm not to have friendly relations with patients might need changing if we want to work with these patients in a positive manner. These changes would require changes in the department’s policies. It might turn out that in practice occupational therapists and hospital administrators would be reluctant to introduce these changes because of today’s emphasis on short-term economic profit.

The furnishing of the occupational therapy clinic also requires special attention; recognizable items from the patient’s culture should be used. For example, a Turkish meal can be prepared, or the practice apartment can be furnished in a Japanese way. Katy Austin (1988), an occupational therapist from New Zealand, presented a paper at the European Congress on Occupational Therapy that explained how a unit of a psychiatric hospital was built and furnished in a Maori way to treat Maoris more adequately.

Case Studies

We illustrate these dilemmas with two of the case studies included in the student’s and teacher’s manuals we produced.

What Should the Aim of Treatment Be?

Mr. O., a 45-year-old man who emigrated from Turkey 20 years ago, was sent to the occupational therapy department in a rehabilitation center. His former job was loading and unloading ships. A few years ago he had had an accident in which he tore the ligaments of both knees and suffered a lower back injury. After this injury he received
rehabilitation. At the end of this period the medical insurance adviser decided that although Mr. O. was no longer able to do his former job, he was fit to work as long as the work was not heavy, and he was thus entitled to some measure of disability compensation. Because of his lack of training, Mr. O. did not succeed in finding another job.

Mr. O. did not agree with the decisions about his recovery and the size of his allowance. He still suffered a lot of pain and could do little because of it. He decided to go back to Turkey to consult Turkish physicians and healers. In Turkey, the physicians told him that he really was severely ill. Back in the Netherlands, he applied for more treatment in a rehabilitation center. After assessing him, the occupational therapist decided that the chief aim of treatment should be to increase his walking and standing endurance so he would be more independent of his family. To attain this goal, she tried to get him involved in purposeful activities. The assessment showed that he used to repair tractors and motorbikes in Turkey. Mr. O. told her that he still liked to do repairs but was no longer able to because of his physical condition. The occupational therapist assigned him to supervise and help a young man in the center who was following a vocational program to see whether he could be retrained as a mechanic.

After 6 months of training, Mr. O.'s endurance had improved from 5 to 15 min, but after that time had elapsed he suffered so much pain that he started to tremble and perspire. The occupational therapist concluded that the complaints were so severe that, although there was no medical evidence for it, Mr. O. was unable to work. On the basis of the occupational therapist's report, he became entitled to a full disablement allowance. The most important points for Mr. O. were that the physical therapist, the occupational therapist, and the physiatrist acknowledged his problem, that they had seen his willingness to do everything he could to improve, and that they had noted his skill at repairing motorbikes. Since his discharge, he has continued to help the young man and is happy he has a new friend.

Evaluating this treatment, one can ask whether the goal of promoting the patient's independence from the family by increasing his endurance was the right one. The treatment result may be described better as acceptance of disability than as improvement of endurance. By performing a supervisory task in which he could show his knowledge and assume a role of responsibility, the patient regained his self-respect.

What is Wisdom?

Y., an 18-month-old girl with quadriplegia resulting predominantly in an extensor spasm, was sent to the occupational therapy department in a general hospital. The referral requested treatment as soon as possible and advice for severe feeding problems and bathing and clothing problems. Taking care of their child with severe disabilities was becoming too much of a burden for the family. The father's parents and grandparents were immigrants from Morocco. Both parents worked the whole day while the grandmother looked after the girl. They all spoke only a few words of Dutch. The occupational therapist did not speak any Arabic. At the time of the first treatment an interpreter was present. The occupational therapist gave advice about posture during feeding. After a few treatment sessions, she decided to visit them at home to obtain an impression of the home environment and see what facilities there were. The family lived in an inner-city apartment on the third floor. There was no elevator in the building. The grandmother lavished loving care on the child, although it was obvious that the care was too demanding for her because she did not know how to handle the spasms. The occupational therapist ordered adapted equipment for sitting and bathing. She gave advice about clothing and playing and stressed the importance of play stimulation for the child's development. Because the apartment was totally unsuitable for a wheelchair, the occupational therapist applied to the municipality for a different house. After the visit, the treatment was continued in the hospital. After a couple of months the occupational therapist realized that neither the treatment nor the advice and equipment had affected the way the grandmother stimulated Y. After a consultation with the grandmother in the presence of an interpreter, the occupational therapist decided to continue the treatment at their home for weekly sessions of 90 min for a period of 6 weeks. She hoped she would be able to attune better to the grandmother's way of looking after the child. After 6 weeks, the occupational therapist understood the grandmother's way of caring for Y. The grandmother was glad that the occupational therapist appreciated her way of doing things. She also understood what was happening in therapy and enjoyed the pleasure her grandchild had when playing with the therapist.

Evaluating this treatment, one can ask whether the therapist should have taken more time to attune to the grandmother's way of doing things in the beginning. The energetic way in which the occupational therapist organized the various facilities, which would have been the right way in Western eyes, obviously did not work.

Guidelines

As part of the project on cross-cultural care, we developed a number of guidelines as recommendations for changing policy and treatment. These guidelines are meant to give occupational therapists some practical ideas on how to adjust therapy in cross-cultural terms. Developing a special policy with structural measures is important—it is not enough just to implement incidental changes. Making policy is time consuming and requires persistence. These recommendations are meant to enable the start of such a process. Exchange of both experi-
ences and research are necessary to develop truly cross-cultural occupational therapy. In the guidelines, we focus on the general policy of the occupational therapy department, the organization and furnishing of the department, improvement of the occupational therapists’ expertise, and treatment procedures. Developing better care for immigrant patients is not a matter of designing a specific method for specific groups of patients. More important is to realize one’s own assumptions and to ask oneself when, where, and why these assumptions are part of treatment. We presented a summary of these guidelines, to help occupational therapists discover their own biases and to adapt occupational therapy service for an increasing number of patients with a non-Western background (see the Appendix for a summary of the guidelines).

Conclusion

Analyzing the main concepts of occupational therapy from the viewpoint of cross-cultural care, we concluded that occupational therapy has incorporated Western white middle-class values into its theory and practice. For example, having personal independence, engaging in activity, and doing activities oneself are emphasized as important treatment goals. Changes in the norms and values underpinning occupational therapy as well as in the attitudes of occupational therapists must be made; occupational therapy departments will have to develop special policies.

Sensitivity and adjustment to cultural differences have long been part of occupational therapy philosophy. To adapt treatment to cultural parameters is, however, a difficult task. We Western therapists view the world through categories, concepts, and labels that are products of our own culture. Realizing that Western culture is dominant and present all around us is a first step in the development of cross-cultural occupational therapy.

Acknowledgments

We thank Harold Alexander and Jan Gunning for their help with the translation and the layout and Mieke Jacobs-Le Granse for help with the literature review. The Hogeschool van Amsterdam gave financial support for the editing of this article.

Appendix

Summary of Guidelines

Fact Finding

- Identify specific ethnic groups treated in the department.
- Obtain support from other disciplines and the administration about adaptations such as signs in various languages.

Increasing the Expertise of the Occupational Therapist

- Follow a course on communicating with specific ethnic groups. (How can I, who belong to a specific ethnic group, communicate with a person who belongs to another ethnic group?)
- Obtain information about culture and lifestyle from specific ethnic organizations.

Making Physical Changes

- Translate information and treatment materials used for patients.
- Adapt the time schedule.
- Adapt activities of daily living settings to incorporate cultural idiosyncrasies.

Adapting Therapeutic Approaches

- Identify areas where cultural aspects may be relevant to treatment.
- Acknowledge the complaints, especially when they are expressed in another way than we are used to in Western society. For example, some people express pain instead of hiding it.
- Focus on similarities with patients rather than differences. For example, being a mother or father.
- Acknowledge the importance of culture.
- Allow time to become familiar with patients’ and caregivers’ values, important symbols, and objects.
- Try to arrange for friendly home visits.
- Set goals that are priorities to the patient—focus on the person’s roles and tasks in the community.

References


Council of the World Federation of Occupational Therapists. (1990). Recommended standards for the education of occupational therapists. Author (For more information, contact Barbara Posthuma, Executive Secretary, Department of Occupational Therapy, Faculty of Applied Health Sciences, Room 2555, Elborn College, the University of Western Ontario, London, Ontario, Canada N6G 1H1).


students and practitioners in the United States and Israel. American Journal of Occupational Therapy, 45, 157-145.


