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Teaching for Cultural Competence in Non-Diverse Environments

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ABSTRACT

Purpose: The purpose of this paper is to present teaching strategies to enhance students' cultural competence in non-diverse educational settings. **Methods:** Utilizing Purnell's cultural competence model and Lattanzi's cultural ladder the authors describe teaching strategies used to promote students' understanding of the complex nature of culture and how the multiple layers of culture influence the healthcare professional-client relationship. Teaching strategies and subsequent student reflections are presented. **Results:** Students adjusted client interventions and plans of care when confronted with various cultural characteristics of their clients. Integrating cultural issues in non-diverse academic settings challenges faculty to create situations that include cultural differences. The Purnell model demonstrates the complex nature of culture and the difficulties in understanding the various dimensions of culture. Lattanzi provides a framework for applying Purnell's model, beginning with cultural sensitivity and awareness, then working toward integration of cultural concepts in clinical interactions. Combining aspects of these cultural models, the authors layered cultural dimensions to course and clinical activities thereby increasing students' awareness of culture's influence on clinical interactions. **Conclusion:** While selection of diverse clinical settings provides invaluable immersion experiences for cultural competence, faculty in non-diverse academic settings can incorporate diversity dimensions within the academic curriculum to prepare students for the multicultural client population they may encounter as healthcare practitioners.

INTRODUCTION

With the United States becoming increasingly diverse, health care professionals face a greater multicultural clientele necessitating that healthcare education programs prepare them to deliver culturally congruent care by including multicultural content in their curricula.¹⁻³ Such education is most effective when individuals make connections with their personal experiences,⁴ yet this proves challenging in health care professional education when the student population is significantly less racially, and ethnically diverse than the client population they treat.^{1,3, 5-9} In addition to differences in race and ethnicity, health care professionals possess higher levels of education than the general public as only 24.4% of the U.S. population in 2006 held a bachelor's degree or higher.^{10,11} Despite the limited diversity in health care professional classrooms, educators are encouraged to implement teaching strategies that promote students' understanding of diversity and culturally congruent care.

The terms diversity and culture are not interchangeable, though are sometimes used that way. The dictionary defines diversity as 'difference from' or unlikeness.¹² Various professional groups recognize diversity as it refers to human groups with respect to race, color, national origin, religion, gender, sexual orientation, gender identity and expression, veteran status, age, socioeconomic status, and disability.¹³⁻¹⁴ For the purpose of this paper, diversity represents the difference between, as well as within human groups, as they relate to race, color, national origin, religion, gender, sexual orientation, gender identity and expression, veteran status, age, socioeconomic status, and disability.

While diversity refers to difference, culture encapsulates more than difference. Purnell and Paulanka¹⁵ define culture as “the totality of socially transmitted behavioral patterns, arts, beliefs, values, customs, lifeways, and all other products of human work and thought characteristics of a population of people that guide their worldview and decision making.” Referring to how culture occurs in lived experiences, Leavitt¹⁶ proposes “that one brings together their behaviors and attitudes in a continuum, enabling a health care system, agency, or individual practitioner to function effectively in transcultural interaction.” In Purnell’s model, he presents cultural competence as a non-linear, conscious process involving multiple characteristics.

Figure 1 - Purnell/Paulanka: Transcultural Health Care, A Culturally Competent Approach, F.A. Davis

Primary characteristics of culture: age, generation, nationality, race, color, gender, religion

Secondary characteristics of culture: educational status, socioeconomic status, occupation, military status, political beliefs, urban versus rural residence, enclave identity, marital status, parental status, physical characteristics, sexual orientation, gender issues, and reason for migration (sojourner, immigrant, undocumented status)

Unconsciously incompetent: not being aware that one is lacking knowledge about another culture

Consciously incompetent: being aware that one is lacking knowledge about another culture

Consciously competent: learning about the client's culture, verifying generalizations about the client's culture, and providing culturally specific interventions

Unconsciously competent: automatically providing culturally congruent care to clients of diverse cultures

The process involves reflecting on one's personal development as it has been influenced by gender, race, ethnicity, religion, education, and socioeconomic status, represented in the inner circle of Figure 1. As one understands oneself, he progresses to

learning about other cultures. In the figure's outer circle, one begins to see the relationship between oneself, others, and the social context of work, family, and community. Beginning with the self and working outward to understand others, one starts to gain an appreciation for cultural similarities and differences and demonstrate the cultural competence characteristics outlined in Table 1.

Table 1 Cultural Competence Characteristics (from Purnell LD. The Purnell Model for Cultural Competence)

- Developing an awareness of one's own culture, existence, sensations, thoughts, and environment without letting them have an undue influence on those from other backgrounds;
- Demonstrating knowledge and understanding of the client's culture, health-related needs, and meanings of health and illness;
- Accepting and respecting cultural differences;
- Not assuming that the healthcare provider's beliefs and values are the same as the client's
- Resisting judgmental attitudes such as "different is not as good;" and
- Being open to cultural encounters
- Being comfortable with cultural encounters
- Adapting care to be congruent with the client's culture
- Cultural competence is an individualized plan of care that begins with performing an assessment through a cultural lens

Building on Purnell's model, Lattanzi created steps to culturally competent practice that begin with self-awareness and work toward culturally congruent interventions.

Figure 2. Lattanzi's Steps to Culturally Competent Practice for the Physical Therapy Practice, F.A. Davis

Other authors offer similar methods to promote cultural competence in health care professionals.^{1,3,17-20} These authors suggest applying teaching methods that increase one's knowledge about different cultural groups; examine one's own cultural beliefs, attitudes and behaviors; immerse individuals in diverse environments; as well as encourage communication about cultural differences. Integrating these cultural strategies in the classroom requires concentrated effort and a commitment by individual faculty as well as the overall educational program. Given the relative homogeneity of health care professional education programs, immersing students in diverse environments prior to clinical internships presents a significant challenge for educators and is complicated by students differing levels of cultural maturity. Yet teaching strategies can be implemented to increase students' multicultural understanding and its associated diversity, in order to move them toward culturally competent care.^{21,22} In this paper, the authors present teaching strategies that utilize Purnell's model of cultural competence and Lattanzi's cultural ladder to infuse culture into a non-diverse professional educational program.

METHODS

Purnell's cultural model guided course content development while Lattanzi's cultural ladder provided the sequence from which culture was integrated into the curriculum. Guided by these two models, the authors developed teaching strategies that employed the multiple dimensions of culture. The overall goal was to increase students' awareness of culture and its influence on professional interactions in the health care setting. Purnell's model focuses on the complex nature of culture that includes multiple life dimensions such as behaviors, heritage, and healthcare practices. The model emphasizes how we influence, and are affected by family, community, and the global society. Lattanzi's model begins with self-examination, progressing up the ladder by moving outward to learn about, and respect others to engage in successful cross-cultural interactions. One ascends to the top of the ladder by applying knowledge and skills gained to demonstrate culturally congruent evaluation, goals, and interventions. As students engage in these examinations of self, family, and community, they travel through 4 steps: unconsciously incompetent; consciously incompetent; consciously competent; and finally unconsciously competent. Purnell notes that becoming unconsciously competent is rare, yet emphasizes the three previous stages. Being unconsciously incompetent, one is unaware of one's own as well as others' culture, thus the rationale for beginning on Lattanzi's bottom rung of cultural self-awareness.

Teaching Strategies

The initial step in the teaching strategy was to ask students to consider their own cultural practices when presented with the dimensions outlined in Purnell's inner circle. They wrote about and discussed high risk behaviors, family roles, health care practices, and communication styles. They explored their values, beliefs and attitudes about these topics, uncovering social experiences that influenced their belief systems. As students uncovered their own culture, course activities were added, requiring them to learn about others' culture, including differing cultural healthcare practices. After exploring self and others, we presented students with clinical cases for which they developed evaluation and intervention procedures.

After students determined their clinical approach, cultural characteristics were layered onto the respective case studies, now requiring students to develop interventions that demonstrated respect for cultural differences. Students reported this layering technique caused them to challenge the assumptions with which they approached the original case, learn more about other cultures, identify ways to demonstrate respect for the recognized differences, and consider changes necessary to provide culturally congruent care. The corresponding classroom conversation focused on appropriate provider-client interactions, cultural rituals, and inclusion of client belief systems in goal planning.

Once in the clinical setting, students were expected to apply the knowledge and skills gained in the classroom. They began using Kleinman's explanatory model interview questions^{23,26} which have been used to train various health care professionals in how to care for patients from different ethnic and cultural groups for over 30 years.²⁷ Kleinman's questions focus on how the client perceives the problem, asking the therapist to step outside oneself to see the clinical problem from the client's perspective. The questions focused on the client, the family, and social situations that can impact and are influenced by the client's injury or illness. Students documented this clinical experience in a narrative that compared using Kleinman's questions to those outlined on many clinical intake forms.

Table 2. Course Activities

Course Diversity Learning Outcomes	Assignments	Case Examples
<p>1. Understand how patient diversity will affect examination, evaluation, and intervention. (Examples included psychosocial issues, socioeconomic status, body size, age, gender, and race to name a few).</p> <p>2. Integrate teaching strategies into intervention plans for patient and family education, respecting the learner's abilities, family, work, cultural, and social situation.</p> <p>3. Demonstrate cultural competence integration within a clinical practice setting by including alternative interview strategies that yield culturally sensitive information. Include information gained from the alternative interview into the client/patient plan of care.</p>	<p>1. Three times during the semester small groups of students were given a specific case based on the region of the spine we were covering: lumbar, sacroiliac, and cervical/thoracic.</p> <p>A. The students were initially given the case history only and had to establish their hypothesis for the PT diagnosis.</p> <p>B. Next they listed what examination procedures they would perform in order to confirm or refute their hypothesis.</p> <p>C. Finally they were given the objective findings from an examination for the patient and had to determine what their final PT diagnosis was and then develop their interventions.</p> <p>2. Once the students presented all of their findings to the class, the instructor layered the case with additional cultural diversity information. Discussion followed related to any changes or recommendations for examination, evaluation, or intervention and teaching strategies.</p> <p>3. Students were required to read Kleinman²³, - Patricola²⁴, and Leavitt¹⁶. They followed these readings by reviewing and discussing two health care interview techniques – the standard biomedical intake questions; and Kleinman's Explanatory questions. Subsequently they viewed a digital video entitled The Culture of Emotions: A Cultural competence and diversity training program²⁵. Following the class session, students were expected to apply their new knowledge in clinical practice.</p>	<p>1. Case example: Thirty-eight year old woman with low back pain for several years; back pain has been mild and centralized until 1 month ago after taking a step aerobics class for the first time. Chief complaint: central low back pain, right buttock pain and right LE posterior thigh pain which is limiting exercise and her daily activities. Worse: with walking, exercising (aerobics class or stair master) and standing for any period of time. Better: with sitting or lying down. ADLs: part-time office/secretarial job; 2 children ages 12 and 14 and spends afternoons taking them to school activities and sports; housework; usually exercises 2-3 times per week doing aerobics classes or machines (stationary bike, stair master). Meds: ibuprofen for pain as needed.</p> <p>Following the objective information that was given, it was determined that the patient had a facet problem at L₅.</p> <p>2. Case modification The patient is 5'3" tall and weighs 250 #s. Would that change your examination or treatment plan?</p> <p>3. Application occurred when students used the standard intake questions on one client then used Kleinman's Explanatory questions on a second patient with a similar diagnosis. From this experience, students wrote a paper contrasting the information they learned about the two clients. Included in the paper was a brief discussion of how their behavior or approach to client care may or may not have changed as a result of the assignment</p>

STUDENT OUTCOMES

Course observations, written reflections, and the clinical narratives were assigned and collected after gaining informed consent from the students as well as approval from the institution's review board. The students' written documents provided qualitative data to support student outcomes. Overall, students responded positively to the activities despite being challenged to question their beliefs about others. When given a client who was obese, several students admitted they were uncomfortable with obese individuals, while others questioned whether they would be able to palpate the skeletal landmarks needed in their examination. Additionally, students found they needed to revise educational strategies outlined in their initial intervention when they learned the parents were obese. The added dimension of obesity caused students to modify their examination and intervention approach while rethinking appropriate communication techniques as well as ways to educate the client about safe methods of exercising. The students generated questions about treatment techniques and appropriate interaction with the client. They raised concerns about how a physical therapist who is small in stature would work with a client who is much larger; or how stronger individuals work with clients who are smaller or frail.

Other socio- cultural considerations were layered onto clinical cases such as a client covered under Medicaid insurance who frequently missed appointments; how to care for a female client of Middle Eastern descent; or what information was needed to treat an individual of African American or Hispanic background who showed signs and symptoms of hypoglycemia following aerobic activity. After each case modification, students were challenged to generate alternative treatment approaches. For example, students focused on treatment adherence with the client insured under Medicaid; however, the authors asked students to consider a scenario where the client had insufficient resources to meet the scheduled appointments. Students subsequently

generated other solutions by modifying treatment frequency, creating more focused home programs, and involving social services personnel.

A subsequent class conversation focused on issues presented by a visiting female scholar from the Middle-East who spoke to the students about her homeland and its health care. She asked students to develop an intervention plan for a woman whose religious beliefs conflicted with their normal treatment procedures for cervical spine or temporomandibular pathologies. She talked with students about outlining strategies for treating clients whose customs prohibited them from working with the opposite gender. By layering cultural dimensions on clinical cases, students confronted multiple dilemmas as they contemplated the racial, ethnic, disability, and gender makeup of the clients they had encountered during their clinical observations and internships.

Students' written reflections of these classroom experiences showed the authors achieved their first learning outcome - that 80% of the students would indicate the cultural infusion teaching strategy provided a valuable method of integrating diversity into the course. All 36 students (100%) indicated this method was quite beneficial by such comments as: "forced us to think outside the box," "gave us real life issues to think about and reflect on how we would handle the situation or what would be different." Results of student assignments demonstrated achievement of the second learning outcome when, in 85% of the clinical cases, students developed 1-2 additional clinical strategies that addressed the diversity topic presented. While students articulated some differences of opinion as to how to tackle each case, they practiced listening to others' perspectives then came to an agreement on culturally appropriate ways to approach the clinical situation.

Moving up Lattanzi's cultural ladder to planning and implementing culturally relevant care, the authors required students to apply their knowledge in classroom and clinical settings. The clinical assignment required students to compare subjective information gained using a standard clinical intake form to that acquired using Kleinman's explanatory questions. Comparing the two methods before using these in a clinical setting, students noted that standard intake forms focused on client information regarding pathology and asked questions in medical terms. In contrast, Kleinman's explanatory questions sought information in context, asking about the client's problem, how it affects function, as well as its effects on the client and client's family's life.^{24,25,27} In their written papers and subsequent discussions, the students found using the explanatory questioning to be effective, yet challenging. They indicated the standard intake form was easier to use and more time efficient due to their familiarity with it. Yet they thought the explanatory questions gave them a better context of the client's problem earlier in their treatment planning. The students wondered whether practice using these questions would enhance the information gained from the client interview without sacrificing time efficiency.

When you are expected to see a certain number of clients or bill a certain number of units in any given day, changing the way you interview a client during the history can slow you down while you are getting accustomed to using a different method than you were trained in. However, I think switching to the explanatory model would benefit many of the clients that therapists see on a daily basis—especially as the cultural diversity in this country continues to increase. Emma

When comparing the two methods, students found that both 1) allow the clinician to extract the client's objective complaints; 2) focus on what the client wants to achieve from therapy; and 3) serve as different pathways to arrive at the etiology, symptoms, pathophysiology, and course of sickness. Yet, students noted differences between the two questioning methods. They found standard questions to be more efficient as they centered on one source of the client's problem, asking pointed questions to get to a specific answer about one underlying cause of the injury or disease. Conversely, they found Kleinman's explanatory method to contain more open-ended questions, allowing the client to tell how he feels about the problem and how the problem affected daily life activities. Such information allowed the students to gain a more holistic understanding of the client's problem sooner than when using the standard intake questions. In addition, students discovered the explanatory questions allowed them to gain insight into the client's beliefs and attitudes about the illness and how this affected the client's life. Because this occurred early in the intervention, students noted they were able to include the information in developing the treatment plan.

Cultural information gained using Kleinman's explanatory questions provided students knowledge that changed their treatment plans or resulted in a different approach to their client's care. Two students, one in a neonatal intensive care unit, and another in a neurorehabilitation unit, incorporated more family considerations into their treatment time. Students found themselves paying more attention to how the intervention affected the family, making modifications that facilitated meeting the client's physical therapy goals.

DISCUSSION

Educating culturally competent health care practitioners presents a challenge to all faculty no matter what degree of diversity exists in the race, color, national origin, religion, gender, sexual orientation, gender identity and expression, veteran status, age, socioeconomic status, and disability within ones' educational program. Integrating culture in apparent homogenous academic environments presents different dilemmas since faculty must create situations that include multicultural characteristics when they do not obviously exist in the students and faculty. The authors found that by integrating culture and its diversity after the students presented their intervention plans yielded opportunities to challenge students' beliefs about clients they might encounter in the clinical setting. Adding an array of cultural dimensions to clinical cases after students planned interventions allowed the authors to push students to consider client care for multicultural and diverse populations. These dilemmas resulted in rich, thought-provoking interactions among students. The experiences helped students think more critically across multiple perspectives in ways they had not considered previously.

Experiencing these culturally layered clinical cases or by using alternative models that gleaned holistic client histories, students indicated they were pushed beyond their comfort zones; yet they learned strategies for working with others different from themselves. Additionally, these experiences gave students practice talking about cultural issues, particularly about their discomfort and how to overcome obstacles presented to them. Through the process they solved a greater spectrum of problems. The teaching strategies employed by the authors demonstrated that by integrating cultural issues into healthcare classrooms, faculty can be successful at getting students to think about their beliefs, open their minds to new perspectives, and encourage students to step outside their comfort zone to learn about others. These classroom activities take students into unfamiliar territory, helping them be more culturally competent and better prepared to address multicultural and diversity issues they will face in the clinical setting.

CONCLUSION

The teaching strategies presented in this paper offer ways for faculty to get students to examine their attitudes and beliefs about culture, gain new information of other cultures, and allow students time to implement their new found knowledge and skills. While the authors believe these are important educational experiences for students in non-diverse educational settings, students still need practice integrating these skills in diverse clinical settings. Faculty can provide such experiences by allowing students to interact with guest speakers who represent a cross section of the students' prospective multicultural client population and by making conscious efforts to select and require clinical internships that are diverse in age, gender, race, ethnicity, religion, socioeconomic status, and work environment.

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