**Developing Cultural Competence in a Multicultural World, Parts 1 & 2**

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**Objectives**

Upon completion of this two-part continuing education (CE) article, you should be able to:

- Define cultural competence.
- Describe the role of culture in a person’s health status and during interactions with health care providers.
- Identify specific knowledge regarding different population groups and cultures including, but not limited to, terminology and demographics, degree of acculturation, socioeconomic status, incidence and prevalence of disease and disability, access to health care, comparative value orientations, verbal and nonverbal communication styles, learning styles, and health beliefs and behaviors.
- Recognize how sociocultural knowledge can be applied to influence the patient-provider interaction positively.
- Apply the concept of cultural competence to your own professional behavior and in the therapeutic environment.

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**Introduction to Part 1**

Today, diversity in the workplace is the norm rather than the exception. Patients and clients are likely to look different from—and think and act differently than—the clinician. They have a wide range of ethnic identities, religions, “material realities” (a term that encompasses socioeconomic status), beliefs, and behaviors that lead to rich diversity and cultural complexity. Each patient, and each physical therapist, is unique. The purpose of this two-part continuing education (CE) article is to help the physical therapist to become culturally competent when working with patients and clients.

Cultural competence is a set of behaviors, attitudes, and policies that come together in a continuum to enable a health care system, agency, or individual practitioner to function effectively in transcultural interactions. In practice, cultural competence acknowledges and incorporates—at all levels—the importance of culture, the assessment of cross-cultural relations, the need to be aware of the dynamics resulting from cultural differences, the expansion of cultural knowledge, and the adaptation of services to meet culturally unique needs.1

For physical therapy practitioners, cultural competence is essential to all five elements of patient/client management: examination, evaluation, diagnosis, prognosis, and intervention. Developing rapport, collecting and synthesizing patient data, recognizing personal concerns about function, and developing the plan of care for a particular patient requires cultural competence. The physical therapist, who sees a wide range of impairments, functional limitations, and disabilities, is expected to meet the needs of a patient within the context of that patient, the patient’s family and community, and the broader cultural setting. By reviewing information on some of the unique characteristics associated with several cultural groups, physical therapists may gain insight and adapt the patient-therapist interaction and the rehabilitation services they provide to create the best plan of care possible.

Understanding the concept of culture is the key to understanding cultural competence. Lynch and Hanson2 describe culture as the framework that guides and bounds life practices. People do not biologically inherit a culture; they learn it. People may share cultural tendencies and pass these tendencies to the next generations; however, cultural frameworks are never rigid, and they are constantly evolving.

Many factors—such as ethnic identification, socioeconomic status, migration history, gender, age, religion, and physical capabilities—have a profound impact on a person’s way of life. Based on these variables, people may be members of several subcultures (smaller, but in some ways distinct, units within a larger culture3). A person’s culture is closely interrelated to value systems, health beliefs and behaviors, and communication styles. Cultural pluralism is an underlying philosophy of this CE article; that is, cultures are different but one is not inherently better or worse than any other. Culturally competent practitioners1,4:
1. **Acknowledge the immense influence of culture.** It is essential to understand that all people are immersed in their own culture—with its associated beliefs, attitudes, and behaviors—which guides their personal and professional interactions. However, human nature is such that everyone tends to be ethnocentric (ie, believing that their own cultural way of life is the norm and the standard by which all others are judged). What we forget is that the next person, who may be from another culture, also may be ethnocentric. This self-awareness (or lack of it) is especially critical when physical therapists work with patients who come from different cultures.

2. **Assess cross-cultural relations and be vigilant concerning the dynamics that result from cultural differences.** With cross-cultural interaction comes the possibility that the other person’s intentions and actions may be misjudged. Each party brings a specific set of experiences and personal and communication styles to an interaction. Physical therapists must be vigilant to minimize misperception, misinterpretation, and misjudgment. With more insight into the patient’s or client’s perspective—and less stereotyping—the ability to develop a mutually advantageous relationship is bound to be enhanced.

3. **Expand their cultural knowledge and incorporate this knowledge into their everyday practice.** If the assumption is that health care professionals can work effectively with people from other backgrounds, increased knowledge about the patient’s or client’s sociocultural context can only improve the relationship. Physical therapists must seek out sociocultural information about the patient or client that will then help them appropriately modify an interview or history—what questions to ask and how to ask them—and modify interventions based on the person’s cultural reality. Physical therapists should ask patients questions about their culture and lifestyle and indicate a willingness to learn about that culture. In that way, each party in the interaction can presume the desire to both give and receive information. It is impossible, and unnecessary, to learn everything about all subcultures, but clinicians must be aware of the ethnographic makeup of the local community and the relevant beliefs and behaviors of their patients and the patients’ families.

4. **Adapt to diversity.** Physical therapists need to develop culturally sensitive examination and intervention techniques that allow a patient to be comfortable during the visit. The physical therapy department or health care environment should be adapted to create a better fit between the needs of the people requiring services and the needs of the clinicians and staff. It is important to remember what cultural competence is not. It is not abandoning your own culture and “becoming” a member of another culture by taking on all of the attitudes, values, and behaviors of that culture.

### Stages of Cultural Competence

The field of cross-cultural health has begun to flourish in this new millennium, and the idea that cultural competence is desirable has become more widely accepted. It is critical that all therapists be culturally competent, regardless of their own ethnic background. In the Thirty-First Mary McMillan Lecture, Ruth Purtilo called for cultural competence to be a non-negotiable skill, tested as rigorously as competence in pathokinesiology or any other field of study.5 (For APTA’s efforts in this arena, see “APTA Initiatives in Cultural Competence.”)

Cross et al1 described six stages along a continuum of cultural competence ranging from cultural destructiveness to cultural proficiency.

In *cultural blindness* (stage 3), clinicians and health care institutions assume that they are unbiased; however, this assumption is based on an incorrect belief that all people are the same. In this stage, facility policies and practices do not recognize the need for culturally specific approaches to solve problems. *Cultural pre-competence* (stage 4) moves toward the more positive end of the continuum. In this stage, therapists recognize weaknesses in the health care delivery system or in their personal cultural knowledge base, and they explore alternatives. They also are committed to responding appropriately to cultural differences. *Cultural competence* is stage 5, and the last stage is *cultural proficiency*, in which physical therapists recognize the need to conduct research, disseminate the results, and develop new approaches that might increase culturally competent practice.

**In my opinion, which is based on my 30 years of experience in this area, many physical therapists—and health care institutions—today are progressing from cultural blindness to cultural pre-competence.**

—Ronnie L. Leavitt, PT, PhD, MPH

Campinha-Bacote6 has suggested four factors that contribute to a culturally competent model of care:

1. Having cultural awareness (“cultural sensitivity” is often the term used), including awareness and minimization of cultural biases.
2. Increasing cultural knowledge (ie, understanding the theoretical and conceptual frameworks for the worldviews of other people).
3. Developing cultural skills (ie, how people of different cultures can be examined and their condition managed appropriately).
4. Having a cultural encounter (ie, exposure to people from different cultures, with an opportunity to help them achieve shared goals).

This article will primarily address the second factor—increasing cultural knowledge—in order to enhance cultural awareness and skill development. Examples will come from a variety of cultures and patient populations and will emphasize those cultures with which physical therapists in the United States are more likely to come into contact because of national demographic trends or their practice setting. Cultural competence in working with patients from any one of these groups could be the sole focus of a CE article.

A strong word of caution is in order. Physical therapists manage individual patients or clients and not a population. Broad categories are practical for descriptive purposes, but they also can be used to perpetuate racial or ethnic stereotyping and prejudices. This article is intended to provide examples of the extensive and diverse cultural landscape in which our patients live. Remember that not only is there interethnic diversity, there is also intraethnic diversity. Clinicians should not make general assumptions about an entire ethnic group any more than they would make assumptions about patients with stroke, Parkinson disease, or joint degeneration.

**Terminology and Demographics**

Terminology for identifying people and groups of people is often controversial. (See "Note on Racial/Ethnic Designations.") From a sociocultural perspective, "ethnicity" is a better label than "race." Ethnic identification is classified by common traits or customs. It is based on a person’s self-identification as belonging to a distinct behavioral group or ideational group (ie, a group with common ideas, values, and opinions) that has a presumed shared cultural heritage. Ethnicity may be based on a person’s color, religion, place of origin or place of ancestry, language, or territory. Race, a concept historically used to divide the world’s population into three biological types (ie, Mongoloid, Caucasian, Negroid), is an increasingly meaningless concept.

According to the US Bureau of the Census, in 2000, approximately 75% of the United States population was white; 12.5% was black or African American; 12.5% was Hispanic or Latino; 1% was American Indian and Alaska Native; 3.7% was Asian, Native Hawaiian, and other Pacific Islander; 2.4% identified themselves as part of two or more ethnic groups; and 5.5% identified themselves as "Other." Understanding the 2000 US Census is somewhat complicated by the fact that it used 63 ethnic categories, instead of the five categories used previously, and by the fact that respondents could select more than one category. This more complex scheme was created to accommodate people who identify themselves in ways that are different from the five typical classifications or who consider themselves “multiracial.”

Broad categories are often a necessary expedient, but they fail to represent subgroups and the presence of intracultural diversity and individuality. For example, the category “Asian” encompasses at least 18 subcultures, and the category “Hispanic” (a term more common on the East Coast of the United States) or “Latino” (a term more common on the West Coast) encompasses more than 20 subcultures. There are more than 500 Native American tribal groups in the United States. “Black” may refer to a person who is African American, Jamaican, Nigerian, and so on. There is enormous individuality among white cultures as well. The term “white” encompasses people whose ancestors come from many European nations. In real-life circumstances, if someone prefers a particular label, that label should be used with that person. Today, the phrase “people of color” is often the preferred term used in the United States for people who are “non-white.”

The future can be imagined by reviewing the recent past. Between 1980 and 1990, the total population of the United States increased by 9.8%; however, the rate of growth varied widely among ethnic groups. The rate of growth of the Asian/Pacific Islander population was 108%, whereas the white population grew by 6%. Between 1990 and 2000, the historical course that was sharply defined during the previous decade continued. During the past two decades, there has been a tremendous influx of immigrants from South and Central America and Asia. Birth rates also are generally higher for the Hispanic/Latino group, especially Puerto Ricans. These trends are expected to continue. Currently, the largest number of immigrants to the United States by far come from Mexico. Based on immigration patterns and fertility rates, the US Bureau of the Census projects that white non–Hispanic Americans will represent approximately 53% of the total population by the year 2050, demonstrating a continuous downward trend from the 2000 Census figures. Hispanic Americans will account for 24% of the population, African Americans 15%, and Asian/Pacific Island Americans 9%.

The great increase in the population over 65 years of age expected during the next decades is also relevant. The future can be imagined by reviewing the recent past. Between 1980 and 1990, the total population of the United States increased by 9.8%; however, the rate of growth varied widely among ethnic groups. The rate of growth of the Asian/Pacific Islander population was 108%, whereas the white population grew by 6%. Between 1990 and 2000, the historical course that was sharply defined during the previous decade continued. During the past two decades, there has been a tremendous influx of immigrants from South and Central America and Asia. Birth rates also are generally higher for the Hispanic/Latino group, especially Puerto Ricans. These trends are expected to continue. Currently, the largest number of immigrants to the United States by far come from Mexico. Based on immigration patterns and fertility rates, the US Bureau of the Census projects that white non–Hispanic Americans will represent approximately 53% of the total population by the year 2050, demonstrating a continuous downward trend from the 2000 Census figures. Hispanic Americans will account for 24% of the population, African Americans 15%, and Asian/Pacific Island Americans 9%.

The great increase in the population over 65 years of age expected during the next decades is also relevant. The relative increase in the population over 65 years of age will be greatest for people of color. The changing demographics within the United States, therefore, provide a pragmatic reason why rehabilitation professionals need to pay more attention to the concept of culture.
An additional observation when examining these population statistics is the substantial disparity between the number of students from particular ethnic groups who are enrolled in health care education programs and their representation in society as a whole. APTA estimates that approximately 10% of its membership are people of color. 10 Although it is ideal for all ethnic groups to be proportionately represented by professional staff within the treatment setting, it is equally (if not more) important for all physical therapists, no matter what their own ethnic background, to be culturally competent. In addition, the didactic and clinical educational materials used in physical therapist professional education have historically used a “Western biomedical model” and a Eurocentric point of view concerning disability, health, and illness with limited regard for sociocultural variables (e.g., visiting a traditional healer or using alternative medicine). This ethnocentrism contributes to a less-than-ideal delivery of care and can result in a cultural clash and conflicting expectations between the patient and the physical therapist.

Special Considerations for Managing A Diverse Patient Population

In an effort to learn about the material realities and beliefs and behaviors of patients and clients and to facilitate the process of becoming culturally competent in the practice of physical therapy, clinicians must, in essence, do a health care ethnography. An ethnography is a description of a culture. It is an attempt to understand another way of life, from the point of view of the people of that culture. The health care ethnographer seeks to learn from people, to observe and be taught by them, and to discover the insider’s (rather than the outsider’s) point of view. 11 This field of study is closely linked to medical anthropology, in which illness and disability—which can be viewed as the culturally mediated responses to impairments and disease—are compared across cultures.

Arthur Kleinman, 12 a psychiatrist and medical anthropologist, has developed one process of medical ethnography that analyzes local health care systems. He developed the “explanatory model” to explain patterns of belief about the causes of illness, the response to specific episodes of sickness, and actions taken to bring about a change in a person’s health status or condition. Explanatory models “are the notions about an episode of sickness and its treatment that are employed by all those engaged in the clinical process. The study of patient and family [explanatory models] tell us how they make sense of given episodes of illness, and how they choose and evaluate particular treatments.” 12(p105)

Open-ended questions should be used to allow patients to discuss their health, based on their perceptions of a particular illness or condition. The physical therapist can ask the patient questions such as:

- What do you call your problem?
- What do you think caused your problem?
- What are the greatest problems your illness has caused for you?
- What do you fear most about the consequences of this illness?
- What are the most important results you hope to get from your treatment?

Although physical therapists need to focus on the patient’s explanatory model, it is essential to understand that clinicians also have an explanatory model and operate within their own distinct culture. The patient and his or her family cannot be expected to always and completely comply with the practitioner’s explanatory model, and the health care professional cannot be expected to “buy into” the patient’s explanatory model.

Several variables—including degree of acculturation, socioeconomic status, the effects of racism, incidence and prevalence of disease and disability, comparative value orientations, methods of communication, learning styles, and health beliefs and behaviors—must be considered during the process of ethnography. Each of these variables must be assessed so that the examination and the interventions may be appropriately modified based on a person’s culture. The variables explored below (and in part II of this CE article) never exist alone. Each is intertwined with the other variables. Furthermore, greater emphasis needs to be placed on the difficult task of sorting out the relative influence of these variables (e.g., separating biological/genetic factors from socioeconomic factors from cultural lifestyle habits). In other words, what is the relative influence of family structure, diet, exercise, alcohol consumption, income, community, and other variables?

Once again, multiculturalism encompasses cultures that differ based on age, color, ethnicity, gender, national origin, political ideology, race, religion, and sexual orientation—and includes the presence and participation of people with disabilities and those from different socioeconomic backgrounds. Thus, we need to sense patterns and variations without overgeneralizing.

Degree of Acculturation

Acculturation is the process by which people from another culture adopt the traits of the mainstream culture. Many of the variables discussed below are more or less significant, depending on the level of acculturation. A person might be:

- highly assimilated (the person has largely adopted the new culture),
- bicultural (the person functions comfortably in two cultures), or
Socioeconomic Status

Socioeconomic status, which includes level of income, level of education, and occupation, is arguably the most relevant variable affecting a person’s worldview and health status. There is a direct linear correlation between class (which is primarily evaluated through socioeconomic status) and health. The relationship of education to health status is especially important—even more than income. Education is associated with the acquisition of beliefs and knowledge about health and with a person’s ability to integrate healthy behaviors into his or her lifestyle. For example, people with higher education levels are less likely to engage in unhealthy behaviors such as smoking. Higher educational attainment is also associated with a lower risk of obesity.

The clinician should be aware that only about 50% of Hispanics have finished high school (46% of Mexican Americans, 60% of Puerto Rican Americans, and 62% of Cuban Americans, compared with 84% of whites). Clinicians should also consider that people with lower educational levels may use “traditional medicine” to a greater extent than people with higher levels of education.

Poverty is not randomly distributed; rather, it is strongly related to race or ethnicity, gender, and age. Although socioeconomic advancement continues for most families, 13% of families in the United States, according to conservative estimates, are below the poverty line, and this figure climbs considerably for some groups. In the United States, about 22% of African American families and 21% of Hispanic families live in poverty, compared with 10.8% of Asian and Pacific Islander families and 7.5% of white families. Intracultural diversity is again apparent. For instance, some of the small but growing subcultures in the Hispanic/Latino population are especially poor. For example, Dominicans in the United States have mean annual earnings below $8,000, and more than one third live in poverty. Female-headed households are associated with poverty, and over 40% of Puerto Rican households are headed by a woman.

These data have tremendous implications. There is a direct correlation between poverty and access to comprehensive, effective, and efficient medical care. The effects of socioeconomic status tend to be stronger for the poorest populations. Poor housing (or even homelessness) and unsafe environmental conditions, inadequate food sources and nutrition, harmful lifestyle habits, and lack of access to transportation are all prevalent. Being poor is also associated with stress and a sense of alienation, hopelessness, powerlessness, and isolation. All of these feelings can lead to further estrangement from (with a concomitant loss of social support systems) and marginal participation in society, including the health care system. Poverty at a young age has multiple effects on health as a person ages, notwithstanding the availability of Medicare.

A number of factors predict the presence of more traditional beliefs and behaviors, including emigration from a rural area, frequent returns to the country of origin, limited formal education, little or no ability to speak or read English, low socioeconomic status, recent immigration to the United States, immigration at an older age, and housing segregation. Typical ways to measure the degree of acculturation are based on the language used within the home, the language of preferred media sources, and the people who are part of the individual’s primary support system. Although physical therapists might not formally measure their patients’ level of acculturation, they can ask questions about these subjects that will help them better understand their patients.

Migration history is one means to assess the degree of acculturation. Physical therapists should be aware of when, why, and how migration occurred. Immigration often does not occur under ideal conditions; therefore, many patients and clients are not seen under ideal circumstances. For example, Mexicans came to the United States in large numbers in 1848 and 1910 during postwar periods; their decision to emigrate was influenced both by the need for a labor force in the United States to build railroads and by the extreme poverty and the religious persecution of Christians in their home country. Since the 1940s, large numbers of Mexicans have come to perform agricultural labor, and this immigrant group remains relatively poor and politically powerless.

Unlike Mexican immigrants, other immigrant groups show more distinct intraethic differences depending on the time of immigration. Vietnamese who arrived in the United States during the mid-1970s were primarily well-educated, upper class, and Christian and were escaping a repressive political regime. In contrast, Vietnamese immigrants during the 1980s were more likely to be escaping economic as well as political deprivation, and they arrived with fewer economic resources, different and more considerable health problems, and a more marginalized social support system. A look at the migration history for the Cuban American population will reveal a similar distinction between the first and second wave of immigrants.

In the United States, the degree to which people acculturate to the mainstream culture (what has been referred to as the “white, Anglo-Saxon, Protestant” culture) is influenced by factors such as age, level of education, number of years in this country, and socioeconomic status. Acculturation may affect people’s health status, their perspective on health, and their interaction with the health care system and the clinician.

The effects of socioeconomic status tend to be stronger for the poorest populations. Poor housing (or even homelessness) and unsafe environmental conditions, inadequate food sources and nutrition, harmful lifestyle habits, and lack of access to transportation are all prevalent. Being poor is also associated with stress and a sense of alienation, hopelessness, powerlessness, and isolation. All of these feelings can lead to further estrangement from (with a concomitant loss of social support systems) and marginal participation in society, including the health care system. Poverty at a young age has multiple effects on health as a person ages, notwithstanding the availability of Medicare.
Poverty among people who are expected to care for their older family members adds to their personal economic challenge and limits the amount of assistance they can provide to their older relatives.²⁵

Moreover, poverty is known to influence the availability of health insurance. Being among the working poor or having no documentation often leads to lack of health insurance. Almost 90% of the people who are uninsured are working, but their employer does not offer health care benefits. More than one third of the Hispanic/Latino population does not have health insurance, and the Hispanic/Latino group is the largest segment of the approximately 43 million people in the United States who do not have insurance. Recent immigrants, including the great majority who are legal residents, also are less likely to be insured.²⁰,²⁶ Furthermore, the changing economic and political landscape of the early 21st century (eg, welfare reform, tighter eligibility requirements and reduced benefits for Medicare/Medicaid and private insurance, and a weakening economy) may significantly affect patients with low income (because of their considerable reliance on Medicare and Medicaid) or those patients who are less acculturated (because they may be uninsured).

Sensitivity to these socioeconomic and cultural issues can be tricky. How can you inquire about these issues without being insulting or without damaging the patient’s pride? This is one area where skill development in cultural competency can be especially important.

Racism

Although a detailed discussion of the effects of racism is outside the scope of this article, physical therapists should be cognizant of the continuing marked effect of racism on health status and health care interactions.²⁰,²¹ (See Smey²⁷ for further information.)

In a recent article in the Journal of the American Medical Association, after adjustment for potential confounding factors, Schneider et al²⁸ reported disparities in the quality of health care for blacks who were Medicare beneficiaries and enrolled in managed care plans. These enrollees were less likely than whites to receive eye examinations, beta blocker medication after myocardial infarction, and follow-up after hospitalization for mental illness.²⁸ Moreover, the collective historical health care experience of African Americans, including the Tuskegee syphilis study (in which the US Public Health Service deliberately withheld treatment from poor black sharecroppers in order to study the natural history of the disease), sterilization initiatives, and sickle cell screening abuses, have led many African Americans to distrust the medical profession.²⁹

Incidence and Prevalence of Disease And Disability

Disease and disability are not randomly distributed. Many factors, including race, ethnicity, age distribution, socioeconomic status, geography, and migration history, play a role in determining the incidence and prevalence of disease and disability. Discovering the determinants of disease (ie, those risk factors related to the development and cause of the condition) is a major aspect of epidemiological work. Sometimes a single variable is associated with a pathology (such as with vector-borne diseases), but, often, several risk factors are associated with a disease. Broadly speaking, risk factors can be related to inherited characteristics, environmental factors, or personal behavior and lifestyle.²⁷,²⁹–³²

In the United States, people of color have many more health problems than the white population.¹⁶,²⁰–²²,⁹,³³ They are also more likely to report poor health and more restricted activity.³⁴,³⁵ Latinos are reported as having significantly more “functional impairments” than blacks or whites, which may result from lower income and education levels and from their residential environment.³⁴ Puerto Ricans have more health problems than any other group.³⁵ Women from all ethnic groups are especially disadvantaged with regard to health status and report greater limitation in activities of daily living.³⁶ People of color have a lower life expectancy, higher infant mortality rates, and higher morbidity and mortality rates for a wide range of diseases. The elimination of health care disparities between people of color and whites is one of the three major goals of Healthy People 2010, a guiding document for the US Public Health Service.¹⁶

Some surprises do exist. For example, although cardiovascular disease is the number one cause of death for older people overall in the United States, Hispanic/Latino people have the same or lower level of heart disease mortality than whites despite high rates of diabetes and obesity and high blood lipid levels. Intraethnic diversity is once again a factor, because this advantage is present for Mexican American men, but not women. Paradoxically, Mexican American men have twice the rate of angina pectoris compared with white men. It is believed that their genetic makeup leaves them vulnerable to some diseases (such as angina and diabetes) but less prone to having a fatal outcome.¹⁴,³⁶,³⁷

Another paradox is that Hispanic/Latino people historically have lower rates of some of the most common kinds of cancer (eg, lung, breast, colorectal, and prostate cancers), yet have higher rates for other cancers (eg, stomach, gall bladder, liver, and cervical cancers).¹⁴,³³ Once cancer is diagnosed, however, the higher-than-expected death rates from cancer among the Hispanic/Latino population are thought to be related to culturally
motivated resistance to screening tests and early treatment because of language and communication barriers and the cultural belief in fatalism.29,38–42

Non-insulin-dependent diabetes mellitus (type II) is the most significant medical concern for Hispanic/Latino and Native American people (and a disease common among African Americans as well).14,43,44 It deserves special attention because of its prevalence and the severity of its complications and consequences. Family history, genetics, obesity, and age are key risk factors. The so-called “thrifty” gene theory related to Mexican Americans and Native Americans with diabetes is an example of the interaction of both genetic and lifestyle variables. When particular tribes were semi-nomadic, they frequently subsisted on a feast-or-famine diet. The tribes developed a genetic ability to metabolize their food efficiently. Today, when people exercise less and food is more abundant (and likely to be high in fats and calories), there is a higher rate of obesity and diabetes. People with more Native American genetic heritage are more resistant to insulin and unable to break down glucose in the blood. On the positive side, some Native Americans have the benefit of a gene that causes their blood sugar levels to respond to moderate exercise more quickly than other groups.14,45,46

African Americans and blacks are disproportionately affected by cardiovascular disease, hypertension, and strokes.43 AIDS is increasingly a disease affecting African Americans and Hispanics.47 Obesity, a health problem unto itself and a risk factor highly associated with disease and disability, is increasingly a problem in the United States, especially so for people of color. African American women have the highest rates of obesity, followed by Mexican American women.14,48 Several factors contribute to obesity, such as genetic admixture, limited ability to metabolize carbohydrates, low socioeconomic status, decreased exercise, and cultural attitudes toward food and weight. Greater degree of acculturation is associated with decreased rates of obesity.14

No matter what the impairment, functional limitation, or disability, the intervention should not necessarily be the same for all people. In an interview for the article “Cultural Competency: Reaching Out to All Populations,”49 Woodruff cited several examples of why physical therapists might need to modify examination procedures and interventions when treating people with darker skin color, such as:

- It is more difficult to see redness on black skin; therefore, the effects of infection are more difficult to assess.
- The presence of keloid tissue scarring after a burn, which occurs in some African American and Arab American patients, and the use of cocoa butter as a treatment of choice for burns may decrease the durability of pressure bandages.49
- A child with sickle cell anemia may benefit from exercise in a pool because the buoyancy of water can support the weight of the limbs and help reduce the pain caused by movement.

Reimbursement policies do not necessarily take this kind of information into account. Medicare, however, has updated its classification system for the evaluation of darker skin for decubitus ulcers, which should help decrease the number of associated amputations.49

Access to Health Care

Regarding access to the health care system, people of color, once ill, are more likely to receive episodic, crisis-oriented care that occurs later and less frequently than for white people. Recent immigrants are typically unfamiliar with how the American health care system works. They, along with many African Americans and Hispanics, will commonly use the emergency department for primary care, which wastes resources and is not conducive to comprehensive care.20 Tran et al19 report community-based social and health services are underutilized by Hispanics.

Strong social networks predict more regular use of the health care system to address medical needs.30 Some of the barriers to formal assistance include lack of knowledge about availability, accessibility, and eligibility for services and discomfort with bureaucracy.51 In addition, there are few health promotion and disease and disability prevention programs. Hispanics and Asian Americans receive fewer preventive screening tests (eg, cholesterol screening) than African Americans and whites.20 Under these conditions, greater complications and higher morbidity rates are inevitable.

Physical therapists need to be knowledgeable about the variables affecting the incidence and prevalence of medical conditions so that they can be better prepared to manage the impairments, functional limitations, and disabilities associated with these conditions; answer patient and family questions concerning the conditions; and develop special preventive and educational programs targeted to people in need.

References


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Introduction to Part 2

Part I of this continuing education (CE) article defined cultural competence, discussed cultural competency, terminology and demographics, and outlined some considerations for physical therapists who are working with diverse patient populations.

This two-part CE offering presents examples of the diverse cultural landscape in which patients live. However, physical therapists manage individual patients and clients and not a population. Broad categories are practical for descriptive purposes, but they also can be used inadvertently to perpetuate racial or ethnic stereotyping and prejudices. Not only is there interethnic diversity, there is intraethnic diversity. Clinicians should not make general assumptions about an entire ethnic group any more than they would make such assumptions with a patient with a stroke, Parkinson disease, or joint degeneration.

Special Considerations for Managing a Diverse Patient Population

In part I, the discussion of special considerations when working with diverse patient populations included the degree of acculturation, socioeconomic status, racism, and the incidence and prevalence of disease and disability in different groups. Part II continues the discussion of these special considerations by looking at comparative value orientations, methods of communication, learning styles, and health beliefs and behaviors.

Comparative Value Orientations: The Individual Versus the Group

In contrast to material culture (the more easily observed and understood parts of culture, such as clothing, food, music, forms of greeting, ceremonial rites of passage), a person’s nonmaterial culture (which includes values and morals) is more difficult to assess. Sometimes similarities in the material cultures of the patient and the physical therapist obscure profound differences in their nonmaterial cultures that are very relevant to the therapist-patient interaction. In fact, comparative value orientations may provide important clues that can help the physical therapist and the patient to better understand each other.

**Table 1** lists recurrent themes and patterns in cultures that many observers have identified.1–3 These cultural elements may be the core of a person’s worldview, or they may be the values that a person lives by. People from groups that have been most heavily influenced by European culture typically will have the values listed in the left-hand column, whereas people from those groups influenced by Hispanic/Latino, Asian, Middle Eastern, or African cultures typically will have the values listed in the right-hand column. However, a person’s worldview also can be heavily influenced by personality traits, socioeconomic status, level of acculturation, and other factors. Moreover, a person does not necessarily fit into a rigid category; he or she may fall at the far end of one dichotomous scale, in the middle of a second, or at the other end of a third.1,3

The defining element represented in **Table 2** may be the comparison between types of social organization and relationships—individualism/privacy versus collectivism/group welfare. There are innumerable ways in which these two “value orientations” can influence the therapeutic encounter. For example, European values emphasize the importance of the individual and the ability of each person to affect his or her future through hard work.2 In this type of cultural orientation, both time and nature are commodities to be used profitably, and the success—or lack of success—of each person is credited to that person. A patient with an individualistic worldview may prefer to use assistive technology in order to live independently. Health care professionals with this type of
worldview might emphasize the autonomy and personal responsibility of their patients and expect them to work hard at therapy.

What if patients have a cultural value system that emphasizes the importance of the group over the individual? To illustrate, in the Hispanic/Latino culture, many cultural characteristics reflect the values of a collectivist society. One of the most significant values is *familismo*, or family commitment and responsibility. The welfare and honor of the family are preeminent concerns. Traditional gender roles within the family—known as *machismo* for men and *marianismo* for women—are related to *familismo*. The oldest man or the father is typically the authority figure and the final arbiter. The mother is central within the household and is responsible for child rearing and the cultural and social stability of the family. She is often described as having a sacrificing nature. Women are considered to be morally and spiritually superior to men; however, men typically make the final decisions within the household.4

In collectivist cultures, kinship bonds across generations are common. Thus, a patient may arrive at the clinic with several family members. The patient may feel there is little point to working too hard because the family will provide care and because the patient believes that much of what happens to people—including disease and disability—is predetermined by fate (fatalism). In order for both the patient and the clinician to “save face,” the patient might act very polite and accommodating when, in fact, he or she may not understand the clinician’s instructions. Patients also might recognize that their goals and the clinician’s goals are not the same. For instance, the patient may not want to use assistive technology because independence is not the goal.

Related collectivist cultural values associated with the Hispanic/Latino culture may include, but are not limited to, *respeto* (respect toward individuals based on age, gender, and social position or authority), *personalismo* (friendliness and individualized attention and responsiveness to interpersonal interactions), *simpatía* (kindness, being nice), and fatalism.5,6

**Pace of life and the notion of time.** Perhaps the most difficult cultural differences to overcome, especially for those with a European cultural viewpoint, relate to pace of life and the notion of time.7

Monochronism is the belief that time is an important concept, that events happen in chronological order, that there is a separation of work tasks and socializing, and that adherence to schedules is important. Many whites are monochronistic: they are action oriented and value punctuality.7,8 Polychronism, on the other hand, is the belief that events can happen concurrently and that fixed schedules are insignificant. The focus is on a more personal interaction, with less concern about completion of the task at hand (ie, the value of personalism). Work orientation and the acquisition of material goods may not be present among people who value a relaxed, relationship-oriented lifestyle more highly.

Imagine the potential for misunderstanding if a Hispanic/Latino man, for example, arrives late for an appointment and expects the therapist to chat for a few minutes about nontherapeutic issues—such as the well-being of his family—and the therapist, already annoyed about her schedule being interrupted, immediately launches into a discussion about how to do exercises. These differences can also have an economic impact; late patients can disrupt a therapist’s schedule and decrease his or her efficiency.

In a rehabilitation setting, even the development of group exercise programs may be influenced by comparative value systems. For example, does the patient value competition or cooperation? Would a patient rather work hard and increase the number of repetitions, or would the patient not want to “show off” to others? Is the patient comfortable exercising among both men and women?

The patient’s opinion on the role and status of medical personnel may be different depending on his or her culture. On one hand, an older patient from Cuba may expect the health care provider to demonstrate respect by addressing them first, by using the proper titles, and by asking about the family. On the other hand, a patient from a Middle Eastern subculture might tend to defer to the health care professional, who is considered to be an authority figure worthy of high esteem. The patient may be especially reluctant to express negative feelings and may be unlikely to share concerns about taking medication ordered by a physician or to ask questions that may be perceived as “stupid.” An interactive conversation about health care options is less likely to occur.9

**Values across the life span.** Comparative value systems may affect the behaviors of patients of a particular age group. For instance, expectations for the behavior of Asian American adolescents may be different from those for the behavior of a typical white adolescent. Older Asian American children are expected to be well disciplined and to take on some adult roles. An older adolescent sibling may be expected to accept personal sacrifice and to care for young children in the extended family while simultaneously working hard to maintain a strong academic record. A sense of duty or obligation to the family may be pronounced and is learned through role modeling. If the older sibling misbehaves, he or she might
be rebuked for not setting a good example for the younger ones.

High expectations may be a source of stress. Adolescents are likely to be recipients of a parenting style that is somewhat controlling, restrictive, and protective. This may lead to distancing behaviors or a distrust of outsiders. Discussions about sensitive topics such as sexuality may need to be avoided, and the patient’s willingness to discuss personal issues related to treatment might be minimal.\textsuperscript{10}

Similarly, there may be special considerations when working with older people. Respect for older people is a value prevalent among many ethnic groups. Signs of respect may include using terms of address such as “Ma’am” or “Sir” or asking for tales of wisdom. In many cultures, it is expected that adult children will provide an economic and social base for their older parents. Older Asian and Hispanic/Latino people are more likely to live with other family members or friends and are less likely to be segregated, to live alone or in a nursing home or other institution, or to use professional home nursing services. Mutual assistance, especially in times of illness, is counted on both because of cultural preferences and because of strategic adjustments to American society.\textsuperscript{4,11,12}

\textbf{Giftgiving.} The issue of gifts is of practical import to the physical therapist. APTA’s \textit{Guide for Professional Conduct} states that the physical therapist should at all times ensure that his or her professional judgment is not affected by a patient’s gift.\textsuperscript{7} The physical therapist should also ensure that the gift has not created an obligation for either the therapist or the patient. The physical therapist, however, needs to consider the patient’s value system when deciding whether accepting a modest gift from the patient or the patient’s family is ethically appropriate. In many cultures, it would typically be a great insult to refuse a gift; a person’s pride may be at stake.

\textbf{Communication Styles}

Communication and language are intertwined with and are inseparable from culture. The ability to communicate effectively, therefore, is an exceptionally important variable when working cross-culturally or seeking to understand a patient’s cultural value system and “explanatory model” (ie, how a patient makes sense of an illness and how they choose treatments). English is the primary language in the United States. Spanish is the second most commonly used language, followed by French, which lags far behind.\textsuperscript{13} However, there are dozens of other languages that are used by large numbers of people in the United States.

Ideally, the physical therapist and patient would speak the same language. More realistically, physical therapists should learn a few key words in the primary language of their patients. Translators are often a necessity, and typically family (often children) or friends are called upon to act as translators. Although this may be the only available alternative, it is fraught with problems. The US Department of Health and Human Service’s Office of Minority Health strongly advises that children should not be used as interpreters, especially for adults.\textsuperscript{14} When a family member or friend is the translator, physical therapists should be aware that they are dealing with an untrained third party who may be “interpreting” the information before passing it on to them and that some topics may be inappropriate to discuss with the translator because they are of a more personal or sensitive nature (eg, family planning, spousal abuse, terminal illness).

If possible a professional translator should be used. Translation requires knowledge of medical terminology, a good memory, the ability to concentrate, and the ability to know how and when to edit messages so that the true meaning can be accurately transmitted. The ideal professional interpreter is bicultural and has a good grasp of both medical and cultural nuances.\textsuperscript{15}

Limited proficiency in English is one of the most important variables associated with poor health status and is a barrier to accessing the health care system.\textsuperscript{3,16,17} Because language barriers are such a significant and prevalent obstacle to good health care, the Office of Civil Rights in the US Department of Health and Human Services has developed policies to better serve people with limited English proficiency, including language assistance appropriate to the needs of each facility.\textsuperscript{15}

\textbf{Interactive styles.} In addition to the spoken word, there are obvious and subtle differences in the interactive styles. For example, verbal communication in individualistic societies is associated with direct, “low-context” communication. Patients with this cultural background may expect that the physical therapist will get right to the point and may assume that they do not have to rely on the surrounding context for interpretation. They would expect that what is found in the verbal message is what is being communicated. The notion of privacy is important, and questions of a more personal nature might be considered off-limits.\textsuperscript{7,8,18}

In contrast, a person from a collectivist culture may speak indirectly, in a more circular fashion, always keeping in mind the need for everyone to “save face.” Communication is more “high-context” and listener-focused (ie, sensitive to situational and contextual features). There may be more “spiral” (or indirect) logic, more indirect verbal negotiation, and subtle nonverbal nuances. The notion of privacy is less pervasive, but no party should be embarrassed or “lose face.” The focus is more on human relationships (eg, \textit{personalismo}). It may take a long time to establish a solid, trusting relationship, but once it exists, it is likely to be strong and lasting.\textsuperscript{8,10,13}
Another difference in verbal communication is the amount of “wait time” or time gaps that occur during conversation. Native Americans typically have a longer wait time than whites because the pace of conversation is slower. Physical therapists should wait until the person has finished speaking before interrupting or asking questions. European Americans typically are uncomfortable with silence. Wait time is also increased when patients need to translate the words into their own language before responding. In some cultures, many people may speak at once.

Different cultural groups also may have many nonverbal, observable differences in communication style. In fact, Mehrabian suggests that as much as 93% of the total meaning of an encounter is communicated by nonverbal factors such as body language (55%) and tone of voice (38%). Differences in interpretation occur with regard to eye contact, facial expression, body movement, personal space, and overall formality. The physical therapist may believe a patient is acting disinterested if eye contact is not direct, when in reality, the patient may believe it is impolite to look directly at someone who is perceived as the authority figure. A physical therapist may always give a firm handshake upon introduction to a patient and may presume that this is an appropriate, friendly, and polite gesture. Native American or traditional Asian American patients, however, may consider this aggressive or hostile, because a subtle, “soft,” nonthreatening handshake is the norm in their cultures.

What is the patient’s preferred requirement for personal space? How close does the patient like to stand when speaking with health care providers? Physical therapists should observe their patient’s response when they stand closer or further away during a general conversation. During a treatment session, does a person of the opposite sex seem more uncomfortable than might be expected? How do people from different cultures stand with each other as compared with how they stand with the therapist? Touch can provide reassurance and kindness, or it can be a discomfort and annoyance.

Gender and age are important variables influencing personal space. For example, people from Hispanic/Latino and Middle Eastern subcultures tend to prefer standing close and are comfortable with physical contact between members of the same sex. People who are members of the orthodox branches of Islam or Judaism, meanwhile, might not be comfortable being touched by someone of the opposite sex.

Learning Styles

The physical therapist who is educating a patient about a diagnosis or a home program must also recognize that many cultures have different methods of teaching and learning. The existence of different learning methods becomes an especially important consideration when the physical therapist is working with a patient who was educated outside the United States or who is a recent immigrant. People of European ancestry, for example, often rely on note taking and studying written texts as well as intense discussions with a great deal of interaction between physical therapist and patient. People of other cultures, in contrast, may rely more on a lecture format with few questions and little discussion. Members of other cultural groups, such as blacks and African Americans, may rely almost entirely on oral training and demonstration. A written list of exercises, even with diagrams, may not be as effective as “hearing and feeling” these exercises. When possible, physical therapists should include family members in discussions about home programs and other aspects of patient care; inclusion of the family is especially important for patients from cultures that have collectivist values.

Written patient instructions should be translated into grammatically correct, simple language using appropriate, meaningful vocabulary to help ensure that these materials are used as intended and are culturally relevant to the patient. The material should be translated back into the original language to see if something does not make sense.

If the patient has limited proficiency in English, it is wise to speak slowly (not loudly) and to avoid colloquialisms and idioms. Statements should be rephrased often, and physical therapists should check to be sure that their patient or client understands their meaning.

Rapport is also likely to be enhanced if the clinic environment has been adapted to make someone from a different cultural background feel more welcome. Therapists should consider the types of magazines that are placed in public meeting spaces or in the waiting area. Are these publications and the signs around the workplace in more than one language? Do pictures in the literature look like the people who frequent the facility? What images decorate the space? A consideration of these questions, an understanding of a range of communication styles (both verbal and nonverbal) and learning styles, and the ability to properly interpret an interaction will undoubtedly minimize barriers that may otherwise exist.

When Differences in Cultural Values And Communication Are Not Considered

If the physical therapist does not consider differences in cultural values and does not act on them appropriately, miscommunication and misunderstanding between the patient and the clinician may be more likely. Based on reports in the medical literature regarding the impact of language and cultural differences on the patient-provider
relationship, it could be inferred that problems in communicating might result in the following:

1. The physical therapist could make errors in the examination and diagnostic process,
2. The patient might not fully participate in the therapy program, or
3. The patient may report overall dissatisfaction with the physical therapy service.

“Folk” Health Beliefs and Behaviors

Historically, models for the provision of care generally have relied on the values and belief systems of the “majority” (i.e., the white middle-class). These models are culturally insensitive because they deny the existence of non-Western systems of thinking.

What is disability? The World Health Organization defines disability as “an umbrella term for impairments, activity limitations and participation restrictions. It denotes the negative aspects of the interaction between an individual (with a health condition) and that individual’s contextual factors (environmental and personal factors).” Although many health care professions, including physical therapy, have embraced this or similar definitions of disability, the concept of disability is not a cultural universal.

As Ingstad and Whyte state, “In many cultures, one cannot be ‘disabled’ for the simple reason that ‘disability’ as a recognized category does not exist. There are blind people and lame people and ‘slow’ people, but ‘the disabled’ as a general term does not translate easily into many languages.” In cultures in which disability does not define who a person is, people with a disability are expected to follow the same life cycle as everyone else.

It is not necessary to catalog every known variation in disability beliefs, but it is appropriate for practitioners to understand how other people conceptualize disability and rehabilitation. This understanding can have a positive effect on the manner in which rehabilitation professionals are received and regarded and on their ability to serve their patients.

Causes of disability and disease. Although there are general similarities among folk beliefs about the causes of illness and disability—including psychological states such as fear, envy, and family turmoil; environmental or natural conditions such as bad air and excess cold or heat; and supernatural causes such as witchcraft or bad spirits—these beliefs also vary. Physical and mental illnesses are sometimes intertwined, and emotional, spiritual, social, and physical factors can be major contributing forces to illnesses. Overall, however, physical disabilities are more accepted by the community and the family than mental disabilities.

Although many people hold folk health care beliefs and Western health care beliefs simultaneously, traditional beliefs from a patient’s cultural background may be brought to the forefront during times of stress or uncertainty, especially in patients with lower levels of education. In an ethnographic study conducted in rural Jamaica, Leavitt recorded that one mother explained that her child’s disability originated from jaundice because the hospital did not have the ability to “burn” the jaundice out when her child was born. Another mother stated that, because she did not eat more nutritious food while she was pregnant, her daughter was born with a disability, when in fact her daughter had Down syndrome. Physical therapists need to recognize that patients express beliefs based on their personal worldview.

In some cultures, people may believe that illness and disability are forms of divine punishment. A person may have sinned or violated a taboo, either in this life or a previous life, thereby causing the wrath of God, which may take the form of an illness or disability visited on the offender or a family member. Many people throughout the world believe in the “evil eye.” The evil eye typically is a spell, usually motivated by envy, that is believed to cause the victim to fall ill. In an article about disability by Mardigos, one Mexican American woman claimed that one of her husband’s previous lovers asked a bruja (a sorcerer or witch) to put a hex on them, which the woman blamed for all of their “bad luck.”

In any culture, there may be people who believe that an imbalance of elements is responsible for an ailment. This “elemental” system resembles the ancient Greek concept of an imbalance of the four humors, and it includes a system of classification for diseases, body organs, herbal remedies, and foods. All four of these mutually complementary forces are required for a person to be in harmony with nature, and a belief in this concept might affect the patient’s decision regarding what medicines to use and foods to eat. In India, the Ayurvedic system equates health with balance. Traditional Chinese medicine requires a balance of yin and yang. The Navajo believe that their health depends on harmony with family, community, self, and nature, and they do not have a concept of communicable disease. Their language, for example, does not have a word for germ.

In some communities, harmony between the physical and spiritual world requires a balance of “hot” and “cold.” Examples of diseases considered to be “hot” by the Hispanic/Latino culture are hypertension, diabetes, acid indigestion, and other diseases characterized by vasodilation and a high metabolic rate. “Cool” remedies such as bananas, passion flowers, and lemon juice are used.
for a “hot” illness. “Cold” diseases include menstrual cramps, pneumonia and other respiratory diseases, colic, and anemia. If a person is anemic, he or she might eat more “hot” foods, such as organ meats with a lot of blood products. Blood is “hot” and is associated with strength, virility, and machismo. For a cold, orange juice (vitamin C) might be recommended by a physician, but the Hispanic/Latino folk tradition is to treat a “cold” with a “hot” remedy such as red chili peppers (which, by the way, also have vitamin C).38–40

Selection of interventions. Decision making about health behaviors can be complex. In some cultures, when a person is sick, the family and a hierarchy of lay healers are often the first line of defense. Next, people seek out either a Western biomedical health care professional or a folk healer who practices traditional medicine. Sometimes, health care professionals and traditional healers are seen simultaneously. Typically, people are more likely to partake in indigenous health care practices if they are less acculturated, poorer, and live in rural areas.41 Practical matters such as cost, severity of illness, and availability of practitioners often determine the utilization of traditional health care practices.41

Treatment for a disease or disability is also culturally specific, although intraethnic variation abounds. Indigenous folk healers, or practitioners of traditional medicine, are prevalent in every society. The curanderos may be preferred by Mexican Americans, the singer by the Navajo, the voodoo priest by Haitians, the santeria by Cubans, the herbalist by the Chinese, and so on. For the Laotian Hmong, the shaman may use herbal concoctions and animal sacrifice.42 In Jamaica, the obeah may use materials such as blood, feathers, parrots’ beak, grave dirt, egg shell, and medicinal herbs to treat a person with a disability.35

In Puerto Rico, an espíritista, usually a female medium, helps people with physical or emotional problems by connecting them with good spirits and exorcising evil spirits.38 For many Native American tribes, “talking circles”—where stories are shared—are used to demonstrate the interconnectedness of life, the cycle of life and death, and the balance in the natural world required for good health. In fact, “talking circles” may be used by health care professionals to educate people about preventive and treatment measures so that the notion of fatalism can be replaced with the idea of control over one’s health.43

There are 2 theoretical explanations for why ritual healing practices may be successful. The first explanation is neurobiological. Endorphins may play a role in diminishing pain.44 The release of these neurochemicals, produced by the brain, may be influenced by psychological experiences (e.g., transcendental meditation).45 The second explanation is the placebo effect, which may help the body to heal itself.46 A placebo may be a word or an action, not just a pharmaceutical substance. By engaging the patient’s mind and emotions, the healer may aid physiological repair.38

Traditional practices may also influence the responses of a patient or client to a Western medical protocol. Many Vietnamese believe that Western medicine is designed to suit the body size of people in Western cultures. Thus, the quantity of drugs prescribed may be seen as inappropriate for the Vietnamese person, who is typically much smaller than the average white American.47 Likewise, the physical therapist working in the area of women’s health might want to know that there may be special considerations associated with childbirth. Different Asian subcultures, for example, prepare special dishes to assist with the involution of the uterus, chase the “bad blood” away, and regulate menstrual flow.10

Often, the use of an alternative treatment is the source of misunderstanding and conflict. A practitioner of Western medicine may perceive that Asian practices used to draw “evil” from the body—such as coin rubbing, in which a coin is rubbed on the skin until a raised red mark appears, or cupping, in which a heated glass is placed on the body to create a vacuum that causes the skin to rise and become red—are harmful to a child.10 On the other hand, a traditional Hmong person may have superstitions about health care practitioners in the United States. Some Hmong believe that US surgeons cut out body parts of the deceased to eat them or to sell them as food.42

The importance of asking the right questions cannot be overemphasized. Masín shares a story about a toddler in an early intervention program in Florida who continued to have seizures even though the child’s mother, a Haitian immigrant who spoke Creole, assured the staff that she was administering the appropriate dose of phenobarbital. When a staff person asked the mother to demonstrate how she was giving the medicine, a cultural variable became apparent. As is customary in many Caribbean nations, the mother was bathing the child in the medicine rather than administering the medicine orally. Other relevant questions in a multicultural pediatric setting might cover infant feeding patterns, family sleeping customs, play routines, and child-rearing practices.

Many texts and studies detail patients’ beliefs in folk illnesses and their use of herbal and other home remedies and alternative healers for conditions as diverse as asthma, diabetes, AIDS, and depression. Yet, most patients do not report the use of complementary and alternative medicines to their health provider.37 Sometimes, home remedies are harmful. One remedy, known as greta or azaron, which is used for gastroenteritis, has a very high lead content and is considered dangerous.37,39,49
When using typical Western physical therapy interventions, it is necessary to consider whether they are appropriate in the context of the patient’s culture. For example, people from many Asian subcultures usually squat rather than sit and thus require greater range of motion in the hip, knee, and ankle, even at the expense of stability. Also, eating with hands or chop sticks may require different movement patterns and range of motion than are typically used by people from European-influenced subcultures.

**Pain across cultures.** The way people react to and feel about pain is very important, because their response to pain can be guided by cultural rules. Researchers on the psychosocial and behavioral aspects of pain have found significant relationships among ethnic variation, perception of pain intensity, and the responses to pain.50,51

In a seminal study, Zborowski50 compared different white populations—including Jewish, Italian, Irish, and “old” or “Yankee” Americans—and determined that some cultural groups, such as Italian Americans, allowed their members to complain about pain, whereas other groups, such as “old” Americans, expected their members to “report” pain in a dispassionate manner. Zborowski also found that members of some groups, including Italian Americans, wanted immediate relief of pain from painkillers, whereas others, including Jewish Americans, worried more about the long-term implications of pain and did not want to use medications for fear that they would mask a more serious problem. Societal rules regarding pain tolerance also promote gender or age differences, but these are not cultural universals.

During the late 1980s, Bates and Edwards51 investigated patients’ meanings and explanations associated with pain. United States–born “old” American (mostly Protestants), Hispanic, Irish, Italian, French Canadian, and Polish people, all of whom were outpatients in a Massachusetts pain treatment facility, were studied. Variation in ethnic identity and locus-of-control style were consistently associated with differences in pain intensity and response. The Hispanic group demonstrated the highest pain expressiveness, the greatest interference with work and social activities, and the highest degree of emotional and psychological stress. The Italian group was second in each of these categories, and either the Polish or “old” American group was the lowest in each category. According to the authors, the results of the study supported the idea of interethnic group variation in the response to pain.

In addition, Bates and Edwards51 reported that intragroup variation analysis demonstrated within-group differences in the response to pain based on both generation and degree of heritage consistency (ie, the degree to which a person’s lifestyle reflects his or her traditional culture). More recent immigrants or people who are the first generation born in the United States, people who have high degrees of heritage consistency, and people who believe that they have a strong support system report less severe responses to pain.51 It also should be noted that physiological or biological differences can result in different responses to and side effects from drugs. Chinese patients, for instance, appear to metabolize drugs differently than white patients and require lower dosages of some pain medications.52–55

**The role of religion.** Health beliefs and behaviors that are closely intertwined with comparative value systems can be related to the role that religion plays in a person’s explanatory model. Religious beliefs and customs may affect the acceptance and the administration of more standard rehabilitation practices. This may be an area in which health care professionals may have difficulty accepting someone else’s moral and ethical viewpoint and actions.

One well-known point of conflict is the refusal of a person who is a Jehovah’s Witness to allow a medical intervention if it requires a blood transfusion. Conflicts also may occur when patients have a strong faith that a supreme spiritual being (eg, God, Allah, Brahma) will cure them, and they, therefore, avoid treatment. A Lubavitcher orthodox Jew may turn to a rebbe for healing prayers or an African American may turn to a “tent meeting.” People from Southeast Asia may adhere to karma, a belief that one’s present life is based on a previous existence, and they thus accept a misfortune as predestined.

Religious beliefs can also affect care delivery. A traditional Muslim woman is forbidden to expose her skin (except for the hands and face) to a man other than her husband, and, therefore, she would require a woman for a physical therapist. The “Sabbath” days mean different things in different religions, and how these religions celebrate the Sabbath may affect patient care. For example, the Jewish Sabbath begins at sundown on Friday and extends to sundown on Saturday, which would affect the times that therapists can provide care, especially in the home.

**Culture-bound syndromes.** Culture-bound syndromes, sometimes referred to as folk illnesses, exist in most cultures. They are associated with unique beliefs about the cause of an illness and may require specific culturally prescribed treatments. Susto is perhaps the most studied culture-bound, psychosomatic illness within Hispanic/Latino subcultures. Susto, or “shock,” occurs when a frightening event causes the soul to leave the body. Symptoms of susto include sleepiness, loss of appetite, insomnia, and generalized depression. Psychiatrists consider these symptoms to be body metaphors for psychological distress.40

A culture-bound syndrome from the Haitian culture is “arrested pregnancy syndrome,” in which a woman who
expects to be carrying a child and feels as though she is pregnant is not actually pregnant. It is often associated with infertility in a culture that highly values the ability to have children. Anorexia nervosa, a psychological disorder with which most US physical therapists are familiar, is considered a culture-bound syndrome of white North Americans.

End of life. Health beliefs and behaviors associated with end-of-life decisions deserve special attention by physical therapists specializing in geriatrics. Although physical therapists do not typically deal with end-of-life decisions, it is, nevertheless, a possible topic of conversation, especially with family members. Because of language and cultural barriers, people of color may not have adequate knowledge of the purpose and availability of hospice services.

In Asian and Hispanic/Latino subcultures that have a belief in fatalism, disclosure of a terminal disease may take away any hope that the patient may have. The family, especially the eldest son, has a very strong obligation to protect loved ones from emotional distress. In actuality, it is not common for elderly Chinese people to discuss the likelihood of death at all, because it is believed to be a bad omen. The Navajo feel similarly; negative thoughts would be in conflict with the concept of hoozah, which involves goodness, harmony, and a positive attitude.

Older adults are likely to have varied attitudes toward advance directives. For example, elderly Chinese people may be less likely to write something down, because they honor the spoken word. Elderly Japanese people tend to place great faith in family and professional relationships, and it is less likely that decisions would be made by the individual alone. For the Navajo as well, major decisions are collaborative, and the family and the tribe would have input into any advance directives.

Hispanic/Latino people generally are less knowledgeable about, and less likely to write, living wills than other ethnic groups. According to Berger, Mexican Americans have a more negative attitude toward advance directives than whites or African Americans, although there is a correlation to degree of acculturation. In general, it is less likely that the Hispanic/Latino person would make these decisions alone. As with many other cultural groups, major decisions are collaborative, and the family would have input into any advance health directives.

Once death occurs, some cultural groups (eg, Orthodox Jews, Christian Scientists) are less likely to consent to an autopsy because they believe a mutilated body may cause suffering in the afterlife. With regard to bereavement, grief responses also depend on personal characteristics and culture. In contrast to the European American culture, in which people are encouraged to grieve and “move on,” many non-Western cultures encourage people to continue their relationship with the deceased, possibly through a specific altar dedicated to the loved one where they can pray or bring food and other offerings.

In sum, although one cannot say with certainty how many individuals have non-Western health care belief systems, physical therapists must consider that these belief systems are more prevalent than they expect. Variables such as the patient’s level of acculturation and place of origin can influence a belief system. Researchers often have a difficult time uncovering a respondent’s belief system because they do not ask the right questions or the respondent may fear looking “ignorant” or “backward.” It is wise to expect that traditional beliefs are somewhere in a person’s cultural background and may be brought to the forefront during times of stress or uncertainty.

Physical therapists as culture brokers. Many people, to varying degrees, intertwine “modern” or “Western” medicine with “indigenous” or “folk” medicine. This intertwining results in medical pluralism (the existence and use of many different health care alternatives within societies). The physical therapist should learn as much as possible about the relevant traditional practices and practitioners in the community. Therapists might ask their patient or client to bring them to a traditional healing ritual. A physical therapist working in an Hispanic/Latino neighborhood or with Hispanic/Latino patients might become familiar with the local botonica (herbal and religious shop).

Physical therapists should be concerned about patient welfare if the traditional healer prescribes an unhealthy, dangerous remedy. Clinicians may want to think in terms of multiple treatment options—each serving its own purpose. In theory, the best scenario for avoiding or reducing conflict and encouraging collaborative relationships among health care providers would involve the therapist serving as a “culture broker,” or a link that connects the patient, the traditional healers, and the mainstream health care system.

More resources on the beliefs and behaviors of a particular cultural group can be found in the Appendix.

Footnotes
* APTA’s Guide for Professional Conduct states, “A physical therapist shall not accept of offer gifts or other considerations that affect or give the appearance of affecting his/her professional judgment.” (Guide for Professional Conduct, Accessed on: November 7, 2002.)

† The Guide to Physical Therapist Practice defines disability as “the inability or restricted ability to perform actions, tasks, and activities related to required self-care, home management, work,

Health Promotion and Disease Prevention

Although an in-depth discussion of health promotion and disease prevention is outside the scope of this article, some general guidelines are useful. The Guide to Physical Therapist Practice states, “Physical therapists are involved in prevention; in promoting health, wellness, and fitness; and in performing screening activities.” Health promotion and disease prevention programs should be culture-specific and address a person’s explanatory model. One size does not fit all.

After an adequate assessment of individuals and the community (eg, statistics on individual health status, community needs, available resources) has been completed and goals have been established, a program targeted to the specific population can be developed. Certain considerations are likely to be apparent: people may not speak English fluently, the group may have a relatively large number of uninsured people (except for Medicare), and there may be identifiable normative cultural value systems (eg, importance of family, respect for elders, desire for personalismo). Key program elements will ideally include:

- hiring personnel who are from the community and who are bicultural, not just bilingual,
- using media in the languages spoken in the community for health education,
- teaching people, especially those who have not completely acculturated, to advocate for their health care and patient rights, and
- collaborating with clergy, community leaders, and like-minded agencies.

Role of Culture in Tests and Measures: The Research Imperative

To be culturally proficient as members of a profession, physical therapists must continue to do cross-cultural research. They must examine the interview techniques and functional and cultural scales that they use to assess patient status, and they must evaluate intervention efficacy.

Most tests and measures have been standardized for European-influenced cultures and lifestyles. For example, an analysis of the Denver Developmental Screening Test (DDST), a commonly used pediatric instrument, has indicated that some developmental skills emerge at significantly different ages for Alaska Native children compared with a group of white, middle-class children in the United States.61

In order for the profession of physical therapy to become culturally proficient, it must make the development of culturally valid standardized screening instruments and culture-specific functional outcome measures and patient satisfaction scales an important goal.

—Ronnie L. Leavitt, PT, PhD, MPH

Similarly, Gannotti et al62 found differences in the scores on the Pediatric Evaluation Disability Inventory (PEDI) when comparing the scores obtained from a population of children living in Puerto Rico with the norms developed in the United States. Gannotti et al noted several social customs that affected the age at which developmental skills were expected to occur. For example, young children in Puerto Rico, in contrast to white children in the United States, typically use a bottle at night for up to 6 or 7 years, might not use a fork for fear of injury, might wear diapers for public outings to avoid the use of public restrooms, and might not learn to put on socks or tie their shoes because they wear sandals secured with Velcro all year. Puerto Rican parental expectations for their children with disabilities are influenced by the Puerto Rican values of interdependence, aiónlar (pampering or nurturing behaviors), and sobre protectora (overprotectiveness). Is the PEDI appropriate to use to evaluate children’s development if the expected developmental age is different for this population?

A new Stroke Impact Scale has been developed for use by physical therapists. Duncan63 noted that this scale has been culturally and linguistically validated for 14 European cultural and linguistic groups. This is an excellent beginning, but further research needs to be done to validate this scale (and other tests) for other prevalent cultural groups in the United States, most notably Mexicans, Asians (eg, Chinese, Indians), Native Americans, and others.63

Many functional tests do not take into account activities that may be everyday requirements for people in certain cultures. Examples of such culture-specific activities include eating with chopsticks, eating with hands, or frequently moving in and out of the squat position. Determining culture-specific norms for functional activities also can help the clinician avoid using ethnocentric standards when assessing areas such as cognition, language skills, learning style, gross motor skills, and fine motor skills.
Preparing for Immersion in a Multicultural Environment

Knowledge about a person’s and a cultural group’s way of life and worldview is bound to help physical therapists practice in a cross-cultural environment. Yet, clinicians are still likely to experience “culture shock.” This term describes the more pronounced reactions to the psychological disorientation most people experience when encountering a culture markedly different from their own.

Culture shock is a cyclical phenomenon, in which a person moves through four basic phases of adjustment: excitement in a new environment, withdrawal and hostility, adjustment and appreciation of differences, and adaptation. Admitting your own ethnocentrism and understanding your own culture are the first steps to moving through this sequence. Physical therapists also should continue to learn about the culture of their patients, ask questions, and be observant. They should have realistic expectations of themselves and others and remember that problems and challenges are inevitable.

What personal characteristics are likely to foster a more successful cross-cultural encounter? A sense of adventure, patience, flexibility, tolerance for ambiguity and differences, a sense of humor, and cultural sensitivity are high on the list. Ironically, many successful health care professionals have some of the characteristics that are not conducive to working cross-culturally—that is, they are task oriented, overachievers, and fearful of “failure.”

Building on Diversity

In this millennium, national population patterns will continue to shift, and physical therapists will increasingly be required to practice in less familiar multicultural settings. The challenges to delivering effective and humanistic care will become even greater than they are today.

In order to ensure that the American health care system better responds to the needs of an increasingly diverse patient population, a growing number of health care organizations and agencies are addressing the issue of cultural competence. For example, the Office of Minority Health in the US Department of Health and Human Services has developed national standards for culturally and linguistically appropriate services. These 14 standards are organized by themes: culturally competent care (standards 1–3), language access services (4–7), and organizational supports for cultural competence (8–14).

Although these standards are intended to be inclusive of all cultures, they are particularly designed to help eliminate racial and ethnic disparities in health care in the United States by making the health care environment more inviting to those groups that historically have not had equal access to health care services. Specific ways to incorporate culturally and linguistically appropriate services can be found in the standards. The use of proactive incentives, mentoring programs, and staff education and training are all suggested as ways to avoid conflicts.

An understanding of the sociocultural variables in the health care setting and of an individual patient’s or client’s worldview is believed to lead to an improved clinical encounter. The term “cross-cultural efficacy” implies that the health care provider has an “ethno-relative” (as opposed to ethnocentric) perspective and believes that there is more than one valid belief system or behavior. Clinicians increasingly understand that a health care interaction that incorporates negotiation and preservation of cultural health-related beliefs and practices will likely increase treatment adherence and self-efficacy for both parties.

As Helen Hislop stated in her address to the World Confederation of Physical Therapy: “The value of diversity, individuality, and improvisation should be apparent to all of us. We are a group of independent clinicians, all playing the same game with the same objective, but each of us produces individual variations on the same basic theme, expressing individuality and talent that can combine to produce a unique effect, never twice the same, but powerful and beautiful.”

References


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Appendix

**Recommended Resources for Specific Cultures and Health Beliefs and Behaviors**

**Textbooks**


**Internet**

Center for International Rehabilitation Research Information and Exchange

The Commonwealth Fund’s 2001 Health Care Quality Survey

Office of Minority Health, Department of Health and Human Services

The Providers Guide to Quality and Culture—the Health Resources and Services Administration resource on providing culturally competent care

Tips on How to Increase Cultural Competency—Department of Minority and International Affairs
Table 1.

Table. The Continuum of Cultural Competence

<table>
<thead>
<tr>
<th>Stage</th>
<th>Name</th>
<th>Definition</th>
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<tbody>
<tr>
<td>1</td>
<td>Cultural destructiveness</td>
<td>People are treated in dehumanizing manner and are denied services on purpose.</td>
</tr>
<tr>
<td>2</td>
<td>Cultural incopacity</td>
<td>Health care systems are unable to work with patients from other cultures effectively; bias, paternalism, and stereotypes exist.</td>
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<tr>
<td>3</td>
<td>Cultural blindness</td>
<td>Presumption is that all people are the same and that no bias exists; policies and practice do not recognize the need for culturally specific approaches to problem solving; services are ethnocentric and encourage assimilation; patients are blamed for their problems.</td>
</tr>
<tr>
<td>4</td>
<td>Cultural pre-competence</td>
<td>Health care system is committed to using appropriate response to cultural differences; weaknesses are acknowledged, and alternatives are sought.</td>
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<tr>
<td>5</td>
<td>Cultural competence</td>
<td>Cultural differences are accepted and respected; continuous expansion of cultural knowledge and resources and continuous adaptation of services occur; continuous self-assessment about culture and vigilance toward the dynamics of cultural differences exist.</td>
</tr>
<tr>
<td>6</td>
<td>Cultural proficiency</td>
<td>Cultural differences are highly regarded; the need for research on cultural differences and the development of new approaches to enhance culturally competent practice is recognized.</td>
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<table>
<thead>
<tr>
<th>Individualist Cultures</th>
<th>Collectivist Cultures</th>
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<tr>
<td>Individualism/privacy</td>
<td>Collectivism/group welfare</td>
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<tr>
<td>Personal control over environment</td>
<td>fate</td>
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<tr>
<td>Time dominates</td>
<td>Human interaction dominates</td>
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<tr>
<td>Pracixe time reckoning</td>
<td>Loose time reckoning</td>
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<tr>
<td>Future orientation</td>
<td>Past orientation</td>
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<tr>
<td>Doing (working, achieving)</td>
<td>Being (personal qualities)</td>
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<tr>
<td>Human equality</td>
<td>Hierarchy/rank/status</td>
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<tr>
<td>Self-help</td>
<td>Birthright inheritance</td>
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<tr>
<td>Competition</td>
<td>Cooperation</td>
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<tr>
<td>Informality</td>
<td>Formality</td>
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<td>Directness/openness/honesty</td>
<td>Indirectness/ritual/“saving face”</td>
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<td>Practicality/efficiency</td>
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<td>Spiritualism</td>
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<td>Values elders</td>
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<td>Relative equity of sexes</td>
<td>Relative inequality of sexes</td>
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