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CULTURAL COMPETENCY: PERCEPTIONS OF SOUTH AFRICAN TRAINED OCCUPATIONAL THERAPISTS

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Dissertation submitted to the Faculty of Health Sciences, University of the Witwatersrand, Johannesburg, in fulfilment of the requirements for the degree of Master of Science in Occupational Therapy.

August, 2012

Victoria, Australia

DECLARATION

I, Alethea Ethel Leendertz declare that this research report is my own work. It is being submitted for the degree of Master of Science in Occupational Therapy by dissertation to the University of the Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination at this or any other University.

…….

……day of ……., 2012

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ABSTRACT

During occupational therapy training in South Africa, students are expected to consider cultural differences when working with patients. This study considered the training offered to students in terms of cultural diversity and the perceptions of 47 novice community service occupational therapists about their cultural competence as well as how these perceptions had changed after three years of clinical practice.

Results indicate that all six participating universities offer training in cultural diversity although university respondents feel this is affected by time, students' attitudes and their inability to reflect. Most newly qualified occupational therapists felt the training was adequate, although they reported difficulty in working with patients from other cultures in clinical practice. The perceived cultural competency level of the newly qualified respondents varied with some respondents still needing to develop awareness and knowledge and others already extending themselves in terms of cultural skill, encounters and cultural desire. Some used rules and knowledge to guide their intervention and language was seen as a major barrier to practicing culturally appropriate occupational therapy,

Three years later three respondents, who could be considered competent occupational therapists, reported using reflection in practice enabled them to consider culture from their clients' unique perspective. They felt personal experience, opportunities from classroom experiences, fieldwork exposure and professional development activities should be used to strive toward becoming culturally competent. The importance of having relevant resources available was highlighted. Recommendations for occupational therapy curriculum development in terms of cultural competence in South Africa are therefore suggested.

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OPERATIONAL DEFINITION OF TERMS

"Coloured"- Four racial classifications are used in South Africa: Asian, Black, Coloured and White. Officially "Coloured" refers to any person of "mixed blood" (Brown, 2000).

Competent occupational therapist – three years of reflective practice. Automatically performs more therapeutic skills and attends to more issues. Able to develop communal horizon with persons receiving service. Sorts relevant data and able to prioritise treatment in light of discharge goals. Planning is deliberate, efficient, and responsive to contextual issues. Uses conditional reasoning to shift treatment during sessions and to anticipate discharge needs, but lacks flexibility of more advanced practitioners. (Schell, Crepeau and Cohn 2003)

Cultural competence is - "a set of congruent behaviours, attitudes, and policies that come together in a system, agency, or among professionals and enables that system, agency, or those professionals to work effectively in cross–cultural situations" p 7 (Cross, Barzon, Dennis and Isaacs 1989).

Cultural competence in health care- " describes the ability of systems to provide care to patients with diverse values, beliefs and behaviors, including tailoring delivery to meet patients' social, cultural, and linguistic needs." p5 Betancourt, Green and Carrillo 2002).

Curriculum - All the learning which is planned and guided by the institution, whether it is carried on in groups or individually, inside or outside the institution (Kelly, 1999).

- is the totality of learning experiences provided to students so that they can attain general skills and knowledge at a variety of learning sites. (Marsh and Willis, 2003)

Developed countries- "can be defined as a country that has a relatively high level of development, based on various factors." (British Red Cross, 2012)

Developing countries- "can be defined as a country that has a relatively low level of development, based on various factors." (British Red Cross, 2012)

Diversity- “the concept of diversity encompasses acceptance and respect. It means understanding our individual differences. These can be along the dimension of race, ethnicity, gender, sexual orientation, socio-economic status, age, physical abilities, religious beliefs, political beliefs, or other ideologies. It is the exploration of these differences in a safe, positive, and nurturing environment. It is about understanding each other and moving beyond simple tolerance to embracing and celebrating the rich dimensions of diversity contained within each individual.”(Definition of Diversity, paragraph 1) (University of Oregon, 1999)

Novice newly qualified occupational therapist - no years of reflective practice and therefore dependent on theory to guide practice. Uses rule-based procedural reasoning to guide actions, but does not recognise contextual cues, and therefore is not skilful in adapting rules to fit situation (Schell, Crepeau and Cohn 2003).

ABBREVIATIONS

CCAI - Cultural Competence Assessment Instrument

HPCSA - Health Professions Council of South Africa

PBL - Problem based learning

SAQA - South African Qualifications Authority

WFOT- World Federation of Occupational Therapists

CHAPTER 1
INTRODUCTION

South Africa, known as the “Rainbow Nation”, is a diverse nation with people from different cultural belief systems, customs, values, religious practices and languages. All these cultural factors influence decisions related to health and medical care made by individuals and health care providers (Muńoz, 2007; Chipps, Simpson and Brysiewicz, 2008).

> “The success of our country depends on how people of South Africa live and work together. In this regard, knowledge and understanding of one another’s culture is crucial” p 1(Tambo, 1997).

In view of the previous segregation of the health care system in South Africa health professionals are still being sensitized to the differences among people and their health-related attitudes, preferences, and behaviours as many health care professions in South Africa are not from the same culture and race group as their patients. Culturally competent healthcare in South Africa should instil respect for the cultural context of each person accessing the health services. Barriers like understanding others beliefs related to health and language still exist and eliminating these will improve patient care, enhance patient satisfaction and increase operational efficiency (Simon and Mosavel, 2010).

Culture reflects an individual’s identity and is therefore an important part of life (Campinha-Bacote, Yahle, Langenkamp, 1996). Understanding cultural diversity and being culturally competent is important in occupational therapy practice as it leads to improved communication between client and clinician, it increases the clinician and students awareness of and sensitivity to cultural beliefs, values, customs and the importance these aspects have on an individual’s life roles and quality of life.(Murden, Norman, Ross, Sturdivant, Kedia, Shah, 2008) .

It is possible that a lack of knowledge of the cultures of other groups may result in a lack of cultural competency. The previous segregation of races in South Africa may have contributed to this problem. Addressing the concept of cultural competence in occupational therapy has always been important because

occupational therapists need a holistic view of their clients including an understanding of their values, beliefs, customs, behaviour standards and the expectations of the society in which the client lives (American Occupational Therapy Association, 2008).

The acquisition and application of knowledge of cultural differences is important in the development of cultural competence in occupational therapy intervention as this enables the formulation of culturally sensitive treatment plans and programmes and to select culturally appropriate activities in partnership with clients (Campinha-Bacote, 1999, Campinha-Bacote, 2002). This is important in helping to reduce barriers during treatment, facilitate the treatment process and contribute to treatment compliance.

The exit level outcomes registered with the South African Qualifications Authority (SAQA) by the Professional Board for Occupational Therapy, Orthotics/Prosthetics and Art Therapy includes outcomes for occupational therapy training in relation to cultural competence. The outcomes state that on completion of an undergraduate degree in occupational therapy candidates must demonstrate an awareness and sensitivity towards culture, language, socio-economic, political, gender and other diversity issues in the South African context and be tolerant of these. The students should also demonstrate the ability to reflect upon own biases and their impact on the relations and interactions with others as well as showing an understanding of these (Health Professions Council of South Africa, 2006).

It is important that South African universities, who train occupational therapy students have these concepts built in to their curricula and they need to continue to develop their curricula to achieve the outcomes required by their students in terms of cultural competency (Health Professions Council of South Africa, 2006). This is necessary in order to meet the diversity challenges particularly evident in clinical practice, as well as accommodating the effect of the changing needs of our society including urbanisation, refugees, disease patterns and access to health care (Myer, Ehrlich, and Susser, 2004).

Since cultural competence has been shown to be informed by concepts of cultural sensitivity, cultural awareness or cultural knowledge, these should be introduced or taught as part of the occupational therapy course as well as in the

sociology (Human Behavioural Science) or anthropology courses required in all South African occupational therapy training (Health Professions Council of South Africa, 2009). An understanding of these terms however does not imply that students will become culturally competent occupational therapist practitioners when qualified. According to Krefting and Krefting (1991) despite developments within the professions body of knowledge, therapists tend to practice,

> "on the level of personal experience and intuition rather than on the level of conceptually sound information that is supported by research" p 104 (Krefting and Krefting, 1991) in relation to cultural competence.

1.1 Statement of the problem:

During occupational therapy student training in South Africa, according to the exit level outcomes, registered with SAQA, occupational therapy students are expected to consider cultural differences of many different population groups when working with clients, as this forms an important part of the occupational therapy process (Muńoz, 2007). Thus it is expected that newly qualified novice community service occupational therapists have knowledge of cultural diversity and sensitivity to cultural differences in the therapeutic situation.

Cultural diversity training is presented differently in individual occupational therapy education programmes. The acquisition of knowledge of cultural diversity is gained in different ways. It is therefore not dependent on curricula content offered within occupational therapy education programmes. Occupational therapy students may have prior knowledge and skills of different cultures gained through a variety of ways and experiences such as exposure to social situations or reading literature on the subject. Each student entering an occupational therapy programme brings unique life experiences to the learning situation. Due to varying levels of personal experiences, occupational therapy students may not however actually have all the necessary tools to meet the challenge of culturally competent practice as they might be at different levels of understanding cultural diversity. Reasons for this may be influenced by lack of exposure to information, lack of experience of working with clients from different cultural groups during their training or engaging with others from different cultures. This places an enormous responsibility on novice therapists

as they are expected to work with clients from cultural backgrounds different to their own, of which they may have no, or limited knowledge.

However as in most professions it is experience in clinical practice in occupational therapy where the gap is bridged from the classroom to competence in professional skills needed in service delivery (Mattingly and Fleming, 1994). Therefore as with other professional skills it is assumed that the skilful use of cultural information (Awaad 2003a) and application of components of cultural competence in the clinical practice context (Balcazar, Suarez-Balcazar and Taylor-Ritzler, 2009) may develop with clinical experience.

There is however very limited research on training in or the therapists' perception of their cultural competence in occupational therapy in South Africa. It is unknown how cultural diversity and development of cultural competence in occupational therapy curricula in South Africa as well as how newly qualified novice community service South African occupational therapist' perceive their cultural competence and what changes they perceive might occur in their competence after three years of clinical experience.

1.2 Purpose of the study

The purpose of this study was to review the curricula of Occupational Therapy courses in South Africa to determine how cultural diversity and cultural competency training are addressed within these courses. The study also investigated the perceptions of cultural competency of novice newly qualified community service occupational therapists as well as changes in these perceptions after three years of experience, by which stage the therapists have reached the competent level of expertise in clinical practice according to Dreyfus' Model of Skill Acquisition (Dreyfus and Dreyfus1986).

1.3 Aim of the Study

The aim of the study was to determine the training in cultural diversity offered in occupational therapy courses and see if this supports the novice newly qualified community service occupational therapist perceptions of their cultural competence. The perceived changes in their perception of the use of cultural information and

cultural competence after three years of clinical experience will also be investigated.

1.4 Objectives of study

1. To review the curricula of the eight Occupational Therapy training centres in South Africa in terms of cultural diversity training
2. To determine perceived adequacy of this training from both the university staff and novice newly qualified community service occupational therapists' points of view as well as the factors affecting the development of cultural competency.
3. To determine how novice newly qualified community service occupational therapists perceive their own cultural competence, using the Model of Cultural Competence.
4. To determine the change that occurs in these perceptions after three years of clinical experience.

1.5 Justification for the study

Training centres for Occupational Therapy in South Africa must ensure that their students achieve the exit level outcomes registered with SAQA. This means that on completion of their course, novice newly qualified occupational therapists must have knowledge of both indigenous and international perspectives, as well as demonstrating an awareness and sensitivity to the influence that diversity in cultural and social systems have on occupational choice and behaviour in the South African context, and should be able to adapt the occupational therapy process accordingly, (Health Professions Council of South Africa 2009.

In order to contribute to Occupational Therapy curriculum development in terms of cultural competence in South Africa, it needs to be established whether these outcomes are included in the curriculum and to evaluate whether students have reached them. Information on how sensitivity to cultural diversity is acquired as well as what level of cultural competence is expected for novice occupational therapists needs to be determined. It needs to be determined if the level of expertise in cultural competence develops with clinical experience from that achieved at exit from the course.

CHAPTER 2
LITERATURE REVIEW

A review of the literature will consider culture, the concept of cultural competency, culture within the health context and the need and use for cultural competence in the health professions. In particular the review focuses on occupational therapy and the application of cultural competency in the South African context.

2.1 Tacit Understanding of Culture

Culture is a unique human feature that is passed on from generation to generation through enculturation (Jenkins, 2010). Culture is dynamic, “emergent” and changeable; it encapsulates self, community and vision (Bonder, Martin and Miracle, 2004, Watson, 2006). Culture connects us to groups to which we belong. Our cultural connection, convey meaning to who we are as individuals in relation to others and our place in the world (Lebaron,2003). There are many varied definitions of culture that can be found in international literature, mostly of Eurocentric origin and description (Ekelman, Bello-Haas, Bazyk and Bazyk, 2003).

Difficulty in defining culture is clearly articulated in literature because scholars hold different opinions as to which elements they consider important and should be included. Scholars mostly present single definitions of culture, highlighting one aspect of culture which therefore results in a vague and inaccurate impression of other elements of culture (Baldwin, Faulkner, Hecht and Lindsley, 2006). This has emerged as an issue because of vast differences in characteristics and behaviours that exist within individuals and social groups (Awaad 2003).

Examples of these differences described by various academics include Ekelman Bello-Haas , Bazyk, and Bazyk (2003) defined culture as a “socially constructed, dynamic perceptual lens from which individuals view the world” p 131 (Ekelman et al, 2003), While Gujral (2000) described culture as “comprising traditional beliefs and social practices that lead to rules for social interaction within a particular locality or social group”. Other definitions suggest culture is passed on

from one generation to the next through observation, modelling or instruction (Bonder,Martin and Miracle, 2004).

Although informative, these definitions may not reflect all aspects that would be considered important in understanding South African culture and traditions that encompass the nation's distinctive groupings. There are a great variety of backgrounds, inclusive of both indigenous people and those descended from Dutch and British settlers. Few attempts have been made to describe a South African definition of culture (South African History Online, 2005).Thorntons contemporary definition of culture below reflects elements of what culture in a country where an official policy was used to discriminate against certain races and cultures for nearly 50 years (American Association for the Advancement of Science and Physicians for Human Rights, 1998) may represent;

> "One of the things that culture does is to create boundaries of class, ethnicity, race, gender, neighbourhood, generation, and territory within which people live….Boundaries divide individuals and groups of people, but they can only do so if the groups so divided share a common belief about what criteria and what rituals constitute a boundary" p 17 (Boonzaier and Sharp, 1988)

It is difficult to coin a single definition of culture that suits South African society because of historical complexities. Cultural groups remained separated in South Africa until 1994 (Dolby, 2001). The establishment of the new democratic constitution that came into effect on 4 February 1997 resulted in the emergence of a consolidated South Africa where each cultural group was acknowledged and recognised within the Constitution (van der Merwe, 1996, Republic of South Africa,2004(a).

2.1.1 Understanding the effect of Apartheid on Culture and Health care in South Africa

The South African population is one of the most diverse and complex in the world. Mid 2010 estimates (South Africa Information, 2010), indicate that there are approximately 49.9 million people of different cultural origins. Seventy nine point four % of the population is "African", followed by 9.2 % that is "White", the

“Coloured” population is 8.8 % and the Indian/Asian population is 2.6 %. Approximately fifty percent of South Africa’s population live in urban areas.

The “African” population in South Africa is an ethnic majority consisting of many different tribal groupings. There are four major ethnic groups in South Africa they include the Nguni, the Sotho-Tswana, the Shangaan- Tsonga and the Venda. Xhosa and Zulu form sub-groups of the Nguni group. There are eleven official languages spoken in South Africa. These include: Ndebele, Sepedi, Xhosa, Venda, Tswana, Southern Sotho, Zulu, Swazi, English, Afrikaans and Tsonga but there are many other unofficial languages spoken in the country (South Africa Information, 2010).The effects of segregation within South African society during the Apartheid era (1948-1994) have had a significant influence on the country’s culturally diverse population groups (Dolby 2001). The ethic majority in the South African population was severely marginalised during the Apartheid era. One of the significant issues brought about by Apartheid, was that the policies and acts that reduced opportunities for interaction between groups of different cultures. The UNESCO report on the effects of Apartheid on Education, Science, Culture and Information (1967) reported that

> “the whole atmosphere of mistrust between people, the basic suppositions of the superiority and inferiority of racial groups, the difficult political problems, the suspicion that government-paid informers exist, make meaningful human relationships not only across colour groups, but within groups themselves, difficult to maintain” p 181 (UNESCO 1967).

Several articles have been written on understanding culture of ethnic minority groups (Bourke-Taylor and Hudson, 2005, Cooper and Powe, 2004, Awaad, 2003, Muńoz, 2007). A few studies describe the effects in relation to disadvantaged ethnic majorities (Spangenberg, 2003, Niemeier, Burnett and Whitaker, 2003). The understanding of the effect of the unique situation in South Africa, where a minority group, defined by race and culture, dominated in all government departments has not been well researched.

While the Truth and Reconciliation Commission, (1995) was used to facilitate the transition from the Apartheid era to rekindle of cultural bonds amongst South Africans, culturally competent health care in South Africa could still be viewed as

being in an infancy stage. Rehabilitation is part of this health care and the access to health services for the majority of clients with disabilities in South Africa is emergent. There is a dearth of South African literature written on cross cultural encounters in the rehabilitation professions, but according to research in other countries it is critical that the developing rehabilitation health service is supported with a culturally proficient work force (Muńoz, 2007, Chipps, Simpson and Brysiewicz, 2008).

The higher education policies in South Africa put in place by the apartheid government from 1959 made it difficult for students other than white students to follow careers in the health professions. Thus prior to the first South African democratic elections of 1994, admission to tertiary education for the majority of non white South Africans was not easily accessed (Boughey, 2009) and health professionals were drawn mostly from the white minority population group. The South African government set up five universities in the 1980s specifically for non-white student groups, two of which offered courses in health sciences. Following the challenges of the apartheid era, significant changes have emerged with increased admission of previously disadvantaged students to training in the health care professions at tertiary institutions (Cloete, 2009).

South Africa's history of racism is still a relevant issue today (Spangenberg, 2003). South African health professionals should be aware of the impact that historical and socio-political factors have had on previously disadvantaged South Africans. These previously disadvantaged population groups may be cautious when establishing a therapeutic rapport with clinicians (Spangenberg, 2003, Niemeier, Burnett and Whitaker, 2003).

The therapeutic relationship between clinician and client is important if adequate care is to be given. It is therefore essential to recognise and understand differences in people (Awaad, 2003) and the cultural background that affects them. Consideration of these factors by health care professionals is particularly important when delivering health services.

Patients or clients are frequently treated by health professionals from different ethnic backgrounds, who may well be from a different race group and who may not be able to speak the home language of the patient consulting them

(Cooper and Powe, 2004, Awaad 2003). Literature reveals that patients or clients tend to seek care from health care providers from their own ethnic or tribal group (US Department of Health and Human Services, 2004). Reasons for this may include cultural identification, feeling at ease and being better understood.

In South Africa this option is not available to the previously disadvantaged majority of non-white South Africans who are still reliant on the underfunded and understaffed public health care system (Mooney and McIntyre, 2008). In addition, the ability of the health care workers to develop effective relationships with the patients may be problematic in the South African public health service, where many patients who have low levels of education must deal with a system which uses English and where a large number of health care workers do not speak indigenous African languages. There are also frequently differences in socio-economic class and cultural background (Levin 2011).

Thus the importance of understanding culture from a South African perspective is central to health care delivery, including the practice of occupational therapy.

2.2 Culture and Occupational Therapy

Understanding the relevance and meaning of culture in occupational therapy provides a framework which supports the philosophy of the profession, which is to understand each person in totality and to appreciate differences in people (Tigges, 1972).

Therefore occupational therapists use a client-centred approach and consider individual differences in their clients' (Hagedorn, 2000). Occupational therapy intervention is considered to be holistic as it includes personal, cultural, physical, social, temporal and virtual contexts, thereby ensuring the inclusion of performance skills, performance patterns and factors that assist or limit performance (American Occupational Therapy Association, 2008).

Watson (2006) defined culture in the context of occupational therapy as:

“A lens for perceiving and understanding how people live socially and simply as individuals”. Culture “shapes the identity which people assume” and “matters because cultural groups do not share the same worldview.” p152

Occupational therapists working in most nations, deal with diverse multicultural societies with past histories of discrimination. Sensitivities may relate to values, beliefs, language, behaviour or meaning ascribed to occupation that can interfere with the therapeutic process during cross cultural encounters. Occupational therapists should guard against generalisations or assumptions in terms of cultural differences (Rochon and Baptiste, 1988, Watson, 2006). It is important to thus understand the role cultural differences play in the therapeutic process and that cultural sensitivity and awareness will result in the best possible outcomes for clients (Seibert, Stridh-Igo and Zimmerman, 2002).

“Therapists must know, accept, and work within the value and belief structures of clients from a variety of cultural backgrounds” p 157(Miller, Menks, Ludwig, Shortridge and van Deusen, 1988).

The World Federation of Occupational Therapists’ (WFOT) has guiding principles on diversity and culture which articulates the importance of occupational therapists being aware of their own cultural background (Kinebanian and Stomph, 2009). Occupational therapists therefore need to be conscious of their own socio-cultural environment and the role culture plays in occupational therapy practice (Krefting , Krefting , 1991)

Occupational therapists need to challenge and critique theories and models used in occupational therapy practice to ensure an inclusive and diversified occupational therapy service is provided to all clients’ (Kinebanian and Stomph, 2009). South African occupational therapist in particular, need to be flexible and adaptable in a variety of clinical situations that includes being able to work with diverse population groups (Watson, 2006).

Kielhofner and Burke (1980) identified the importance of cultural considerations during therapeutic encounters. They stated that Occupational therapists working with clients should always be conscious of cultural considerations during a therapeutic encounter (Kielhofner and Burke 1980). They

need to consistently consider a client's culture in addition to functional issues being addressed. This is echoed by

> "Occupational therapists value the importance of understanding clients' cultural values and beliefs in developing effective and appropriate interventions that will meet the needs of each individual" pg 134 (Ekelman, et al, 2003).

Therefore developing knowledge and awareness of culturally diverse clients must be the responsibility of the occupational therapist (Paul, 1995). Factors such as: workload, access to professional development opportunities and cost, may all act as barriers preventing therapists from developing their skills in becoming culturally competent health care providers. Most concerning are occupational therapists who may not be willing to engage in self assessment or diversity focussed activities as they may perceive themselves as being culturally competent Jones, Blair, Hartery and Jones (2004). They indicate that these therapists may not be aware of their own biases; reinforcing a tunnel vision and stereotyped views of other cultures (Jones et al, 2004).

While there is a general awareness of the importance of culture in caring for patients or clients (Bonder, Martin and Miracle, 2004), there is however a lack of knowledge and understanding of how it should be embedded in the principles of occupational therapy (Iwama, 2004). Occupation defined in models of occupational therapy are based on a westernised concept and may not be universally accepted by other cultures (Awaad, 2003).

The relationship of occupational therapy and occupation, must also consider the way culture influences peoples' view of occupation and the effect of this view in relationship to their health (Bonder, Martin and Miracle, 2004). Occupational therapists thus need to be aware that there are differences in how cultural groups perceive occupation or activity participation and that occupation may be interpreted differently within cultural groups (Bonder, Martin and Miracle, 2004, Awaad, 2003,Bourke-Taylor and Hudson, 2005). Occupations may have common features but are enacted according to specified culturally accepted rules for engagement which encompasses roles: environment, activity, content, context, pattern, affect and outcome (Bonder, 2001).

The effect of culture on occupation is not clearly described in literature (Bonder, 2001) because of the dilemma of defining culture (Baldwin Faulkner, Hecht and Lindsley, 2006). The understanding of the relationship between culture and occupation (Bonder 2001) is therefore a significant issue from an occupational therapy perspective. The importance of this should not be underestimated.

There is insufficient guidance on how culture relates to occupation and how therapists can address culture during their interventions (Bonder, Martin and Miracle, 2004) even though occupational therapy has at the core of its philosophy the enablement of individuals from different backgrounds by participation in tasks that have meaning to them. Thus the understanding of culture which has a significant impact on a client's values, beliefs, and their behaviours must be emphasised in the profession.

Culture influences the individual's perception of illness, health and expectations of therapy. Culture also dictates the meaning attached to activities and how they fit into the context of a group or individual's life (Watson, 2006, Ekelman et al, 2003). Culture also influences the occupational patterns and occupational choices made by clients and their families. This impacts on the client's choice of activity, engagement in particular occupations and perceptions about the value of particular occupational roles (Bonder, Martin and Miracle, 2004). Krefting and Krefting (1991) noted that it is important to recognize individual differences in cultural identities and the impact of these on occupational performance and that occupational therapists must evaluate the client's cultural background and use the information gathered to plan culturally appropriate interventions. By considering a clients cultural background in therapy, participation will be made more meaningful to the client (Levine 1987).

It is important that culture and meaningful occupations are central to occupational therapy intervention (Bonder, 2001). All occupational therapists should understand its importance within the profession (Iwama, 2007).

Therefore it is essential that in training occupational therapists should acquire a breadth of knowledge and an awareness of culture relevant to the contexts in which they will work. Skilfully selected assessments and intervention approaches could influence the client's readiness to receive and use information

provided by that therapist regarding their health needs (Campinha -Bacote,Yahle and Lanenkamp,1996). Clients are more likely to engage in the occupational therapy process and comply with therapeutic regimes when these criteria have been met.

Occupational therapists should develop cultural sensitivity; as practitioners using a culturally sensitive approach can provide interventions in a manner that is appropriate to the individual and meets their expectations (Suarez-Balcazar Rodawoski, Balcazar,Taylor-Ritzler, Portillo, Barwacz and Willis 2009). An awareness of diversity and cultural sensitivity should be included in undergraduate training with reinforcement later from either experience or further training so occupational therapists become culturally competent.

2.3 Cultural Competence

Hanley (1999) identifies “self-knowledge”, “experience” and “positive change” as essential elements in cultural competence. Several attempts have been made to describe cultural competence, (US Department of Health and Human Services, 2004), there are however no commonly accepted definitions (National Centre for Cultural Competence, nd). The myriad of definitions suggest that cultural competence is multifaceted (Muńoz, 2007) but includes: the ability to see patients as unique individuals have unconditional positive regard for them, develop a good therapeutic relationship, and to explore the patient beliefs, values, their understanding of dysfunction and to base treatment on a partnership (Saha, Beach and Cooper 2008).

Since cultural competence is difficult to define there is no conclusive agreement on how to provide the necessary knowledge, skills and experiences, to effectively serve diverse groups (New South Wales Health Department, 2010). Authors have identified common features in cultural competency such as its changing nature, individualism and group dynamics on culture (Bonder, Martin and Miracle, 2004, Bourke-Taylor and Hudson, 2005, Watson, 2006).

Several authors have described cultural competence as a journey. It entails the desire to experience, continuously learn and self-reflect to eventually emerge with a sense of heightened cultural awareness of their own customs, beliefs, values

and behaviours and sensitivity to those of others (Ekelman et al, 1999). Achieving cultural competence requires a behavioural change that encompasses self-knowledge, experience and a positive attitude (Hanley, 1999).

2.3.1 The cultural competence continuum

There are several models of cultural competence cited in the literature that guide cultural competent clinical practice. Some models describe cultural competence as a continuous learning process that consists of stages that continue to develop as cultural competency increases (American Institutes for Research, 2002).

Examples of models and assessment tools for cultural competence include:

- The LEARN Model (Berlin and Fowkes, 1983) is used to complement a structured interview. The strategy is used to support listening to the client's perspective and to negotiate with the client cultural differences that need to be considered during health care provision**.**
- Campinha-Bacote's (1999) Model of Cultural Competence in Health Care consists of five inter-woven constructs namely; "cultural awareness", "cultural knowledge", "cultural skill", "cultural encounters" and "cultural desire" that make up cultural competence which is discussed under cultural competence in occupational therapy (2.3.2)
- The Cultural Competence Self Assessment Questionnaire (Mason, 1995) is based on the Child and Adolescent Service System Program Cultural Competence Model. It is used to represents people and organisations according to the knowledge, skills and values they have. These aspects can apply both to health professions and to individuals (Mason, 1995). This cultural competency continuum has been developed to assess an individual's or organisations cultural competency over time. The progressive building blocks have been detailed extensively in literature with the view of guiding individuals or organisations' along a path toward achieving cultural competency (Mason, 1995, Linsey, Robins and Terrel, 2003, Cross, Bazron, Dennis and Isaacs, 1989).

- Cross, et al (1989) describes cultural competence on a continuum consisting of six points namely: “cultural destructiveness”, “cultural incapacity”, “cultural blindness”, “cultural pre-competence”, “cultural competence” and “cultural proficiency”. A culturally competent health system will incorporate within the organisation strategies to assess, implement, evaluate and measure progress towards achieving a more culturally competent health service (Cross, 1988).The progressive points on the cultural competence continuum describe how to advance along the continuum to achieve cultural competency. To be able to progress along the continuum, health providers need to embrace diversity, be aware of cultural dynamics and their own cultural biases. The process starts at “cultural destructiveness” that is the most negative and ends with “cultural proficiency” on the other end of the continuum (Cross, 1988, White, 2010).

The five progressive stages to developing cultural competency according to Cross (1988) are therefore

- Cultural Destructiveness - This encompasses and reflects beliefs, attitudes, stereotypical views, policy generalisations and practices that are destructive to cultural groups (National Centre for Cultural Competence). The intent is aimed at cultural destruction (Cross, 1988).
- Cultural Incapacity refers to the inability to bridge cultural barriers that impact on service provision to culturally diverse communities or individuals they serve (Hanley, 1999). There is an inability to respond to a range of preferences or requirements of culturally and linguistically diverse or minority communities (National Centre for Cultural Competence, nd, Cross, 1988). Cultural incapacity is characterised by strong racism, biases, impartiality, discrimination and a strong belief in racial superiority (Cross, 1988). Today, an example of cultural incapacity in a health setting may occur in situations where interpreters are not provided to facilitate therapeutic intervention or inappropriate clinical conclusions are drawn based on stereotypical racial views or lack of knowledge of subtle cultural nuances (American Institutes for Research, 2002, Remer, 2007).
- Cultural Blindness is the third stage or mid-point on the continuum that reflects an attempt to be unbiased. There is a belief that everyone

irrespective of culture or racial group are the same and should be treated the same (Cross, 1988). This phenomenon is characterised by policies and approaches that encourage integration without acknowledging cultural differences, values or traditions. Cultural strengths are ignored and assimilation encouraged. There is a belief that approaches used by certain cultural groups are applicable to all cultures. Ethnocentric viewpoints belittle the beliefs or customs of others. Few structures exist in organisations that enhance cultural knowledge (National Centre for Cultural Competence, nd). An example of cultural blindness in occupational therapy is where differences in people are not acknowledged. A simple greeting to a client can be seen as being culturally blind when therapists do not see cultural differences in individuals. In an attempt to be polite, clients are greeted in a language where on the basis of the client's physical features, it is assumed that they would speak that language. Kofi Glover, political science professor at the University of South Florida said, "A shared complexion does not equal a shared culture, nor does it automatically lead to friendships" (Taylor, 2007).

- Cultural Pre-competence is the conscious knowledge of an organisation's capacity and values and ability to respond successfully to linguistically and culturally diverse population groups. Shortfalls are recognised in terms of strengths and weaknesses. An effort is made to develop characteristics that support, respond to and value the provision of quality care. There is an awareness of and commitment to human rights and equity that supports a diverse workforce. A feature of cultural pre-competence includes acceptance, respect for differences in others and making a concerted effort in recognise these differences in the form of ongoing cultural self - assessment, continuous education to expand knowledge on cultural differences that exist in individuals and to adapt service delivery models within the organisation to better address the needs of all population groups accessing the service (National Centre for Cultural Competence, nd). An example of acknowledging cultural diversity among employees is having a luncheon where staff from different cultural backgrounds can dress in traditional attire and share traditional foods as a means of learning from each other. There is more involved in understanding cross cultural encounters than the willingness of health care providers to engage in activities that

promote cultural competence. Only a genuine desire to work effectively with culturally diverse clients will make a successful culturally competent health care provider (Campinha-Bacote, 1999, American Institutes for Research, 2002).

- Cultural Proficiency is the acceptance and respect of cultural differences. Culturally relevant service models are continuously reviewed to meet the needs of culturally diverse population groups accessing the service (Weaver, 1993). Active research such as client satisfaction surveys to reduce barriers and improve service delivery to culturally diverse clients and communities is carried out.

Extensive research and literature on culturally competent practice and models exists in disciplines such as nursing and psychology (Muńoz, 2007, Suarez-Balcazar et al, 2009). Recently culturally competent practice has generated increased research interest and activity within the field of occupational therapy internationally. This appears to have been sparked by an increased awareness of culturally sensitive health care delivery. Aspects included in this are: having the workforce diversity reflect the patient population, the availability and use of translators, ongoing staff training in cultural competence, partnership with communities, the use of community health workers, and the satisfaction of the patients with the health service (Saha, Beach and Cooper 2008).

Cultural competency literature in occupational therapy is still sparse but studies that have been done reveal evidence of occupational therapy moving toward culturally sensitive practice. However there is a need to develop a wider resource base that is specific to the profession (Awaad, 2003a).

2.3.2 Cultural competency and Occupational Therapy

The development of cultural competency models in occupational therapy is relatively new and therefore models that have not evolved from the profession itself are being considered for use in the profession. Occupational therapy literature has established the relevance and need for cultural competence (Muńoz, 2007) and cultural competency among occupational therapists (Wells, 2005).

> "Occupational Therapists are increasingly working in diverse areas of practice, in diverse settings and with diverse client groups. Accordingly understanding of the complexities of interactions between service providers and clients, relative to the environments and contexts in which they come together, are requisite to competent practice" pg 129 (Whiteford and Wright St -Clare, 2002).

Models of cultural competency developed in other disciplines, have been adapted to suit occupational therapy practice (Muńoz, 2007).

A conceptual framework for cultural competence for rehabilitation practitioners and students has since been developed by Balcazar, Suarez-Balcazarand Taylor-Ritzler (2009). Various components that are involved in the development of cultural competency have been described by them and include in agreement with Awaad (2003) the primary points in cultural competency that should be considered when adopting a model of cultural competency in occupational therapy.

- knowledge and understanding the theory and characteristics of culture, including the cultural characteristics, and behaviours related to health-related practices.
- the skilful use of cultural information
- an awareness of one's own cultural identity (Awaad 2003a, New South Wales Health Department, 2010) and understanding the position of privilege (Balcazar, Suarez-Balcazar and Taylor-Ritzler, 2009)
- application of all components into the clinical practice context with the goal of delivering culturally competent care (Balcazar, Suarez-Balcazar and Taylor-Ritzler, 2009).

A lack of knowledge about culture, and a lack of awareness of one's own cultural identity will affect rapport with clients from diverse backgrounds, as the client and therapist have multicultural identities (Muńoz, 2007) and each aspect affects service provision.

Knowledge of culture means gaining accurate information about cultural differences that includes client beliefs about issues related to health. Understanding

the clients' view point pertaining to their own health and the understanding of disease as it relates to all population groups is important to occupational therapy practitioners. A lack of knowledge and understanding of a client's culture will result in conflict and lack of trust between the therapist and client and therefore treatment programs may not reflect required health outcomes (Campinha-Bacote, 1999; Camphinha-Bacote, 2002).

The skilful use of cultural information is the ability to enter into an initial interview with a client, have the skill to collect relevant cultural information from the client and carry out the necessary assessments accurately and in a culturally appropriate manner (Chipps, Simpson and Brysiewicz, 2008; Camphinia-Bacote, 2002).

The willingness to "want" to engage in cultural encounters, extend knowledge of different cultures and aspire to become culturally skilful is called culture desire. Genuine qualities in keeping with cultural desire include availability, flexibility, openness and commitment. The motivation to learn and continuously extend cultural knowledge should be an ongoing process (Campinha-Bacote, Yahle and Lanenkamp, 1996).

Therapeutic rapport and effective communication will be facilitated by the skilful use of cultural information. Encompassing knowledge of an array of verbal and non verbal social rules such as symbolism, culturally overt norms, and phrases that are inherent to social interaction and verbal communication should be part of this process as they are also important (Awaad, 2003).

Campinha-Bacote (2002) identified several elements of cultural awareness that entails reflecting on one's own value system, beliefs, practices and views of other cultures. A cultural encounter is about practitioners developing self-awareness of their perceptions of others who are culturally different and respecting diverse points of view, without this there is a risk that the practitioner may impose their cultural viewpoints on the client (Camphinha-Bacote, 2002). The ability to apply these components is important as therapists often fail to recognise that in every encounter culture has to be considered (Bonder, Martin and Miracle, 2004).

Even with awareness of the primary points listed above cultural competency is not a “state of being that can be achieved’ p 256 (Muńoz, 2007) but a process of conscious self reflection and development of a clinical sense that guides occupational therapy clinical practice. Therapists need to reflect on their therapeutic encounters with clients to determine the effectiveness of culturally competent interventions in contributing to improved health outcomes for their clients (New South Wales Health Department, 2010).

Reflective thinking is an important part of developing cultural competency. Identifying assumptions which underlie clinical practice based on their own culture and evaluating these assumptions in relation to the patients’ culture allows reflective therapists to adjust their practice for alternative belief and values about life, illness, and occupation. This reflection needs to be based on knowledge and training (Odawara, 2005).

2.3.3 Development of the professional skill of cultural competence

Factors affecting the training in cultural diversity can be difficult as gaining adequate knowledge is affected by the layers of culture which has been compared to the analogy of an iceberg (Mason,1995). Like an iceberg, part of culture is above water; it is the knowledge we have of cultural characteristics, history, values, behaviours and beliefs that makes specific elements of culture easy to identify and just as nine tenths of the iceberg is hidden under water, so is nine tenths of culture. This out of sight knowledge of culture has been termed “deep culture” it includes abstract aspects of behaviour, work ethic, how we problem solve and the meaning of justice. It is breaking through stereotypes that enables individuals and organisations to “enter the deep waters of culture”, which will result in positive change in dealing with cultural differences (Hanley, 1999; Mason, 1995).

While occupational therapists can be trained in cultural sensitivity to increase their awareness and knowledge of other cultures; without exposure and experience therapists will be unable to recognize “deep culture” and may ignore cultural differences. Having awareness, knowledge and understanding of subtle nuances of different cultures is essential in the understanding of cultural differences (Ashridge, 2006). The inclusion of cultural competency into occupational therapy student

training should therefore serve as a foundation for students to develop knowledge and an understanding of the hidden, “deep culture” and move towards becoming culturally competent, an essential element for skilled practice (Suarez-Balcazar et al, 2009).

Research demonstrates that occupational therapists that have had training in cultural competency (Whiteford et al, 2002) have increased knowledge of different cultures when compared to other occupational therapists that have not. Levels of cultural understanding were improved by including both formal and informal education. This improved occupational therapy services to culturally diverse clients (Shim 1999).

The application of cultural competence in clinical practice is being assessed however by observable links drawn between therapeutic outcomes reflecting clients have adhered to their treatment plans. There are no definite measures that inform us of the effects our level of cultural competency has had on the therapeutic encounters with our clients or clients (New South Wales Health Department, 2010). Occupational therapists need to gain experience of different viewpoints to succeed in integrating the patient’s cultural values into their therapeutic interventions (Bonder, Martin and Miracle, 2004).This means having the ability to draw on a range of skills to direct culturally appropriate decisions which will be possible as therapists’ progress through the stages of developing cultural competency (Muńoz, 2007, Wells, 2005).

While most work in comparing novice and expert clinicians has been done in the field of clinical reasoning the stages used adapted from Dreyfus’ Model of Skill Acquisition, could be useful for considering other professional skills like cultural competence (Schell, Crepeau and Cohn, 2003). Occupational therapists can gain confidence in working with clients from diverse cultural backgrounds by following the points listed above to develop and establish cultural competency. This may allow therapists who are novices, who are dependent on theory to guide practice and who are not expected to recognize contextual cues and thus adapt the situation to struggle to apply cultural competence in practice. With experience occupational therapy practitioners can move through various stages to become experts and may be considered competent after three years of practice. At this stage they are able to

attend to more issues and intervention planning is responsive to contextual issues. They however still lack the flexibility of more advanced practitioners in dealing with patients. (Schell, Crepeau and Cohn, 2003)

Rasmussen Lloyd and Wieland, (2005) have identified differences in cultural awareness and perceptions between occupational therapy students and clinicians in developed countries such as Britain, Canada and America. The education and attitudes of qualified therapists therefore needs to be addressed and they should also update their application of cultural knowledge by attending or participating in regular educational workshops or activities on cultural diversity (Niemeier, Burnett and Whitaker, 2003).

Even with attendance at a cultural competency workshop, Steed (2010) found that qualified therapists in Louisiana, attitudes towards African American clients did not change and still held significantly negative attitudes, even though they believed that they listen to and educate, these clients (Steed, 2010). Thus strategies other than education also need to be considered.

An early introduction to the awareness of cultural issues is therefore necessary in occupational therapy. Cultural knowledge and application in occupational therapy education has been deemed important within the curricula if culturally sensitive practice and cultural competence is to be promoted in occupational therapy. Without this training therapists may not perceive the importance of considering or including cultural differences in treatment. Furthermore, treatment can be complicated or challenging when therapists struggle to integrate cultural considerations in therapy particularly when cultural issues are overwhelming or difficult to conceptualize (Suarez-Balcazar et al, 2009).

2.3.4 Cultural competence in occupational therapy education programmes

Newly qualified occupational therapists knowledge of how different cultural issues relate to healthcare or occupations of choice may differ. Prior to graduating occupational therapy students are required to spend a minimum of 1000 clinical hours at approved fieldwork placements that spans the duration of the occupational therapy course (World Federation of Occupational Therapists, 2002). These

fieldwork placements should provide students with learning opportunities to acquire, practice, and develop new skills in using the cultural information they have been taught. Fieldwork experience is an essential element in intercultural learning experiences to prepare occupational therapy students for working with a diverse group of clients (Whiteford, Wright St -Clare, 2002).

The sharing of cultural experiences is an essential and rewarding aspect of an occupational therapists education. The mutual engagement between students and clients must be facilitated so the students learn about their own and the clients differences. It is important to ensure that their own cultural viewpoints do not restrict their ability to appreciate differences in others (Bourke-Taylor and Hudson, 2005).

Students should therefore be taught about cultural diversity and be given opportunities to develop their cultural competency during their training. Multicultural training is important as the lack of knowledge of and limited social interaction with culturally diverse clients or individuals may cause cross cultural conflict in the occupational therapy process (Muńoz, 2007). Cultural competence training is more than passing on knowledge of culture (Bussema and Nemec, 2006). The primary principle described by Awaad (2003) and Balcazar,Suarez-Balcazar and Taylor-Ritzler (2009) indicate that it is also about self reflection and exploration and discovery of our own biases and application in the clinical situation (Camphinha-Bacote, 2002).

While numerous studies have shown a need for improved cultural sensitivity among health carers, few have established the effectiveness of cultural sensitivity programmes (Majumdar,Browne, Roberts and Carpio, 2004, Whiteford and Wright St -Clare 2002). This is because few articles have been written on cultural competency in health professions' tertiary education programmes. Suggestions in recent research indicate that programmes should consider cultural background including the patients' religion, customs and moral values, clinical skills in terms of self-awareness and patient centeredness, communication skills for cross-cultural communication and translator guides (Crenshaw, Shewchuk; Qu; Staton; Bigby; Houston, Allison and Estrada, 2011).

Literature highlights the importance of including cultural competency training within health professional curriculums and cautions against a generic approach for

teaching all health professionals together in cultural competency. Discipline specific training is recommended for students so they are able to apply the principles relevant to their practice (Nochajski and Matteliano, 2008). Positive outcomes have been shown with medical students who participated in cultural competency education. It was found that they had an improved understanding of others. Discipline specific education programmes thus have the potential to enable future practitioners to provide culturally responsive health care delivery (Majumdar et al, 2004).

Student training and evaluation in cultural competency should be supported by sound research. Krefting and Krefting (1991) suggest that any research on cultural competency in occupational therapy should be evidence based. Watson (2006) cited the importance of challenging the profession's body of knowledge so as to match cultural needs within different contexts as there is a risk of imposing Eurocentric Western models and practices upon populations who may have very different belief systems (Awaad, 2003a).

White (2010) determined the effect of an experiential learning program on the knowledge, attitudes and beliefs of first-year occupational therapy students towards Aboriginal Australians. She found that few first-year occupational therapy students had negative attitudes towards Aboriginal Australians with an increase in empathy and understanding of Aboriginal culture in students who attended the learning programme when compared to those who did not. These changes were however not sustained; indicating this type of programme may be needed in later years when it is combined with clinical practice.

The ongoing need for training and exposure to a variety of diverse clients during training as an occupational therapist was also emphasised by Murden et al, (2008). They found that 72 occupational therapy students and new graduates showed some knowledge and awareness of cultural issues throughout their training. The understanding of cultural diversity and cultural sensitivity showed that although they were aware it was required for culturally competent practice after graduation, more exposure to cultural issues in their training and fieldwork was needed (Murden, Norman, Ross, Sturdivant, Kedia, Shah 2008).

Educators thus have an important role in enabling students to become critical thinkers and develop problem solving skills which impact on the “attainment of cultural competency”. There is a need to investigate other modules to facilitate the development of cultural competency among students (Yang, Shek, Tsunaka and Lim, 2006). Fieldwork evaluations could verify how students apply cultural knowledge during fieldwork practice so that training needs can be reviewed when necessary (Yeun and Yau, 1999).

Research findings in one country however cannot be generalised to another. Inclusion of more training and fieldwork exposure to improve cultural competence within occupational therapy educational programmes (Rasmussen, Lloyd and Wieland, 2005) is essential in South Africa because of its past history and the continued effect this still has in health care. This confirms the need for research into culture specifically related to health care from a South African perspective, but also in the framework of occupational therapy, both South African and worldwide.

2.4 A South African Perspective

2.4.1 Culture, cultural competence and health care in South Africa

In South Africa, there is a need for more evidence based research to develop a body of research linking cultural competent intervention to health care outcomes. The complexities of culture and health are often entwined in culturally diverse societies like South Africa, where clients may bypass formal health systems to looking for help from traditional healers (Muńoz, 2007; El Safty, 2001).

Thus in a country like South Africa that consists of elements from both developed and developing countries, formal medical care and traditional medical practitioners play an important role in health care delivery (Department of Health, 1997). The health system in the new South Africa has therefore been transformed to support and acknowledge the importance of the role of traditional healers in health care delivery.

> “The client’s beliefs about their illness and that concept about their health within the framework of African culture are more social than they are biological.” p SIV24 (Kubukeli, 1999).

In every health intervention, the cultural encounter is unique to the South African context and care must be taken not to impose, Eurocentric Western models of occupational therapy practice that are not appropriate or relevant to the local situation (Bonder, Martin and Miracle, 2004; Awaad 2003). This is because individuals learn about matters concerning health from their own cultural belief system which reinforces the need to provide culturally acceptable health services (Muńoz, 2007; New South Wales Health Department, 2010).Thus there may be a reluctance of population groups in South Africa to use formal health services related to their pervious exclusion from diversification of the workplace and education and their lack of understanding of Western health care.

In South Africa diversification of staff in the health care services remains an ongoing developmental process. Health practitioners are trained in the Western world view of health care and more traditional health care views are not incorporated in health care education.

The change in both health care curricula and the health service need to be approached with care as South Africa is a diverse multicultural society with a long history of discrimination. Social, political, economic and cultural factors should direct curricula development which is still undergoing the changes necessary to enable healthcare practitioners to respond to challenges in diverse contexts (Ramklass, 2009).

Applying approaches in dealing with cultural differences are not easy because people tend to be sensitive to terms such as culture, ethnicity, race, population group or tribe. These terms stem from injustices from the Apartheid era, and are prone to misuse or abuse (Tambo, 1997). South Africa has one of the most impressive and progressive constitutions in the world, which embraces cultural, religious and language diversity.

> “The State must, in compliance with section 7(2) of the Constitution, respect, protect, promote and fulfil the rights enshrined in the Bill of Rights, which is a cornerstone of democracy in South Africa” p 2 (Republic of South Africa, 2004a)

Although the South African constitution thus champions the importance of providing services that are accessible to culturally diverse communities, there is a dearth of local research on the cultural competency of South African health professionals. Health care service providers need to actively promote culturally competent clinical practice among their health care workers through the incorporation of professional development initiatives and education (Niemeier, Burnett, Whitaker, 2003).

In South Africa, each health professional body is regulated by the Health Professions Council of South Africa (HPSCA). One of its several functions is to regulate professional conduct and behaviour, education and training and ethical behaviour. The Council has formulated ethical and professional rules to guide health professionals and by which health professionals should abide. In its document, clinical practice is described as a reciprocal relationship between client and health professional that is based on mutual trust (Health Professions Council of South Africa, 2009). The author however could not find any documentation related to standards or education for teaching of cultural competent to health professionals for all South Africans. At times providers and clients may share similar ethnic or racial heritage, but aspects of diversity remain and need to be addressed (Schim, Doorenbos and Borse, 2005). There is evidence of lack of cultural competence and discrimination both inter tribal and against foreigners from Africa when accessing the health services in South Africa (Human Rights Watch, 2009).

There is however a scarcity of local literature that relates to the cultural competency of South African occupational therapists although numerous studies have been conducted in the United States of America (Wells, 2005) , Australia and New Zealand (Whiteford and Wright St-Clare, 2002; Kristy and Gibbs, 2005). Therapists are yet to engage in research that may pave the way in adding cultural competency as a descriptor within capability profiles of their workforce (Chipps, Simpson and Brysiewicz, 2008).

International literature suggest that there are approaches available to South African practitioners that can aid in reducing barriers in understanding and communication processes that arise from racial, ethnic, cultural and linguistic differences. For example a “rules approach” strategy may be an option when

working with clients from different cultural groups. This means that by establishing a baseline understanding of a particular culture, a health care provider may be more skilled in asking culturally appropriate questions about preferences of the individual (Bonder, Martin and Miracle, 2004). Gaining knowledge and understanding of how culturally learned values and customs influence an individual's health belief system, may support the clinical encounter (Ekelman et al, 2003).

2.4.2 Cultural competence and occupational therapy in South Africa

The use of occupational therapy theory and practice in developing countries including South Africa has evolved from a Western perspective. Studies on cultural competence have shown that there are incongruities between the beliefs and values of clients from non European cultures and occupational therapists trained to understand health from a Western perspective (Iwama, 2007).

The profession needs to broaden its value base to acknowledge other cultures, particularly when considering beliefs about issues of personal causation, independence and family. Cultural values at the family level between different cultural groups in South Africa for example are based on very different values and belief systems (Sudarkasa, 2004). The Zulu proverb "umuntu ngumuntu ngabantu" meaning a person is a person because of people, expresses common traditional African cultural values of which community is central (Manda, 2009). The traditional African family includes extended family and is characterised by resource sharing, connectedness and organisation particularly around specific cultural practices and cultural values (Sudarkasa 2004, Zhong and Lai, 2008, Samovar, Porter and McDaniel, 2009) that differ from the Eurocentric perception of family structure or the nuclear family. Comparatively in families of European descent, the view of the nuclear family is a smaller, flexible family unit with its relative separateness, inward looking way of life and individual decision making reflecting a different social perspective on their view of life. A number of Asian cultures co-exist with a combination of these family structures (De Silva, 2003; Daver-Berenson, 2011).

Beliefs about the origin of disease and disability are not accounted for in the frames of references used in occupational therapy that are based on psychotherapeutic and counselling theories. These have been challenged and

deemed irrelevant in meeting the needs of the majority of South Africans (Spangenberg, 2003) and although diversity and human rights are covered as part of occupational therapy training in South Africa, curricula are traditionally based on Eurocentric theoretical frameworks and occupational therapy training models that stem from British origins (Davy, 2003).

There are bound to be many challenges or conflicts when occupational therapists attempt to implement Western based models of occupational therapy practice within traditional communities (Bourke-Taylor and Hudson, 2005). It is important that therapists understand cultural differences among clients and their perceptions of health. South African occupational therapists have been criticised for being too dependent on models and theoretical frameworks that come from developed countries like the United States, Canada, the United Kingdom and Australia, designed for cultural contexts different to South Africa (Joubert, 2003). Occupational therapy practice based on, "principally Anglo-American" make it difficult for South African occupational therapy students to assimilate and practice the profession (Awaad, 2003a).

In order to attain cultural competence there is a strong need for South African occupational therapists to also develop a unique "Afro centric model" (Joubert, 2005). Both a Eurocentric and Afro centric worldview should be considered by South African occupational therapists because of the diverse population mix. Even then uniformity should not be assumed considering the cultural distinctiveness within different population groups (Watson, 2006).

The meaning of culturally specific norms, idioms and symbolism across the many South African cultures, should form the basis for culturally competent practice (Awaad, 2003a). "The complexity of culture and diversity means that a universal approach is neither available nor desirable" p 12 (Kinebanian, Stomph, 2009)

Sherry (2010) in her view of cultural competence in occupational therapy in Africa includes all of the points made above but adds the aspects of poverty or socioeconomic status which result in powerlessness and low self worth and the politics of power in the health provider patient relationship. She feels occupational therapists use a process when encountering cross-cultural issues where first behaviour is observed and then the underlying theoretical concepts are considered.

The power dynamics within the therapy situation precede the exploration of the personal implications of the cultural issues to be faced in therapy. Every cross-cultural interaction has some power dynamics, determined by people's respective ethnicity, other demographics and the context of the service. In occupational therapy the relationship between therapist and the patient or community must become a partnership (Sherry, 2010).

Cultural competency develops from the motivation to learn more about others that are different. The foundation of which is based on knowledge, attitude, skill and the ability to consider and negotiate many elements that encompass a cultural context. Therefore studies pertaining to cultural competency done in other countries can provide South African occupational therapists with a basis from which to develop their own framework for cultural competency training (Watson, 2006; Joubert, 2003; Awaad, 2003a). Establishing this type of information bank is essential for the training of a culturally competent occupational therapy workforce. In South Africa this responsibility rests with tertiary institutions as they are in the business of training a future workforce. Thus research on the effectiveness of cultural competency training and the measurement of cultural competency among occupational therapists, as in other countries, may be based initially at these institutions (Joubert, 2003; Ekelman et al, 2003; Balcazar, Suarez-Balcazar and Taylor-Ritzler, 2009).

2.5 Measurement of cultural competency

Health professionals because of their awareness of the need for culturally competence have designed cultural competency assessment tools. These are used to identify an individual’s level of cultural competence and serve as a reference point on a path to becoming culturally competent (NC Department of Health and Human Services, 2008). There is limited research however on the validation of cultural competency assessment tools and models (Balcazar, Suarez-Balcazar and Taylor-Ritzler, 2009)

There are several cultural competency assessment tools that encompass common elements of awareness, knowledge and skill (Campinha-Bacote, 1999;Kim Cartwright, Asay, D'Andrea, 2003; Sodowsky, 1996;Muńoz, 2007; Balcazar,Suarez-

Balcazar; Goode, 2009 and Taylor-Ritzler, 2009). These assessment tools include self-assessment questionnaires, surveys and sensitivity scales. All of these measures are valuable in assisting therapists or students to self-reflect as they generate discussion and contribute to the development of cultural awareness, knowledge and skill (Rasmussen, Lloyd, Wieland, 2005; Nochajski and Matteliano, 2008; Balcazar, Suarez-Balcazar and Taylor-Ritzler, 2009; Brach and Fraser, 2000).

The effectiveness of using a cultural assessment tool is reflected in a study by Schim et al (2005), where different variables associated with cultural competence among urban hospital based health care providers in Ontario (Canada) and Michigan (US) were reviewed. This cultural competency assessment tool was designed to measure cultural diversity experience. Results of the study revealed that clinicians who had previous cultural training scored higher on the cultural assessment tool. Therefore using a tool to measure cultural diversity awareness, sensitivity and competence among staff is a move towards becoming culturally competent. Existing measures however do have problematic assumptions about the definition of cultural competence and very few are standardised (Suarez-Balcazar et al, 2009). These assume that individual knowledge may be accurate and adequate for change. The assessment of culturally competent clinical practice is needed if health professionals are to move forward in understanding, teaching and practicing as well as evaluating cultural competence (Kumaş-Tan, Beagan,Loppie, MacLeod and Frank,2007).

> "Cultural awareness is the foundation of communication and involves the ability of standing back from ourselves and becoming aware of our cultural values, beliefs and perceptions" p 2 **(**Quappe and Cantatore, 2005).

Campinha-Bacote's (2002) model of cultural competency and elements contained in the cultural competence checklists of Campinha-Bacote (2002), American Speech-Language- Hearing Association (2010) and Goode (2009) will be considered in the data collection process. Awareness, knowledge, skill, clinical encounters, perception and sensitivity are important elements in shaping attitudes towards developing cultural knowledge and skill. This will be considered in the data

collection process to elicit the perceptions of newly qualified occupational therapists entering the workforce.

CHAPTER 3
METHODOLOGY

3.1 Overview of the study

The research project followed three distinct parts. A mixed methods study design was used to integrate different qualitative and quantitative techniques for data collection and analysis. A mixed method was used as this allowed for extra perspectives into the subject being researched that could not be achieved with a quantitative study alone.

> "This form of research is more than simply collecting both quantitative and qualitative data; it indicates that data will be integrated, related, or mixed at some stage of the research process." p 2 (Cresswell, Fetters and Ivankova, 2004)

MIXED METHODS STUDY

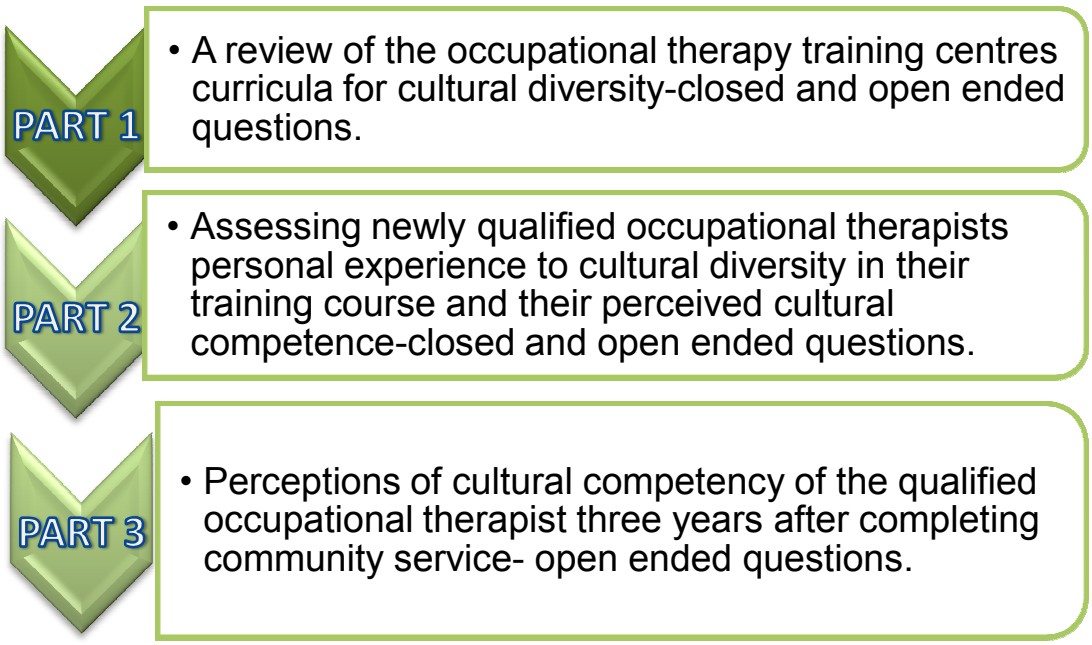


Figure 3.1 Outline of the Study

Parts 1 and 2 of the study consisted of a quantitative survey study design with a qualitative element using open ended questions. While the use of quantitative techniques guided the research and allowed lecturers at the training centres and newly qualified occupational therapists completing their year of community service to answer questions about the cultural diversity and competence in their training, the addition of a qualitative element allowed their lived experience to be included to give depth to the study. This provided an opportunity to gain insight into the processes and events which affected their experience beyond the elements already identified in the quantitative survey (Borkan, 2004).

Part 3 was an investigative qualitative study using a phenomenological approached. An email based questionnaire with open ended questions was used to allow the researcher to establish the lived experience of some of the occupational therapists who had been involved in Part 2 of the study three years later. The questionnaire allowed the respondents to describe their perceptions of cultural competence from their own perspective (Finlay, 2008).

3.2 PART 1: REVIEW OF THE OCCUPATIONAL THERAPY TRAINING CENTRES CURRICULA FOR CULTURAL DIVERSITY EDUCATION

3.2.1 Research design

A quantitative cross sectional survey method was used to establish the course content, teaching methods and time allocated in presenting cultural diversity within the occupational therapy student training programmes in South Africa. A questionnaire was developed for this purpose as this method for collecting responses is deemed more objective than an interview process (Milne, 1999). A qualitative element in terms of open ended questions were however included. Since the survey allowed for anonimity it was expected that the participants would also be more likely to be honest in their responses (Evaluation Research Team, 2008).

Questionnaires are a common evaluation tool used in quantitative survey research. A well designed questionnaire will reduce the likelihood of gathering unusable information (Evaluation Research Team, 2008). Piloting of a questionnaire is important to obtain valid and reliable results (Colorado State University, 2002). The advantage of using a survey method in this study is that it can be distributed through a range of media including mail, telephone or online and it enables the researcher to collect data from large or small population groups and is valuable in gathering data that is unique to individuals such as knowledge, beliefs, attitudes and behaviours (Evaluation Research Team, 2008).

A qualitative element was added to the questionnaire in the form of open ended questions to establish the percetions of the respondents in terms of their expeiences within the teaching of cultural diversity.

3.2.2 Population

The entire population of eight occupational therapy training centres in South Africa was approached to determine their course content when dealing with cultural diversity. The curricula content and teaching process of the participating occupational therapy training centres were reviewed.

3.2.3 Measurement tool

3.2.3.1 Cultural Diversity Questionnaire (Appendix C)

A questionnaire was deemed appropriate to achieve objective one of the study. The questionnaire was developed from Guiding Principles on Diversity and Culture by Kinebanian, Stomph,(2009) to explore cultural diversity training within South African occupational therapy education programmes as no other questionnaire was available for assessing the presentation of cultural diversity in occupational therapy curricula. These guidelines are endorsed by the World Federation of Occupational Therapists (Kinebanian and Stomph, 2009).

In the guidelines the authors describe common elements related to cultural diversity and cultural competence that need to be included in the education process to prepare occupational therapy students for practice.The ten questions chosen for the questionnaire consisted of a combination closed and open ended questions to establish undergraduate training in cultural diversity. Closed-ended questions were used at the start of the questionnaire. These were followed by open ended questions (Colorado State University, 2002). The questions addressed key elements of curriculum namely; content, education and practical activities.. Questions focussed on:

- Undergraduate training in cultural diversity
- Introduction of cultural diversity within the occupational therapy programme
- Addressing cultural diversity within the curriculum and teaching cultural diversity
- Challenges and support experienced regarding the teaching of cultural diversity

3.2.3.2 Validity of the Questionnaire

Content validity of the questions was determined by reviewing a cultural competency curriculum guide for occupational therapy that is based on the Cultural Competency Model of Camphina Bacote,(2002). The guide was developed by Nochajski and Matteliano, (2008) with the purpose of developing existing curricula to enhance cultural competence training within education programs (Nochajski and

Matteliano, 2008). The guide contains five objectives that are aligned with the five constructs ofthe Cultural Competency Model (Camphina Bacote,2002). This guideline was deemed relevant to this study.

A pilot test was done to see what responses the questionnaire would generate to help the researcher refine the questions for the study. Two staff members at the Occupational Therapy Department of the University of Witwatersrand were approached for convenience purposes to review the questionnaires. They were not involved in the formal teaching of cultural diversity directly. The reviewers were involved in fieldwork supervision that included cultural awareness that formed part of the students learning outcome. They were asked to comment on the form for clarity of the questions asked, relevance to the topic, complexity and appropriateness of the questions. From the verbal feedback received, both reviewers reported that the questions related to obtaining content information from the occupational therapy programme and were deemed relevant.

3.2.4 Research Procedure

3.2.4.1 Ethical considerations

Once ethical clearance had been obtained from the Human Research Ethics Committee at the University of the Witwatersrand (Appendix A) the Heads of Departments of Occupational Therapy at eight universities in South Africa where occupational therapists are trained were contacted to gain permission to do the study. An envelope containing a letter introducing the researcher's study (Appendix B) and asking for permission for the information required to be supplied by the department was posted to each Department of Occupational Therapy. The letter included the request for permission to have a member of staff involved in the presentation of cultural diversity training answer the questionnaire (Appendix B).

The member of staff who agreed to complete the questionnaire was sent an information sheet, a consent form (Appendix C) and a questionnaire (Appendix D) and they were requested to sign the informed consent form if they agreed to take part in the study. Assurance of confidentiality was communicated in the information sheets sent to the universities.

Participants not wanting to take part could withdraw and not answer the questionnaire as participation was voluntary. Confidentiality of the returned questionnaires was protected by ensuring the names of informants would be kept separate and known only to the researcher. Other information for this part of the research would be coded to make sure that the content revealed in the questionnaires could not be traced back to the respective universities.

3.2.4.2 Data collection

The participants were asked to provide a detailed outline of their course as well as answer questions on the teaching methods used and the hour allocation for the course in the attached questionnaire (Appendix D). A self-addressed envelope was included in which to mail the questionnaire back to the researcher. Universities that had not responded by the return date on the questionnaire were contacted telephonically, by email and with information sheets being faxed twice with follow up phone calls.

After the questionnaires were returned to the researcher the responses to each questionnaire were checked and deemed valid as the lecturers were able to answer all the questions posed.

3.2.4.3 Data analysis

The information obtained was analysed and compared. Summaries of the content covered in South African universities were analysed using descriptive statistics. This included means and percentages of the universities that replied, the range of hours used to teach cultural diversity, the adequacy of the course, the use of reflective thinking, the methods used to teach as well as the number of aspects covered in the course. These results were represented in graphs and tables.

Responses to the open ended questions were interpreted by summative and directed content analysis and used to inform the quantitative data as concepts as well as the use of words in the text were identified.(Hsieh and Shannon, 2005). Content analysis focuses on the content or meaning of the text obtained in the open ended questions, This is used to provide knowledge and understanding of cultural diversity and cultural competence from the lecturers point of view by using

subjective interpretation of the content of answers. A classification process of coding and identifying themes in the data was followed.

3.3 PART 2. THE NEWLY QUALIFIED OCCUPATIONAL THERAPISTS EXPOSURE TO CULTURAL DIVERSITY IN THEIR TRAINING AND THEIR PERCIEVED CULTURAL COMPETENCE.

3.3.1 Research design

A mixed quantitative survey cross sectional design with qualitative open ended questions was used with newly qualified novice occupational therapists completing their year of community service to establish their personal experience and exposure to cultural diversity within their course. This design best suited the study as the researcher wanted to collect data from the group of therapists to capture their experiences at that specific point in time. Novice occupational therapists were chosen as they could best reflect on their experience as students. Literature indicates that at this stage these therapists may still be dependent on theory to guide practice.(Schell, Crepeau and Cohn, 2003).

3.3.2 Participant selection

Newly qualified occupational therapists completing their community service in Gauteng Province were included. The researcher had access to information relating to where each community service occupational therapist studied and was able to ensure representation of participants from all the universities who train occupational therapists in South Africa, hence the exclusion of other provinces.

Inclusion criteria

- any newly qualified therapist completing their community service in the year in which the research took place.

3.3.3 Sample size

In total fifty community service occupational therapist placements were allocated to Gauteng in the research year (Government Gazette, 2006). Invitations to participate in the study were sent to all occupational therapists in Gauteng who were completing their community service year.

3.3.4 Measurement Tool

3.3.4.1 Cultural Competence Questionnaire (Appendix G)

Although a number of questionnaires were available for assessing cultural competence very few of these were standardised or useful for the assessment of cultural competence in occupational therapy. Of the limited number of validated measures available to assess cultural competence ten have some validity or reliability data but have been developed and validated in the fields of nursing and counselling psychology (Suarez-Balcazar et al, 2009). Permission could not be gained to use a questionnaire which was considered - The Cultural Competency Self-Test "Improving Patient Care: Cultural Competence" (Sutton, 2000).

A questionnaire was therefore designed by the researcher to assess the perceived cultural competence of novice community service occupational therapists.

The questions included information about (Forwell, et al, 2001, Fortier, Bishop, 2004).

- where participants completed their occupational therapy training programme,
- if they received training or exposure to diverse cultures,
- their perceptions of the level of training received at their training institution,
- at which point of their course cultural diversity was introduced,
- whether they felt that cultural diversity was adequately addressed
- if they experienced challenges when working with diverse cultural groups.

The researcher purposefully excluded the demographic detail of the population group of participants in the questionnaire for this part of the study as it may be perceived by respondents as offensive due to the nature of the study (Geldenhuys andde Lange, 2007) but other basic demographic details such as age, gender and language which may be related to cultural diversity training at

undergraduate level where requested. The participants contact details such as their email addresses were requested for Part 3 of the study.

A combination of question types were used to establish undergraduate training in cultural diversity. The eight questions selected consisted of closed and open ended questions with place for comments once a choice of answer had been made. (Colorado State University, 2002). The questions asked were parallel to questions asked in Part 1 where key elements of curriculum content, reflective strategies and challenges were addressed. Some questions were similar to those asked in Part 1 to determine whether similar perceptions existed between students and lecturers experience of cultural diversity training and development of cultural competence in the courses reviewed.

3.3.4.2 Validity of cultural diversity questionnaire

Content Validity

Content validity was established by three clinical occupational therapists in the field selected by using convenience sampling. The questionnaire was reviewed by two newly qualified occupational therapists and one senior occupational therapist.

The occupational therapists were asked to comment on the clarity, relevance, complexity and appropriateness of the questions. No changes were made to the questions on the basis of verbal feedback from the reviewers. The only change made to the layout of the questionnaire included a space for general comments.

Data saturation

This was achieved by obtaining data that presented no new answers to the questions. Questionnaires were completed by the majority of the novice community service occupational therapists and all the responses were included in the study. The sample was however heterogeneous in nature which may have affected this aspect.

Data triangulation

This was achieved by comparing the quantitative data about the training, comfort of working with clients and self reflection obtained from the lecturers at the universities and the novice community service occupational therapists,.

Peer Review of codes

Coding was reviewed by a colleague and the supervisor of the project. Coding was discussed and altered until agreement of categories and themes were achieved.

3.3.5 Research Procedure

3.3.5.1 Ethical considerations

Information letters inviting participants to take part in the study contained an overview of the research project and the reasons for it being done (Appendix E). Participants were asked to complete a consent form (Appendix F). The information sheet informed participants that their participation was voluntary, the study posed no risks to them, and they were entitled to refuse to participate. Participants could withdraw from the study at any time. The participants identities would be kept confidential and only responses would be used for data analysis. Feedback on the study would be provided on request.

3.3.5.2 Data collection

The Gauteng Department of Health was contacted by telephone to request information on community service placements for occupational therapists in Gauteng. Each placement was then contacted to determine if there were community service occupational therapists working there. Consent was obtained from each therapist prior to sending the questionnaire by fax, email or by hand delivery, at a pre-determined community service meeting.

A field test of the questionnaire was done using answers and general comments from 15 respondents who returned their questionnaire to the researcher at the community service meeting.

The only comment was received after the field test that suggested the spacing between the questions be reviewed. The feedback was used in the questionnaire layout in Part 3

The questionnaires were returned in a sealed envelope or by email or fax to the secretary of the Department of Occupational Therapy at the University of the Witwatersrand, who removed all identifying information like email addresses and fax numbers from the replies.

3.3.5.3 Data analysis

Descriptive statistics were used to analyse the data from the questions. Percentages and medians were used to determine the frequency of the answers given and these were represented in graphs and tables.

Comments on the questions were analysed using directed content analysis based on the framework and priori themes from Campinha-Bacote (2002) Model Of Cultural Competence in Health Care. Directed content analysis is a deductive method of coding data (Mayring, 2000) which is done using existing theory or prior research about a phenomenon which allows for further description within the model described (Hsieh and Shannon, 2005). The existing research helped to focus the initial coding scheme or relationships between codes using the operational definitions for each category identified from the constructs of cultural competence described by Campinha-Bacote (2002). The main strength of using the directed approach for analysis was that existing theory could be used to support the results and this could be extended. This approach does have some limitations in that the data was approached with an informed bias.

To achieve neutral or unbiased results, the audit process was used and operational definitions created which were examined before the analysis was started to confirm the accuracy of the predetermined categories (Hsieh and Shannon, 2005).

3.4 PART 3. QUALIFIED OCCUPATIONAL THERAPISTS PERCEPTIONS OF CULTURAL COMPETENCE THREE YEARS AFTER COMPLETING COMMUNITY SERVICE

3.4.1 Research design

A qualitative investigative method consisting of a set of structured open-ended questions was used to establish the perceptions of issues of culture and cultural competency, of some of the occupational therapists who had participated in the study Part 2, in their practice over the last three years. He study was done three years after they completed their year of community service as newly qualified occupational therapists. According to Schell, Crepeau and Cohn (2003) after three years of reflective practice an occupational therapist can be considered competent.Their performance of therapeutic skills has become more automatic and attention can be given to other issues in therapy when compared to a newly qualified therapist. Occupational therapists with experience may be more responsive to contextual issues including cultural issues but may lack the flexibility of more advanced practitioners.

This phenomenological approach was used as the researcher aimed to investigate qualified occupational therapist experiences of cultural competence by focussing on intentionality of each respondent's conscious interpretation and perception of a lived experience and what it means to them. (Finlay, 2008)

3.4.2 Participant subject selection

Participants would be selected from the cohort of 43 who agreed to take part in further research when completing the informed consent form in Part 2 of the study. The selection of participants was all those who agreed to participate in Part 3.

3.4.3 Sample size

Eight participants representing different universities were purposefully selected to be interviewed to achieve data saturation. More would be added if data saturation was not achieved.

Inclusion criteria
Any participant

- that had taken part in the initial study three years earlier and
- agreed to participate in another interview now

3.4.4 Measurement tool

3.4.4.1 Cultural Competence Question Schedule (Appendix I)

The results of Part 2 of the study highlighted a number of issues that novice newly qualified occupational therapists still faced in terms of practicing their profession with cultural competence. These issues were considered when drawing up a schedule of seven questions which was developed from the results of Part 2, as well as Campinha Bacote's (2002) model of Cultural Competency and the Cultural Competency Self Assessment Checklists of Goode (2009) and the American Speech-Language Hearing Association, (2010).

The initial part of the questionnaire with closed ended questions was designed to obtain demographic data about their work history and present work circumstances.

The open ended questions considered a change in perception of various concepts as well as how barriers seen in Part 2 were addressed and if these could be overcome.

Open ended questions considered the occupational therapists

- understanding of cultural competency and cultural diversity,
- communication barriers in practice,
- formulating treatment programmes,
- cultural norms and values,
- knowledge, skill and cultural encounters,

- working in a cultural context of a client.

These open-ended questions were designed to link with contemporary health issues facing occupational therapy practice within a South African context to add thick data to the study. These were based on the numerous challenges identified in Part 2 that occupational therapists face that impact on quality service as well as those identified by the Department of Health (Department of Health, 2007).

3.4.4.2 Validity of the Questionnaire

Content validity

Content validity was established by emailing a draft questionnaire to three colleagues in Allied Health disciplines and an expert in the field of cultural diversity training in Australia. These participants were purposefully selected for their expertise.

Inclusion criteria

Allied Health clinicians involved in direct patient care with five or more years of experience.

or

An expert who had published in the field of cultural competence with 10 years experience in occupational therapy

On the basis of verbal and written feedback and discussion from the reviewers, several changes were made to the questionnaire. The inclusion of population groups was challenged and the term “coloured" had to be justified and defined. Some questions were rephrased, and inclusion of graduation year was recommended. An error in the international dialling code was highlighted and the reduction of the number of questions requiring narration was suggested with the advice of using prompts during the interview (Appendix I).

3.4.5. Trustworthiness

Data saturation

Questionnaires returned from each stakeholder in Part 2 were correlated the information about where they qualified was reviewed to obtain a heterogeneous sample of eight participants from the original cohort. When there was a poor response other participants were included and in all 20 participants who had agreed to be contacted were approached in an attempt to achieve data saturation.

Thick data

Thick data was obtained by including only open-ended questions that require narration to ensure a richness of contextual detail, in the questionnaire for this aspect of the study. Thick data was obtained by interviewing the participants with experience of cultural interactions over three years of clinical practice within the context of the South African situation.

Data triangulation

This could only be achieved with comparison of the literature and reports on cultural competence in occupational therapy as no other data was available for the participants in terms of their clinical practice

Peer Review of codes

Coding was reviewed by a colleague and the supervisor of the project. Coding was discussed and altered until agreement of categories and themes was achieved. The researcher bracketed with a colleague so that she was aware of her own biases in terms of practice and cultural differences.

3.4.6 Research Procedure

3.4.6.1 Ethical considerations

Information sheets inviting participants to take part in Part 3 of the study described: an overview of the study and brief reasons for the projects delay (Appendix H),informed participants that their participation was voluntary that the study posed no risks to them that they were entitled to refuse to participate and

could withdraw from the study at any time. The participants were assumed to have given informed consent to be contacted if they returned the questionnaires. Participants gave verbal permission to be recorded when they were contacted for the telephone interviews. Confidentiality was ensured as only responses and no names were used for data analysis. Feedback on the study was provided on request.

3.4.6.2 Data Collection

Respondents of Part 2 of the study were contacted by email and invited to participate in Part 3 of the study. An information sheet reminding the respondents of the purpose of the study (Appendix H) and an electronic questionnaire (Appendix I) consisting of the close ended questions were emailed to them; they were requested to complete the electronic questionnaire as well as to participate in a telephone interview. Respondents were asked to complete the questionnaire and respond within one month.

Those respondents who replied by email were then contacted by telephone at a time that was convenient and asked to complete a telephone interview on the question schedule in Appendix J. The interviews lasted for about 60 minutes and were recorded for analysis. The recordings were transcribed for analysis by the researcher. The tape recordings were listened to repeatedly during the transcribing process. The text was read and key sentences highlighted. The researcher continued to review the data until no more themes could be identified. The researcher determined the themes within the text. The themes that emerged were tabled into phrases which became categories. These were condensed further into subcategories and then codes (Granenheim, Lundman, 2004, Insites, 2007, Taylor-Powell, Renner, 2003).

After the content analysis, the researcher identified the need for additional biographical information that was required to collate a respondent profile. Additional questions were emailed to obtain the information (APPENDIX K).

3.4.6.3 Data Analysis

Data analysis of the close ended questions was descriptive in terms of the aspects covered related to where they had worked, age and their present working situation. Open ended questions were analysed using open inductive coding which was used to identify codes, subcategories and categories. The three themes that emerged around the perceptions of cultural competence of the competent occupational therapists were then presented.

CHAPTER 4
RESULTS
PART 1, PART2 AND PART 3

4.1 PART 1 REVIEW OF THE OCCUPATIONAL THERAPY TRAINING CENTRES CURRICULA FOR CULTURAL DIVERSITY EDUCATION

4.1.1 Introduction

A total of eight universities were invited to participate in the study. A response rate of 75% was obtained after reminders were sent out. The universities that responded have mixed groups of students in terms of gender and race within all four years of undergraduate training. Three universities were willing to provide the researcher with access to the outline of their cultural diversity course content. One of these universities requested that the course content not be published. The remaining three universities did not have a specific course outline as cultural diversity training is embedded within their curriculum. Modules or course codes would not have provided the researcher with the detail of content.

4.1.2 Questionnaire

4.1.2.1 Cultural Diversity in the Curriculum

4.1.2.1.1 Inclusion of cultural diversity in the curriculum

All six participating universities included cultural diversity training within their curricula. Descriptive analyses of content using questionnaires were selected. The responses were collated (Milne, 1999) and indicated that this training was presented in three different ways. These were: specific units or courses; emergence of elements of cultural diversity within modules and tutorials and / or interwoven throughout the curricula.

All of the universities reported that cultural diversity training was interwoven throughout the occupational therapy curricula, while 83% of the respondents also reported that focused attention was placed on the emergence of a theme of cultural

diversity within curriculum, modules and tutorials following fieldwork experiences (Figure 4.1).

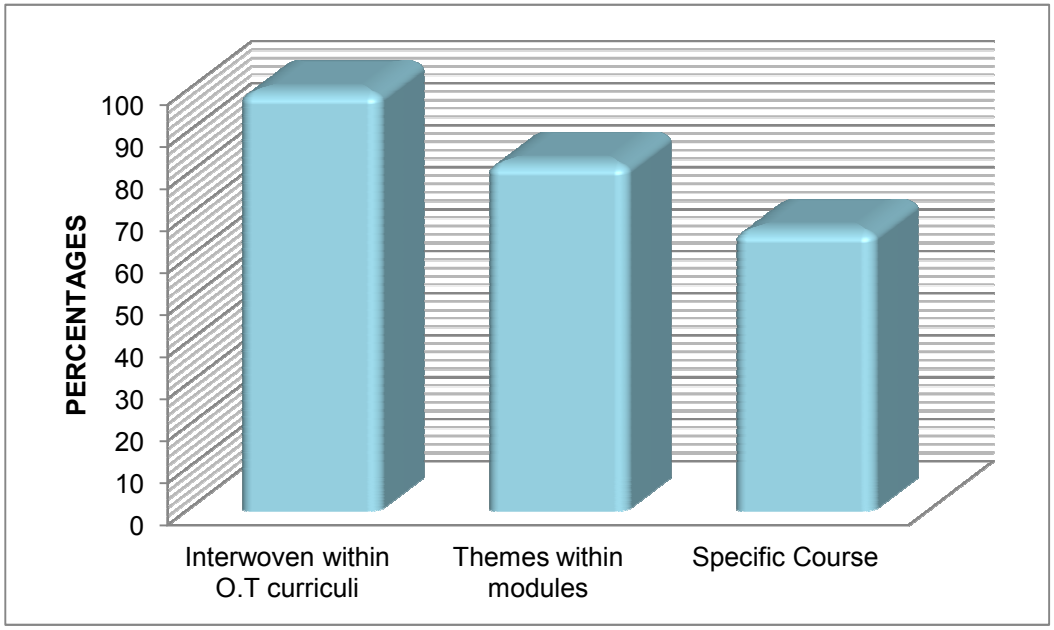


Figure 4.1 Percentage of different methods used for inclusion of cultural diversity into occupational therapy curricula

Only 66.6 % of respondents reported that cultural diversity was addressed through formal course work. Other university respondents indicated that they thought that cultural competence should be a more generic subject related to disability as a whole rather than being addressed in the occupational therapy curriculum.

- "I think OT education in general needs to address this issue collectively to design a curriculum that adequately addresses it especially from a disability perspective."

4.1.2.1.2 Adequacy of cultural diversity in the curriculum

Respondents statements were analysed by content and responses were sorted into three categories. Fifty percent of the respondents reported that cultural diversity training *was not adequately* addressed within the occupational therapy curricula.

- “Not currently. In my view students should be taught to consciously be aware of the potential impact of their own worldview on clients and patients with other world views to whom they render a service.”
- “This is difficult to say because the curriculum is designed to be integrated around themes […]”

Another 33 % of respondents identified that improvements could be made in terms of “*more time and attention”.* “It is a pertinent issue-could therefore receive more time and attention.” Figure 4.2 indicates that only 17% of the respondents thought that cultural diversity was adequately addressed.

- “We give transformation a lot of focus and prominence.”
- “Students might have cultural components highlighted - but learning about OT in itself is cultural competence training.”

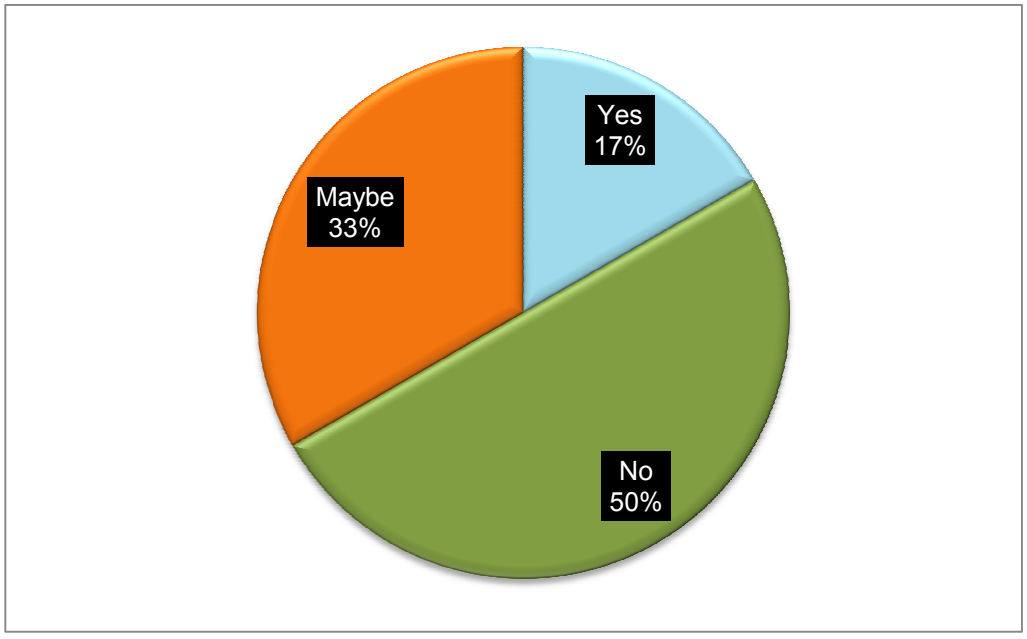


Figure 4.2 Percentages representing adequacy of cultural diversity training perceived by university respondents

4.1.2.1.3 Formal hours for cultural diversity in curriculum

Hours allocated to teaching cultural diversity varied between the six universities (Figure 4.3).

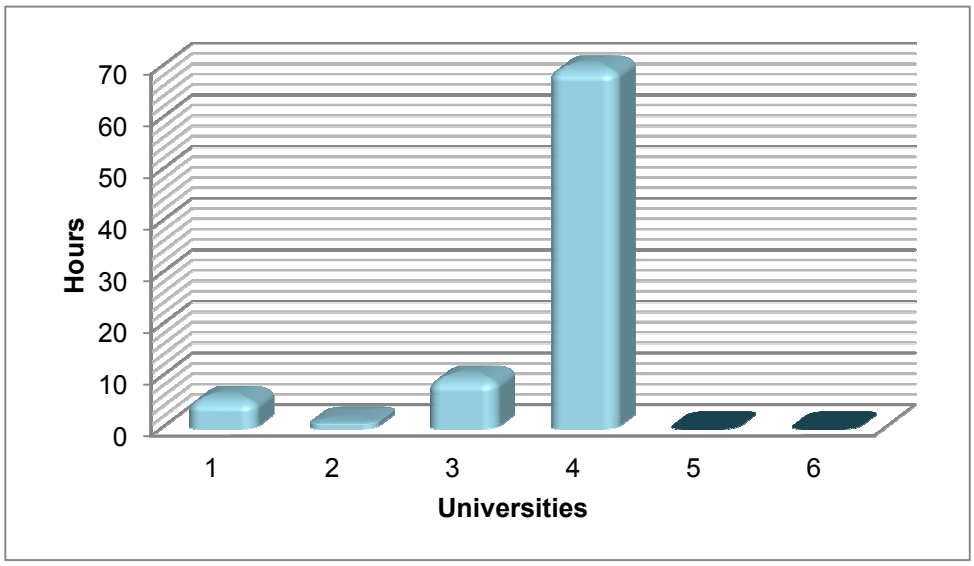


Figure 4.3 Hours allocated to teaching cultural diversity

Responses were analysed according to allocated and unspecified hours. Fifty percent of the universities specified between 1.5 to 6 hours and one university (17%) reported 70 hours in the first year. Thirty three percent of the universities specified 1.5 to 8 hours in second and third year and one university (17%) specified 6 hours in fourth year. Sixty six percent of the universities had specific hours while others did not (Figure 4.3).

4.1.2.2 Addressing cultural diversity within the curriculum

Sixty seven percent of the universities introduced cultural diversity training in their curricula though a combination of faculty foundation courses or modules, problem based learning, tutorials and fieldwork. Thirty three percent reported that cultural diversity is woven into first to fourth year occupational therapy subjects, including problem based learning, through emergence of a theme and fieldwork.

4.1.2.2.1 Teaching methods

Cultural diversity is taught in a number of different ways. Teaching was placed into six categories using summative content analysis; lectures, problem based learning, discussion, use of audio-visual aids, reflective logs and tutorials. One hundred percent of the universities used a range of lectures to address cultural diversity either formally or indirectly.

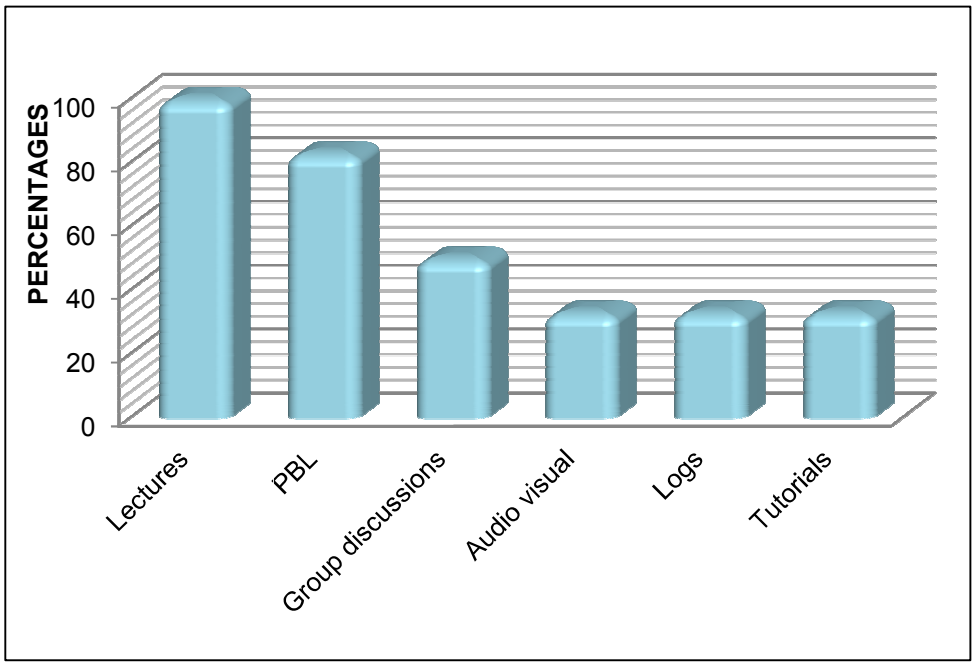


Figure 4.4 Teaching methods used in cultural diversity training

Eighty three percent of universities used problem based learning (PBL) to develop themes including aspects of cultural diversity while 50% used group discussion.

Thirty three percent included the use of audio visual resources for example; music and the same percentage used reflective logs and tutorials (Figure 4.4).

4.1.2.2.2 Reinforcement of cultural diversity training in fieldwork

Responses were analysed and seven methods of reinforcing cultural diversity in fieldwork were found. These included choice of treatment modalities, portfolios, reflective logs, discussion, tutorials and lectures (Figure 4.5).

Four universities (66.6%) used treatment modalities as a means of reinforcing cultural diversity training, and 50% of the universities included discussion. Only 33.3% of the universities make use of tutorials, with 17% using lectures, portfolios and reflective logs in reinforcing cultural diversity in fieldwork.

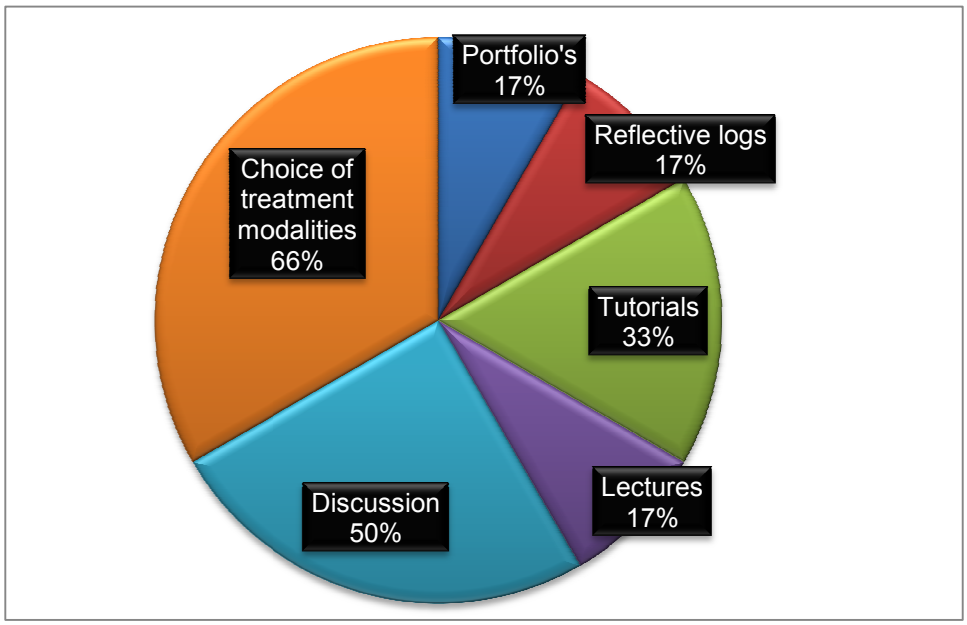


Figure 4.5 Cultural diversity reinforced in fieldwork

4.1.2.2.3 Reflective Learning

Responses to the inclusion of reflective learning was analysed and categorised according to formal learning tasks and informal learning tasks. One hundred percent of university respondents indicated that reflective learning was used. Eighty three percent of universities reported formal reflective tasks and the rest (17 %) reported that reflective learning occurred informally (Figure 4.6)

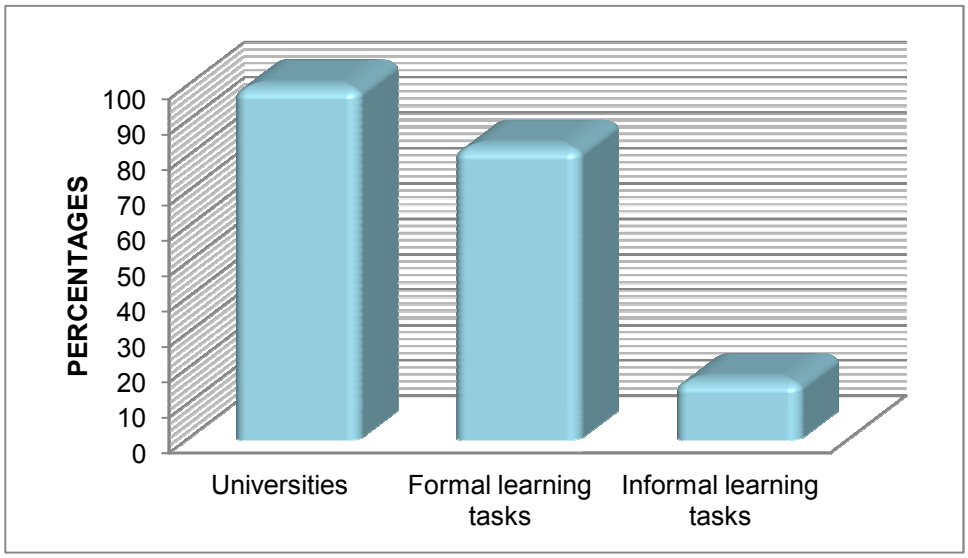


Figure 4.6 Inclusion of reflective learning represented in percentages

4.1.2.3 Challenges experienced regarding the teaching of cultural diversity

Eight three percent of universities identified challenges with teaching cultural diversity. Seventeen percent reported none.

The respondent's statements were analysed using summative content analysis to count the words related to each of the constructs of Campinha-Bacote's (2002) Model of Cultural Competency.

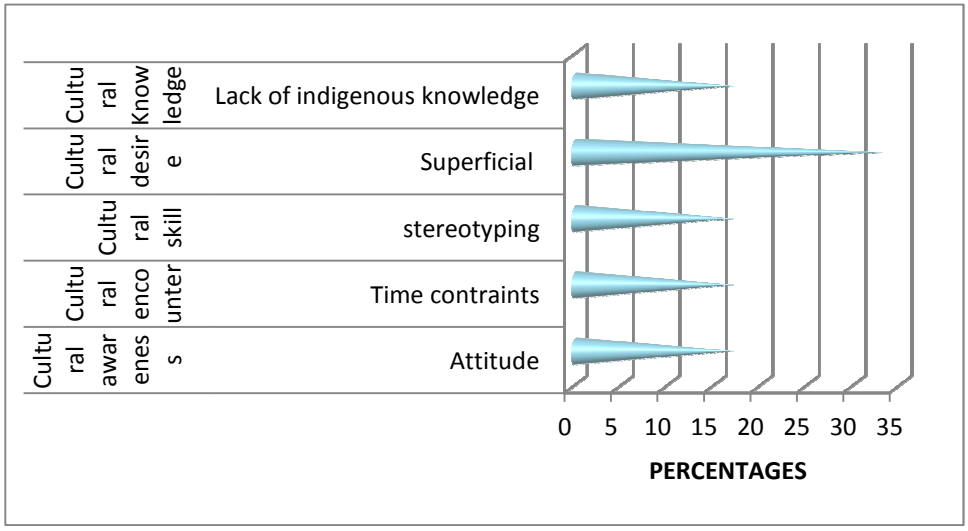


Figure 4.7 Challenges identified during the teaching of cultural diversity according to the constructs of Campinha-Bacote's (2002) Model of Cultural Competency

The information obtained revealed several themes in addressing cultural competency within occupational therapy programmes in South Africa. Narratives of university respondents revealed the complex nature of teaching cultural diversity in the following comments in the themes based on constructs of Campinha-Bacote's (2002) Model of Cultural Competency .

Lack of indigenous knowledge,

"We are fortunate in having a very good cultural mix in our classes and this lends itself to using participatory student sharing to share aspects of diversity. Challenges are the lack of adequate indigenous knowledge in OT."

Superficiality

due to an inability to connect with discussions on cultural diversity

"groups will intellectualise discussions and not connect with the impact this has on themselves. They therefore will keep the discussion at a superficial level."

Stereotypical views

"To ensure that one doesn't focus on stereotypical ideas and that a wide spectrum is covered."

Time constaints within education programme

"There wasn't enough time to fit it into an already full timetable and as a result it was not comprehensive."

General attitude of occupational therapy students to cultural diversity training.

Respondents felt that this differed depending on the students and their maturity.

"This is not a question that is easily answered, it depends from person to person and one class to the next."

"For me, within a conservative Afrikaans environment, it appears at times that especially Afrikaans speaking students lack the emotional & cultural maturity to differentiate between moral sensitivity and religious issues when it comes to intellectual discourse."

4.2 PART 2. THE NEWLY QUALIFIED OCCUPATIONAL THERAPIST'S EXPERIENCE AND EXPOSURE TO CULTURAL DIVERSITY IN THEIR TRAINING COURSE AND THEIR PERCEIVED CULTURAL COMPETENCE.

4.2.1 Introduction

Placements where novice newly qualified occupational therapists completed their community service in Gauteng Province were identified. Three agencies reported that they had no community service occupational therapists and thus 47 newly qualified community service occupational therapists were targeted to participate in the study. Thirty eight newly qualified community service occupational therapists completed the surveys indicating a return rate of 80.85%.

4.2.2 Demographics

Data revealed two Indian and no African and Coloured participants (Figure 4.8). Ages of respondents varied between 22 years old and 29 years old. All respondents were female and one was married. Participants completed the questionnaire in English.

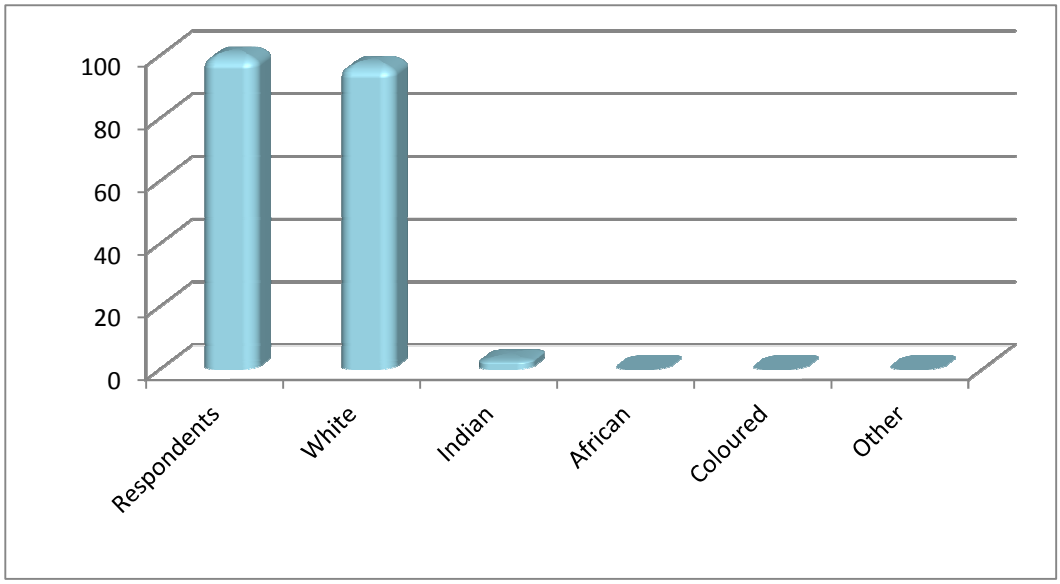


Figure 4.8 Represents the trend in student demographics

4.2.2.1 University attended

Seven universities were represented in the responses from 80.85% of the participants (Figure 4.9). The largest percentage of responses received was from newly qualified community service occupational therapists who attended universities based in the Gauteng Province.

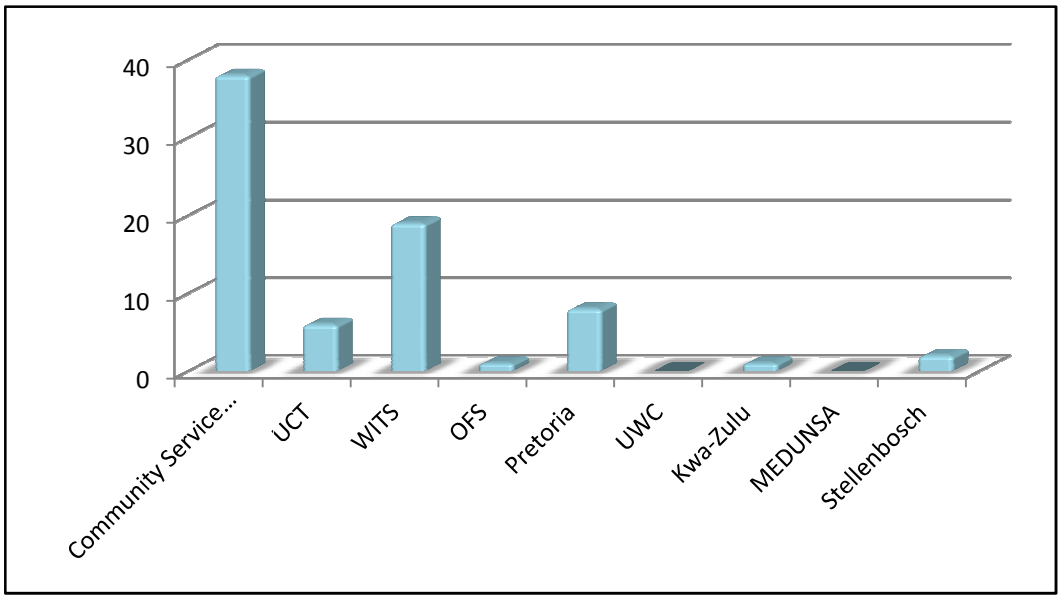


Figure 4.9 Universities represented in responses received from newly qualified occupational therapists

4.2.2.2 Inclusion in the curriculum

One hundred percent of respondents indicated that they received cultural diversity training from their training centre (Figure 4.10).

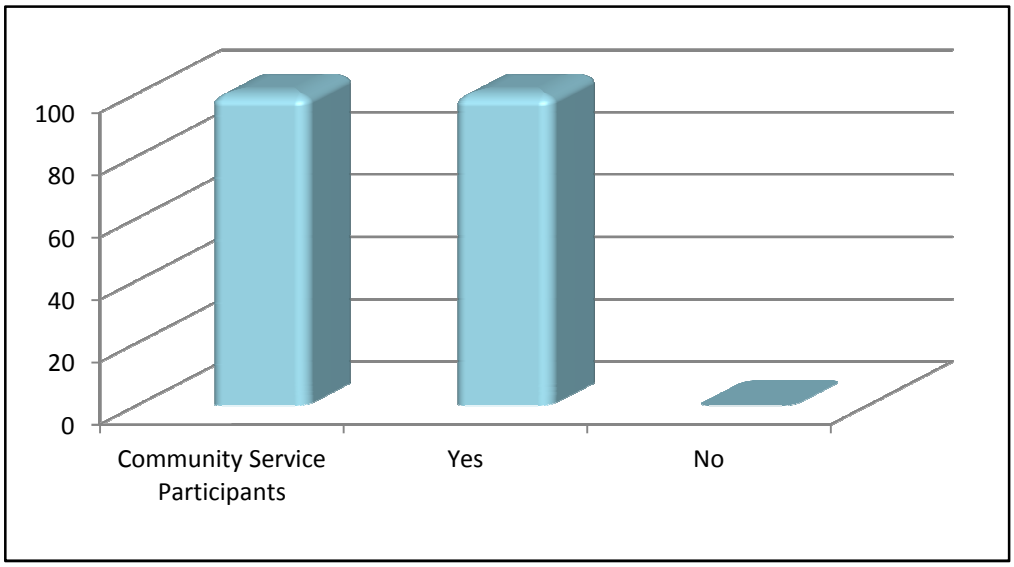


Figure 4.10 Inclusion of cultural diversity training within curriculum

4.2.2.3 Adequacy in the curriculum

Seventy three percent of the respondents agreed that they received adequate training and exposure to be able to work with clients from different cultural backgrounds to their own. Twenty seven percent of the respondents disagreed (Figure 4.11).

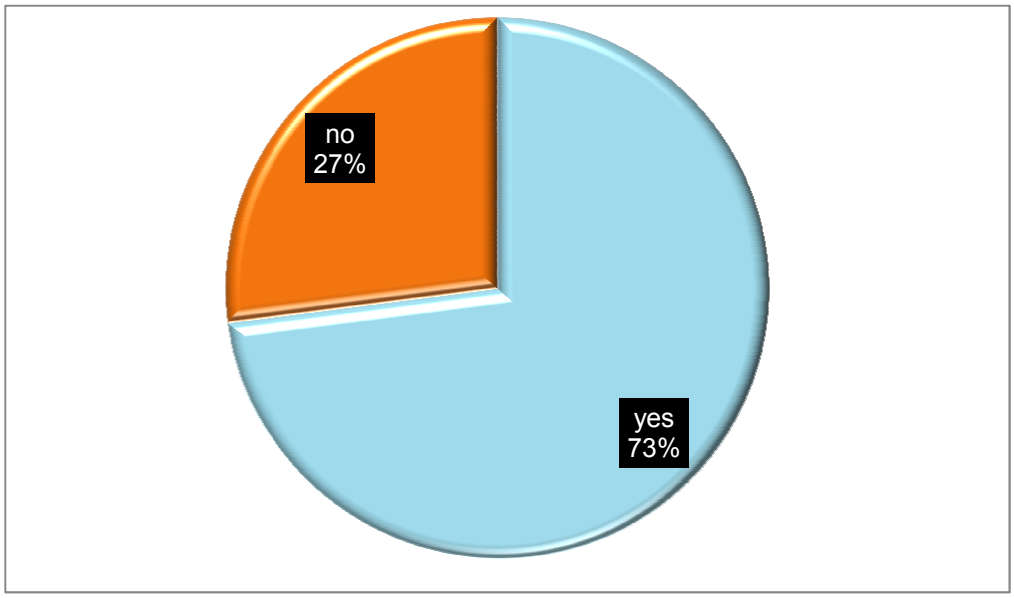


Figure 4.11 Percentages representing adequacy of cultural diversity training perceived by newly qualified occupational therapists

4.2.2.4 Introduction to cultural diversity

Cultural diversity was introduced into the occupational therapy programme at different study years.

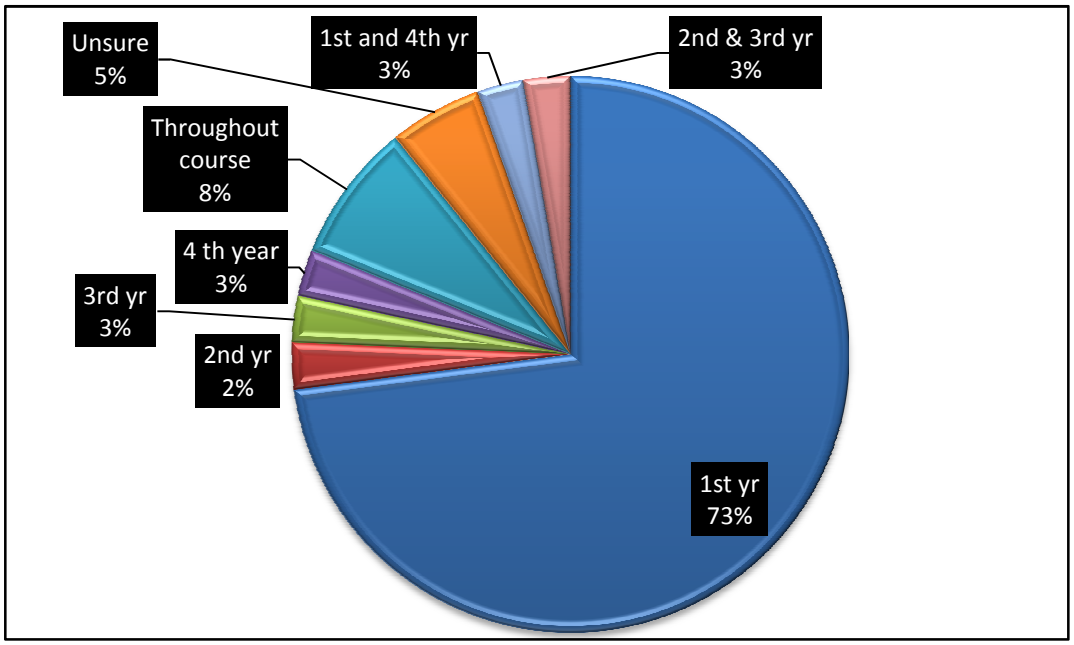


Figure 4.12 Percentages reflecting introduction of cultural diversity training within occupational therapy curriculum

Seventy three percent of respondents reported it was introduced in first year, 2% reported it was started in second year, with 3% reporting cultural diversity was introduced in third year, and 3% in fourth year. Some respondents (8%) reported cultural diversity was taught through all years of the course with 3% reporting it was taught in first and fourth year and another 3% in second and third year. Five percent were unsure of when it was introduced (Figure 4.12).

4.2.3 Cultural competence of community service occupational therapists in working with diverse cultural groups

4.2.3.1 Barriers and facilitators

4.2.3.1.1 Working with diverse cultural groups

Forty percent of respondents reported they did not experience difficulty working with clients or patients that differed from their own culture; 57% percent of the respondents experienced difficulty with working with the diverse cultural groups of patients they encountered. The others did not comment (Figure 4.13).

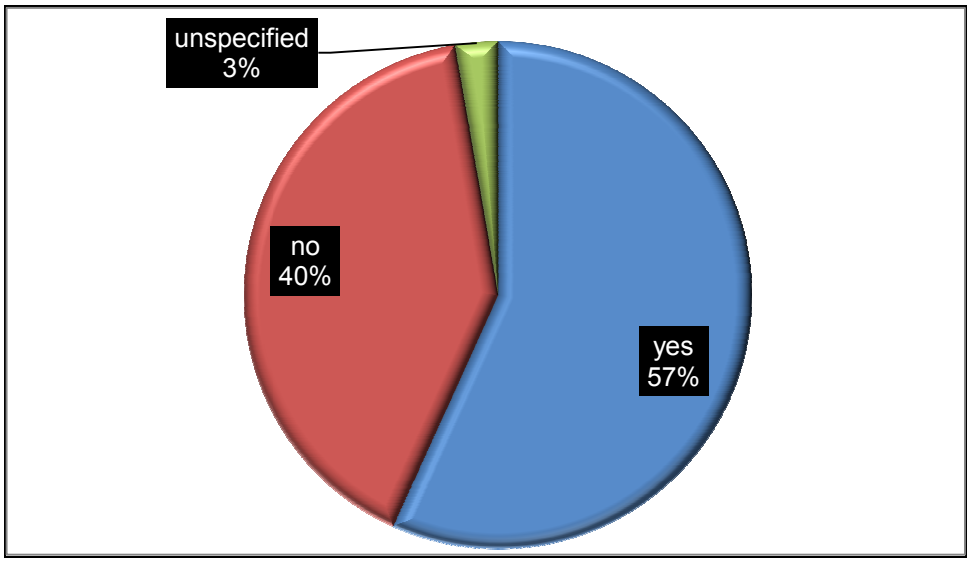


Figure 4.13 Percentage of respondents experiencing challenges working with diverse cultural groups.

Analysis by university attended where there were more than six respondents indicated similar results for each institution (Table 4.1).

Table 4.1 Difficulty with working with diverse cultural groups by training centre

Institution attended	Frequency	Percentage	Frequency	Percentage
	Difficulty		No difficulty	
UCT	5	83.3%	1	16.6%
Wits	14	73.68%	5	26.31%
Pretoria	6	75%	2	25%

4.2.3.1.2 Use of reflective learning strategies

Seventy three percent of newly qualified community service occupational therapists used self reflection about cultural diversity in clinical practice the rest did not (Figure 4.14).

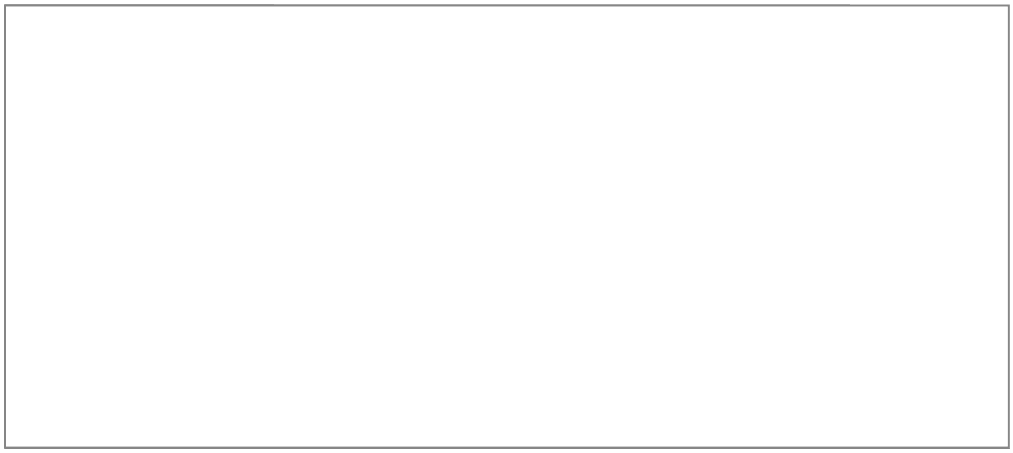


Figure 4.14 Percentage of respondents who used reflective learning strategies during clinical practice.

Analysis of the respondents from the universities that had more than six respondents indicated differences in the percentage who reported using this technique to improve their cultural competence (Table 4.2).

Table 4.2 Self reflection by newly qualified community service occupational therapists by institution attended

Institution attended	Frequency		Frequency	
	Reflect	Percentage	Don't reflect	Percentage
UCT	3	50%	3	50%
Wits	13	68.42%	6	31.58%
Pretoria	3	37.5%	5	62.5%

4.2.4 Perceptions of newly qualified community services occupational therapists about their cultural competence

Respondents shared their perceptions about working with diverse cultures in open ended questions. These represented both facilitators and barriers to their perceived cultural competence as well as their reflections on their own experience. The six components of the Model of Cultural Competency by Campinha-

Bacote(2002) were used for the priori catagories in the directed content analysis of the community service occupational therapists opinions.

Table 4.3 Perceptions of newly Qualified Community Services Occupational Therapists about their Cultural competence

Theme	Category	Subcategory	Code
Developing Cultural competence (Campinha-Bacote 2002)	Cultural Awareness	Aware of cultural differences	• difficulty in understanding • had adequate exposure to different cultures
		Relevance to practice	• not necessary for practice • know everything
	Cultural Knowledge	Provided with information	• adequate information • other activities • clinical experience
		Inadequate preparation	• not addressed in the curriculum • knowledge of another language • just too much to know • difficult to access resources
	Cultural Skill	Language	• inability to communicate effectively • opportunity to learn
		Therapy and activities	• providing therapy • compliance with treatment • appropriate activities
		Clinical reasoning	• correct intervention • a way forward
	Cultural Encounters	Need to be experienced	• respect for differences • wide exposure
		Difficult to cope with differences	• no one could give answers
	Cultural Desire	Need to know and learn	• to improve their clinical practice
		Making sense of differences	• to consult others • reflect

The only theme for this section was **Developing Cultural Competence.** The categories, sub- categories and codes are presented below

4.2.4.1. Cultural Awareness

Respondents briefly expressed their awareness of their own cultural identity (Awaad, 2003a) in their comments under the questions and differences in others they encounted in their work environment.

Aware of cultral differences

They were aware that their own culture is different and the **difficulty in understanding** differences in others. They felt this lack of understanding other cultures may have been influenced by limited opportunities to work with colleagues and clients from different cultures during their training. One respondent felt it was only possible to appreciate another culture from her own view of it.

- “[…], certain cultural practices were only learnt through my work experience.”
- "[…], unfamiliar with their practices and dealing with those from other cultures and understanding them.”
- “[…] as much as you try to understand another culture you will only ever be able to understand it through your own eyes.”

Others felt that they received **adequate exposure** to working with different cultures during their training and were more confident about their understanding of cultural differences.

- “Practical’s were done at government and private hospitals, and rural and urban settings which exposed us to a wide range of patients from different cultures and socio economic backgrounds.”
- “As part of the course we were made aware of different cultures and we worked with clients from different cultural backgrounds throughout the course.”

Relevance to practice

Some respondents felt that there was **no need to know about other cultures** as this was not necessary in their practice.

- "This year I was not faced with treatment difficulties in terms of diverse cultures, so it was not a need for me."

For other respondents they felt their course exposed them extensively to cultural diversity from first year through to fourth year so that they already **knew everything** they need to know about other cultures and cultural diversity.

- "In first year we took a whole year of "cultural studies" in fourth year we worked and lived in the community."
- "I feel I have a sound knowledge and understanding of other cultures and never felt the need to research the topic more."

4.2.4.2 Cultural Knowledge

The repondents differed in their perception of their knowledge and understanding of the theory and characteristics of culture, including behaviours of clients related to health-related practices. Opinions were split about the depth and adequacy of the information they had received.

Provided with information

Positive comments indicated some respondents felt they had been given the knowledge and mechanisms to deal with cultural diversity in their training. They stated that their knowledge came from being educated about different cultures in the curriculum as well as by people from those cultures with whom they could interact. The majority of respondents felt that they had been provided with **adequate information** on cultural diversity during their training (Figure 4.11)

- "We were educated about various cultures, their beliefs and traditions as well as acceptable behaviour when interacting with them. We were educated by people from each of the different cultures and had opportunities to interact and ask questions."

Some respondents had been exposed to **other activities** outside of the traditional curriculum like cultural evenings.

- "We also had several cultural evenings where we had the opportunity to dress, eat and experience some of these cultural traditions."

Clinical experience with clients from different cultures and the information they received in the curriculum provided them with knowledge about different cultures over the duration of the occupational therapy course.

- "As part of the course we were made aware of different cultures and we worked with clients from different cultural backgrounds throughout the course."

Inadequate preparation

Other respondents indicated that their knowledge was inadequate and that they did not have knowledge about the cultural practices of others and how to deal with this. Twenty seven percent of respondents felt that their knowledge was inadequate as cultural competence was **not addressed in the curriculum** in enough detail (Figure 4.11).

- "I do not feel that we are culturally competent in working with diverse cultural groups. It is briefly discussed through the four year degree but not emphasised significantly or looked at in enough detail."

- "Working in the government sector in SA has numerous challenges, and in my opinion cultural diversity is one of the most significant that we are not adequately prepared for."

- "It was very basic- example, a black man should not do cooking and don't cut hair and nails in the house."

The lack of adequate training in cultural diversity included specific aspects which they found affected their cultural competence like **knowledge of another language**.

- "It would have been great if the course in occupational therapy could have included more information, lectures and experience with regard to cultural diversity; especially language courses."
- "[…] an African language was not part of the curriculum."

There was also the opinion that there is **just too much to know** about all the different cultures in South Africa to easily be culturally competent and it would not be possible to gain the required information.

- "It is difficult to know everything about each culture and to what extent culture principle or norms are practiced by individuals."

Respondents also found it **difficult to access resources** on cultural diversity and had to expand their knowledge of other cultural groups by asking clients or other informants. Time constraints were identified as a barrier to gaining knowledge about different cultures and their customs.

- "I have not yet been able to locate literature South African based that is of much help on the matter. I think this research invaluable."
- "Limited amount of time. I'd rather use the time to read up on certain conditions or occupational therapy treatment."

4.2.4.3 Cultural Skill

In the clinical practice context respondents reported on their skill in using cultural information and being culturally competent (Balcazar, Suarez-Balcazar and Taylor-Ritzlerl, 2009) including collecting relevant information in an appropriate way (Chipps, Simpson, Brysiewicz, 2008). Respondents identified specific areas related to culture that affected their ability to practice and work within a team with cultural competence.

Language

The different languages spoken presented a specific problem for these South African responents when needing to deal with patients from different cultures. Most felt this was difficult to address with the patients. Language differences were

seen as the most commonly reported challenge and affected their **ability to communicate effectively.**

- "There are many challenges I'm faced with when working with people from other cultures. It is often very difficult to provide sufficient treatment due to language barriers and cultural differences."
- "Language and cultural barriers and differences. Just sometimes difficult to overcome."

The problem of needing and using another team member to translate and the effect this has on the accuracy of communications was of concern.

- "A language barrier plays a huge role even if you have a translator; still difficult to relay the correct message to the patients."

The challenge of the large number of different languages spoken was also viewed as an **opportunity to learn**. Respondents reported making an effort to increase their language skills in order to overcome cultural differences.

- "Language barrier is difficult and I think working with anyone from a different culture is challenging […] but provides an opportunity to learn."
- "I try to increase my vocabulary in different African languages as it shows patients and their families that you respect them and their culture. The family and the patient then respect you more and are more active in therapy as they see you have made an effort to make them feel more comfortable."

Therapy and activities

Taking the effect of culture into consideration when **providing therapy** was a second challenge reported by the respondents. They reported difficulty with aligning nonverbal communication, providing advice about activities and accommodating their activities of daily living in their occupational therapy programmes.

- "[…] family dynamics were challenging to understand; different ways to greet cultural groups, different ways to show emotion and ways of comforting (e.g. counselling). Understand that they have different ways of living and place different importance on life tasks."

Respondents felt that cultural differences were also responsible for patients not understanding and being **non-compliant with treatment**. The different expectations of the patients based on their cultural beliefs in relation to African philosophy were also difficult for the respondents to come to terms with.

- "[…] cultural understanding of illness sometimes leads to patients not participating in medical or therapeutic interventions."
- "In some African cultures, elderly patients feel that it is now their children's turn to take care of them. For example, if they have had a CVA and so they don't participate in therapy and don't want to become independent again."

A lack of understanding of other cultures also affected the respondents ability to choose **appropriate activities** for some patients.

- "I find it difficult to give cultural and gender appropriate activities to black and Indian men."

Clinical reasoning

Different cultural beliefs present a third challenge in the respondent's ability to use clinical reasoning to identify possible dysfunction and provide the **correct intervention** for patients.

- "[…] in psychiatry, many people believe that their ancestors call them and speak to them and although this is a culturally significant experience, it is difficult to define the boundary between psychosis and cultural beliefs."

Respondents felt that being able to use clinical reasoning was **a way forward** in dealing with the problem they face in terms of providing adequate culturally appropriate intervention.

- "[…] we left university with the basics for each area available in OT and clinical reasoning to sort out problems we don't know about."

4.2.4.4 Cultural Encounters

Cultural encounters included the respondent's awareness of their own perceptions of cultural differences and their ability to respect the diverse points of view of the individuals they treat and work with.

Need to be experienced

Respondents felt their experience as students and their exposure to different cultures had helped them achieve both awareness and **respect for the differences** between the cultures they encountered.

- "I think we were made aware that things may be approached differently in different cultures however I feel that working in that culture provides a better understanding."
- "Even though I think I still have some difficulty with understanding cultural diversity; I feel this will come from experience only and that the institute exposed me as best as they could."

Clinical practice in different settings was found to result in **wide exposure** to different cultures and seen as a good way to gain experience and exposure to cultural differences.

- "Practical's were done at government and private hospitals, and in rural and urban settings which exposed us to a wide range of patients from different cultures and socio economic backgrounds."
- "I think it is a challenge to expose students to all different cultures in South Africa but our fieldwork from first year assisted us the most in this regard."

They also learnt from exposure to others they studied and worked with in terms of cultural differences outside of their formal training.

- "Learnt a lot from people I worked with not really training."

- "With regards to cultural aspects, I will discuss the matter with colleagues who understand more about that culture."

Difficult to copewith differences

Respondents reported that they found it difficult to deal with the cultural differences they encountered and that exposure had **not provided the answers**. The majority had difficulty in treating patients and working with people from diverse cultures (Figure 4.13).

- "As community service OT, I have been exposed to this issue on a daily basis and as mentioned, it has been the cause of much frustration and contributed significantly to feelings of burn out."
- "Since working at a psychiatric institution with users from completely different cultural backgrounds to myself, I have now come to realise the major impact it has on therapy. This has been the cause of much frustration and feelings of incompetence."

4.2.4.5 Cultural Desire

Respondents differed in their attitude to wanting to embrace and become more culturally competent. Some wanted to engage in cultural encounters, extend knowledge of different cultures and aspired to become culturally skilful (Campinha-Bacote,1999, Ekelman et al, 1999) while others felt that this was not neccesary.

Need to know and learn

Respondents expressed the importance of learning**to improve their clinical practice**and the willingness tofind out about the culture of others as the need arose.

- "I do feel I was brought up needing to understand more about other cultures and as all different cultures started to reintegrate my understanding improved. It's not always about reading up and learning through formal training i.e. lectures, it is about communicating and forming relationships with people in other cultures that will build understanding and harness specific strengths in clinical practice."

- "If there are cases or situations that we don't understand they will always be looked up and we will search to find the information that we don't have."

Making senseof differences

The respondents reported that they commonly got information about culture from other people or those involved, either colleagues or patients. They expressed the need **to consult and also reflect** on what they learnt so they could use the information in practice.

- "I don't necessarily read up but I ask the people around me or I ask the patient."
- "I speak to professionals from different cultures to ask about things I don't know or understand."
- "I don't read up on it, but consult others of the same culture to assist me in reflection."
- "I generally ask the client or a staff member of that specific culture on cultural aspects."

4.2.5 Summary

Results indicated that the majority of newly qualified community service occupational therapists felt they had adequate information about cultural diversity in their training. All the university respondents indicated that diversity training of some form is offered in all courses but were not always adequate in their opinion. Some university respondents reported time, student attitudes and maturity as factors affecting the teaching of cultural diversity.

Most community service occupational therapists working with patients from different cultures expressed a desire to become culturally competent. They felt they had had various levels of preparation at university in terms of cultural diversity and still viewed culture from a theoretical and sometimes stereotypical perspective. They were aware of the need to gain experience so they could accommodate

culture in their therapy and saw language as a major barrier in terms of providing culturally appropriate therapy.

4.3 PART 3 QUALIFIED OCCUPATIONAL THERAPISTS PERCEPTIONS OF CULTURAL COMPETENCETHREE YEARS AFTER COMPLETING COMMUNITY SERVICE

4.3.1 Introduction

Three years after completing their community service, all the respondents who agreed to be contacted later were approached. Twenty three emails were sent out with a response rate of 13 % returned by email agreeing to participate in telephone interviews. Unfortunately only three participants were willing to continue with the study and since a number of different responses were obtained from them for a number of questions it cannot be confirmed that data saturation was achieved.

4.3.1.1 Profiles of Respondents

Respondent 1

White, 29 year old, English speaking female, who is also able to communicate in Afrikaans. After graduating from the University of Cape Town, the respondent completed her community service in Gauteng and has since joined a private psychiatric clinic in Cape Town where she has worked for three years. The respondent is now working in private practice as an occupational therapist in psychiatry.

Respondent 2

White, 27 year old, Afrikaans speaking female, who is also able to communicate in English and Sepedi. The respondent graduated from the University of Stellenbosch and completed her community service year in Pretoria. The respondent has completed her training in neuro-developmental therapy and is in the process of completing her sensory integration training. She currently works in the private sector in the paediatrics and medico- legal field of practice.

Respondent 3

White, 27 year old Afrikaans speaking female, who is also able to communicate in English and has a working knowledge of German. She reports that she has learnt a few social phrases and words in Tswana, Sepedi and Zulu. Respondent 3 graduated from the University of Pretoria and completed her community service year in Pretoria where she worked until October 2011. While working there she did locum work for two private practices and started her own private practice specialising in psychiatry and vocational rehabilitation and is currently in full time private practice.

4.3.2 Competent Occupational Therapists perceived experiences of cultural competence three years later

Competent respondents with three years experience shared their perceptions and experiences about working with diverse cultures in open ended questions.

Table 5.1: Perceptions of cultural competency of competent occupational therapists

Theme	Category	Subcategory	Code
Cultural competence-What it means and meant then	Present understanding	Divesity and competence Still learning	▪ Specific characteristics ▪ Sensitive to patients' culture ▪ Need for resources
	Past reflections	You can't know it all Change in worldview	▪ Training ▪ Culture shock
Cultural competence-Can it be improved	In training	A good start	▪ Basic grounding
	In practice	Use opportunities Exposure in clinical settings	▪ Open discussion ▪ Attitude • Learning in situ
Cultural competence-Personal growth	Learning more	Willingness to change	▪ Learning opportunties ▪ Clinical experience
	Becoming culturally competent	Professional development	▪ Patients as people ▪ Continued challenges

Facilitators and barriers to working with diverse cultures were identified in the transcripts and new perceptions were explored using inductive coding.

4.3.2.1 Theme 1: Cultural Competence-what it means and what it meant then

4.3.2.1.1Present understanding

When describing what cultural diversity and cultural competence meant to them now and in practice the respondents identified patient centeredness as important.

Diversity and Competence

When asked about their understanding of cultural diversity and cultural competency, respondents simply used several semantic descriptions. Some respondents defined culture in figurative terms while others referred to culture in terms of specific distinguishing characteristics.

- "The term refers to the fact that there are different cultures each with their own set of cultural ways of thinking, habits, rituals etc."
- ."Um well, I think in South Africa we have studied the people that not only come from different races and different religions and um… different frames of reference and cultural diversity. I think it just refers to people of different origins, languages, races, religions etc."

Respondents were however now able to reflect on cultural competence in their practice in terms of being sensitive to patients' cultural needs and seeing treatment from the patient's point of view.

- "Um I think it means having a knowledge and a sensitivity to where other people are coming from and as a therapist you may have a different culture to one of your clients."
- "having an awareness of that culture, and when you choose your therapies and modalities especially when you are working in communities it causes you to be aware of where other people are coming from."

- "The competence part you know is if you could be sensitive to that and other peoples points of view you most likely will have more success uhm ja."

Still Learning

Respondents acknowledged the dilemma of understanding cultures within South Africa and felt that they still needed to learn a lot. They felt that **resources were needed** and should be made available to all occupational therapists for ongoing improvement of their cultural awareness.

- "but maybe providing some kind of resource so that they know if you were going to [...] If I were going to Johannesburg maybe giving some resources in terms of Xhosa or Zulu but I think we were well prepared."

- "I would say continue to provide students with as much exposure as possible and to provide resources where they can read-up when they feel unsure etc."

4.3.2.1.2 Past reflections

When reflecting on their training as undergraduates and whether they were prepared for the barriers experienced in working with patients of different cultures the respondents felt that they could never have been prepared for all eventualities

You can't know it all

Respondents felt that there were so many different cultures and nuances related to them that they could never know everything. Preparing students to have an in-depth knowledge of every culture within South African society would be an impractical expectation.

- "it is an impossible task to prepare ..... for the immense variety of cultures we have here."

- "considering that people are going all over the country it's not possible to prepare everyone."

Change in worldview

Respondents reported personal challenges while working within communities and cultures different to their own as a student and after qualifying. Their experiences were described as difficult to come to terms with especially when they were faced with a combination of complex social and culture based issues. They recalled some of these experiences as having affected their world view of working within culturally diverse communities different to their own.

- "I can't think of anything specific uhm…but definitely as a student um […] I did experience culture shock especially for example going into the Cape Flats areas like gangsterism and completely being taken out of my own frame of reference by being put into something that is 5km down the road … that is completely different um…that was a big challenge for a student and as a community service therapist."

4.3.2.2.Theme 2 Cultural Competence- Can it be improved ?

In terms of the advice that respondents would give both the training centres and newly qualified community service occupational therapists, they felt that they had received as much preparation as they could assimilate during training and that having an open mind and using opportunities to learn about culture both in the class and in clinical practice was important. Understanding cultural differences comes from working and being around people of different cultures.

4.3.2.2.1 In training

Respondents acknowledged the importance of cultural diversity training in developing cultural competence. At an undergraduate level they felt that the universities they were at had provided adequate preparation in terms of theory and clinical exposure for working with different cultures (Campinha-Bacote, 1999, Camphinha-Bacote, 2002).

A good foundation

The challenges their training centres faced in preparing students to work with the diverse range of cultures found within South Africa was recognised and it was

felt that on the whole what was done provided them with the a good basic grounding in cultural diversity.

- "I think it was positive that they tried to equip us but I also think that it is important especially in S.A. "
- "they did and we had a lot of emphasis on community entry and how to actually approach a community that is different to your own ja, more so I think in third and fourth year and beginning of our training."
- "I think every student needs to have that uhm ja, learn those principles um. I don't think it is possible for them to teach more language than they did. "
- "I think we definitely got exposure to different cultures um and I think there is only so much that can be done to prepare you so the university tried to give us lessons in Xhosa and Afrikaans and so on um [...]"

4.3.2.2.2 In practice

When considering what newly qualified occupational therapists should do in terms of preparing themselves to work with patients of different cultures, the respondents recognised the importance of discussion and experience in the clinical field.

Use opportunities

They felt that students and new graduates should use the opportunities given to develop cultural awareness and knowledge. There was a view that personal bias was challenged when issues surrounding diversity were **openly discussed** and when therapists had an attitude which made them open to using the knowledge gained to understand cultural differences. This could create awareness amongst students who may not have otherwise have interacted with individuals different to their own cultural background.

- "[...] there was a lot of debate in our classes; there were people who got quite uncomfortable when there was mention of other religions. It

can make people uncomfortable and can put some people off. That is a disadvantage, pushing people to actually think a bit more."

- "I think it draws on personality and your own ability to just be open minded and actually ask the people when you don't understand, maybe their practices in religion or cultures are interested um… I think we could sometimes have a bit of a superiority complex and just think we better than everybody else… attitude is probably one of the biggest barriers."

Exposure in clinical settings

Respondents felt therapists should value their clinical experiences as a good learning opportunity to engage with different cultures. One of the respondents recalled the importance of being aware of the differences in others and identified cultural knowledge and sensitivity as an enabler in developing cultural skill **by learning in situ** (Balcazar, Suarez-Balcazar& Taylor-Ritzler 2009, Awaad2003a).

- "[...] I don't know if it is adequate or what more you could do other than being in that environment with the people and learning from them....that is the way to learn… and I think that prepared us uhm…",

- "Um… if I look back, I can remember one specific incident we had working….I think the most important thing that actually helped us basically[…] our practical block that we worked in; where you get your community area and you try and….. ja."

- "Develop an understanding of the community and the cultural context within which they worked. By being given opportunities to develop their cultural knowledge of that community and working with the people in the community they felt they became more cultural competent."

4.3.1.3 Theme 3 Cultural Competence -Personal Growth

4.3.1.3.1 Learning more

In their community service year and in the years since respondents were provided with opportunities to extend their knowledge. They reported using these opportunities to improve their ability to treat and to communicate with their patients.

Willingness to change

Some respondents indicated that personal preference and willingness to continue to learn about cultural differences of others; being provided with **learning opportunities** in the form of in service training and the chance to learn a language during their years of practice, (Ekelman et al, 1999 and Hanley,1999) influencedwhere they chose to work as therapists.

- "[...] in-services were provided on different Sotho cultures and Pedi beliefs; exposure to cultures in psych especially is very helpful."

- "Um, I think specifically community service, the very rural ones um […] because I was the only person of my background. No one could speak a language I could understand. I had to learn the language. It was fine."

Some respondents felt that the professional development activities offered at their place of work, focussed mostly on developing clinical skills rather than developing cultural diversity skills.

One respondent felt that since qualifying none of the courses she has attended have provided any components that consider cultural diversity as part of the clinical course. She appears not to have been **ready** to hear and understand what was being included about cultural diversity in the course at that time.

- "I think that all the training was clinical, like wheelchairs, substance abuse and group work...all very clinical not anything that related to working with different cultures."

Another respondent felt that the understanding of subtle nuances of culture developed only after working as a qualified occupational therapist. **Experience in the clinical field** is what facilitated this understanding.

- "[…] We received a lot of theory on some of the numerous cultures in our country but I also felt that I learned much more when dealing with the clients .Some of this happened undergrad but most happened after I started working… from different cultures because even people in the same culture may have different cultural beliefs depending on whether they are more traditional or liberal etc."

- "Yes, I have had to deal with patients and their families with difficult culture related issues.....experience in being in a community setting for long really helped me to understand."

4.3.1.3.2 Becoming Culturally Competent

The respondents showed an ability to take the cultural context into account by getting to know their patients and being flexible in their inteventionsas well as use their experiences to become more culturally competent.

Professional Development

Some respondents experience allowed them to appreciate that client centered practice and understanding patients as people by the building of relationships and the use of a therapeutic milieu focussed on the patients, facilitated bridging cultural differences or barriers (Campinha-Bacote, 2002; American Speech-Language- Hearing Association, 2010 ;Goode, 2009). Getting to know the patient as a person allowed them to understand their needs better and allowed them to feel more at ease in asking patients for direction in terms of what was acceptable culturally and meant the errors they made in relation to cultural norms were more easily accommodated. They learnt from their mistakes adding to their cultural competence.

- "Well…I don't know, I think if people are passionate about working in a community or if that's what they want to do. I will just encourage people to be open minded and to instead of treating people like their

clients …to get to know them as human beings as opposed to just clients with problems that need to fix."

- "If you approach clients with a warm heart, a willingness to learn and try to be sensitive to your client's needs, it won't be a train smash if you get something culturally wrong. Your therapeutic relationship will pull you through and you'll know next time not to do it…and if you are unsure about something, don't be afraid to ask your client!"

The homogeneity of the occupational therapists working in South Africa, the majority of whom are whites females and the fact that one respondent mostly treated patients from her own cultural group were seen as continued challenges to achieving cultural competence.

- "[…] the advantages I have experienced, is having some knowledge beforehand […] I think that is a definite advantage uhm. A lot of people who tend to study OT are very homogenous group you know; white women mostly uhm and I think it's having the education that makes you open your eyes and think […] that you will be working with a diverse population… definite advantages. I don't think there are any disadvantages […]"

- "Difficult to answer because I work mainly within my frame of reference at the moment um... I rarely face it. I mean, every now and then, you know. I have clients with different viewpoints. I don't see it as a problem."

4.3.3 Summary

Despite differences between the respondents' perceptions of cultural competency, all respondents used reflection within their practice that enabled them to consider the importance of culture from their clients' perspective. Respondents described the challenges of working within different cultural contexts and had personal experiences of issues encountered when working within an unfamiliar environment or situation. Respondents expressed that all opportunities or modes of developing cultural competency should be used to develop cultural awareness and

to strive toward becoming culturally competent. These ranged from classroom experiences, fieldwork exposure, and professional development activities. The importance of having relevant resources available to students and therapists was highlighted. These were highlighted as valuable in providing information and guidance to therapists that may reduce potential cultural barriers that could be encounter and may eventually lead a therapist closer to becoming culturally competent.

CHAPTER 5
DISCUSSION
PART 1, PART 2 AND PART 3

The inclusion of cultural diversity in the occupational therapy student undergraduate training in South African universities will be discussed as well as the perceptions of newly qualified occupational therapists completing their community service about their training in cultural diversity and their cultural competence.

A sample of South African universities who answered the questionnaire about cultural diversity in the curriculum may not have been representative. The sample was heterogeneous in terms of their history with two previously all white Afrikaans language universities and two English language universities included (Figure 4.9). The other two universities were set up specifically for other race groups although instruction was in English. All these universities are now open to all races and have mixed classes although the majority of students still reflect the race groups for whom the universities previously existed. This is in line with university registrations reported for 2007. Even though the enrolment of African students has increased since 2004, the ratio of white student graduation rates is still higher than African students. Coloured and Indian students remain underrepresented in the public higher education system (Cloete, 2009).

This distribution was reflected in the respondents for the study, the majority of who were white and came from the two English language universities and one Afrikaans language university.

Although this sample was representative of the community service occupational therapists working in Gauteng at the time of the study it indicates the continued imbalance of trained professionals across the race groups in South Africa (Boughey, 2010). This distrubution of respondents provides information from the perspective of mainly one race group in South Africa (Figure 4.8) and is therefore not represenative of the entire South African population. Results should be considered in this light and may not be generalisable to other provinces in South

Africa where the racial distribution of newly qualified community service occupational therapists differ.

The all female sample is reflective of the occupational therapists in South Africa as this profession is female dominated as in other Commonwealth countries (Grant, Robinson and Muir, 2004).

5.1 Addressing cultural diversity in the curricula

Objective1 is discussed in relation to a review of the teaching of cultural diversity training and the adequacy of this training in the occupational therapy training centres in South Africa as the course content for this aspect was not available. The perceived adequacy of the training of occupational therapy students and the factors affecting the development of cultural competency are discussed in relation to objective 2.

5.1.1. Inclusion in the curriculum

Educators in occupational therapy have an important role in enabling students to become aware of their own cultural identity and the need to be sensitive to cultural differences of their patients and the implication of this in therapy (Yeun Yau, 1999). According to Jeffreys (2006) the development of cultural competency should be a seamless thread within the curriculum and all universities in South Africa that responded to the questionnaire on the inclusion of cultural diversity in the curricula indicated that this is the case. Cultural diversity training is interwoven throughout the occupational therapy curricula in structured and unstructured modules and specific courses (Figure 4.1) (Jeffreys, 2006).

Although 33% of the universities have no formal coursework related to cultural diversity at all (Figure 4.1) the respondents indicated that the staff rely on the emergence of a theme of cultural differences during tutorials and reflections after fieldwork. The variation in the formal hours for teaching cultural diversity reported by the university respondents may also be the reason for the limited curricula content made available to the researcher (only 33% of respondent universities were willing to provide the researcher access to their curricula). It is possible that as most of the cultural diversity training does not occur in formal

teaching hours dedicated to the topic, no curricula which reflect the content of what is taught are available. This made it difficult to comment on the adequacy of the discipline specific cultural diversity training and contemporary strategies provided to South African occupational therapy students. The curricula content made available to the researcher contained a broad range of subjects and module codes that did not highlight where cultural diversity was taught.

Formal cultural diversity training that was presented directly or indirectly was done so in a combination of formal lectures, PBL sessions, group discussions and other supplementary sessions (Figure 4.4). The different teaching methods used in between 100% - 33% of universities were aimed at imparting knowledge and understanding about the theory and characteristics of culture as well as providing students with awareness of their own cultural identity (Awaad, 2003a). These teaching strategies were supported by international trends in the literature that indicate that more indirect approaches which include active student participation, open discussion, fieldwork experiences, case studies, and problem-based learning applications are the best methods of teaching cultural diversity (Ekelman, et al., 2003; Yeun , Yau , 1999). There is however no definite agreement on how best to provide cultural knowledge and skills (New South Wales Health Department, 2010).

The teaching strategies used by the respondent universities did not include cultural diversity as the primary objective of the lesson and may account for the discrepancy in the number of hours the university respondents reported. Only one university reported having a timetabled course that specifically related to cultural diversity in the first year of study, with 50% of the others reporting short introductory courses in this year. Cultural diversity was not taught in a direct or indirect way in first year in the other 33% of respondent universities.

This is of concern as White (2010) found that few first-year occupational therapy students had negative attitudes towards other cultures when she assessed them at this stage in an experimental cultural learning programme. While all the community service occupational therapists in the study agreed that they had received training in cultural diversity (Figure 4.10), only 73% indicated that they were introduced to cultural diversity in their first year and 8% reported that it was addressed throughout their course (Figure 4.12). Between 33%-17% of the

university respondents reported cultural diversity training was continued for between one and eight hours in the second to fourth year of training. This later training has also been shown by White (2010) to be important as she found that knowledge and attitudes achieved in first year were not sustained indicating a need for the cultural training to be continued in later years.

It appears that educators at the universities use consistent learning opportunities and teaching strategies to encourage critical thinking and develop problem-solving skills to impact on the attainment of cultural competency by weaving it throughout the curriculum (Jeffreys, 2006, Campinha-Bacote, 2002).

Respondents from the universities were aware that learning styles are as individualised as worldviews and the way in which the individual student learns influences how they assimilate information; an important aspect to knowledge acquisition. Making sure students are aware of the out of sight knowledge of culture or “deep culture” cannot be achieved by providing knowledge about cultures in an attempt to break down stereotypes (Hanley, 1999, Mason, 1995). This is because cultural competence training is more than passing on knowledge of cultural diversity (Bussema and Nemec, 2006) and should include self–reflection and discovery (Camphinha-Bacote, 2002) as well as application in the clinical situation. Training of occupational therapists in South Africa according to exit level outcomes set by the HPCSA should result in students having bothan awareness and sensitivity towards cultural differences as well as the ability to reflect on their biases and the impact this will have on the relations and interactions with clients and other staff (Health Professions Council of South Africa, 2006).

All the universities reported using formal and informal reflective learning (Shin,1999) in relation to cultural diversity with 83% reporting this was formally included in the course. This provided students with learning opportunities to acquire, practice, and develop skills in culturally appropriate practice (Muńoz, 2007) which is eventually achieved by a process of conscious self reflection (Wells, 2005). Some of this reflection was facilitated in the context of fieldwork and seven methods of reinforcing cultural diversity in fieldwork were reported when training students in this study. Only 17% of the universities however made use of reflective methods

like portfolios and reflective logs in conjunction with fieldwork to encourage students to reflect on their own cultural viewpoints.

The use of fieldwork to integrate cultural diversity, (an essential element in the intercultural learning experience (Whiteford and Wright St -Clare, 2002)), was reported to be used by all of the universities as their students were exposed to patients and clients of different cultures in different contexts. While the students gained experience in clinical practice, other formal methods of reinforcing cultural diversity in clinical fieldwork were provided. Discussion groups, tutorials, and lectures were used by between 17%-50% of the universities to prepare and assist the trainee therapists in addressing cultural differences in intevention with patients. (Suarez-Balcazar et al, 2009).

The most common method of reinforcing cultural diversity in fieldwork reported by 66% of universities was achieved in facilitating the selection of treatment modalities, confirming the specificity of the cultural diversity training to occupational therapy (Figure 4.5). This suggests that cultural diversity training is tailored to the profession. This way of teaching cultural diversity is in line with the opinion of Jeffreys (2006) who feels to achieve cultural competence, cultural diversity training should be adequately integrated within the curricula to provide students with the necessary tools for them to develop an awareness of cultural differences. Evidence within the literature supports that an integrated curriculum serves as a platform from which students can draw from a knowledge base to explore their own preconceived views of cultures different to their own and to transcend these views through self reflection (Muńoz, 2007, Bussema Nemec, 2006, Awaad 2003a, Suarez-Balcazar et al. 2009, Camphinha-Bacote, 2002).

This opinion is in contrast with the university respondent who felt that cultural competence and diversity shouldn't be as profession specific and that a generic course with health sciences to address the topic related to disability as a whole would be preferable. Literature cautions against this generic approach in teaching cultural competency. Discipline specific training is recommended (Nochajski, Matteliano, 2008) as integrating cultural diversity training within the curricula enables occupational therapy students to link the relevance of cultural diversity training within clinical practice and not see it as "isolated" or "abstract" (Nochajski

and Matteliano, 2008). Thus the knowledge provided and the reflection and skills practiced should relate to the context of occupational therapy and the impact of culture and cultural differences on occupational performance.

5.1.2 The adequacy and effectiveness of cultural training

The adequacy of the training used by the universities to prepare their students to work within culturally diverse communities is discussed in relation to the reported comments of the university respondents and the community service occupational therapists.

Problems with the perceived adequacy of cultural diversity training were related amongst over things to the vast discrepancy in the formal hours allocated within the courses at the various universities to this training. Only the university respondent that reported seventy hours of formal training in first year felt the training was adequate (Figure 4.2) as it was an area focussed on in training. One respondent felt that just by studying occupational therapy, the development of an understanding of cultural differences and competence would be supported by the philosophy and constructs of the profession, which makes it easier to facilitate cultural competence in the training.

In contrast 73% of the community service respondents (Figure 4.11) indicated that they felt cultural diversity training at their university was adequate**.** The same percentage of community service respondents indicated that cultural diversity was introduced in their first year of study. This is in line with the recommendations of Nochajski and Mattelino (2008) who suggest that at the very least the exploration and understanding of the students' own culture should be taught in the first year of occupational therapy training or in the undergraduate course students complete before starting occupational therapy in the United States. South African students usually enter occupational therapy training straight from school as the initial training is an undergraduate degree. The introduction of these concepts in first year is essential if students are to become culturally aware and have cultural knowledge (Nochajski and Mattelino 2008).

The 27% of community service respondents who felt the training was not adequate reported information and knowledge received was superficial and they felt

unprepared for dealing with other cultural groups. This was supported by the university respondents who indicated that the training on cultural diversity was inadequate and suggested that there is a need to review the teaching of cultural diversity training with more time and attention being allocated to this in training to increase the cultural encounters the students experience (Campinha-Bacote, 2002). They also felt that students were not overtly and consciously being made aware of their own worldview in relation to that of other cultures. This was possibly due to the lack of a formal curriculum and course in cultural diversity to support the other teaching strategies used in imparting this concept.

These finding highlight the need for a review of the teaching of cultural diversity in all first year occupational therapy curricula as evidence within the literature suggests that a lack of knowledge in cultural diversity may lead to conflict when working with clients from different cultural backgrounds (Muńoz, 2007).

While 83% of university respondents involved in the study reported several challenges in the effectiveness of the training provided in cultural diversity, they felt this was also related to the facilitation and development of cultural competence in students (Figure 4.8). The inclusion of cultural diversity in the curriculum cannot ensure that students gain knowledge and experience that will result in cultural competence. In line with the Model of Cultural Competence (Campinha-Bacote 2002) opinions expressed by university informants revealed that students showed poor social desire and tended to relate superficially due to their lack of willingness to connect with in depth discussions on cultural diversity. They presented with stereotypical views affecting their skill in dealing with patients.The attitude of the occupational therapy students affected their willingness to address their lack of knowledge and the lack of their own cultural awareness. Twenty percent of university respondents reported that the general attitude of students toward cultural diversity was a barrier (Figure 4.8).

This may be related to the different levels of readiness of students when addressing issues relating to cultural diversity that the university respondents pointed out. The fact that occupational therapy students in South Africa usually start their training as they finish 12 years of schooling means they often have very little life experience. Maturity amongst other qualities has been shown to be a predictor

of cultural competency (Kawashima, 2008). Respondents from the universities reflected concerns about the knowledge students had about other cultures as well as the maturity of the students and their ability to understand the importance of their own cultural awareness and cultural diversity in occupational therapy (Campinha-Bacote, 2002). This is supported by the finding of Gordon (2006) in a study on physiotherapy students where problems attaining cultural competence were related to “students immaturity, the lack of diversity experience and student resistance to cultural pluralism” p 187 (Gordon, 2006).

One aspect that university respondents reported on that facilitated the development of an understanding of cultural differences was the cultural mix of students in the occupational therapy classes. This mix of races and cultures has occurred since universities have been allowed to admit all race groups since democracy in 1994. This is not the case however in all occupational therapy training in South Africa where the legacy of different race universities still lingers at some universities with most classes having a majority of students of the race group the university served under the Apartheid government (Cloete 2009). Therefore this may not be an advantage at all universities. There is also a lack of opportunity for some students to mix with students of other racial groups as many of these groups still live in separate areas.

The effectiveness of the training and the maturity of the students in assimilating the necessary skills was also reflected in the perception of the community service occupational therapists, 73% of whom reported that they found difficulty in working with other cultures (Figure 4.13). This finding was similar for respondents from all three universities where the majority of the community service occupational therapists had trained at and appears incongruous in view of the number that reported adequate training in cultural diversity (Table 4.1).

This possibly relates to the need for awareness and experience of different cultures during training to be accompanied by a process of conscious self-reflection about culture of clients. It is essential in guiding occupational therapy clinical practice if culturally appropriate decisions are to be made (Muńoz, 2007, Wells, 2005). This can only be assessed by observing and reflecting on therapeutic outcomes and linking this to client adherence (New South Wales Health

Department, 2010). In this study only 57% of community service therapists reported that they continued to use reflective learning strategies in their practice. More community service respondents that graduated from English medium when compared to Afrikaans medium universities reported that they still use reflective learning strategies in relation to their cultural competence.

It appears that confidence in working in a culturally diverse client group needs to be facilitated after graduation and that maturity and experience are needed to consolidate the learning that occurs at university (Yanget al., 2006, Murden et al., 2008).

5.2 Cultural competence of newly qualified community service occupational therapists

Objective 3 relates to the cultural competence of the novice community service respondents which was considered using priori themes based on the Model of Cultural Competence (Campinha-Bacote 2002). The reflections of the 47 newly qualified occupational therapy graduates indicate a diversity of views that support their comments above about their training and their ability to practice in relation to their percieved cultural competence.There were diverse views about whether their training and the exposure to other cultures they had were sufficient to provide them with the base needed to become culturally competent.

5.2.1 Cultural awareness and knowledge

Most respondents reported that their experiences as students allowed them to develop an awareness of their own cultural identity (Awaad, 2003a) and appreciation that there were differences in others they encounted in their learning and work environment.

The respondents continued to express a concern about understanding the differences they saw in others. This may be related to their lack of knowledge, reflective practice and experience. It is difficult to assess since no clear picture about how much exploration of their own cultural identity through reflection, stereotypical viewpoints and understanding of their own biases (Awaad, 2003a, Balcazar, Suarez-Balcazar and Taylor-Ritzler, 2009) was obtained. A lack of deep

reflection in terms of cultural diversity for occupational therapy students as reported by the university respondents is however consistent with the abilities of newly qualified occupational therapists (Schell, Crepeau and Cohn2003)

There were certainly some respondents who showed very little reflection and insight into the need for cultural awareness and knowledge and who indicated they did not feel the need to learn about other cultures because they did not treat a diverse patient group or because they felt they had all the information they needed. These respondents indicated that they were not willing to engage in diversity and awareness issues and may be aware of their own biases and view of other cultures (Jones et al, 2004). The respondents with these attitudes may be considered culturally blind on the continuum of cultural competence described by Cross (1989). They appear unlikely to reflect on the changing and many sided identities clients may present with as globalisation affects perceptions and membership to a single cultural group (Watson 2006). They may not consider changing cultural differences in each client and accommodate their cultural strengths into their therapy (Cross 1989).

Being culturally aware is an important step which should be developed by the time the occupational therapist starts their community service practice. This awareness should lead to a process of change from within the therapist, supported by knowledge and understanding in assisting them tto deliver culturally responsive health care to patients or clients from diverse backgrounds (Majumdar et al, 2004).

The repondents however differed in their perception of their knowledge and understanding of the theory and characteristics of culture, including behaviours of clients related to health-related practices. Opinions were split about the depth and adequacy of the information they had received. The majority of community service respondents perceived the knowledge they were given during their training as adequate. This training in some centres was extended by cultural activities outside of clinical training, but most knowledge was gained from exposure to patients and colleagues of other cultures which was reported as providing the greatest opportunity in developing an awareness of their own and others cultural differences as well as gaining knowledge about other cultures. It must be remembered though that for the most part newly qualified therapists in this study who practice in

Gauteng, work in health care settings which means they may not be exposed to the patients' own context or neighbourhood which can limit their knowledge and understanding of the patients' culture (Nochajski and Mattelino 2008).

Although some students felt they had had adequate opportunities to treat patients from other cultures this was not true for everyone. This may be due to the limited number of adequately accredited clinical training placements available to occupational therapy training centres in South Africa (Emslie 2012). This means that students may be placed in sites where there are a limited number of clients or a very homogeneous population of clients.

For those newly qualified respondents who felt that their knowledge was inadequate, they indicated that this was an aspect that needed to be better addressed in the curriculum in a formal way. One respondent felt they were given information which encouraged stereotyping of activities according to patients' gender and culture. She adhered to the rules about the use of activities and set taboos about actions with no understanding of what and why this should be. This places some respondent on a level of cultural pre-competence as the willingness to engage and change has been made without the understanding and integration of the knowledge gained into the practice and philosophy of occupational therapy (Cross 1989).They realised that there is a limited amount of information that can be assimilated during their training and that they would have to use other resources to obtain knowledge. They indicated that a lack of time and suitable resources were a hindrance in following this course.

One aspect that was singled out as particularly important in terms of affecting the cultural knowledge was the lack of knowing an appropriate language in which to communicate with their patients. Newly qualified community service respondents felt that the inclusion of a language course in their training would have helped. Although five of the eight medical schools in South Africa have offered a course in the indigenous South African language most commonly spoken in the area in which they operate since 2003 (Levin 2011), this has not extended to all the occupational therapy courses. Some respondents in this study recognised the challenge presented by the different languages spoken in South Africa as an

opportunity to increase their language skills in order to overcome cultural differences.

5.2.2 Cultural Skill and Encounters

Forty one percent of community service occupational therapists identified language as a barrier in working with diverse cultures and the lack of a common language as one of the greatest barriers in obtaining cultural information from a client and affecting the ability to carry out the assessment process in a culturally appropriate manner (Chipps, Simpson, Brysiewicz, 2008).Being able to talk a common language was considered an essential cultural skill in improving both the satisfaction of the patients and decreasing frustration levels for health care workers. Being able to speak to a patient directly, overcomes challenges and barriers related to effective communication, and eliminates the need for a translator as errors made in the translation process have been found to be important causes of miscommunication when dealing with patients (Levine 2011).

Newly qualified community service respondents reported similar problems when working through a translator especially in a resource challenged country like South Africa, where translators are others members of staff not employed or trained for the role of translating. Levin (2011) suggests that if another language is not taught then translators and the skill of using translators in courses like occupational therapy where cross-cultural and cross-language communication is used, should be taught. Reducing language barriers is essential for health service delivery if misinterpretations of treatment which lead to reduced compliance and health outcomes are to be reduced (Wieslaw, 2009).

The respondents also identified a reduction in compliance and a lack of understanding of the occupational therapy programmes due to problems with language and differences in nonverbal communication. This was reported as affecting the treatment process which becomes compromised when therapists struggle to integrate cultural considerations (Suarez-Balcazar, Suarez-Balcazar and Taylor-Ritzler, 2009) within the occupational therapy process.

The ability to provide advice, accommodate appropriate activities of daily living and choose appropriate therapeutic activities was compromised by a lack of

communication. Respondents felt this resulted in clients not understanding what was required and not being compliant with treatment.

Thus the respondents' cultural skill was mostly at a pre competence level in dealing with the beliefs of patients based on different philosophies and the expectations the patients had of occupational therapy. Although well aware of difference they were still not sure how to accommodate for these in therapy. (Cross 1989) This level of pre competence may have been affected by the fact that occupational therapy practice in South Africa is based on Eurocentric world view and the majority of the respondents in this study were white making it challenging for them to develop the cultural skills needed to accommodate and adjust to the African worldview of the majority of their patients (Joubert 2003).

Community service occupational therapists have had different experiences in working with culturally diverse patients at undergraduate level and since qualifying. A few community service occupational therapists respondents felt that they received adequate exposure to different cultures at undergraduate level during their fieldwork placements at government and private hospitals in both rural and urban settings. They identified the cultural encounter as most beneficial to developing awareness of the need to be culturally competent and the need to respect the cultural difference of their patients (Camphinha-Bacote, 2002,Rochon, Baptiste, 1988, Watson., 2006). The majority however still felt they had difficulty working with patients of other cultures. They felt that they did not have answers for the everyday problems they faced in terms of cultural issues as newly qualified community service therapists. They admitted to feelings of incompetence and frustration because of this.

The use of clinical reasoning was seen as the solution to overcoming the challenges related to cultural competence and that continued encounters with patients of different cultures would assist in this process. Experience in the clinical field and contact with colleagues of other cultures was viewed as important for continued growth in cultural competence.

Fifty nine percent of the newly qualified community service occupational therapists describe self-directed ways they used to reducing cultural barriers. Some therapists used cultural encounters with staff and clients as a facilitator to improve

their own knowledge and understanding by asking questions and discussing aspects they did not understand. Other therapists saw increasing their vocabulary in another language as a means to reduce language barriers. Reading about a particular culture was also seen as an enabler. This indicates that some may have reached a level of cultural competence within the context they were working in.

5.2.3 Cultural Desire

Therapists should want to engage in cultural encounters, extend knowledge of different cultures and aspire to become culturally skilful (Campinha-Bacote,1999, Ekelman et al, 1999). The respondents in this study varied in their attidude in wanting to achieve this goal as some of them felt this was not necessary for their practice. Other respondents reportedactively seeking information to improve their ability to deal with cultural difference and also reported reflecting on what they learnt and experienced in parctice.

Most newly qualified community service occupational therapists highlighted the importance of being interested in working within the community and the willingness to learn about other cultures. Reflective thinking however is an important aspect in developing cultural competence (Odawara 2005), if therapists are to continue on their journey of providing culturally appropriate intervention as they become more experienced. It seems that for some the training and knowledge they received has set them on the right path but this was not true for all newly qualified respondents. Both this cultural desire and reflection are seen as a catalyst to developing cultural knowledge and becoming culturally competent.

In this study it was apparent that all the factors that influence the training in cultural diversity and the development of cultural competence had resulted in students leaving the course at different levels on the continuum described by Cross et al, (1989). Respondents perceptions fell into the the categories of“cultural blindness”, “cultural pre-competence” with none reporting “cultural proficiency”.

This is the expected level for novice newly qualified occupational therapists to have achieved as they are still dealing with the application of theory and are not yet proficient at adapting therapy to the contextual factors(Schell, Crepeau, Cohn 2003). It would appear though that these newly qualified therapists did demonstrate

some of the expected exit levels outcomes in terms of cultural competence set by the HPCSA in that they had achieved an awareness of cultural, gender and language differences and were tolerant of these. Other factors mentioned in these outcomes like socio-economic, political, and other diversity issues in the South African context were not specifically mentioned by any respondents.

Although some respondents reported using reflective practice not everyone appeared to be aware of their own biases and the impact of this on therapy and therapeutic relationships (Health Professions Council of South Africa, 2006).

5.3 Limitations of the study

Numerous attempts on behalf of the researcher were made to engage the two remaining universities who did not initially agree to participate in the study but no response was received including the return of the consent form declining participation in the study.

The researcher was unable to access the course content of each participating university. The thirty three percent that were obtained were not included due to inferences that could be drawn as to which university had supplied the information.

The validated Cultural Competence Assessment Instrument (CCAI) for assessing cultural competence in occupational therapists was only developed by Suarez-Balcazar et al. (2008) in 2008 and not published until later. Thus there was no valid standardised questionnaire for the assessment of occupational therapists available at the time Part 2 of this study was completed.

The number of newly qualified community service participants, while not a small sample for a qualitative study, were a homogeneous group and therefore diverse views from participants of different cultural groups was not achieved. The information was not based on verbal responses so no prompts could be used to extend the data (Cresswell, Fetters and Ivankova 2004).

5.4 Summary

In accordance with international suggestions occupational therapy training in South Africa at all universities that responded to this study are training students in cultural diversity at some level and all newly qualified community service respondents reported having received some training. (Suarez-Balcazar et al, 2009). Methods used to present this information concur with suggested teaching strategies which allow for the transfer of both knowledge and experience of different cultures.

Hours formally allocated to the teaching of cultural diversity differ amongst universities but the theme was interwoven through all the curricula adding to the development of cultural competence within the profession of occupational therapy. Formal and informal teaching strategies were included that reinforcedcultural issues in fieldwork.

It is of concern that the awareness of cultural issues is not provided early at all the training institutions some students therefore do not benefit. Students should be provided with opportunities to gain experience and internalise the concept over a period of four years.

Although the majority of newly qualified community service occupational therapists felt the training in cultural diversity was adequate, most university respondents disagreed and felt more time and attention should be given to this construct. Eighty three percent of university respondents (Figure 4.8) acknowledged challenges with teaching cultural diversity. This was related to lack of time and the students' attitudes, lack of knowledge about other cultures and issues with their ability to reflect. The information gained from university respondents suggest that there is an urgent need to review the teaching of cultural diversity within the curriculum so that current challenges with teaching cultural diversity can be addressed.

Newly qualified community service respondents reported difficulty with working with patients or clients of different cultures even though they felt their training was adequate. Only just over half of them reported that they still used reflective learning strategies in relation to their practice with clients. The development of cultural competence during occupational training may be hampered

by the maturity level of the students. Thus it appears that reinforcement of learning strategies and further training to develop cultural competence is needed for newly graduated occupational therapists in their community service year.

The reported cultural competency level of the newly qualified respondents varied in all the aspects of cultural competence. They felt there were challenges and facilitators in all the different levels with some respondents still needing to develop awareness and knowledge and others already extending themselves in terms of cultural skill, encounters and cultural desire. The respondents still had problems adapting therapy to fit the patients' cultural context and some still used rules and knowledge to guide their intervention and activity choice although they were aware of cultural differences. The use of cultural competency self assessment tools could assist clinicians to gain an awareness of their level of cultural competency (Goode, 2009). Occupational therapists could be better informed of how to work with clients from different cultural backgrounds by increasing their knowledge of models of cultural competency. (Nochajski, Matteliano, 2008)

Language was seen as a major barrier in terms of practicing culturally appropriate occupational therapy. Self directed learning is an enabler to bridge language barriers. Learning basic social phrases to enhance rapport between client-therapist is important. It is an inexpensive way to improve communication in resource challenged environments. The newly qualified therapists also had problems with appropriate intervention in terms of understanding other world views. Universities should include language courses within the occupational therapy curricula that should be link to cultural diversity. In this way, students may familiarise themselves formally with the cultural aspects of communication (Lubinski, Matteliano, 2008). This may assist newly qualified occupational therapist to understand the view points of others.

5.5 Determining change in respondents perception

The fourth objective of the study was to determine the change that occurs in these perceptions after three years of clinical experience. A sample of 13 % of occupational therapists who participated in Part 2 of the study, agreed to participate in Part 3; three years after completing their community service year. Their perceptions in relation to their understanding of cultural competency, reflection on their undergraduate cultural diversity training and community service year and their perceptions of what needs to be considered in the future will be discussed relative to the three themes which emerged from the data analysis.

Due to the very small sample of respondents for this part of the study it was impossible to achieve data saturation. Even after emails were sent a second time no other responses were received. The small sample and the homogeneous nature to the three respondents who were all white females working in private practices affected the trustworthiness of the data. It cannot be assumed that there is limited variation as the richness of the data obtained may be affected (Patton 2002). The following discussion and the results must be viewed in this light.

5.5.1 Understanding cultural diversity and cultural competence

The respondents in this part of the study still viewed cultural diversity as a difference between cultural groups in terms of rituals and as related to different religion and language. They did not include differences according to socio-economic status or the power relationships between the therapists and the patient described as political factors by Sherry (2010). These aspects are considered important by the HPCSA (2009) and an understanding of these aspects is emphasised by Spangenberg (2003) as possibly impacting on the patient establishing a therapeutic rapport with clinicians (Watson 2006,Health Professions Council of South Africa, 2009).

This view of cultural diversity may have been limited by the homogeneous sample who come from a previously advantaged group and who may not be aware of the impact historical and socio-political factors have on previously disadvantaged South Africans (Niemeier, Burnett and Whitaker (2003). It may also be unrealistic to expect compentent occupatonal therapists with only three years of experience to

incorperate such a wide contextual view into their practice (Schell, Crepeau and Cohn 2003).

Although only one respondent defined cultural competency in terms of the specific elements of awareness, knowledge and sensitivity (Campinha-Bacote, 2002, American Speech-Language- Hearing Association, 2010, Goode, 2009) and expressed the opinion that this should be considered before the functional needs of the patient (Kielhofner and Burke 1980). All the respondents did reflect on the need to be sensitive to the patients' culture.

The respondents in this part of the study had become aware of the influence of cultural identity on occupation and the effect this had on the success of therapy and thus adjusted their choice of therapies and modalities to the patient's point of view (Bonder, Martin and Miracle 2004).This showed a change from their views expressed as newly qualified community service respondents, where some respondents were more concerned still with generalisations or assumptions about culture when planning treatment. According to Watson (2006) this is realisation that 'being' precedes 'doing'that leads occupational therapists to "finding answers to the matter of cultural competence" p156 (Watson 2006).

Development of the understanding of the effect of culture in therapy and cultural competence is the responsibility of each occupational therapist and health care workers must have willingness and motivation to learn and continuously extend cultural knowledge (Campinha-Bacote, Yahle and Lanenkamp, 1996). Respondents expressed the need to know more about cultures as an ongoing process but were concerned about the lack of specific resources in terms of culture and occupation in South Africa.

They felt this impacted on their knowledge from when they were students to the present time. It appears that only one book published in 2010 covers any of these aspects (Sherry 2010).The importance of having resources available for occupational therapy in South Africa was further emphasised by the respondents who felt that occupational therapists can never be prepared for all eventualities in their training. Because of the diversity of cultures in South Africa (South Africa Information, 2010), therapists can never know it all or stop learning.

Respondents indicated that they used opportunities that were provided since they had qualified to continue in their learning about cultures with one respondent having learnt another language to communicate with her patients. These respondents were willing to learn and continue to change which supports the work of Niemeier, Burnett and Whitaker, (2003). They state that the updating of cultural knowledge by participating in regular workshops or activities on cultural diversity is a must for qualified therapists (Niemeier, Burnett and Whitaker, 2003) as concepts related to culture should continue to be reinforced after occupational therapists have qualified to develop their cultural competency (Suarez-Balcazar, Rodawoski, Balcazar,Taylor-Ritzler, Portillo, Barwacz, Willis, 2009). Cultural competency enables culturally responsive care (Muńoz, 2007).

Only one respondent reported having no further education related to cultural diversity post qualifying, indicating that most courses offered related to clinical skills rather than this aspect of occupational therapy. This brings up the question of what further education or courses related to cultural awareness and knowledge are available to occupational therapists practicing in South Africa once they qualify. This is important in a country where the effect of the previous segregation of races and socio-economic groups has resulted in little understanding of circumstances other cultural groups live in (Dolby 2001).

Lack of exposure to other cultures in South Africa may be one of the reasons that students and therapists are not always aware of the challenges they will face in working with other cultural groups. One respondent reported difficulty coming to terms with completely different living environments and cultural norms that differed from her own. The respondent recalled experiencing culture shock when working within a culturally diverse community different to her frame of reference indicated that just learning about cultural diversity and being aware of differences in class was not adequate preparation for entering a community with a different worldview.

None of the respondents brought up the concern within the South African occupational therapy literature about the Eurocentric worldview used in the training of occupational therapists in this country (Joubert 2005). This may have been related to the sample and their own Eurocentric worldview related to their cultural group. It appears that the understanding on this level may be outside the

understanding of occupational therapists with only three years of experience. They still need to develop a deeper understanding of the overall picture in relation to cultural contexts which may only develop as they become experienced occupational therapists with more years of reflective practice (Schell, Crepeau and Cohn 2003).

5.5.2 Preparing for practice

Literature emphasises the sharing of cultural experiences as an essential part of occupational therapy education for students to learn about their own and others differences. This should be more than the gaining of knowledge of culture (Bussema and Nemec, 2006). Looking back the respondents felt that attitude, perhaps seeing oneself as superior, was the greatest barrier to students and newly qualified therapists becoming culturally aware and gaining knowledge. Exploration and openness to understanding and using this knowledge in discovering their own biases (Camphinha-Bacote, 2002) and for application in the clinical situation (Awaad 2003, Balcazar, Suarez-Balcazar and Taylor-Ritzler 2009) should be the outcome achieved by therapists in terms of cultural competence. Respondents reflected these principles in their interviews as they felt students and new graduates should be encouraged in an open attitude to discussing and learning about cultural issues.

Cultural desire or the willingness to want to engage and become culturally skilful must be present before any headway can be made in starting the progression towards cultural competence (Campinha-Bacote, Yahle and Lanenkamp, 1996). One respondent had noted that this open attitude was not always present in students and some students were reluctant to address or reflect aspects such as other religions. This is confirmed by the lack of cultural desire or cultural blindness still reported by some newly qualified community service respondents. Literature indicates that cross-cultural exchanges can raise personal and ethical dilemmas (Muńoz 2007).

It is important therefore that occupational therapy students and newly qualified therapists are guided and given information so they have adequate knowledge prior to being asked to discuss or reflect on cultural aspects. Discussion and reflection on these issues should then be in a non threatening facilitated

situation so they do not withdraw from the learning situation. Due to the past history of discrimination and segregation in South African some aspects of cultural diversity may need to be approached with more care as there may be sensitivity to terms of ethnicity, race, population group or tribe as these terms have been and are prone to misuse or abuse (Tambo, 1997).

Unlike some reports from newly qualified community service occupational therapists, in hindsight all three respondents did feel the preparation and training they were given in terms of cultural diversity as students was adequate. Training in cultural diversity is essential if students cross cultural conflict in the occupational therapy process is to be avoided (Muńoz, 2007).

The occupational therapists that have had this training have increased levels of cultural understanding improved by both formal and informal education. Respondents agreed that the training centres had provided adequate formal knowledge. It was however the more informal experience in fieldwork placements which respondents felt most contributes to the preparation and consolidation of awareness of diverse communities and knowledge in working within a range of diverse cultures and languages. The role of fieldwork practice in developing cultural diversity has been established (Yeun and Yau, 1999) and it is only with exposure and experience that therapists will be able to recognize “deep culture” and not ignore cultural differences. (Ashridge, 2006).The understanding of the hidden, “deep culture” allows a therapist to move towards becoming culturally competent, (Suarez-Balcazar et al, 2009).

5.5.3 Developing cultural competence

Culturally competency according to Watson (2006) is the belief occupational therapists have in occupation and their desire to serve will lead them to reach out to the ‘being’ of patients. This means recognizing the person in the patient and adjusting the therapy (“doing”) to accommodate them in a negotiated partnership within which a mutually agreed on intervention plan is implemented.

This is the connection described by the three respondents in this study as they had come to this realisation and all of them emphasised success in dealing with cultural difference was as a result of seeing the patients as the person first. It is

this connection that assists in overcoming cultural limitations (Watson 2006). Respondents indicated it was their clinical experience that allowed them to find some of the answers and to real understanding of the importance of getting to know the patient as a unique person. This improved their practice as they felt this real understanding of client centredness that they had developed improved their cultural skilland resulted in a therapeutic relationship of give and take. They could learn from mistakes related to cultural differences they made as the trust within the relationship allowed for this. They also felt at ease asking patients what they could and could not do in terms of their culture. These concepts are supported by the literature which indicates theimportance of relationships in achieving culturally sensitive care (Muńoz 2007, Odawara 2005) and that the development of cultural competence is related to the therapist's skill in building relationships with their patients.These respondents could be considered to have reached a level of cultural proficiency within the sphere of individual patient treatment (Cross 1989) and had achieved professional development in terms of flexibility and being able to appreciate the patients' context (Schell, Crepeau and Cohn, 2003).

Since all the respondents were in private practice and saw patients on an individual basis they did not comment on community cultural competence or other aspects of cultural competence related to the health care system like the availability and use of translators and the satisfaction of the patients in relation to their practice.

Respondents were however aware of challenges that still exist in occupational therapy in South Africa in terms of providing a culturally competent sevice. One respondent felt that the disproportionate number of white females in the occupational therapy profession in South Africa presents a problem in that they mostly work with cultures that are different from their own. Although these respondents have treated patients from many different backgrounds in their community service year most are now in practices that can only be accessed by patients with sufficient resources. This is either the patient's own financial resources or support from bodies like the Workers Compensation Fund (Department of Labour 2012).

They probably see few disadvantaged patients. One respondent working in a private practice was not dealing with many patients from cultures other than her

own. Thus as discussed above in 6.1 no concerns about the power relationships within the therapeutic relationship in view of socioeconomic and past political and segregation issues were brought up by these respondents.

5.6 Summary

Respondents related their understanding of cultural diversity and cultural competency in terms of differences between cultural groups, races, religion and language and that these were important considerations within a treatment context (Awaad 2003, Balcazar, Suarez-Balcazar and Taylor-Ritzler 2009).The respondents descriptions of cultural diversity and cultural competency did not reveal significant insight into their personal views of the influences of socio-economic, power relationships and political factors they may have encountered while working within different cultural contexts. However they all expressed the importance of being prepared prior to engaging with different cultures. This meant being open to learning about differences in others, reflecting on personal biases and being willing to change these perceptions (Campinha-Bacote, 2002, Yahle and Lanenkamp, 1996). Having the right attitude was seen as important in moving toward becoming culturally competent.

CHAPTER 6
CONCLUSION

In conclusion, I would like to revisit the “statement of the problem” in the introductory chapter that turns on South African trained occupational therapists working with individuals from diverse cultural backgrounds. The study emerged into three distinct streams.

The aim of the study is to determine if the training in cultural diversity offered in occupational therapy courses supports the newly qualified community service occupational therapist perceptions of their cultural competence. The perceived changes in their perception of the use of cultural information and cultural competence after three years of clinical experience will also be investigated

6.1 Objectives of study

To review the curricula of the eight occupational therapy training centres in South Africa in terms of cultural diversity training

In Part 1 of the study six occupational therapy training centres participated in the study. It was found that occupational therapy programmes in South Africa offered cultural diversity training in three different ways. Cultural diversity training is interwoven throughout the curricula; attention being given to the emergence of themes within cultural diversity that occurred within modules and other units or specific courses.

The findings revealed differences in opinion that emerged amongst university respondents’ who participated in the study where half felt that cultural diversity training was not adequately addressed and some of university respondents articulated personal challenges they experienced during teaching cultural diversity while 17 % did not. Challenges were identified as lack of indigenous knowledge, stereotypical views, time constraints within the education programme and the general attitude of occupational therapy students to cultural diversity training. There was a significant difference in time allocated to teaching cultural diversity from first year to fourth year. Fifty percent of universities allocated 1 ½ to 6 hours in first year

while another university reported an allocation of 70 hours in first year. Overall 66 % of universities allocated time toward teaching cultural diversity.

Training centres need to review the teaching of cultural diversity within their curricula in view of the results obtained where 83 % of university respondents reported a range of challenges influencing the teaching of cultural diversity.Training centres need to be aware of the importance of this aspect to equip the students with a knowledge base from which to reflect on their readiness to becoming culturally competent.

To determine perceived adequacy of this training from novice newly qualified community service occupational therapists as well as the factors affecting the development of cultural competency.

In Part 2 of the study, seven universities were represented with a response rate of 80.85 %. The data revealed that 73% of respondentsperceived their training and exposure to cultural diversity within their course as adequate. They felt that this enabled them to be able to work with clients from different cultural backgrounds to their own. The data obtained regarding the teaching of cultural diversity correlated with data obtained in part 1 of the study. Even though 8% of the respondents were unsure of when it was introduced into the curriculum, all agreed that cultural diversity training was included in their training.

Fifty seven percent of respondents reported challenges when working with diverse cultural groups. These challenges emerged because novice community occupational therapists had varying levels of understanding of cultural knowledge, cultural skill and cultural encounter experiences. One hundred percent of the university respondents reported the inclusion of self reflection as a teaching strategy that is introduced through either formal or informal learning tasks; yet only 73% of respondents used self reflection in their clinical practice to guide their decision making processes.

Training centres need to be aware of this aspect and should reinforce the importance and value of reflective practice in developing cultural competency and not only the benefit it has in developing knowledge and clinical skills.

To determine using the Model of Cultural Competence how novice newly qualified community service occupational therapists perceive their own cultural competence

The Model of Cultural Competence (Campinha-Bacote, 2002) was used to compare how novice newly qualified community occupational therapists perceived their own cultural competence. The reflections of 47 newly qualified occupational therapy respondents were analysed and revealed a split in responses. Some respondents felt that they knew enough about cultural competency or knowledge of other cultures was not relevant to their clinical situation. Otherrespondents felt that they had cultural awareness that developed through personal experiences or through their undergraduate training andsome felt they had limited knowledge. Language barriers were the most widespread challenge experienced. The need to know and learn and asking others when unsure were identified as important in developing cultural competence. A few respondents suggested that increasing one's vocabulary in an unknown language could reduce communication issues and extending ones exposure to cultural events or activities could develop cultural specific knowledge.

Training centres who do not have time allocated to teaching cultural diversity, should consider the value of having cultural diversity tutorials, modules or units within their curriculum as this may facilitate the occupational therapy student's need to know and learn about other cultures. An example of this is given by one of the respondents who reported the benefits of being exposed to cultural activities outside the traditional curriculum.

To determine the change that occurs in these perceptions after three years of clinical experience.

In part 3 of the study,facilitators and barriers to working with diverse cultures were reviewed three years after occupational therapists completed their community service year. The Model of Cultural Competency by Campinha-Bacote (2002) was used to compare the perceptions of experienced occupational therapists. The findings revealed the importance of cultural desire in working with diverse cultural

groups; where attitude, open-mindedness and willingness to learn about other cultures emerged as being important in their journey to becoming culturally competent.

Organisations need to be aware of the importance of ongoing professional development as a facilitator to assist occupational therapists to develop their knowledge of cultural competency.

6.2 Recommendations

Part 1 and Part 2 of the study validates the importance of the need to review the training students receive in cultural diversity at undergraduate level. The findings highlight the need for further exploration of cultural diversity training to develop a South African theoretical framework from which to introduce and expand cultural diversity awareness and training.

This brings into question the need to develop models of occupational therapy specific to the South African population mix and not necessarily based on the Eurocentric view used presently (Joubert 2005).

The results confirm a significant difference in how challenges were perceived and experienced by educators in delivering cultural diversity training. Furthermore the need for training in cultural diversity during the community service year emerged as important as respondents were not always aware of the potential challenges when working with other cultures due to lack of exposure.

There is a link between culture and a student's learning style; educators need to use a range of teaching strategies (Leighton Lindsay, 2010). This part of the study suggests an urgent need to review cultural diversity training offered within the undergraduate occupational therapy programme.

The role of the educator in the "attainment of cultural competency" and the need for continuous exposure to cultural diversity training after graduation is emphasised by Yang, Shek, Tsunaka, Lim, (2006) and Murden, et al (2008).

The introduction of self assessments or checklists early in the students training may provide valuable insight into their level of cultural competency as they embark on their journey to becoming culturally competent therapists.

Cultural diversity course content and objectives contained in occupational therapy curricula should be made available. The importance of doing this is to make all aspect of cultural diversity training overt to students. Training should be started in first year and continued in all years after that.

Graduated occupational therapists may have different levels of cultural awareness and understanding. The inclusion of professional development activities and access to resource materials for community service occupational therapists may be helpful in reducing cultural barriers. This will enable therapists to continue to develop cultural knowledge and skills.

Educators may have varying levels of expertise in teaching or including cultural competency content within their course (Chisholm, 1994).

. Further research into cultural competency levels of educators presenting the course is valuable.

Fieldwork evaluations could verify how students apply cultural knowledge during fieldwork practice so that training needs can be reviewed when necessary. No one in this study mentioned fieldwork evaluations being used to verify how students apply cultural knowledge during fieldwork practice (Yeun Yau, 1999). Integrating cultural competence within clinical fieldwork is important in developing practical skills. The inclusion of cultural competency within fieldwork evaluation may assist students in identifying their levels of cultural competency (Nochajski, Matteliano, 2008).

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APPENDIX A

ETHICAL CLEARANCE CERTIFICATES

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

Division of the Deputy Registrar (Research)

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)
R14/49 Leendertz

CLEARANCE CERTIFICATE	**PROTOCOL NUMBER M060840**
PROJECT	Assessment of Cultural Competence of Newly Qualified Occupational Therapists in South Africa
INVESTIGATORS	Mrs A Leendertz
DEPARTMENT	Occupational Therapy Dept
DATE CONSIDERED	06.08.25
DECISION OF THE COMMITTEE*	APPROVED UNCONDITIONALLY

Unless otherwise specified this ethical clearance is valid for 5 years and may be renewed upon application.

DATE 06.09.29 **CHAIRPERSON** ..... (Professor M Vorster)

*Guidelines for written 'informed consent' attached where applicable

cc: Supervisor : Mrs D Franzsen

DECLARATION OF INVESTIGATOR(S)

To be completed in duplicate and **ONE COPY** returned to the Secretary at Room 10005, 10th Floor, Senate House, University.
I/We fully understand the conditions under which I am/we are authorized to carry out the abovementioned research and I/we guarantee to ensure compliance with these conditions. Should any departure to be contemplated from the research procedure as approved I/we undertake to resubmit the protocol to the Committee. **I agree to a completion of a yearly progress report.**

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG
Division of the Deputy Registrar (Research)

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)
R14/49 Mrs Alethea Leendertz

CLEARANCE CERTIFICATE	**M120685**
PROJECT	Assessment of Cultural Competence of Newly Qualified Occupational Therapist in South Africa (Previously M060840)
INVESTIGATORS	Mrs Alethea Leendertz.
DEPARTMENT	Department of Occupational Therapy
DATE CONSIDERED	Ad hoc
DECISION OF THE COMMITTEE*	Extension Approved

Unless otherwise specified this ethical clearance is valid for 5 years and may be renewed upon application.

DATE 04/07/2012 **CHAIRPERSON** .....
(Professor PE Cleaton-Jones)

*Guidelines for written 'informed consent' attached where applicable
cc: Supervisor : Mrs Denise Franzsen

DECLARATION OF INVESTIGATOR(S)
To be completed in duplicate and **ONE COPY** returned to the Secretary at Room 10004, 10th Floor, Senate House, University.
I/We fully understand the conditions under which I am/we are authorized to carry out the abovementioned research and I/we guarantee to ensure compliance with these conditions. Should any departure to be contemplated from the research procedure as approved I/we undertake to resubmit the protocol to the Committee. **I agree to a completion of a yearly progress report.**

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES...

APPENDIX B

PERMISSION REQUEST

Date:…….

For attention:……

Dear .....

Permission requested to have questionnaires completed.

My name is Alethea Leendertz. I am currently a registered master's student at the University of the Witwatersrand. My research turns on *Cultural Competency in Occupational Therapy: Perceptions of Newly Qualified South African –Trained Occupational Therapists*

This study is being done due to a dearth of local research that relates to the cultural competency of South African occupational therapists. Newly qualified occupational therapists may be at different levels of understanding cultural diversity and may influence clinical practice.

I would like to invite your department to take part in this study and would therefore like to ask your permission to have the attached questionnaire completed by an occupational therapy academic staff member. The participant completing the questionnaire will not be further involved in the study.

The study will pose no risks to the participant or university. Participation is voluntary and the participant or university is entitled to refuse to participate or may discontinue participation at any time. No costs will be incurred by the university or the participant. Costs relating to postage will be covered by the researcher. The university and participant's identity will remain anonymous and will only be used for data analysis and will be available for inspection to insure quality assurance.

If your institution is willing to participate in the study, I would appreciate it if the person completing the questionnaire would sign the consent form and return it in the

self addressed envelope enclosed. If you wish to have feedback from the project this will be provided at your request.

Thanking you in advance for your participation.

Yours sincerely,

…….

Alethea Leendertz
Occupational Therapist

PERMISSION TO DO RESEARCH

I……., Head of Department of Occupational Therapy hereby

- ☐ Agree
- ☐ Disagree

That the questionnaire may be completed on behalf of the University of……..and understand that the institution's name will remain anonymous in the study.

The name of the staff member designated to complete the questionnaire is .....

Signed:……. Date:.....

……

University stamp.

APPENDIX C

INFORMATION SHEET OCCUPATIONAL THERAPY LECTUER

Dear Colleague,

My name is Alethea Leendertz. I am currently a registered master's student at the University of the Witwatersrand. My research turns on *Cultural Competency in Occupational Therapy: Perceptions of Newly Qualified South African –Trained Occupational Therapists*

This study is being done due to a dearth of local research that relates to the cultural competency of South African occupational therapists. Newly qualified occupational therapists may be at different levels of understanding cultural diversity and may influence clinical practice.

I have been provided with your name by your Head of Department and would like to invite you to take part in this study and would therefore like to ask you to complete the attached questionnaire

The study will pose no risks. Participation is voluntary you are entitled to refuse to participate or may discontinue participation at any time. No costs will be incurred by you. Costs relating to postage will be covered by the researcher. Your identity will remain anonymous and will not be used for data analysis and will be available for inspection to insure quality assurance.

If you are willing to participate in the study, I would appreciate it if you would sign the consent form and return it in the self addressed envelope enclosed. If you wish to have feedback from the project this will be provided at your request.

Thanking you in advance for your participation.

If you have any questions please feel free to contact me at 011-7173701. If you have any ethical concerns please contact the secretary of the Human Research Ethics Committee at the University of the Witwatersrand, Anisa Keshav at 011-71234 or ansia.keshav@wits.ac.za

Yours sincerely,

…….

AletheaLeendertz
Occupational Therapist

CONSENT FORM (OT LECTURER)

Academic staff member consent

I…….hereby

- ☐ Agree
- ☐ Disagree

To complete the questionnaire on behalf of the University of……..and understand that my name and the institution's name will remain anonymous in the study.

Signed:……. Date:

……

University stamp.

APPENDIX D

QUESTIONNAIRE- OCCUPATIONAL THERAPY LECTURER, CULTURAL DIVERSITY

INSTRUCTIONS
Please complete this questionnaire as it relates to your institutions current occupational therapy programme.
Please complete the questionnaire by **15 February** and return it in the enclosed reply envelope. For Attention: ALETHEALEENDERTZ

1. Does your institution offer undergraduate training in cultural diversity?

……

……

……

2. Which courses offer this?

……

……

……

3. At which point of the occupational therapy course is cultural diversity offered?

……

……

……

4. How is cultural diversity addressed within your curriculum taught? (Examples:
Lectures, fieldwork, videos, films, or other media resources.

……

……

……

5. How many hours are allocated to teaching cultural diversity at under graduate level? This excludes clinical fieldwork hours and behavioural science subjects.

……

……

……

6. What challenges, if any, do you experience regarding the teaching of cultural diversity?

……

……

……

7. Do you think that cultural diversity training is adequately addressed within the occupational therapy curricula? Please state why?

……

……

……

8. How is it reinforced in fieldwork?

……

……

……

9. What self reflection is required from the students?

……

……

……

10. Are you willing to provide an outline of your course? YES ☐ / NO ☐

If yes, the researcher will arrange for the outline to be collected from your department.

OTHER COMMENTS?

……

……

……

.....

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.....

APPENDIX E

INFORMATION SHEET (NEWLY QUALIFIED OCCUPATIONAL THERAPISTS

Dear Occupational Therapist

My name is Alethea Leendertz. I am currently a registered master's student at the University of the Witwatersrand. My research turns on *Cultural Competency in Occupational Therapy: Perceptions of Newly Qualified South African –Trained Occupational Therapists.*

I would like to invite you to take part in this study. This research is being done due to a dearth of local research that relates to the cultural competency of South African occupational therapists. Newly qualified occupational therapists may be at different levels of understanding cultural diversity and this may influence clinical practice. Your involvement in this study will therefore provide valuable information.

The study will pose no risks to the participants. Participation is voluntary and the participant is entitled to refuse to participate or may discontinue participation at any time.

No costs will be incurred by the participant/s. All costs relating to postage of questionnaires and focus groups will be covered by the researcher. The participant's identity will remain anonymous and will only be used for data analysis. If you are willing to participate in the study, I would appreciate it if you would agree to complete a questionnaire and attend a focus group. The questionnaire will take 15 minutes of your time and names will not be required so information will be confidential. If you agree to be part of the focus group you will be required to attend for 1 or 2 entire mornings. The focus group will be tape recorded for data collection purposes and will be listened to and transcribed by the researcher. The tapes will be deleted at the end of the research so confidentiality will be ensured.

If you wish to have feedback from the study, this will be provided at your request.

If you have any questions please feel free to contact me at 011-7173701. If you have any ethical concerns please contact the secretary of the Human Research Ethics Committee at the University of the Witwatersrand, Anisa Keshav at 011-71234 or ansia.keshav@wits.ac.za

Thanking you in advance for your participation.

Yours sincerely,

…….

AletheaLeendertz

Occupational Therapist

APPENDIX F

OCCUPATIONAL THERAPIST -INFORMED CONSENT FORM

Delete which is not applicable:

I ……...am able / unable to participate in the study.

Please tick ☑ one of the following boxes:

☐ I am willing to complete the questionnaire at the start of my community service and return by email.

☐ I am willing to participate in a telephonic interview after completing 6 months community service that will be tape recorded.

☐ I do not wish to participate in a telephonic interview but I am willing to complete the interview questions electronically (email) after completing 6 months community service.

I may be contacted by:

EMAIL: …….

TELEPHONE: (Area code)…… HOME:……

Mobile NO:…….

I ……give my consent to participate in the study and I am of the understanding that I can withdraw at any stage of the study.

Signed:……. Date:…….

Tertiary institution where qualification was obtained……..year of graduation……

APPENDIX G

QUESTIONNAIRE - NEWLY QUALIFIED OCCUPATIONAL THERAPIST, CULTURAL COMPETENCY

INSTRUCTIONS

Please complete this questionnaire as it relates to your personal experience of cultural diversity.
Please complete the questionnaire ASAP and return it to WITS OT Dept with the placement supervisor or current OT student.
For Attention: ALETHEALEENDERTZ

Institution at which Occupational therapy programme was completed

☐ Wits ☐UWC☐ Stellenbosch University ☐MEDUNSA

☐ Pretoria University ☐UCT☐ Free State ☐Kwa Zulu Natal

1. Did you receive training or exposure either through formal lectures or informally in working with diverse cultures?
   Please tick ☑ one of the following boxes:

   ☐ Yes

   ☐ No

2. Do you think that you received sufficient training to be able to work with clients or patients from a different cultural background to your own? If no, state your reason.
   Please tick ☑ one of the following boxes:

   ☐ Yes

   ☐ No

Reason…….....

.....

.....

3. At what point of the occupational therapy programme or course was cultural diversity introduced?

Please tick ☑ one of the following boxes:

☐ First year ☐ Third year

☐ Second year ☐ Fourth year

☐ Other

Please specify…….....

.....

.....

.....

4. How was cultural diversity addressed within your training taught?

Please tick ☑ one of the following boxes:

☐ Lectures ☐ fieldwork ☐ videos ☐films ☐ Case discussions

☐ Problem based learning ☐ Group discussions

☐ Other media resources

Please indicate…….....

.....

.....

5. Do you think that cultural diversity training within your course was addressed adequately? If no, state your reason.

Please tick ☑ one of the following boxes:

☐ Yes

☐ No

Reason:

…….....

.....

.....

6. Do you experience any challenges in working with diverse cultural groups? If yes, state your reason.
   Please tick ☑ one of the following boxes:

   ▢ No

   ▢ Yes

Reason…….

7. Do you use personal reflective strategies in clinical practice presently? Please explain your response.
   Please tick ☑ one of the following boxes:

   ▢ No

Reason……

……

……

.....

   ▢ Yes

Reason……

……

……

.....

GENERAL COMMENTS?

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.APPENDIX H

INFORMATION SHEET OCCUPATIONAL THERAPISTS TO PARTICIPATE IN -PART 3 OF RESEARCH STUDY

Dear ……..

You were previously, three years ago invited to participate in a research study, Cultural Competency in Occupational Therapy: Perceptions of Newly Qualified South African – Trained Occupational Therapists (Clearance certificate M060840).

The research project was suspended temporary due to relocating overseas. I would like to invite you again to participate in the last phase of the study.

In summary, I am a registered Masters student at the University of the Witwatersrand. This research project is being done due to a dearth of local research that relates to the cultural competency of South African occupational therapists.

*Part 1*consisted of a review of the Occupational Therapy centres curricula for cultural diversity.

Part 2 consisted of assessing newly qualified occupational therapists personal experience and exposure to cultural diversity in their training

Part 3 will review the perceptions of cultural competency of occupational therapists who participated in Part 2, three years after starting community service.

The study will pose no risks to the participants. Participation is voluntary and the participant is entitled to refuse to participate or may discontinue participation at any time. No costs will be incurred by the participant/s. The participant's identity will remain anonymous and will only be used for data analysis.

If you are willing to participate in the study, I would appreciate it if you would consider:

- Completing a detailed questionnaire and return it to me electronically within one month. The questionnaire will take about 10 minutes of your time and names will not be required so information will be confidential.
- Participating in a telephonic interview for approximately one hour that is at a time that is convenient to you.

Could you please let me know by email at your earliest convenience if you would like to participate in completing the questionnaire and telephonic interview. The interviews will be recorded for analysis purposes and you will be asked to give verbal consent for this.

If you wish to have feedback from the study, this will be provided at your request.

If you have any questions please feel free to contact me at 61 44 7638612. If you have any ethical concerns please contact the secretary of the Human Research Ethics Committee at the University of the Witwatersrand, Anisa Keshav at 011-71234 or ansia.keshav@wits.ac.za

Thanking you in advance for your participation.

Yours sincerely,

Alethea Leendertz

Email: aleendertz@bigpond.com

Mobile: +61 44 7638612

APPENDIX I

PERCEPTIONS OF CULTURAL COMPETENCY OF QUALIFIED OCCUPATIONAL THERAPISTS THREE YEARS AFTER COMPLETING COMMUNITY SERVICE.

QUESTIONNAIRE

Thank you in advance for agreeing to participate in Part Three of the research project. responses will remain confidential.

Please complete the questionnaire and return it electronically aleendertz@bigpond.com

1. For statistical purposes only, which population group do you identify with?

   Click here to enter text.

   ☐ Not willing to answer

2. And again, for statistical purposes, what is your age?

   Click here to enter text.

   ☐ Not willing to answer

3. At which university did you complete your Occupational Therapy qualification?

   ☐ Stellenbosch University

   ☐ University of Cape Towm

   ☐ University of the Western Cape

   ☐ Medunsa

   ☐ Kwa-Zulu Natal

   ☐ Pretoria University

   ☐ Free State University

   ☐ University of the Wiwatersrand

4. Are you currently employed as an Occupational Therapist

☐ Yes

☐ No

5. Describe the type of occupational therapy services you provide.

Click here to enter text.

Thank you for completing the questionnaire.

APPENDIX J

PERCEPTIONS OF CULTURAL COMPETENCY OF QUALIFIED OCCUPATIONAL THERAPISTS THREE YEARS AFTER COMPLETING COMMUNITY SERVICE.

TELEPHONIC INTERVIEW

1. Please describe your understanding of cultural diversity.
2. Please describe your understanding of what it means to be culturally competent.
3. Reflecting back on your undergraduate cultural diversity training or exposure, do you think you were adequately prepared in addressing potential barriers such as communication, understanding cultural norms or working within a cultural context of the client?
4. Reflecting back on your past community service experience. Do you think you have gained more awareness, knowledge and skill in working with culturally diverse population groups?
5. What feedback would you give to the university you studied at regarding your experience of cultural diversity training at undergraduate level?
6. What advice would you give to new graduates in preparing themselves to work within diverse cultural groups?
7. During your community service year, did you participate in professional development activities that enhanced your awareness, knowledge and skills in working with culturally or linguistically diverse communities?

APPENDIX K

Additional questions emailed to respondents after telephonic interview

1. Which university did you study at?
2. Please provide details of your work history and experience as an OT.
3. Your first language spoken and other languages spoken.