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# Culturally Competent Occupational Therapy in a Diversely Populated Mental Health Setting

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*Cultural sensitivity is a crucial component of health care provision, particularly in psychiatric settings. As society becomes more multicultural, it is essential for occupational therapists to continue to develop cultural competence, which is defined in this paper as an awareness of, sensitivity to, and knowledge of the meaning of culture. At San Francisco General Hospital, an innovative multicultural model consisting of special focus programs is used. The key to the success of such programs is a culturally competent professional staff.*

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The level of cultural diversity encountered by occupational therapists can vary greatly depending on the work setting and locale, but we can anticipate that regardless of location, a more culturally diverse patient population will be seen in practice. Statistics from the 1990 U.S. census show that the growth of racial and ethnic minorities has occurred faster in the 1980s than at any other time in the 20th century (Barringer, 1991). Since 1980, there has been a 107% increase in the Asian/Pacific Islander population and a 53% increase in the Hispanic population. Although this growth has been concentrated in large metropolitan cities and western states (Schreiner, 1991), the cultural makeup of the entire United States is changing. It is projected that by the year 2080, people of color will constitute 45% of the population (Wattenberg, 1991).

San Francisco has a population rich with cultural diversity; over half of the city's population is made up of people of color. This diversity is reflected in the patient population of San Francisco General Hospital, a public hospital and medical center affiliated with the University of California. Over 10 years ago, the Department of Psychiatry of San Francisco General Hospital began developing ethnically oriented special focus programs. This model of culturally focused programming is nationally recognized for being innovative and was acknowledged in 1987 when awarded a Certificate of Significant Achievement by the American Psychiatric Association (APA). The framework for this article is the cultural focus model of San Francisco General Hospital, and the purpose is to introduce the concept of cultural competence and discuss the importance of culture for occupational therapy in mental health settings.

## The Importance of Culture in Mental Health Care

Cultural awareness is necessary for the provision of all quality health care, but it has particular importance for the mental health field because of the nature of practice. Concepts of normal and abnormal behavior are the basis for psychiatric diagnosis. However, as Kraft (1979) stated,

> "Normality, however, can differ cross culturally. Certain sects and societies may revere persons who hear voices, but in many parts of the world they would be hospitalized. What is normal to one can be abnormal to another." (p. 8)

Because the concept of normality is undoubtedly value laden, the issue of culture must be addressed not only in the treatment process but also in the evaluation and diagnostic processes. This is acknowledged in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders* (3rd ed., rev.) (*DSM-III-R*) by the following statement:

> When the DSM-III-R classification and diagnostic criteria are used to evaluate a person from an ethnic, or cultural group different from that of the clinician's, and especially when diagnoses are

made in a non-Western culture, caution should be exercised in the application of DSM-III-R diagnostic criteria to assure that their use is culturally valid. (APA, 1987, p. xxvi)

Occupational therapists perhaps have a cultural advantage in the psychiatric setting because of their focus on the ability to function in a given environment rather than on symptomatology.

A patient with a psychiatric disorder often displays poor self-esteem and self-concept. These deficits can be compounded when the patient is a member of a disenfranchised group. However, the inclusion of significant cultural awareness in the treatment regimen can empower and validate the patient with a psychiatric illness.

Culture can also be used to help develop insight in patients who come from disenfranchised populations. Possibly, the development of insight can be encouraged through the acknowledgment and understanding of some of the socioeconomic conditions and inequities pervasive in the Euro-American dominant society.

## Culturally Focused Programming

The concept of a unit set up to meet the cultural and linguistic needs of ethnic groups was envisioned in 1979 by staff psychiatrist Francis Lu, who is currently the director of inpatient services at San Francisco General Hospital. From the 1979 National Institute for Mental Health Conference on Ethnic and Minority Curriculum Development, a seed was planted about how to provide the best culturally sensitive psychiatric care to ethnic and minority patients. Dr. Lu "believed that acutely disturbed patients could benefit from services provided by professionals who spoke the same language and understood cultural values and beliefs" (Schwartz, 1990, p. 818). At that time, over 21% of the population in San Francisco consisted of Asian/Pacific Islanders. No other psychiatric inpatient unit was in existence to address the needs of this specific population. Dr. Lu approached the San Francisco community service agencies and leaders of the Asian/Pacific Islanders community to gather support for the idea. The University of California, San Francisco, and the Department of Psychiatry at San Francisco General Hospital were supportive of his efforts to recruit a staff of professionals to set up a special focus unit (Schwartz, 1990). This model has grown to include five programs on special focus units: Asian/Pacific Islander, Latino, African Peoples, Women, and HIV (human immunodeficiency virus).

The definition of culture used in the special focus programs includes more than race and ethnicity. Gender, religion, socioeconomic status, sexual orientation, age, environment, illness, family background, and life experience are all a part of a person's culture; therefore, many subcultures are seen within each focus program. For example, the HIV program of San Francisco General Hospital addresses the needs of several cultures and subcultures that exist within the larger population of people with HIV. "The impact of AIDS has been most notable in three subpopulations in the United States: the gay community, intravenous drug abusers and minority groups, particularly Blacks and Hispanics" (Scaffa & Davis, 1990, p. 69). People who share several cultural components may not share the same values and beliefs, so broad statements about particular cultures are avoided. Thus, although one's culture is acknowledged on the special focus units, the uniqueness of each individual is also acknowledged.

Each focus program seeks to promote cultural sensitivity and awareness, including languages, life-styles, and history. The primary goal of all of the special focus groups is to provide high quality, innovative psychiatric care on both an individual and group basis. In addition, the special focus units are committed to establishing liaisons with the community to improve continuity of care and to provide resources and support for families and significant others. The programs also provide multidisciplinary training and research opportunities and in-service education as well as consultation for hospital staff and community members.

## A Culturally Competent Staff

For the purposes of this article, *cultural competence* is defined as an awareness of, sensitivity to, and knowledge of the meaning of culture. It includes one's openness and willingness to learn about cultural issues, including one's own cultural biases. Cultural competence is an evolving process that depends on self-reflection as well as on the contributions of people from other cultures.

Ideally, culturally competent therapists have specific and extensive knowledge of the language, values, and customs of a particular culture. Patients respond with a sense of relief and calmness when the staff speaks their language. This helps to gain the patient's trust as well as gather accurate information about the patient. In the San Francisco General Hospital programs, interpreters are used along with multilingual clinicians to decrease the language barrier that often occurs with patients whose primary language is not English. However, as important as language is, it is not essential to one's being culturally competent.

A major component of cultural competence is an acknowledgment and awareness of one's own culture and a willingness to explore one's own feelings and biases. To help determine what feelings and biases are brought into the therapeutic relationship by both the therapist and the patient, one should reflect on various cultural beliefs and values. Beliefs involving spirituality, family structure, gender roles, and health care can greatly affect the therapeutic relationship. Cultural traits that influence social interactions must also be acknowledged. These traits may include cooperation and competition; individual and

group emphasis; independence, interdependence, codependence, and dependence; authoritarian and democratic styles; assertive, aggressive, and passive behaviors; private and social orientation; and formal and informal approaches. These values and beliefs are often where differences are encountered in practice. The mere fact that one's ideas and attitudes come from a different setting or environment than the patient's can cause cultural bias. For example, it is common to describe poor eye contact as a symptom of social withdrawal or depression, but in many Latino and Asian cultures, it is common to avoid eye contact as a gesture of respect for the health care professional.

A culturally competent therapist reinforces the beauty of culture, incorporates it in therapy, and is open to different ways of engaging the patient in treatment. As previously stated, knowledge of various aspects of different cultures is extremely helpful to the therapeutic process, but the development of cultural competence depends more on attitude than on specific knowledge. For example, in an environment that is essentially bicultural, it is possible to have staff that are intimately versed in both cultures. However, cities such as San Francisco are multicultural in the true sense of the term, representing numerous cultures from all corners of the globe. It is unrealistic for therapists to know every language, let alone dialect, that is found in such an environment. But what can be expected and encouraged is sensitivity to and respect for other cultures. Patients themselves can be excellent resources for therapists to increase their knowledge of a particular culture. When patients perceive an attitude of open-mindedness from the staff, they may begin to describe methods of healing used in their culture that could be successfully combined with the therapist's recommended treatment.

Although each inpatient psychiatric unit at San Francisco General Hospital has a specific focus, cross-culturalism and subcultures are seen on every unit, such that staff needs to know how to treat patients from various backgrounds. Recruitment is geared toward attraction of a culturally diverse professional staff with an interest in working with a diverse group of patients. Additionally, in-service staff education about cultural issues is strongly emphasized.

The occupational therapy staff represents the nature of this environment and is committed to the concept of culturally focused treatment. As part of the occupational therapy staff and student intern orientation, the Cultural Competence Questionnaire (see the Appendix) is used as a self-evaluation tool. This tool was designed by the occupational therapy staff of San Francisco General Hospital to assist clinicians in developing basic cultural competence. Multilingual occupational therapists are particularly valuable within the Asian and Latino programs, in which many of the patients do not speak English. Occupational therapists are members of the various special focus task forces sponsored by the hospital that consist of hospital staff and interested community members.

## Program Descriptions

The *Asian Focus Program,* the first special unit, began with one bilingual Chinese nurse and Dr. Lu in 1980. The program expanded to include a director, an occupational therapist, social workers, nurses, and psychiatrists. Liaisons were developed with the hospital's interpreter services to assist in communicating with the patients. Each ethnic subgroup of Asian-Americans has its own unique culture and language. Patients served are from Vietnam, Laos, Cambodia, China, Hong Kong, Taiwan, the Philippines, Samoa, Korea, and Japan. Issues of migration, war and trauma, religious and spiritual beliefs, medicine, and family dynamics are all integral aspects of the evaluation and treatment process.

The *Latino Focus Program* uses a multidisciplinary team and works closely with the department of psychiatry's Latino Task Force in developing and implementing culturally relevant treatment, teaching, and research. Approximately half of the Latino patients are monolingual in Spanish, and many are recent arrivals to the United States from El Salvador, Nicaragua, Cuba, Mexico, and Puerto Rico. Given the political climate and economic situations of their respective native countries, the patients' psychosocial issues can be quite diverse. For example, posttraumatic stress disorder is commonly seen among Latino patients from war-torn countries, and issues relating to separation from family are also prevalent. Although Spanish is the common language among the different ethnic groups, each culture is unique, with its own nuances of communication, including slang and gesture.

The *Women's Focus Program* is situated on the same unit as the Latino Focus Program. It grew out of a need to address female psychiatric patients with specific needs. The first group of patients treated were women with severe mental illness who were also pregnant. The program explores such medical issues as medication compliance, liaison with obstetric and gynecologic services, and education about the medical and psychological aspects of pregnancy, labor, and delivery. Program implications due to longer hospitalization and specialized treatment plans (i.e., nutritional needs, prenatal education) are issues of the unit. The program also addresses the needs of women who have been sexually assaulted or physically abused. Staff meetings and special conferences are used to cope with staff's reactions toward patients who are both pregnant and psychotic. Such legal issues as reproductive choices need to be addressed continually. Consultation is given to members of other units who work with women who have been sexually assaulted or physically abused. Special problems of substance abuse and aging in women are also addressed.

The *African Peoples Focus Program* was developed in response to the recommendations of the San Francisco General Hospital's Black Task Force. Issues of recruitment, training, and education and the celebration of culture through ethnic art, music, food, media, and holidays are emphasized. Discussion of racial issues, promotion of a sense of identity, and the opening up of new avenues of experience are ongoing aspects of the program. The program works to promote black patients' positive self-esteem, which is necessary in maintaining an adaptive level of functioning, and has developed community liaisons to improve the continuity of care through inpatient-outpatient transitions.

The *HIV Focus Program* (previously known as the AIDS Focus Program) began in 1985 as a program to care for patients with HIV. Patients are assisted in coping with the psychiatric symptoms of HIV through a thorough diagnostic assessment and comprehensive treatment approach. The family and significant others are involved in assessment, treatment, and support. Specific objectives of the HIV Focus Program include provision of education about HIV and its prevention to patients and significant others and provision of an atmosphere in which HIV is destigmatized and where patients and their families can feel safe.

## Occupational Therapy Intervention

In occupational therapy, the use of the cultural nuances, traditions, and norms of a particular treatment population is a powerful concept. The acknowledgment of cultural characteristics enhances communication between the patient and therapist and facilitates the much-desired therapeutic alliance. However, if a patient's culture is not taken into consideration, negative consequences are likely to occur. For example, intrinsic to occupational therapy is a belief that independence is important, but not all cultures share this value. For example, in many cultures, a young adult is expected to live at home until marriage and may experience conflict when an occupational therapist focuses on independent living and household management skills.

The inclusion of culture provides a wealth of resources that one can draw on when developing treatment modalities. Activities selected from the patient's cultural experience are generally more meaningful, relevant, and intrinsically motivating and therefore have greater therapeutic value (Hopkins & Tiffany, 1988). Activities themselves are socioculturally regulated (Cynkin, 1979); therefore, programming is a logical extension of appropriate occupational therapy treatment.

The person's culture provides a point of reference that can include habits, practices, and expressions. Music, dance, poetry, art, philosophy, myths, legends, politics, spiritual practices, and daily living regimens are all variables to be considered in the exploration of a people's culture for the purpose of developing meaningful treatment. For example, the occupational therapist planning to use food in an activity must not only consider the types of food eaten in a specific culture but also the rituals regarding how the food is prepared and shared.

The occupational therapy modalities used in the special focus programs share common goals of creating opportunities for patients to experience success, reinforcing a sense of self, learning from each other, and providing intrinsically motivating culturally based activities.

Flexibility of programming is essential in a multicultural environment. For example, members of some cultural groups would be offended by a group grooming activity and would feel more comfortable using self-care supplies in their own bathrooms. But members of other cultures commonly help each other with makeup or hairstyles and could benefit socially from such groups. The planning of several activities to address the same therapeutic goals is particularly helpful when one is working with a diverse group of patients. A patient who sees crafts as diversional and impractical may readily engage in a work project, whereas another patient may see a work project as exploitive and prefer a craft project, in which the finished project may be kept.

The meaning of a particular project may be different for different groups. People personalize their work whether it is a recipe or a craft project. This personalization component may include symbols that reflect cultural values. For example, the use of texture, colors, tools and decorations may have specific meanings for a particular patient (i.e., the colors chosen may be in the flag of the patient's country of origin). The use of particular spices or cooking methods or the role of food may also reflect family traditions or cultural customs. Symbols, customs around food or gift giving, the importance of the work ethic, and national pride may all be reflected in different ways, although all members of the group may be working on the same craft or cooking project.

Holidays from various cultures provide opportunities for special decorations and foods that can be prepared within occupational therapy. Holidays are often religious in origin, and some sensitivity to divergent beliefs among patients can help make everyone feel included. Generally, the level of interest expressed by patients will dictate the degree to which holidays are celebrated. As in any activity, holiday activities reflect age-appropriate interests. Some of the holidays that have been celebrated on the special focus units include the Chinese New Year, Cinco de Mayo, Juneteenth, Mexican Independence Day, and Kwaanza.

Patients may feel more comfortable in an environment that reflects their culture, as it is familiar and perhaps less anxiety producing. Wall decorations that include diverse cultural images can reinforce a sense of self for the patients. Music is a powerful therapeutic tool for the facilitation of affective response (MacRae, 1992). Mu-

sic is inherently cultural, and the dynamics of a particular group will dictate the selection of music. Classical, jazz, salsa, and pop music all create different tempos, energy, and opportunities to socialize in a group.

Facilitation of socialization within a diverse group can be a challenge, and the occupational therapist's skills in activity analysis and adaptation are often used. Nonverbal activities such as moving to music, feeding and grooming animals, or crafts that can be demonstrated are helpful when the patients speak different languages. Having a patient share or teach the group a game or recipe from his or her culture can facilitate interaction and incorporate cultural awareness into treatment.

Occupational therapy modalities cut across cultures, yet can be tailored to be more meaningful for specific groups of people or individuals. Nurturing tasks involving animals and plants are nonverbal activities that not only can be used with non–English speaking patients, but also can be empowering experiences for patients with HIV who are facing issues related to loss and death at a time when they may feel dependent and helpless. By paying close attention to the properties and demands of an activity as well as the importance of the activity to the patient, the occupational therapist can choose therapeutic interventions that are culturally sensitive.

## Discussion and Recommendations

We believe that all therapists have a responsibility to develop cultural competence by being open to inspection of their own culture and developing an interest and knowledge base about other cultures. Furthermore, we have found that cultural competence is a lifelong process, and staff must continually learn about different cultures and discover the unique cultural background of each patient.

Methods to increase the focus on a patient's culture can easily be implemented in a treatment program. These include multidisciplinary case conferences with attention to the patient's culture, consultation with staff from other cultures, staff education about issues, and an active consideration of all patients' cultures during the assessment and treatment planning process.

This article is primarily a description of one model. Descriptions of other models, case studies, and various cultures and subcultures within the United States would be useful information to further programming and treatment planning. ▲

## Appendix
## Cultural Competence Questionnaire[a]

These questions are to help you think about the role of culture within treatment.
1. Are you open to the cultural experience?
2. Do you acknowledge that culture is an important consideration in treatment?
3. Do you recognize that there is cultural bias from both the therapist and the patient?
4. Have you explored your feelings about culture and how these feelings affect interactions with patients?
5. Do you understand how Euro-American culture affects the treatment setting?
6. Are the patients utilized as a resource in understanding cultural beliefs, family dynamics, and patients' view of illness?
7. Are the patients encouraged to utilize resources commonly used within their own culture that they see as important?

[a]Designed by the occupational therapy staff of San Francisco General Hospital.

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