World Federation of Occupational Therapists Bulletin

ISSN: 1447-3828 (Print) 2056-6077 (Online) Journal homepage: http://www.tandfonline.com/loi/yotb20

Occupational therapy and cultural understanding – Cross-cultural experiences in a newly established occupational therapy service in Qinghai Province, China

Gaby Scheidegger & Marion E. Torrance-Foggin

To cite this article: Gaby Scheidegger & Marion E. Torrance-Foggin (2015) Occupational therapy and cultural understanding – Cross-cultural experiences in a newly established occupational therapy service in Qinghai Province, China, World Federation of Occupational Therapists Bulletin, 71:2, 88-95, DOI: 10.1179/2056607715Y.0000000001

To link to this article: http://dx.doi.org/10.1179/2056607715Y.0000000001

Research paper

Occupational therapy and cultural understanding – Cross-cultural experiences in a newly established occupational therapy service in Qinghai Province, China

Gaby Scheidegger[1], Marion E. Torrance-Foggin[2]

[1]Chinserve, Gümmenen, Aarberg, Switzerland, [2]Plateau Perspectives, Ardgay, UK

Good cross-cultural understanding and communication is required to provide a high quality and equitable occupational therapy (OT) service. In this study we explored the cross-cultural understanding of OT staff in a newly established OT department in Qinghai Province in Western China using semi-structured interviews. Although the OTs, who were still in the process of developing an understanding of their service even within their own culture, showed some understanding of the cultures of their clients, their main desire was to demonstrate that they treated all clients equally and without prejudice. The therapists' thinking in this emerging setting is described and discussed. We conclude that there is a real need, in China, for training in the development of cultural competency for OTs. In areas where there are many distinct cultures, the employment of interpreters who not only translate but act as cultural advocates would greatly improve the overall quality of the service.

Keywords: Cultural learning, Language interpretation, Religious beliefs, Health advocate, Hui, Tibetan, Han Chinese

Introduction

Occupational therapists (OTs) around the world face cross-cultural situations in their daily practice in which they are challenged to respond with cultural awareness and sensitivity. The practitioner and client each bring their own cultural background to the treatment setting. Their attitudes, values and beliefs may be very different (Balcazar Suarez-Balcazar, Taylor-Ritzler, & Keys, 2010; Kronenberg, Algado, & Pollard, 2005; Munoz, 2007; Scheidegger, Lovelock, & Kinébanian, 2010; Talero, Kern, & Tupe, 2015; Winkelman, 2009; Zango, Flores, Moruno, & Björklund, 2015). This means that there are challenges in communication as well as in finding culturally appropriate approaches to assisting with activities of daily living, occupation and other aspects of therapies.

Within the occupational therapy literature, there is a recognised need for further research about specific cross-cultural situations around the world (Awaad, 2003; Bourke-Taylor & Hudson, 2005; VanLeit & Crowe, 2009). Chiang and Carlson (2003) suggest studying the experiences of OTs who have worked in a different cultural environment for a significant period of time as one way in which occupational therapy could expand its knowledge on cultural issues.

This study sets out to evaluate the cross-cultural understanding in a newly established OT service in a hospital in Qinghai province in Western China. The population of Qinghai Province is socially and culturally extremely diverse, with three main resident nationalities: the Han Chinese, the Tibetan and the Hui nationalities (Goodman, 2004). These nationalities have significant differences in how they live their lives and express their own identity and culture in separate communities. They come from remote nomadic areas, villages and from within the city itself. All are potential clients at this newly developed Occupational Therapy department of the Qinghai Red Cross Hospital (QHRCH), one of the main regional hospitals located in the provincial capital, Xining (Qinghai Red Cross Hospital, 2015). At the time of the study, the OT department comprised a team of six OTs: four local rehabilitation OTs (all Han Chinese, from Qinghai) and two Western OTs (Swiss and American). The national staff members all graduated within the Chinese education

Correspondence to: Gaby Scheidegger, Chinserve, Switzerland. Email: gaby@chinserve.ch

DOI 10.1179/2056607715Y.0000000001

system in Rehabilitation Therapy, which used both Western and traditional Chinese medicine philosophies and approaches (Zhuo, 2006) and focussed on physical ability. They were then further trained on the job (in clinical skills and theory) by the expatriate OTs. They were also given several training sessions by visiting international physiotherapists (PTs) as there were no PTs in the region. Serving clients from all resident nationalities, the Han Chinese and Western therapists (OTs) at the OT department were confronted and challenged with issues of cross-cultural communication and treatment on a daily basis.

Cultural learning is an on-going contextual, developmental and experimental process of personal growth (Balcazar *et al.*, 2010; Campinha-Bacote, 2002; Ingram, 2012; Suarez-Balcazar *et al.*, 2011; Suarez-Balcazar *et al.*, 2009; Whiteford & Wright St-Clair, 2002; Winkelman, 2009; Wray & Mortenson, 2011). Cultural awareness is the first step towards cultural competence (Campinha-Bacote, 2002; Suarez-Balcazar *et al.*, 2011; Winkelman, 2009), and involves self-examination and in-depth exploration of one's own cultural and professional background.

The first author is a Swiss OT, who lived and worked for 17 years in the Qinghai Province, in several cross-cultural settings. Her experiences facilitated the reflection on her own cultural background and contributed an understanding of local cultures and languages. Since 2009 she has been leading the development of the first OT department at the QHRCH. The second author is a British Community Paediatrician who has lived and worked primarily in the rural areas of Qinghai, for over 15 years in development work including training doctors and setting up rehabilitation services.

The uniquely diverse cultures in the catchment area of this hospital, and the long-term observation and experience of the Chinese and Western OTs working together, represent a good environment in which to explore how cultural awareness may develop from an OT perspective. This paper seeks to shed light on challenges and opportunities in therapy development work by evaluating the current status of cultural awareness within local practitioners in this newly developed department, with regard to their contact with clients. Customs, beliefs and values, in relation to health, illness and rehabilitation are explored.

The study aims to answer the following research question: What is the cross-cultural understanding of the Chinese OTs in this newly developed department and how do they understand the influence of culture on the understanding and effectiveness of OT?

Method

Because the study question was concerned with the subjective experience of a small number of participants and their views around cultural awareness, a qualitative approach was taken (DePoy & Gitlin, 2005; Denzin & Lincoln, 2005; Polit & Beck, 2008). The focus was to investigate the perspectives of the Chinese OTs and to explore how they experienced and made meaning of their cross-cultural therapeutic encounters. An interview design was chosen, to elicit fuller data about the OTs' views (Kvale, 1996). Research and Ethics Governance Committee of the University of Brighton approved the study and written consent from the hospital director were obtained for the interviews. Clear inclusion and exclusion criteria as well as interview procedures were defined in advance. Since the first author worked as a foreign expert in the OT department, a Chinese research assistant of the same cultural background and similar age as the interviewees but not from the hospital, was appointed to support the informed consent process (Polit & Beck, 2008) and to conduct the interviews (Kvale, 1996). The Chinese OT's, one male and three female, between 20 and 30 years of age, with a Chinese rehabilitation degree (Kangfu) and additional training in international OT and PT, had worked for one to three years at the department. All four gave written consent before the recorded interview and after the interview they gave verbal consent for the use of recorded data.

Given the explorative nature and the complexity of the issues, we used a semi-structured interview design, to allow space for clarification and detailed understanding. Following the culture of the interviewees, questions were indirect and often narrowed down on the topic in a circular manner, thus designed to avoid confrontation or 'loss of face' (embarrassment) (Winkelman, 2009). The interview guide (designed in advance) led through more general questions about the wider context of their work before narrowing the question to a more personal therapy, culture and experience focus (Humbert, Burket, Deveney, & Kennedy, 2011; Kvale, 1996).

Audio-recorded interviews (all of them around 40 minutes) were transcribed immediately after the interviews, translated into written English. This transformation from spoken to written language was 'meaning-based' (keeping the spoken language structure) as opposed to a literal word-to-word translation (Adams, Miller, Craig, Nyima, Sonam, Droyoung, Lhakpen, & Varner, 2005). We annotated the translation, aiming to represent as closely as possible the OTs' voices, ensuring proper interpretation.

Due to the cross-cultural character of the study, we used the 'analysis method framework' (Krueger, 1994; Ritchie & Lewis, 2003; Srivastava & Thomson, 2009) which facilitated a deductive-inductive approach for text analysis and provided a structure to analyse the interview data in a qualitative manner. (1) We

started by immersing ourselves in the whole data set and then (2) listed the key ideas and recurrent themes. The whole process was discussed with an external advisor. Hence in the analysis process we started with the bigger picture, leading to a thematic framework. This framework then guided the process of systematic indexing in which we rearranged the data by developing maps to produce a clearer overview. This mapping and interpretation was influenced by our original research theme. Further themes, emerged from within the data. This categorisation is reflected in the results section. In this way, the analysis process started deductively from pre-set aims and objectives and in a second part inductively led to the findings (Pope, Ziebland, & Mays, 2000).

Results

The interview texts revealed the following recurring themes and concepts in three broad categories. Themes were brought together here across all interviews, with efforts to retain the language of the respondent as close as possible to *'original'* (Ritchie & Lewis, 2003).

1. The Chinese OTs' own understanding of OT and provision of services

- Rehabilitation is a new field in Qinghai – I learned about it

'*I did not know about rehabilitation myself when I started medical school.* '*Before I studied, I saw children with disabilities on the street and I did not realize that their situation could be improved… after I studied, I started to realize more.'* It was a new profession and a new approach, *'rehabilitation has just developed in the recent years*'. OT was new to clients too: *'It is new. Most people do not know about the possibilities of therapy – but now OT becomes more and more popular.'* Knowledge was passed on by word of mouth and television, *'they hear from friends, other clients, advertisements*'.

- Different types of treatment – what we can do

The OT department offered therapy to clients from the orthopaedic, neurological and paediatric departments: *'We have patients who have a paraplegia, hemiplegia, and there are children with a cerebral palsy. There are also clients after bone fractures, and also depression and so on.'* There was a treatment plan with a way to approach clients: *'We check the clients' first and make an assessment, then we make a treatment plan, then we start to train/exercise the clients every day, and after the treatment, we write the process down and keep a track.'* For therapy '*we use active movements and passive movements'*, as well as doing casts and positioning. *'In the case of hemiplegia, in the early phase, . . ., we treat these patients on the bed or beside the bed, and do some passive activities, then teach them to do active exercises, and then add balance, sitting and standing balance, coordination, . . . furthermore we do speech therapy . . . and in a later phase we help them to overcome limitations by applying adaptations, like walking aids and activities of daily living (ADL)*'. The aim was to practise with them activities of daily life and skills for living independently: '*The most important aspect of ADL training, is for the client to go back to the family and manage to eat and get dressed by themselves, or if there is no one to take care of them, for them to be able to move and turn in the bed, and move from the bed to the bathroom by themselves. The main aim is for them to manage at home*'.

- Selling our therapy service – we need to explain it

The OTs learned to understand their OT role and position within the hospital system: '*The doctors give surgery and the nurses give the injection, we finish the middle process*'. Since OT treatment was not generally covered by the health insurance, *'we need to ask for permission, before we start the treatment*'. Information about the therapy offered therefore had to come first: *'We let them know about our treatment and the influence/possible outcome for their sickness*'. The agreement for OT was often the family members' decision. Conflicts sometimes arose between the cost of therapy and the client's needs. The family's decision to engage in the OT process was strongly influenced by their financial situation: '*If they agree or not, depends on their finances. The cultural background does not say anything about their economic situation. No matter if the person is Han Chinese, from Hui nationality, or a Tibetan, there are poor families amongst all of them*'. However, the OTs tried to find ways to make OT accessible: *'If the families are poor, we encourage them to do it, because it is surely beneficial for their recovery*'. Furthermore, they tried to reduce costs: *'For those who are really poor, we sometimes deduct some money, for example we treat them 8 times but count 5 times … they can learn to do their therapy themselves at home*'. Fortunately there '*are also clients who have money, and they think health is important, the body is important, no matter how much it costs; they want the treatment*'.

2. The Chinese OTs' perceptions about resident nationalities

- We see clients from mainly three different nationalities

All interviewed Chinese OTs were aware of the three main nationalities living in Qinghai province: '*There are Tibetan, Hui and Han patients*'. All expressed that there were cultural differences expressed in religion, language and food. Among the answers, some statements stood out: '*Tibetans, or let's say minorities generally, are very united. Their sense of unity is very strong*'. While some OTs felt that there was not much difference between cultures, others made some statements of comparison: '*I think our Han culture is getting more lazy and less connected, but the minorities, they feel like a big family, they are more united*'.

- We interact with different nationalities – but treat everyone the same

The OTs were aware of the existence of different resident nationalities: '*No matter if they are Tibetan, Hui or Han Chinese, they are all the same. They all are treated the same way; their cultural background does not influence the treatment. I think patients' nationality and culture does not influence my* therapy *and it does not influence how I treat the patient*'. In their search for suitable therapy content the OTs focussed more on the client's interests than on where they came from: '*I look at their individual interests, and I learn about the person's interests and hobbies*'. The OTs compared their relationships with their clients geographically: '*If they are from the city, or from the countryside, all in all this does not have an influence, I always treat everybody the same.'* It was perceived that all clients received therapy freely: *'No matter whether you are a Han Chinese or from a minority group or even from a nomad place, if they come, they all want to cooperate with the treatment*'.

- Importance of food and eating – OTs gave recommendations

The OTs knew about some food habits of the different nationalities and perceived this as one of the main visible cultural differences: Hui nationalities only eat halal food (Bueno, Ghafoor, Greenberg, Mukerji, & Yeboah, 2013), which they prepare in their own homes or eat in Islamic restaurants. '*The eating aspect is most important. . . . Hui minorities do not eat pork or blood. I adjust my way of speaking; I avoid these sensitive (unclean food) words. Muslims cannot eat our food but the other way around we (Han Chinese) are able eat their food*'. The OTs were sensitive to the use of appropriate words and behaviour when Islamic people are around them and tried not to offend them. Tibetan nationalities' food habits are influenced by their Buddhist religion, the concept of reincarnation and the barrenness of their land in the high altitudes. *'Tibetans, normally like to eat yak butter, . . . and further they also like to eat raw meat*'. There are specific animals Tibetan people normally do not eat: '*Tibetans, do not eat fish, dogs, horses, donkeys, and rabbits*'. Their main dish consists of roasted barley flour, '*they eat Tsampa*'. The Han Chinese OTs argued that, '*Tibetans, they are like us. They do not have that many food restrictions*'. Nevertheless, the OTs made food suggestions: '*We recommend them not to eat yak butter . . . we tell them to eat less of the dried raw meat*'. The OTs were convinced that: '*The meat is not so clean, there are little insects inside the meat, which cause infection and it is not good to eat too much of it*'. To clients with food related illnesses (diabetes, heart disease) the local OTs would give specific advice: '*In those cases we often like to give them recommendations about what kind of food is good for them to eat, like eating more vegetables, and less meat*'.

- Language is a recognised barrier in communication – we need translators

Clients from the Qinghai nationalities speak different languages. The OTs admitted that there were *'some difficulties, because of the different languages.*' There were still Tibetans mainly coming from the countryside, who did not understand Chinese. The OTs admitted: *'I am not able to speak Tibetan; … sometimes they are not able to understand me, either. … We need to find someone for translation.'* It is important to find an interpreter who speaks the same dialect, *'they even have different Tibetan dialects'* (Lhasa, Kham and Amdo). The OTs had learned some basic Tibetan words, finding that it increased the client's openness to treatment: '*I learnt some simple words like, "move the leg", … "pull", "stand", … "painful or not"*'. They realized that: *'Just to have professional knowledge is not enough, but learning some other languages is also important.'* Furthermore they learned that it was important to explain OT according to the clients' educational background: '*Patients coming from some areas in the countryside, are not so well educated and do not understand professional wording.'*

The Hui minorities coming to the hospital, *'normally speak Qinghai dialect (of Chinese). There are some other dialects, such as Salar language* (Salar minority people are another resident Islamic people group), *and they use some Arabic when they pray. I adjust my way of speaking.*' The Han Chinese OTs realized: '*We Han Chinese people sometimes are unaware of this; we speak words that could hurt them … this we should avoid.'* Generally, the OTs felt comfortable using the spoken local dialect in order to draw closer to the clients: *'If we use the Qinghai dialect to say things, they will feel closer … and … more connected.'*

3. The Chinese OTs 'explicitly' expressed their cultural understanding and awareness

- Culture does not matter – patients are all the same C

All OTs made strong statements about the 'sameness'/ equality of all clients: '*Patients are all the same – the influence of culture is not so big and they are not influenced greatly by their cultural background.' 'We have not met the kind of situation, where culture has much influence.' 'They are people who need treatment as people with disability. They are all the same, and they are the same colour as I am.'* Regardless of cultural background: *'We should respect each other.'* This genuine respect affected the OTs who would wait for the client to talk rather than ask direct questions: *'We won't ask about their background, we will not set out to get to know their customs and beliefs initially. In the treatment process, if they mention it, we can talk about it but if they don't mention it we will not ask about it.'*

The OTs viewed their work as more practically-oriented and did not see any influence of culture on treatment: *'We do not have to adjust treatments for different cultures … these functional trainings will not affect their social customs, we really won't affect or influence their religion or rules.'* Their focus is more on the person than on their culture: *'With different people, we use different games, because they grew up in different cultural backgrounds, their hobbies and interests are not the same.' There is no cultural influence or certain minority group that has something you cannot do. There is nothing like that.'*

- Specifics about religion – we see expressions/ distinctions

Although the OTs thought that there were no relevant 'cultural differences' they did observe expressions of belief. Tibetan people pray publically: *'Everyone prays with those prayer beads … everyone prays until the prayer beads are getting smaller and smaller, they really pray a lot.'* The OTs perceived effects of religion: *'Tibetans are very polite, even some educated people are not as polite as they are; I feel it is like this, maybe because of their nationality and belief.'* Tibetan Buddhism and Islam are visible over the whole Qinghai province. There are monasteries or mosques in every village and religious festivals are celebrated regularly. The young OTs were aware of an older and a more modern version of religious expression in the Islamic community: *'The new one is more open, the old one is traditional.'* Ramadan is celebrated every year, '*and they go to the mosque to pray every day*'. Besides the strict food regulations Muslim people normally do not smoke and drink. There are still arranged marriages: *'Young men and women are not allowed to meet freely, especially from the woman's side. Their family arrange the marriage.'* Marriage is often a family agreement and the social pressure to be married before 25 years old is quite strong. However, the OTs commented: *''Girls' marriage rate is high… some of my patients marry early when they are still in their teens.'* Reflecting on their religious knowledge the OTs admitted: *'I only know superficial things … like the eating habits. I do not know about other aspects.'*

- Education–not culture matters

During the interview dialogue the OTs reflected on aspects other than culture that influence a person during the recovery process in the hospital. All of them agreed that the educational level mattered more than anything else: *'Level of education, educated or not, this matters most. People who did not go to school, are able to understand less.'* The OTs thought there was a direct relationship between education and the understanding of the rehabilitation processes: *'If someone went to school, there is an understanding of curing a disease, … the patients then also have better co-operation with the doctor, … and they do what we tell them.' 'If they are not educated, they do not understand the meaning of moving or not moving … if they are highly educated, they will be able to understand that to do this kind of treatment will be good for their recovery.'*

Discussion

To develop a new OT service where it is almost unknown brings great opportunities but also certain challenges. As the OTs openly admitted, OT was a new concept for them and the people they served. Even as they were trying to understand it in the context of their own culture and environment, they were also seeing clients from a variety of cultural backgrounds. Daily exposure to the needs of their clients in the hospital setting not only gave them the opportunity to explore the purposes of their profession and service, but also to explain their service to colleagues and clients. This should support their learning process and strengthen their sense of professional identity (Li-Tsang, Choi, Sinclair, & Wong, 2009). Indeed, the OTs were excited to explain their new profession to the interviewer as well as to their clients. Their developing sense of professional identity and role within a multidisciplinary context was also expressed in the culturally strong statement 'we finish the middle process' (Nakamura, 1997).

They explained that although they worked with the client, there was also the need for the family agreement and participation, bringing a need for systemic dialogue. However as clients, or their families, paid for

the services themselves, the emphasis of the intervention tended towards a basic rehabilitation of physical function. This is described in other Asian settings as well (Kronenberg, Pollard, & Sakellariou, 2011). Despite being primarily trained as OTs there was often a strong focus on physical intervention. However, they did understand the core values of an OT service with regard to activities of daily living and developing skills for independent living (WFOT, 2015). Although they had made these huge leaps in their understanding of their service and profession from their training, from clinical exposure to clients, explaining their service to clients and colleagues alike and working, how much had any of these affected their cross-cultural awareness and understanding and how does that affect their interaction with the clients and their families?

The OTs knew about the existence of the several ethnic groups and described differences between them. Although there were statements that did carry some prejudice, they seemed to be aware that there were different customs that affected lives today. Some even commented on their differences and compared them positively with their own culture as in the comment about the social grouping. They recognised differences in food, family and community relations and religion. The explanations were largely those of external observation than that of detailed understanding. In some contexts, assumptions and generalisations were made from simple observations. However, there was an expressed fear of asking about cultural details in case this should cause offence, which is a reasonable concern.

In Qinghai, there is an awareness of different food customs. The need to give food advice as a health professional, even if not trained to do so, is in fact a cultural viewpoint. However, as the OTs recognised, it was not always well received cross-culturally. One OT's comment suggested that there was some frustration about food restrictions of one group compared to others. A greater in-depth understanding of the differences and attitudes with some self-reflection is required (Balcazar *et al.*, 2010).

Community relations were admired in contrast to the culture of one OT. It is certainly true that decisions are often made by families, contributing to the bias towards physical rehabilitation. Although some claimed a client-centred approach many responses suggested that there was a rather top down approach to therapy; their concern was that clients would 'cooperate' or 'do what we tell them'. This would be consistent with their cultural background and education. This inadequate assimilation of the client-centred approach may be consistent with the lack of reflection on how much the client may or may not have been in agreement with the family. Focus for treatment should be person centred, with a primary focus independent living and occupation (Whiteford & Wright St-Clair, 2002). However, an understanding of different cultural views which affect families and the need for independence, schooling or employment was not expressed. The authors' experience is that there is often a discrepancy between the client's desire for occupation and the family's belief that a client should be cared for because of disability. This is an area where cultural beliefs may be strong. The model of human occupation (Kielhofner & Burke, 1980; Suarez-Balcazar *et al.*, 2009) has acknowledged culture as an aspect that affects occupational choices. The connection of religion to culture and behaviour was expressed but the understanding was external such as observing the use of prayer beads. In-depth understanding was lacking. No connection was made as to how this may affect their response to therapy. Although some cultural awareness was expressed, there was not yet much clear reflection on how this affected therapy or therapy plans. The main thrust of the respondents was to express their desire to treat all as equals and to show no prejudice. Most of their responses were aimed at this, even in their expression of fear that they would offend if they asked questions. However, they seemed to confuse equality with uniformity. In their attempt to ensure they treated people equally, they had to ignore any differences. In other words, if they allowed their therapeutic interview to be affected by culture, that would be to treat them as if of a different status. However cultural competence may reduce disparities in health care (Brach & Fraserirector, 2000). This anxiety is clearly an obstacle to a fuller understanding.

In terms of priority, the OTs volunteered what they felt to be the key issues for patient care. They believed that finance had a much bigger impact than culture. Here they showed sensitivity to those who could not afford treatment and a desire to find imaginative ways to help them out. They believed that rural versus urban setting had much more impact than culture and stressed the importance of education more than culture. Without education clients did not *'cooperate as well'*. If they were educated they would '*follow instructions better*'. In the OT's cultural background there is a strong belief that education is extremely important and also that education consists of learning facts, rather than necessarily processing new ideas and thoughts. These responses show that their aim was for clients to do what OTs say rather than that of a two-way exchange, to reach a good therapeutic plan that can then succeed.

Finally all agreed that communication was of great importance and that there was a need for interpretation. Many from the countryside did not speak Chinese well and had difficulty understanding what

was being said. The use of relatives and neighbours come at a high cost of confidentiality. Confidentiality is certainly not practised a great deal in the hospital setting, although, some clients are definitely grateful when a confidential consultation is offered. Such interviews again may assist a more in-depth conversation. Good outcomes have been shown where community health care workers can act as advocates for patients. We suggest that interpreters who are trained to act as 'cultural advocates' in the hospital context could not only help communication but help the OTs to learn more about the cultures of their clients without fear of giving offence. Such a service should be introduced and evaluated.

'Cultural desire' is often referred to as the central component of cultural competence because it demonstrates a sincere ambition to care for persons with different values and beliefs and to use such experience as learning opportunities to build relationships (Campinha-Bacote, 2002; Ingram, 2012). Cultural desire includes a genuine passion to be open and flexible with others, to accept differences, build on similarities and to be willing to learn from others as cultural informants. This type of learning involves a real concept of caring (Bueno *et al.*, 2013). It is a life-long process that has been referred to as cultural humility (Campinha-Bacote, 2002; Tervalon & Murray-García, 1998).

Cultural competence has been defined as cultural learning and awareness stimulated by self-examination and in-depth exploration of one's own cultural background, values, personal biases and prejudices (Balcazar *et al.*, 2010; Ingram, 2012). This process allows the health professional to explore values and beliefs without imposing their own beliefs on the others (Balcazar *et al.*, 2010; Campinha-Bacote, 2002; Suarez-Balcazar *et al.*, 2011; Winkelman, 2009). Cultural competence consists of five key constructs: cultural awareness, cultural knowledge, cultural skill, cultural encounters, and cultural desire (Balcazar *et al.*, 2010; Campinha-Bacote, 2002; Ingram, 2012). Reflecting on the process of this study, several OTs indicated a need to learn about the culture. It may be that, as they suggested, the study itself stimulated some early cultural awareness. Their training to date has not included cultural competence and it is unlikely that most of them have been exposed to it previously in their education. Given itsimportance in the service to people of such diverse cultural backgrounds, a training in 'Culturally Responsive Care' should be introduced (Talero *et al.*, 2015). In addition we also strongly recommend access to interpreters who can not only translate, but also act as advocates for their culture to promote better understanding in the clinical setting (Jackson-Carroll, Graham, & Jackson, 1998).

Conclusion

The OTs were committed to providing a service that was accessible to everyone regardless of culture. They had little knowledge or perception of OT prior to their training and were in the process of developing their service and sense of professional identity. They were well aware of differing cultures in their region but their prime concern was to demonstrate that they treated all the same and hence their work was unimpaired by prejudice. They also demonstrated that they cared for those who were poor. They believed it was financial constraints rather than cultural understanding that was the main barrier to accessing therapy and lack of education that kept them from accepting and 'complying' with the treatment plans and not culture. Their understanding of culture was superficial and sometimes quite inaccurate. They did not express any understanding of how their own culture related to their presentation of their profession. However, they all felt the need for translation to communicate better and were anxious that any questions about culture would be badly received by the families concerned.

This study raised an awareness of the need for cultural understanding amongst the OTs who were interviewed, and training in the development of cultural competence. Given their fear of causing offence by asking about culture and their clear recognition of the need for translation, interpreters who act as cultural advocates could greatly reduce the language barrier while helping improve the OTs understanding of the relationship between culture and concepts of therapy. A study to evaluate such an intervention would be of great value. This study also reveals a further need to study the understanding of Occupational Therapy by the clients of different cultures.

References

Adams, V., Miller, S., Craig, S., Nyima, Sonam., Droyoung, Lhakpen, & Varner, M. (2005). The challenge of cross-cultural clinical trials research: Case report from the Tibetan autonomous region, People's Republic of China. *Medical Anthropology Quarterly*, *19*(3), 267–289.

Awaad, T. (2003). Culture, cultural competency and occupational therapy: A review of the literature. *British Journal of Occupational Therapy*, *66*, 365–362.

Balcazar, F. E., Suarez-Balcazar, Y., Taylor-Ritzler, T., & Keys, C. B. (2010). *Race, Culture, and Disability, Rehabilitation Science and Practice*. Sudbury, MA: Jones and Bratlett Publishers.

Bourke-Taylor, H., & Hudson, D. (2005). Cultural differences: The experience of establishing an occupational therapy service in a developing community. *Australian Occupational Therapy Journal*, *52*, 188–198.

Brach, C., & Fraserirector, I. (2000). Can cultural competency reduce racial and ethnic health disparities? A review and conceptual model. *Medical Care Research and Review*, *57*(4 suppl), 181–217. doi: 10.1177/1077558700574009.

Bueno, B., Ghafoor, F., Greenberg, N., Mukerji, R., & Yeboah, L. (2013). Significance of culture when working with clients and their families. *World Federation of Occupational Therapists Bulletin*, *67*(1), 49–54. doi:10.1179/otb.2013.67.1.011.

Campinha-Bacote, J. (2002). The process of cultural competence in the delivery of health care. *Journal of Transcultural Nursing*, *13*, 181–184.

Chiang, M., & Carlson, G. (2003). Occupational therapy in multicultural contexts: Issues and strategies. *British Journal of Occupational Therapy*, *66*, 559–566.

DePoy, E., & Gitlin, L. N. (2005). Introduction to Research. Understanding and Applying Multiple Strategies (3rd ed.). St. Louis-London-Philadelphia-Sydney-Toronto: Mosby.

Denzin, N., & Lincoln, Y. (2005). *Qualitative Research*. Thousand Oaks, CA: Sage Publications, Inc.

Goodman, D. S. G. (2004). China's Campaign to "Open Up the West": National, Provincial and Local Perspectives. *The China Quarterly*, *178*, 317–334. doi:10.1017/S0305741004000190.

Humbert, T. K., Burket, A., Deveney, R., & Kennedy, K. (2011). Occupational therapy practitioners' perspectives regarding international cross-cultural work. *Australian Occupational Therapy Journal*, *58*(4), 300–309. doi:10.1111/j.1440-1630.2010.00915.x.

Ingram, R. R. (2012). Using Campinha-Bacote's process of cultural competence model to examine the relationship between health literacy and cultural competence. *Journal of Advanced Nursing*, *68*(3), 695–704. doi:10.1111/j.1365-2648.2011.05822.x.

Kielhofner, G., & Burke, J. P. (1980). A model of human occupation, part 1. Conceptual framework and content. *American Journal of Occupational Therapy*, *34*(9), 572–581.

Kronenberg, F., Algado, S., & Pollard, N. (2005). *Occupational therapy without borders*. Philadelphia: Elsevier Limited.

Kronenberg, F., Pollard, N., & Sakellariou, D. (2011). Occupational therapies without borders: Volume 2. Towards an ecology of occupation-based practices. Churchill Livingstone: Elsevier.

Krueger, R. A. (1994). *Focus groups: A practical guide for applied research*. Thousand Oaks, CA: Sage Publications.

Kvale, S. (1996). Interviews: An introduction to qualitative research interviewing. Thousand Oaks, CA: Sage Publication.

Jackson-Carroll, L., Graham, E., & Jackson, J. C. (1998). *Beyond medical interpretation: the role of interpreter cultural mediators (ICMs) in building bridges between ethnic communities and health institutions: Selecting, training and supporting key outreach staff*. Seattle: Community House Calls, Harborview Medical Centre.

Li-Tsang, C. W. P., Choi, P. K. K., Sinclair, K., & Wong, R. S. M. (2009). An explorative study of an emerging practice clinical education programme for occupational therapy students. *Hong Kong Journal of Occupational Therapy*, *19*(2), 44–49. doi: 10.1016/s1569-1861(10)70003-6.

Munoz, J. P. (2007). Culturally responsive caring in occupational therapy. *Occupational Therapy International*, *14*, 256–280.

Nakamura, H. (1997). *Ways of thinking of Eastern peoples: India, China, Tibet, Japan* (2nd ed.). New York: Columbia University Press.

Polit, D. F., & Beck, C. T. (2008). *Nursing research: generating and assessing evidence for nursing practice*. (8th ed.) Philadelphia: Lippincott Williams & Wilkins.

Pope, C., Ziebland, S., & Mays, N. (2000). Qualitative research in health care. Analysing qualitative data. *British Medical Journal*, *320*(7227), 114–116.

Qinghai Red Cross Hospital. (2015). Qinghai Red Cross Hospital (QHRCH). Retrieved from http://www.qhhsz.com/en/default.asp on March 25, 2015.

Ritchie, J., & Lewis, J. (2003). *Qualitative research practice: A guide for social science students and researchers*. London: Sage Publications Ltd.

Scheidegger, G., Lovelock, L., & Kinébanian, A. (2010). The daily lives and occupations of Tibetan families who have a child with disabilities. *Scandinavian Journal of Occupational Therapy*, *17*(4), 286–298. doi:10.3109/11038120903287174.

Srivastava, A., & Thomson, S. B. (2009). Framework analysis: A qualitative methodology for applied policy research. *Journal of Administration and Governance*, *4*(2), 72–79.

Suarez-Balcazar, Y., Balcazar, F., Taylor-Ritzler, T., Portillo, N., Rodawoski, J., Gracia-Ramirez, M., & Willis, C. (2011). Development and validation of the cultural competence assessment instrument: A factorial analysis. *Journal of Rehabilitation*, *77*, 4–13.

Suarez-Balcazar, Y., Rodawoski, J., Balcazar, F., Taylor-Ritzler, T., Portillo, N., Dariusz, B., & Willis, C. (2009). Perceived levels of cultural competence among occupational therapists. *The American Journal of Occupational Therapy*, *63*, 498–505.

Talero, P., Kern, S. B., & Tupe, D. A. (2015). Culturally responsive care in occupational therapy: an entry-level educational model embedded in service-learning. *Scandinavian Journal of Occupational Therapy*, *22*(2), 95–102. doi:10.3109/11038128.2014.997287.

Tervalon, M., & Murray-García, J. (1998). Cultural humility versus cultural competence: A critical distinction in defining physician training outcomes in multicultural education. *Journal of Health Care for the Poor and Underserved*, *9*(2), 117–125. doi:10.1353/hpu.2010.0233.

VanLeit, B., & Crowe, T. K. (2009). Influencing health and well-being internationally using an occupation-based perspective: Reflections from Cambodia. *Occupational Therapy in Mental Health*, *25*, 83–92.

WFOT. (2015). Definitions of Occupational Therapy from Member Organisations. Retrieved from http://www.wfot.org/ResourceCentre.aspx on January 7, 2015.

Whiteford, G., & Wright St-Clair, V. (2002). Being prepared for diversity in practice: Occupational therapy students' perceptions of valuable intercultural learning experiences. *British Journal of Occupational Therapy*, *65*, 129–137.

Winkelman, M. (2009). *Culture and Health. Applying Medical Anthropology*. San Francisco CA: Jossey-Bass.

Wray, E. L., & Mortenson, P. A. (2011). Cultural competence in occupational therapists working in early intervention therapy programs. *Canadian Journal of Occupational Therapy*, *78*(3), 180–186. doi: 10.2182/cjot.2011.78.3.6.

Zango, M. I., Flores, M. J., Moruno, M. P., & Björklund, A. (2015). Occupational therapy culture seen through the multifocal lens of fieldwork in diverse rural areas. *Scandinavian Journal of Occupational Therapy*, *22*(2), 82–94. doi:10.3109/11038128.2014.965197.

Zhuo, D. H. (2006). Present situation and future development of occupational therapy in China. *HKJOT*, *16*, 23–25.