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Cultural competence among occupational therapy students at the University of the Free State, South Africa

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The study investigates occupational therapy students' perceptions about cultural competence and assessed their levels of competence to determine whether the undergraduate occupational therapy curriculum at the University of the Free State sufficiently equips students to become culturally competent professionals. A descriptive study was undertaken, using a non-standardised questionnaire. Students did not feel sufficiently equipped regarding cultural competence, and their levels of competence ranged between cultural incapacity and pre-competence. The results support students' perceptions that the current occupational therapy curriculum at the University of the Free State does not sufficiently equip them to become culturally competent.

Kulturele bevoegdheid onder Arbeidsterapie-studente aan die Universiteit van die Vrystaat, Suid-Afrika

Die studie het arbeids-terapie-studente se persepsies oor kulturele bevoegdheid ondersoek en hul vlak van bevoegdheid bepaal om vas te stel of die voorgraadse arbeidsterapie-kurrikulum aan die Universiteit van die Vrystaat studente voldoende voorberei om tot kultureel-bevoegde beroepslui te ontwikkel. 'n Beskrywende studie is onderneem deur 'n nie-gestandardiseerde vraelys te gebruik. Studente het nie voldoende toegerus gevoel ten opsigte van kulturele bevoegdheid nie, en hul vlakke van bevoegdheid het tussen kulturele onvermoë en pre-bevoegdheid gewissel. Die bevindinge ondersteun studente se persepsies dat die huidige arbeidsterapie-kurrikulum aan die Universiteit van die Vrystaat hulle nie voldoende toerus om kultureel bevoegd te word nie.

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Diversity and transformation have become very relevant issues following the first democratic election in South Africa in 1994 (Duncan *et al* 2005).[1] The Constitution of the Republic of South Africa provides for rights such as equality and human dignity, freedom of religion, belief and opinion, freedom of expression as well as language and culture (RSA 1996: 1254-57). It prohibits any form of discrimination on the basis of, among others, race, religion, culture, belief or language. Subtle discrimination in the form of culturally incompetent health care is a likely possibility for health care professionals in a young democracy, and it can be concluded that the South African Constitution compels South African health care professionals to display an extensive degree of cultural competence. Inevitably, the question arises as to how, in a multi-cultural environment, cultural competence can be taught in addition to the skill to individuate one's own world view and beliefs?

Culture is an imperative concept in occupational therapy as the areas, specifically occupations and roles, with which this client-centred health profession is mostly concerned, are culture-specific.[2] To the knowledge of the researchers, although the importance of cultural competence is widely recognised in the literature (*cf* Awaad 2003), no studies have been done in South Africa – and few in other countries – on the perceived level of cultural competence of students in the health professions. In an undergraduate tertiary curriculum that aims to equip students to become competent client-centred practitioners, development of cultural competence should be addressed with consciousness and deliberation.

1. Aims

This study aims to explore the levels of competence and perceptions regarding cultural competence among occupational therapy students in their second to fourth year of study at the University of the Free State (UFS) in Bloemfontein, South Africa. The students' perceptions

1 The following final-year occupational therapy students at the time of the study are acknowledged for their contribution to this research as part of a research project in 2007: Mrs C van Zyl (née Botha), Ms E Currie, Ms C Koch, Ms A Lekhehle and Ms M Meyer.

2 *Cf* Adams 2009, Awaad 2003, Balinger & Wiles 2001, Joubert 2009.

pertaining to the existing occupational therapy curriculum in their development of cultural competence were also investigated.

For the purpose of this article, cultural competence will first be conceptualised, and then contextualised within the framework of occupational therapy, in order to provide the reader with a theoretical background against which the methodology and results of the study will be discussed.

2. Cultural competence

Awaad (2003: 356) defines culture as

> ... the accumulation of non-material influence that defines the learned identity and behaviours of an individual and the social group(s) to which he or she belongs.

Culture affects our view of life and therefore has an influence on everything we think, believe and do. In brief, culture plays a pivotal role in shaping our identity (Watson 2006: 152) and more specifically our choice of occupations, thus substantiating culture as a core consideration for occupational therapists.

While there are many definitions of cultural competence, the essential description of this skill is depicted as the ability to

> ... respond respectfully and effectively to people of all cultures, classes, races, ethnic backgrounds, sexual orientations, and [...] religions in a manner that recognises and values the worth of individuals, families, tribes and communities and protects and preserves the dignity of each (CWLA 2007: 1).

Dillard *et al* (1992: 722) describe cultural competence as "an awareness of, sensitivity to and knowledge of the meaning of culture", while the CWLA (2007: 2) emphasises the need to develop a skill to "... operationalise this knowledge into [...] routine functioning". For occupational therapists, cultural competence will mean to relate to a client in such a way that intervention and interactions are culturally and contextually appropriate to the client.

As cultural competence is such an abstract, multidimensional concept, the authors designed a diagram based on the work of other

researchers to summarise the concept of cultural competence (*cf* Figure 1).[3]

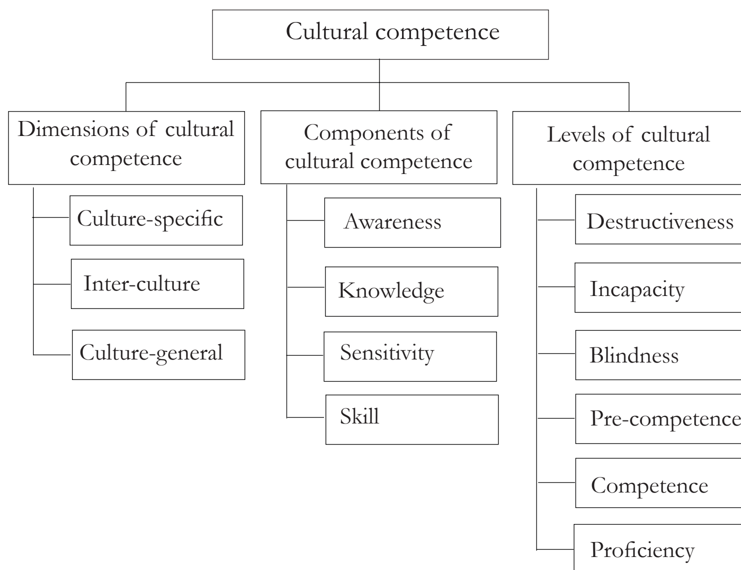

Figure 1: Schematic representation of the dimensions, components and levels of cultural competence

2.1 Dimensions of cultural competence

There are three dimensions of cultural competence (Figure 1): culture-specific competence refers to the ability to relate to a specific culture such as your own, with its unique rituals and norms; inter-cultural competence refers to the ability to relate cross-culturally with cultures different from one's own, and culture-general competency refers to the acknowledgement and professional recognition and valuing of cultural differences in the clinical setting (Odawara 2005: 326). All of these dimensions need to be present should a therapist wish to deliver culturally competent service to all clients, and this is only possible

3 *Cf* Odawara 2005, Dillard *et al* 1992, CWLA 2007, James 2006. Cross *et al* (cited by Wittman & Velde (2002)).

when all the components of cultural competence are present for all three dimensions.

2.2 Components of cultural competence

Various descriptions of components of cultural competence have been suggested in literature, including James (2006) and Suarez-Balcazar *et al* (2009). For the purpose of this study, the four components identified as being essential in developing cultural competence as described by James (2006) were chosen (*cf* Figure 1).

According to James' (2006) description, cultural awareness refers to developing an understanding of another ethnic group, and usually involves internal changes in terms of attitude and values. Ways to develop cultural awareness include acknowledging personal biases, being prepared to extend oneself psychologically and physically to the client population, and recognising one's own comfort level in different situations (James 2006).

Cultural knowledge entails familiarisation with selected cultural characteristics, histories, values, beliefs, and behaviours of the members of other ethnic groups. Ways to obtain cultural knowledge include knowing how others view your culture, gathering specific information pertaining to other cultures, and sharing knowledge and experiences with others (James 2006).

Cultural sensitivity involves knowing that cultural differences and similarities exist, without assigning values to those cultural differences. It also relates to a willingness to deliver culturally relevant and culturally specific service (James 2006).

Cross-cultural skills are manifested in culturally sensitive and appropriate practice. It may be developed through "... formal coursework, informal interaction and networking, and experience" (James 2006: 2). Cultural competence is an involved process of learning and practising within the framework of the elements of cultural competence, requiring long-term commitment (James 2006: 1).

2.3 Levels of cultural competence

According to Cross *et al* (Wittman & Velde 2002), development of cultural competence occurs on a continuum where an individual

moves through six stages or levels (*cf* Figure 1). The authors interpret these levels as representative of the hierarchical manifestation of the components of cultural competence. Descriptions of levels are quoted directly from the source to prevent changes to any part of the original meaning.

2.3.1 Cultural destructiveness

Cultural destruction

> ... is characterised by the purposeful destruction of a culture, as exemplified when persons of colour are denied access to their natural healers or purposely put at risk in medical or social experiments (Wittman & Velde 2002: 454).

For the occupational therapist, such actions usually imply unethical behaviour. Cultural destructiveness may be characterised as, for example, trivialising or demonising the role of traditional health practitioners due to unfounded biases.

2.3.2 Cultural incapacity

Cultural incapacity refers to

> ... individuals or organisations that do not intentionally seek to be culturally destructive but lack the capacity to help minority clients or communities [...] Such incapacity frequently occurs in healthcare systems, which are traditionally paternalistic in nature (i.e. believing in the supremacy of the knowledge of the dominant culture) (Wittman & Velde 2002: 454).

In the South African context, the term “minority client”, as used by Wittman & Velde (2002), refers to the majority of the South African population who remain socio-economically marginalised as a result of the political history of the country. Occupational therapists in clinical settings in South Africa are still often subjected to a systematic paternalistic hierarchy (Van der Merwe 2006: 122) where the role of the occupational therapist is prescribed by biomedical imperatives, as opposed to valuing the holistic, client-centred paradigm of occupational therapy. The strain between the prescriptive biomedical imperatives often situated within a patriarchal discourse, and the client-centred values of occupational therapy may put the occupational therapist in South Africa at risk of cultural incapacity.

2.3.3 Cultural blindness

Cultural blindness is characterised by the

> ... belief that colour or culture makes no difference and that all people are the same; cultural strength is ignored and assimilation is encouraged (Wittman & Velde 2002: 454).

This may happen when a therapist treats a client from a different culture than that of the therapist, and executes treatment in the way the therapist thinks is best, without considering the client's culture; for example, choosing an activity without considering the appropriateness of such an activity for the specific client. According to Wittman & Velde (2002: 454), "... [t]herapists in any of these three stages: destructiveness, incapacity or blindness, may be considered to be culturally incompetent".

2.3.4 Cultural pre-competence

Cultural pre-competence is characterised by

> ... the realisation of agency or individual weakness in serving minorities and attempts to improve some aspects of service relevant to a specific population. Two dangers exist at this stage: tokenism and a false sense of accomplishment or failure that prevents forward progress along the continuum from occurring (Wittman & Velde 2002: 454).

For the occupational therapist, cultural pre-competence may manifest when entering into a community setting with the sincere intent to work with a client-centred approach, but lacking the skills to facilitate long-term agency of the community members, for example, results in unsustainable community projects.

2.3.5 Cultural competence

Cultural competence features

> ... acceptance of and respect for cultural differences. Continuing self-assessment regarding culture, attention to the dynamics of differences and a continuous expansion of cultural knowledge and resources occur (Wittman & Velde 2002: 454).

Cultural competence requires the occupational therapist to be constantly reflecting on subconscious ideological assumptions.

2.3.6 Cultural proficiency

Cultural proficiency is characterised by

> ... holding culture in high regard and promoting competency in others. The difference between the competence and proficiency stages is the extent to which the therapist or system regards cultural differences and similarities (Wittman & Velde 2002: 454).

These six levels provide a systematic way of considering the degree of an individual's cultural competence, and give an indication of what therapists should strive to achieve as they develop from one level to the next.

3. Contextualising cultural competence in occupational therapy

3.1 Previous research on cultural competence in occupational therapy

Based on determinants such as globalisation, cultural competence is increasingly receiving attention and deserves consideration in curricula worldwide. Most of the literature on cultural competence, which the researchers were able to obtain, is based on British, Canadian, American and Australasian studies.[4] This information may be of some value, but certain limitations to the application of these studies' results on South African students and therapists are recognised. The South African context is stringed with many variables, including diversity, residual effects of apartheid and a majority (developing) world context – in contrast with the minority (developed) countries where previous studies were performed. To the authors' knowledge, no literature is available on research done on cultural competence involving South African occupational therapy students or therapists. This lack of information emphasises the need for research in what can be regarded as a fundamental consideration for the occupational therapy profession in South Africa.

4 *Cf* Odawara 2005, Rasmussen *et al* 2005, Murden *et al* 2008, Suarez-Balcazar *et al* 2009.

3.2 The importance of cultural competence in occupational therapy

It was established earlier that culture not only contributes to a person's identity, but also plays an irrefutable role in the individual's occupational functioning. Viewed from this perspective, cultural competence can be regarded as a key element of holistic, client-centred occupational therapy (Awaad 2003). Evidence also indicates that the presence or lack of cultural competence in the therapist can impact on therapeutic outcomes, treatment implementation, compliance and follow-up (Muñoz 2007).

Cultural competence allows the occupational therapist to assist the client in engaging in culturally meaningful occupational experience, promoting occupational justice (Odawara 2005: 333). Therefore, an occupational therapist who is not culturally competent is at serious risk of not only ineffective treatment, but also unethical behaviour.

Resulting from the submission of the Occupational Therapy Association of South Africa (OTASA) made to the Truth and Reconciliation Commission (TRC) in 1997, the OTASA Code of Ethics and Professional Conduct (OTASA 2005: 2) states that:

> ... [o]ccupational therapy services shall be provided equitably and shall not allow prejudice or discrimination toward a patient/client on the basis of race, culture, language, age, sexual orientation, disability, socio-economic status, to result in an infringement of their privileges or rights. Neither personal bias nor personal favour shall be permitted to influence service delivery.

From this Code it is evident that occupational therapists practising in South Africa are obliged to be at least free of prejudice toward issues such as culture. However, when read in conjunction with the first regulation in the same section, which states that occupational therapists must "demonstrate a sincere concern for the wellbeing of clients [...] and act in the best interests of the individual [...]" (OTASA 2005: 2), it is evident that cultural competence is of the essence for ethical practice.

3.3 Teaching cultural competence in occupational therapy education

Several scholarly articles have been written about teaching cultural competence in occupational therapy.[5] Wittman & Velde (2002) are of the opinion that the level of critical reasoning necessary for the development of cultural competence cannot be obtained at an undergraduate level. However, most authors agree with Forwell *et al* (2001: 91) that developing cultural competence is a lifelong process and therefore a dynamic process of becoming rather than a static state of being, implying that the process of developing cultural competence can and must be addressed in undergraduate occupational therapy curricula.

In the submission to the TRC made by OTASA in 1997, the profession pledged to train professionals with a sincere concern for human rights and human dignity (OTASA 2008: 18). In addition, the central governing body for quality assurance in South Africa has set certain "Exit Level Outcomes" to be achieved by graduating students in order to qualify as occupational therapists (HPCSA 2006). Exit Level Outcome 9 states that students should

> ... demonstrate in-depth knowledge of occupational science and occupational therapy and its practice within the South African and global context acknowledging both indigenous and international knowledge or perspectives (HPCSA 2006: 10).

Some of the associated assessment criteria include to "[d]emonstrate an awareness and sensitivity of the influence that diverse cultural and social contexts and systems have on occupational choice and behaviour", and to

> ... [d]emonstrate an understanding of and ability to reflect upon own biases and their impact on the relations and interactions with others; service providers; colleagues; service recipients (HPCSA 2006: 10).

These requirements imply that a certain level of cultural competence needs to be achieved by students in occupational therapy by the time they have completed their undergraduate training.

5 *Cf* Wittman & Velde 2002, Ekelman *et al* 2003, Forwell *et al* 2001.

Cultural competence has, *inter alia*, been defined as "... an awareness of, sensitivity to, and knowledge of the meaning of culture" (Dillard *et al* 1992: 722).

In their study, Ekelman *et al* (2003) identified four strategies, used in the training of health care professionals to become more culturally competent, which reflect these components of cultural competence. The strategies include (Ekelman *et al* 2003: 134):

- knowledge-oriented strategies that focus on information about students' own and other cultures;
- awareness-oriented strategies that focus on experiential learning and creating opportunities for students to apply critical thinking skills by interpreting situations from different viewpoints;
- affect-oriented strategies that attempt to "facilitate the student's ability to empathise with others by participating in activities that require the student to process feelings", and
- skill-oriented strategies, which focus on the incorporation of the knowledge, awareness and affect competencies in intervention planning and execution.

3.3.1 Knowledge-oriented strategies

This is the most elementary of the strategies and focuses on the dissemination of information pertaining to culture. Knowledge of the client's, the student's or the therapist's own culture (Forwell *et al* 2001), as well as that of occupational therapy (Awaad 2003, Kondo 2006) must be attained. These three cultural dimensions are described below as they relate to the development of cultural competence.

- The client's culture

  Odawara (2005: 325) states that understanding a client's cultural background is essential when the student or therapist helps the client to choose and engage in culturally meaningful occupations.

- The student or therapist's culture

  Knowledge about the nature of one's own cultural beliefs and values assists in understanding the dynamics between one's own culture and that of a person from another culture, and improves awareness of the impact of one's own culture and world view on one's approach when working with clients (Odawara 2005: 326).

- The culture of occupational therapy

  Much bias has been noted in the culture of occupational therapy. Kondo (2006: 174), for example, argues that words that are central to occupational therapy, such as "occupation" and "independence", are not applicable to all cultures. This may be due to the way in which these terms are typically defined and conceptualised from a western perspective, which may differ from that of the client. Iwama (2005a & 2005b) points out that "conventional occupational therapy" emerged from Western cultural contexts and, if applied without alteration to non-western societies, can cause therapy to fail or even be harmful. Therefore, students need to carry extensive knowledge of how the culture of occupational therapy relates to the culture of its consumer in order to allow for truly culturally competent practice.

3.3.2 Awareness-oriented strategies

The focal point in awareness-oriented strategies is to afford students the opportunity to become aware of their own cultural views (which include the culture of occupational therapy), as well as the culture of clients. Students must be allowed to evaluate and understand the influence of these cultures on each other (Ekelman *et al* 2003: 131-2).

3.3.3 Affect-oriented strategies

Empathising with individuals of other cultures and processing feelings related to cultural experiences form the basis for affect-oriented strategies (*cf* Ekelman *et al* 2003). Odawara (2005: 326) asserts that the real challenge lies in viewing the world from the viewpoint of the client. Students should have the opportunity to experience the world of the client in order to integrate the values of the client into their own as occupational therapists. Only then can the client's cultural values be integrated into the intervention process.

Affect-oriented strategies allow students to acquire sensitivity towards other cultures, leading to the development of skills such as managing different cultures in treatment planning or intervention (Forwell *et al* 2001: 91-2).

3.3.4 Skill-oriented strategies

Skill-oriented strategies require students to be flexible and creative in considering diversity issues when adapting and applying intervention plans to individual clients. These strategies encourage students to incorporate knowledge, awareness and affective competencies (sensitivity) into service delivery (Ekelman *et al* 2003: 131).

Teaching cultural competence on an undergraduate level requires an integrated educational approach, incorporating the elements mentioned above, as cultural competence is not a static state to be obtained, but an integrated process that needs to be encouraged and developed. It is argued that developing the components of cultural competence, namely knowledge, awareness, sensitivity and skill through the strategies mentioned above, contributes to the student's move along the continuum of the levels of cultural competence towards culturally competent graduates. Based on the culturally diverse context in South Africa, cultural competence within all the dimensions needs to be achieved.

3.4 Cultural competence and the occupational therapy curriculum of the University of the Free State

3.4.1 Vision, mission, values and cultural competence

The Department of Occupational Therapy at the UFS subjects itself to the vision, mission and values of the University, the Faculty of Health Sciences and the School for Allied Health Professions. The values relating to cultural competence set by the UFS as an academic institution, include fairness, integrity and service (UFS 2007); for the Faculty of Health Sciences, tolerance of diversity and respect for different ideologies (UFS 2005), and for the School for Allied Health Professions it includes internationally recognised ethical principles, integrity, equity, and tolerance of diversity including cultural and other differences (UFS 2005).

Values, such as fairness, integrity and ethical principles, imply at most an ethical life attitude, and do not require an active change in behaviour according to any specific client factor such as culture, socio-economic status or religion. The only term used in direct connection with culture is "*tolerance* of diversity including cultural [...]

difference" (UFS 2005: 1). However, tolerance is defined as to permit without protest or interference, implying at most a passive acceptance of cultural diversity without any active effort to change one's own behaviour in relation to that. It is clear that tolerance (in fact viewed as a condescending term in diversity literature) is not enough if we want to develop true cultural competence among students, as cultural competence requires actively "... learning new patterns of behaviour and effectively applying them in the appropriate settings" (King *et al* 2006: 3).

3.4.2 The occupational therapy curriculum

Cultural competence is not expressly addressed in the occupational therapy curriculum at the UFS. There appears to be a gap between expressed ethical values (such as stated by the UFS), and a clear indication of how to operationalise these values into culturally competent practice.

Strategies employed indirectly by the Department of Occupational Therapy at the UFS that may contribute to the development of cultural competence among students focus primarily on knowledge- and awareness-oriented strategies in the form of single lectures about general concepts such as diversity, traditional health care practice and ethics. Students are also exposed to clients from diverse cultural backgrounds during clinical fieldwork from the second semester of the second year of study to the end of their fourth year (fieldwork experiences increase exponentially in frequency and duration of placements from the third to the fourth year). However, no specific strategies (such as structured reflection on cultural competence) are employed during clinical practice in order to facilitate the development of cultural competence along the continuum of the levels of competence. Reflexive reports are required of students, but only relating to specific clinical skills.

There is much room for improvement in the utilisation of awareness- and affect-oriented strategies, in particular, which can supplement skill-oriented strategies for effective learning to take place, as well as the integration of the value of diversity that is beyond the intellectual conceptualisation of the notion of "tolerance".

Through deliberation and a reflective process, consensus was obtained in the Department of Occupational Therapy that students

attain the exit level outcomes set by the Professional Board of HPCSA for Occupational Therapy, Medical Orthotics/Prosthetics & Art Therapy (2005: 13) during their years of study at the UFS. One example of a relevant outcome to the topic of this study states:

> [Students should] demonstrate an awareness of, sensitivity towards and tolerance of cultural, language, socio-economic, political, gender and/or other diversity as evident in the South African context.

It is believed that Clinical Occupational Therapy contributes significantly to students' cultural competence development. However, there seems to be a conflation in the underlying assumptions of the curriculum between what ethical practice entails and what culturally competent practice would entail in the sense that ethical practice does not automatically imply culturally competent practice. Therefore, the opinion holds that the current outcomes are not sufficient to develop true cultural competence, and amendments to the curriculum are necessary.

It can therefore be construed that certain shortcomings are observed in the policies of the UFS and the occupational therapy curriculum if they do strive towards educating truly culturally competent students. However, efforts are continuously made to improve policies and curricula in order to keep abreast of the latest trends and changes. Consequently, one of the aims of this project was to provide some assistance to the Department of Occupational Therapy in adapting policies and curricula to ensure the development of cultural competence among undergraduate students.

3.5 Synopsis

Currently, in occupational therapy, cultural competence is of the essence for ethical and culturally relevant practice. Various factors contribute to the necessity for cultural competence. After a comprehensive literature overview the authors constructed a schema (*cf* Figure 2) depicting the complex relation of concepts related to cultural competence in occupational therapy.

The ethical obligation and commitment to occupational justice that is central to the contemporary paradigm of occupational therapy and necessitates serious consideration of culture in occupational therapy intervention are found at the core of the schema.

Surrounding these core elements in Figure 2 are the legislative determinants that legally bind therapists to deliver a service that is in accordance with the Constitution of the Republic of South Africa; the educational outcomes that require the training of occupational therapists to become culturally competent in order to qualify in this profession, and the concept of client-centred occupational therapy, where the occupation prides itself on a holistic intervention approach to clients, prioritising the client's needs and desires, thus emphasising the importance of cultural competence in occupational therapy.

The outer circle represents culture as it relates to occupational therapy. Culture determines individuals' identities, assumptions, roles and occupations, and must therefore be considered in occupational therapy intervention.

While all the aforementioned states as to why cultural competence is essential in occupational therapy, the four elements of cultural competence that must be acquired are shown at the bottom of the illustration in Figure 2. The authors conclude that it is essential for both therapists and students to develop a high degree of cultural awareness, knowledge, sensitivity and cross-cultural skills. These attributes will empower them to deliver ethical, client-centred, relevant care to clients in the democratic, post-apartheid South African context.

4. Methodology

4.1 Study design

A descriptive study design was used to answer the research question: What are the levels of, and perceptions regarding cultural competence among occupational therapy students in their second to fourth year of study at the University of the Free State? A cross-sectional, analytical component was added to compare the different year groups of students with regard to their degree of cultural competence.

4.2 Sample

Seventy-four registered occupational therapy students in their second to fourth year of study at the UFS were approached for participation in the study in 2007. Participants included in the study could be male or

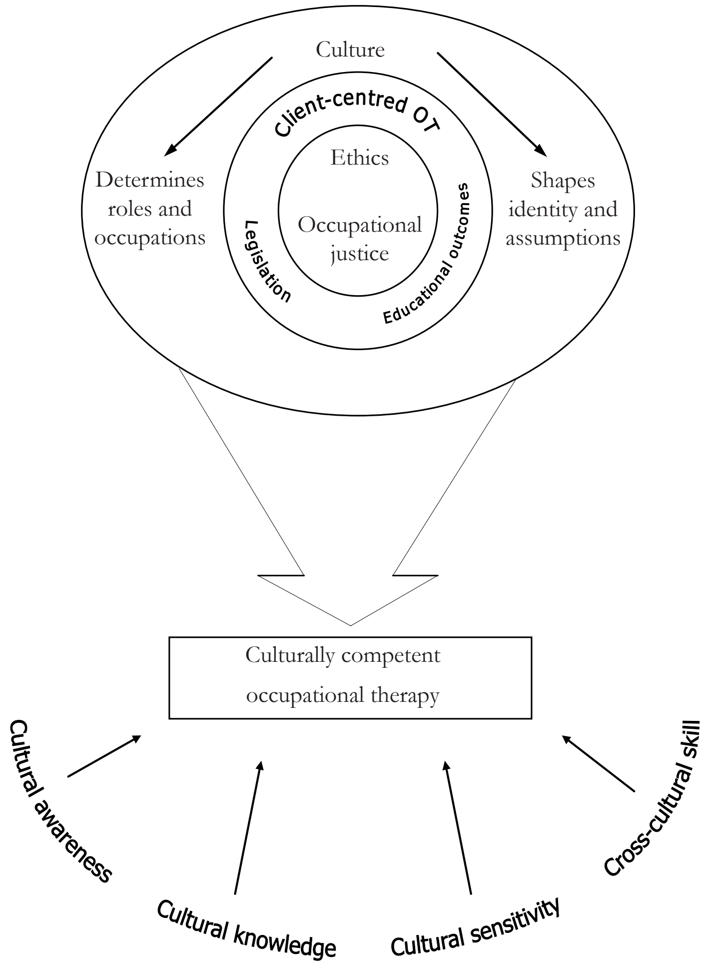

Figure 2: Schematic representation of cultural competence as relevant to occupational therapy practice

female occupational therapy students from any cultural background or ethnic group, and had to be registered for the degree Baccalaureus in Occupational Therapy at the UFS. Participants had to be in their second, third or fourth year of study in occupational therapy, and should have started their studies in occupational therapy directly after school. The following students were excluded from the study: all first-year occupational therapy students, due to their limited exposure

4.3 Measurement

Information was obtained by means of a paper-and-pencil questionnaire. The questionnaires were administered at a pre-arranged time in a lecture room at the Dept of Occupational Therapy, UFS. The questionnaires and consent forms were provided to the participants to be completed individually and collected immediately upon completion. Participation was voluntary, and all information was treated confidentially. The researchers were involved in the acquisition of informed consent as well as the distribution and collection of questionnaires, thus complete anonymity could not be guaranteed. However, no personal identification was required on the questionnaires.

The questionnaire was compiled by the researchers, and the following sources were used in the compilation of the questionnaire:

- For the indicators of cultural awareness, knowledge, sensitivity and cross-cultural skill James (2006) served as the main source for items regarding students' cultural competence.
- Ekelman *et al* (2003) contributed to indicators for the elements of cultural competence as well as questions related to the curriculum.
- Information pertaining to levels of cultural competence, including indicators of each level, was obtained from Wittman & Velde (2002).
- Requirements for cultural competence, as set out by the HPCSA (2006), were taken into consideration.
- A questionnaire compiled by Cheung *et al* (2002) was consulted. This questionnaire focused only on cultural awareness (an element of cultural competence), but was useful in guiding the researchers in the formulation of questions.

- A study by Rasmussen *et al* (2005), utilising the questionnaire compiled by Cheung *et al* (2002), was also consulted.

This process yielded a questionnaire that included sixteen items, of which six were open-ended questions to assess the levels of cultural competence represented by the formulation of the students' answers. The remainder of the questions were constructed to reflect perceptions regarding cultural competence in various ways, including "yes-no" and five-point rating scale type questions.

A pilot study was conducted on a sample of six occupational therapy students (two from each year group) who did not comply with all the inclusion criteria and were excluded from the final study, in order to increase the validity and reliability of the questionnaire. Feedback from the pilot study helped clarify ambiguous questions and refine the questionnaire before the final execution of the project.

4.4 Analysis

Descriptive statistics, namely frequencies and percentages for categorical data, and medians and percentiles for continuous data, were calculated. Groups were compared by means of 95% confidence intervals. The Department of Biostatistics at the UFS analysed the data.

4.5 Ethical considerations

The protocol of the study was approved by the Ethics Committee of the Faculty of Health Sciences, UFS (ETOVS Nr 08/07). Written consent for students to participate in the study was obtained from the Vice-Rector: Academic Planning, the Head of the School for Allied Health Professions, and the Head of the Dept of Occupational Therapy. Participants received verbal and written information before commencement of the study. In order to protect their rights, all the participants signed a consent form, emphasising that participation in the study was voluntary; that a student could withdraw from the study at any time; that names were omitted from the questionnaires, and that information obtained would be kept confidential.

5. Results

5.1 Demographic data

Fifty-one occupational therapy students participated in the study, of whom 21 (41.2%) were second-year, 17 (33.3%) third-year, and 13 (25.5%) fourth-year students. The age of the participants ranged between 19 and 22 years (median age 20 years). With regard to home language, 43 (84.3%) participants were Afrikaans-speaking, seven (13.7%) English- and one (2.0%) Sesotho-speaking. All participants were female; 50 participants (98.0%) were white and one participant (2.0%) was black.

5.2 Assessment of perceptions and levels of cultural competence

Five separate categories emerged and will be discussed, namely general perceptions, cultural knowledge, awareness, sensitivity, and levels of competence. Assessment of skill levels was not included in the study, as its assessment by means of a questionnaire would not have been feasible. In addition, the questionnaires were not validated to measure skill, but rather constructed to measure perceptions.

5.2.1 General perceptions

Twenty-six (50.9%) participants indicated that, in comparison to clients from their own culture, they felt less comfortable when working with clients from cultures different from their own. Nineteen (37.3%) participants felt equally comfortable with clients of either their own or different cultural backgrounds, while six (11.8%) pointed out that they felt more comfortable working with clients from a culture different from their own.

No statistically significant difference between comfort levels of the different year groups, compared by means of 95% confidence intervals, was observed (95% CI for second- versus third-, second- versus fourth- and third- versus fourth-year students were respectively [-0.3% ; 55.5%], [-12.1% ; 48.6%] and [-41.4% ; 21.9%]). However, when asked whether they felt more comfortable with clients from other cultures than at the beginning of their studies in occupational therapy, 14 (66.7%) second-year students indicated that they were

more comfortable as their studies progressed, while 16 (92.3%) third-year and 12 (94.1%) fourth-year students answered affirmative in this regard. The difference between the second- and third-year participants was statistically significant (95% CI [0.01%; 49.3%]).

5.2.2 Cultural knowledge

The questionnaire did not assess knowledge *per se*, but rather these students' attitude towards and perceptions about cultural knowledge. It was found that 32 (62.7%) students have never or seldom made an active attempt to gather information and obtain knowledge of a client's culture. Thirteen (25.5%) participants sometimes made an attempt to obtain information on a client's culture, while only six (11.8%) students indicated that they would mostly or always make an attempt to acquire information on a client's culture.

It was also found that ten (19.6%) students did not perceive themselves as being aware of how persons from other cultures viewed their own culture, while 28 (54.9%) indicated that they had some idea, and 13 (25.5%) indicated that they knew reasonably well how their culture was viewed by others.

5.2.3 Cultural awareness

It is cause for concern that ten (19.6%) participants revealed that they have not previously considered culture in the assessment and/or treatment of a client. Results of participants' feedback on the question: Have you ever consciously considered a patient's culture in the evaluation and/or treatment planning of a patient? are shown in Figure 3 for each academic year group and for the group as a whole.

5.2.4 Cultural sensitivity

With regard to the willingness to approach the client with cultural sensitivity, only nine (17.6%) students indicated that they would always be prepared to work from the client's cultural frame of reference. Sixteen participants (31.4%) indicated that they would mostly be willing, and 20 (39.2%) would sometimes work from their client's cultural frame of reference. Six (11.8%) students indicated that they would seldom or never consider the client's cultural frame of reference.

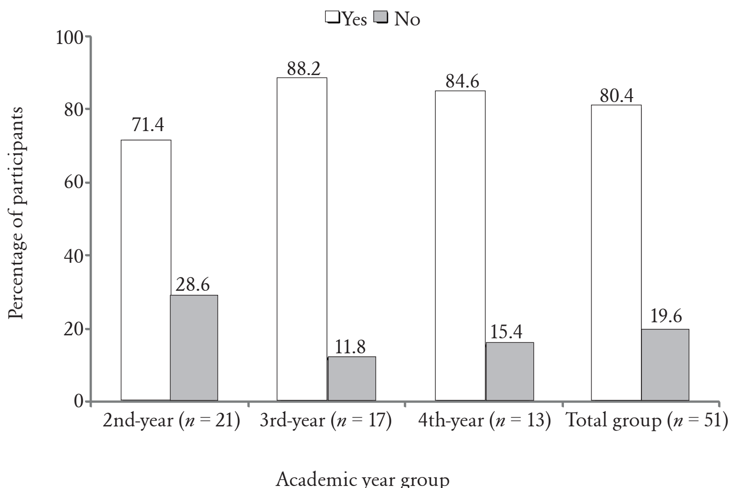

Figure 3: Participants' feedback on the question: Have you ever consciously considered a patient's culture in the evaluation and/or treatment planning of a patient?

Twenty (39.2%) participants regarded sensitivity to cultural differences as an important issue in the therapy setting. In response to an open-ended question asking whether clients from other cultural groups should be treated differently than clients from their own cultural background, 22 (43.1%) students emphasised the importance of equality and no discrimination on the basis of culture.

5.2.5 Levels of cultural competence

In order to evaluate participants' levels of cultural competence, students were asked to motivate answers to questions about cultural knowledge, awareness and sensitivity. Indicators of the different levels of competence, as described earlier, were used to assess participants' responses and categorise each response as representative of a specific level of cultural competence. The questions intended to elicit indicators of levels of competence are summarised in Table 1. This table also provides examples of answers representative of the different levels of competence, together with a motivation for the allocation

of a specific level to the answer. Students' responses marked with an asterisk (*) were translated from Afrikaans.

Using a pre-determined protocol for scoring, responses were scored independently by two pairs of researchers, and levels allocated by each pair were then compared for consistency. Where differences of opinion existed, discussion took place among researchers in order to determine the most probable level of competence reflected by the answer.

Table 1: Questions designed to elicit and answers indicative of level of cultural competence

Introductory and follow-up questions	Answer options to introductory questions	Examples of answers	Motivation for allocation of level (Wittman & Velde 2002)
In comparison to a patient from your own culture, how comfortable do you feel to treat a patient from another culture? Please motivate your answer.	Very uncomfortable; Less comfortable; Just as comfortable; More comfortable; Much more comfortable	Level 2: It is easy to feel superior and also more in control. They also do not judge so easily.*	Believes in the superiority of his/her own culture.
		Level 3: [I] try not to make a distinction. [An] occupational therapist should remain objective.*	Believes that culture makes no difference; all people are the same.
		Level 4: It is difficult to communicate with them. Cultural differences make it difficult to know if you are possibly unintentionally upsetting them.	Realises own weaknesses in treating clients from different cultural groups.

Introductory and follow-up questions	Answer options to introductory questions	Examples of answers	Motivation for allocation of level (Wittman & Velde 2002)
Have you ever consciously considered a patient's culture in the evaluation and/ or treatment planning of a patient? If YES, explain how.	Yes No	Level 3: All students who answered 'No' to the introductory question; thus not providing further explanation.	A 'no' answer would indicate the notion that culture makes no difference – treating from the student's perspective.
		Level 4: With the choice of activities for assessment – what that culture will like to do e g cut and paste soccer pictures, string beads, etc.*	Exemplifies attempts to improve consideration of culture, although danger of tokenism and false sense of accomplishment exists.
Do you think that persons from other cultures should be treated differently from patients from your own culture? Please motivate your answer.	Yes No	Level 3: They remain people and have just as many activities to do as others and want to be just as independent as others.*	Indicative of belief that culture does not make a difference and that all people are the same.
		Level 4: Cultures have different religions and norms that you have to adapt to.*	Indicates sensitivity to cultural differences and attempts to improve service delivery in that regard.

Introductory and follow-up questions	Answer options to introductory questions	Examples of answers	Motivation for allocation of level (Wittman & Velde 2002)
To what extent are you willing to work completely from the cultural viewpoint of your client, even if it differs completely from your own viewpoint, and/ or the viewpoint of OT, provided that it is within the ethical guidelines? Please explain your answer.	Never Seldom Sometimes Most of the time Always	Level 2: I do not want to change my norms to treat others.*	Lacks capacity to help clients from other cultures, as the student is unwilling to move from own cultural viewpoint.
		Level 3: I feel more comfortable with what I know and what has been taught to me so it's easier.	Ignores cultural strength of client; executing treatment in the way the student thinks best due to own comfort levels.
		Level 4: We must consider others' way of doing things and to get him/her independent in the things that they do, especially if it is culturally bound.*	Showing willingness to extend self in order to optimise service to client from a different cultural background.
		Level 5: As long as it is within ethical guidelines, I believe that it is important to work from the viewpoint of the client as the client needs to become integrated into his community and culture again. It is therefore important not to judge or try to change the client's viewpoint.	Indicates acceptance of and respect for cultural differences beyond just willingness to incorporate client's cultural viewpoint (evidence of self-reflection).

The feedback did not consistently reflect the same level of competence in each participant's questionnaire, on the 6-level continuum described earlier. For example, one student scored level 4 (cultural pre-competence) on one question, level 3 (cultural blindness) on two questions, and level 2 (cultural incapacity) on the other question. Therefore, a specific level of competence could not scientifically and reliably be allocated to each individual participant. Hence, the results on this specific component of cultural competence

could only be indicated as a range of functioning, being that levels of competence among the students who participated in this study ranged from level 2 (cultural incapacity) to level 4 (cultural pre-competence) on the cultural competence continuum identified by Wittman & Velde (2002).

Only three (5.9%) students obtained a level 5 score (cultural competence) on one of the four questions evaluating the level of cultural competence. Answers given on each of these four questions are reflected in Table 2 as a percentage of the total number of answers (204) that indicated each level of competence. These results, however, are not indicative of the number of students that function on each level, but only of the number of answers corresponding to each level.

Table 2: Comparison per year group of participants' response to questions evaluating levels of cultural competence

Level of cultural competence	Number (%) of answers			
	2nd-year (*n*=21)	3rd-year (*n*=17)	4th-year (*n*=13)	Total group (*n*=51)
Total number of answers	84	68	52	204
1. Cultural destructiveness	0	0	0	0
2. Cultural incapacity	10 (11.9)	3 (4.4)	3 (5.8)	16 (7.8)
3. Cultural blindness	23 (27.4)	26 (38.2)	19 (36.5)	68 (33.3)
4. Cultural pre-competence	49 (58.3)	39 (57.4)	29 (55.8)	117 (57.4)
5. Cultural competence	2 (2.3)	0	1 (1.9)	3 (1.5)
6. Cultural proficiency	0	0	0	0

No statistically significant differences in the levels reflected by the answers between the different year groups were observed when compared by means of 95% confidence intervals.

5.3 Perceptions regarding the occupational therapy curriculum of the UFS

Thirty-two (62.7%) participants were of the opinion that the current UFS occupational therapy curriculum does not sufficiently equip them to work with clients from other cultures. In comparative data, a tendency was observed among fourth-year students (*n*=7; 53.8%), who perceived the curriculum as more conducive to the development of

their ability to work with clients from other cultures, than second-year students (*n*=6; 28.6%), although the difference was not statistically significant (95% CI [-7.4% ; 52.6%]). The same tendency was noted between third- and fourth-year students (95% CI [-15.5%; 47.2%]). Figure 4 shows a comparison of the different year groups' opinion with regard to the sufficient provision of culture-related curriculum content.

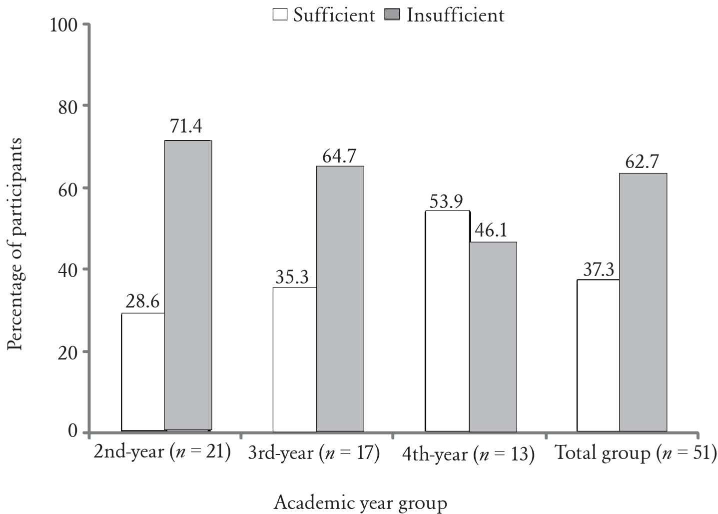

Figure 4: Students' perceptions regarding the sufficiency of the UFS occupational therapy curriculum in equipping them to develop cultural competence

Clinical experience (*n*=19; 37.3%), sociology modules (*n*=15; 29.4%), and modules dealing with interpersonal relationships (*n*=10; 19.6%) were components of the current occupational therapy curriculum which students perceived and identified as most useful in the development of cultural competence.

6. Discussion

Over half (51.0%) of the participants perceived themselves as uncomfortable, and consequently not sufficiently competent, when working with clients from cultural backgrounds different from their own. However, recognising one's own level of discomfort in dealing with clients from diverse cultural backgrounds is regarded as one of the first steps towards becoming culturally competent (James 2006). These results do not necessarily reflect negatively on the students' levels of competence. The most frequent reasons provided for feeling less comfortable with clients from other cultures were feeling unequipped to deal with cultural differences (n=37; 72.5%) and a fear of misunderstandings due to linguistic or other culture-specific differences (n=26; 51.0%).

Other results from the questionnaire also highlighted linguistic problems. South Africa has 11 official languages, and the majority of learners receive their primary and secondary schooling in either Afrikaans or English, which is very often not their mother tongue. In addition, a substantial proportion of South Africa's historically disadvantaged population is not fluent in either Afrikaans or English, further widening the gap between different cultural and language groups. Twenty-one (41.2%) participants indicated that introducing a basic course in an African language (one of the other nine official languages recognised in South Africa) into the existing occupational therapy curriculum would contribute positively to their ability to engage with clients from other cultures. Being able to speak the client's language will contribute to better communication with clients from different cultural backgrounds, thus promoting the development of cultural competence. Although this is a positive and commendable suggestion by the students, the linguistic differences in South Africa are so complex that learning one of the other official languages would not necessarily equip a therapist to work in every part of the country. This issue, however, is beyond the scope of this discussion.

A significant difference (95% CI [0.01%; 49.3%]) between second- and third-year students was observed with regard to the level of discomfort experienced with clients from different cultures in comparison to the beginning of their studies. A possible explanation could be that clinical training only commences in the second semester

of the second year, and exponentially increases in frequency and duration of placements as from the third year. Students therefore experience a substantial increase in exposure to clients from diverse cultures in the third and fourth years of study, compared to the second year in which clinical training is limited. This observation is supported by Forwell *et al* (2001: 92), who stated that practical experience in working with diverse cultures is the most important contributing factor in developing cultural competence.

Students' attitude towards the acquisition of cultural knowledge was a cause for concern. Only six (11.8%) students indicated that they would mostly or always make an effort to obtain information on a different culture. Gaining cultural knowledge can be done independently, and students do not need to rely on the content of the curriculum to address this component of cultural competence. The vast majority of the group (*n*=45; 88.2%), who indicated that they had never, seldom or sometimes made an active attempt to obtain information on cultures different from their own, clearly reflects a need for the sensitisation of students to the importance of improving their cultural knowledge.

Less than 20% (*n*=10) of the participants were not aware of how their own culture was viewed by persons from different cultures. According to James (2006), an important part of growing in cultural knowledge is to be aware of how individuals from other cultures view one's own culture. It could therefore be regarded as an encouraging finding that over 80% (*n*=41) of the students were either somewhat or reasonably aware of other cultures' view of their own culture.

Ten students (19.6%) indicated that they never considered cultural issues when dealing with clients. Although it might not appear to be a substantial number, it was a disturbing observation when viewed against the values of occupational therapy as a profession and the expected outcomes required for students in this field. In addition, no statistically significant difference in the feedback from students in different year groups was found in this regard. It could therefore be deduced that the lack of considering cultural issues when dealing with clients did not occur exclusively or primarily among less experienced students with limited exposure to the clinical environment.

With regard to cultural sensitivity, 26 (51.0%) students indicated that they were only sometimes, seldom or never prepared to work from the client's cultural frame of reference. Seven (26.9%) of these students, in other words 13.7% of the total group, indicated that religious concerns were their main objection and that they were not willing to engage in any practices contrary to their religious practices. For example, one student responded:

> I am prepared [to work from my patient's cultural frame of reference], but I refuse to do it if it goes against my religion [translated from Afrikaans].

Although this issue was raised by a minority group of students, it is still an important finding that may imply that strong religious convictions may in some instances hamper the development of cultural competence. It is a topic beyond the scope of this article that needs further investigation.

The majority of students (*n*=30; 58.8%) agreed that cultural differences should be seriously considered when working with clients. However, 22 (43.1%) participants were of the opinion that equality and no discrimination on the basis of culture were important issues when working with patients. It may be challenging, especially for students, to distinguish between accommodating a client's cultural preferences and "preferential treatment" (or discrimination) on the basis of culture, in particular in the post-apartheid South Africa where these seemingly opposing constructs are still emotionally laden to a considerable extent. Consolidating these issues should be addressed directly and boldly to empower students to respond competently in any cultural setting.

The levels of cultural competence among occupational therapy students at the UFS ranged between level 2 (cultural incapacity) and level 4 (cultural pre-competence) on the 6-level continuum of cultural competence. These results correlate with literature and support the opinion of Wittman & Velde (2002: 456), who argue that a level of cultural competence cannot be attained on undergraduate level (with only 1.5% of answers in our study being indicative of a cultural competence level).

With reference to Table 2, two further observations merit attention. First, no significant difference in the level of answers from

second- to fourth-year students was found. This finding, supporting the students' view, could be pointing towards the current curriculum not sufficiently equipping students to become more culturally competent.

Secondly, it should be noted that some (41.1%) of the participants' answers did not indicate adequate competency levels as would be expected, and reflected levels 2 and 3 (cultural incapacity and blindness, respectively) on the cultural competence continuum. The fourth-year students' answers would be expected to reflect at least level 4 of cultural competence, in other words pre-competence or higher. The finding that none of the year groups' answers reflected cultural destructiveness (level 1 competence), cannot compensate for the extremely low number (1.5%) of answers reflecting cultural competence (level 5) and none reflecting cultural proficiency (level 6 – defined as "holding culture in high regard and promoting competency in others"). Current levels of cultural competence in this particular group of students should therefore be regarded as unacceptable, considering the ethical and legal obligations of occupational therapists, educational outcomes required to be achieved by students, and the current era of accountability, which will not excuse nor tolerate blindness or incapacity regarding culture-related issues.

Less than 40% of the total group of participants indicated that the occupational therapy curriculum offered by the UFS sufficiently equipped them to deal with cultural differences in the clinical setting. It should be noted, however, that this opinion increased from 28.6% in second-year to 53.9% in fourth-year students. This finding is similar to that of Rasmussen *et al* (2005: 306), who reported that more senior than younger students had a greater rate of agreement with the statement that educational training could improve cultural awareness. This observation might be ascribed to longer exposure to the curriculum content (that is, learning more as the course progresses) and/or increased exposure to clinical settings where the value of the educational training can be realised.

Although only 37.3% of the participants were of the opinion that clinical experience was most useful in the process of developing cultural competence, literature suggests that practical experience is one of the most important means to enhance the development of

cultural competence (*cf* Kronenberg & Pollard 2005, Suarez-Balcazar *et al* 2009). Students identified additional subjects such as anthropology (suggested by 62.7%) and an African language (suggested by 41.2%), as discussed earlier, that could be included in the existing curriculum to enhance their ability to work with clients from other cultures.

7. Limitations of the study

When examining and interpreting the results presented in this article, certain limitations should be borne in mind. The study was conducted at only one university in South Africa, and therefore the findings of the study cannot be regarded as representative of perceptions of the entire South African population of occupational therapy students. Because of the strict inclusion criteria, the sample size was relatively small and represented 68.9% of the total group of occupational therapy students at the UFS at the time of the study. The sample was also primarily from one gender and cultural grouping, with 100% of participants being female, 98.0% being white. The sample size could potentially have influenced the validity of this investigation and the comparisons between year groups, most of which did not show statistically significant differences.

The questionnaire was not a standardised measuring instrument. It only aimed to assess students' perceptions and the extent of their competence as indicated by their perceived general behaviour. Answers to open-ended questions were interpreted by the researchers using specific information gained from scientific literature. However, the results pertaining to levels of competence remain mere interpretations of selected patterns of behaviour or thought that might indicate certain levels of cultural competence. Therefore, the greatest limitation in this respect is the danger of generalisation of certain behaviours as indicative of certain levels of competence, while cultural competence is not in any respect such a one-dimensional concept. By interpreting different questions (not only one) in the assessment of levels of competence, an effort was made to counter this limitation as far as possible.

Each participant's level of competence could not be specifically determined. The reasons for this include that accurately evaluating levels of competence would require a longer, more in-depth

questionnaire, focusing on all the different characteristics of each of the levels, and that the questionnaire was not a standardised instrument for measuring levels of competence. Therefore, any conclusions with regard to each participant's specific level of competence would be unreliable and invalid. Results of answers were consequently only indicated as a range of levels.

8. Recommendations

This article emphasised the importance of cultural competence in various instances. Based on the results of the study, follow-up investigations pertaining to specific aspects of cultural competence, detailed studies on levels of competence (utilising a measuring tool that focuses on all the different characteristics of each of the levels) or cultural competence among other populations may be considered. It is strongly recommended that more research on cultural competence be done in South Africa, in particular, among both qualified occupational therapists and students and students in other health professions.

Future researchers may want to include qualitative methods such as focus group interviews that will allow for feedback and triangulation. This is especially relevant where people's attitudes and perceptions are researched.

From the study it was deduced that students had certain needs for curriculum adaptations, and it is recommended that the Department of Occupational Therapy at the UFS and other universities in the country consider these needs when revising curricula.

9. Conclusion

This research showed that second- to fourth-year occupational therapy students at the UFS neither perceived themselves to have a sufficient degree of cultural competence, nor did their answers indicate sufficient levels of competence. There was little difference between the levels of answers provided by different year groups, indicating little, if any, growth in cultural competence from the second to fourth year of study. With regard to levels of cultural competence, over half of the participants' answers were indicative of cultural pre-competence (level 4). The majority of the remaining answers indicated a level of cultural

blindness (level 3), with a few indicating cultural incapacity (level 2). These levels of cultural competence are not acceptable within a client-centred profession such as occupational therapy.

The results support students' perceptions that the current occupational therapy curriculum at the UFS (that does not include any specific activities for the promotion of cultural competence in students) only coincidentally contributes to the development of cultural competence to a limited extent. It is inferred that, although it is assumed that cultural competence is implicitly addressed by the curriculum, the curriculum does not sufficiently equip students to become culturally competent. The curriculum is currently in the process of being revised, and serious consideration should be given to the findings with regard to specific needs as emphasised by the participants in this study.

Cultural competence is a highly relevant topic in occupational therapy, especially in view of the multicultural nature of societies worldwide. In order for students to become culturally competent professionals, they need training in cultural competence at undergraduate level. Students and educators should understand cultural competence more as a process of becoming, a development of moral sensitivity and an attitude of commitment that requires responsibility and dedication from all parties involved. From this point of view, we conclude that cultural competence should be reinforced in the process of professional development and education to perceive and pursue social and occupational justice (Duncan *et al* 2005), and as such train occupational therapists with the ability to truly practise occupational therapy (James 2006).

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