

## **Working with people from diverse cultures; cultural competence a knowledge domain or a way of being?**

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Through the process of globalisation people across the world have become more interconnected. There are huge opportunities for global engagement, working and living in countries which are not the place of one's birth. Alongside this is an increase in the number of people leaving their country of birth due to war and conflict. The United Nations Refugee Agency (2015) identified that one in every 122 humans is a refugee, displaced or seeking asylum. This process of living in a country different to one's birth can have significant impact upon individuals' health and wellbeing and therefore creates an increased need for healthcare services. Individuals from ethnic minority groups often experience poorer health outcomes both physically (World Health Organisation 2016) and mentally (Aggarwal 2016). These poorer health outcomes are often compounded as these individuals can also experience difficulties accessing health care services for a variety of reasons including; inability to speak the language of the country of residence, lack of understanding of how to access healthcare services as well as differing cultural beliefs and practices. Once they access healthcare then they can also experience difficulties in engaging with healthcare professionals due to their differing cultural values and beliefs. Yet a vital part of professional therapy practice is the development of a therapeutic relationship and integral to this is provide care that takes into account individuals personal beliefs, properties and preferences for managing their health (Muñoz 2007).

Cultural competence is often seen as a way in which these difficulties can be ameliorated. Internationally, there is an interest and focus on cultural competence in caring professional

relationships. Within the fields of therapy, research on cultural competence has been conducted in countries such as America (Smith et al 2014), Norway (Fougner and Horntvdt 2012), Canada (Gerlach 2015), South Africa (Mji 2008) and Ireland (Beagan and Chacala 2012) to name but a few. However cultural competence itself, has led to debates; it is often interpreted as an in-depth understanding of different cultural groups and indeed much work on cultural competence has focussed on developing practitioners understanding of cultures different to their own. Heaslip (2015) has previously questioned whether this is possible, whether practitioners truly can have an in-depth understanding of every culture in the world. Even if they could, the premise is based on homogeneity within cultural groups, yet we question whether all cultural groups are entirely the same. Research by Heaslip (2015a) with Gypsy Roma Travellers, a group that are generally perceived (within the United Kingdom) to be homogenous group and indeed there are some shared cultural values with regards to nomadism. However within this cultural group there are also many different and distinct subgroups such as Irish Travellers, Romany Gypsies, Eastern European Roma, English Travellers, Showman, Boaties and New Age Travellers and each group has their own distinct cultural identity. Her research identified that even within a family there can be distinct differences in cultural perspectives and views. For example, within with one family (Irish Travellers) there were three sisters, each had difference cultural views regarding work, marriage and family. Two of the three sisters had chosen to marry young and would only consider marrying a fellow Traveller, they perceived their role was to have children and look after the family home and wished to travel and be as nomadic as possible. The third sister, had very different views she has a short period studying at a university, and was now training as a beauty therapist. She was divorced (having married outside of the community) and now wished to focus on her career. Rather than seek a nomadic life she wished to live in a house and be settled. Herein lays the problem with viewing cultural competence as a knowledge base domain.

In contrast, we perceive cultural competence to be a way of being, a commitment towards accepting that others have different perceptions and values than oneself, irrespective of which cultural group they may belong to. In this way cultural competence is a lifelong commitment rather than a means to an end (Tervalon and Murray-Garcia 1998). Seeing cultural competence is this way transcends beyond that of race to include other cultural groups including age, gender, sexuality, religion as well as different ethnic groups of the same colour as oneself. It also allows for the possibility that culture is a shifting identity and as such the cultural values one has as a child are not necessarily the same values they have in their 40s and indeed may not be their values in their 80s. As human beings experiences in their lives shape them both though the physical encounters they have but also their

psychological processing of these, enabling the possibility of human growth, development and change.

If we accept culture as this individual evolving, changing construct then this makes our roles as health care professionals more complex. Our experience of working with students and qualified healthcare practitioners has informed us that individuals are often frightened of offending clients as the majority of practitioners enter the field of healthcare with a true desire to improve the lives of others. In this fear, rather than feeling confident and honest to openly admit they have a lack of understanding regarding other cultures they tend to withdraw within themselves and avoid the subject. This is when inadvertent poor cultural practices can occur as it can interfere with the whole assessment process, which then leads to poorer treatment plans and any culturally required adaptations to treatment cannot occur.

Heaslip (2015b) ABC approach to providing culturally sensitive care (table 1) can be used as a really simple guide in practice as an aide memoire to working with individuals from different cultural groups.

**Table 1: ABC Approach to Culturally Sensitive Care (Heaslip 2015b)**

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| <ul style="list-style-type: none"><li>• A=Attitude: being open to seeing, valuing, and appreciating another person's view of the word, which may be different from the one you know</li><li>• B=Behaviour: acting in a way that validates and respects personal cultural beliefs. Adapting ones behaviour to accommodate the others perspective or view</li><li>• C=Communication: this can be achieved with the simple question 'Is there anything that you think I need to know about you or your beliefs in order to work with you?'</li></ul> |
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Using the example is individuals in the Gypsy Roma Travellers community who are often perceived by the public in very negative ways due to a transient, nomadic lifestyle which has become synonymous with criminal behaviour and refuse waste. This can result in a very negative perception of individuals in the community (**attitude**) leading to two practitioners coming together for a double visits because they are frightened to attend the clients home alone (**behaviour**). The impact of this on communication is twofold, for the practitioner due to their fear they seek to undertake the assessment/treatment as quickly as possible and for the individual client they may feel invaded, uncomfortable having two outsiders in their home, leading to them to either reduce their answers in the assessment or be more guarded in what they choose to share. Alternatively they may ask family members to be present and this in turn can lead to conflict as the practitioners may feel more uncomfortable having other people present in the assessment process. This again reflects differences in cultural values, experiences of working with the community highlighting a very open,

culture in which families are very involved in each other's lives and health this can be in contrast to the very individualistic nature which is predominate in those outside of Gypsy Roma Traveller culture. This simple example can show how inadvertently poor practice can occur even from well-meaning healthcare practitioners. In contrast, we recommend practitioners having the confidence to ask (**communication**) individuals if there is anything they should know about them, their beliefs or preferences in order to be able to provide care and treatment, and be receptive to acting upon the information they receive from clients. Doing this would enable a more open and honest dialogue with clients and assist in addressing poorer health outcomes for individuals within these groups.

In conclusion, we would like to encourage practitioners to see cultural competence not as a knowledge domain in that they have to know about all of the different cultural beliefs of individuals but as a way of being, a way of practicing. In this way, it is okay not to know the clients' cultural beliefs before engagement but rather a commitment to working with the client, asking them what is important to them within the context of their therapy and what in particular they feel you need to know in order to work with them. Doing this, would enable more culturally sensitive therapy care to be provided.

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