Chapter 2: Cultural Competency for Massage Therapists

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Learning objectives

- Define the terms cultural competence, race, ethnicity and culture as they apply to the health and wellness field.
- Describe how race and culture relate to health.
- Identify patterns of health disparities and strategies to address them.
- Appreciate diversity and the importance of effective cross-cultural communication in clinical encounters.
- List assessment tools to help therapists identify personal attitudes toward culture and cultural differences, and improve communication between clients or patients and massage therapist.
- Recognize the effect of stereotyping.
- Identify the language associated with stereotyping.
- List strategies to uncover stereotyping.
- Describe three models of effective communication for providing culturally competent care.
- Describe the impact of practicing culturally competent care.
- Describe the potential impact of limited English language (LEP) proficiency on health outcomes.
- Describe legislative actions to address equity in language access for LEP patients.
- Identify reasons for under-utilization of interpreters for LEP patients in health care settings.
- List types of interpretation services.
- Describe qualities of working effectively with an interpreter.
- Describe strategies to improve interpretation services in own practice.

Acronyms used throughout this CE activity

AAMC - Association of American Medical Colleges.
ACGME - Accreditation Council for Graduate Medical Education.
AMTA - American Massage Therapy Association.
AHRQ - Agency for Healthcare Research and Quality.
CDC - Centers for Disease Control and Prevention.
CLAS - HHS's Standards for Culturally and Linguistically Appropriate Services.
EPoCH - AMA’s Educating Physicians on Controversies in Health.
HHS - U.S. Department of Health and Human Services.
IOM - Institute of Medicine.
LCME - Liaison Committee on Medical Education.
LEP - Limited English proficiency.
NCHD - National Commission for Human Development.
NCHS - CDC’s National Center for Health Statistics.
TACCT - AAMC’s Tool for Assessing Cultural Competence Training.

Overview

- Commissioning three papers (Betancourt 2003; Tervalon 2003; Kagawa-Singer 2003) to establish the basis for deliberations on the domains of cultural competence.
- Convening an expert panel to identify the major domains of cultural competence training and to develop a Tool for Assessing Cultural Competence Training (available online at http://www.aamc.org/meded/tacct/tacct.xls) in the undergraduate medical school curriculum and all health professions programs.

This continuing education activity is the initial program designed to introduce cultural competency to massage therapists. The majority of the material in this program is derived from the primary study group of physicians, but similar findings are expected to occur across all health professions. In certain case discussions, the massage therapist can imagine similar situations as it applies to their field.

The AAMC’s Tool for Assessing Cultural Competence Training (TACCT) outlines the domains and specific components for cultural competency training in medical schools. The TACCT provides a framework for CME activity. This activity is divided into four sections:

1. Cultural competence rationale, context, and definition.
2. Impact of stereotyping on clinical decision-making.
3. Cross-cultural clinical skills.
4. Working effectively with interpreters.
Health professionals are becoming increasingly aware of the need to provide health care services that are respectful and responsive to cultural and linguistic needs. Using the framework of the AAMC’s Tool for Assessing Cultural Competence Training (TACCT), this section will review the domains covering the rationale, context and definitions of key terms used for cultural competency training for health professionals.

Defining cultural and linguistic competence

As the linguistic and cultural diversity of the United States population grows, health care professionals are becoming increasingly aware of the need to be linguistically and culturally competent. Despite this increasing awareness, there is no consensus on how to define cultural and linguistic competence. What is common to their definitions is the need to be respectful and responsive to cultural and linguistic needs. The Office of Minority Health’s Recommended Standards for Culturally and Linguistically Appropriate Health Care Services (CLAS standards) defines cultural and linguistic competence as:

*A set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations. “Culture” refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, norms, arts, institutions, and organizations.

Cultural competency and health care education

Cultural competency is now recognized by various governmental and accreditation agencies as essential for improving patient or client health status, access to health care and for eliminating disparities in treatment delivery. As shown in the figure on the next page (Anderson 2003), health care system interventions to increase cultural competence can include programs to recruit and retain staff who reflect cultural diversity of community, use of interpreter services or bilingual providers, cultural competency training for health care providers, use of linguistically and culturally appropriate health education materials and culturally specific health care settings. Health may be improved through these approaches because clients gain trust and confidence in accessing health care, and health care providers increase their ability to understand and treat a culturally diverse clientele. The effectiveness of these interventions can be assessed through intermediate outcomes as well as health outcomes.

In 1999, the Accreditation Council for Graduate Medical Education (ACGME) identified six core competencies for physicians: patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice. The fourth competency requires interpersonal and communication skills resulting in effective information exchange and collaboration with patients, their families, and other health professionals (Accreditation Council for Graduate Medical Education, 2002). The fifth competency, professionalism, includes “sensitivity to a diverse patient population.”

In addition to these new accreditation standards, many organizations, including the Institute of Medicine and the American Medical Association (AMA Policy H-295.905 Promoting Culturally Competent Health Care), encourage medical and graduate schools to provide training in culturally competent health care and health disparities. The Institute of Medicine recommended in its *Unequal Treatment* report that cross-cultural education should be integrated into the training of all current and future health professionals.

The Society of General Internal Medicine Health Disparities Task Force recommends that a curricula “address 3 areas of racial and ethnic health disparities and focus on:
- Examining and understanding attitudes, such as mistrust, subconscious bias and stereotyping, which practitioners and patients may bring to clinical encounters;
- Gaining knowledge of the existence and magnitude of health disparities, including the multifactorial causes of health disparities and the many solutions required to diminish or eliminate them.
- Acquiring the skills to effectively communicate and negotiate across cultures, languages and literacy levels, including the use of key tools to improve communication” (Smith, 2007).

Need for linguistic competency (see Section 4)

A wide range of approaches has been used to provide interpretive services for patients with limited English proficiency (LEP), ranging from using family members or friends, community language banks, telephone interpreters, contracted interpreters, bilingual staff, and on-staff salaried interpreters. Although family members or friends are commonly used, confidentiality is breached, and the quality of interpretation is frequently inadequate, possibly leading to misunderstandings. Given the fact that more than 100 languages are spoken in the United States, all health care professionals should be trained how to work with interpreters.

Not addressing language barriers during the informed consent process undermines the ethical obligation fundamental to the relationship between a caregiver and client or patient (Woloshin *et al.*, 1995), and has potential legal ramifications as well. The risk of medical malpractice associated with language discordance between providers and patients is reduced when competent medical interpretation is provided. Although medical liability lawsuits are most commonly settled out of court and the terms of the settlements are not revealed, there are a few published reports that detail the circumstances leading to a medical mishap related to language barriers (Harsham, 1984; Carbone *et al.*, 2003).

The federal government has recognized the barriers that can be created by language discordance between providers and clients and has articulated the responsibilities of service providers toward LEP clients. These responsibilities have a legal basis in Title VI of the Civil Rights Act of 1964, which states in part that “No person in the United States shall, on the grounds of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected...
to discrimination under any program or activity receiving federal financial assistance” [Civil Rights Act of 1964, Section 601, 78 Stat. 252 (42 USC 2000d)].

Department of Health and Human Services (HHS) regulations require all recipients of federal financial assistance from HHS to provide meaningful access to LEP persons, at no cost to the client [45 CFR § 80.3(b)(2)]. Pursuant to this, guidelines have been published by the Office for Civil Rights (OCR) of HHS (revised final guidance published August 2003) that elaborate what constitutes “meaningful access” for LEP patients (Office for Civil Rights, 2003).

### Define race, ethnicity, and culture

Changes in the racial and ethnic composition of the population have important consequences for the nation’s health because many measures of disease and disability differ significantly by race and ethnicity. One of the main goals of U.S. public health policy is the elimination of racial and ethnic disparities in health. Diversity has long been a characteristic of the U.S. population, but the racial and ethnic composition of the nation has changed over time. In 2006, about 30 percent of adults and over 40 percent of children were racial or ethnic minorities. Moreover, the percentage of the population that is of Hispanic or Asian origin has more than doubled in recent decades. In the 1980 and 1990 decennial censuses, Americans could choose only one racial category to describe their race (Grieco 2001). Beginning with the 2000 census, the question on race was modified to allow the choice of more than one racial category. Although, overall, a small percentage of persons of non-Hispanic origin selected two or more races in 2006, the percentage of children described as being of more than one race was more than twice as high as the percentage of adults. The number of American adults identifying themselves or their children as multiracial is expected to increase in the future (Waters 2000).

“Race” and “ethnicity” are variable and fluid terms, and there is no consensus as to what either means. Patterns of human genetic variation are not well described by concepts of “race” or “ethnicity” because these notions include socio-cultural and political factors.

To be consistent with the latest research on causes of health disparities, as well as the findings from the Human Genome Project, it is recommended that a more socio-cultural definition of race be used:

> “Any of several extensive human populations associated with broadly defined regions of the world and distinguished from one another on the basis of inheritable physical characteristics, traditionally conceived as including such traits as pigmentation, hair texture, and facial features. Because the number of genes responsible for such physical variations is tiny in comparison to the size of the human genome and because genetic variation among members of a traditionally recognized racial group is generally as great as between two such groups, most scientists now consider race to be primarily a social rather than a scientific concept.” (The American Heritage® Science Dictionary. Houghton Mifflin Company. 2002)

Genetic variation can be used to make a reasonably accurate prediction of geographic origin of an individual (at least, if all grandparents came from the same part of the world). However, the National Human Genome Project found that any two human individuals are approximately 99.9 percent the same genetically, and the most important genetic material for human functioning is in the shared set (Bonham 2005).

The federal standards for racial and ethnic data note that these categories represent “social-political constructs and should not be interpreted as being scientific or anthropological in nature” (Office of Management and Budget 1997). As the American Sociological Association has noted: “Although race is a social construct (in other words, a social invention that changes as political, economic and historical contexts change), it has real consequences across a wide range of social and economic institutions (American Sociological Association 2003).

While significant, persistent differences in life expectancy, mortality, incidence of disease, and causes of death are well documented between racial groups, “social and economic factors, uneven treatment, public health policy, and health and coping behaviors play a large role in these unequal health outcomes.”

### Case study

Adriana, a 4-year-old girl, has been experiencing pain in her joints that keeps her up at night. Based on an initial screening, she has been undergoing treatment by a pediatric physical therapist. However, she has not been responsive to the therapy. Her therapist suggests to the parents that she be reevaluated by a pediatric specialist. An only child, Adriana and her parents emigrated from Greece two years before. Her parents are frantic, having taken her to many doctors to find out what is wrong. One of her physicians performs a complete blood count (CBC), hemoglobin electrophoresis and sickle cell test and finds that she is positive for sickle cell disease. Adriana finally receives the treatment that she needs.

#### Discussion

Sickle cell disease is an inherited form of anemia in which the body produces abnormally shaped (sickle) red blood cells. Approximately one in 12 black Americans has sickle cell trait, however, people of African descent are not the only ones affected by this disease. Sickle cell disease is also present in Portuguese, Spanish, French Corsicans, Sardinians, Sicilians, mainland Italians, Greeks, Turks and Cypriots. Sickle cell disease also appears in Middle Eastern countries and Asia.

Today, millions of people all over the world have sickle cell anemia. Because skin color, self-reported or observed race cannot be used to predict accurately who has sickle cell trait or disease, universal screening is now recommended and practiced throughout the United States. In just four years, universal screening in the state of California identified 58 more nonblack infants with sickle cell disease and 6,921 nonblack infants with sickle cell trait compared to ethnically targeted screening.

**SOURCE:** Panepinto 2000; Brosco 2006; Grosse 2005; Shafer 1996; Mack 1989

### Identify how race and culture relate to health

A person’s culture and self-identify are influenced by their race and ethnicity, religion, gender, sexual orientation, age, disability, socio-economic status, and linguistic ability (e.g., people with limited English proficiency (LEP), low literacy skills, hearing impaired). These factors are integrally related.

Economic, social and cultural factors can influence social disparities in prevention, early detection, diagnosis, treatment, post-treatment quality of life, and survival and mortality. For example, racial disparities in asthma emergency department use, hospitalization, and death are much greater than those in asthma prevalence. Possible explanations include more severe disease among racial and ethnic minorities, greater environmental obstacles (e.g., residence in more polluted or high poverty areas), lag in uptake of medical advances to control asthma symptoms among health care providers who treat black children, and lack of asthma education or difficulties in adopting certain asthma control methods by black families (Akinbami, 2006).
Identify patterns of national data on disparities

With the January 2000 launch of “Healthy People 2010,” the elimination of health disparities was firmly placed on the national disease prevention and health promotion agenda.

As of this writing, the elimination of health disparities remains on the national disease prevention and health promotion agenda, with the following goals being proposed for Healthy People 2020 (to be launched in January 2010):

- Achieve health equity, eliminate disparities and improve health of all groups.
- Eliminate preventable disease, disability, injury and premature death.
- Create social and physical environments that promote good health for all.
- Promote healthy development and healthy behaviors across every stage of life (Secretary’s Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2020, 2008).

Describe health data with immigration context

The substantial increase in new immigrants to the United States has raised awareness of the need for health professionals to be more linguistically competent. Between 1970 and 2004, the percentage of the U.S. population that was foreign-born more than doubled.

In 2004, there were 34.2 million foreign-born people, representing nearly 12 percent of the civilian non-institutionalized population of the United States. Foreign-born persons may be United States citizens by naturalization or they may be noncitizens of the United States. Foreign-born noncitizens may be either legal or illegal U.S. residents.

The proportion of foreign-born noncitizens living in the United States is growing more rapidly than that of naturalized citizens. In 2004, the number of foreign-born noncitizens reached 21.1 million, representing 7.3 percent of the U.S. civilian non-institutionalized population.

Noncitizen foreign-born persons are disproportionately low-income and uninsured (Kaiser Commission on Medicaid and the Uninsured 2003). They are also more likely than naturalized citizens to face other barriers to accessing health care, including ineligibility for many government-sponsored programs and difficulty in finding providers who speak their language and provide culturally-sensitive care (Ku 2001).

Race and culture in the medical interview

To reflect the sociocultural definition of race, it is suggested that if you use race to describe a client or patient, you record it in their social history or subjective information, not the medical history (Anderson 2001). Since self-report is considered to be the “gold standard” for the identification of someone’s race, allow clients or patients to self-identify their race or races. Do not use race as a proxy for social class, genetic variation or other elements of the social history. Most importantly, be mindful of the potential influence of racism in the health and wellness environment.

A client or patient’s culture can shape his or ideas of what constitutes illness as well as acceptable treatment (Juckett 2005). What is important to recognize is that providers and patients may differ in their perception and use of time, personal space, gestures, eye contact, body language, and preferences for whether and how bad news should be shared.

Several communication models exist to help elicit patients’ perception of their condition, and what treatments they have tried. These communication models can also be helpful in facilitating a mutually acceptable plan of treatment. Two examples of cross-cultural communication models include Kleinman’s (1978) and LEARN (Berlin 1983). Kleinman’s tool to elicit health beliefs in clinical encounters includes the following questions:

- What do you call your problem? What name does it have?
- Why do you think it started when it did?
- What does your condition do to you? How does it work?
- What do you fear most about your disorder?
- What are the chief problems that your condition has caused for you?
- What kind of treatment do you think you should receive?
- What are the most important results you hope to receive from the treatment?

Similarly, the briefer LEARN communication model includes:

- Listen with sympathy and understanding to the patient’s perception of the problem.
- Explain your perceptions of the problem.
- Acknowledge and discuss the differences and similarities.
- Recommend treatment.
- Negotiate agreement (Berlin 1983).

It is important to remember to remain nonjudgmental about differences in beliefs about what the problem is and what the causes are. Correcting a client or patient’s different beliefs about their condition may lead the person to withhold future thoughts and interferes with building a trusting relationship. Treating patients with respect and...
allowing them to openly discuss differences in health beliefs permits them to reveal their medical history and symptoms so that you can make an accurate plan of treatment and so that they will be willing and able to adhere to your advice.

**Health provider’s self-assessment and reflection**

Most health professionals harbor some assumptions about patients, based on characteristics such as race, ethnicity, culture, age, social and language skills, education or socioeconomic status, gender, sexual orientation or disability. Often unconscious, these assumptions are so deeply rooted that even when a client or patient behaves contrary to assumptions, the therapist may view this as an exception to the rule.

A conscientious therapist – who is aware of these underlying assumptions – will work hard to ensure that these prejudices do not interfere with designing an appropriate treatment plan.

Two different types of self-assessment tools are available for massage therapists to assess conscious and unconscious preferences, beliefs and related practices. Completion of self-assessment tools should be accompanied by reflection of how this new information on personal experiences, biases and beliefs can be used to ensure that they do not negatively affect the care that is provided to patients.

**Value importance of diversity in health care**

According to the Health Resources and Services Administration, racial and ethnic minorities (particularly African-Americans, Mexican Americans, Native Americans, and mainland Puerto Ricans), and people from socioeconomically disadvantaged background are significantly underrepresented among health professionals. As the Sullivan Commission on Diversity in Health Workforce has noted, “African Americans, Hispanics and American Indians combined make up more than 25 percent of the U.S. population but represent less than 9 percent of nurses, 6 percent of physicians, 5 percent of dentists, and similar low percentages of other health professions.”

In certain regions of the country, the disproportion is worse. In an extensive review of the literature, the Health Resources and Services Administration (2006) found that underrepresented minority health professionals, particularly physicians, disproportionately serve minority and other medically underserved populations.

Racial and ethnic minority patients tend to receive better interpersonal care from practitioners of their own race or ethnicity, particularly in primary care and mental health settings. Non-English speaking patients experience better interpersonal care, greater medical comprehension, and greater likelihood of keeping follow-up appointments when they see a language-concordant practitioner, particularly in mental health care.

These findings suggest that greater health professions diversity will likely lead to improved public health by increasing access to care for underserved populations, and by increasing opportunities for minority patients to see practitioners with whom they share a common race, ethnicity or language.

**Summary**

The United States lags behind other developed countries in key health indicators, and significant differences in health and health care persist by race, ethnicity and socioeconomic status. As the linguistic and cultural diversity of the United States population grows, health care professionals are becoming increasingly aware of the need to be both linguistically and culturally competent.

Although there is no consensus on how to define cultural and linguistic competence, what is common to their definitions is the need to be respectful and responsive to cultural and linguistic needs. A sociocultural definition of race is recommended because the National Human Genome Project has found that any two human individuals are approximately 99.9 percent the same genetically, with the most important genetic material for human functioning in the shared set.

Health care system interventions to increase cultural competence can include programs to recruit and retain staff who reflect the cultural diversity of their community, use interpreter services or bilingual providers, provide cultural competency training for health care providers, use linguistically and culturally appropriate health education materials and create culturally specific health care settings.
SECTION 2: IMPACT OF STEREOTYPING ON CLINICAL DECISION-MAKING

Definition of stereotype

A stereotype is a preconceived, rigid idea unrelated to experience or new information that ascribes uniform descriptors about individuals based upon their group membership (Gilbert & Hixon, 1991, Maas). For example: all men are tall; all women want to have children; boys are unemotional; girls are overly verbal. Stereotypes do not originate from self-description; rather they are imposed by others who define individuals. When a person does not fit a stereotype, language is often used, such as “you aren’t like other (people within the group).”

Stereotypes often have negative connotations and rarely represent the true picture of a person.

The health implications of stereotypes is that therapists may resort to shortcuts with patient groups (based upon ethnicity, religion, socioeconomic status or disease state), and thus fail to explore how health is impacted by both individual and group-bound beliefs. These short cuts can result in unintended consequences, such as naming and blaming patients (for example, the bad or difficult patient; the noncompliant patient).

History and language of stereotyping

When individuals outside of any group come to join a new group, there is pressure to “fit in.” The term used for this is acculturation (versus retaining group values, beliefs and traditions from the group you were born into – inculturation).

For many years, the definition of success in the U.S. was being American – as in losing languages other than English, changing eating habits to pizza and hamburgers and adopting habits of others who live in the U.S. The ultimate success was then homogeneity of culture, to make everyone in the U.S. exactly alike.

The reality is, however, that everyone in the U.S. has never looked or been alike. In terms of geography, Southern culture varies from northern, people who live in the heartland vary from those who live on the coasts. Floridians are different than Washingtonians. The range of acceptable difference, however, contains attitudes, perceptions and behaviors that are considered “American.” And the current trend is to value the diversity of individuals and groups and identify how the diversity of groups aids in creative problem solving and resilience in our society.

When addressing issues of similarity and dissimilarity, there are issues of xenophobia, classism and ethnicism that play a powerful role on many members of our society.

Xenophobia is fear of outsiders, which can be based upon how individuals look and dress and is irrational (as are all phobias). At its heart is fear of groups of people. Like other aspects of culture that are learned, fear of others is often taught by families to their members.

Classism relates to the “haves and have-nots.” At the extreme, social Darwinists believe that those who achieve or are successful do so because they are deserving or good, and those who do not are not deserving or faulty in some way.

Ethnicism, racism, sexism and homophobia are all active elements in U.S. society. The concepts make many people uncomfortable, and many would prefer not to be challenged by them.

Often what a society aspires to be is confused with how it actually operates. At the heart of these and other “isms” is oppression of a minority group or a group that is perceived to have less power or influence than the majority. The dominant group benefits from the disparate treatment of the subordinate group and is able to maintain status, power, influence and wealth.

This pertains to health care because affluence is a positive predictor of health. The ability to have insurance and identity (and have a relationship to a primary care physician) predicts better health outcomes. Conversely, disenfranchised groups with limited access have worse health outcomes.

The words used for stereotyping have existed for decades if not longer (Daniels 1991). In the U.S., newcomers or immigrants have often been stereotyped using the same words or language. Described as “lazy, dirty, promiscuous, drunk, deceitful, unable to show restraint (particularly with vices), inferior of intellect, unworthy,” the new immigrants of the 1920s (who were Italian, Irish, German) were stereotyped. Those individuals were the “cheap labor” of their day and helped launch the industrial revolution, being paid a mere pittance. Living in decrepit tenements with few resources, their illnesses were attributed to innate traits and their choice of living in substandard ways. Today, the terminology is “blame the victim.” With many of these immigrants, acculturation and affluence dislodged these stereotypes (although some still exist in some areas).

Today, there may be less overt terminology when encountering an operating stereotype – “weird, odd, exotic, strange” are often used to describe elements outside of the range of the viewer’s norm.

Recognize that the term “traditional” is a culturally relative term. Whose tradition? Most individuals see the world based upon an interpretation that is usual, ordinary or expected. If turkey is what you consume at Thanksgiving, then Falafel would appear odd or unusual. If you mean agreement when you smile, for example, you are likely to read a smile as you would send it (“he is agreeing”), when in fact there is a “differential diagnosis of interpretation of behavior” (Nunez, 2000). A smile indeed may mean agreement, but it also may mean fear, disagreement or derision.

Learning what expectations the sender has for behavior and how else the behavior can be interpreted is a skill of culturally effective communication.

Populations or groups at risk for stereotyping

As mentioned above, stereotyping often occurs for individuals who are perceived to be less powerful or subordinate to others. Frequently, the same stereotypic terms are heard in the clinical setting when caring for people of color.

For example, an African American man reports that his physician always puts on gloves and never really examines him with a stethoscope although he comes in every two months to control his blood pressure (leading to the presumption that this behavior is a result of the physician’s impression that the patient is not clean and not worth getting quality care).

Urban minority girls frequently receive testing for STIs, yet majority girls in suburbs do so much less frequently – even though they both may be sexually active and at risk. The implication thus becomes that minority girls are promiscuous and that white majority girls are not at risk for STIs.

Across gender groups, women are perceived to be less powerful. From a purely economic perspective, women in the same occupation of a similarly ranked man, make 80 cents to a man’s dollar. Thirteen million of the 140 million women in the 2000 census live in households below the federal poverty level of 2001. (Hobbs F, 2000. Women’s Health USA 2003.)
This economic disparity plays an even larger role in aging because more often than not, the elderly are financially disadvantaged women. Elderly patients may be told that a dowager’s hump or loss of height is probably caused by “getting old” instead of being checked and accurately diagnosed for osteoporosis, a pathologic condition and not an invariable occurrence with age.

As mentioned earlier, non-elderly women as a group are also at risk for stereotyping. Women are more likely than their male counterparts to seek needed therapy, but this access does not result in health equity. Women as compared to men are less likely to be offered cardiac catheterization. Although coronary artery disease occurs more frequently in men, more than half a million more women than men die of myocardial infarctions (MIs) annually. Minimization of symptoms, being trivialized or not having experiences affirmed still occurs for many women. Symptoms that are vague are often attributed to being “all in your head.” Emotional responses, such as tears, are often difficult for therapists to handle and result in quick termination of visits because of their discomfort.

Religious minorities are another group at risk for stereotyping. Not all therapists are comfortable discussing spirituality and its role on health. The omission of information about the role of religion on health is significant for many patients. For example, an African-American patient with poorly controlled HTN is told by her physician that she “just needs to stop eating salt pork.” Indignantly, she tells him that she is a practicing Muslim (and as such, she does not eat pork).

Lack of familiarity with habits, religious traditions and preferences of various groups can result in unintentional or prejudicial comments or interpretations.

Sexual minorities are another group at risk for stereotyping. Unkind and disrespectful treatment of gays and lesbians is a too frequent occurrence in the health care setting. A stereotype of gay men is that they are not manly. Gay and straight men can adhere to rigid sex role stereotypes (muscle bound, for example) or not. A stereotype of lesbians is that they do not have sex with men, yet 70 percent of women who identify as lesbians have had sex with men. Whether due to fear, aversion or discomfort, massage therapists may stereotype clients or patients with conditions that are perceived to have a high degree of stigma (in this case, mental illness, HIV/AIDS or drug addiction).

Unlike diseases or conditions that are not perceived with stigma (e.g., heart disease or cancer), a therapist may view a client or patient’s mental health or addiction as a character flaw instead of the illnesses that they are. HIV/AIDS, in a similar fashion, at times evokes fear in providers (which shows a lack of understanding of the basic principles of transmissibility, for example) and a similar “blame the victim” attitude.

Lesser quality of care delivery because of stereotyping contributes to health disparities. For example, most health professionals would feel well versed in adhering to principles of privacy and respecting the limitation of health information beyond those who the client or patient designates. Yet, if the client or patient has HIV and asks the therapist to not share her or his diagnosis, some therapists might feel that the client or patient “wants them to lie” and may even have a difficult time respecting their autonomy.

As a sole factor that certainly compounds other factors, poverty alone is a health risk. Lack of adequate resources (whether food stores with fresh produce or available transportation to health centers) adversely affects health. Too often, health care providers clump various health risks into a patient-behavior blend. It is not dissimilar to the 1920s when overcrowding and lack of facilities resulted in ill health that was attributed to the patient, and not to the environment.

The shortcut of patient behavior as invariably traveling together with ill health then becomes the new stereotype – the bad, difficult, non-compliant patient – rather than perhaps a person who is having trouble making health a priority.

### How might unconscious stereotypes or social shortcuts undermine the delivery of quality care?

- **Equitable** – Do I embed quality assurances that evaluate the degree that I deliver the same quality of care, regardless of personal characteristic (age, gender, ethnicity, religion, geography, sexual orientation, socioeconomic status, special needs, and so on)?
- **Efficient** – Do I ensure that my mindfulness of wasted resources (personal energy and ideas, supplies, equipment, advocacy) occurs equally with all of my patients, or do some groups or people push me to an overemphasis on “not wasting resources”?

These questions are not presented in a “blame the therapist?” perspective; rather they are a mechanism to uncover hidden bias. What massage therapists aspire to as a professional – excellence, high-quality care delivery and doing no harm – are noble. To improve within the systems of care where health professionals work (which themselves are in need of quality improvement and caregiver-generated ideas and advocacy), a realistic appraisal of both the areas of excellence and areas needing attention need to be identified. This duality of an appraisal – strengths-based and deficit identification – is useful for therapists as well as a framework to evaluate even the most vulnerable clients and patients.
SECTION 3: CROSS-CULTURAL CLINICAL SKILLS

Communication skills are at the core of culturally sensitive practice, whether the skills involve taking a medical and social history, explaining and performing a physical examination or procedure, obtaining informed consent, or counseling about lifestyle and diet modification. This section will review some models of effective cross-cultural communication that apply to most client or patient encounters, and provide examples of poor communication based on poor or limited technique, lack of knowledge, personal biases or lack of attention.

Models to enhance cross cultural communication

Skills for working in a culturally sensitive manner extend from basic communication skills for offering compassionate care. Perhaps it can be said that “every encounter is a cross-cultural encounter” because there are both apparent similarities and differences between a therapist’s and patient’s real or perceived differences in beliefs about disease etiology and treatment, the role of self-care, treatment of conditions, and decision-making and communication styles.

Both the therapist’s and client or patient’s values and expected outcomes of the encounter can generate issues (whether explicit or implicit) that may be interpreted as “cultural.” For example, a white, highly educated man faced with the diagnosis of a potentially terminal, serious condition that his physician believes will respond favorably to chemotherapy (with toxic side effects) may choose an unproven complementary treatment rather than chemotheraphy. This can happen even after the evidence for lack of effectiveness is presented to him, because of his strong spiritual beliefs.

A patient of Chinese origin brought up to expect a paternalistic relationship with his caregivers faced with a similar diagnosis may choose chemotherapy over traditional Chinese medicine, not because of the available evidence presented, but out of respect and deference to his health provider’s opinion.

In addition, either patient may value the input of the family (different members, such as parents, spouse, siblings or children). A rigid “one-size-fits-all” approach to persuade both these patients to undertake chemotherapy immediately as the only option can damage the professional relationship, resulting in loss of trust or poor communication, and lead to adverse health, emotional and psychosocial outcomes. These adverse outcomes may be manifested in subtle ways, such as failure to follow up with appointments, or failure to take medications despite agreeing to the prescription.

Both of these encounters would benefit from a culturally sensitive approach using skills that recognize the patient’s values and consideration of other factors in his or her own decision-making process, as well as respect for the role of the family in decision-making.

So what are these skills for demonstrating cultural humility [Lavizzo-Mourey 1996, Tervalon 1998, Kim-Goodwin 2001] that have been demonstrated to optimize patient interactions, reduce health disparities and improve health outcomes?

Several cross cultural communication models have been published for use in medical education settings. Some are designed to reduce health disparities [Cooper 2006]. They have qualities in common in that they advocate an approach that is inclusive of the patient, family and community resources, and that includes negotiation as a key element.

They can be used for interviewing and counseling a client or patient as well as for their family.

Therapists may choose to use one of these models to guide their cross-cultural encounters and to assess their own proficiency, especially when faced with challenging encounters or situations.

The ETHNIC model (Levin 2002, Like 1996) relies on:

- **Explanation** (“What do you think may be the reason for your symptoms? What do friends and family say about these symptoms? Have you heard about it on TV or radio?”).
- **Treatment** (“What kinds of remedies and medicines have you tried? What treatment are you seeking from me?”).
- **Healers** (“Have you sought advice from folk healers, friends or others? Please tell me more.”).
- **Negotiation** (negotiate options that are mutually acceptable, ask the patient what results he expects from your intervention).

The L-E-A-R-N model [Berlin 1983] recommends that providers:

- **Listen** with sympathy and understanding to the patient’s problem.
- **Explain** their own perceptions of the problem.
- **Acknowledge** and discuss the differences and similarities between them and the client or patient.
- **Recommend** treatment.
- **Negotiate** for agreement.

The most practical of tools, the generic “Kleinman questions” [Kleinman 1978] developed by Dr. Arthur Kleinman, an anthropologist, address the patient’s concerns from the patient’s perspective and can be directly applied in practice in diverse settings to address issues of language, spiritual beliefs, religion, disability, ageism, sexual orientation, country of origin and race. The Kleinman questions include:

- What do you think has caused your problem?
- Why do you think it started when it did?
- What do you think your condition does to you?
- How severe is your condition? Is it a short or long course?
- What kind of treatment do you think you should receive?
- What are the most important results you hope to achieve from this treatment?
- What are the chief problems your condition has caused for you?
- What do you fear most about your condition?

The use of some of the above questions (or the approaches of the ETHNIC or LEARN models), allow a massage therapist to explore the reasons for choices made by clients or patients and as such, may result in a higher quality of care.
Communication skills

Case study

A 25-year-old Muslim woman has been referred to a physical therapist by an orthopedic physician. Her planned marriage is being delayed until she regains her motor skills after a car accident. Her physical therapist, who is not Muslim, notes the patient’s religion from the intake form and her use of a head scarf, and asks, “How many wives does your future husband have?” The young woman is offended and asks if she can see another provider.

Discussion

The therapist appears to have made an assumption about the cultural differences between her and her patient based on the patient’s self-stated religion and possibly her appearance. This assumption is perceived as offensive by the patient, with adverse consequences for the relationship.

If the L-E-A-R-N model had been applied, the therapist might have asked “What are your expectations of the therapy?” then, after the patient’s explanation, followed with “I see that you would also like to complete your Masters in Engineering.” Then the therapist might have explained, “I am not Muslim, so please could you explain if and how your religious or personal beliefs guide your therapy or treatment choices?” Finally, the therapist would acknowledge the choices that were not acceptable to the patient, and negotiate to select from the remaining available choices based on factors valued by the patient.

The application of systematic tools for interacting with clients or patients (for history-taking, education, negotiation and counseling) in encounters will help therapists avoid pitfalls that result from assumptions and stereotypes held about clients or patients based on appearance or other cues or the therapist’s own inherent biases.

Cultural knowledge

Communicating with clients and patients in a manner that is open to consideration of their personal, community, spiritual, family and social values is one step toward establishing the foundation of a culturally sensitive practice.

Recent focus in medical education has emphasized an approach that avoids categorization of clients and patients by race, language, orientation, or religion [Geiger 2001, Tervalon 2003, Bentacourt 2003] to avoid the mistake of stereotyping them. Instead, there is an emphasis on an approach that recognizes the individuality and uniqueness of every client using “cultural humility.” Massage therapists should recognize the layers of influence that patients’ values and worldviews contribute to their perception of health and illness, their own biases toward offering options for care, and the role of an entire office, hospital and community in providing a culturally appropriate experience in the health care setting [Nunez, 2006].

Importantly, massage therapists also need to recognize and address their own attitudes as well as barriers and facilitators for decision-making. A therapist’s attitudes, especially unconsciously held attitudes, can affect health care outcomes. Therapist self-awareness of their own attitudes may help to reduce differences in decision-making that may, at least in part, be responsible for health disparities.

Section summary

Models of effective cross-cultural communication focus on client/patient-centeredness, negotiation, shared decision-making, recognition of the patient’s values and beliefs and the family and community’s involvement in the patient’s health.

Eliciting the patient’s views of his own condition and health is key to avoiding pitfalls associated with stereotyping and the adverse consequences resulting from making a priori assumptions.

The root causes of health disparities reside in the client or patient, the caregiver and the system within which the two interact, and conscious knowledge of the causes will lead to action to address the disparities.

SECTION 4: WORKING EFFECTIVELY WITH INTERPRETERS

Background - Scope and impact of the problem

According to the U.S. Census Bureau [U.S. Census Bureau 2008], among 262 million people in the U.S. aged 5 years and older, 47 million (18 percent) speak a language other than English at home and 21 million (8 percent) have limited English proficiency (LEP), a proportion that has steadily increased from 4.8 percent in 1980 to 6.1 percent in 1990.

Studies conducted by the Commonwealth Fund [Princeton Survey Research Associates 2001] suggest that one in five Latino patients with limited English proficiency have gone without health care when needed because of language obstacles, and that minority patients face greater difficulty in communicating with their therapists and are more likely to forgo asking questions of them [Princeton Survey Research Associates 2001]. It may thus be important to establish client or patient preferences locally by conducting surveys or directly asking clients and patients about their preferences for language access.

In addition, health outcomes and health care utilization was found to be poorer for LEP medical patients in terms of medications prescribed, intravenous treatment started, number of tests and procedures ordered, and inappropriate use of procedures with subsequent increased expenses and longer stays for adults [Waxman 2000, Bard 2004, Bernstein 2002] and pediatric [Hampers 2002, Lassetter 2004] patients. For preventive care, one study [De Alba 2006] found that English-proficient Latino patients were twice as likely to receive a recommendation for a Pap smear from physicians compared with LEP Latino patients.
Resource utilization

There is evidence of underuse of professional interpreters and overreliance on untrained interpreters [Hornberger 1997] in health care settings, even in practices with a high number of LEP patients, with a resulting increase in the number of errors, misunderstandings and poor treatment adherence [Flores 2003]. Factors identified as barriers to use of professional interpreters include excessive time spent waiting, awkward communication and poor interpreter availability [Burbano 2003], failure of staff to identify LEP patients needing interpreters [Bonacruz 2003], perceived added time for encounter, and the perceived increased cost of professional interpretation [Karliner 2004]. However there is evidence to show that use of professional interpreter services is cost-effective over the long term, by improving the quality of client/patient-therapist communication and health care access and delivery [Jacobs 2004].

Strategies to address language barriers

Strategies for providing language services

Hundreds of languages are spoken across urban and rural settings in the U.S. and the Institute of Medicine [National Academy of Sciences 2008] reported that more than 50 percent of health providers surveyed believed that patients did not adhere to treatment because of cultural issues, while more than 50 percent of health providers have received no language or cultural competency training.

Planning to address language needs should include designation of responsibility (leadership), conducting an analysis of local need, identifying community resources followed by implementing the services, training staff, notifying patients of services, and evaluating and reviewing the quality of services. Some guidelines offered by the Commonwealth Fund [Youdelman 2005] to address local needs for language services include:

- Language access planning – An employee or team member can be designated to develop a language plans to meet client or patient needs.
- Language needs can be determined at first point of contact with the receptionist, for example, using flash cards that state “I speak… (specific language)” to identify patient language preference.
- Recruitment should include hiring of bilingual mid-level practitioners.
- Dual role bilingual staff with training and language proficiency can be rewarded for their additional interpretation roles.
- Interpreter services may be sought from agencies by contract, or by using community resources such as hospitals, colleges and community groups.
- Written translated materials can be obtained and made available.

The type of interpreting service to be provided should be considered for the local community and the LEP group served. Although traditional face-to-face professional interpreting is used in most health care settings, and is superior to non-professional interpreting [Lee 2002], and resources to provide this service may be limited.

Other methods of interpreting have been studied and these include telephone interpreting (contracting with the telephone services for interpreter services at specific hourly rates) and videoconferencing [Jones 2003].

Overall, studies have demonstrated that patients are most satisfied with language proficient health providers, and satisfaction is similar for other methods, including face-to-face, telephone and video-interpretation.

Provider education

In addition to observance of CLAS guidelines by the health and wellness industry, training for health providers to work effectively with interpreters has been shown to increase the use of professional interpreters and health provider satisfaction with the care they provide [Fagan 2003, Richardson 2003].

Effective interaction with interpreters is a standalone and distinct skill domain in the AAMCs Tool for Assessing Cultural Competency Training [Association of American Medical Colleges 2008] with the following stated learning objectives for health providers such as massage therapists: Describe functions of an interpreter, list effective ways of working with an interpreter, identify and collaborate with an interpreter.

Various curricula have been described for teaching health professionals to work with interpreters, including an online case-based interactive module [NYU School of Medicine 2008, Kalet 2005]. When working with interpreters, most guidelines address the following issues with similar suggested behaviors for providers:

- A trained interpreter should always be used when available.
- Avoid untrained interpreters (such as relatives or untrained staff) who are likely to compromise the accuracy of terminology.
- Use of relatives, especially children of patients, creates problems with social roles, sensitive issues and compromises the ethics of confidentiality.

- Seating should promote direct eye contact between caregiver and patient throughout the encounter and reduce the likelihood of diverting attention from the patient. Equilateral triangle seating or having the interpreter sit just behind and to the side of the patient are both acceptable positions.
- The interpreter should be oriented to the role expected by the therapist if unfamiliar to the therapist.
- The therapist should explain the role of the interpreter to the client or patient and ask whether the patient is comfortable with this.
- The therapist should request word-for-word interpretation from the interpreter without paraphrasing.
- The therapist should use short sentences in “digestible chunks,” allowing for interpreter understanding and accurate interpretation and allowing for repetition for clarification.
- The therapist should listen actively to the client or patient and the interpreter and summarize what is said.
- The therapist can ask the client or patient to “back interpret” or summarize what he said to verify the accuracy of the interpretation and the patient’s understanding.
- Visual aids and written handouts should be used where available, appropriate to the client or patient’s literacy level.
- The interpreter should accompany the client or patient to schedule follow-up appointments.
Case study

A 60-year-old Hispanic woman is about to be interviewed by a female therapist with a male interpreter sitting next to the client. The therapist, upon entering the room and sitting down opposite the client and interpreter, immediately asks the client through the interpreter “What can I do for you today?” The client is silent. The therapist then asks the interpreter “Why does she not speak?” The interpreter shrugs and asks in English how long the interview will take.

Discussion

In this scenario, the therapist failed to orient the interpreter to his role in the encounter and her expectation of the interpretation process. More important, the therapist failed to discuss and explain the interpreter’s role with the client, including getting the client’s permission to work with this interpreter.

In this instance, the client has a personal problem that she is uncomfortable discussing in front of a male interpreter, and has thus chosen to remain silent rather than reveal her reasons for the visit. The client would have liked to have had the option of a female interpreter.

So, despite using the best of communication styles (an open-ended question, “What can I do for you today?”) to begin the interview, the therapist has now encountered a communication problem secondary to not working effectively with the interpreter that is likely to negatively impact the outcomes of the client’s care (for example, the ability to elicit a full history and adherence to a treatment plan).

Interpreters in some settings may have their own viewpoints about how providers should communicate with a client or patient through them, and these views should be taken into consideration when interacting with an interpreter.

Examples of things that interpreters should not be asked to do independently (without the provider present) include the following:

- Keep the LEP client or patient company.
- Explain procedures without the provider being present.
- Take a medical history.
- Sign or explain a consent form without full explanation from the provider and in the presence of the provider.

LEP encounters without adequate language interpretation are at risk of lower client or patient satisfaction and poorer health outcomes.

Lack of knowledge of the impact of language access on health care, changing local community demographics, and logistic barriers contribute to underutilization of interpreters.

Professional interpreter services can be provided by face-to-face, in-person interpretation, contracted telephone interpretation, and videoconferencing; and written translated materials that should be made available to LEP patients.

Recommendations for working effectively with an interpreter include early role setting and orientation of the interpreter, communicating with the client or patient to establish expectations, and use of appropriate eye contact, body language, sentence structure and construction and seating arrangement to respect the client or patient’s needs and culture.

Resources

Section 3 Resource (URLs)

The following online resources provide tools for improving provider cultural competence.

- HRSA (Health Resources and Services Administration) Cultural Competence Resources for Health Care Providers http://www.hrsa.gov/culturalcompetence/.

Section 4 Resource (URLs)

Health and wellness professionals may need to reference resources for guidance on hiring, interacting with and assessing interpreters in their own practice settings. Online resources provide different types of information to assist with these needs.

- The Robert Wood Johnson Foundation has established efforts to describe language technologies for emerging Spanish-speaking settings available at: http://www.hablamosjuntos.org/.
- ‘Providing Language Services in Small Health Care Provider Settings: Examples from the Field’. Is a guide developed by the Commonwealth Fund to improve the provision of language access in smaller community settings. It is available at: http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=270667.

References

Overview


Section 1


Section 2


Section 3


Section 4

- American Medical Student Association. Achieving Diversity in Dentistry and Medicine (ADDM). Available at: http://www.amsa.org/addm/

American Medical Student Association. Achieving Diversity in Dentistry and Medicine (ADDM). Available at: http://www.amsa.org/addm/


Section 4


CULTURAL COMPETENCY FOR MASSAGE THERAPISTS

Final Examination Questions
Select the best answer for each question and mark your answers
online at Massage.EliteCME.com.

1. Which of the following is a part of the American Massage Therapy Association’s Code of Conduct?
   a. Being able to speak another language.
   b. Acknowledge the inherent worth and individuality of each person.
   c. Working with minorities.
   d. Provide an interpreter when needed.

2. Which of ACGME’s six core competencies for physicians include “a sensitivity to a diverse patient population?”
   a. Sympathy.
   b. Empathy.
   c. Bilingualism.
   d. Professionalism.

3. How is “race” defined:
   a. By differences in skin color.
   b. By differences in cultural practices.
   c. There is no particular definition; “race” is a variable and fluid term.
   d. Societal roles.

4. Which of the following is part of the “Healthy People 2010” agenda for the elimination of health disparities?
   a. Eliminate preventable disease, disability, injury and premature death.
   b. Create physiological environments that promote good health for all.
   c. Provides valuable information when there are language barriers.
   d. Improve the health of one’s own ethnic group.

5. Which population is most likely to be uninsured?
   b. Foreign citizens.
   c. Foreign-born non-citizens.
   d. Lower income brackets.

6. All of the following questions are a part of the Kleinman model except:
   a. What do you call your problem?
   b. What name does it have?
   c. What do you think caused your problem?
   d. What is your perception of your problem?

7. How is a “stereotype” defined?
   a. By a client or patient’s cultural mannerisms.
   b. As a preconceived, rigid idea unrelated to experience.
   c. As a preconceived, rigid idea related to experience.
   d. There is no particular definition; “stereotype” is a variable and fluid term.

8. Which of the following is a culturally relative term?
   a. Traditional.
   b. Race.
   c. Ethnicity.
   d. Culture.

9. Which sole factor compounds health risks?
   a. Language barriers.
   b. Minority status.
   c. Poverty.
   d. Stereotyping.

10. Which is an example of something that interpreters should not be asked to do?
    a. Keep the LEP client or patient company.
    b. Accompany the client or patient to make another appointment.
    c. Asking the patient to summarize what has been said.
    d. Asking the interpreter to repeat what the patient said.