

Feature Article

Cultural differences: The experience of establishing an occupational therapy service in a developing community

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Aim: This paper documents the subjective experience of a Western trained occupational therapist as she establishes a service in a community that is developing its health-care services. The community is located in the Dominican Republic.

Method and Results: Ethnographic interviewing was used to document the tasks and events that occurred during this 6 month project. Challenges arose related to the region's developing health, education and community services, training the local workers and the reaction of the recipients of occupational therapy service. The contrast in beliefs, values and cultural customs between the therapist and the local people contributed to the challenge.

Conclusion: This study indicates that exporting Western occupational therapy services without any changes causes significant conflict for the professional and the clients. Furthermore, this study demonstrates the importance of understanding cultural differences between the therapist and client, as well as the need for occupational therapy services in communities that seek to improve the health and abilities of the local people requiring rehabilitation services.

KEY WORDS community development, culture, ethnographic methodology, occupational therapy, rehabilitation.

Introduction

The history of the occupational therapy profession shows an evolution from the initial recognition that all individuals are unique, to the multifaceted understanding of people and the sociocultural context from which a client has formed beliefs, values, customs and through which occupations are then determined

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(Black, 2002). Occupational therapy is practised in most Western cultures and finds its place as a prominent discipline in the field of rehabilitation. The profession is expanding on a worldwide scale, to encompass service provision to regions of countries, and entire countries where occupational therapy service was not previously available.

Occupational therapy and community development

The World Health Organization (1986) supports initiatives that improve and promote health for all people, and occupational therapists are increasingly concerned about the needs of people in under-resourced areas of Western countries or in countries that seek to improve health-related services. Such regions of the world acknowledge the human right to health and education, by establishing services that support these aims. The occupational therapy profession is committed to actions that promote health, prevent disease and disability, and increase the availability of services to people in need (American Occupational Therapy Association (AOTA), 2001; Canadian of Occupational Therapy (CAOT), 1998). Wilcock (1998) defined the community development model of health promotion as 'Community consultation, deliberation, and action to promote individual, family, and community-wide responsibility for self sustaining development, health, and well being' (p. 238). Consequently, through such self-determination, a community takes responsibility for defining needs, planning solutions, organising local resources, and implementing actions to promote health, economic and social advantages for the community.

Krefting (1992) discussed the problem of implementing rehabilitation services in the Third World, noting that occupational therapy consultants favour exporting 'service models to Third World countries that are similar to those used in developed countries' (p. 758). For the readers' information, it is important to explain the term 'Third World' in the context of

Krefting's article and as it is used in this paper. Third World refers to a region where basic human needs such as food, shelter, and health care are inadequately available to the population that requires sustenance. Such areas may be yet to develop community infrastructure in human services such as education, transport and communications. Krefting noted that most Third World countries place a high priority on the prevention of disability through initiatives such as public health measures and immunisation programs, rather than addressing the existing needs of disabled persons. Among other major considerations, Krefting emphasised the importance of the region's potential to sustain a rehabilitation service and stated that the 'question remains whether the model of occupational therapy used in developed countries can encompass the rehabilitation needs of the Third World' (p. 761).

Culture of occupational therapy

Reviews of the culture of occupational therapy reveal that core concepts underpinning the profession also reflect our firmly Western origins. Occupational therapists are a cultural group with a common language, frames of reference, domains of concern, and goals for practice. Over a decade ago, Kinebanian and Stomph (1992) reviewed occupational therapy literature on the topic of cross-cultural care and concluded that the 'white, middle-class values of our profession ... create obstacles to cross-cultural care' (p. 752). Realising that our profession is based on the Western view of the world is 'the first step toward the development of cross-cultural occupational therapy' (p. 756).

More recently, Fitzgerald, Mullavey-O'Byrne and Clemson (1997) surveyed 86 occupational therapists about issues in their clinical experiences of intercultural care of clients, and found that value conflicts between the therapist and client was the most frequently occurring topic raised. Therapists' personal and professional values interfered with the outcome of interaction with clients from different cultural groups, although more often than not, the therapists failed to recognise 'the juxtaposition of the values of occupational therapy as a profession with those of the client' (p. 10).

Awaad (2003a) reviewed the culture of occupational therapy and emphasised the need for occupational therapists to understand their own cultural background, both personal and within the culture of occupational therapy, as well as seeking an understanding of the cultural norms and variances of the groups that he/she is providing service to. Recommendations for providing service that is sensitive to the culture of clients are available (Krefting, 1991;

MacDonald, 1998; Wells & Black, 2000), although some of the crucial issues surrounding the epistemology are not so easily addressed. Cultural studies have demonstrated the incongruence between the beliefs of some clients and their Western therapists, supporting the profession's need to broaden its value base to acknowledge other cultures (Evans & Salim, 1992; Huttlinger *et al.*, 1992; Jungersen, 1992; Krefting, 1992; Meyers, 1992; Spadone, 1992). Such studies emphasised the differences in belief about issues of personal causation, independence, family, and even the origin of disease and disability.

Presently, the cultural generality of underlying theories and assumptions that are the foundation of our profession is in question (Chiang & Carlson, 2003; Iwama, 2003). Iwama calls for enquiry and amendment of epistemology grounding occupational therapy to broaden its relevance to the non-Western cultures of the world. The author exposes the deep entanglement of biomedical truths, and beliefs about personal causation, independence and humans as principally occupational beings, as potentially choking the ability of the profession to appropriately service our non-Western clients. Iwama states that 'Failure to allow culturally relevant development of occupational therapy will further entrench non-Western occupational therapy in a form lacking the power to facilitate meaningful process in people's lives' (p. 587).

Culture, competency and occupational therapy

Culture may be defined in many ways, although several commonalities exist between definitions. Fitzgerald *et al.* (1997) described culture as the 'learned and shared patterns of perceiving and adapting to the world' (p. 3). This includes behaviours, beliefs, values and attitudes that are characteristic of a population of people. Furthermore, culture is a concept that is dynamic and continually changing. Bonder, Martin and Miracle (2004) have further evolved this concept, defining culture as a 'symbolic system that emerges through the interaction of individuals' (p. 162). Such a definition of culture as 'emergent' allows for variation in the experience and perspective of individuals within a culture, and for the changing nature of culture within the individual and a group.

Bonder *et al.* (2004) note the mistaken description of the culture concept as meaning one's ethnicity and race. This common interpretation of the meaning of culture has resulted from the predominant description of cultural groups by the significant characteristics of people in the groups, or the rules associated with the beliefs and behaviours of people in the groups. Culture is a concept that should not be confused with the term

ethnicity. The terms are easily differentiated, as ethnicity refers to the 'identity derived from membership of a group united by a common culture, religion or language within a national society' (Howarth & Jones, 1999, p. 452).

Research in occupational therapy has frequently confused studies of ethnic groups with studies of culture; the former being the most commonly found in the literature (Dyck, 1992, 1993; Meyers, 1992). Litterst (1985) provided early warnings to the profession that inappropriate labelling of ethnic or subgroups could result from a misuse of the culture concept. Such presumption and generalisation perpetuates stereotypes and perceptions of entire groups of people that appear to be easily categorised by some homogeneous characteristic(s) (Krefting, 1991). Hasselkus (2002) attends to the problem of ethnocentrism, noting the tendency of the observer to view the unfamiliar culture as inferior in comparison to their own. Hasselkus explains culture in terms of the similarities and differences that we experience when we interact with others. While new cultural experiences can provide positive and enriching experiences, our own cultural perspective can constrain and restrict our ability to appreciate differences.

Black (2002) traces the changes within the profession that have resulted in wider acceptance of the importance of cultural competency for occupational therapists working within diverse multicultural Western nations such as Canada, the USA, Australia and the United Kingdom. Long defined in the literature, cultural competency refers to one's 'awareness of, sensitivity to and knowledge of the meaning of culture. It includes one's openness and willingness to learn about cultural issues' (Dillard *et al.*, 1992, p. 722).

Few published studies document the occurrences and experiences of occupational therapists as they establish services for people in other cultures. Anecdotal accounts by occupational therapists are found in the literature (Fudge, 1992; Wilson-Braun, 1992), and include visits or consultations within regions of countries such as Guatemala and Ecuador. Other accounts include more theoretical discussions of the cultural issues evident from the authors practice in a culture other than their own (Awaad, 2003b; Trafford, 1996). Chiang and Carlson (2003) discussed strategies for the profession to more appropriately address cultural diversity. The authors concluded that researching the 'experiences of occupational therapists who have worked in a different cultural environment for a significant period of time would be one way in which the largely Western-based profession of occupational therapy could expand its knowledge of cultural issues' (p. 565).

This study investigated the experience of an American trained occupational therapist recruited to establish

an occupational therapy service in a public hospital in a developing community in Santiago, Dominican Republic. The occupational therapist was contracted for a 6-month paid term by local authorities. The directive was to establish a department that would be continued by local workers. Local hospital officials wanted an ongoing service, sustained by their own staff, following the success of pilot occupational therapy services provided by the informant's undergraduate program.

The Dominican Republic occupies the eastern two-thirds of the island of Hispaniola, next to Haiti. The Dominican Republic is the second largest country in the West Indies after Cuba, and has a Spanish speaking population of nearly 9 million people. The economy is dependent on agriculture and tourism. Literacy is 85% of the population and the average life expectancy is 69 years. Gross domestic product (GDP) is US\$6300 per capita. These figures may be compared to the USA and Australia to demonstrate the differences between these countries. The USA has a GDP of US\$36 300 per capita, a life expectancy rate of 77 years and literacy levels of 97%. Australia has a GDP of US\$26 900 per capita, a life expectancy rate of 80 years and literacy levels of 100% (National Geographic Society, 2004).

Prior to her departure for the project, the informant had worked in a major Midwestern American hospital for 18 months, was proficient in Spanish, and had volunteered her occupational therapy skills (as an undergraduate, and new graduate) in the region of the hospital in the Dominican Republic for a total of 4 months in the previous 4 years. Because of the limited funding available for this project, the occupational therapist was paid from her arrival in the Dominican Republic and was expected to commence service provision immediately.

The purpose of this research was to investigate the subjective experience of the informant. Broadly, the ethnographic interview approach addressed the following question — What was the experience of an American occupational therapist as she established an occupational therapy service in the Dominican Republic?

Method

Ethnographic interview methodology was selected as a means of exploring the phenomena of the experience of the occupational therapist in the natural setting described. Ethnography is a qualitative methodology that is characterised by a naturalistic focus on the everyday interactions of participants within a cultural scene (Minichiello, Sullivan, Greenwood & Axford, 2004). Furthermore, data is not prestructured or organised based on previous knowledge or experience in any

way, but is coded and categorised as the participant's experience is investigated via observation or interview. While classic ethnography involves the researcher as the participant observer of the studied setting, the presence of the researcher may alter the behaviour of people in the research setting. In this case, the single informant was interviewed after she had left the cultural scene for two reasons: (i) to avoid contamination of the cultural scene; and (ii) for logistical purposes related to this unfunded study.

Informed consent was gained prior to the interviews commencing. Interviews were conducted by the first author, an Australian trained occupational therapist, with the single informant, an American trained occupational therapist, over a 6-week period. The informant is the second author of this article. The interviews occurred in Chicago, the mutual place of residence for the author and the informant at the time. The ethnographic interview method, according to Spradley (1979), was selected to thoroughly investigate the cultural scene and the events that occurred. Spradley details both the method of data collection and the analysis of data by using a systematic approach that gives full interpretation of the informant's experience in their words and from their perspective.

The investigative approach of this method means that the informant's personal account is constructed in a disciplined process. First, in-depth interviewing occurs, is transcribed and then analysed for key terminology. Key terminology are determined solely from the informant's description of her experience and were explored using the informant's language. An example includes the key terms of 'charlas' and 'work environment'. Once located in the verbatim transcriptions, these terms were further explored for using continued questioning so that the experience of the informant was entirely explored. Interviews were conducted by initially using descriptive and structural questions, followed by contrast questions as the verbatim transcriptions were analysed. Examples of such questions from the interview and data collection process included the following: a descriptive question included 'Describe what you were doing when you were "teaching and supervising"' and 'Describe what a typical work day would be like'; a structural question included 'What were all of the reasons that you experienced "frustration" in your role as an occupational therapist'; and a contrast question included 'What were some of the differences between the way the men and women responded to you in therapy'.

The transcriptions of the informant's descriptions and responses to questions were analysed after three interviews, so that the information could be organised into the meaningful parts of the informant's whole experience. Such 'parts' are termed domains, and

included the following examples of over 40 domains that were revealed based on the informants description of her experience: (i) kinds of feelings the occupational therapist experienced; (ii) characteristics of life in the Dominican Republic; (iii) results of attitudes towards disability; and (iv) steps in setting up an occupational therapy department. Further data collection (interviews) and interpretation of data continued as the domains and folk terms were analysed taxonomically and componentially. This stage in the interview process involved extensive graphing and tabulation of terms and themes so that all angles were covered in completing the informant's whole experience. Taxonomic analysis occurred on such domains as life in the Dominican Republic including places, people and culture. Componential analysis was completed by contrasting such domains as reactions and characteristics of patients, with diagnostic groupings. Finally, the domains were organised into meaningful themes that could be described within a succinct format.

Data collection and the cultural scene

Interviews began 6 days after the informant's departure from the Dominican Republic. The cultural scene explored during the initial interview process was the occupational therapy department within the outpatient clinic, located inside the public hospital. The clients were from various campos (mountain areas), the slums of Santiago or poor pueblos (towns) in the Cibao valley. People from these areas were poor, uneducated and may not have known 'how old they were (or even) ... the day, year or month.' The informant described their lives as 'simple', and extended families lived within small houses. The hospital itself was indicative of the poverty and living conditions in the local region.

I'd walk in and see lots of trash on the floor every where. Then I'd see maybe a dog. There were no windows or doors; everything open to the outside. Going up to the patient floors you could smell the uncleanliness of the place. The patient's families would have to bring bedding, food, and care for the patients completely ... nothing was sterile, nothing was clean.

Data management and analysis

The reader is referred to Spradley (1979) for a more complete description of the interview and interpretation process already briefly described, as this methodology was strictly adhered to throughout the present study. The interviews were conducted using the three types of questions described. Domain analysis of the transcription occurred after the third and fourth interviews to organise the information, before interpretation of the data could be completed taxonomically

and componentially. The themes of the experience were extrapolated and separated by direct quotations and case studies provided during interviews. The informant provided photographs, objects from the cultural scene and a 300-page journalised day-to-day account of her experiences over the 6-month period. The data from the interviews, photographs and the journal were combined and verified for triangulation purposes to add to the rigour of this methodology.

Results

Three main themes were revealed: (i) challenges related to life in a community developing health and other human services; (ii) challenges related to working with the local workers; and (iii) the reaction of clients to occupational therapy. The descriptions of the events and experiences are documented directly from the analysis of the data, using the language and descriptions as recorded directly from the informant. Multiple minor themes were extrapolated and included within the main themes and there is much overlapping between themes. Because of the mass of information gained when using ethnographic methodology, the authors have selected representative quotes and case examples from the data to enhance the readability of the results.

Challenges of life in a community developing human services

Life in an underdeveloped country caused many daily challenges. Poverty, 'lack of resources', 'lack of education' among the local people, and the inefficiency of systems that resulted in 'waiting and waiting and waiting for equipment and supplies', all caused difficulties. 'When I got there, my head was in the clouds and then I got grounded in the reality of Third World life.'

Being an outsider

The informant lived with a 'very supportive' family in their 'three storey cement' home, in an upper middle-class neighbourhood. The family consisted of a retired couple, and their maid. The 'Dona', 'the lady of the house' and the maid were very close friends, even though the maid was at the Dona's 'beck and call'. The informant stated that she also developed a close friendship with the maid also. 'She was 30 years old. She worked so hard. Her day consisted of dusting, mopping and cleaning and scrubbing ... picking fruit, picking up after everyone, while the Dona would just sit there and yell commands at her'. The informant would arrive home from work and help, telling the maid to sit down and 'I'd make her a coffee'. But the Dona would 'tell [me] to stop putting my dishes in the sink or helping out. That was very different for me.'

The informant experienced differences in many circumstances from feeling 'very American walking down the street 10 times faster than everyone else' to guilt about what she earned in relation to the local people. The informant discovered that her therapy colleagues earned 3000 pesos a month, while the maid earned only 1200 pesos per month. 'And there I was making 9000 pesos [Approximately US\$500] a month. That was difficult to swallow. I felt guilty. I know it was because I was an outsider and giving training but I felt bad.'

Managing without material resources

Setting up the occupational therapy department began with being given a room 'with nothing in it and ordering basic furniture such as a table, chairs, a mirror and even a sink.' Lack of equipment and supplies and an inefficient and untimely ordering system resulted in many items failing to arrive before the occupational therapist completed her job. The informant stated, 'Everything seemed like such a huge process ... it was a cultural thing more than anything. Tomorrow really meant sometime next week to them. Waiting was a constant thing and very frustrating.'

Environmental challenges

Environmental barriers resulted in poor attendance — people arrived days or hours late, if at all, on many occasions. The informant stated 'I gained a lot of patience while I was there!' Rain meant that public transportation did not operate. Clients travelled for hours on foot to attend therapy.

The environment was not even friendly for people without disabilities. You could be walking and there is a six foot hole in the ground unmarked ... It's not, 'How many stairs to your house?' It's 'How many hills? What kind of terrain do you have to cross to get to your home?'

Delayed start to rehabilitation

People with injuries and disabilities were cared for in the home by extended family. Medical advice to look after such family members and strong kinship values meant that there were many tragic cases of delayed rehabilitation. 'I'd see people a year after they'd had a stroke.' Furthermore, the informant said:

I saw this little girl who had fallen out of a mango tree and she was paralysed from the waist down. The doctors said 'There is nothing we can do for you — go home and lie in bed.' Then when the family finally had enough money to go back and see the doctor, he said 'put her in therapy.' But it was after three years so she had contractures.

Another boy had a motorcycle accident and,

18 months later he arrived in a wheelchair with his whole body contracted. His elbows were contracted and hands stuck resting on his chest. He was contracted into a chair position because he'd been up in the mountains being cared for by his family. The doctors said 'Look after him until he gets better and then go to therapy.'

Local workers: Work skills and professional behaviour

Educating and supervising the local workers was necessary as they were to continue the service at the completion of the occupational therapist's contract. The local workers were from the established physical therapy (physiotherapy) department. The workers were a mix of students, unlicensed physical therapists, and licensed physical therapists. The licensed therapists had graduated from the local University 'Technician of Physical Therapy' program. The unlicensed physical therapists had been trained on the job. Two of the licensed physical therapists were assigned to the occupational therapy department to work with the informant.

Educating the local workers

Teaching responsibilities included giving tutorials and meeting the continual demand for education from the local workers. The informant was overwhelmed by the amount that the local therapists needed to be taught. 'I felt too much pressure with people yelling my name, "what should we do about this" and "you should know." It was almost too much pressure.' None of the local therapists were able to evaluate clients.

When the patients came into this clinic, to give you a perspective, they would lay down on the bed and the therapist would put on the TENS unit or the hot pack ... not one question about where you live, or home environment ... other therapists would slap on the heat and do a little massage and leave without hardly interacting.

Typically, the local therapists had previously received a card or referral from the physician saying 'apply heat 20 min, PROM, AROM of UE, increased gait'. The therapists' just did what the card said. Their documentation was to mark the back of the card that they had come.' The occupational therapist attempted to make up an evaluation form but the therapists 'were lost with this.' Consequently, the occupational therapist designed a descriptive evaluation form that was more successful ... 'Describe where [they] live ... what they were responsible for at home ... did they plan to return to work ... did they have to look

after someone at home.' Physical aspects of the evaluation were also functional 'can they reach their head, the small of their back.'

Another teaching responsibility included doing a lab practical for the therapists once per week. These sessions were interactive and included one-handed dressing techniques, scapula mobilisation and a demonstration of assistive equipment from catalogues and of donated equipment sent from a company in Chicago (USA) that had been generously shipped to support the occupational therapist. Throughout these sessions, the informant realised that she was 'fighting the knowledge that they don't have'.

At the end of the contract, the informant wanted the local workers to see that:

It's nice that someone talks to the patient first and finds out what their daily lives are like — where they come from, more personal information in order to tailor the therapy. And just making that person an active participant, not just trying modalities on them, or moving their arm passively. Maybe they got the idea that therapy enabled the patient ... I hope that I achieved that.

Professional behaviour of local workers

Professional behaviours familiar to the occupational therapist were absent in the local work environment. Confidentiality was not valued as the therapists 'would just spill' client's details to whoever asked. Safety was not considered as the therapists would 'just get up from next to his client and leave ... not saying where he was going.' The informant was concerned about the importance of safety, and the legalities of confidentiality. These were issues that were 'learned in orientation at any hospital in the United States', while 'safety and independence [was] just ingrained in the US in OT school.'

Behaviour and expectations of clients attending occupational therapy

Local custom including strong family values, interdependence between family members in daily life, and beliefs about disability, treatment and therapy, all influenced the success of this venture. Hardship and struggle were inherent to life in the area. The local people expected obstacles and gained pleasure from family, their friends and their 'good sense of humor'. The informant stated that 'a day never went by that I didn't laugh'. Even when patients had a home program encouraging them to practise upper body dressing, such patients would return to therapy 'tell[ing] me that their wife would just put their shirts on, they would be laughing, everyone seemed to be laughing along! Even the kids would enjoy the therapy.'

Family care reducing the need for independent functioning

The informant stated that adults and children with disabilities were cared for 'There is always someone there to help you so you don't need to do things for yourself ... [and the person] lost their sense of independence from the beginning.' The informant noticed that 'independence was not so sought after as it is in the US.' A young boy who had his legs and fingers amputated was completely cared for by his mother (dressing, feeding, toileting).

Then I gave him a regular fork and a banana and he just ate it. I was all ready to build up a fork and make a special adaptation. He was like 'Oh, I can do this!' I told him there were lots of things he could do for himself.

Perceptions of the therapist and therapy

The clients attending occupational therapy 'thought they were receiving something special' because the occupational therapist was American. Being a 'Gringa', 'Americana', a white girl, the people assumed that the occupational therapist 'was someone with a good education', or a doctor. The informant noticed that the clients 'were in awe and felt like they needed to perform.' However, many clients came to the hospital 'not to do therapy, but to receive therapy.' They were expecting the same therapy that they received in physical therapy. 'Patients would come in take their shoes off and lay down before I said hello. They would be shocked to find out that someone [wanted] to find out what kinds of activities [they did] at home.'

Some clients misunderstood and would return to the physical therapy area after occupational therapy 'saying "that woman is not giving our children therapy" ... they went back to the other area because they wanted someone else to do it.' The informant noticed differences between herself and the clients that attended occupational therapy, in regard to the meaning of disability. 'Once someone had a disability, even a broken wrist, they were considered severely disabled.' Attending therapy was a part of being cared for as a result of their disability. The clients 'had no concept of rehabilitation or returning to life and work.'

A young 35 year old man in a motor vehicle accident had lost function in his left arm but he was still walking. I asked if he was still working and he was shocked. He said he wasn't working. I asked 'What did you do before?' he said 'I worked in a colmado' which is a little store, and I said 'why don't you do that now?' He said, 'Look at me. I am completely disabled.'

The occupational therapist stated that people did benefit from intervention. An example was a little girl with a 35-degree flexion contracture of the elbow.

The physical therapist came to me and said, 'Here is the girl. We've been pulling on this arm and we cannot get it straightened.' The little girl was in tears ... so I taught the parents scar management ... (told) the little girl what I was going to do ... massage and stretch out her arm. I'd give her bean bags to throw and get her to reach. She didn't cry and her mom could see that it helped her.

Discussion

The results of the present study investigating the experience of one American trained occupational therapist as she established an occupational therapy service in a region of the Dominican Republic were that it was both challenging and worthwhile. The therapist implemented occupational therapy practices that were based thoroughly on the Western model of rehabilitation, which was the dominant model for the occupational therapy profession at the time. Worthwhile aspects included establishing the service, educating local therapists, providing therapy that enabled the clients to be more involved in the occupations of their daily lives, educating clients about their own conditions, and contributing to the improvement of services available to the people in need of them. Particularly challenging aspects were related to simply adjusting to a different culture with different customs, adjusting to the realities of life in a rural community with poor health, education and community resources, and the clients' reactions to occupational therapy.

Challenges arose as the occupational therapist applied her Western model of practice to the needs of the local clients. Differences between the beliefs, values and cultural customs of the occupational therapist and the recipients of her services caused conflict. The differences in belief that challenged this project were: the meaning of having a disability; the effect of the disability on the individual's roles and daily occupations; one's place within the structure of kinfolk; the purpose of therapy; and the belief that hardship was a part of life to be accepted. Differences in values were closely entwined and included the strength of family interdependence, the importance of friendship and humour, the concept of personal causation, and that timing and efficiency was not as important as achieving your eventual goal. The occupational therapist discovered many differences in the meaning of concepts that were important to her — time and waiting; the value of work; the characteristics of professional behaviour including conduct, safety, documentation and

confidentiality; the interaction between the therapist and client; and the meaning and purpose of therapy.

The experience of the informant in the present study supports the supposition that the Western occupational therapy practice cannot fit within a non-Western framework without some modification on behalf of the service deliverer and the client group. Examples in the present study include the occupational therapist's adaptation of the evaluation form and attempt to train the staff to interact with the patients and achieve client-centred goal setting. Krefting (1992) provided insights into the need for occupational therapists to appraise the assumptions underlying dominant practice and to understand the health and cultural context of people in developing countries in order for the rehabilitation needs of such places to be met. Core underlying concepts that do not easily transcend cultural barriers are: personal autonomy, the concepts of performance and achievement in occupation, and goal-directed intervention (Awaad, 2003a; Fitzgerald *et al.*, 1997; Hasselkus, 2002; Kondo, 2004). The present study supports the importance of competently considering the impact of these concepts on the practice of occupational therapy. Further reflection on the meaning of these concepts in relationship to the experience of the informant is helpful for future similar ventures.

Personal autonomy

Personal autonomy refers to issues around one's ability to influence and direct one's own life events. Such is a core belief in the pursuit of empowering our clients and client-centred practice (Awaad, 2003a; Law, Baptiste & Mills, 1995). In the present study, the occupational therapist faced obstacles as she attempted to implement client-centred practice, as many of the clients wanted to receive therapy, rather than participate. Collaboration between therapist and client for mutually agreed goals was difficult with the many conflicts of values mentioned. Differences between the therapist and the clients' values, beliefs and goals are the principal reasons that occupational therapists face barriers to achieving client-centred practice (Sumsion & Smyth, 2000; Wilkins, Pollock, Rochon & Law, 2001). The informant in the present study certainly experienced such differences in this project.

Independence is associated with having a choice and control of one's own future and goals in life and taking responsibility for those choices (Kinebanian & Stomph, 1992). Such a philosophy involves recognising the individual as a self sufficient unit, not reliant on family or community. Occupational therapy literature acknowledges the belief in some cultures that interdependence and the individual's place within the family unit are of utmost importance (Iwama, 2003; Meyers,

1992; Nelson & Allison, 2000). Belonging and the strength of the community, not the individual, is of value for many people of the world. Kinebanian and Stomph conclude that the interests of a client are best served within their own cultural group, and it may therefore be 'advisable to define the aim of occupational therapy in terms of interdependence rather than independence' (p. 752).

Concepts of performance and achievement in occupation

Performance and achievement refers to the Western belief that competence, mastery and being productive in occupations of one's choice is central to human experience (Awaad, 2003a). The general view is that hardship and life challenges can be overcome through hard work. Occupational therapists believe that meaningful and productive occupation is health promoting in individuals, communities and societies (AOTA, 2001). Trombly (1995) speaks for the profession when occupation is named as our main therapeutic medium. Other cultures place different values on engaging in occupation when one is ill or disabled. The local clients in the present study were seen to abandon involvement in self care, domestic duties, and work, considering themselves too disabled to participate. Furthermore, they accepted hardship as a part of life and used humour to cope with challenges that their Western counterparts may resist or seek action against. Indeed, enduring hardship is viewed as virtuous by people in some other cultures (Kondo, 2004).

Goal-directed intervention

Goal-directed intervention is central to occupational therapy. Awaad (2003a) refers to the common goals of treatment including independence, balance in one's daily occupations and achievement of one's highest functional skill level in chosen occupations. Concepts such as independence, time, illness and recovery are variable depending on the culture of the recipient.

Time has both a subjective quality and wider cultural meanings. The time use of clients and the balance of their occupations is of concern to occupational therapists (Farnworth, 2003). Western attitudes that time is to be organised and used efficiently is in stark contrast to some other non-Western views (Yulmambirra, 2000). The behaviour of the clients in the present study demonstrated cultural differences in time concepts such as tempo, punctuality, and past and future time orientation. This proved to be a source of frustration and accommodation for the occupational therapist in the present study. Although the lack of punctuality of patients and the speed of daily life did frustrate the informant, she did adjust her own expectations to promote the success of the program.

The concept of illness and recovery is an important core belief in occupational therapy practice. Law (1991) says of the profession, 'we believe that health is determined by an individual's purposeful engagement in occupation and by a balance of self care, productivity and leisure' (p. 174). Furthermore is the assertion that facilitating a client to be involved in purposeful activity improves the person's occupational functioning (Wood, 1998). As described, the behaviour of the clients in the present study demonstrated that they believed that acquiring an illness or disability meant that the person needed to do very little for themselves. Therapy was thought to improve a client's condition without any effort from the individual. Such ulterior views on illness and disability, and the consequential role of therapy are well represented in the culture literature. Kinebanian and Stomph (1992) made the important point that the profession's emphasis on promoting function in people who may be sick or disabled through engagement in activities or occupation 'contrasts sharply with the way most non-Western cultures treat sick or disabled persons' (p. 753). The client may expect the therapist to 'do something' to them to make them better. The authors acknowledge that people from such cultures do 'believe that submitting to treatment is the right attitude' (p. 753).

Without such insights into the culture of a client, a therapist could easily misinterpret the client's behaviour as non-compliance or disinterest in their own condition. In the present study, initial attempts to collaborate and form a therapeutic relationship with clients proved to be difficult. However, the client's response to becoming actively involved in treatment was positive and helpful in several case examples.

Summary and recommendations

Although the present study is specific to the experience of one occupational therapist within a single geographical area in the Dominican Republic, insight into many current theoretical and clinical practice issues may be gained from this unique project. It is important to note that the individual personality traits of the informant in the present study are highly specific and not important in the knowledge gained from her experiences. Similarly, it is not the intention of this author to suggest generalities about the ethnicity of the occupational therapist or the individuals who received services. To do so would be undermining the complexities of one's culture.

The findings of the present study are that the delivery of occupational therapy services based on the Western practice did face challenges as it was transplanted directly into a community in a region that was seeking to develop its health services. Conflict

was experienced at a personal and professional level for the occupational therapist, as differences between beliefs, values and cultural customs were revealed throughout the project. The events and individual stories are unique and general themes of professional importance have been described and discussed.

Further research recommendations include: (i) the development of epistemology that is appropriate to non-Western cultures; (ii) guidelines for successfully implementing occupational therapy services tailored to people in need in developing communities; (iii) investigation of exactly which strategies promote successful occupational therapy programs for the staff and clients in developing/non-Western communities by researching the experience of the local people; (iv) further investigation of the extent to which culturally based differences in values and beliefs interfere with the therapist-client relationship in practice within Western multicultural nations; and (v) improved training and wider appreciation of the importance of cultural competence among practising therapists.

In summary, this paper introduces the challenging events that can occur when living and working in a developing community, and reiterates the need for the occupational therapy profession to renew and revise some of the core themes underlying its practice. The documented scenarios are a reminder of the existence of many people who may benefit from occupational therapy service, and of the many fascinating cultures that make up the people of the world. Of interest to occupational therapists is what happens when a meeting of a Western profession and a culture unfamiliar with occupational therapy practice occurs. What is evident from this project is that the encounter ends with change for both the therapist and the recipient of therapy. Some values, beliefs and customs clash leaving frustration and bewilderment. Other aspects are more positive, resulting in both parties walking away from the exchange with a greater understanding of themselves and the meaning of their daily lives.

Epilogue: The data in this project was collected in 1999. Since the occupational therapist completed her contract, the department has been staffed by a non-Western occupational therapist and the two physical therapy technicians who were trained during this project. Occupational therapy students from a major Midwestern American college completed placement at the department on a regular basis between 2000 and 2002.

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