

Towards culturally competent professional practice: exploring the concepts of independence and interdependence

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Abstract

Health and social care practitioners increasingly work with clients from diverse cultural backgrounds. While health and social care systems have emphasized the importance of culturally competent practice, professional practice has been influenced by values such as independence, a western notion that places value on the individual. It has been suggested that interdependence, a notion that places value on the family and/or community, can serve as an alternative to independence in culturally diverse practice. Using interviews with thirteen occupational therapists working in culturally diverse social care teams in London, this study aimed to explore whether the concept of interdependence could serve as an outcome and, whether it is more likely to result in actualizing culturally competent practice. The findings of this study add to the discourse in social care concerning the sources of associations made between the concepts of care and dependence, the positive meaning associated with independence and whether independence does support personal empowerment of service users. We suggest that interdependence better reflects the essence of social care delivery as a collaborative and respectful process between clients, care-givers and professional practitioners regardless of background, culture and societal expectations.

Keywords: qualitative research, occupational therapy, interdependence, independence

Introduction

There is a growing demand for cultural competency as health and social care practitioners increasingly encounter clients from different cultural backgrounds. The significant influence of culture on professional practice has been identified by others (Betancourt *et al.*, 2003; Bourke-Taylor & Hudson, 2005; Hopton & Stoneley, 2006; Capell *et al.*, 2008). Betancourt *et al.* (2003) also highlighted significant social and cultural influences at organisational and structural levels; these are also important as they influence overarching ways of delivering health and social care services. Cultural competency, therefore, should be an integral part of all practice if clients are to receive equal access to health and social care regardless of their cultural background (Betancourt *et al.*, 2003; Capell *et al.*, 2008). Moreover, Suarez-Balcazar *et al.* (2009) state that cultural competency and client-centred practice should be inseparable if practice is to be delivered in a way which is fair for all.

Cultural competence refers to a process by which health and social care practitioners respond to people from different cultures, who may speak different languages, come from different social classes, religions or ethnic backgrounds in a respectful way that affirms and values the individual and their family (NASW, 2001). Dillard *et al.* (1992) further defined cultural competence as *'an awareness of, sensitivity to, and knowledge of the meaning of culture'* (p.722). If professionals are to deliver appropriate client-centred interventions they need to be both culturally aware of and sensitive to their own cultural values and beliefs, values and beliefs as well those of the clients with whom they work (Awaad, 2003; Betancourt *et al.*, 2003). Suarez-Balcazar *et al.* (2009) describe cultural competence as a skill that can be acquired through practice, while others describe cultural competence as an ongoing, complex process that encompasses understanding the influence of several skills and characteristics (Muñoz, 2007; Capell *et al.*, 2008). Cultural competency requires effort and commitment on the part of

individual practitioners to frequently relearn and unlearn about diversity (Dillard *et al.*, 1992; NASW, 2001), while a lack of understanding of the process, its meaning and dynamics contributes to a lack of consistency and clarity generally about the meaning and delivery of culturally competent practice (Betancourt *et al.*, 2003; Muñoz, 2007).

Cultural competency is often poorly defined in the literature. While some studies do address the process of cultural competency it is rarely discussed in depth and often identified as an issue peripheral to the research, or only understood in a partial way (Iwama, 2003; Hopton & Stoneley, 2006). In this study it was understood to mean a process that comprised a set of skills needed by occupational therapists so that they were able to respond to the specific cultural needs and idiosyncrasies of the people with whom they worked (otherwise referred to as *clients*), and that the therapists could deliver culturally competent practice within the context of the health or social care team in which they worked.

Independence in occupational therapy

Independence is a relative concept with multiple inferences and meanings (Bowers, 2001; Tamaru *et al.*, 2007; Fox, 2010). For example, a wheelchair user can be independent from others in performing activities of daily living but dependent on the wheelchair for support and mobility. A person with dementia may be able to make a hot drink independently but dependent on others because of risk factors such as using matches or gas appliances to heat the water on a stove. In this study, independence is defined as a state of being self-sufficient, not requiring the help or assistance of others to perform necessary daily tasks and occupations.

Traditionally, the achievement or restoration of independence has been an important aim of occupational therapy and the focus of health and social care practitioners in general (Yang *et al.*, 2006; Whiting & Whiting, 2003). Independence has long been viewed as a healthy condition while dependence has been viewed as a deficiency (Whiting & Whiting, 2003). However, as the term independence is informed by western Anglo-American models of practice its place, cross-culturally, has been questioned. For example, Yang *et al.* (2006) investigated the applicability of occupational therapy models in Singapore, and found that occupational therapists had difficulty delivering their services to clients because of the focus on independence. They concluded that independence was a western cultural artifact neither appropriate nor relevant to Singaporean cultural values. Further studies that have a clear focus, and that are aimed specifically at investigating the value and influence of independence on occupational therapy practice in specific cultures, are important if we are to measure the impact on actualizing culturally competent practice (Whiteford & Wilcock, 2000).

Interdependence in occupational therapy

Interdependence refers to the social relations between clients and the important others, which are conducive to health and social care provision and reception (Bowers, 2001; Hansebo & Kihlgren, 2001; Sharma & Kerl, 2002; Stanhope, 2002; McWilliam, 2009; Fox, 2010; White *et al.*, 2010). In the literature, the term interdependence is associated with the *give-take relationships* where *help and support* is offered and received to enable any individual living in the community, whether disabled or non-disabled, to function and be integrated into society (Adams, 2009; Hammell, 2009; Fox, 2010). Humans are social beings who relate to each other through spoken words as well as body language and by seeking and offering help, for example through teaching and learning, bringing up children, taking care of older people, or buying something in a shop. Researchers have demonstrated a significant and undeniable need for interdependence in promoting health and quality of life (Beeber, 2008; Fox, 2010). Interdependence is an inevitable part of the intervention process as therapeutic outcomes would not be elicited without relationships between carers, clients and professionals (Hansebo & Kihlgren, 2001). Yet the health and social care literature rarely acknowledges or employs interdependence either as a notion or as a term, making its use vague and unclear (Whiting & Whiting, 2003). There is a need to explore the meaning and use of interdependence within

occupational therapy and in health and social care generally. In this study interdependence is used to refer to the state of being interrelated within an array of social relations and to be a realistic and natural representation of the state of humans as social beings, including within health or social care settings.

Interdependence versus independence

Interdependence is viewed as much more naturalistic, realistic and reflective of the reality of humans as social beings than independence (Hopton & Stoneley, 2006; White *et al.*, 2010). White and colleagues argue that the notion of interdependence preserves communities and societies, whereas a focus on individualism and individual freedom undermines social interaction and the role of others. There are increasing calls for interdependence to act as an alternative aim to that of independence for individuals and their families, as it is associated with positive therapeutic effects on health and quality of life (Fox, 2010). Stanhope (2002) and McWilliam (2009) assert that the notion of interdependence empowers clients to adapt and manage their health condition in the context of their physical and social environment. Whereas the notion of independence has the effect of segregating clients from their social relations in order to actualize self-care management, Nolan (2001) and Beeber (2008) recommend interdependence (rather than independence) as the aim or outcome of healthcare as it is more likely to result in the promotion of health, quality of life and client-centred practice, especially for older people. Moreover, Fox (2010) posits interdependence as a more realistic goal to underlie practice within health and social care generally; and Stanhope (2002) states that the adoption of interdependence is associated with a better prognosis for clients with mental health conditions. The impact of adopting values of both independence or interdependence within the practice of occupational therapy generally and cultural competency specifically, have been only rarely researched. Therefore this study aimed to explore firstly, whether the concept of interdependence can serve equally well as an alternative aim of occupational therapy and, secondly, whether interdependence is a more appropriate notion for actualizing culturally competent practice, as perceived and experienced by occupational therapists.

Method

A qualitative, descriptive approach was used as the purpose of the study was to explore occupational therapists' views and experiences of interdependence and cultural competency (Hammell *et al.*, 2005; Finlay & Ballinger, 2006). The study was designed in two stages. The first stage comprised individual interviews with occupational therapists currently working in community-based teams with clients from diverse cultural backgrounds. The second stage comprised individual interviews with two independent experts in the field of occupational therapy theory and practice in order to extend the findings of the first stage interviews and confirm (or refute) data already generated (Sim & Wright, 2002).

Sample and recruitment

London has the highest proportion of multi-ethnic communities in England (ONS, 2009). A Primary Care Trust (PCT) in one of the most culturally diverse boroughs in London (DMAG, 2007) was selected for the first stage of the study. The setting ensured participants would routinely encounter clients from a range of diverse cultural backgrounds which would enable them to provide rich data needed to address the research aim. A sample size of twelve to fifteen participants was deemed appropriate to allow sufficient rich, in-depth data to be gathered for the first stage of the study (Finlay & Ballinger, 2006). In the first instance, the Team Manager responsible for occupational therapy services was contacted and was asked to support the study, and sent copies of the invitation letters and information about the proposed research. Following discussion, the manager sent the invitation letters and information by email to fifty-five occupational therapists working within the PCT. Criteria for selecting participants were that they had to have been working as an occupational therapist for at least three years either at the research site or other similar site in the UK or other country, in order to meet the

requirement of a certain level of proficiency or expertise in multicultural practice. Each was contacted by the first author (WD) and, following a meeting to further explain the research, the eligibility requirements and to answer any questions, thirteen occupational therapists agreed to participate and gave their written consent. Participants worked in a range of teams including older adults, intermediate care, mental health, children, physical health including medical, surgical, orthopaedics and neurological services.

For the second stage of the study, prominent occupational therapy theorists were identified by their contribution to the field of occupational therapy theory in the UK, as identified by a search of the literature and publications in the field of occupational therapy theory and philosophy. Participants were identified through the Head of Education and Learning and the Research Development Officer at the College of Occupational Therapy, the professional body for occupational therapists practicing in the UK. Eighteen potential experts were identified and each was contacted by email with information about the study and an invitation to participate in the second stage of the study. Two of these responded. Each was contacted (by WD), and following further discussion about the research, each consented to take part in the study. Ethical approval was sought and obtained from the Research and Development Office at the research site, and from an NHS Research Ethics Committee, reference 08/H0701/88.

Data collection and procedures

Data collection was based on one semi-structured, in-depth interview with each occupational therapist. The interview explored each participant's knowledge and experience of the topic of study: namely their understanding of the terms independence and interdependence and whether interdependence is a more appropriate notion for actualizing culturally competent occupational therapy practice. All interviews were tape recorded and transcribed verbatim and the interview narratives used as data for analysis. The researcher who conducted the interviews (WD) also kept a field journal. This was used to record events, thoughts and insights that occurred during the whole of the data collection period and used to supplement and support the data analysis process.

The semi-structured interview was selected as the method of data collection for both stages of the study. The use of a topic guide in the interview ensured that interviews remained focused and that the data generated was relevant to the research question. Questions included:

1. Can you describe the ultimate aim of your work with your clients?
2. In your mind, what is the position of independence in occupational therapy?
3. According to your experience, what is your understanding of interdependence?
4. What should be done and where to start if occupational therapists are to achieve cultural competency?

These questions were a guide only and were typically followed by prompts, such as *Could you explain that further? Can you give an example?*

Following completion of these interviews, data were analysed using content analysis (see next section). Next, two further interviews were conducted, one each with the two occupational therapy theorists who formed an 'expert panel'. The questions asked were developed from initial findings arising from the first level of analysis of the interviews with the thirteen practicing therapists. From these initial findings some therapists placed a high emphasis on independence and some saw independence as the main aim of occupational therapy, thus questions included:

1. Do you agree that independence is the ultimate aim of occupational therapy?
2. Do you think that emphasizing the notion of independence in occupational therapy would enable the delivery of a culturally competent practice?
3. Do you think that there is enough attention and recognition to the concept of interdependence in occupational therapy?

4. Where do you think occupational therapy is placed in relation to the achievement of cultural competency? Why?
5. What should be done and where to start in order to achieve cultural competency in occupational therapy?

One individual interview was conducted with each of the thirteen occupational therapists. Each interview lasted between 60-90 minutes. Two further interviews were conducted, one each with the two occupational therapy theorists, each of which lasted for about 90 minutes.

Data analysis

Following a period of familiarisation with the data, the transcripts from the first round of interviews were read and re-read. Data generated were in narrative form in an attempt to keep the data whole. Next, thematic content analysis was used to analyse all interview data from the first round. MAXQDA2 was used for coding and retrieving data segments. It also facilitated the tabulation of coded data against the initial list of themes and sub-themes, as well as sorting it into organized thematic charts. The analysis process was adapted to suit the idiosyncrasies of the study in such a way that the focus of the analysis did not only target the data content but also the way and the context in which data were generated through notes from the researcher's field journal (Finlay & Ballinger, 2006).

Although the main approach adopted for data analysis was thematic content analysis, the principles of narrative analysis were also incorporated in the process. This allowed for reflection on the way the data were treated. For example, data were not treated as separate chunks but rather as accounts that were part of an interrelated whole, linking with each other allowing for associations to be made and interpretations to be built. Analysis focused on the purpose behind the data as well as the key messages of the text. This was clearly evident in the coding, where the aim was not to reduce the data into manageable chunks using a pre-established code system, but rather to carry out the process of coding/indexing alongside the construction of the coding system.

The initial themes and questions generated, following analysis of the first stage interviews formed the questions for the second round of interviews. Following these, the next iteration of analysis was carried out and data again collated by themes. The initial versions of the coding comprised three main themes that included: cultural competency and occupational therapy, independence and cultural competency, interdependence and cultural competency. A further round of analysis took place to ensure that interpretations were reflective of the content and key messages of original data. Next, interpretations from the second round interviews were generated in the same way referring back to initial interpretations from the first round interviews. Finally, the overall themes were drawn out of the whole analysis process for first and second rounds of interviews.

Findings

Following data analysis, three overarching themes were identified each with sub-themes. These can be found in **Table 1** and will be discussed separately.

Theme 1. Independence as an outcome

1.i Independence: an overarching aim of healthcare

Participants stated that independence constituted the identity and the ultimate aim of occupational therapy:

... from an OT point of view, you always will try and work towards getting as independent as possible. I think that's kind of like brained... you know kind of washed into our brains to what can we do, how can we support the patient to get more independent, what can we provide to

Table 1. Themes and sub-themes

Major Theme	Sub-theme
1. Independence as an outcome	1.i) An overarching aim of healthcare
	1.ii) An overarching aim of occupational therapy
	1.iii) Independence and cultural competency
2. Interdependence as an outcome	2.i) Interdependence and occupational therapy
	2.ii) Interdependence as an outcome of occupational therapy
	2.iii) Interdependence and cultural competency
3. Culturally competent practice	

get them more independent, what can we remove around in their home to make them more independent. [P2]

Moreover, participants perceived independence to be the ultimate aim of healthcare generally and other professionals did not see it as exclusive to occupational therapy:

I mean pretty much in healthcare, pretty much what everybody does is linked to independence, it's not exclusively OT... [P5]

There was a lack of consensus concerning the meaning of independence and some participants used the concept of independence (the doing of occupational tasks or roles without help) interchangeably with the performance of meaningful occupations on one's own. For example:

The word independence is to be able to do it yourself without support but I think as an occupational therapist and having to be creative in ways that people can achieve what they need to do, I think the meaning of independence has maybe changed a little bit in that, mmm, I've seen people achieving tasks but with support or with equipment or you know in a very different way to traditionally independent... [P11]

Although you say that you are kind of independent in everything, in some areas you are interdependent... like [having] a milkman who is delivering milk at your doorstep. [P10]

When exploring these definitions in more depth, independence seemed to reflect the essence of occupational therapy which was to enable participation in meaningful occupation:

I think that is what occupational therapy is, it's about engaging and participating... [P8]

1.ii Independence: an overarching aim of occupational therapy

Independence as an outcome of occupational therapy seemed to be a concept that was implicit in the healthcare system:

Generally here the services are aimed at people being as independent as possible, aimed at people being able to look after themselves and stay in their own homes for as long as possible... [P1]

This may be as a response to increased pressure from healthcare providers to facilitate early discharges which, in turn, can reduce costs and pressures on services by freeing up more beds and reducing staffing:

I guess probably part is quite financial as well in that you can get people to monitor their own conditions, it's easy you can have... you don't need so many health professionals involved ... but people are managing alternative conditions themselves so they only need their input from professionals at certain points along the way... [P8]

Some participants attributed the focus on independence to the western (Anglo-American) orientation of occupational therapy. This philosophy was constructed and developed within the western world and for their indigenous societies, which emphasized values such as independence:

A western society is so much on independence... [P6]

A lot of the thinking and writing has come from people who are embedded in western culture thinking. So they're embedded in the 'self as central' thinking rather than a collectivist type of thinking and, from that, then the whole thing... if you look to some of the professional models of occupational therapy, in the middle of it, it's me, me, me, you know it's the individual at the centre, which is a very western cultural way of looking at life. [P13]

While the study did take place in the UK, historically a country that would embrace western notions such as independence, the applicability and relevance of independence to people living in the UK but from a different, non-western, cultural background can be questioned:

... if you see occupational therapy as people maintaining their own health through doing, then that is not going to be acceptable to a lot of people... is not appropriate, not in some cultures, and not at a certain time and not even within subcultures in the UK... [P14]

1.iii Independence and cultural competency

Focusing on actualizing a state of independence sometimes resulted in participants neglecting the needs of, or even marginalizing clients from non-western cultural backgrounds. When there was a focus exclusively on independence some participants observed that this could risk imposing service-focused outcomes on clients instead of responding to their specific cultural (client-focused) needs:

If you use the concrete term of independence the whole time, then you're not gonna achieve cultural competence. You might get it right for a lot of the times but for the people that don't see independence as a high priority, you're really gonna let them down... [P1]

This, it was claimed, could result in clients' needs not being met or at best a service that was unresponsive to specific goals and cultural needs of individuals:

We work in a goal orientated service so if people don't want to improve, we tend not to be working with them. [P7]

Some participants stated that the focus on independence clashed with the delivery of culturally competent practice:

... culturally competent, no I don't think to do with independence really... [P12]

Theme 2. Interdependence as an outcome

2.i Interdependence and occupational therapy

Most participants stated that the term interdependence was rarely used:

I haven't really used that term myself within my career, I haven't come across it... [P11]

Although the term interdependence was not used, participants had witnessed and experienced the intertwined, joint and reciprocal relationship between themselves, their clients and clients and their carers.

... it was very much a joined thing, so it's almost like looking at the two of them as one... because she relies so heavily on him and what they do is so intertwined... [P5]

They had also observed or experienced *interdependence* in different contexts for example in work, social and personal contexts. Thus the connotations associated with interdependence were understood and the implications obvious even though the term interdependence was not use in the workplace.

Sometimes you're doing it [occupation] for itself, sometimes you're doing it for somebody else and sometimes somebody else is doing it for you and to me that's the rich life... [P9]

2.ii Interdependence as an outcome of occupational therapy

Interdependence was perceived as essential in enabling the intervention *process* of achieving outcomes. Through interdependence, the important others in the client's life, such as those of carers, supporters and supervisors, could play several significant roles in facilitating the delivery of occupational therapy:

... a facilitatory role... to help them get dressed and manage their money, to provide for their basic needs in terms of feeding, hygiene, to decide for them what they need to be doing, to support them with the roles such as their parenting roles, to advocate for them in that's... particularly when there is a language barrier... [P7]

Interdependence was noted as an important factor when working as an occupational therapist with clients and their families, as the development of a collaborative and therapeutic relationship (a form of interdependence) would encourage trust and therefore more likely active involvement with the therapy:

The family members can act as... like advocate or intermediary person that actually can help the therapist with providing that treatment because ...especially if the patient is quite scared and doesn't trust the therapist, it could be really useful in gaining trust... [P3]

In addition, when working closely together (interdependently) with the client and their important others, these family members can act as a constant source of supervision and care for clients who have impaired mental capacity such as older people with dementia, or clients with other conditions affecting insight or cognition. Thus, if the important others were included as part of the process of treatment and taught to deliver services at the clients' home environment, this would help to ensure greater continuity in the type of care or treatment and any therapeutic benefits for the recipient. This might help reduce risks and enable clients to also work collaboratively with therapists to achieve outcomes. For example, the provision of care for clients who require constant supervision or to be mobilized to prevent pressure ulcers. Thus important others become an essential part of the team as they assume the role of a healthcare assistant by supervising or carrying out interventions when the therapist is absent, especially within the client's home environment:

I'm thinking about falls again... they've got a lot of these rugs lying around and you think about the word if they picked them up and then you involve the other family members with that and making to do that as well. [P8]

The family have basically gone in there and taken on the role of almost like therapy assistants, kind of like what home rehab would do but they've been getting him up and moving... [P5]

2.iii Interdependence and cultural competency

Participants acknowledged that interdependence is a concept that reflects the reality of being human, regardless of cultural background:

We're all kind of interdependent and interconnected mmm I think that's there in all the culture, maybe the... kind of the intensity varies... [P10]

There is a strong emphasis on the value of interdependence and social relations in some communities more than others. In these communities interdependence is perpetuated and synthesized within the sociocultural fabric of their life. This kind of cultural emphasis on the value of interdependence is apparent in the customs and traditions in these communities: for example where there is an emphasis on living in extended families. Here it is normal for others in the family to provide care in cases of illness or disability and a stress on making decisions collectively with other members of the social unit:

The elder son or daughter from these bigger families will often want to be like, well no, come through me, and their actual... the elderly person will be quite happy to allow their son or daughter to make those decisions on behalf of them... [P3]

Participants acknowledged the influence of interdependence on their practice and the need to adapt their approach to correspond appropriately to the cultural context in which they were working:

For example an Asian lady I've got now, I'd definitely go through all... maybe one or two of the sons or daughters to talk about it, make sure they're happy with it and as well as the person involved, so they're going to be using it and all gonna be involved... [P3]

Theme 3. Culturally competent practice

With regards to cultural competency, participants did not report any link with independence or interdependence as a way of actualizing cultural competence. Participants acknowledged that an understanding of the client and their culture and background was very important as cultural influences, as well as what the client does and the particular way it is done. Cultural competence appeared to be understood as a function of individual therapists rather than being influenced by notions of independence or interdependence:

You being culturally competent is you have an understanding of how your clients' culture impacts on their daily living tasks and you then use that information to help make realistic goals with your patient about what you want to work towards... [P13]

Discussion

A significant finding of this study was that occupational therapy practice had shifted from a client-centred approach of enabling participation in meaningful occupation towards a service-focus where notions of independence predominate over client preferences. With such a focus, client-centred care that focuses on personal choice, autonomy and empowerment of individuals can be undermined. The study set out to explore the concepts of independence and interdependence, and whether using interdependence as an outcome is more likely to result in

actualizing culturally competent practice. None of the participants in this study used interdependence as an outcome, so discussion focuses on current practice as experienced by these thirteen occupational therapists and the independence – interdependence continuum.

UK social care policies are strongly rooted in principles of supporting independence, autonomy, and personal empowerment, and little attention is paid to other concepts such as dependence and interdependence (Nolan, 2013; Fine & Glendinning, 2005). This places an unrealistic demand on frail clients who require constant care because of age or condition (Nolan, 2013). Independence is associated with positive outcomes though the sources of that is not rationalized nor researched (Nolan, 2013; Fine & Glendinning, 2005). On the other hand, dependence is associated with negative outcomes and is used to measure the degree of assistance needed or level of care (Nolan, 2013; Fine & Glendinning, 2005). The source of these value-laden terms has been poorly researched and are poorly understood, and there is a need to construct a new conceptualization of care that encompasses dependence, interdependence and independence (Nolan, 2013; Fine & Glendinning, 2005).

Independence versus interdependence

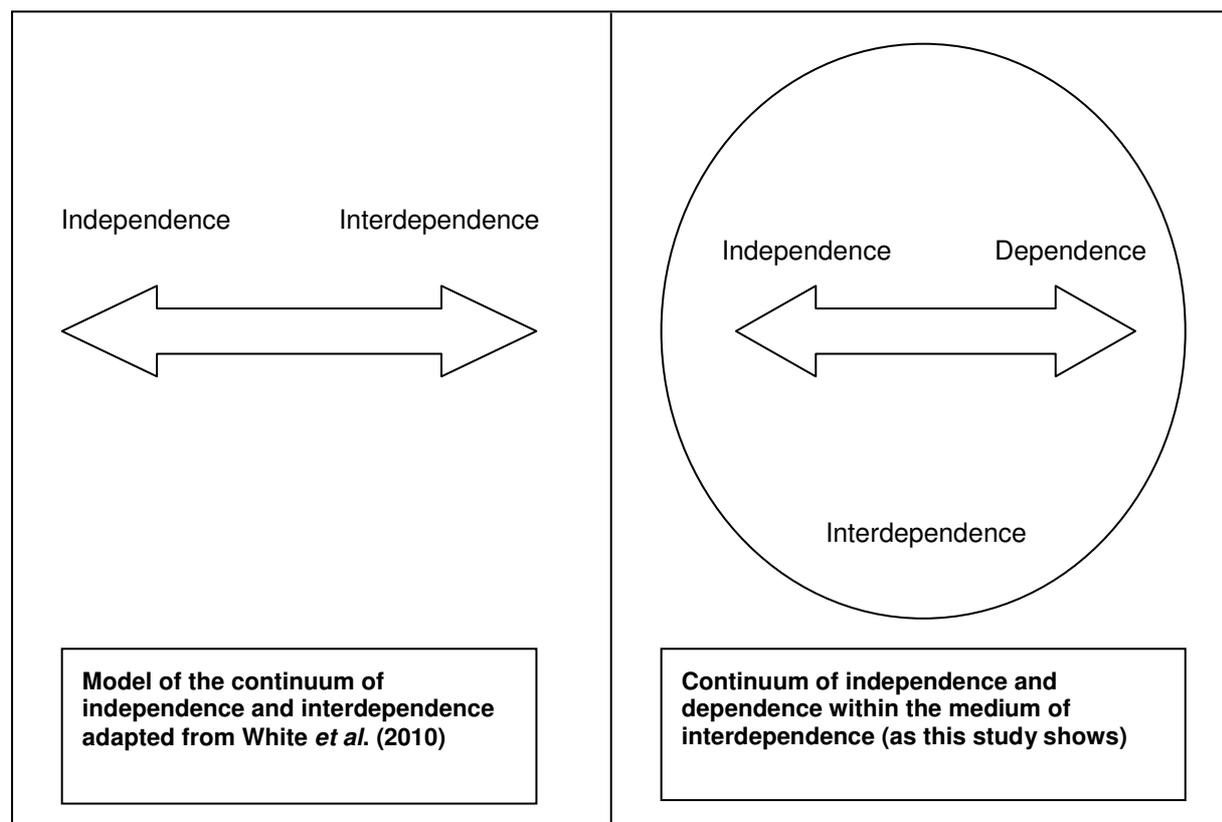
It has been suggested that interdependence and independence sit at either end of a continuum implying that they are at odds with each other (Beeber, 2008; White *et al.*, 2010). In this study we suggest that interdependence is the original state of being and independence is an emergent state, accomplished by choice within an overall network of social relationships (**Figure 1**). We assert that total and complete independence is not possible in all aspects of living and consequently cannot be used to describe an overall (or ideal) state of being. By living in communities, shopping at the store or purchasing manufactured goods and services from others, there will always be aspects of our lives for which we are dependent. Thus it could be said that human beings move between a state of independence and dependence within the overarching context of interdependence and social relationships (Hopton & Stoneley, 2006; White *et al.*, 2010):

Most care in the UK is provided by important others (Beeber, 2008; Fox, 2010). Despite this, the notion of interdependence is poorly acknowledged or researched in health or social care contexts. Yet, as identified in this study, interdependence is essential for facilitating health and social care delivery and accomplishing client-centred outcomes that support client choice. Further, in certain situations the involvement of others becomes indispensable in substituting for lost ability, reducing risks and promoting clients' safety (Beeber, 2008). For example, for clients with dementia, interdependence between client, family, carers and professionals is essential if realistic support and supervision are to maintain safe individual, family and community outcomes. A state of independence would be unrealistic because of a deteriorating health condition (Hansebo & Kihlgren, 2001). Moreover, interdependence corresponds with the aspirations of many clients for good quality of life, with strong social ties between people and communities and thus integral to the delivery of client-centred care (Bowers, 2001; Stanhope, 2002; McWilliam, 2009). Through interdependence, quality of life, healing and adaptation can be promoted by preventing the negative effects of social isolation (Sharma & Kerl, 2002).

Interdependence and the delivery of health and social care

The involvement of carers/important others through the support they provide represents a form of interdependence and a valuable source of unpaid work. This in turn has positive effects on reducing the costs of, and pressures on, healthcare services. Fox (2010) argues that the principle of delivering 'care' encapsulated in health and social care systems contradict the overarching aim to actualize a state of independence. Moreover, many health and social care professionals regularly use other forms of interdependence as a source of support and assistance to facilitate recovery, adaptation and re-establishment in the community (Adams, 2009; McWilliam, 2009). This can be formal sources of care such as care agencies or other forms of social relations such as the involvement of family members. The findings of this study

Figure 1. (Left) The conceptual model of interdependence adapted (White *et al.*, 2010)
 (Right) The conceptualization of interdependence offered in this study



suggest that while the overall aim of occupational therapy is often independence, the delivery of occupational therapy is in itself a form of interdependence and should be overtly acknowledged as such in education and practice. Further research would establish if this is also true for other professional groups.

Paving the way for a culturally competent profession

The values of individualism and standing out from the crowd may be prevalent in some cultures but collectivism and conforming to the societal structure are dominant in others (Iwama, 2003; Kondo, 2004). Independence and interdependence are both cultural-specific values. Independence is entrenched in western societies as a healthy state and as a way of promoting autonomy, while dependence is regarded as an unhealthy, unacceptable and unsatisfying way of living (Hammell, 2009). In other cultures, the notion of interdependence constitutes a source of wellbeing and satisfaction while independence impedes the assumption of interdependent roles (Hammell, 2009). In such cultures, dependence could even be viewed as an acceptable way of living in cases of illness and disability (Iwama, 2006; Hammell, 2009). Therefore, while independence is a value that is emphasized in some cultures, interdependence is perpetuated and favoured in others (Sharma & Kerl, 2002; Bourke-Taylor & Hudson, 2005; Hopton & Stoneley, 2006; Yang *et al.*, 2006). This renders both independence and interdependence as specific sociocultural values and, therefore each on its own could not result in the actualizing of cultural competency if either were adopted solely as outcomes.

Cultural competency is a complex process (Betancourt *et al.*, 2003; Muñoz, 2007; Suarez-Balcazar *et al.*, 2009) that relates to core concepts of and principles of health and social care

practice and therefore, should be actualized in practice (NASW, 2001; Iwama, 2003; Kondo, 2004; Yang *et al.*, 2006). Despite this, research is neither directed at illuminating the process of cultural competency, how it occurs and its dynamics, nor at questioning the underlying core concepts of professional values and their potential to actualize a culturally competent practice.

In occupational therapy, many scholars have noted that current theory and practice is based on western values, designed for those who understand and live by western values and perspectives (Awaad, 2003; Bourke-Taylor & Hudson, 2005; Iwama, 2006; Yang *et al.*, 2006). Such a philosophy emphasizes the values of individualism, independence and doing implicit in western cultures but not client values of choice and collectivism. Such values are often associated with eastern cultures (Kondo, 2004; Hopton & Stoneley, 2006) or other ethnic communities and this raises ethical issues concerning the delivery of client centred, equal and holistic health and social care for all, especially multicultural societies such as those seen in the UK (Awaad, 2003).

Conclusion

This study found that, while the notion of interdependence is not used overtly in occupational therapy theory and practice it is described and understood by those delivering health and social care services. We suggest that the term interdependence should be introduced into the theory, practice and professional terminology of health and social care professionals including occupational therapists. Integrating interdependence into everyday practice would reflect the reality of clients as social and occupational beings living as part of a family and social group. Additionally it would reflect the essence of health and social care delivery as a collaborative and empowering process between clients, family members, carers and professionals regardless of culture, background or ethnic group. We suggest that interdependence as a concept has been neglected in health and social care practice despite it often being reflective of the true nature of humans as social beings. Further research is needed to consider the place of interdependence in the delivery of health and social care by other professional practitioners.

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Key findings

1. Interdependence reflects the essence of health and social care practice as a collaborative and empowering relationship between clients, carers and professionals regardless of culture.
2. Cultural competence is understood as a dynamic state of individual practitioners rather than outcomes of interventions.

What the study has added

Interdependence is highly relevant to practice outcomes and should be added to the professional terminology of health and social care practitioners.

References

- Adams, F. (2009) 'The culture of soup', *South African Journal of Occupational Therapy*, **39**(1), pp. 8-10.
- Awaad, T. (2003) 'Culture, cultural competency and occupational therapy: a review of the literature', *British Journal of Occupational Therapy*, **66**(8), pp. 356-362.
- Beeber, A. (2008) 'Interdependence: building partnerships to continue older adults' residence in the community', *Journal of Gerontological Nursing*, **34**(1), pp.19-27.
- Betancourt, J.R., Green, A.R., Carrillo, J.E., & Ananeh-Firempong, O. (2003) 'Defining cultural competence: a practical framework for addressing racial/ethnic disparities in health and healthcare', *Health Policy Reports*, **118**, pp. 293-302.
- Bourke-Taylor, H. & Hudson, D. (2005) 'Cultural differences: the experience of establishing an occupational therapy service in a developing community', *Australian Occupational Therapy Journal*, **52**(3), pp. 188-198.
- Bowers, H. (2001) 'Promoting interdependence: a new challenge in developing services for older people?', *Managing Community Care*, **9**(6), pp. 34-39.
- Capell, J., Dean, E. & Veenstra, G. (2008) 'The relationship between cultural competence and ethnocentrism of healthcare professionals', *Journal of Transcultural Nursing*, **19**(2), pp. 121-125.
- Data Management and Analysis Group [DMAG] (2007) *Demography Update October 2007*, <http://legacy.london.gov.uk/gla/publications/factsandfigures/dmag-update-20-2007-ons-ethnic-group-estimates.pdf> (accessed 9 March 2011).
- Dillard, M., Andonian, L., Flores, O., Lai, L., MacRae, A. & Shakir, M. (1992) 'Culturally competent occupational therapy in a diversely populated mental health setting', *American Journal of Occupational Therapy*, **46**(8), pp. 721-726.
- Fine, M., & Glendinning, C. (2005) Dependence, independence or interdependence? Revisiting the concepts of 'care' and 'dependency', *Ageing & Society*, **25**(4), pp. 601-621.
- Finlay, L. & Ballinger, C. (2006) *Qualitative Research for Allied Health Professionals: Challenging Choices*, Chichester: J. Wiley & Sons.
- Fox, A. (2010) 'From independence to interdependence: integration means 'think family'', *Journal of Integrated Care*, **18**(2), pp. 41-48.
- Hammell, K. (2009) 'Sacred texts: a sceptical exploration of the assumptions underpinning theories of occupation', *Canadian Journal of Occupational Therapy*, **76**(1), pp. 6-22.
- Hammell, K., Carpenter, C. & Dyck, I. (2005) *Using Qualitative Research: A Practical Introduction for Occupational and Physical Therapists*, London: Churchill Livingstone.
- Hansebo, G. & Kihlgren, M. (2001) 'Carers' reflections about their video-recorded interactions with patients suffering from severe dementia', *Journal of Clinical Nursing*, **10**(6), pp.737-747.
- Hopton, K. & Stoneley, H. (2006) 'Cultural awareness in occupational therapy: the Chinese example', *British Journal of Occupational Therapy*, **69**(8), pp. 386-389.
- Iwama, M. (2003) 'The issue is. Toward culturally relevant epistemologies in occupational therapy', *American Journal of Occupational Therapy*, **57**(5), pp. 582-588.

Iwama, M. (2006) *Kawa Model: Culturally Relevant Occupational Therapy*, London: Churchill Livingstone.

Kondo, T. (2004) 'Cultural tensions in occupational therapy practice: considerations from a Japanese vantage point', *American Journal of Occupational Therapy*, **58**(2), pp.174-184.

McWilliam, C. (2009) 'Patients, persons or partners? Involving those with chronic disease in their care', *Chronic Illness*, **5**(4), pp. 277-92.

Muñoz, J. (2007) 'Culturally responsive caring in occupational therapy', *Occupational Therapy International*, **14**(4), pp. 256-280.

NASW (2001) *NASW Standards for Cultural Competence in Social Work Practice*, Washington DC: National Association of Social Workers.

Nolan, M. (2001) 'Adult/elderly care nursing. Successful ageing: keeping the 'person' in person-centred care', *British Journal of Nursing*, **10**(7), pp. 450-454.

Nolan, M. (2013) '*Successful ageing: keeping the 'person' in person-centred care*', *British Journal of Nursing*, published 27/09/13, doi: <http://dx.doi.org/10.12968/bjon.2001.10.7.5330>.

Office of National Statistics (2009) *London: Resident population estimates by ethnic group*, <http://neighbourhood.statistics.gov.uk/dissemination/LeadTableView.do?a=3&b=276743&c=London&d=13&e=13&g=325264&i=1001x1003x1004&m=0&r=1&s=1396110839893&enc=1&dsFamilyId=1812&nsjs=true&nsck=false&nssvg=false&nswid=1222>

Sharma, P. & Kerl, S. (2002) 'Suggestions for psychologists working with Mexican American individuals and families in healthcare settings', *Rehabilitation Psychology*, **47**(2), pp. 230-239.

Sim, J. & Wright, C. (2002) *Research in Healthcare: Concepts, Designs and Methods*, Cheltenham: Nelson Thornes.

Stanhope, V. (2002) 'Culture, control, and family involvement: a comparison of psychosocial rehabilitation in India and the United States', *Psychiatric Rehabilitation Journal*, **25**(3), pp. 273-280.

Suarez-Balcazar, Y., Rodawoski, J., Balcazar, F., Taylor-Ritzler, T., Portillo, N., Barwacz, D. & Willis, C. (2009) 'Perceived levels of cultural competence among occupational therapists', *American Journal of Occupational Therapy*, **63**(4), pp. 498-505.

Tamaru, A., McColl, M. & Yamasaki, S. (2007) 'Understanding 'independence': perspectives of occupational therapists', *Disability and Rehabilitation*, **29**(13), pp. 1021-33.

White, G., Simpson, J., Gonda, C., Ravesloot, C. & Coble, Z. (2010) 'Moving from independence to interdependence: a conceptual model for better understanding community participation of centers for independent living consumers', *Journal of Disability Policy Studies*, **20**(4), pp. 233-240.

Whiteford, G. & Wilcock, A. (2000) 'Cultural relativism: occupation and independence reconsidered', *Canadian Journal of Occupational Therapy*, **67**(5), pp. 3243-36.

Whiting, S. & Whiting, J. (2003) 'The conceptual development of dependence, independence, and interdependence as potential nursing diagnoses', *International Journal of Nursing Terminologies & Classifications*, **14**(4), Supplement:10.

Yang, S., Shek, M., Tsunaka, M. & Lim, H. (2006) 'Cultural influences on occupational therapy practice in Singapore: a pilot study', *Occupational Therapy International*, **13**(3), pp.176-192.

Notes on Contributors

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Gill Chard is a qualified occupational therapist who worked in health and social care practice in hospital and social care for 20 years. These included inner city, urban and rural areas as well as health and social work teams. For the past 20 years she has worked as Lecturer, Associate Professor and Professor of Occupational Therapy in the UK, Republic of Ireland and Canada. She has a long standing interest in occupational therapy and qualitative research in community practice with older people and is an educator, researcher and writer.

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