Culturally sensitive care

Author: Stéphanie De Maesschalck

Case study

Wahidullah (24) and his wife Habiba (20) fled Afghanistan a year and a half ago. They have been married for five years and are childless. They have been recognised as refugees and live in a reception centre. Both are taking Dutch lessons and by now speak Dutch moderately well. Wahidullah sleeps badly and has frequent nightmares, Habiba suffers a lot from headaches and generalised weakness, for which doctors cannot find an explanation. She often cries when she is alone. She prefers not to go to Dutch class anymore because she is too tired. She feels as if she has failed as a woman because she is not pregnant yet.

General

- Increasingly, social workers find themselves with clients who have a migration or refugee background. This poses several challenges. The first and often foremost of these is the language barrier: the complete or partial lack of a common language complicates the counselling process. In the fact sheet on language support, you will find information on how to break down that language barrier. The second challenge is the cultural barrier.

- A few decades ago, when migration was still limited, we could find out what the specific customs of certain groups were: with whom can I shake hands with whom can I not? What are culturally specific explanatory models for people from Türkiye, for example? This is called a *culture-specific* approach.

- Nowadays, people migrate from all parts of the world. Given this **super-diversity** that our society is evolving towards, it is impossible as a counsellor to know all aspects of patients' different cultural backgrounds.

- Culture-sensitive care means that **counsellors are aware of the possible influence of the** patient's **different cultural background**. This influence manifests itself, for example, in the way of expression or in the request for help.

- The aim of culture-sensitive care is to **take cultural factors into account** while striving for **mutual understanding and equal care**. In this way, we engage with clients in an open and curious way, without falling into stereotypes and prejudices.

In practice

Attitudes

1. Cultural awareness

- We too are the result of a culturally shaped upbringing and environment.
- As social workers, we too take learned values and norms with us.

In Belgium, the average age to become a mother is 28.5 years. In Afghanistan, it is a lot younger. Is that cultural? Or sociologically determined? Does it have to do with access to, or knowledge of, contraception?

2. Reflexivity

- Reflexivity refers to the awareness that **several possible solutions to a problem are valuable**. It is the skill of seeing a thought or attitude that you take for granted or normal as just one of several possible solutions.

  Wahidullah decides he wants to start working as soon as possible. His reasoning is that as a good husband, he should be able to financially look after his wife so that she can stay at home. He also wants to help support his family back home.

- We use Pinto's three-step model (DSM). This is a reflection method in the event of an impending misunderstanding or conflict. You go through **three steps** or phases before taking action:

  Patient x often arrives late for appointments. This is blamed on his culture. It leads to resentment. The other day a conflict arose because he couldn't get his turn.

  Step 1: **get to know your own (culture-specific) norms and values**.
  What rules and codes influence your thinking, acting and communicating?

  Arriving on time is very important here in Belgium. Arriving late is considered disruptive. Appointments are kept to the minute, unless there is a good reason.

  Step 2: **get to know the other person's norms, values and codes of behaviour**.
  Separate opinions about the other person's behaviour from facts. Examine what the other person's 'strange' behaviour means.

  In patient x's home country, arriving on time is a stretch. For example, when a lecture is scheduled at 9 a.m., people usually start around 10 a.m. Illiteracy or social factors may also come into play, as in the case of single mothers. So the undesirable behaviour is not always purely cultural.

Step 3: **decide how to deal with the differences in norms and values**. Next, determine where your boundaries lie: how much can you accept from the other person? To what point can you adapt? Make those limits clear to the client.

Provide clear, understandable information about the appointment system. What exactly are the consequences of not arriving on time? Why? Verify that the client has understood. Give them time to adjust.

The goals of this model are:

- to eliminate prejudices
- to understand and respect each other's norms and values
- to clearly communicate one's own boundaries to others
- to avoid irritation, misunderstanding but also excessive tolerance.

3. An open attitude and respectful curiosity

Take an open attitude to questions: why does the other person do what they do? What is culturally determined, what is contextual, what social, what individual?

Knowledge

Knowing your client's context is the basis for a good relationship. It is often complex. After all, there may be factors in many different areas of life that affect the client's well-being or health. How do you get to know the context?

1. A thorough intake

- What is the country, region of origin? Education, language skills, employment? Current status in the asylum procedure? The family context: here and in country of origin? Are there people left behind? Has the client lost loved ones: in the home country or along the way?
- What is the client's story?
- What is the client's current life situation like? How do they feel? What are their current capabilities, limitations, perspectives?

2. Intersectional thinking

- This refers to the intersections of different social and personal elements and struggles within one person.
- These are always simultaneously present and interacting with each other.
- It offers us a kaleidoscopic view of who we are: individuals are not defined by one aspect of their background or culture.
- Try to identify the complex influence of nationality, gender, ethnicity, sexual orientation and religion.

3. A relationship of trust

Many refugees live in complex contexts. This makes it challenging for social workers to provide efficient care. Often, there is also an entire previous history of care. Working on a long-term relationship of trust can improve the quality of care. For this, several things are essential:

- Allow enough time.
- Emphasise confidentiality.
- Explain what you are doing and why you are doing it.
- Ask for their assessment.
- Involve the patient actively in their own care.

Skills

1. Communication around cultural differences

Do you suspect that certain cultural norms and values have an impact on therapy or the doctor-patient relationship? Explore these factors:

- Trace the 'patient's trail': what does the patient think about their own illness? What explanations does the patient have for it? What are his expectations? What questions, concerns, fears does the patient have? What is the request for help?
- Show the patient that you are interested in their (cultural) background and context. Keep an open mind.
- *Patient-centredness*: explore the patient and their context. Include that information in the different stages of consultation. *"Health care that meets and responds to patients' wants, needs and preferences and where patients are autonomous and able to decide for themselves."*

2. *Shared decision making*

- Patient adherence increases when they agree to the proposed treatment plan. Set shared, achievable goals. Break down the goals into smaller sub-goals.
- Actively involve the patient in the development of a treatment plan: ask if they understands everything. Are there any comments or questions? What does the patient think of the plan? Is it feasible in their context?
- In cases of poor adherence: ask the patient to actively participate in finding a solution, a treatment plan that fits within their context. Appeal to the patient's own responsibility: if the patient is actively involved, they will make their own suggestions, with a higher likelihood of compliance.