Ethnicity & Health

ISSN: 1355-7858 (Print) 1465-3419 (Online) Journal homepage: https://www.tandfonline.com/loi/ceth20

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To cite this article: Aniek van Herwaarden, Els W. M. Rommes & Nienke C. Peters-Scheffer (2019): Cultural competence in lifelong care and support for individuals with intellectual disabilities, Ethnicity & Health, DOI: 10.1080/13557858.2019.1591348

To link to this article: https://doi.org/10.1080/13557858.2019.1591348

Published online: 08 Mar 2019.

ETHNICITY & HEALTH
https://doi.org/10.1080/13557858.2019.1591348

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Cultural competence in lifelong care and support for individuals with intellectual disabilities

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ABSTRACT

Objectives: Although an extensive amount of research has been devoted to models defining cultural competence of healthcare professionals in short-term care, there is unclarity about the cultural competencies that professionals providing lifelong care and support should have. The current study aimed to explore which cultural competencies are used by these healthcare professionals, and whether these competencies enabled them to make cultural adaptations to their regular care practices.

Design: To investigate cultural competencies and cultural adaptations, semi-structured in-depth interviews were conducted with eight professionals who provide lifelong care and support to individuals with intellectual disabilities. Five cultural competencies were explored: awareness, knowledge, skills, motivation, and encounters.

Results: A thematic analysis of the interviews revealed that professionals providing lifelong care and support used all cultural competencies in their care practices. Moreover, our analysis suggested that these competencies could be categorized as either practical or analytical cultural competencies. Although these competencies were conditional in order to make cultural adaptations to care practices, the presence of cultural competencies did not automatically lead to these cultural adaptations.

Conclusions: All five cultural competencies were used by professionals in lifelong care and support. Our analysis revealed that both practical and analytical cultural competencies were essential in providing culturally sensitive lifelong care and support. We additionally suggest that the cultural competence of professionals is necessary, but not sufficient, for making cultural adaptations to lifelong care and support for individuals with intellectual disabilities. In many cases, other factors also played a role in a professional's final decision to adapt their care practices.

ARTICLE HISTORY
Received 18 September 2018
Accepted 28 February 2019

KEYWORDS
Cultural competence; cultural decision-making; intellectual disabilities; care practices; qualitative research

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Introduction

Modern globalization and the growing number of immigrants in Europe is increasing the diversity of the Dutch population in terms of their country of origin, ethnicity, culture, and religion (Laban and Van Dijk 2013). More than twelve percent of the Dutch population has a non-western migration background (Statistics Netherlands 2018), and are referred to as ethnic minorities within this article. This changing diversity in the Dutch population should be reflected in increasing numbers of care receivers from ethnic minority groups in the Dutch healthcare system.

National as well as international research on (mental) healthcare for ethnic minorities shows concerning results however. Healthcare services were found to be less accessible for ethnic minorities (Scheppers et al. 2006). This is concerning, as some ethnic minority groups are more vulnerable to mental health problems than the ethnic majority (Belhadj Kouider, Koglin, and Petermann 2014), because they are faced with more risk factors (e.g. traumatic pasts, lack of social support, underemployment; Kirmayer et al. 2011). And although differences exist between minority populations from different cultural backgrounds, the use of mental healthcare by adult ethnic minorities is equal to that of the indigenous adult population (Uiters et al. 2006), and ethnic minority youth are even underrepresented in mental healthcare (De Haan et al. 2012), despite their heightened vulnerability. Failure of receiving appropriate mental healthcare leaves room for mental health problems to evolve, leading to an overrepresentation of ethnic minorities in intensive, forensic mental healthcare (Bellaart 2007). Thus, the existing body of research suggests that ethnic minorities do not receive sufficient nor adequate mental healthcare.

The quality disparity within mental healthcare services could be addressed by practicing culturally sensitive care. *Culturally sensitive care* is generally defined as care that incorporates an understanding of and empathy for patients' values, beliefs, and goals (Lindsay et al. 2014), and is provided by *culturally competent* healthcare professionals. The now classical definition of cultural competence was introduced by Cross et al. (1989) as follows:

> A set of congruent behaviors, attitudes, and policies that come together in a system, agency, or amongst professionals and enables that system, agency, or those professionals to work effectively in cross-cultural situations.

Throughout the years, researchers have built on this definition to develop various conceptual frameworks describing cultural competence of professionals. Sue and Sue (2012) described cultural competence along three dimensions, which are considered fundamental for many other cultural competence models and theories:

(1) *Cultural awareness* of one's own assumptions, values, and biases, and how these differ from those of the care receiver.
(2) *Cultural knowledge*, defined as the understanding of the worldview of the care receiver, in a nonjudgmental manner.
(3) *Cultural skills* to develop appropriate intervention strategies and techniques (i.e. intercultural communication and exercising institutional interventions, while not being restricted to conventional methods).

In addition, Sue and Sue (2012) noted that becoming culturally competent is an active, ongoing process that never reaches an end point, and stated that the therapist must

continuously recognize the complexity and diversity of the client and client populations (p. 44). To date, this conceptual framework has been widely researched, criticized (e.g. Kirmayer 2012), and extended. A review study by Alizadeh and Chavan (2016) suggested the addition of two dimensions to the original cultural competence framework of Sue and Sue (2012), namely the '*Cultural encounters/interactions*' and '*Cultural motivation/desire*' competencies. The cultural encounters competency was defined as the ongoing process of having intercultural experiences, facilitating the refinement of one's values and beliefs about the culture of the other. The cultural motivation competency was defined as the willingness to engage, participate, and learn about cultural diversity, which in turn refers to the willingness to enhance one's cultural awareness, knowledge, and skills.

The conceptual framework of cultural competence has been widely used as a framework in cross-cultural studies on healthcare and it has been implemented in training programs for healthcare professionals. These training programs were found to increase the cultural competence of healthcare professionals (e.g. Beach et al. 2005; Truong, Paradies, and Priest 2014).

A vast amount of research has been devoted to cultural competence in healthcare and cultural adaptations in psychiatry (e.g. Ekblad and Kastup 2013), medical care (e.g. Dauvrin and Lorant 2014; Harmsen et al. 2005), or both (e.g. Denier and Gastmans 2013; Park et al. 2011). These psychiatric and medical practices are often referred to as 'cure practices', addressing their therapeutic and short-term character. However, less attention has been dedicated to cultural competence and adaptations in lifelong care and support (i.e. care practices) such as the care for individuals with chronic psychiatric diseases or intellectual or physical disabilities. This is unfortunate because cultural competence and adaptations may be even more essential for individuals who receive lifelong care, as this form of care is intensive and takes place in their daily living situation, such as in residential facilities. Professionals who provide lifelong care may encounter different cultural habits or different ethical issues than professionals providing short term care, as their work incorporates nutrition, nursing, supporting daily activities, long term developmental goals of the care receiver, or making the care receiver feel at home.

Because care practices seem so different to cure practices, the validity of the competencies that lead to these practices may be questioned (Francisco and Carlson 2002). For example, the third dimension of the cultural competence model by Sue and Sue (2012) predominantly addresses the skill of adapting one's communication style towards patients, because cure practices (particularly in mental health) mainly consist of verbal treatment. Lifelong care and support, however, consists of more than verbal treatment and focuses also on daily living practices and long-term development of care receivers. Moreover, individuals who receive lifelong care and support are often (partially) unable to verbally communicate their needs and wishes, due to communicative and cognitive impairments. Clarity about the specific cultural competencies needed in such care seems particularly vital, as the quality of intercultural lifelong care and support was suggested to be lower for ethnic minorities with intellectual and developmental disabilities than for individuals with these disabilities who belong to the ethnic majority (Magaña et al. 2012). This quality disparity may also explain the underutilization of lifelong care by ethnic minorities with intellectual disabilities (ID; Durà-Vilà and Hodes 2012). Hence, ethnic minorities with ID are suggested to have a 'double disadvantage', indicating both difficulties pertaining to their disability as well as to cultural differences (Allison and Strydom 2009; Francisco and Carlson 2002).

All in all, because of the potential differences between care and cure practices, cultural competence in lifelong care and support could involve other qualities in addition to those described in the dominant theoretical framework. Hence, the need for a qualitative investigation into the lifelong care and support for ethnic minorities with ID has previously been expressed (Raghavan and Small 2004).

The current study

The objective of the current study was to provide insight into the intercultural lifelong care and support for people with ID (defined as having an IQ score below 70 and limited adaptive functioning). Our research question was: Which types of cultural competencies (i.e. awareness, knowledge, skills, motivation and encounters) do healthcare professionals use in lifelong care and support of individuals with ID and to what extent do these competencies lead to adjustments to their regular care practices? First, we examined whether the five cultural competencies were present amongst healthcare professionals in lifelong care and support and reviewed their specific characteristics. Secondly, we explored the relationships between the cultural competencies of healthcare professionals and their care practices. Previous research suggested that the presence of cultural competencies automatically led to 'cultural adaptations': adaptations to regular care practices in the direction of culturally specific wishes of the care receiver (Sue and Sue 2012). We therefore expected that the presence of cultural competencies facilitates the healthcare professionals to adapt their practices to the care receiver's cultural background.

Methodology

Respondents

In order to explore intercultural lifelong care and support, we conducted several in-depth, semi-structured interviews with healthcare professionals who were employed by a healthcare organization in the Netherlands. This organization provides care for children, adolescents, and adults with ID who belong to the ethnic majority and minority population across three different departments: residential care, daycare or work facilities, and outpatient care. This organizational structure provided the possibility to include multiple comparable but independent settings (triangulation of sources). Participants were recruited through the personal network of the third author and a researcher from the organization. The participants were approached on the basis of the heterogeneity of their background characteristics (diversity sampling) and were asked whether they knew any colleagues who would also wish to participate (snowball sampling). We invited the participants to participate via e-mail or phone.

Of the ten professionals we approached, two declined to participate, indicating that they felt they had 'too little experience with ethnic minority care receivers' to be able to answer our questions. The professionals each had at least one year of experience in providing healthcare services to individuals with an ID who belonged to an ethnic minority group, with some possessing more than 15 years of experience. This resulted in a final sample of eight respondents, who were 25–59 years old, all female, and whose educational level varied from a bachelor's degree ($n = 5$) to master's degree ($n = 2$). The different

respondents provided care for individuals with various levels of ID: mild ID ($n = 2$), severe ID ($n = 2$), or all levels of ID ($n = 4$). Respondents had different job titles, such as personal mentor, psychologist, or sexual therapist, and therefore provided different healthcare services including the support of daily activities or behavioral therapy. Although the respondents did not vary in sex or ethnicity (except for one professional, whose mother was of Indonesian origin), this sample was representative of the population of professionals in this organization.

Data collection

The individual semi-structured interviews took place at the healthcare location in which the professional was based, in a separate office, and lasted 44–104 min. The interviews were held by a research employee and two students, who were trained in semi-structured interview techniques. At the start of the interview, the professionals were asked to envision one of their ethnic minority care receivers and use this particular, representative case to answer the questions. Respondents were asked to describe recent and concrete examples of intercultural encounters with this specific care receiver. During the interviews, additional case descriptions and examples were provided by respondents, other than the requested case. This variety of case descriptions increased the reliability and (external) validity of our data.

The topic list for the interviews was derived from the literature on intercultural care practices and developed during multiple consultations within the research team. The topic list consisted of: (1) the experienced intercultural differences between the professional and the care receiver, (2) the way professionals dealt with those differences, (3) the factors influencing their practices when dealing with the differences, (4) the cultural competences that supported them when dealing with the differences, and (5) the ways in which they were supported by their organization. The majority of the data used in the current study were derived from questions one, two, and four. Additional questions were posed about specific tasks related to the respondent's specific job position.

Ethical approval for this procedure was obtained from the board of client representatives at the collaborating institution. In this article, the names of the respondents have been replaced with pseudonyms for confidentiality.

Data analysis

The audio-recorded interviews were transcribed verbatim and anonymized. We began the data analysis by selecting relevant sections of the interviews for data analysis by multiple researchers. Several discussions were held to reach an agreement on which sections should be included. The chosen sections were coded by using a deductive coding approach based on the 'cultural competencies' framework, which involved searching for statements in which the professionals addressed one of the five cultural competencies. Not all of the data immediately fit under the codes deduced from the literature. Therefore, the remaining statements were openly, thematically coded, allowing new themes and categories to emerge from empirical observations. Three researchers separately read the transcripts several times and used an open-code approach, labeling (characteristics of) the selected sections (e.g. 'providing chicken instead of pork', 'professional reads Koran'). These

codes were classified into categories, such as: 'cultural adaptation', 'practical knowledge', or 'analysis of values care receiver'. From these codes, new elements to the existing theories were induced. Lastly, a selective coding approach was used to identify relationships between the existing categories and the newly identified themes, to understand how cultural competencies relate to cultural adaptations.

Results

Below, we describe the cultural competencies used by respondents in intercultural situations and how these competencies were related to their intercultural care practices. Many professionals described intercultural encounters with the parents of the care receiver instead of the care receivers themselves. This is because many care receivers are unable to verbally communicate and so a lot of decisions in the healthcare process are made in interaction with the parents, rather than with the individual with ID.

Cultural competencies and their characteristics

Cultural competencies

In the interviews, respondents provided statements explicitly addressing their cultural competencies. Professionals described their cultural awareness through references to their own cultural background, such as Dutch or Western, suggesting the awareness of a cultural difference (e.g. Celine: 'We see it from a Dutch perspective', Patricia: 'We are very structured as Dutch people. (…) We see parenting through Western eyes.'). In addition, various professionals indicated the importance of possessing cultural knowledge (e.g. Patricia: 'But I think if you (…) possess knowledge about the culture, (…) then you can sometimes better understand why a child behaves like that.'). The respondents also addressed their cultural skills when describing how they made cultural changes to specific institutional protocols and general caring techniques. They stated that they found it very important to be motivated to gain cultural competencies and make cultural adaptations to provide good intercultural care (e.g. Heidi: 'Someone really has to want [to provide good intercultural care]. (…) I am very interested in everything that is new and everything I don't know about, and I like new challenges.'). Professionals stated that providing appropriate care for their culturally diverse care receivers was very valuable to them, showing dedication, eagerness to learn, and curiosity towards intercultural care (e.g. Esther: 'I did my very best, because it was so meaningful to me.'). Also, the cultural encounters competency could be identified in interview responses. The professionals described how their intercultural encounters enabled them to acquire or develop their cultural awareness, knowledge, and skills (e.g. Esther: 'I have been involved in [the care for] this family for about five years. Well, at some point you just learn.'). Also, the cultural encounters seemed to be a context in which the professional-client relationship could develop. Professionals stated that building a relationship of trust with the care receivers and their families required time (e.g. Ingrid: '(…) but I also think it has to do with the fact that they are here longer, so I see the parents already for a longer period of time. So then you gradually [come together more]'). They additionally described how cultural encounters outside the care context facilitated their other cultural competencies, such as developing cultural awareness because they had a culturally diverse group of friends.

Thus, all cultural competencies seemed relevant for the professionals providing lifelong care and support, indicating that the theoretical framework proposed in the introduction is also applicable this care practice.

Interdependence of cultural competencies

In addition to explicit statements in which respondents described their cultural competencies, the competencies could also be deducted from descriptions of intercultural care situations. For example, Patricia recalled the following interaction with the Antillean mother of a care receiver:

> Patricia When that Antillean mother heard we had an Antillean son-in-law, she said, 'Oh, then you know how to take care of the hair of my girls'. Then I said, 'Yes, that will be fine'. (…) [We use our] knowledge and we also acknowledge them in what they need. We don't say, 'You have frizzy hair, that is complicated, so we'll shave it off'. We say, 'You have frizzy hair, that takes a lot of work to maintain well, we'll do our best'.

In this example, Patricia showed that she was aware of the cultural difference in hairstyle (cultural awareness), and that she possessed knowledge about the specific care required for the hair of the care receiver (cultural knowledge). Moreover, she described that she had both the skills and motivation to take care of the hair style of the care receiver (cultural skills and motivation). She also suggests that her experience in other intercultural situations with her son-in-law provided her with cultural competencies (cultural encounter). This example illustrates that a single case description of an intercultural encounter, could reflect multiple cultural competencies. This suggests that the cultural competencies are highly intertwined and interdependent.

Practical cultural competencies

In our analysis, we were able to identify a set of case descriptions which referred to rather practical cultural differences. The case description from Patricia is an example of what we would like to call *practical cultural competencies*, which entail everyday, practical, and visible cultural differences. The cultural competencies of Patricia entailed that she saw a visible difference in hairstyle and knew how to take care of it. She did not conduct an in-depth analysis of what the hairstyle may mean to the cultural identity of the care receiver, and how this cultural identity may be expressed in other ways. Other examples of practical cultural competencies are awareness about the care receiver wearing a headscarf or wanting halal food (practical cultural awareness) or knowing that one should take off their shoes during a home visit (practical cultural knowledge), both without the need to be necessarily aware of or understand the reasons behind them, nor the need to find out other differences resulting from an analysis of the care receiver's underlying values or belief system.

Analytical cultural competencies

In addition to these practical cultural competencies, respondents described situations in which they showed what we will call *analytical cultural competencies*, which do require an analysis of the care receiver's values. An example of these cultural competencies was provided by Esther. During several interactions with the parents of the care receiver,

Esther got the impression that they were not quite enthusiastic about the developmental stimulation that she provided to their child with an ID. She described how she then asked the parents about their cultural beliefs regarding healthcare:

> Esther I (…) asked them about the Koran, (…) about what having a handicapped child means in Islam. (…) But then father told me that he is Kurdish, and I did not know that. In the Kurdish community, [the meaning of a handicapped child] is that Allah trusts [the parents] to take good care of his most vulnerable possession. What he said was (…), 'That is why I spoil my son, why I take care of him, but you only want him to learn things'.

In this example, Esther described how she was aware of the fact that the seeming lack of enthusiasm of the parents regarding the treatment of their child may have been associated with a cultural difference in values (analytical cultural awareness). Moreover, Esther seemed motivated to examine the underlying values or beliefs of the parents regarding lifelong care and support (analytical cultural motivation). By using her analytical skills of intercultural communication, she acquired in-depth analytical cultural knowledge about certain values within the Kurdish community. These cultural competencies could be categorized as analytical because they refer to cultural values about care, rather than practical, visual differences, and they therefore require analytical and reflexive competence from the healthcare professional. Other examples of analytical cultural competencies are arranging female staff to take care of female care receivers and male staff take care of male care receivers according to the cultural values of the care receiver (analytical cultural skills) or being aware of differences in values concerning education, such as the most important things to learn or the best educational methods (analytical cultural awareness). Also, one respondent showed analytical cultural motivation to understand the beliefs of her care receiver by reading parts of the Koran and the Bible to expand her analytical cultural knowledge. We could not make the distinction between practical and analytical for the competency of cultural encounters.

Cultural competency and cultural adaptations

Practical cultural competency and cultural adaptations

In addition to mapping the cultural competencies of professionals in lifelong care and support, the current study aimed to investigate the extent to which these competencies lead to adjustments to regular care practices. An example of a case in which practical cultural competencies led to cultural adaptations was provided by Francine, who took the care receivers to a market at the local Mosque:

> Francine One very nice thing is that (…) there is a Mosque around the corner. And during the summer there is some kind of market, I don't know, I suppose it is called differently. But we always go there with the residents and the entire family of [the Turkish care receiver] is there as well. They all eat food and so on, and it is just so very nice.

Francine stated that she did not have in-depth knowledge of the meaning of this market, but her practical cultural knowledge about the existence of the market made her visit the market as an engaging activity for the care receivers. This could be considered a cultural adaptation to her regular care practice. In our analysis, practical cultural

competencies of care professionals seemed to lead to a single cultural adaptation. An example of this relationship was provided by Ingrid, who made a cultural adaptation to the food provided at the institution:

> Ingrid Well, (…) I [only recently] started to think about it (culture). Because I actually don't know a lot about the parents of my clients in that field and I am not really into it and I don't really see it. I don't really speak with the parents about this. The only difference is with food, when a child asks to have chicken. No other than that it does not play a role.

From this citation, we can deduce that Ingrid does not use analytical cultural competencies, as she does not know, nor is she aware, of in-depth differences regarding culture. She shows her practical cultural competencies with regards to food wishes and adjusts the meals to the specific wish that the care receiver expresses. as she says she does not know about culture, and that this wish regarding food may cohere with certain cultural values. And although her practical cultural competencies allow her to make this cultural adaptation of providing chicken instead of pork, she does not explore how cultural values that correspond with this wish may play a role in other areas.

Analytical cultural competency and cultural adaptations

The possession of analytical cultural competencies also led to making cultural adaptations; in fact, they typically led to not one, but multiple cultural adaptations in different life areas. We will elaborate on this finding using the previously mentioned case of Esther, who spoke to the father of the care receiver about care values (i.e. spoiling his son instead of teaching him many things). By gaining in-depth and analytical information about care values, Esther developed a deeper understanding and respect for the values of the care receiver and their family regarding the provision of care. This additionally provided her with the opportunity to explore different areas of life in which these values were expressed. Esther for example visited the family at home and joined them for dinner:

> Esther We always wanted that he [care receiver] stayed skinny and that he lived healthy. He got one cracker and one sandwich in the morning and fitted an amazing size (…). When I visited his parents, it turned out they found him way too skinny. They asked: 'Is our son doing well, because (…) he is not growing well?' (…) And then we started to eat with the whole family around one table, and I found myself sitting there with a spoon containing rice and tomatoes from their country of origin in one hand and a chicken wing in the other and the whole family had their mouths full. I never experienced such a nice atmosphere while eating. In the car on my way home I knew we had to change. He (the care receiver) must eat because [otherwise] he will never feel at home in the place he currently lives [the institution].

During Esther's exploration of how care values were expressed (i.e. the home visit), she found out that the family's care values were also expressed through sharing food and dining together. She realized that this expression of values did not correspond with the care practices at the institution, as the care receiver was faced with certain food restrictions. Her analytical cultural competencies therefore led not only to adaptations regarding developmental stimulation (see previous quote from Esther), but also to cultural adaptations regarding the amount of food provided to the care receiver.

So, although practical and analytical cultural competencies may eventually lead to similar cultural adaptations, analytical cultural competencies enable care professionals to explore how cultural values impact other life areas and subsequently make multiple cultural adaptations in a variety of life areas.

Relationship between cultural competency and cultural adaptations

In most cases, both practical and analytical cultural competencies led to the implementation of cultural adaptations requested by the care receivers; however, this was not always the case. This became clear, for example, in a case description from Celine:

Interviewer	Do you have the idea that there are perhaps differences in the way of upbringing of children raised in the Democratic Republic of Congo (DR Congo) and the Netherlands?
Celine	Yes, (…) I also asked about that and then mother says: 'In DR Congo, the children of all families in the village are always outside. The parents work on the land and are not actually with their children during the day. And children from all ages raise each other (…)'. Parents also have limited awareness of what their child does or is able to do. In the village where they come from, they don't go to school, so yes that is very different. (…) They find it really difficult that their child must do a lot already and that there are a lot of rules about whether or not a child can go to a regular school (…). We try to explain a lot (…). It is mainly about providing parents with information about how things are here in the Netherlands, because that is what they have to deal with. Here, they cannot say, 'We let our child stay at home to work on the farm', because from five years old [their child] is obliged to go to school.

From Celine's statement it appeared that she was *aware* of the cultural difference in the way children are brought up, and she shows *motivation* to expand her *knowledge* about the situation in the care receiver's country of origin, and about the parent's opinion of the Dutch educational system. Using a cultural *encounter,* she used her cultural *skill* of interculturally communicating an explanation of the Dutch educational system to the parents of the care receiver. Although Celine seemed to possess all the cultural competencies on an analytical level, she stated that she was not able to adapt her practices to the cultural wishes of the parents, because of the legal obligation to provide aneducation in the Netherlands. This case suggests that possessing all the cultural competencies does not necessarily lead to care providers making cultural adaptations to their regular care practices. Other factors besides the cultural competence of the professional (in this case on the organizational and the societal level) can hinder the implementation of cultural adaptations.

Discussion

The current study aimed to investigate intercultural lifelong care and support for individuals with ID, and the cultural competencies of healthcare professionals who provide this care. Interviews with healthcare professionals revealed characteristics of these cultural competencies, and their relationship to cultural adaptations in intercultural care practices.

Our respondents described their cultural competencies through several statements and case descriptions of intercultural situations, similar to those described in previous research (e.g. Alizadeh and Chavan 2016; Sue and Sue 2012). The cultural competencies of

awareness, knowledge, skills, and motivation could be categorized into practical and analytical cultural competencies. Practical cultural competencies were related to observable cultural characteristics, such as awareness about clothing or knowledge about hairstyles. Analytical cultural competencies regarded cultural differences which required an in-depth analysis of the care receiver's values or belief system, such as knowledge about the ideological or religious meaning of a disability. These findings are in line with suggestions of Resnicow et al. (1999), who described similar structures in their work on cultural sensitivity in substance abuse prevention. They defined 'surface' structure cultural sensitivity as interventions which are matched to the observable characteristics of the target population. The 'deep' structure cultural sensitivity of interventions means that interventions are adjusted to the cultural, social, psychological, environmental and historical factors that influence health behaviors (Resnicow et al. 1999). In line with this, respondents in the current study who showed practical cultural competencies were culturally sensitive to observable factors, and those who showed analytical cultural competencies were culturally sensitive to cultural values. Research on deep- and surface-based adaptations also showed that especially interventions which are culturally sensitive on the 'deep' showed enhanced effectiveness (Van Mourik et al. 2017). The current study showed that having analytical cultural competencies could lead to cultural adaptations similar to those made by professionals who had practical cultural competencies, and so one type of cultural competency may not per se have a larger effect. Nevertheless, analytical cultural competencies allowed the care professionals to explore how other practices in different life areas could also be adapted to the cultural values of the care receiver. Exploring how certain values may have implications for care practices in multiple life areas is specifically important for professionals providing lifelong care and support because it involves so many aspects of daily life.

Although the cultural competencies of awareness, knowledge, skills, and motivation could be categorized as practical or analytical cultural competencies, such a distinction did not clearly appear in our data for the competency of cultural encounters. In line with previous literature, cultural encounters functioned merely as a context in which professionals used and developed their other cultural competencies and build their professional-client relationship (e.g. Alizadeh and Chavan 2016).

We also found that professionals combined all of their cultural competencies to adapt their regular care to the care receiver's cultural wishes. This is in line with the study of Campinha-Bacote (2002), who stated that all cultural competencies are interdependent and must all be addressed by a professional to provide culturally sensitive healthcare. Despite this, the current study revealed that possessing all cultural competencies did not automatically cause professionals to make cultural adaptations to their regular care practices. Such adaptations could be hindered by other influencing factors (e.g. organizational- and societal-level factors). Dealing with these factors will likely be important to eventually being able to adapt regular care practices to the care receiver's culture. And although cultural competence models in the literature generally emphasize the individual cultural competence of the care professional (e.g. Sue and Sue 2012), we suggest that dealing with organizational and societal factors may also be an important competency. Exploring how professionals deal with such factors may lead to important insights into the complex relationship between cultural competencies and cultural adaptations of regular care, and why the former does not automatically lead to the latter.

The current study was one of the first to examine intercultural encounters in the lifelong care and support for individuals with ID. One methodological strength of this study was that the data analysis was conducted by multiple researchers, who separately selected and coded the relevant sections from the interviews. Moreover, the analysis of the possible relationships between the themes was performed during multiple consultations within the research team. This study was however not conducted without limitations. First, it is questionable whether our respondents would correctly judge the effects of their cultural competence and adaptations on the care receiver. The bias in these self-evaluations of cultural sensitivity is a widely known limitation of research on cultural competence of healthcare professionals (Alizadeh and Chavan 2016). More specifically, a recent meta-analysis revealed that respondents in such studies tended to give socially desirable answers to questions related to their cultural competence (Larson and Bradshaw 2017). Moreover, all our respondents were employed by one care organization, which may limit generalizability of our results to other care institutions. Future researchers may therefore wish to adopt a multi-center mixed-method approach to overcome bias in cultural competency measurement, incorporating interviews with care receivers and their families in addition to professionals, as well as observational measures (Deardorff 2006). Lastly, although the population of individuals with ID is one of the largest groups receiving lifelong care and support, the results of the current study may not be generalizable to other populations receiving lifelong care and support (e.g. individuals with physical disabilities). The replication of the current study with other populations of care receivers may therefore be necessary.

By performing a qualitative investigation of intercultural situations as described by professional care providers, we were able to confirm the existence of all cultural competencies in healthcare professionals providing lifelong care and support. Moreover, this study on long term care and support is the first empirical basis for the distinction between practical and analytical competencies in healthcare professionals. These results can be implemented by integrating both practical and analytical cultural competencies in training programs for professionals in lifelong care and support. Our findings suggest that professionals often used their cultural competencies to make cultural adaptations to their regular care practices, but not in all cases. Therefore, more research should be devoted to organizational and societal factors that may complicate (or support) the implementation of cultural adaptations, in order to enhance the quality of culturally sensitive lifelong care and support for individuals with ID.

Acknowledgments

The authors warmly thank the respondents for their willingness to share their experiences. The authors would also like to thank Hanne van Sambeek, Maroesjka Bourgondiën and Lisa Buijnink for their contribution to the current study by means of data collection and data processing.

Disclosure statement

No potential conflict of interest was reported by the authors.

Funding

This research was funded by Driestroom.

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