Social Workers as “Cultural Brokers” in Providing Culturally Sensitive Care to Immigrant Families Raising a Child with a Physical Disability

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Although culturally sensitive care is acknowledged as the gold standard in pediatric rehabilitation, very little is known about the social worker’s role in providing culturally sensitive care to immigrant families raising a child with a physical disability. This study draws on in-depth interviews with 45 clinical staff within two pediatric rehabilitation settings. Study findings, which are embedded within a “cultural brokerage” framework, showed that social workers’ understanding of culturally sensitive care involved being aware of their biases and how their own cultural or professional orientation may influence their interaction with patients. These results also highlighted common challenges that social workers encountered in providing culturally sensitive care. These challenges included language barriers, discrepancies between clinicians’ and patients’ cultural orientation, gender and generational differences, lack of knowledge of resources, and difficulties building rapport and trust. Social workers sought to overcome these challenges by working as “cultural brokers” to link immigrant families to resources and to mediate differences between patients’ and clinicians’ cultural orientations.

In conclusion, social workers play a critical role in providing culturally sensitive care to immigrant families raising a child with a disability.

KEY WORDS: child disability; culturally sensitive care; immigrant; rehabilitation

Providing culturally sensitive care to patients from an ethnic-minority background is an essential component of family-centered care (Epley, Summers, & Turnbull, 2010; King, Teplicky, King, & Rosenbaum, 2004). Culturally sensitive care refers to health care providers developing an understanding of empathy for patients’ values, beliefs, and goals, which is essential for effective health care delivery (Daudji et al., 2011). There is increasing evidence that providing culturally sensitive care to immigrant families can be strenuous because of language barriers and differences in health beliefs (that is, causes of disability, needed services, and roles of family) between clinicians and patients. Although ethnic-minority groups are often in great need for health care, they encounter many barriers in accessing services (Hasnain et al., 2011; Niemeir, Burnett, & Whitaker, 2003). Evidence shows that discrepancies between families and providers can influence health outcomes (Carrett, Dickson, Whelan, & Roberto-Forero, 2008; Yu, Nyman, Kogan, Huang, & Shwalberg, 2004). Most research on culturally sensitive care focuses on ethnic-minority groups, and less is known about recent immigrants. Furthermore, very little is known about culturally sensitive care within pediatrics rehabilitation and especially about the role of social workers (SWs).

The intersection of culture and disability is complex, whereby culture and disability are shaped by socially and individually defined values and beliefs (Ripat & Woodgate, 2011). The meaning of disability, and particularly whether the source is individual or societal, varies greatly by culture and influences how a family copes with their child’s disability (Ripat & Woodgate, 2011). For example, disabilities that limit independence may affect identity by Western standards; meanwhile, in other cultures, disabilities that limit one’s ability to contribute to social and familial relationships may be more important (Ripat & Woodgate, 2011). People in some cultures experience stigma and shame as a result of having a disability (Daudji et al., 2011). Therefore, clinicians should be aware that clients from ethnic-minority backgrounds may have different views of disability and health care based on their social and cultural experiences (Welterfin & LaRue, 2007). This is often challenging...
because most clinicians are trained from a Western perspective and lack training in working with families from diverse backgrounds (Welterlin & LaRue, 2007).

**CULTURALLY SENSITIVE CARE IN SOCIAL WORK**

There is an increasing emphasis on addressing the diversity of patients in the delivery of health and social services (Boyle & Springer, 2001; Breland & Ellis, 2012). Culturally sensitive care in relation to social work refers to “a set of congruent behaviors, attitudes and policies that come together in a system, agency or among professionals and enable that system, agency or those professionals to work effectively in cross-cultural situations” (Cross, Bazron, Dennis, & Isaacs, as cited in National Centre for Cultural Competence, 2006, p. 3).

In working with multicultural groups, the cultural values of the social work profession (typically based on Western Anglo American values) and those of non-Western cultures sometimes clash and can lead to challenges in providing care (Yan & Yuk-Lin, 2005). For example, Western values typically include independence and autonomy, which can be perceived differently for some cultural groups (Iwama, 2007) who place greater value on the collective identity of family (Mohammed, Busaidy, & Borthwick, 2012). Cultural differences require SWs to develop strategies to effectively meet the needs of diverse clients, who often have little knowledge of their host country’s health system.

Within a social work framework (that is, McPhatter, 1997), there are three key components of culturally sensitive care: (1) an awareness of and sensitivity to one’s own values, biases, and power differences with patients (that is, having a “grounded knowledge base” involving a critical analysis of the gaps and weaknesses in cultural knowledge; and reformulating new knowledge while incorporating information that involves culturally diverse communities); (2) knowledge of the practice environment, including developing an understanding of patients’ culture and values; and (3) effective communication with patients, including valuing others’ worldviews, using cross-cultural communication skills, moving toward acceptance, and engaging a culturally diverse population (McPhatter, 1997; Sue & Sue, 1990; Yan & Yuk-Lin, 2005).

Although SWs are trained to use these principles within their practice, little is known about their experiences of doing so, especially within the field of pediatric rehabilitation. The present study addresses this gap in the literature. Most research on culturally sensitive care in social work focuses on education or mental health services. Focusing on recent immigrants is particularly important in this study setting because Canada has the highest per capita immigration rate in the world (Dolin & Young, 2004), and the number of immigrants to this country continues to rise (Statistics Canada, 2008).

**THEORETICAL PERSPECTIVE: SOCIAL WORKERS AS CULTURAL BROKERS**

It is important to recognize how the broader sociopolitical environment affects social work practice, particularly with culturally diverse patients (Galambos, 2003). From an ecological perspective, this means that the social environment and the individual mutually influence each other. The practice of social work is often rooted within dominant Western societal values that influence the experience between culturally diverse groups and SWs (Galambos, 2003; Yan, 2008). This can create discrepancies in expectations and priorities, however, because individuals are situated within different social positions (Yan, 2008). For example, patient culture is shaped by many socio-structural forces (including ethnicity, immigration, poverty, and gender) (Lo, 2010).

Our study draws on concepts of cultural brokerage and cultural labor (Lo, 2010; Lo & Stacey, 2008) to frame our findings. Cultural brokerage refers to “bridging, linking or mediating between groups or persons from different cultures” (Lo, 2010, p. 487). Clinicians often find that their patients and families, especially those from an ethnic-minority background, operate with a different cultural orientation than their own (Lo, 2010). Consequently, such differences can create challenges in assisting the client. To help bridge this gap, clinicians must incorporate their perspectives with their patients’ orientation and engage in cultural translation between the two different orientations (Lo, 2010). Cultural brokerage also involves establishing long-term relationships and working with patients’ relational networks to create a familiar environment for the patients and family (that is, development of rapport and trust) (Lo, 2010). Such cultural labor involves specific tasks that take time and resources (Lo, 2010). We argue that SWs act as...
cultural brokers and perform cultural labor in working with immigrant families who are living with a child with a disability. Although some work has explored cultural brokerage among physicians and their patients, a gap exists in understanding the role of SWs as cultural brokers. The present study focuses on SWs’ experiences of providing culturally sensitive care to immigrant families who are raising a child with a physical disability (that is, cerebral palsy, spina bifida, muscular dystrophy, and other congenital disabilities). We focused on youths within the child development programs (that is, physical disability) at two rehabilitation centers with comparable client groups.

OBJECTIVES
The objectives of this study were (a) to explore SWs’ experiences of providing culturally sensitive care to immigrant families raising a child with a physical disability; (b) to explore the common challenges that SWs encounter in providing culturally sensitive care; and (c) to understand how SWs act as a cultural broker in providing culturally sensitive care, as perceived by other clinicians.

METHOD
Design
We used a qualitative design drawing on in-depth interviews, which is a suitable methodology for an underexplored area (Grbich, 2007). We endeavored to understand SWs’ experiences of culturally sensitive care among immigrant families who are raising a child with a physical disability. Ethical approval was obtained from the research ethics boards of two pediatric rehabilitation centers.

Sample and Recruitment
This article is part of a larger study on culturally sensitive care within pediatric rehabilitation. A purposive sample of SWs, occupational therapists (OTs), and speech-language pathologists (SLPs) were recruited from the child development programs at two Canadian rehabilitation centers. Our sample was drawn from two different cities within Canada varying in terms of immigration. Toronto is one of the most multicultural cities in the world, where half its population is born outside of Canada (City of Toronto, 2011). The top visible minority groups in Toronto are South Asian, Chinese, and African American. Quebec City is French speaking, with a more recent immigration history, where immigrants make up 11.5 percent of its total population. The largest sources of immigrants to Quebec are Algeria, Morocco, France, China, and Columbia (Citizenship and Immigration Canada, 2012).

Our inclusion criteria for clinician participants were that they (a) had at least two years of experience providing rehabilitation services to children with disabilities; (b) had at least one year of experience working with immigrant families raising a child with a physical disability; and (c) were currently working as a registered clinician (Lindsay, Desmarais, Tetrault, King, & Pierart, in press).

Clinicians who were thought to meet the inclusion criteria were invited to participate via a letter and information package. Those who were interested in participating in the study and who met the inclusion criteria were invited to take part in an interview at a time of their choosing. Reasons for not taking part included lack of time, being currently on leave, or not meeting the inclusion criteria.

Our sample consisted of 45 clinicians (10 SWs, 19 OTs, and 16 SLPs). For this article, we focus only on the SWs’ experience of providing culturally sensitive care and also how they act as a cultural broker to assist other clinicians within pediatric rehabilitation, as perceived by other clinicians. The adequacy of the sample size was determined when no new or relevant data emerged regarding a theme; each theme was well developed in terms of its properties, and the relationships among the themes were well established (Grbich, 2007).

Data Collection and Analysis
Data were collected from February 2012 to August 2012. Interviews lasted between 22 and 65 minutes, with an average of 39 minutes. Interviews followed a semistructured guide, including the following topics: (a) their previous training and experience with providing culturally sensitive care; (b) participants’ understanding of culturally sensitive care; (c) their experiences working with immigrant families raising a child with a physical disability; (d) the characteristics of their work with immigrant families that differed from the work they do with Canadian-born families; and (e) the way they worked with other clinicians to provide culturally sensitive care.

A narrative analysis was applied as the analytic framework for the study (Grbich, 2007). This approach is useful for gaining an in-depth
understanding of the participants’ experiences. Trained research assistants who were experienced in qualitative research conducted the interviews. All interviews were audio recorded and transcribed verbatim (with the removal of names and places) and entered into NVivo 10 (QSR International, 2012), a qualitative data analysis software program. The first author and two research assistants verified the accuracy of all transcripts. The analysis began with two members of the research team (trained in qualitative research) and two research assistants reading through each transcript several times independently while noting key themes (using an open coding approach) around SWs’ culturally sensitive care experiences and their role in acting as cultural brokers. Our research questions, including the concepts of cultural brokerage and cultural labor, served as a guide for analyzing the key themes emerging from the data. A constant comparative approach was used until consensus was reached among the research team on the final coding scheme. Several strategies were used to ensure rigor and trustworthiness (transferability, dependability, confirmability) of the findings (Krefting, 1991). These strategies included prolonged engagement (the research team has experience with culturally sensitive care among clinicians); peer debriefing (formal and informal discussions among research team); and thick description whereby themes included rich descriptive accounts and quotes that were reflective of the range of ideas expressed by the participants (Grbich, 2007). Direct quotes that were representative of each key theme were abstracted while considering the whole context of the interview. Member checking was conducted at the end of interviews and through a presentation to participants to ensure that the key themes reflected participants’ experiences. An audit trail of key analytical decisions of how the key themes developed was also kept. Reflexivity and bracketing were also conducted in each team meeting to consider any bias of the team’s experiences or positions and how this may have influenced their interpretation of the findings (Grbich, 2007; Krefting, 1991).

RESULTS
First, we describe what culturally sensitive care means to SWs and how they practice it with immigrant patients who are raising a child with a disability (that is, being aware of their biases and how their own cultural or professional orientation may influence their interaction with patients). Next, we outline common challenges SWs encountered in providing culturally sensitive care. Challenges included language barriers, discrepancies between clinicians’ and patients’ cultural orientation, gender and generational differences, lack of knowledge of resources, and difficulties building rapport and trust.

Then, we show how SWs act as cultural brokers to enhance the care provided to immigrant families. SWs sought to overcome challenges by working as cultural brokers to link immigrant families to resources and to mediate differences between patients’ and clinicians’ cultural orientations.

Meaning of Culturally Sensitive Care in Social Work
Being Aware of Biases. SWs described their understanding and conceptualization of culturally sensitive care as being aware of their background and biases. They also indicated the importance of knowing how their cultural orientation may influence the interaction with patients and families. For example, one SW described what culturally sensitive care means to her:

It would be admitting you don’t know a whole lot about who you are dealing with. Most people probably don’t even acknowledge or are aware of their prejudices. I think that’s what in terms of social work you’re taught to be aware of those things [sic]. (SW 1)

Many SWs within this sample understood culturally sensitive care to mean that they should not be making assumptions about patients but rather should be trying to see things from patients’ perspective to better meet their needs. For example,

It’s really understanding where is this person within their culture. What are the things that are important to them? How do we support them to be able to assist their child and within that realm of cultural sensitivity—so it’s really hearing from them? (SW 2)

Other SWs emphasized the importance of developing an understanding of the patient’s perspectives and belief systems to try and bridge the gap between two different cultural understandings:
Being culturally sensitive in the sense that you’re trying to reach out to all families and making sure that across cultures, across language barriers, families are having a better understanding of what staff are trying to say or trying to communicate. (SW 4)

The meaning SWs placed on providing culturally sensitive care helped them to tackle the challenges they encountered in working with immigrant families. Participants said that being culturally sensitive involves taking time to get to know patients and their family to understand what is important for them and how their cultural beliefs may influence their ability and motivation to implement recommended therapies.

**Common Challenges in Providing Culturally Sensitive Care**

SWs described several common challenges they encountered in providing culturally sensitive care to immigrant families living with a child with a disability.

**Language Barriers.** First, and arguably the most challenging, was language barriers. For example, “the most obvious would be a language barrier . . . the parent does not speak any English” (SW 1). Another went on to say, “language barriers, it does make it more challenging because there needs to be good communication between school and home too” (SW 2). Many immigrant families seen in these two rehabilitation centers do not speak English, and there was the added challenge of working with interpreters, which takes time and often hinders the establishment of rapport with families.

**Differences in Cultural Views.** A second obstacle SWs encountered included discrepancies between Western cultural values (rooted within social work practice) and the cultural values of immigrant families, specifically regarding use of outcome measures and aspects of practice. One SW described what this meant in her practice:

> There are times I don’t administer outcome measures that I know have Western assumptions in them. For example, there’s a family assessment measure that assumes family members equally share household responsibility. It can be disruptive or make people uneasy when they see the question . . . I stopped administering that form until I had a better sense of how they functioned and what they value and whether it is appropriate for me to administer that kind of tool that is normed on a Western family. (SW 3)

Another participant described often having to explain to parents the importance of using assistive technology for their child or engaging in therapy that other clinicians recommended, to further their child’s development. For instance, a SW said: “We try to inform the parent as much as possible about rehab. The parent has to understand the importance of using the equipment” (SW 6). Some SWs gave examples of how immigrant families were reluctant to advocate for resources for their child because it was not culturally appropriate for them to be assertive with authority figures. A SW highlights one such case:

> It is very common that I find recent immigrants in particular have come from different reference points around people in authority so they’re very reluctant to advocate and stand up for their child because they don’t want to challenge anyone . . . so helping the family to learn to be assertive and being able to ask for what their child needs. There’s an added level when a family comes from a culture where it’s not appropriate to do that. (SW 9)

SWs commented that supporting families could empower them to more actively participate in decision making around their child’s care.

**Gender and Generational Challenges.** A third challenge in providing culturally sensitive care involved gender and generational discrepancies within families that influenced how disability was perceived and responded to within a family. For instance, SWs described how, in many immigrant families, the man is the head of the household and makes all of the decisions about the child’s care even though the mother was often the primary caregiver for the child. This often made it problematic to gather all of the necessary information to be able to fully support the family. A SW commented:

> Sometimes fathers aren’t around and it’s only the moms and I’ve had family meetings where the moms say nothing and you deal with the father who is the decision-maker. It’s tricky for the team to know how to deal with the
mom; how to support mom but still being respectful to the father and to the family. (SW 8)

A related obstacle that SWs spoke about was around generational differences not only between youth and parents but also between parents and grandparents. Such differences were often a result of parents and children having different cultural belief systems because children were immersed and growing up within a different culture from that of their parents. For example,

I often notice that for those who’ve been here longer you see the issues between children and parents because the children have been exposed to a Canadian, Western school system and peers and they start forming beliefs around that. Parents may hold on tightly to a belief system from the home country. (SW 6)

There were similar examples of discrepancies between immigrant parents and grandparents because of the perceived stigma associated with having a child with a disability. To illustrate, an SW described her experience:

Parents can have a different belief system and that can cause tension between parents and grandparents. I had one family that didn’t want to tell the grandparents, who were living in their home, that their child had gone through this [diagnosis of disability] because culturally, it would have been seen as the mother’s fault. (SW 7)

SWs described how some families experienced stigma, within the culture they came from, attached to having a disabled child. Clinicians now had the added strain of convincing families that people with disabilities are included in school and mainstream culture within Canadian society. A SW said, “In some cultures I’m noticing there’s a lot of shame around a disability. . . . A person is often shunned or hidden away. A lot of it is trying to understand where they’re coming from but reframe it and help them understand it’s out of their control” (SW 4).

Lack of Knowledge of Resources. A fourth challenge SWs encountered in providing culturally sensitive care to immigrant families was that these families often lacked knowledge of resources and supports available to them to help support their child. SWs commented that this could be a result of immigrants and refugees often encountering more barriers in navigating the health and social systems (because of language barriers, poverty, and so forth). Participants also described how immigrant families are often in a situation of poverty, and obtaining or making appointments is often a strenuous process:

People taking two or three buses, two hours to get here is really tough. . . . One client lives in his living room in a two-story social housing unit. He’s waited for eight years for a social housing transfer. All of his equipment is in his living room. They have to carry him up and down stairs to use his shower. It’s not safe at all. (SW 9)

Families were often busy trying to make ends meet in juggling multiple jobs on top of settling into a new country. Thus, getting their child into appointments for therapy was not always their top priority.

Trust and Rapport. A fifth challenge included building rapport and trusting relationships, which was often difficult for refugees coming from war-torn countries. For instance, one informant expressed her reality like this: “I had some people that came from a refugee camp and to get them enrolled in recreational activities; they did not want that. They didn’t want to get out of the house because they feared they would be killed” (SW 6). SWs had to take extra time to ease such fears to help these families to integrate into society.

In sum, SWs encountered several challenges in working with immigrant families who are raising a child with a disability. They performed much cultural labor and acted as a cultural broker to overcome these challenges to help improve the care for immigrant families.

SWs as Cultural Brokers to Enhance Care Provided to Immigrant Families

SWs engaged with families and other professionals in several ways to link immigrant families to resources and to mediate differences between how disability is perceived and responded to in their cultural background and how it is responded to in the country they are now living in (Canada) and where
they are receiving care for their child. SWs helped families directly and also acted as a facilitator between families and other allied health professions.

**Listening and Engagement.** For SWs to be a competent cultural broker, they needed to spend more time (than they would for nonimmigrant families) engaged in listening and developing an understanding of families’ cultural background, their priorities, and their views of disability and in taking time to build rapport and advocate for families’ needs. The participants in our sample explained that this cultural labor involved asking families what their priorities are and what is important to them. For instance, one SW offered the following explanation:

> It's really understanding where is this person within their culture... . . . What does this mean to you to have a child with a disability? What does this mean to your culture? How would you approach this? Disability is viewed very differently from across cultural settings and it really impacts how they even want to share the news that their child has a disability with family members within their culture... . . . [F]or a lot of them it’s not hard to engage as far as it is just to be respectful, to hear what is what they wanted to share. (SW 5)

Others described that to be an effective cultural broker, it is essential to be aware of one’s own perspectives while actively engaging families to gain a better understanding of their cultural orientation regarding health services. For example, a SW described “listening to what everybody has to say and not making assumptions. But at the same time being open to understanding things based on the differences” (SW 8). Another SW relayed her situation:

> Working in the most multicultural city in the world where as a white woman I’m a minority. I need to be able to engage people who usually are not from my background and their primary language is not mine. The meaning they make of disability, their culture, their values may not be mine. I need to be skilled at being able to be curious and sensitive and nonassuming no matter what they look like, or speak like or what generation they are from in their culture... . . .

> For me I need to have a good understanding of their goals to set their goals collaboratively or it wouldn’t be meaningful for them. (SW 3)

**Building Trust and Rapport.** SWs thought it was important to build rapport and trust with patients. They did this by engaging patients in their care, being respectful, and taking time to listen to their perspectives so their therapy could fit within their cultural beliefs. To illustrate that, one SW proposed the following:

> I try to go in with an open mind and say, “show me how I can be a support to you.” . . . You are working on engaging with the client and family and trying to complete an assessment and come up with some mutual goals that they want to work on. (SW 7)

These examples highlight the important cultural labor SWs performed in developing a familiar and engaging environment and mediating cultural differences between clinician and patient.

**SWs’ Role as Cultural Brokers in Providing Culturally Sensitive Care**

**Gaining an Understanding of Clients’ Background.** Other health care providers who work with immigrant families (that is, OTs and SLPs) commented on the important role SWs play in serving as a cultural broker to engage their patients in therapy. For instance, SWs tried to find out as much background information as they could to support families and also to help other clinicians to work with these families. A SW explained how this occurs in her practice:

> I see the family at orientation. So whatever I find out in that discussion, you know ESL [English as a second language], religion, family, level of independence. I’ll find out what I can then I’ll pass that on to my colleagues. (SW 1)

Other clinical staff described how they often rely on SWs to debrief them on relevant knowledge about the family that could be relevant for the therapy they will be offering:

> Our social worker is the number one [person I go to]. Is there something that I should be aware
of? 'Cause you certainly don’t want to make the wrong recommendation. Certain people you have to approach at a certain protocol for families. I need to ask the dad first and ask permission for this or ask certain questions why they’re not using equipment. 'Cause they have different beliefs or biases about it too. (OT 17)

SWs were perceived to play an important role in being able to take extra time to help families process and understand their child’s diagnosis and to connect families to needed resources. Many clinicians shared a similar experience as the one outlined below:

I feel social workers are particularly important when we have immigrant families. These families often have quite a few questions we don’t always have time to answer. We see the child quickly and then it’s on to the next one. Social workers have more time to sit down with the family and explain things to them. It’s extremely helpful. (OT 28)

Clinicians agreed it is important for SWs to support immigrant families to understand who is involved in their care and to clarify things. One OT described the valuable role SWs play in performing cultural labor and helping to link families to resources. For example,

It makes our job easier if they [immigrant patients] already have a good understanding of the situation, of who we are, and which resources are available to them. I really feel it’s detrimental to our intervention when we only have time to work on the child’s therapy without addressing the family’s social issues. (OT 18)

In working as a part of a multidisciplinary team, clinicians relied heavily on SWs to be the cultural broker between immigrant families and clinicians. For instance,

The social worker who was the person most involved in the intervention worked very hard on this issue. . . . It can be interesting to have a social worker who can handle all aspects of resources and adaptations. They can help us understand how parents experience a situation.

They can also help us find ways in which we can adapt. (SLP 16)

Other SLPs agreed that SWs were helpful for linking immigrant families to resources:

We are lucky that we have the benefit of social workers to break down the resources that are available within the hospital and within the community. . . . Our social workers are fantastic with getting the whole information and teaching them to navigate the system. (SLP 6)

**Connecting Clients to Resources.** An important role SWs played in working with immigrant families was connecting them to resources to assist with their child’s well-being: “providing information and resources, supporting the resources and assisting parents so they better understand the how’s and the why’s but also the other way around. We try to understand their values, their ways of being, to help during their rehab” (SW 5). In working with immigrant families, it is all about connecting the family to needed supports because some of them have not been in the country for very long. Indeed, a SW shares: “The settlement and support services that are out there are helpful. If they’re not connected with something like that I will try to connect them. . . . A lot of the resources and support is around explaining the school systems” (SW 7). Other health professionals (that is, OTs, SLPs) relied on SWs to help immigrant families to navigate through the health and social system to link them to resources. An OT mentioned how she relies on SWs: “Navigating the health care system. . . . that wasn’t something I was doing. But the social workers definitely try and take a role in that” (OT 7).

In summary, SWs performed cultural labor and acted as a cultural broker in several ways to link immigrant families to resources and to mediate differences in cultural orientations between them and other clinicians. They did this to help advocate for families so that they could receive care and resources that were meaningful and relevant to them.

**DISCUSSION**

This study addresses a key gap in the literature by focusing on the experiences and role of SWs in providing culturally sensitive care within pediatric rehabilitation. Our findings highlight that the
meaning of culturally sensitive care to SWs involves acknowledging one’s own biases and assumptions and gaining an in-depth understanding of the families’ perspective and what is important for them. Doing this helps to make therapy more relevant and engaging for families. This finding is consistent with culturally sensitive care models commonly used in social work (that is, McPhatter, 1997) that outline the importance of developing an awareness of and sensitivity to one’s own values, biases, and power differences with patients and understanding their values and priorities (McPhatter, 1997; Yan & Yuk-Lin, 2005).

A second key finding highlighted the common challenges that SWs encounter in providing culturally sensitive care. These included language barriers, discrepancies between clinicians’ cultural orientation and immigrant families’ cultural values, gender and generational differences, lack of knowledge of resources and ability to navigate the health care system, and difficulties building rapport and trust, especially with refugee families. These findings are similar to past research on culturally sensitive care highlighting that differences in health beliefs, views of disability, and language barriers can create obstacles for clinicians providing services to clients whose first language is not English (Casado, Negi, & Hong, 2012) who are ethnic minorities (Kirsch, Trentham, & Cole, 2006) and who have a child with a disability (Lindsay, King, Klassen, Esses, & Stachel, 2012). Previous work also showed that immigrant families often have difficulties in navigating the health care system (Hernandez, Nesman, Mowery, Acevedo-Polakovitch, & Callejas, 2009). Some past research on immigrant families with a disabled child also found that male head-of-household models could create challenges for clinicians who are trying to obtain information from mothers, often the primary caregivers (Lindsay et al., 2012). Further, our findings illustrate that SWs often had to act in a family-centered way with immigrant families who felt stigma and shame of having a child with a disability. Experiencing stigma and blame is consistent with past research on South Asian immigrant mothers’ views of raising a child with a disability (Daudji et al., 2011).

One challenge that was not seen within our findings but is often mentioned in other studies (Chipps, Simpson, & Brysiewicz, 2008; Lindsay et al., 2012) is a lack of training around culturally sensitive care. The fact that SWs in our sample did not mention this suggests that, compared with other types of clinicians, they received adequate training in dealing with culturally diverse clients. However, further research is needed to explore this in more depth. SWs may also be in a good position to help train other clinical staff in how to work with immigrant clients.

Our findings highlight how SWs act as cultural brokers to enhance the care provided to immigrant families. SWs performed cultural labor to link immigrant families to resources and to mediate differences between patients’ and clinicians’ cultural orientations. Our results show that SWs spent much time engaged in listening and developing an understanding of families’ cultural background, especially their priorities and views of disability, taking time to build rapport and advocate for families’ needs. These findings are consistent with similar research on cultural brokerage among physicians (Lo, 2010). Some evidence suggests there is a need for a deeper appreciation of the complex interplay between patients’ and clinicians’ cultural values and priorities (Dickie, 2004; Lindsay et al., 2012). Indeed, communicating effectively with patients, incorporating their worldviews, and engaging a culturally diverse population are critical components of providing culturally sensitive care within social work (McPhatter, 1997; Yan & Yuk-Lin, 2005). SWs should continue their excellent work in linking families to resources and mediating differences in how disability is perceived and responded to.

It is important to consider the limitations of this study. This research focused on providing culturally sensitive care to immigrant families with a child who had a physical disability within two different urban areas. Future research should explore how SWs act as cultural brokers within other settings (both pediatric and adult), in other places (rural and urban), and with other types of disability (for example, autism, intellectual disability).

CONCLUSION
Our findings suggest that SWs play a critical role in providing culturally sensitive care to immigrant families raising a child with a disability. SWs engaging with immigrant families should be cognizant of the challenges, such as therapist–family differences in cultural beliefs and values regarding how disability is viewed. Although SWs encounter several challenges in providing culturally sensitive
care to immigrant families with a disabled child (that is, language barriers, discrepancies between clinicians’ and patients’ cultural orientation, gender and generational differences, lack of knowledge of resources, and difficulties building rapport and trust), they act as cultural brokers to link immigrant families to resources and to mediate differences between patients’ and clinicians’ cultural orientations. SWs should take time to gain an understanding of the family’s cultural background to build trust and rapport while also recognizing their own biases.

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