An Intensive Cultural Experience in a Rural Area

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More well-trained mental health professionals serving rural and minority populations are needed. This article describes an intensive clinical experience for psychiatric mental health nursing graduates in the rural, culturally diverse Tri-Cities (Pasco, Richland, and Kennewick) of Washington. Before discussing the short-term learning experience and outcomes, the social history of the area is explained because of its impact on current health needs and the kinds of learning opportunities available. In addition, personal reflections of student participants are included. (Index words: Culture; Rural; Nursing education; Psychiatric nursing) ***J Prof Nurs 19:126-133, 2003. © 2003 Elsevier Science (USA). All rights reserved.***

MENTAL HEALTH: Report of the Surgeon General (U.S. Department of Health and Human Services [U.S. DHHS], 1999) calls for a societal commitment to improve the mental health of the nation. In particular, there is a need for more well-trained mental health professionals to serve rural and minority populations and to reduce the stigma of mental illness among the general population. Mental health: Culture, race, and ethnicity (U.S. DHHS, 2001), a supplement to the earlier report, focuses particularly on eliminating mental health disparities and promoting mental health among all ethnic groups. The University of Washington program to prepare advanced practice psychiatric mental health nurses has had a significant focus on cultural competence and on caring for marginalized and underserved people for many years (Boutain & Olivares, 1999; Thomas, Brandt, & O'Connor, 1999). More recently, in recognition of the serious shortage of mental health providers in rural areas, the program has expanded to the Olympic Peninsula and other rural areas in western Washington (O'Connor, Thomas, Albert, Kim, & Potter, 2002).

The opportunity for an additional focus on cultural competence in a rural area came about as an invitation from Guillermo V. Castaneda, M.B.A., Executive Director of Community Health Center La Clinica in Pasco, in eastern Washington. Along with other administrators in the area, he invited a University of Washington faculty member (M.D.T.) to place graduate students in area agencies where they could gain clinical experiences with Latino and other rural populations. Washington's Tri-Cities—Pasco, Richland, and Kennewick—have complex histories. There are many Latino farmworkers, including migrants. In addition, many scientists and engineers work at the Hanford Site (managed by the U.S. Department of Energy).

Clinical experience in the Tri-Cities would be valuable for students in gaining a greater understanding of diverse rural communities. Planning a short-term, 3-day experience seemed most feasible because of the distance between the University and the Tri-Cities and the family commitments of some students. This article addresses the social history of the area because of its impact on current health needs and the kinds of learning opportunities available. The intensive short-term learning experience and outcomes also are discussed. In

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addition, personal reflections of the predoctoral teaching associate (S.A.O.) and 2 master's students (H.J.K., C.B.) are included. This article is intended to add to the literature on creative ways of enhancing the cultural competence of learners (Ailinger, Zamora, Molloy, & Benavides, 2000; Currier, Omar, Talarczyk, & Guerrero, 2000; Fahrenwald, Boysen, Fischer, & Maurer, 2001; Ryan, Ali, & Carlton, 2002; St. Clair & McKenry, 1999).

A Social Historic Perspective of the Tri-Cities

CULTURAL LEGACY AND ECONOMIC FORCES

At the time of the Lewis and Clark expedition, the broader area around what is now the Tri-Cities was home to American Indian groups whose descendants include the Cayuse, Nez Perce, Palouse, Umatilla, Walla Walla, Wanapum, and Yakama (Bard & McClintock, 2002; Gerber, 2002). Although a few prospectors, missionaries, and cattle ranchers had come to the area by the middle of the 19th century, it was really the arrival of the railroads in the early 1880s that led to the establishment of nonindigenous people. Northern Pacific Railroad engineers platted 2 towns near the confluence of the Snake and Columbia Rivers as headquarters for the region. Virgil C. Bogue, principal assistant engineer, named one town Pasco because he remembered the landscape and frigid winds of a mining town, Cerro de Pasco (Oberst, n.d.), in the Andes Mountains. The other was named Kennewick from the American Indian word meaning "a grassy place" (Gerber, p. 18).

The establishment of the railroad, considered Washington's great marker of progress, opened the Tri-Cities to nonindigenous settlement. Irrigation of the land by railroad entrepreneurs brought an increasing agriculturally oriented population to the area. Between 1902 and 1903, Kennewick's population grew from 50 to 500. As American Indian groups were confined on smaller reservations, former reservation land was sold ("Railroads top state's century of progress," 1999; Zeisler-Vralsted, 1998).

In addition to the railroad, harnessing the 3 great rivers—the Columbia, the Snake, and the Yakima—for additional irrigation projects set the stage for agricultural production and shipping (Gamboa, 1990; "Railroads top state's century of progress," 1999). Crops such as hops, sugar beets, asparagus, mint, and orchard fruit required intensive labor. The labor pool changed from American Indian to people of Japanese and Filipino descent, but, with the advent of World War II, migrant workers of Mexican descent predominated (Gamboa; Lemos, 1974).

In 1943, the Hanford Engineer Works (later termed the *Hanford Site*) was established on the Columbia River to produce plutonium for the nation's atomic weapons. The town of Richland, with only 200 inhabitants, was chosen as the operating village for nuclear workers and their families. This wartime town was replanned and substantially rebuilt as a suburb-like town between 1946 and 1960 (Abbott, 1998, Gerber 2002), and it became "a middle-class island in the larger Tri-Cities area. Residence was limited to Hanford employees and direct support workers" (Abbott, p. 102). "By both design and default, then, people of color were pushed into Pasco—and there they lived in the poorer parts of town" (Findlay, 1999, personal communication). Plutonium production continued at Hanford after World War II during the Cold War. Over the years, the Hanford Site has evolved; engineers and researchers now focus on decontamination, waste remediation, and environmental research. Along with farming, Hanford continues to be central to the modern economy (Abbott; Gerber).

In 2000, population was 32,066 in Pasco, 38,708 in Richland, and 54,693 in Kennewick. Historic differences among the communities in terms of ethnic distribution continue: Pasco's population was 56.3 percent Hispanic; Richland's was 4.7 percent; Kennewick's was 15.5 percent. Those identified as Asian constituted 4.2 percent in Richland, 1.8 percent in Pasco, and 2.2 percent in Kennewick. African-Americans comprised 1.4 percent in Richland, 3.4 percent in Pasco, and 1.2 percent in Kennewick. Fewer than 1 percent of all 3 communities were American Indians or Alaska Natives (U.S. Census Bureau, 2002). Differences among the communities in educational attainment and income level also were present in 1990, the most recent year for which such data were available (Table).

A HEALTH CARE HERITAGE

Changes in the Tri-Cities created pressures on the health care system, resulting in linguistic, educational, and cultural challenges. The Sisters of St. Joseph of Carondelet opened Pasco's first hospital in 1916 with the spirit of "bringing wholeness to the healing process, a spiritual dimension beyond the reach of medicine" (Cammut, n.d., p. 18). The care of the poor, although met by the Sisters, was not adequate for the growing population. Other health care facilities followed to serve different groups, including for-profit hospitals and various private clinics. In the late 1970s, the Kennewick Primary Clinic in Kennewick and the Eastside

TABLE. Comparison of Tri-Cities Communities

Community	Total Population (2000)	Percent Hispanic (2000)	Percent Holding Bachelor's or Higher Degrees (1990)	Median Household Income (1989, 1990)
Pasco*	32,066	56.3	8.8	$17,897
Richland	38,708	4.7	34.7	$36,626
Kennewick	54,693	15.5	19.8	$28,261

Data from U.S. Census Bureau 2002a, 2002b, 2002c. *Data for Pasco likely represents an undercount of Mexican migrant workers whose education is typically a 3rd grade level in Mexican schools and whose household income levels are less than $10,000/year (Castaneda, personal communication).

Family Health Clinic in Pasco opened to serve the poor (Pruitt, 1979). By the 1980s, however, the burgeoning, mostly Spanish-speaking, migrant farm-working community lacked affordable health care. Three Hispanic women—Berta Cantón, Minnie Pesina, and Rosalva Ingram—along with other concerned citizens, founded what later became La Clinica in Pasco (Gomena, 1980; Pesina, 1999). Their desire to open a clinic was based on their belief that migrants and Spanish-speaking immigrants deserved health care in a setting where their cultural, physical, mental, and spiritual needs were understood. La Clinica moved to its present location in Pasco in 1982, and the next year Guillermo V. Castaneda became the executive director. A dental clinic was added in 1985, a mental health clinic was added (discussed more fully later) in 1987, and a housing program was begun in 1993 that has constructed 130 homes. The clinic now has 260 employees.

A CONCERN ABOUT MENTAL HEALTH CARE

During the community mental health movement of the 1960s, a survey identified mental health needs in the Tri-Cities area (Bi-County Social Planning Council, 1962). A significant recommendation of the report was that affordable mental health services should be provided. The report recognized the need for including ethnic groups in planning mental health programs, but it took more than 2 decades to develop a cross-cultural mental health program. Meanwhile, the Sisters of St. Joseph of Carondelet had developed a system of care that included mental health and drug and alcohol inpatient and outpatient services (Cammut, n.d.). This system evolved to become the Lourdes Health Network and includes the Lourdes Counseling Center.

After the Washington legislature passed mental health reform legislation in 1989, Regional Service Networks (RSNs) were created to administer mental health funding. The Tri-Cities are part of the Lower Columbia RSN, geographically the largest, serving 11 counties. The RSN administrators soon discovered that cross-cultural mental health services were not adequate and worked to improve them (Donley, 1990 D. Hopper, personal communication, August 26, 1998). Several agencies applied for funding to enhance cross-cultural mental health services in the RSN, and La Clinica, under the leadership of Guillermo V. Castaneda and Berta Cantón, was selected. They established Nueva Esperanza (New Hope) Counseling Center to serve Pasco's previously underserved Spanish-speaking migrant and immigrant populations (Metcalf, 1989). La Clinica and Nueva Esperanza have emerged as part of the health care system in the Tri-Cities to provide cross-cultural health care addressing physical, mental, linguistic, and spiritual needs.

The Educational Experience

This clinical learning experience was an optional alternative practicum in the graduate psychiatric mental health nursing curriculum. The goals for clinical practicum, at all sites, include (1) improving assessment, decision-making, and intervention skills; and (2) developing greater understanding of the advanced practice nursing role. For this particular clinical experience, additional specific goals included (3) learning about the historic, cultural, and socioeconomic factors that influence how clients seek care, the context for care, and advanced practice roles in providing care; and (4) gaining an understanding of the overall organization of care in the RSN, including the kinds of services offered by various Tri-Cities agencies. By completing this practicum, the student earned a quarter credit.

Learning experiences also occurred both before and after travel to the Tri-Cities. The students received reading materials describing the cultural history of the area, the Hanford Site, the development of services for migrant workers, and the services of the agencies to be visited. At a class meeting the week before the trip, the reading materials were discussed and travel logistics finalized.

The Tri-Cities are 226 miles from the University of

Washington, necessitating arrangements for travel and lodging. We used university vehicles to transport faculty and students. Students also had the option of traveling in their own cars, and 2 students did so. Because we could obtain reduced state-government rates for lodging, the costs were kept relatively affordable.

The students' central learning experiences in the Tri-Cities occurred during a very intensive time period. We left the University on Sunday afternoon and returned on Tuesday evening. On Monday and Tuesday, we had a variety of experiences, including observation of the services offered by La Clinica Community Health Center and its mental health division, Nueva Esperanza Counseling Center in Pasco. In addition, students learned about the Lourdes Health Network, especially its Behavioral Health Services Division, which is based in Richland, but offers a variety of services throughout the broader geographic region. These services include a chemical dependency treatment facility and a clubhouse named Wilson House.

The Executive Director of La Clinica Community Health Center and the Director of Nueva Esperanza Counseling Center described to the students the people they serve, the broader networks of community and migrant health centers as well as the context of the RSN for mental health services, the wide variety of services offered, and how these services are funded. In addition to primary care and mental health services, other services offered include dental care; nutritional services for women, infants, and children; and programs for developing housing. Students could observe practitioners delivering health care, sometimes with the aid of interpreters. Students learned about how care was adapted to the specific people being served. For example, at La Clinica, rather than expecting a mother to make appointments for each child, a woman who had taken time off from field work could be seen with all her children in a walk-in clinic. Continuity of care was enhanced by transmitting information for follow-up care to the migrant clinic in the area to which clients would be traveling. Students could see how interpreters were used and how important it is for practitioners to speak at least some of the client's language. At Nueva Esperanza, students observed a bilingual therapist and a bilingual client switching between English and Spanish during a play-therapy session.

Barbara Mead, ARNP, Executive Director for Lourdes Counseling Center and an advanced practice nurse, talked with students about advanced practice roles, characteristics of the people served, and how health services are organized and provided. Students learned the significance of sensitivity in the way mental health services are delivered to groups in whom mental illness is stigmatized. For example, the services were located in accordance with the desires of rural clients and some scientific workers who preferred to obtain mental health services when the services are housed with other health care services. Students observed and talked with participants in a clubhouse program and on inpatient psychiatric and chemical dependency units. Recognition of the kinds of services needed and the ways in which clients were referred within and across agencies also was part of the student experience.

A high point of the Tri-Cities experience was a barbecue for farmworker families and some staff members from the agencies visited by students. This was an opportunity for the students to talk with farmworkers, sometimes with translators, and to learn about their daily lives, how they managed child care, their preferences and choices in crops, where they had traveled from, and where they would go when they left the Tri-Cities area.

Before returning to the University, a debriefing meeting was held in which the students discussed highlights of their time in the Tri-Cities and particular experiences that had been meaningful for them. After the trip, the students wrote reflection papers focused primarily on the historic, cultural, and socioeconomic factors in seeking help and care and what they had learned personally from their experiences.

Discussion of Outcomes

The strengths and limitations of this learning experience can be considered in terms of the its opportunities and the parallels with other kinds of learning experiences. The Tri-Cities trip provided excellent learning experiences for gaining an understanding of cultural difference and its relevance in health care. The experience was an optional offering in the graduate program, so there could have been a self-selection process especially appealing to students interested in cultural competency or rural health.

But, although it was short term, the educational outcomes echoed the observations of other investigators concerning the effects of experiential cultural learning. St. Clair and McKenry (1999) found that undergraduate nursing students who had a 2-week international immersion underwent a transformation that moved them from ethnocentrism toward a more relativistic perspective. Those students identified their learning as going beyond the understandings they obtained in classroom settings. Kirkham (1998), in a study of re-

cently graduated nurses, found that the nurses described the experience of caring for culturally different clients with varying degrees of commitment and diverse levels of insight. Kirkham conceptualized these differences in commitment and insight as occurring along a continuum from resistant care through generalist care to impassioned care. Nurses providing impassioned care were thoughtful in their descriptions of cross-cultural care and devoted to caring for clients who were different. Each impassioned nurse characterized an awakening to the imperative of culturally sensitive care, often through an experience of living in another country. Although a lengthier experience in the Tri-Cities would probably have had a greater impact, student evaluations and papers reflected significant changes in perspectives. However, a short-term intensive experience probably works especially well where cultural and language difference is greatest. Students were much more aware of cultural differences with Latino clients. Differences that were more subtle (e.g., rural values and ways of life) were not recognized as fully as they would be in longer engagement.

In addition to cultural learning, a second outcome was learning about the systems of providing health care services in this rural area. Researchers who have focused on delivery of health care, especially mental health care, in rural communities recommend matching the delivery system to the rural environment, rather than applying an urban model. They further suggest building on natural strengths of rural communities, for example, by formally integrating natural helpers into systems of care; integrating physical and mental health systems as well as considering ways to increase the availability, accessibility, and acceptability of services; and coordinating the services that are available (Bushy, 2000; Kane & Ennis, 1996; Wagenfeld, Murray, Mohatt, & Debruyn, 1997). Students could see how these recommendations had been implemented in the Tri-Cities. For example, the volunteer conducting the older adult peer program at Nueva Esperanza explained how natural helpers were involved. The administrator of Lourdes Counseling Center talked of increasing the availability, accessibility, and acceptability of services by offering mental health services and general health services together in satellite clinics. Planning for identified needs and orienting services to clientele could be seen in the way dental care and housing and nutrition programs were offered at La Clinica. Coordination of services was reflected in the way clinicians and administrators referred clients to appropriate services. The director of Nueva Esperanza provided an overview of the Lower Columbia RSN and how mental health services are delivered to clients in the Tri-Cities and the broader RSN. Students also learned about advocacy and how services are funded for low-income clients through granting mechanisms.

The opportunities for cultural learning and systems level learning—all in a short time period—made this a rich, intensive experience. This was enhanced when the students reflected on specific incidents and what they had learned; this occurred in a scheduled session immediately before returning to Seattle and in the reflection papers written later. Although informal discussion of the experiences occurred throughout the stay in the Tri-Cities, providing additional time for reflection during the experience probably would have been useful. This would have allowed an additional exchange of experiences and observations along with the opportunity to analyze and solidify ideas. The students described by St. Clair and McKenry (1999) experienced culture shock, fear of the unknown, intimidation by the cultural differences, shame resulting from preconceived ideas, and powerlessness in the face of oppression, poverty, and suffering. Although such experiences are less pronounced in the Tri-Cities, such factors should not be underestimated.

The Tri-Cities clinical experience, although brief, had significant educational benefits and showed that even short-term learning experiences can provide greater understanding of rural communities. Accompanying this article are personal reflections by a predoctoral teaching associate and 2 students in the master's program at the time, highlighting their personal responses to the experience.

Reflections

A REFLECTION ON SPIRIT OF MIGRANT CARE BY SERGIO A. OLIVARES

When this experience was offered to students and because my dissertation involved the history of migrant clinics and their creation of mental health services, my investment in having graduate psychiatric nursing students understand the historic and social aspects influencing mental health care was clear. When I interviewed Latina board members, a Latina nurse, and a Latina mental health provider for my dissertation research, and reviewed students' reflections about the experience, the importance of spiritual care in the context of mental health became evident. Hispanics and those interested in migrant and immigrant health struggled mightily to build these clinics. Their triumphs of spirit are found in the structures and services created to care for migrants and immigrants and an-

swered many of their prayers of finding relief in an otherwise inhospitable world.

As a result, people being served at these clinics have a place of refuge. As Maria McCluskey (1999), a Latina nurse, stated succinctly, migrant clinics rest on sacred ground; the clinics are symbolic communal spiritual centers. I hope that all nurses who read this article will be inspired to work in these clinics to contribute to and learn from a traditionally underserved (physically, mentally, and spiritually) group of people.

EXPERIENTIAL LEARNING IN THE TRI-CITIES BY CHERYLE BEILKE

I have a personal interest in working with underserved people and a curiosity about cultures different from my own, so I was attracted immediately to the Tri-Cities class. I value diversity and believe that cultural competence is crucial to caring for people in a holistic fashion. Because I learn best through direct participation, I wanted to experience how cultural competence was practiced in the culturally diverse communities of the Tri-Cities.

The Tri-Cities trip gave me positive models of culturally competent health care. I will focus primarily on my experience at Nueva Esperanza and La Clinica, where there was a sense of community spirit in addressing health care access for a primarily migrant Latino population. A holistic approach was evident in the consideration of housing, nutrition, and the cultural meanings of health care. The cultural strengths of family and community bonds were drawn on to improve conditions for the Latino and migrant workers. The benefits of familiarity with differing cultures and the health care beliefs that might be held by clients were evident in the care observed at Nueva Esperanza and La Clinica.

Many areas of the country are struggling with the language barriers intensified by the influx of immigrants. Some people have become polarized between expecting everyone to adapt and learn English and regarding it as a caregiver's responsibility to make accommodations for clients with English as a second language. I believe that familiarity with the primary language of clients is a part of my role. Having traveled to South America and speaking only minimal Spanish made me appreciate how frightening it can be to not know the language. Even with excellent translators, the cultural nuances were difficult to understand. Treating a person holistically requires understanding the language and the culture behind the words; consequently, the concept of cultural interpreters rather than just language interpreters is important and was exemplified at Nueva Esperanza and La Clinica.

Although some of the challenges I observed in the Tri-Cities seem unique to a rural setting—especially issues for migrant workers—most also are encountered in urban areas. Cities have transient populations, homeless families, and great diversity of cultural and socioeconomic conditions. Using the strengths of these cultures to improve health care as was done in the Tri-Cities could be a model for any health care delivery system.

AN AWAKENING AND A TRANSLATION TO KOREA BY HYUN JUNG KIM

Cultural competence is a concept I had not really thought about before coming to the United States. Living in this country has been a struggle for me as an international student. I have experienced and learned a different language, customs, and culture. Because I know how hard it is to adjust to a totally different environment, culture became one of my interests. Therefore, when I saw a flyer about a trip to the Tri-Cities, I thought this would be a good opportunity to observe how health care is delivered to clients with different languages and cultures.

I think that one of the hardest things for a person living in a foreign country is to explain a health problem to a health care provider in a second language because fear is added to a feeling of isolation as a nonnative speaker. I experienced this even though I can communicate in English. I previously had a very unpleasant 15-minute medical encounter that I would never want to experience again. So I wanted to observe ways in which this anxiety could be relieved and how clients seek care in another language. I had not known many Hispanics in Seattle, and I thought going to a Hispanic community and learning about their lives would be a valuable experience.

This trip to the Tri-Cities gave me a better understanding of the similarities and differences in human lives. I learned that family is a crucial part of nursing care. I observed the tight bonds among family members through visits at La Clinica and at a dinner with Mexican families. I also learned that stigmatization of mental illness was an issue that we had to be concerned with as patient advocates. I saw the arrangement for mentally ill clients at Lourdes Counseling Center. Because of concerns about people knowing each other in the rural area, mental health clinics were located with medical clinics to protect patient privacy. It was a thoughtful consideration for clients and made the agency more accessible and available.

Also, this trip made me think about how problems with differences can be overcome. When a language barrier keeps clients from seeing health care providers, interpreters or bilingual staff can be a solution. Despite the limitation of not always translating the precise nuance of the client's language, an interpreter gives a client a way of communicating and the power to be assertive. With the help of bilingual staff and interpreters, clients could get what they wanted from their health care providers. Problems arising from economic differences were alleviated by nutritional and housing programs. I especially liked the housing program through which families came together and worked a certain amount of time each week building houses for each other. Through this experience, they learned building skills, obtained a new house, made friends and had social interactions, and increased their self-confidence. This program was well adapted to the needs of the population.

My trip to the Tri-Cities made me think of Southeast Asian workers in my home country of Korea. Koreans do not emphasize cultural differences. Probably because Korea is homogenous racially, people overlook the broad meanings and range of culture and its differences. However, Korea is no longer a place where only Koreans live. During the 1990s, many Southeast Asian workers have come. As guest workers, they have limited access to the health care system, and, unfortunately, we do not have agencies to meet their health needs.

Some might argue that Korea does not have a health care system good enough to even take care of our own people; this raises questions about sharing our resources with foreigners. However, I believe that true sharing means not sharing just what is left over but, rather, sharing what I have now. It does not matter with whom I share. I hope that the importance of cultural diversity is acknowledged and appreciated in the health care area in Korea, and I hope that Korean people learn respect for cultural differences and, therefore, respect for people from different cultures. To survive in a rapidly changing international society, we need to learn and prepare for diversity. Lastly, I also hope I can contribute to the future of Korean society where everybody is fully aware of cultural diversity, accepts it, is grateful for it, and enjoys it. I believe that what I experienced in the Tri-Cities will help me to make my contribution to this future.

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