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Social and Cultural Concepts Module: Curricula to Foster Cultural Responsiveness

Abstract
The lack of racial diversity in the occupational therapy profession as well as its educational programs are obstacles in providing culturally responsive care to serve all people, populations, and communities. Research has shown that student engagement in case studies, activities that emphasize exposure to diverse populations, reflective journaling, and interviewing someone from a different culture are effective in developing practitioners who are more culturally responsive. Students from one culturally diverse occupational therapy program took a nine-hour Social and Cultural Concepts Module (SCCM) that incorporated best practice pedagogy for teaching cultural responsiveness. A one group pretest-posttest design was utilized to explore how well-prepared the students believed they were to meet the needs of diverse communities following the module. Data was collected from 35 entry-level doctor of occupational therapy students from four major race/ethnicities using the Interprofessional Education Health Disparities Series Survey (IPE-HDSS). Of the 30 items measured, 22 items showed a significant positive difference from the pretest to the posttest. Results demonstrated a change in the students' self-reported knowledge of culturally responsive care following classroom instruction. This study provides insight into the need for culturally responsive curriculum to be integral to occupational therapy education.

Keywords
Diversity, interprofessional education, health disparity, implicit bias, survey

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ABSTRACT

The lack of racial diversity in the occupational therapy profession as well as its educational programs are obstacles in providing culturally responsive care to serve all people, populations, and communities. Research has shown that student engagement in case studies, activities that emphasize exposure to diverse populations, reflective journaling, and interviewing someone from a different culture are effective in developing practitioners who are more culturally responsive. Students from one culturally diverse occupational therapy program took a nine-hour Social and Cultural Concepts Module (SCCM) that incorporated best practice pedagogy for teaching cultural responsiveness. A one group pretest-posttest design was utilized to explore how well-prepared the students believed they were to meet the needs of diverse communities following the module. Data was collected from 35 entry-level doctor of occupational therapy students from four major race/ethnicities using the Interprofessional Education Health Disparities Series Survey (IPE-HDSS). Of the 30 items measured, 22 items showed a significant positive difference from the pretest to the posttest. Results demonstrated a change in the students' self-reported knowledge of culturally responsive care following classroom instruction. This study provides insight into the need for culturally responsive curriculum to be integral to occupational therapy education.

INTRODUCTION

Stark healthcare disparities exist in the United States (U.S.) among racial and ethnic groups, stemming from unequal access and treatment (Smedley, Stith, & Nelson, 2003). The manner in which a healthcare practitioner conceptualizes and understands the

culture of a patient and uses this understanding to extend care in a culturally responsive manner is critical to leveling health inequities. Culturally responsive care is defined as "the ability of individuals and systems to respond respectfully and effectively to people of all cultures, in a manner that affirms the worth and preserves the dignity of individuals, families, and communities" (Leigh, 2017). The term "cultural competence" is also commonly used, but is less accurate because it suggests an endpoint. The health science accreditation language has not yet reflected the newer language of "cultural responsiveness" which more closely mirrors lifelong learning in the area of cultural awareness and practice.

As a healthcare profession, occupational therapy must play its part in reducing healthcare disparities by educating its practitioners and students in the important concept of cultural responsiveness. In order to serve a diverse community (American Occupational Therapy Association [AOTA], 2007), occupational therapy as a profession must prepare its workforce to improve "health, well-being, and quality of life for all people, populations, and communities" (AOTA, 2016). Graduate students of health science programs, particularly within occupational therapy, who have been exposed to culturally responsive curricula will be significantly more prepared in serving diverse communities as they embark on their profession. This is an important factor which will hold significant implications for the improvement of health outcomes by reducing currently existing health disparities within the U.S. healthcare system.

The authors' institution, a university in the U.S. which is committed to serving diverse communities, is positioned well to diversify the healthcare practitioner workforce. Statistics have shown that health providers of color tend to be committed to serve the communities from which they come (Walker, Moreno, & Grumbach, 2012). All of the authors of this study identify as people of color and wish to eliminate health disparities. The entry-level occupational therapy doctorate (OTD) program at this university required students to take an evidence-based Social and Cultural Concepts Module (SCCM) that utilized best practice to teach cultural responsiveness. Using a one- group pretest-posttest design, the authors attempted to answer the following research question: Is there an increase in OTD student knowledge of culturally responsive care following exposure to a module about cultural responsiveness?

LITERATURE REVIEW

Donoso Brown, Muñoz, and Powell (2011) conducted a survey of occupational therapy programs across the U.S. to gather and examine their multicultural training practices. A total of 78 programs responded for a response rate of 54 percent. The survey was structured into four main categories of multicultural knowledge, multicultural skills, teaching methods, and contextual supports. Results showed that the top four effective teaching methods were (1) case studies, (2) activities that emphasized exposure to diverse populations, (3) reflective journaling, and (4) interviewing someone from a different culture. Based on these findings, this literature review is focused on best practice and research showing the effectiveness of these four major themes, and they are discussed in detail for lessons learned regarding creating culturally responsive

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curricula in occupational therapy. These themes also informed the development of the SCCM.

Case Studies

The use of case studies is commonplace in health science curricula but there is limited research showing the use of case studies to teach cultural responsiveness. In a pilot study, Jackson (2011) assessed physical therapy students' perceptions on the effectiveness of a mixed-methods approach used to teach cultural competence. Teaching methods included reviewing case studies related to cultural issues, reflective journaling, patient interviews, and providing staff services on cultural competence during the internships serving diverse populations. Of the 18 physical therapy students who participated in the study questionnaire and phone interview, 100% reported that cultural competency trainings were a necessary and effective component to their physical therapy program. The data revealed that the most effective experiences of the trainings were clinical experiences, exposure to diverse patient populations, cultural self-awareness, and identification of stereotypes.

Exposure to Diverse Communities

Much of the literature regarding exposure to diverse communities was about participants travelling internationally outside of the U.S. Crowe, Sanchez, Weber, and Murtagh (2016) examined the influence of a cultural immersion experience on personal and professional healthcare practices among occupational therapists (n=8) and occupational therapy students (n=2). The immersion experience was a 10-day course in Oaxaca, Mexico where the participants were exposed to alternative and complementary medicine through interactive sessions with traditional healers. Openness was one of many themes that emerged from the immersion experience, which may guide occupational therapists to become better providers for their clients. Humbert, Burket, Deveney, and Kennedy (2011) investigated the perspectives of occupational therapy students who have engaged in cross-cultural learning and service experiences. Three main themes rose from this study: connectedness, cultural awareness, and complexity. These themes highlighted the idea of building rapport and relationships with people around them while experiencing a culture other than their own, identifying and understanding other cultures and responding to the differences of cultures appropriately, and viewing international learning experiences as dynamic and having many angles and different features. While in Guatemala, Lawson and Olson (2017) explored the perspectives of nine American occupational therapists working with limited resources impacted their current practice settings by allowing them to be creative and focus on building rapport despite any limitations. These studies suggest that the complexity and challenges of engaging in immersion experiences needs to be recognized to further explore ways curricula and faculty can best support culturally responsive care.

Reflective Journals

Research related to reflective journaling as a tool for teaching cultural responsiveness was prevalent. In a study by Govender et al. (2017), occupational therapy students used reflective journals to demonstrate cultural sensitivity and to understand culture as

specific to each person, intricate, forever-evolving, and diverse. However, after reflection, a significant number of occupational therapy senior students perceived themselves as generally culturally incompetent. Moreover, occupational therapy students reported having inadequate training in cultural competence and possessing limited exposure to others. To be culturally responsive, occupational therapy students need to continuously engage in self-reflection, redress power balance, commit to an authentic relationship, be open to other cultures, as well as learn their biases or preconceived notions.

Isaacson (2014) used both qualitative and quantitative research methods to assess if nursing students' quantitative evaluation of cultural competency was similar to their reflections of understanding a certain culture before and following a cultural immersion experience. Similar to Govender et al. (2017), Isaacson also demonstrated that reflective journaling played a critical role in understanding cultural competency. Both Isaacson (2014) and Taliaferro and Diesel (2016) used reflective journaling to show the level of cultural competence among nursing students considerably increased following an immersion experience. Additionally, through reflective journaling, nursing students had improved understanding of daily challenges experienced by Native Americans/American Indians.

More pertinent to culturally responsive curricula based in the U.S., Schuessler, Wilder, and Byrd (2012) examined the effectiveness of reflective journaling in nursing students' development of cultural humility in the U.S. rather than in another country. This qualitative study followed the students over a two-year period. While being immersed in a clinic primarily used by people living in low-income public housing, the students, mostly white females from suburban areas, were asked to write about their experiences with open-ended prompts from the researchers. Eleven themes emerged from the data collected: (a) practicing nursing skills, such as taking a manual blood pressure; (b) understanding the significance of culture in clients' lives; (c) valuing community nursing; (d) being cognizant of health disparities in the U. S. healthcare system; (e) planning and implementing health promotion education projects; (f) identifying trust as a critical aspect of community nursing; (g) reflecting on the impact of being supportive, encouraging, and nonjudgmental while assisting clients; (h) increasing confidence in themselves as nurses; (i) perceiving the significance of health promotion and disease prevention; (j) altering their views of people from different cultures; and (k) reflecting on their own practice. The study demonstrated that there was progressive growth in the students' critical thinking and cultural humility, and was one of the few studies in the literature review which included the racial identification of the participants.

Based on these studies, occupational therapy educators should place much emphasis on reflective journaling since it plays a critical factor in understanding if students are culturally competent. If students' reflective journals indicate the students do feel culturally incompetent, educators can devise a broad range of measures aimed at improving their cultural responsiveness. To be culturally responsive, occupational therapy students should continuously engage in self-reflection.

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Interviews

Interviews provide a window to another person's worldview (Mills et al., 2017). In a mixed methods study conducted by Caplan and Black (2013), nursing, occupational therapy, and athletic training students (n=109) were required to research and conduct a cultural competency interview with someone from a different cultural context than their own to determine key themes that arose from the experience and how they affected attitudes, knowledge, and self-awareness. The study showed that the nursing and athletic training students were better at responding to objective questions in comparison to the occupational therapy students, who were better able to respond to self-reflective and open-ended questions. Open-ended questions may be helpful to occupational therapy students for reflective assignments.

Employing people of color as standardized patients in simulation experiences, Ndiwane et al. (2017) aimed to improve cultural humility in the health assessment process for nurse practitioner students by using interviewing as the primary method to reach their goal. This study integrated the Objective Structured Clinical Examination (OSCE) to assess prior knowledge of the participants and analyze their experience. The study included nurse practitioner students in adult gerontological advanced health assessment department where 64% of students indicated that they had no prior courses or program in cultural humility. Utilizing the OSCE, the participants completed a pretest, viewed a reference video depicting a cultural assessment interview with an African American patient, and participated in a simulation interview with standardized patients, all of whom were African American. Debriefing suggested statistically significant increase in knowledge of patient care and challenges. This study also uncovered clinical strengths and weaknesses of interpersonal behaviors including interviewing and assessment skills, problem solving, patient teaching, and synthesis of clinical knowledge.

Several limitations were noted among the studies reviewed in all four areas. Several studies had a small sample size, indicating a potentially unreliable representation of larger populations. Due to the lack of previous research evaluating the effectiveness of cultural competency training practices among educational healthcare settings, most of the studies analyzed for this review were categorized as Level IV evidence (Howick et al., 2011). Due to the qualitative nature of the content upon gathering and assessing information from student or educator's perspectives regarding cultural competency, study results could not be compared across a cohesive instrument for measurable outcomes. Additionally, several studies lacked representation from several racial minority groups which may have biased the results. Despite such limitations, all the analyzed studies concluded that cultural competency training and practices were perceived as an effective and necessary component within healthcare educational programs. Moreover, the four educational methods discussed in detail could be low cost, low tech, and easily incorporated into existing curricula. The SCCM which served as the context for this study used all four methods.

METHODS

Study Design

This study used a one-group pretest-posttest design to examine the cultural responsiveness of students in an entry-level OTD program in the U.S. The purpose of the study was to evaluate if there was an increase in student knowledge of culturally responsive care following exposure to the SCCM. The Institutional Review Board at the university approved this research.

Participants

The participants were a convenience sample taken from 42 students in their first year of the OTD program who were enrolled in OT 701 Integrative Seminar in Occupational Therapy Practice (the course which contained the SCCM). Participation in the study was anonymous and voluntary, and there was no grade attached to either of the surveys.

Instrument

The Interprofessional Education Health Disparities Series Survey (IPE-HDSS) was used to assess cultural awareness and responsiveness. This tool was developed by an assistant professor (Hammer, 2014) in the School of Nursing at the university, who facilitated its use. The instrument was initially used at the university's Interprofessional Health Disparities Series pilot program in which the principal author was core in developing the curriculum along with her health science faculty colleagues. Pre- and post-tests consisted of the same 30 questions and utilized a Likert-type five-point-scale of "strongly disagree" to "strongly agree" with an option for "neither agree nor disagree".

Additionally, the principal author designed a student demographic form to collect participants' age, sex/gender, race/ethnicity, primary/language spoken in their home, and the state in which the participant planned to practice after graduation.

Procedures and Description of the Module

Prior to the SCCM, the students completed the Physician's Practical Guide to Culturally Competent Care (U.S. Department of Health and Human Services, 2013), an online course to explore and familiarize themselves with culturally responsive care. Students were required to submit a certificate of completion to their instructors. The SCCM consisted of a 3-week module, taken consecutively, that was comprised of three, 3-hour classes, for a total of 9 hours. The SCCM was a combination of lecture, group discussions, individual reflections, community building activities, and simulated case scenarios. The common themes that were addressed included: self-awareness, reduction of health disparities and effectiveness of the culturally responsive curriculum. The SCCM curriculum is described in Table 1.

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Table 1

Social and Cultural Concepts Module Curriculum

Category	Session 1	Session 2	Session 3
Objectives	1. Describe the major social determinants of health and the causes of health disparities. 2. Gain self-awareness of how your worldview affects your delivery of healthcare.	1. Describe how an interprofessional and occupation-based approach to health care contributes to improved health outcomes for populations and individuals.	1. Develop at least one interprofessional and occupation-based approach to reduce health disparities that would likely improve patient and population health.
Assignments (due before session)	Office of Minority Health module certificate (discipline-based); pre-survey	Non-graded quiz on definitions of stereotypes, generalizations, and health disparities	Post-survey done after Session 3 but before the 8th week of the course
Content	• Ground rules and active listening Activity (community building, self-awareness) • Culture definition (lecture) • Implicit bias (lecture & activity) • Silent Beats, (Chu, 2001; video) & guided questions (process)	• First memory of difference activity (self-awareness, process, community building) • Beads-Concept of Privilege activity (Sgoutas, n.d.) • Process being in dominant and non-dominant groups	• Worlds Apart, (Grainger-Monsen & Haslett, 2004; video) & guided questions (process) • Case study of how to advocate for vulnerable people and populations • Closure (trust, community building)
Format	Dyads, small & large group discussions, individual reflection, process activities, community building activities, lecture bursts (short content lectures throughout session, ranging from 5-15 minutes at most), simulated case scenarios		

At the start of the first SCCM session, the students who agreed to participate in the study completed the demographic form and pre-test of their self-report of knowledge of cultural competence. The principal investigator asked students to use a self-chosen, three-digit identifier on both documents, and secondary investigators signed a confidentiality document which stated that they would not reveal the students' identifiers to anyone.

The first session was conducted with the entire class of 42 students. The difference between generalizations and stereotypes, implicit bias, concept of privilege, and dominant and non-dominant groups were explored in relationship to health disparities (Shea, 2017). The second class was conducted in 3 separate sections of 14 students each. Students were asked to discuss if they had any early memories of feeling different or experiences of prejudice. The discussion entailed identifying and articulating personal, social, and cultural beliefs and biases in a small group setting. The third and final class of the module was also conducted in 3 separate sections of 14 students each, and they utilized case studies of racially diverse clients with the intent to foster personal strategies in culturally responsive care for serving individuals and populations. After the third class, participants were instructed to voluntarily complete the post-survey and return it to the principal investigator.

Data Analysis

Data analysis was completed on the pre- and post-test scores obtained from the IPE-HDSS. The IBM SPSS Statistics for Windows, Version 24.0 was used to analyze the quantitative data. The exact sign test was performed on all 30 survey questions to determine consistent differences between pairs of observations such as cultural responsiveness levels before and after the SCCM. Portney and Watkins (2015) state the sign test is an instrument used to test relative differentiations. The pre-post responses of strongly disagree, disagree, neither agree nor disagree, agree, strongly agree were compared.

RESULTS

Thirty-nine students agreed to participate in the study and completed the demographic form. All of them were 22 years of age or older. Four subjects identified as male while the remaining subjects identified as female. Four major race/ethnicities surfaced, and the majority of the subjects primarily spoke English in their homes and wished to practice in California upon graduation. Demographics are listed in Table 2.

Table 2

Participant Demographics

Demographics	**Students (n=39)**
Age	**n**
Under 25	15
25-35	18
36-45	5
46 and above	1

DOI: 10.26681/jote.2019.030304

Sex/Gender	
Female	35
Male	4
Unspecified	0
Other	0
Race/Ethnicity	
American Indian or Alaska Native	0
Asian	10
Native Hawaiian or other Pacific Islander	0
White	13
Hispanic/ Latino* or Black/ African American	7
Other	9
Primary language spoken at home	
English	36
Spanish	2
Other	1
State in which the student planned to practice after graduation	
California	36
Other	2
N/A	1

*Hispanic/Latino or Black/African American were listed together for the sole purpose of aggregating data to ensure privacy of respondent answers. Demographic questions were designed by E. Ching (Unpublished instrument).

Thirty-nine participants completed the IPE-HDSS. Out of those 39 students, 35 surveys were deemed usable for the study (n=35).

This quantitative, inferential study analyzed discrete ordinal, non-parametric data. The reliability of both the pre-survey and post-survey was excellent with reliability coefficients of .83 and .93, respectively. Since the pre- and post-test data were not

symmetrically distributed, an exact sign test was used to compare the differences in students' knowledge over the two time periods, instead of the Wilcoxon's sign test. It must be noted that there was a risk of Type I error (Portney & Watkins, 2015) given the lengthy number of items (30) and the number of tests to which the data was subjected.

Of the 30 items measured, 22 items showed a significant positive difference from the pre-test to the post-test scores, indicating that knowledge of the majority of the items improved over time (Figure 1).

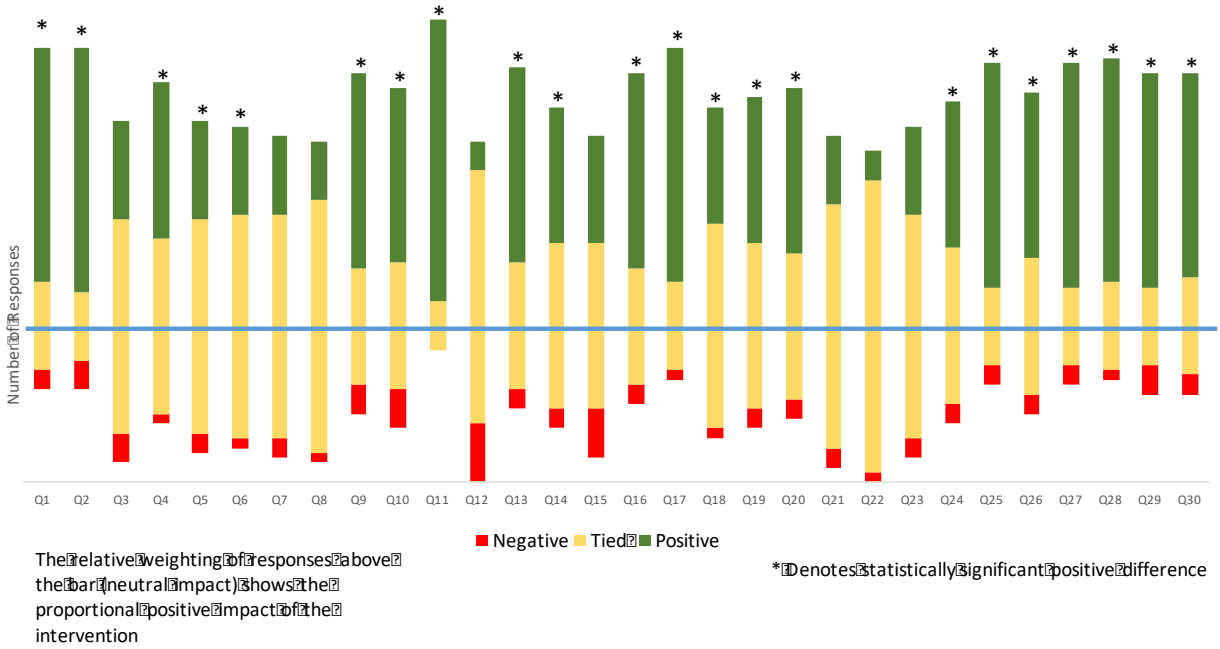

Figure 1. Distribution of survey scores—negative, neutral & positive. The relative weighting of responses above the bar (neutral impact) shows the proportional positive impact of the intervention. Statistical data to make this graphic were provided by N. Dasgupta (2018).

The median of the differences between the two scores for each of the 22 items showed a statistically significant increase, $p < 0.05$. Eight of the 30 items measured did not show a statistically significant increase over the two time periods (Table 3).

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Table 3

Interprofessional Education Health Disparities Series Survey (IPE-HDSS)

Question	Pre-Test Median	Post-Test Median	Significance
Q1: I am confident in my ability to use language access services effectively within a health care setting.	3	4	<.001*
Q2: I have knowledge of skills involved in working with language access services.	3	4	<.001*
Q3: Cultural awareness impacts the provision of health care.	5	5	.092
Q4: I am familiar with research on inequities in health care.	4	4	<.001*
Q5: The following patient factors impact the quality of health care: Gender.	4	5	.039*
Q6: The following patient factors impact the quality of health care: Race or Ethnicity.	5	5	.021*
Q7: The following patient factors impact the quality of health care: Sexual Orientation.	5	5	.109
Q8: The following patient factors impact the quality of health care: English speaking vs. non-English speaking.	5	5	.125
Q9: I am familiar with cultural issues related to health and illness.	4	4	<.001*
Q10: I am knowledgeable about cultural groups with whom I have worked in the clinical setting.	3	4	.004*
Q11: I have participated in a program where I learned about reducing disparities in health care.	3	4	<.001*
Q12: I am interested in learning more about reducing disparities in health care.	5	5	.508
Q13: I am familiar with the Kleinman questions.	2	3	<.001*

Q14: I am familiar with LEARN.	3	4	.004*
Q15: I am familiar with CLAS (Culturally & Linguistically Appropriate Services) standards.	4	4	.210
Q16: I am familiar with IOM report: Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care.	2	3	<.001*
Q17: I am familiar with USDHHS Office of Minority Health (OMH) Cultural Competence Training.	2	3	<.001*
Q18: My professional program at University effectively addresses cultural issues affecting health care.	4	5	.003*
Q19: My professional program at University effectively addresses professional role development related to cultural issues impacting health care.	4	5	.002*
Q20: My professional program at University developed my skills to treat all patients equally.	4	5	.001*
Q21: One aspect of my professional role is being an agent of change to reduce disparities in health care.	5	5	.180
Q22: As a health professional, I plan to be an agent of change to reduce disparities in health care.	5	5	.625
Q23: Non-verbal communication affects/impacts the provision of health care.	5	5	.065
Q24: I am aware of my styles of non-verbal communication.	4	4	.002*
Q25: I am capable of assessing a client's risk for limited health literacy.	3	4	<.001*
Q26: I am capable of developing health education materials for various literacy levels.	3	4	.001*
Q27: I am aware of one or more health literacy tools & how they are used.	3	4	<.001*
Q28: I am knowledgeable regarding the unique values, roles/ responsibilities, & expertise of my & other health professions.	3	4	<.001*

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Q29: I am confident in my ability to express my knowledge & opinion to team members with confidence, clarity & respect, working to ensure common understanding of information & treatment/care decisions.	3.5	4	<.001*
Q30: I am confident in my ability to engage diverse healthcare professionals & associated resources to develop strategies to meet specific patient care needs.	4	4	<.001*

Note: Significant findings include a gray highlight and an asterisk ($p<0.05$). Questions in column 1 are from the Interprofessional Education Health Disparities Series Survey (IPE-HDSS) by M. Hammer (Unpublished instrument). Printed with permission from M. Hammer.

DISCUSSION

The findings of this study show that the implementation of the SCCM improved student self-perception of cultural responsiveness. Comparison of the pre- and posttest scores indicated that students who completed the module demonstrated an overall improvement in self-perception of cultural responsiveness and perceived comprehension of the impacts of being culturally aware. Students showed improvement in all but eight items on the 30-item survey. Most notable were the results showing significant positive differences in items addressing the effectiveness of the current curriculum at the university, self-perception of culturally responsive skills, and best practices in culturally responsive care. Students perceived that the curriculum was effective as it related to cultural issues affecting healthcare and the role of the health care professional. Students reported increased self-perception of culturally responsive skills as evidenced by 6 of 7 items on the surveys showing significant, positive change.

Six items addressed familiarity with best practices for culturally responsive care. These included knowledge of a variety of culturally responsive assessments, reports, and frameworks: Kleinman et al.'s eight questions for cultural assessment (Kleinman, Eisenberg, & Good, 1978), the LEARN (Listen, Explain, Acknowledge, Recommend, Negotiate) communication framework (Berlin & Fowkes, 1983), the CLAS (Culturally & Linguistically Appropriate Services) standards (U.S. Department of Health and Human Services, Office of Minority Health, 2013), the IOM report on unequal treatment in healthcare and the cultural competence training developed by U.S. Department of Health and Human Services Office of Minority Health (Smedley, Stith, & Nelson, 2003). These findings suggest that use of an educational module such as the SCCM is effective in helping students identify resources to provide culturally responsive health care services.

In previous studies, it has been noted that longer exposure to culturally responsive education may result in significant negative changes in pre- and post-test survey results (Jackson, 2011). This phenomenon has been attributed to the growing awareness of

one's ignorance. Participants may understand that there are aspects of culturally responsive healthcare of which they not cognizant, however, there are also aspects they do not realize they are not yet aware of. As one gains increased education and experience, one may realize how much one does not know and may lower one's ratings for self-perceived knowledge of cultural responsiveness (Govender et al., 2017). In this study, three weeks of education was enough to result in significant changes in the students' perceptions.

All eight items with no significant change were rated "strongly agree," with the exception of Q15 which was rated at "agree." This suggests that participants at the start of the study felt cultural awareness impacts the quality of healthcare, their role as health professionals are to reduce disparity in the provision of care, and a general interest in learning more about how to do so. This study contributes to the growing body of evidence provided by cultural responsiveness pre- and post-test findings and with the increasing knowledge of the impact of cultural awareness on future practice.

Classroom instruction on cultural responsiveness may serve to promote increased cultural awareness for providing culturally sensitive care. A variation of classroom instructional methods such as teaching along with interactive and self-reflective activities provides a wider learning opportunity to gain culturally responsive knowledge (Donoso Brown, Muñoz, & Powell, 2011). The current study incorporated lecture and handouts on the difference between generalizations and stereotypes, implicit bias, the concept of privilege, and the exploration of dominant and non-dominant groups in relation to health disparities. Smaller group discussions on early memories of difference were done for students to identify and articulate existing personal social and cultural beliefs and biases in a small group setting. Case studies of racially diverse clients were used with the intent to utilize personal strategies to foster culturally responsive care in serving individuals and populations. Similarly, the study by Grady, Brungardt, and Doll (2018) utilized a combination of lecture, discussion, case-based instruction, and role-playing simulation to teach cultural awareness and sensitivity through a one-day module. Combining a mixture of learning methods provides students the opportunity to gain knowledge in extended topics related to cultural awareness and sensitivity that can carry over to practice when working with clients from diverse cultural backgrounds.

Limitations

This study used a convenience sample of first-year OTD students enrolled in a practice seminar in a culturally diverse and progressive area of the U.S. which may not be wholly representative of other occupational therapy programs in the country. One limitation of this study was that, despite being in a culturally diverse area, most of the participants in the study were between 25 and 35 years of age, white, and female. This population is consistent with the current trend in the profession as the U.S. Department of Labor (2018) reported that in 2017, 87.6% of occupational therapists were women and 82.9% were white.

Another limitation of this study was related to the test itself. The language used in some the questions of the IPE-HDSS and the similarity of the questions to statements may

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have prompted participants in the study to respond more favorably due to the leading language in the questions.

Additionally, the self-assessment did not account for non-native English-speaking participants' level of comprehension. For a future investigation into student knowledge regarding culturally responsive care it would be beneficial to use questions that have less emotive language, i.e., "Does the professional program that I am in at the university help develop skills to treat all patients equally?", instead of, "My professional program at the university developed my skills to treat all patients equally." Constructing questions in this way may lead to higher self-assessment scores in student knowledge about culturally responsive care.

IMPLICATIONS FOR OCCUPATIONAL THERAPY EDUCATION

In order to provide efficient multicultural practice, students should be provided with a culturally responsive curriculum to gain the knowledge and skills required for working with culturally diverse clients. Cultural training and experiences within the curriculum may be a significant factor for developing cultural awareness and competency. Therefore, it is fundamental that occupational therapy programs implement modules dedicated to cultural topics as this holds strong implications for addressing and ameliorating current health disparities. The correlation of culturally responsive student preparedness in the provision of quality care among diverse patient populations should be regarded with more urgency when considering the professions' impact on the short- and long-term trajectory of healthcare equity within the U.S. This is of exceptional significance as recent trends show that in most areas, health disparities continue to remain the same or have worsened over time (Agency for Healthcare Research and Quality, 2016).

According to the AOTA's (2013) Societal Statement on Health Disparities, "Occupational therapy practitioners have the responsibility to intervene with individuals and communities to limit the effects of inequities that result in health disparities." The authors of this study propose that in order to carry out this act, a practitioner must not only recognize health disparities when they emerge but must also be invested towards addressing them. Culturally responsive curricula may serve as an essential measure for equipping practitioners with the discernment, sensitivity, and skills for effectively confronting such disparities and inequities should and when they arise. Also noted among factors for decreasing health inequities highlights how diversity among practitioners can improve health outcomes for people of color (Walker, Moreno, & Grumbach, 2012). This factor parallels the important role of mentoring more youth of color into the occupational therapy profession for the attainment of knowledge and equal opportunities to become members of a field that currently lacks cultural diversity among student bodies and workforces (Skowronski, 2017). While the AOTA's (2016) 2025 vision of Diversity and Inclusion seeks to lessen health disparities and diversify the profession, plans of transitioning to entry doctoral-level by this time may have adverse effects on these very goals. Statistics show that disparities in higher educational attainment continue to rise between whites and other racial and ethnic groups, becoming more pronounced at the postsecondary level (Office of Planning, Evaluation

and Policy Development Office of the Under-Secretary U.S. Department of Education, 2016). If current trends continue, the transition to entry-level doctoral programming may create exclusionary measures that will negatively impact educational access for students of color, thereby, sustaining or worsening diversification of the field, including disparities in health and healthcare. This would suggest that focusing efforts and resources into developing and preparing culturally responsive occupational therapists through quality, sound curricula would, therefore, be of the utmost importance when considering the overall, prominent lack of diversity among the student body and workforce populations as indicated by current trends (Data USA, 2018).

Recommendations for Future Research

Further research on the educational development of a culturally responsive curriculum within occupational therapy programming is recommended based on current literature and the findings of this study. The results of this study indicate that cultural sensitivity is impacted through classroom curricula for students in an entry-level OTD program. The inclusion of a variety of occupational therapy programs should be explored to determine whether these findings are generalizable across the U.S. Future research with the inclusion of a wider demographic of students is needed. Longitudinal studies should also be explored to examine the effectiveness of culturally responsive curriculum over time.

CONCLUSION

This study answers the call to address the gap in literature regarding cultural responsiveness in occupational therapy education, practice, and research. All the authors identify as people of color who wish to reduce health disparities which disproportionately affect communities of color. The authors hope to have made the case for culturally responsive curricula in occupational therapy education at every degree level. Culturally responsive education in occupational therapy will contribute to culturally responsive occupational therapists and occupational therapy assistants striving toward the goal of health equity for all.

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