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Ethics, Cultural Humility, and Client-Centered Care in Occupational Therapy

Introduction

The idea of cultural competence has recently taken a backseat to cultural humility. Cultural humility is an ongoing, reflective process of treating others with respect by identifying and addressing one's own biases as well as power imbalances that can impact relationships. Cultural humility is becoming the norm because it is not something that can be gained from simply acquiring knowledge about specific cultures. This concept requires a greater commitment from providers, especially those dedicated to providing person-centered care. According to the Occupational Therapy Practice Framework, culture is one of several client factors that contribute to a person's identity as well as their occupational performance. Therefore, occupational therapy services cannot be effective or tailored to the person unless a provider administers them using cultural humility.

Section 1: Defining Cultural Humility

References: 1-6

One of the best ways to differentiate between cultural competence and cultural humility is by understanding their relationship to one another. Cultural competence (sometimes termed cultural awareness) is an older and much more broad concept. There are various definitions of cultural competence, but the most widely accepted of those includes attitudes, behaviors, and policies that allow individuals and systems to effectively navigate a range of cross-cultural contexts. As you can see, this definition encompasses someone's knowledge and awareness of other cultures as well as the establishment of culturally sensitive procedures and best practices. Cultural competence was also designed to be applicable to many situations, which tends to make it less effective for more personalized fields such as healthcare. Upon reading its definition, it's also clear that cultural

competence does not necessarily guide someone in implementing the behaviors and systems it outlines. This is one of its most glaring limitations for the healthcare professions.

For some time, medical providers were required to take courses on cultural competence, either for their licensure or due to employer mandates. However, taking these courses did not necessarily mean providers took it one step further to deepen their knowledge or provide services any differently. This is yet another major limitation of cultural competency. These requirements were considered best practice in the 1990s and early 2000s because they helped providers better *understand* other cultures, which was deemed sufficient at the time. However, the landscape of healthcare and society is changing rapidly, making it more crucial for providers to offer culturally appropriate and quality care to diverse populations rather than simply being 'effective' in their interactions.

This has led to the rise of cultural humility – a more nuanced and advanced skill that incorporates cultural understanding with a dynamic set of interactions that build respect and tolerance between individuals of various backgrounds. Cultural humility is defined as the continual process of acting respectfully toward others. This can only be done by looking inward toward one's biases and on a larger scale toward power imbalances and systemic barriers that affect individuals of various cultural backgrounds. This concept is especially important for occupational therapists and other healthcare providers because respect is a foundational part of the treatment process. If therapists don't treat their patients with respect – both in a general sense and related to cultural, race, ethnicity, religion, and other demographic features – this can majorly impact the therapeutic relationship.

The absence of cultural humility has a ripple effect that leads to lower levels of participation along with poorer health outcomes such as limited benefits from treatment and inaccurate or incomplete diagnoses. When healthcare workers

demonstrate a lack of cultural humility, this can also contribute to feelings of distrust that many individuals (especially those from disadvantaged groups) have toward healthcare professionals. On a larger scale, a lack of cultural humility can lead to unsettling trends such as poorer quality care for certain cultural groups. A lack of culturally-informed care can also reinforce the health behaviors of many disadvantaged groups, who are already at risk of trends such as under-utilization, over-utilization, and general misuse of health services. These health trends magnify existing health disparities while potentially even contributing to the development of new disparities and gaps in care. In summary, failing to utilize cultural humility adds to the growth of systemic issues within the healthcare field and detracts from the positive impact health professions have a distinct duty to make.

Research has shown many similarities between the negative outcomes resulting from cultural incompetence and those stemming from poor cultural humility. However, the positive outcomes associated with cultural humility exceed those linked to cultural competence because of how much more advanced the skill is. Slightly dated research shows that cultural humility is associated with enhanced communication between providers and patients, the provision of more personalized care, and improved patient engagement. Schiavo (2023) and Prince et al. (2021) state that cultural humility encourages better adherence to provider recommendations, a greater sense of belonging from patients, and fewer inequities. These benefits were seen in public health as well as clinical settings. These same researchers found that cultural humility increased trust between providers and patients, leading to an overall stronger patient-provider relationship. Benefits also extend to the therapists, as cultural humility is known to promote lifelong learning and encourage greater growth to individuals.

A patient's culture is very close to their identity, therefore it branches out to many aspects of the treatment process. This includes the ways providers and patients

communicate; the norms, routines, and roles a patient holds (in terms of gender, behavior, and society); a patient's values; and the way a patient expresses discomfort, pain, and other forms of distress. In addition, culture influences a wide range of someone's views on life, which are closely related to therapy, including family, personal responsibilities, parenting, caregiving, group dynamics, change, motivation, and disability. Patients may also come to therapy with many of their own assumptions about therapy such as the way therapists are 'meant' to behave, the meaning of touch, personal disclosure, the exchange of gifts, greetings both formally and informally, and more. In order to honor a patient's views and beliefs while also taking any assumptions they hold into consideration, therapists must be well-versed in cultural humility. In order to properly use cultural humility in practice, therapists must know certain principles and skills that allow them to practice in a culturally appropriate manner.

In the next section, we will review literature on the topic of cultural humility, which will discuss benefits, skills, and outcomes associated with this concept in greater depth. We will also detail the ways cultural humility intersects with ethical and client-centered care in the field of occupational therapy.

Section 1 Personal Reflection

Would a therapist choosing to use cultural competence in the workplace be making an ethically inappropriate decision? Why or why not?

Section 2: Foundations of Cultural Humility in Practice

References: 7

Before making the choice to use cultural humility, it is important to understand what skills it comprises as well as what evidence there is to support the concept

as a whole. This not only allows therapists to appropriately utilize cultural humility, but to fully integrate it into existing ethical and client-centered practices at the core of occupational therapy.

The following are the main skills required to thoroughly utilize cultural humility in occupational therapy practice:

- Empathy
- Compassion
- Adaptability
- Awareness of environmental factors and the influence they have on power imbalances and biases
- Acceptance and tolerance
- Respect for others, including their background, their autonomy, and any other rights they have (as a patient and a human)
- Humility that applies to any situation, whether immediately relevant to cultural awareness or not
- Two-pronged accountability, including your personal actions as well as those of any institution you are affiliated with (this applies whether you are part of leadership or not)
- An open mind
- The ability to admit when you are wrong or don't know something
- A commitment to lifelong learning
- The ability to adopt a worldly perspective that is ever-evolving

- Asking questions when you don't fully understand someone's views or background

Just as with occupational therapy frameworks and models, cultural humility comes along with various principles that guide its theoretical and practical use. These include:

1. Consistently making time for self-evaluation and self-reflection.
    - **How to do this:** While most of these tenets should be practiced on an ongoing basis, this tenet should come first each time because this is the main way in which therapists practice cultural humility. Therapists can practice self-evaluation and self-reflection by taking a critical look at their own actions and beliefs associated with them, then relating this to the care they provide. Providers should not plan to do this at major or pivotal moments in the treatment plan or their career, rather this should be an ongoing and even natural process that is present even within the smallest moments.
2. Avoiding stereotypes and assumptions about culture and adjacent areas of a person's identity, including religion, ethnic background, behavior, and abilities.
    - **How to do this:** Therapists can uphold this tenet by asking questions to gain information about each and every one of their patients. This is essential because even clients of the same culture are likely to have variations in their experiences, language, and practices. These can stem from the region their family is from, the number of generations they have in this country, the specific traditions they were raised with, and more.

3. Identifying power imbalances that exist within rehabilitation and other healthcare settings. Regardless of how an organization and/or provider presents themselves, these imbalances will always innately exist because one party is presenting to the other with a distinct set of needs that can make them vulnerable. Therapy verbiage sometimes even reflects this as a weakness by referring to potential goal areas as “deficits” or “challenges.

    - **How to do this:** In order to follow this tenet, therapists should always act in a way that simultaneously empowers and motivates their patients. The best way to do this is by educating patients that the collaborative nature of the therapy process is essential to positive outcomes. Building rapport is key in this process, but should not be limited to the first session. Rapport helps build trust and should be fostered throughout the plan of care.

4. Taking advantage of learning opportunities at every point in your life and professional career.

    - **How to do this:** It is important to make this distinction because these two areas of a therapist’s growth may be on completely different trajectories. Therapists can put this into practice – and honor both of these areas – by accepting they will never have all of the answers and refraining from acting as if they do. It is important for a healthcare provider to be able to say, “I don’t know,” and follow that response with steps that allow them to learn. In this process, therapists must be comfortable relying on colleagues, patients, leaders, and the greater community to help them grow as a person and therapist.

5. Focusing on the partnership that is the patient-provider relationship.

- **How to do this:** While personal sharing and your accounts of certain life experiences can make patients feel more comfortable, there is a time and a place for that. Ensure this type of sharing never comes before active listening by allowing your patients to speak and asking for more information when needed. For example, when presenting the therapy plan of care to your patient, ask them first about their views on therapy and medical care in general as well as what could be included in the plan that better honors their culture. Remember that patients are people just like we are, meaning they also have assumptions that can impact the therapy process. While it's not necessarily our role to change those assumptions, it's important to understand them to more meaningfully collaborate and work toward effective solutions.

6. Asking thought-provoking questions that allow for further discussion.

    - **How to do this:** When therapists find it is appropriate and they are able to, asking patients open-ended questions can shed valuable light on their lived experience. Some examples of questions that can assist with a therapist's use of cultural humility include:

        - What is your primary language?
        - What does your culture mean to you?
        - What impact does your culture have on your identity?
        - What is considered rude in your culture?
        - What greetings or other traditions are common in your culture?
        - What practices or aspects of your culture might surprise people because of how different they are?

- What do you believe to be true about your condition, injury, or illness?
- Do you believe your condition, injury, or illness can improve?
- How do you view illness or disability?
- How do you learn best? What do you need available to learn best?
- What people do you have to help with treatment or care on a regular basis?

The answers to these questions are important to know for the therapeutic partnership and the working relationship of the patient and provider. But this information also helps therapists understand why someone may function in a certain way that may or may not warrant OT intervention. However, some patients may not have the ability (cognitive or otherwise) to answer questions such as those that pertain to what they need to learn. The therapist must use alternative methods to obtain the answers to those questions. There are various health literacy tools to help with that, which we will discuss in a later section.

In addition, therapists should take body language into consideration. Non-verbal communication varies from culture to culture and can provide just as much information as verbal communication does.

7. Acknowledging the views of others and respecting a patient's expertise related to themselves.

- **How to do this:** This principle relates closely to others that discuss power imbalances and focus on the therapeutic relationship, which involve honoring and uplifting the patient. Therapists must find a healthy middle ground between factoring in a patient's knowledge of themselves

(along with their bodies, minds, and lives) and our own expertise in the medical field. Patient education is a large component of what we do as therapists, but it should not take precedence over a patient's feelings on this topic. Education should also not be generalized, boilerplate content that applies to all patients, all patients with a certain diagnosis, etc., as this does not take culture into account.

8. Forming partnerships with others around you.

    - **How to do this:** Relationships are key to properly utilizing cultural humility. We mentioned earlier the importance of prioritizing the patient-provider relationship as well as leaning on others to help you learn new skills. Forming partnerships with others (not just patients) can help you learn what you need to grow as a provider. This tenet allows therapists to add more 'tools to their toolbox' in a variety of ways – connections with people, online and text resources, therapeutic programming, and more. Each of these partnerships expands a therapist's skillset, which deepens the efficacy of their practice.

To expand upon the thought-provoking questions mentioned above and ensure providers obtain relevant cultural information, therapists can also ask questions about strengths and supports as they pertain to their culture. While most of the answers to these questions can offer valuable information on a patient's background, it is up to a therapist's judgment how they bring them up. For example, some of the more general questions may be integrated into intake forms or other pieces of documentation. Other subject matter (such as those related to immigration) may be more sensitive for patients, so it may be better for therapists to bring them up once they have built some rapport with the patient or when the timing is right.

Regardless of how they are mentioned, some of the following questions can offer valuable information on a patient's background:

- What personal ties do you have with your country of origin?
- How did you participate in your culture before coming to this country? How do you participate in your culture now?
- How long have you been in this country?
- Did you have any major setbacks or difficulties during the immigration process? What about as you were getting used to life in a new country?
- Did you experience any changes in social status, financial standing, or other parts of your life by coming to a new country?
- How many generations of your family have lived in this country?
- Have you returned to your country of origin since you initially came to this country?
- Do you speak more than one language? If so, which one are you the most comfortable communicating in?
- How comfortable are you with speaking, writing, and being spoken to in English?
- What views do you have on drug and alcohol use, and how do these views differ from the views of most other people in your culture? (This may be more fitting if asked in a mental health or substance use disorder treatment setting.)
- What pieces of generational wisdom have been passed down to you from those in your family?

- What role did extended family play in your upbringing and what role do they currently play in your life?
- What activities or strategies have you used to cope with difficult times in your life? Are these specific to your culture or things you have personally turned to?
- What type of support did you receive from your community? What role did you play within that community?
- Have you ever experienced oppression, racism, or prejudice? If so, how did you persevere through those times?
- Do you experience any barriers to engaging in your cultural practices or maintaining a strong sense of heritage?
- What role has spirituality or religion played in your life – both practices and beliefs?

Section 2 Personal Reflection

How can therapists incorporate some of these discussions while not interrupting the flow of a treatment session?

Section 2 Key Words

Accountability - The personal acceptance of one's own behaviors, including their decisions, actions, and the consequences associated with each; people who are accountable for both good and bad outcomes are better able to build trust with others and grow from what they have done

Assumption - The act of taking information at face value and maintaining the belief it is true without seeing any evidence

Bias - When someone is unfairly slanted either for or against something; biases can be unconscious or conscious and can apply to objects, people, and ideas; all biases stand to impact someone's decision-making abilities and can have a major ripple effect in society

Power imbalance - An unequal allocation of influence between two people or two groups of people; similar to biases, power imbalances can impact decision-making and extend throughout various systems

Self-evaluation - The structured process of assessing one's performance, skills, and other metrics; self-evaluation utilizes formal or informal tests or involves a comparison between these areas and a certain set of criteria

Self-reflection - An internalized look at the intrinsic factors that relate to someone's performance, such as their background, thoughts, experiences, and beliefs; self-reflection is a deeper process than self-evaluation, though it tends to be more informal due to its lack of a defined structure

Stereotype - Fixed beliefs about people, objects, or ideas that tend to be widely accepted and deprive someone of individuality

Section 3: Literature on Culture Humility and Occupational Therapy Practice

References: 8-26

The Occupational Therapy Code of Ethics is perhaps one of the most closely related pieces of literature that intersects with the concept of cultural humility. This applies to nearly all principles, though some relate more clearly than others.

Cultural Humility & OT Code of Ethics

Cultural humility emphasizes a patient's autonomy by removing power imbalances and more clearly delineating a patient's rights. This act also encourages their self-determination, which is another aspect of this principle that acknowledges their ability to hold their own values, views, and decision-making skills. Justice aligns with cultural humility in one of the most obvious ways due to its focus on the inclusion of patients regardless of any attributes such as religion, race, socioeconomic status, and more. Since cultural humility contributes to positive health outcomes and attempts to eliminate large-scale disparities and health inequities, these two ideas work closely together.

Providers are only able to do good if they have a complete understanding of a patient's needs and lives, which brings us to beneficence. Therapists who actively put cultural humility into practice are able to provide better care than those who do not. (We will review more literature in this section that specifies just how that care is better.) Those who fall into the latter category cannot truly say that they have done all they can to be well-intentioned in their care efforts. Non-maleficence states that therapists must act in a way that prevents their patients from experiencing any harm. Therapists who fail to take their patients' cultural needs into account place these individuals at risk of receiving inappropriate care as well as experiencing a host of negative consequences associated with that care. Providers may make medical errors and overlook pivotal aspects of care if they hold firm to biases, stereotypes, and assumptions. This can result in negligence or, in some cases, direct and intentional harm to patients.

This is not to say that other principles and aspects of the OT Code of Ethics do not pertain to cultural humility. However, these are just a few examples that outline just how closely related the two are. This is a clear demonstration of just how

essential cultural humility is to the proper provision of occupational therapy services across the spectrum of care.

Research Applications for Cultural Humility in OT

There is a range of other literature on the use of cultural humility in various areas of healthcare. This literature not only expounds upon some of the specific aspects of cultural humility, but also discusses the outcomes associated with the use of cultural humility in rehabilitation fields.

Singh et al. (2022) conducted a scoping review protocol that looked at the specifics of applying cultural humility within OT practice. This review involved using the Integrated Knowledge Translation approach, which involves engaging all users with any knowledge on the topic in the research and practical use of cultural humility. They also found the social constructionism paradigm to be critical, as this allowed for ongoing reflection as well as an intersectional lens. Consultations with recommendations were considered to be the most important outcome from this study, which tells OTs just how essential others are to the process of cultural humility. This shows there are several theoretical foundations that support cultural humility and further justifies its use in our field.

A study from Stubbe (2020) assessed gaps in culturally appropriate care within the psychiatry field, which has applications to mental health occupational therapists as well as OTs working in other settings. The five most prominent gaps were seen between cultural values, patient preferences as to their provider that stemmed from cultural differences, perceptual bias/racism in treatment settings, communication barriers, and cultural differences between patient and provider regarding how they explained illness, health, and treatment models. The last of these gaps emphasizes the strong intersection between cultural humility and health literacy, which we will discuss in another section. Some of the more

practical issues stem from communication difficulties, though patient preferences and perceptual biases should also be honored as quite significant in terms of the quality of care provided. These researchers state that open reflection is essential to the co-construction of a treatment plan. While OTs have long aimed to make the treatment process collaborative, this emphasizes that the onus for this collaboration is on both parties to gain a greater understanding of each other's goals and work.

Kokorelias et al. (2025) performed a scoping review to determine how cultural humility is discussed within OT literature as well as explore its applications in practice. Results showed that cultural humility was most often discussed alongside self-awareness and egolessness; supportive interaction; and self-reflection and critique. There were the most parallels between cultural humility, societal contexts, and practice contexts in the Canadian Practice Process Framework (which are similarly found in the American Occupational Therapy Association's OT Practice Framework). This study showed cultural humility is not specific to one population or practice setting. It can also be used to address each and every one of a patient's OT goals.

The American Occupational Therapy Association (AOTA) published a somewhat dated opinion piece about the paradigm shift from cultural competence to cultural humility. This piece emphasizes the key component of flexibility in a cultural humility framework and lends evidence to its diverse set of applications compared to cultural competency. OTs must be adaptive in their work – not only to meet each individual patient's needs, but also to remain competent as a provider.

Lerner & Kim (2022) discuss the link between cultural humility and anti-racist practices. These researchers discuss how, much like cultural humility, anti-racist practices involve therapist self-reflection though they also incorporate critical

practice and occupational science foundations. Other important concepts that help with the adoption of both include intersectionality (which we mentioned earlier), understanding the differences between equality and equity, and having knowledge of both target and agent groups. Power imbalances consist of both, as systematically disadvantaged individuals make up target groups while agent groups are those who possess social power. Therapists aiming to improve their cultural humility while also practicing in an anti-racist manner should look toward frameworks such as the cycle of socialization (the idea that individuals internalize societal views, making it difficult to break free from oppressive and intolerant behaviors), the window of tolerance (identifying the ideal level of arousal where someone functions best), and systems theory, which states that all parts of any organization are interdependent. Therapists should also understand somatic racism, which shows that racial trauma extends far beyond the mind to also impact the body. Somatic racism is especially important from a disease management and prevention standpoint, which is becoming an increasingly significant part of an OT's role in today's healthcare systems. Lastly, the Four I's Framework details that oppression exists in individuals who internalize it as well as interpersonally, through institutions, and via ideologies. Anti-racist interventions that can deepen a therapist's knowledge include body awareness, deep listening, journaling, race caucusing, somatic healing, and the act of deepening one's relationships. OTs have existing expertise in many of these interventions and incorporating others into their repertoire can further improve the care they provide, allowing them to treat a more diverse set of patients.

Another study explored the use of similar interventions to instill cultural humility as well as compassion in students participating in health profession programs. Or et al. (2024) looked at how an 8-minute mindfulness practice performed up to four times per week for two weeks influenced these skills. Results showed that students experienced significant improvements in cultural humility, compassion,

and mindfulness as a result of the intervention, which took the form of a loving-kindness meditation. Even though brief and not connected to traditional teaching methods used with cultural humility, this practice showed promise in improving these skills in early years of a therapist's practice. Such data can be used to support the use of mindfulness exercises in conjunction with other cultural humility training.

Working therapists, occupational therapy professors, and occupational therapy students can utilize many of these tools to enrich their cultural humility skills. Anderson (2022) also expresses how modeling and experiential learning strategies can help with the implementation of cultural humility in any clinical and academic settings. Chesser et al. (2025) expands upon this in a scoping review that looks at how to foster cultural humility in OT and PT students. This study found that service learning, didactic curricula, and experiential curricula were the most effective ways to teach cultural humility, though a combination of approaches clearly proved to yield the best results.

While we've mentioned that cultural humility tends to be a more complex and advanced skill compared to cultural competency, research shows they should be taught in much the same way. A systematic review from Lam (2022) showed the best outcomes were seen as a result of curriculum-based interventions, service learning intervention, and combination interventions. This echoes some of the previous studies we've reviewed. However, these researchers found that service learning opportunities focused on culture tended to have the biggest impact on a patient's willingness for services and ability to engage despite communication barriers. Combination interventions tended to work most in a general sense rather than eliciting certain results. These findings are important because the aforementioned outcomes also apply to cultural humility and, since research also shows the efficacy of these interventions when measuring cultural humility, providers should understand what their learning process will yield. Just as a

patient's learning needs should be taken into consideration for the provision of culturally appropriate and effective care, therapists also benefit from a variety of learning mediums to obtain and use a skill as nuanced as cultural humility.

A scoping review from Meechan et al. (2024) looked at culturally responsive OT practice with First Nations Peoples. This is an important piece of research, as not much literature looks at the effects of cultural humility on specific cultures. These researchers found quite a bit of crossover between the Indigenous Allied Health Australia (IAHA) framework capabilities and the principles and skills associated with cultural humility. These framework capabilities include proactivity, inclusive engagement, accountability, self-awareness, cultural respect, and leadership. While the results of this study showed that OT practice tended to vary in its ability to link back to these capabilities, this research should still inform providers' work. Clinicians can use this framework along with pieces of cultural responsiveness training to assist with their cultural humility efforts. These results would be even more powerful if they were used to help develop an OT-specific framework to guide practice.

In addition to classroom settings, cultural humility is equally as important in occupational therapy mentoring within academia. Njelesani et al. (2025) found that most students sought mentors who were able to support them through the complex transition from academia to the clinic. However, students also strongly desired mentors who were adept in understanding workplace discrimination, anti-racist practices, and utilized empathy and cultural humility in their work. This shows that students present with multi-faceted needs when it comes to properly preparing them to enter the OT field.

Just as with mentoring, other learning opportunities should be integrated into various aspects of OT curriculum. Naber et al. (2021) notes that embedded learning experiences can encourage students' ability to learn through their lived

experiences, since cultural congruence and cultural humility should be central goals for both physical and occupational therapy education. Researchers note this can be done using a curricular shift to incorporate cultural opportunities throughout various courses. Naber found these changes were associated with a greater appreciation of how personal circumstances affected health outcomes as well as awareness of equity and diversity. Earlier pieces of research discussed how continual paradigm shifts have led to the adoption of cultural humility as opposed to more simplistic concepts such as cultural awareness and competence. It seems a similar trend can potentially affect change in OT curricula that leads to the proper instruction of cultural humility to OT students.

Chen et al. (2021) aimed to determine the efficacy of workshop-based interventions at instilling cultural humility in students as part of occupational therapy education. Since workshop interventions are a type of experiential learning, this study shed more light on how beneficial this specific type of education is for OT students. The 4-week educational workshop was not associated with significant changes in outcome measure scores, though participants did report feeling more prepared within their academic program and learning about the range of cultural factors that affect not only their treatment but also their interactions with others. While this research may not be enough to support the sole use of workshops for teaching cultural humility, it shows potential for this type of learning experience to complement others that address this skill.

Tilstra et al. (2023) discusses student use of learning activities with a multi-cultural focus to foster an integrated skill: cultural competence with humility. There is a particular dearth of research on this topic, as it combines both skills in a more unique way. For the purpose of this study, researchers broke this concept into four components: cultural desire, cultural knowledge, cultural awareness, and cultural skills. Students found cultural knowledge to be the most important construct

related to cultural competence with humility. Both quantitative and qualitative data showed that students' skills in cultural competence with humility improved after the activities. Therefore, these results can inform the creation and modification of occupational therapy curricula to include these activities, which appear to assist students in developing a blend of two essential cultural skills.

Tilstra et al. (2024) explored the ways OT and counseling graduate students perceived their own self-reflection abilities after engaging in the COPE program, which consisted of interprofessional engagement opportunities between these two disciplines in the community. Results showed an improvement in all domains. While this proves the benefit of cultural humility-focused programs on their own, it also emphasizes the importance of turning these learning opportunities into interprofessional collaborations. Making education have this component allows students not only to learn from their patients, but also their colleagues. Since ongoing learning is such a core tenet of cultural humility, therapists should get in the habit of involving various other people in the process.

Dated literature published in the Canadian Journal of Occupational Therapy discusses how culture is not merely composed of someone's race and ethnicity. In the true sense of the word, diversity pertaining to culture also includes someone's disability, gender identity, socioeconomic status, sexual orientation, religion, and similar factors. Since these factors all have a distinct impact on well-being and occupational performance, it is essential they are more broadly included as part of the term culture. One reason for this is due to their influence on social hierarchies, which are critical in determining the opportunities available to someone and (subsequently) their mental health. Therefore, this research suggests that therapists have a duty to incorporate this definition of culture into all theories and other aspects of occupation. In order to focus on culture at such a formative level, therapists must take steps such as engaging in the critical appraisal of theory bases and using clinical judgment to choose what is best for

the patient. This allows occupational therapists to fully integrate culture and diversity into their practice.

At a time when cultural humility was not yet as prevalent as it is now, a dated literature review covered the topic of cultural safety to assist with health equity and replace cultural competency. This review defined cultural safety as the practice of creating environments (therapeutic, educational, or otherwise) where a diverse set of individuals can engage in meaningful activities without fear of prejudice or persecution due to a sense of security and respect from those around them. These researchers pointed out how therapists who commit to cultural safety must be willing to challenge existing practices as well as structures currently in place. However, this doesn't lead to better outcomes on its own, as therapists must also ensure all organizational objectives are clearly associated with health equity. As you can see, the concept of cultural humility is closely intertwined with health equity, which means therapists must take steps beyond fostering their own growth and development to ensure more far-reaching effects.

Other dated research shows that using the diversity context is another way for therapists to address culture in their treatment. This lesser-discussed context intersects with each of the other contexts therapists learn about, since diversity is a fluid concept influenced by social, temporal, spatial, physical, and cultural constructs. In order to not only acknowledge this context but properly address it, therapists are urged to utilize contextual analyses at multiple points in the plan of care. While contextual analyses are considered part of the fabric of an OT's work, therapists may substitute this type of critical thinking for more generic or standardized treatments. This is especially likely to happen to OTs experiencing burnout or working in fast-paced, high-stress environments. However, these analyses offer the ability for truly individualized treatment and more appropriately honor the profession's roots in quality, person-centered care.

Section 3 Personal Reflection

How can research findings on teaching cultural humility to OT students also apply to OT practitioners?

Section 3 Key Words

Anti-racist practices - Actions that actively oppose racist behaviors at various levels within our society, including institutionally, systemically, and interpersonally

Cultural congruence - Ensuring someone's behaviors are in sync with the individual or group's beliefs, traditions, values, and needs

Equality - The even distribution of resources and supports to everyone, regardless of their abilities

Equity - The thoughtful and fair distribution of resources and supports, which are determined by someone's abilities and areas of need to ensure equal chances of success

Intersectional lens - A way of viewing various components of someone's identity based on an intersectional framework; this framework states that attributes such as sexual orientation, gender, race, religion, socioeconomic status, geographic region, class, and more all blend to create a unique experience for each individual

Negligence - The omission of steps that properly take someone's care into consideration, leading to some kind of harm; negligence occurs when a duty of care was breached, patient harm resulted, and there is a connection between this breach and the patient's harm

Perceptual bias - Taking a subjective perspective in situations based on one's own background, emotions, values, beliefs, etc.

Self-determination - The acknowledgment of a person's right to their own views, values, and decision-making abilities

Social constructionism - A sociological concept that states the meaning and truths of life are fluid due to deep influences from culture, language, and social factors on an ongoing basis

Section 4: Health Literacy & Managing Biases

References: 27-53

We've mentioned health literacy and bias as two critical aspects of properly implementing cultural humility. Just as a lack of knowledge about someone's culture and background can serve as a barrier to treatment and negatively impact health outcomes, failure to address health literacy can do the same. As such, health literacy should be a major focus for providers, both in the evaluation and treatment phases, as it allows therapists to properly cater their services to the patient. Therapists should also aim to overcome their personal biases, as this prevents them from providing culturally effective care.

Studies have covered both of these topics and highlight their importance as well as their link to cultural humility. Therapists can properly address biases and health literacy through several assessment tools and action steps.

Health Literacy Principles & Literature

Especially during COVID-19, community-based organizations (CBOs) were placed under undue pressure to address health disparities – which have been present for years but grew to critical levels as a result of the pandemic. This showed an even more distinct need for CBOs to increase health literacy knowledge and enhance their cultural humility, as the diverse set of people they treat will continue to

grow. Allen-Meares et al. (2024) conducted a study called Project MUSE, which addressed this disparity in CBOs by integrating wraparound services to assist with comprehensive care using a stronger focus on a variety of patient needs. This study involved training CBO staff in the implementation of wraparound services to increase the well-being of their patients along with community members.

Wraparound services in this study stayed true to their roots (helping families and young children grappling with various types of instability due to mental health concerns and trauma histories), as they are considered effective for this population. However, these wraparound services were even more far-reaching by also involving clinician education on health equity, health literacy, cultural humility, and social determinants of health. Services additionally entailed education on application techniques that improved the sustainability of adopting such recommendations. SMARTIE goals played a big part in this study. SMARTIE goals are similar to SMART goals, but with the incorporation of 'inclusive' and 'equitable' as goal components. Education discussed ways to build trust as that was another major factor that impacted health literacy and the development of health disparities.

Methods discussed included sponsored events in community locations as well as door-to-door canvassing. As was mentioned in other aspects of cultural humility training, consultations with educators were offered as part of this training, which helped with individual cases and more nuanced concerns. Specific to health literacy, some topics of discussion included strategies to identify low health literacy, the ways health literacy impacts care and outcomes, and ways to promote better health literacy. (We detail some of those methods below).

Results of this study showed that the training may have been inaccessible to staff compared to leaders, as attendance was poor for this group due to scheduling conflicts and workload-related problems. The biggest area of improvement was

seen in participant confidence identifying best practices associated with health literacy. Other improvements were seen in greater confidence in identifying social determinants of health and health literacy concerns. This demonstrates how much health literacy should be thoughtfully integrated within existing care efforts for the best results.

Therapists can address health literacy in some of the following ways:

- Avoid using jargon in written and oral communication with patients by breaking down complex terms and concepts into more easily understood parts
- Use proper non-verbal communication by making eye contact and facing the patient when having a conversation with them
- Limit the information you give to patients to 3 main points per visit
- Ask patients how they would prefer health information
    - Providers may think supplementing verbal information with written information (e.g. handouts, pamphlets, etc.) is the best way to disseminate education to patients, it's best to ask their preferences.
- Properly assess someone's learning style and abilities at the start of (see below for a list of tools to assist with this)
- Screen patients for need of language services and preferred languages during the consent process and treatment sessions
- Perform medication reviews for all patients, especially older adults, those who recently started new medication(s) or were recently diagnosed with a chronic condition, those taking multiple medications, individuals who are medically complex or have multiple co-morbidities, and anyone at risk of complications

- Schedule follow-up appointments
- Give patients referral reports with contact information for any referrals that are made
- For therapists working in inpatient settings, ensure education is being provided each step of the way to assist with care navigation, disease management, and exercise programs alike
- Screen for non-medical needs (e.g. needs related to social determinants of health), such as personal safety, transportation, food, housing, childcare, health insurance, and employment

Healthcare organizations can address health literacy in some of the following ways:

- Conduct widespread health literacy assessments
- Train staff at every level in health literacy
- Create welcoming clinical environments
- Ensure providers have access to resources to help improve patient education, including interpreters, visual aids and training in active listening
- Simplify all large-scale written communication using informative, actionable headings
- Pencil in session time for all therapists to review information taught with patients
- Extend these tenets to digital health literacy by making portals, apps, and website user-friendly in terms of adoption, access, and use
- Post clear signage within buildings

- Support patient health management efforts on their own to improve disease management and adherence to plans of care
- Encourage therapists to make patient education and/or self-management goals any time they identify a patient with low health literacy
- Help providers and other related staff plan out processes to be followed for scheduled admissions in hospitals
- For inpatient organizations, make protocols surrounding shift change huddles and bedside reporting
- For inpatient organizations, ensure each patient who is discharged receives a post-discharge phone call from a knowledgeable staff (e.g. a clinician who has performed a chart review)
- Follow three main objectives to ensure health literacy is addressed: communication, ease of navigation, and patient engagement/self-management
    - Communication goals can be addressed by providing resources to improve spoken and written communication.
    - Ease of navigation goals can be achieved by improving patients' ability to navigate physical healthcare spaces as well as the healthcare system as a whole.
    - Patient engagement and self-management goals can be addressed by utilizing culturally-sensitive strategies that either improve a patient's ability to care for themselves or give patients the resources to improve these self-care abilities.

Organizations and therapists can both use the following tools to assess health literacy:

1. Organizational Health Literacy Assessment
2. Teach-back method - Used to ensure comprehension of verbal concepts.
3. Show-back method - Used to ensure comprehension of device or adaptive equipment use.

1. PFE Hospital Evaluation Metric 3 (PFE Leader or Functional Area)
2. PFE Hospital Evaluation Metric 4 (Patient and Family Advisory Council or Representative on Quality Improvement Team)
3. PFE Hospital Evaluation Metric 5 (Patient(s) and Family on Hospital Governing and/or Leadership Board)
4. Health Literate Health Care Organization-10 (HLHO-10)
5. Health Literacy Environment Review
6. Communication Climate Assessment Toolkit (the workforce development, performance evaluation, and data collection domains are particularly relevant to cultural humility)
7. Health Literate Health Care Organization-10
8. Health Literacy Environment of Hospitals and Health Centers (HLE2)
9. The SMOG (Simple Measure of Gobbledygook) Readability Formula
10. Health Literacy Advisor
11. The CDC Clear Communication Index
12. Principles of Plain Language
13. Health Literacy Universal Precautions Toolkit
14. Patient Education Materials Assessment Tool (PEMAT)

15. Health Literacy Online, 3rd Edition
16. Ten Attributes of Health Literate Health Care Organizations
17. National Action Plan to Improve Health Literacy
18. Ask Me 3: Good Questions for Your Good Health
19. American Speech-Language-Hearing Association (ASHA) Policies and Procedures Check-in
20. Healthy Schools Healthy Communities (HSHC) - can be used to structure health literacy and cultural humility efforts in schools through multi-level engagement at various levels (student, family, and community). Chiefly, this initiative addressed access to food and physical activity as means of improving health literacy.
21. Cornerstone Care Coordinated Approach to Child Health (CATCH) Model - was used to train teachers and other individuals working in schools about physical activity, exercise, and other similar means to improve the health of the children they serve.
22. River Valley Healthy Communities Coalition (RVHCC) Health Information Literacy Outreach Project - another initiative that involved the development of a health literacy curriculum implemented by librarians and teachers within a rural school district. Therapists working with young adult students who display a range of needs can mirror this work to improve patients' ability to find digital health information, gauge its reliability, use the content to improve their knowledge about health, and disseminate these skills with others they know.
23. Integrated Health Literacy Program (IHLP) - was used within the school systems to teach educators how to embed health literacy and cultural

humility learning into their curricula. This program is ongoing and therapists can use it to guide their own ability to address health literacy in schools and other pediatric settings.

Managing Biases

Another essential part of cultural humility is the ability to overcome one's biases, which can only be done by first identifying and recognizing the biases that you possess. Many therapists may especially struggle with this, as it can be difficult to gain a different perspective on yourself. However, it is possible as long as you keep an open mind and follow certain steps. Therapists should also keep in mind that it is not a realistic or practical goal to eliminate implicit biases since each person has them and they tend to be very ingrained. Instead, it is recommended to manage those biases in a way that allows you to behave in a socially appropriate manner.

Research from Sevestre (2025) explored implicit bias in occupational therapy fieldwork educators to determine not only how present it was in their practice, but also to learn about how they instruct students on such matters. The study took a hermeneutic phenomenology approach to explore this concept. Results found that OT fieldwork educators did have a strong focus on client-centered treatment in practice. However, this researcher also discovered that providers had little to no understanding of implicit bias and how it affected their work. Although, the fieldwork educators who participated in this study were able to properly reflect on clinical scenarios and their own responses to real situations involving bias. Manalang et al. (2024) presented research on the use of inter-institutional dialogue and JEDI modules as a way for OT educators to manage implicit bias and prepare students for fieldwork. This content was effective when used in three academic programs to understand what methods students would like educators to use to increase their understanding of implicit bias management.

Other mediums for teaching implicit bias have been explored. Bakski & Jarrard (2021) suggested the use of a community action poverty simulation to improve student insight into implicit bias along with social inequities. Serrano-Diaz et al. (2025) notes that the most effective way to address this problem from a longitudinal standpoint is to improve representation in the OT profession, create educational and work settings that are culturally safe for all individuals, and develop policies that protect the dignity of both therapists and patients.

Some dated literature outlined a model to assist with addressing biases in healthcare in an attempt to help providers treat in accordance with cultural humility. This model emphasizes the use of the Five Rs Framework to identify and manage biases as follows:

- **Reflection**, which is defined as pausing frequently to consider all aspects of a situation and the learning opportunities it presents.
    - Providers should ascribe as much meaning as possible to the encounters they are part of.
    - Clinicians must explore their own emotional responses to patient suffering, either physically, mentally, or on a larger scale such as societally and systemically. This exploration should lead healthcare providers to challenge various treatment situations while remaining true to themselves.
    - The best way to achieve these goals is by asking yourself what you took away from each person who you shared encounters with.
- **Respect**, which involves honoring anyone you engage with by offering care and consideration for their needs and feelings.

    - Providers should focus on respect by extending this consideration to patients, their caregivers, their family, and all other members of the interprofessional team.
    - Clinicians can also practice respect in healthcare settings by honoring the boundaries of those they work with, work for, and treat.
    - Respect toward patients most often takes the form of incorporating their choices and preferences at all times during the evaluation and treatment process.
    - Therapists must also remember that a patient's decisions may not always follow the recommendations you make for them nor will they always align with your personal or professional values. However, it is important for them to have the ability for choice regardless.
- **Regard** means understanding that each person you interact with has their own implicit biases, even the patients we treat. These biases will impact a person's responses, behaviors, views, and more.
    - Therapists should keep in mind that it is their duty to put someone else's biases aside when treating them, as they are coming to you with a problem they need help with.
    - Just as therapists must regard the patient and the details about their life, therapists must also be mindful of how they are presenting themselves in terms of their non-verbal communication, demonstrated empathy, the time and other resources they are giving, and how they speak to those around them.
    - Even when working with patients from similar cultures to them, therapists should still maintain that patient's individuality and refrain

from making any assumptions about them or their lives. This is what helps form and nurture the best relationships.

    - The overarching goal of this step is to ensure that no aspects of a patient's interaction are driven by unconscious biases.

- **Relevance** is at the forefront of all clinical practice, as cultural humility is linked to all aspects of patient-centered care.

    - Providers can understand and put this into effect by using the biopsychosocial model to understand the various factors that influence a patient's life as well as their current presentation and circumstances.

    - Therapists should focus on the relevance of cultural humility by asking themselves how cultural humility relates to each encounter they have and learning the various forms it takes.

- **Resiliency** involves remaining strong while adhering to the principles of cultural humility.

    - This step may be more difficult than some of the others, as clinician burnout levels are rising and can make it difficult to fully execute this and similar plans. However, it is your duty as a provider (whether experiencing burnout or not) to minimize your personal emotions and prevent your own experiences from negatively impacting patients.

    - On the other side of the spectrum, the practice of cultural humility and identifying implicit biases can also serve as a protective factor for burnout symptoms such as depersonalization and emotional exhaustion.

- As with many of the other steps, therapists can target resiliency by asking how their personal fortitude was impacted by each interaction and taking the steps necessary to build it up again, when necessary.

Section 4 Personal Reflection

Do any OT-specific frameworks have crossover with the Five Rs plan used for implicit bias? If so, which ones?

Section 5: Guided Plans for Cultural Humility Use

References: 54-65

In the previous section, we reviewed some tools therapists can use to deepen their understanding and use of various parts of cultural humility. However, they do not necessarily outline the details of putting cultural humility itself into practice. Since this skill is made up of several components, it is important to create a guided plan that allows therapists to effectively handle each. Therapists can use the following steps to create a plan for integrating cultural humility into their practice:

1. Firstly, therapists must gain a greater understanding of themselves by identifying both implicit and explicit biases.

   How: Providers can use Harvard's Implicit Association Test, which involves giving some background information about yourself as well as attitudes and beliefs on various questions pertaining to culture, religion, gender, and sexuality. While this test is a great starting point, it's best to take several tests and collectively look at their results for a more broad view. Some other tests include the Hawai'i Implicit Bias Initiative; the University of Oregon's Unconscious and Implicit Bias Workshops; the Georgetown

University National Center for Cultural Competence's Cultural and Linguistic Competence Health Practitioner Assessment (CLCHPA); the American Speech-Language-Hearing Association's Self-Reflection Check-in, Culturally Responsive Practice Check-in, and Gender Inclusivity Check-in.

2. Use the results from these tests to create action steps for addressing those biases and continually seeking out learning opportunities.

3. Take a scoping look at the technology, tools, and skills you need to succeed in your practice area. Create additional action steps based on this information.

4. Take a scoping look at the technology, tools, and skills you need to successfully serve the greater community. Create additional action steps based on this information.

5. Gather insights from community cultural leaders regarding their impressions on healthcare initiatives (or lack thereof), areas of need, and biases present in your community. Create additional action steps based on this information.

6. Engage in role-based learning that is culturally and linguistically appropriate for both your community and practice area.

   How: Role-based learning should reflect the areas of need identified earlier in these steps.

7. Talk to other providers in your work setting to learn about their successes, concerns, and areas of improvement they have identified specific to cultural humility. Create additional action steps based on this information. This can be especially helpful for providers who are new to an organization, but is also appropriate at any other point in their professional development journey.

Since cultural humility is multi-faceted, this plan allows each person to create action steps that are catered to their specific needs. Most of these steps will hinge on the results from implicit bias tests, discussions with community members, and more. Therefore, each therapist's action steps will be unique to them and their geographic region. The individualized nature of this process allows therapists to identify the areas of growth that best support them and the work they do.

Section 5 Personal Reflection

What differences might be present in the guided plan of an OT who works in a skilled nursing facility with patients predominantly from one cultural group and the guided plan of an OT who works in private practice with patients from a wide range of cultural groups?

Section 6: Case Study #1

A 31-year-old Nigerian female is admitted to an inpatient hospital for a urinary tract infection. This woman is 7 months pregnant and is seen by a female OT early in her admission to assess her cognition and address some functional concerns. She was also referred to PT, though she declined to see the male therapist when he arrived.

She did not report any pain or other symptoms when asked, and maintained a largely stoic demeanor with the therapist. This patient is new to the hospital, so none of the healthcare providers have any health history on her. Early in their first meeting, the therapist asked the patient directly about this and the patient stated she doesn't have any health conditions or problems. However, the OT catches a glance of a mostly covered medical alert bracelet on her wrist.

The patient only responds to the therapist by nodding or saying ‘yes’ or ‘no,’ and doesn’t give any more elaborate replies. However, non-verbal signs indicate that she is experiencing discomfort despite the therapist not knowing where this discomfort is. The therapist documents this as such and tells the patient she will be back tomorrow for their first session together.

During that session, the therapist records the patient’s vitals and notices her blood pressure is 140/90. She asks the patient how she is feeling and she nods yes. So the therapist completed her session with the patient, but ended a little early since the patient appeared to be getting tired. She came back several hours later to treat someone else, and received news that this patient had a stroke and passed away.

1. What ethical, cultural, and professional errors did this therapist make?
2. What indications did this patient give that indicated specific cultural needs?
3. At what point(s) did the therapist have the opportunity to practice cultural humility?
4. What steps should this therapist have taken to better address this patient’s cultural needs?
5. What steps should this therapist have taken to better address this patient’s medical needs?
6. What might be the first step on this therapist’s guided plan for improving cultural humility?

Section 7: Case Study #1 Review

This section will review the case studies that were previously presented. Responses will guide the clinician through a discussion of potential answers as well as encourage reflection.

1. What ethical, cultural, and professional errors did this therapist make?

   This therapist failed to test the patient's health literacy at multiple points: at the beginning of their first encounter (the assessment), during the first treatment, and after noticing that the patient only nodded and gave one-word answers to all questions. The therapist saw evidence (i.e. the medical alert bracelet) that the patient has some form of medical condition and took her simple nod as meaning she doesn't have a health history. The therapist noticed the disconnect between the patient's verbal reports declining pain or other symptoms and the patient's non-verbal communication (which visibly indicated discomfort), but didn't make a culturally appropriate decision afterwards.

   Lastly and perhaps most importantly, the therapist continued to base her clinical decisions solely on the patient's responses rather than acknowledging clear evidence of a medical emergency. This led to a major (and preventable) medical error that involved ignoring obvious stroke warning signs and failing to take proper action to prevent or manage the very early stages of stroke.

2. What indications did this patient give that indicated specific cultural needs? Why could those actions, responses, beliefs be attributed to the patient's culture?

   The patient declining to work with the PT (who happened to be male) very well could have been due to her cultural background. The disconnect

between the patient's verbal (e.g. stating she wasn't in pain and didn't have any medical concerns) and non-verbal (e.g. being in visible discomfort) accounts was also a potential indication of cultural needs. This may have been the result of a language barrier, due to distrust of medical providers, or it could have been attributed to her cultural views on pain, disability, and medical conditions. The patient may not be comfortable acknowledging pain, she may have difficulty coping with the emotions that come along with pain, she may not have adjusted to the idea of pain having a place in her life, or may feel that not talking about it and maintaining a strong stance helps with the healing process.

However, it is impossible to tell exactly what (if any) cultural beliefs contributed to this behavior, as the therapist did not address any of this with the patient. Similarly, the patient may feel that whatever she is experiencing (pregnancy, UTI, elevated blood pressure, or the reason for her wearing a medical alert bracelet) is not a medical condition and is either a passing health issue or something else entirely. Either way, there were clear indications from this patient that she had cultural needs that were not being attended to.

3. At what point(s) did the therapist have the opportunity to practice cultural humility?

   The therapist could have used the information about the patient declining to work with a male provider to build rapport and discuss her cultural background and preferences. Even if the therapist failed to address health literacy from the very start of this encounter, the discussion would have given her a second chance to more obviously see any language barriers that were present and act accordingly. Toward the end of the scenario when the patient appeared tired, the therapist should have recognized that this was a

major departure from the patient's typically stoic presentation with providers and taken appropriate action.

4. What steps should this therapist have taken to better address this patient's cultural needs?

   The therapist should have done the following upon working with this patient:

   - Prepare tools to properly test health literacy
   - Address health literacy immediately after meeting the patient
   - Build rapport to simultaneously learn about the patient's culture, background, and health history
   - Ask the patient if there is anything the therapist can do to make her feel more at ease or comfortable during her time there
   - Promptly address any communication barriers that interfere with the assessment and treatment process

5. What steps should this therapist have taken to better address this patient's medical needs?

   The therapist should have done the following upon working with this patient:

   - Determine what, if any, physical therapy-related needs this patient may display
   - Attempt to request medical records for this patient to get a fuller picture of her circumstances
   - Inquire about the patient's medical alert bracelet directly

- Obtain and use alternative pain assessments such as the Wong-Baker FACES Pain Scale to gauge the patient's pain
- More closely look at the patient's lethargy and other potential signs of a medical emergency
- Seek immediate help from nursing in response to the patient's elevated blood pressure levels
- Follow that organization's protocol for emergency situations

6. What might be the first step on this therapist's guided plan for improving cultural humility?

   This therapist should not only aim to learn more about Nigerian cultures, but also other aspects of this patient's circumstances. The therapist made several missteps related to health literacy, pregnancy, stroke care, and more that reflected a lack of proper knowledge in those areas. It is recommended that the therapist develop a plan to improve their cultural humility skills and include education in each of the above areas to start. From there, they can ask their coworkers what resources they took advantage of to improve cultural humility as well as general continuing education that may help grow skills in more specialized areas. Discussions with hospital leaders can also help them understand what cultural groups they should expand their knowledge to include.

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