Cultural Awareness, Ethics, and OT Clinical Practice

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SESSION OVERVIEW

Learning objectives

1.	**Define and differentiate**	cultural humility and cultural competence within occupational therapy practice.
2.	**Examine**	how personal biases and systemic power dynamics influence evaluation, goal setting, and intervention planning.
3.	**Identify**	culturally responsive strategies for conducting assessments and delivering client-centered care.
4.	**Adapt**	therapeutic activities and treatment plans to align with clients' cultural values, roles, routines, and health beliefs.
5.	**Apply**	culturally respectful communication techniques to improve therapeutic rapport and adherence.
6.	**Develop**	at least one concrete action step to integrate ongoing cultural humility into clinical practice and interprofessional collaboration.

Agner, 2020; AOTA, 2020; Kokorelias et al., 2025

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SESSION OVERVIEW

Significance for occupational therapy

- ❑ The American Occupational Therapy Association (2020) explains that clients bring diverse cultural, social, and linguistic backgrounds into occupational therapy.
- ❑ These experiences influence what clients consider meaningful, how families organize daily life, how health and disability are understood, and which outcomes feel useful or acceptable.
- ❑ Agner (2020) describes cultural humility as ongoing self-reflection with attention to power, while Kokorelias et al. (2025) connect cultural humility with practice processes and contexts.
- ❑ Cultural competence contributes the knowledge and skills needed to adapt care to the individual client.

Together, these approaches can strengthen trust and participation while helping practitioners recognize barriers that contribute to unequal access and outcomes.

Agner, 2020; AOTA, 2020; Kokorelias et al., 2025

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SESSION OVERVIEW

Workshop sequence

- ❑ Wittman and Velde (2002) argue that cultural competence requires intentionally designed learning experiences that promote critical thinking.
- ❑ Following that approach, this session begins with a small-group case analysis before formal instruction, then returns participants to the same case after learning about humility, competence, regional diversity, and clinical application.
- ❑ The before-and-after structure allows participants to identify how reflection, communication strategies, and attention to culture and power influence clinical reasoning.

The final activity asks each participant to develop one action step for clinical practice or interprofessional collaboration.

AOTA, 2020; Wittman & Velde, 2002

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I. SMALL GROUP BREAKOUT

Initial small-group breakout

- ❑ Alex Morgan is a 62-year-old adult admitted to inpatient rehabilitation after a left middle cerebral artery stroke. Alex presents with right-sided weakness, expressive aphasia, decreased endurance, and difficulty completing dressing, bathing, meal preparation, and medication routines. The anticipated discharge plan involves returning home with family support.
- ❑ The referral asks occupational therapy to address self-care, home management, upper-extremity function, safety, and caregiver education. Alex communicates preferences through short phrases, gestures, and a communication board.

This is a fictional case created for the workshop. Every group will use the same clinical information.

Workshop case informed by the client-centered and culturally responsive practice concepts in Agner, 2020, and Kokorelias et al., 2025.

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I. SMALL GROUP BREAKOUT

Initial breakout task

- ❑ Without receiving additional cultural information, develop an initial occupational therapy plan of care. Identify the evaluation priorities, proposed goals, treatment approaches, discharge recommendations, and communication strategies your group would use.
- ❑ As you work, document the assumptions your group makes about Alex's preferred occupations, family roles, independence, safety, home routines, decision-making, and willingness to use adaptive equipment.

Keep your original plan. You will revisit the same case after the presentation and compare what changed.

Agner, 2020; Kokorelias et al., 2025

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II. INTRODUCTION

Cultural competence

- ❑ Cultural competence through cultural awareness and knowledge, cultural skills, and organizational support for multicultural practice (Suarez-Balcazar et al, 2009).
- ❑ Occupational therapy practitioners must understand the client's sociocultural background and illness experience (Odawara, 2005).
- ❑ The American Occupational Therapy Association (2020) connects this preparation with culturally appropriate care. A practitioner may modify an interview, use language assistance, reconsider an assessment, or change an intervention so that care fits the client's context rather than requiring the client to fit a standard clinical routine.

Odawara, 2005; Suarez-Balcazar et al., 2009; AOTA, 2020

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II. INTRODUCTION

Cultural competence: knowledge, skills, and support

- ❑ Cultural competence as more than knowledge about cultural groups. It includes awareness of one's assumptions, skills for gathering culturally relevant information, and organizational support that allows practitioners to respond effectively (Suarez-Balcazar et al., (2009). Knowledge becomes useful when it improves the questions asked and the choices offered.
- ❑ In occupational therapy, competence includes selecting appropriate assessment methods, arranging language access, adapting education, recognizing culturally shaped occupations, and documenting the client's own priorities. Organizations contribute through interpreter services, inclusive policies, representative materials, supervision, and time for collaborative care.

Suarez-Balcazar et al., 2009; AOTA, 2020

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II. INTRODUCTION

Cultural competence in the OT process

Evaluation	Gather an occupational profile that includes cultural identity, communication preferences, family roles, health beliefs, routines, supports, and barriers. Examine whether standardized procedures fit the client's language and experience.
Goal setting	Translate the client's desired roles and participation into collaborative goals. Clarify what independence, safety, recovery, caregiving, and acceptable risk mean to the client.
Intervention	Adapt activities, instructions, timing, materials, environments, and caregiver participation. Explain clinical reasoning and negotiate when recommendations conflict with beliefs or routines.
Outcomes	Evaluate whether therapy improved participation that the client values. Document accommodations and ask whether the plan remains meaningful and feasible.

Odawara, 2005; AOTA, 2020; Suarez-Balcazar et al., 2009

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II. INTRODUCTION

Cultural humility

- ❑ Cultural humility is defined as a lifelong, learning-oriented approach to working with people whose cultural backgrounds and life experiences may differ from those of the practitioner. It requires openness, self-awareness, self-reflection, and willingness to recognize gaps in one's knowledge without shame or defensiveness (Agner, 2020).
- ❑ Agner also emphasizes bias and power. Rather than assuming that professional training provides complete understanding, the practitioner treats the client's experience and interpretation of daily life as essential knowledge for evaluation and intervention.

Agner, 2020

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II. INTRODUCTION

Cultural humility as an ongoing practice

- ❑ Cultural humility as a lifelong orientation rather than a level of mastery. The practitioner remains open to correction, recognizes that every client's cultural experience is individual, and accepts uncertainty as part of ethical clinical reasoning. Learning continues before, during, and after each encounter (Agner, 2020).
- ❑ Cultural humility requires identifying recurring practices such as self-reflection, supportive interaction, attention to context, and continued learning (Kokorelias et al., 2025)
- ❑ Cultural humility therefore appears in ordinary clinical behaviors: asking permission, acknowledging limited knowledge, inviting disagreement, revising assumptions, and seeking feedback about whether care fits the client's life.

Agner, 2020; Kokorelias et al., 2025

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II. INTRODUCTION

Cultural humility and cultural competence

Cultural competence	Develops knowledge and skills for culturally responsive practice. It can improve preparation, communication, assessment selection, and intervention planning.
Cultural humility	Maintains a continuous learning stance. It emphasizes self-reflection, recognition of bias, attention to power, and respect for the client's expertise in lived experience.
Clinical relationship	Competence helps the practitioner prepare. Humility prevents knowledge about a group from becoming certainty about an individual. Effective practice requires both skill and continued curiosity.

Agner, 2020; AOTA, 2020

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II. INTRODUCTION

Accountability and relationship repair

- Reflection must lead to action.
- When a practitioner recognizes bias, dismisses a belief, mispronounces a name, overlooks a family role, or makes an incorrect assumption, cultural humility supports acknowledging the error and repairing the relationship.
- A brief, direct apology can be followed by a question about what the client needs next.
- Accountability also extends to systems.
- Practitioners can identify policies that restrict language access, exclude family participation, rely on culturally inappropriate assessments, or label structural barriers as nonadherence.
- Documentation, supervision, case conference, and quality improvement provide opportunities to challenge these patterns and advocate for change.

Agner, 2020; Kokorelias et al., 2025; AOTA, 2020

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II. INTRODUCTION

Relevance to occupational therapy practice

- Occupational therapy focuses on participation in meaningful occupations.
- Meaning develops within personal, family, community, and cultural contexts.
- A technically appropriate intervention may still fail when it conflicts with the client's roles, routines, priorities, resources, or understanding of health and disability.
- Culturally responsive practice strengthens clinical reasoning by asking whose goals guide the plan, how the environment supports or restricts participation, and whether the recommended occupations reflect the client's values.
- These questions apply across physical rehabilitation, mental health, pediatrics, school practice, community programs, and home-based care.

Agner, 2020; Odawara, 2005; Kokorelias et al., 2025

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III. DIVERSITY IN OCCUPATIONAL THERAPY PRACTICE

Diversity in occupational therapy practice

- Culture extends beyond race and ethnicity.
- It can include language, socioeconomic position, age, geography, religion, gender, sexual orientation, disability experience, family roles, migration history, professional identity, and membership in other communities.
- Each person holds several identities at the same time.
- These identities intersect and may influence access to services, previous experiences with health systems, expectations of practitioners, preferred ways of communicating, and the practical choices available during care.
- Practitioners should explore these influences with the client instead of assuming that one identity explains the person's behavior or decisions.

Agner, 2020; AOTA, 2020

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III. DIVERSITY IN OCCUPATIONAL THERAPY PRACTICE

Culture and meaningful occupation

- Sociocultural background and illness experience influence engagement in meaningful occupation.
- Culture can shape which occupations receive value, who performs them, when and where they occur, and what they communicate about identity or belonging.
- The same task can carry different meanings for different clients.
- Cooking, caregiving, work, worship, leisure, grooming, and community participation may include meanings that a standardized activity analysis does not fully capture.

Practitioners therefore need to ask how an occupation fits the person's life.

Odawara, 2005

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III. DIVERSITY IN OCCUPATIONAL THERAPY PRACTICE

Culture, roles, and daily routines

- ❑ Ideas about independence, caregiving, privacy, productivity, rest, and family responsibility vary within every community.
- ❑ A client may define successful participation as completing a task alone, directing another person, contributing one part of a shared routine, or maintaining a valued role despite changed performance.
- ❑ Clinical goals should reflect the client's desired pattern of participation.
- ❑ When a practitioner automatically treats independence as the best outcome, the plan may conflict with a family's preferred interdependence or with the client's understanding of dignity and support.

Agner, 2020; Odawara, 2005

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IV. CULTURAL COMPETENCE IN OCCUPATIONAL THERAPY

Cultural competence in occupational therapy

Culturally responsive communication	Use respectful language, identify communication preferences, arrange qualified interpretation when needed, and verify understanding.
Assessment and intervention	Consider whether assessment methods fit the client's language and experience. Adapt intervention while preserving the therapeutic purpose.
Values, beliefs, and traditions	Ask how routines, relationships, health beliefs, and cultural practices influence meaningful occupations and participation.

Salimbene, 2015; AOTA, 2020.

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IV. CULTURAL COMPETENCE IN OCCUPATIONAL THERAPY

Culturally responsive communication

Key points

- ❑ Use respectful, person-centered communication
- ❑ Ask rather than assume
- ❑ Consider preferred language, communication style, and health literacy
- ❑ Use qualified interpreters when language barriers exist
- ❑ Be aware of differences in nonverbal communication
- ❑ Confirm understanding using teach-back

OT example

A therapist notices a patient giving short responses and avoiding eye contact. Rather than assuming disengagement, the therapist explores whether communication preferences, language, or cultural norms may influence the interaction.

Salimbene, 2015; UWMC, 2011.

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IV. CULTURAL COMPETENCE IN OCCUPATIONAL THERAPY

Adapting assessments and interventions

Key points

- ❑ Consider whether standardized assessments reflect the patient's cultural and lived experience
- ❑ Identify environmental, family, and social factors that influence occupational performance
- ❑ Adapt interventions while maintaining the therapeutic goal
- ❑ Incorporate meaningful occupations and routines
- ❑ Ask the patient what works for them
- ❑ Document clinically appropriate adaptations

OT example

A recommended home exercise program does not fit the patient's daily routine. The practitioner collaborates with the patient to incorporate therapeutic movement into meaningful household and family activities.

Salimbene, 2015; Agner, 2020.

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IV. CULTURAL COMPETENCE IN OCCUPATIONAL THERAPY

REMEMBER

Same therapeutic goal

≠

the same intervention for every patient

The activity, communication approach, supports, and context should fit the individual while preserving the clinical purpose.

Salimbene, 2015; Agner, 2020.

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IV. CULTURAL COMPETENCE IN OCCUPATIONAL THERAPY

Respecting cultural values, beliefs, and traditions

Key points

- ❑ Ask about values, beliefs, traditions, and routines that influence care
- ❑ Respect preferences related to food, clothing, touch, modesty, family involvement, and caregiving
- ❑ Recognize the role of family and community in decision-making
- ❑ Avoid stereotyping based on cultural identity
- ❑ Balance cultural preferences with safety, ethics, and clinical responsibilities
- ❑ Incorporate the patient's priorities into goal setting

OT example

Before planning a bathing intervention, the practitioner asks about preferences related to modesty, caregiver gender, privacy, and family involvement.

Salimbene, 2015; Agner, 2020.

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V. CULTURAL HUMILITY IN PRACTICE

Self-reflection and self-awareness

- ❑ Examine our own cultural identity, experiences, and assumptions
- ❑ Recognize that our perspective is not universal
- ❑ Consider how our experiences influence clinical decisions
- ❑ Remain curious rather than assuming we already understand
- ❑ Be willing to learn from the patient
- ❑ View cultural humility as an ongoing process rather than a completed skill

Self-awareness helps practitioners recognize when assumptions or professional habits are shaping the encounter.

Agner, 2020; Kokorelias et al., 2025.

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V. CULTURAL HUMILITY IN PRACTICE

TAKEAWAY

Cultural humility begins with understanding ourselves before attempting to understand others.

Agner, 2020; Kokorelias et al., 2025.

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V. CULTURAL HUMILITY IN PRACTICE

Recognizing personal bias

- ❑ Everyone has biases; awareness is the first step
- ❑ Bias can influence clinical reasoning, communication, expectations, and treatment decisions
- ❑ Distinguish between what we know and what we assume
- ❑ Pause when a patient's behavior challenges our expectations
- ❑ Seek additional information before drawing conclusions
- ❑ Use objective clinical observations and patient-reported information

Agner, 2020; AOTA, 2020.

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V. CULTURAL HUMILITY IN PRACTICE

Reframing assumptions about participation

Instead of	Ask
"This patient isn't motivated."	**"What factors may be affecting this patient's participation?"**

Possible considerations

- ❑ Pain or fatigue
- ❑ Language barriers
- ❑ Cultural expectations
- ❑ Previous health-care experiences
- ❑ Mental health or cognitive factors
- ❑ Family expectations
- ❑ Limited understanding of therapy goals
- ❑ Intervention lacks meaning for the patient

Agner, 2020; Salimbene, 2015.

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V. CULTURAL HUMILITY IN PRACTICE

Addressing power imbalances

Key points

- ❑ Recognize that practitioners hold professional knowledge and institutional authority
- ❑ Patients may feel vulnerable, dependent, or hesitant to disagree
- ❑ Encourage shared decision-making and meaningful choices
- ❑ Explain the purpose of assessments and interventions
- ❑ Invite questions and disagreement
- ❑ Respect the patient's preferences and priorities

OT example

The practitioner asks which functional activity is most meaningful to address first rather than automatically choosing the practitioner's preferred intervention.

Agner, 2020; Kokorelias et al., 2025.

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V. CULTURAL HUMILITY IN PRACTICE

TAKEAWAY

The patient is the expert on their own life. The practitioner brings clinical expertise to the partnership.

Agner, 2020; Kokorelias et al., 2025.

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IV. CULTURAL HUMILITY IN PRACTICE

Self-reflection and self-awareness

- Cultural humility requires continuous self-reflection on the assumptions, biases, and reactions that arise in relationships with clients.
- Self-reflection and critique as recurring cultural humility practices in rehabilitation literature.
- Reflection may occur before an encounter, during a moment of discomfort, or after reviewing a decision.
- Useful questions include: What outcome am I privileging? What does this reaction reveal about my expectations? Whose perspective is missing? What institutional pressure may be influencing this plan?

Agner, 2020; Kokorelias et al., 2025

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IV. CULTURAL HUMILITY IN PRACTICE

Recognizing personal bias

- Bias can involve race, ethnicity, language, weight, disability, mental illness, age, gender, socioeconomic status, or any other identity.
- Bias may appear as lowered expectations, excessive protection, assumptions about family involvement, judgments about adherence, or pressure to accept the practitioner's preferred version of independence.
- Discomfort provides information.
- When a client's decision feels unreasonable, the practitioner can pause and examine whether the disagreement reflects an immediate safety concern, a difference in values, limited options, or an untested assumption about what a good life should look like.

Agner, 2020

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IV. CULTURAL HUMILITY IN PRACTICE

Power imbalances in therapeutic relationships

- Occupational therapy practitioners hold professional authority.
- They often control assessment procedures, access to equipment, treatment schedules, documentation language, recommendations, and information that influences discharge or service eligibility.
- Clients may also depend on institutions that restrict time, choices, or movement.
- Cultural humility asks practitioners to make this power more visible and to share decisions whenever possible.
- Clear explanations, genuine choices, permission to disagree, and documentation of the client's own priorities can support a more collaborative relationship.
- Practitioners should also identify policies or reimbursement pressures that limit client choice.

Agner, 2020; Kokorelias et al., 2025

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V. CULTURAL COMPETENCE IN OCCUPATIONAL THERAPY

Culturally responsive communication

- Culturally responsive communication begins with curiosity and respect.
- Practitioners can ask how the client prefers to be addressed, who should participate in decisions, what language or communication method works best, and how the client understands the health condition and proposed services.
- Open-ended questions allow clients to describe meaning and context.
- Reflective listening and teach-back help practitioners confirm understanding without placing responsibility only on the client.
- When differences arise, the practitioner can explain the clinical concern, invite the client's perspective, and negotiate an approach that preserves dignity and choice.

Agner, 2020; AOTA, 2020; Kokorelias et al., 2025

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V. CULTURAL COMPETENCE IN OCCUPATIONAL THERAPY

Establishing comfort and trust

- ❑ Ask whether this is the client's first experience with the health system and explaining team roles, referral processes, and what will happen during care.
- ❑ Orientation can reduce uncertainty that might otherwise appear to be hesitation or lack of participation.
- ❑ Ask how the client wants to be addressed and why the client believes the visit is occurring.
- ❑ Practitioners should ask about goals before acting, observe the client's cues, and avoid interpreting eye contact, handshakes, silence, or physical distance through only the practitioner's own cultural expectations

UWMC, 2011

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V. CULTURAL COMPETENCE IN OCCUPATIONAL THERAPY

Language access and health information

- ❑ Use a qualified interpreter when a client uses another language or needs communication access.
- ❑ Family members should not replace an interpreter for health information.
- ❑ Occupational therapy practitioners should also offer information in the client's preferred format, which may include writing, pictures, demonstration, or a combination.
- ❑ Teach-back checks how clearly the practitioner communicated.
- ❑ The client can explain or demonstrate the information in their own words.
- ❑ Documentation should identify communication preferences, the interpreter or accommodations used, and the client's expressed understanding so the team can provide consistent care.

UWMC, 2011

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V. CULTURAL COMPETENCE IN OCCUPATIONAL THERAPY

Working effectively with an interpreter

- ❑ Brief the interpreter about the purpose of the encounter, speak in short and organized segments, allow time for interpretation and reflection, and avoid interrupting.
- ❑ The practitioner should face and speak directly to the client rather than treating the interpreter as the primary participant.
- ❑ Meaning should be checked through paraphrasing, demonstration, or teach-back rather than yes-or-no questions.
- ❑ Gestures, facial expressions, silence, and tone may add information, but their meaning should be verified with the client.
- ❑ The practitioner remains responsible for clear communication and for protecting confidentiality.

Salimbene, 2015; UWMC, 2011

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V. CULTURAL COMPETENCE IN OCCUPATIONAL THERAPY

Respectful touch and nonverbal communication

- ❑ Explaining what the practitioner will do and what the client may feel before any examination, procedure, transfer, positioning, or hands-on intervention.
- ❑ The practitioner should request permission and ask about preferences related to touch, privacy, modesty, clothing, and the gender of the provider or interpreter.
- ❑ Eye contact, silence, facial expression, physical distance, and emotional display may carry different meanings.
- ❑ Practitioners can remain at the client's physical level, use open-ended questions, and check the meaning of nonverbal responses instead of assuming that nodding, smiling, or limited eye contact communicates agreement.

UWMC, 2011

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V. CULTURAL COMPETENCE IN OCCUPATIONAL THERAPY

Adapting assessments

- Assessment results may reflect language proficiency, educational experience, familiarity with testing, cultural expectations, or environmental opportunity in addition to the ability the tool intends to measure.
- Practitioners should review whether the assessment was developed and validated for the client's population and whether interpretation or modification affects standardization.
- The occupational profile provides essential context for standardized results.
- Practitioners should document accommodations, explain limitations in interpretation, and avoid presenting culturally unfamiliar tasks as neutral measures of ability.
- When a tool does not fit, clinical reasoning should include alternative methods such as observation in meaningful tasks, caregiver input with the client's permission, and repeated assessment across contexts.

AOTA, 2020; Kokorelias et al., 2025; Odawara, 2005

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V. CULTURAL COMPETENCE IN OCCUPATIONAL THERAPY

Traditional practices and the plan of care

- Respectfully ask about home remedies, traditional healers, foods, herbs, body practices, and spiritual or religious approaches.
- The practitioner can determine whether a practice is beneficial, neutral, potentially harmful, or likely to interact with treatment, medication, equipment, or precautions.
- When a practice is not contraindicated, incorporating it may preserve meaning and strengthen collaboration.
- When safety concerns exist, the practitioner should explain the specific risk, invite the client's reasoning, and seek an acceptable alternative.
- Ridicule or immediate dismissal can damage trust and prevent clients from disclosing practices that affect care.

Salimbene, 2015

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V. CULTURAL COMPETENCE IN OCCUPATIONAL THERAPY

Adapting interventions

- Intervention should connect with occupations the client values and with routines that can continue outside therapy.
- Adaptation may involve changing the activity, materials, setting, communication method, schedule, level of family involvement, or expected form of participation.
  - For example, meal preparation training should reflect foods, tools, kitchen practices, family roles, and dietary beliefs that are relevant to the client.
  - Dressing goals should consider preferred clothing and assistance patterns.
  - Community mobility planning should account for transportation access and the places the client actually needs or wants to reach.

The practitioner confirms fit by asking for feedback and revising the plan as the client's needs become clearer.

Odawara, 2005; Agner, 2020; Kokorelias et al., 2025

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V. CULTURAL COMPETENCE IN OCCUPATIONAL THERAPY

Respecting values, beliefs, and traditions

- Respect does not require the practitioner to agree with every belief or choice.
- It requires an effort to understand how the client's values influence occupational decisions and to avoid treating difference as pathology.
- When safety, ethics, or legal responsibilities create limits, the practitioner should explain those limits clearly and explore acceptable alternatives.
- Traditions and beliefs should be discussed at the individual level.
- Knowledge about a community can help a practitioner ask better questions, but it should never replace the client's own account.
- People within the same culture differ by generation, religion, geography, socioeconomic context, family experience, and personal preference.

Agner, 2020; Odawara, 2005

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VI. COMMON CULTURES IN OUR REGION

Selected cultural communities in California

- Current U.S. Census Bureau data shows:
  - 41.2% of Californians identify as Hispanic or Latino
  - 17.5% as Asian, 6.4% as Black
  - 4.3% as American Indian or Alaska Native
  - 0.6% as Native Hawaiian or Other Pacific Islander.
    - Latino
    - Chinese American, Filipino, Vietnamese
    - African American
    - Middle Eastern
    - Native American
    - Pacific Islander

U.S. Census Bureau, QuickFacts: California, 2020–2025 data.

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VI. COMMON CULTURES IN OUR REGION

Self-care and cultural responsiveness

- Self-care evaluation uses defined activities and consistent clinical criteria.
- Culture does not change the activity being evaluated, but it may affect whether the assessment environment allows the client to demonstrate usual or preferred performance.
- Eating, oral hygiene, toileting, bathing, dressing, footwear, and bathroom transfers involve privacy, touch, food practices, clothing, gender preferences, religious observance, family roles, and personal meanings of independence.
- Occupational therapy practitioners should ask which factors matter to the individual client before interpreting performance.

Community knowledge supports respectful questions. The client determines whether a possible cultural consideration is relevant.

AOTA, 2020; Agner, 2020; Odawara, 2005

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VI. COMMON CULTURES IN OUR REGION

Cultural considerations across self-care

Eating and oral care	Ask about preferred foods, utensils, hand use, dentures, oral-care products, mealtime routines, fasting, and whether adaptive equipment is acceptable.
Toileting and bathing	Protect privacy and ask about cleansing methods, use of water, bathing routines, hair and skin care, modesty, religious washing, and same-gender assistance.
Dressing and footwear	Ask about religious or traditional clothing, head coverings, jewelry, fasteners, customary footwear, and clothing the client expects to wear at home.
Transfers and caregiving	Assess the actual bathroom environment and ask who may assist. Do not assume that relatives are available, willing, trained, or authorized to provide intimate care.

AOTA, 2020; UWMC, 2011; Salimbene, 2015

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VI. COMMON CULTURES IN OUR REGION

Self-care performance, preference, and context

- Occupational therapy practitioners should distinguish physical or cognitive inability from language misunderstanding, modesty, religious preference, unfamiliarity with the clinical environment, reluctance to perform for an unfamiliar practitioner, or lack of access to the client's usual clothing, food, utensils, and equipment.
- Before concluding that a client cannot perform an activity, provide qualified language assistance when needed, explain why the task is being observed, arrange appropriate privacy, and offer a reasonable opportunity to use customary items or routines when clinically safe.
- Evaluate performance using the applicable clinical criteria.

Document the context that influenced performance and avoid interpreting cultural preference as impairment.

Agner, 2020; AOTA, 2020; Kokorelias et al., 2025

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VI. COMMON CULTURES IN OUR REGION

Latino/Hispanic communities

Latino and Hispanic are broad identities that include people with roots in Mexico, Central America, South America, the Caribbean, Spain, and the United States. Country, region, race, Indigenous identity, migration history, generation, language, religion, and family traditions may all shape experience differently.

Cultural humility means using background knowledge to prepare respectful questions while allowing the client—not a cultural label—to explain which identities, values, relationships, and occupations matter in care.

Agner, 2020; AOTA, 2020; Salimbene, 2015.

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VI. COMMON CULTURES IN OUR REGION

Latino/Hispanic background and context

Language	Ask the client's preferred language and literacy needs; arrange a qualified interpreter when needed and speak directly to the client.
Relationships	For some clients, personal warmth, respect, trust, and time spent building rapport may support disclosure and participation.
Family and health	Ask whom the client wants involved, how decisions are made, and whether spiritual beliefs, traditional remedies, food practices, or access barriers affect daily occupations.

These are possible influences—not universal Latino/Hispanic traits.

Salimbene, 2015; University of Washington Medical Center [UWMC], 2007, 2011; Agner, 2020.

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VI. COMMON CULTURES IN OUR REGION

Latino/Hispanic clients: clinical and self-care application

Ask how the client describes the condition, which routines matter, and what assistance is acceptable before modifying self-care tasks.

SELF-CARE AND ROUTINES

- ❑ Use familiar foods, utensils, grooming items, clothing, and bathing routines when feasible.
- ❑ Ask about modesty, touch, same-gender assistance, and privacy during toileting, bathing, and dressing.
- ❑ Explore whether independence means doing the task alone or participating with family assistance.
- ❑ Check whether prayer, remedies, diet, or caregiving schedules affect treatment timing.

COMMUNICATION AND PLANNING

- ❑ Use a qualified interpreter; do not rely on family for clinical interpretation.
- ❑ Use teach-back or demonstration because polite agreement does not prove understanding.
- ❑ Invite the client to identify desired family involvement in training and discharge planning.
- ❑ Offer choices and explain the purpose of adaptive equipment, home programs, and precautions.

UWMC, 2007, 2011; Salimbene, 2015; Agner, 2020; AOTA, 2020.

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VI. COMMON CULTURES IN OUR REGION

Latino/Hispanic Communities: OT Considerations

Important: Latino/Hispanic populations are highly diverse. Cultural practices can vary significantly by country of origin, generation, language, and family traditions.

Potential Cultural Considerations

- ❑ Family and close social relationships may play an important role in healthcare decisions
- ❑ Familismo may influence preferences for family involvement and caregiving
- ❑ Some patients may prefer Spanish or another language rather than English
- ❑ Respectful, relationship-based communication can be important
- ❑ Religious or spiritual beliefs may influence health perspectives
- ❑ Traditional remedies or healthcare practices may be used alongside medical care

OT Practice

- ❑ Ask: "Who would you like involved in your care?"
- ❑ Determine preferred language rather than assuming
- ❑ Use a qualified medical interpreter when needed
- ❑ Incorporate meaningful family roles and routines into goals
- ❑ Ask about traditional practices without judgment
- ❑ Connect therapy goals to meaningful daily activities

Best Outcomes

Build trust + involve the patient's support system + communicate clearly + connect therapy to meaningful occupations + address language needs.

Agner, 2020; AOTA, 2020; UWMC, 2007, 2011; Salimbene, 2015.

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VI. COMMON CULTURES IN OUR REGION

Asian communities

Asian is a broad racial and geographic category encompassing East Asian, Southeast Asian, South Asian, and other communities—including Chinese, Filipino, Vietnamese, Korean, Japanese, Indian, Pakistani, Cambodian, Hmong, Thai, and many additional identities. These communities do not share one language, religion, history, family structure, or health belief system.

Variation within each community may reflect region, ethnicity, generation, migration or refugee experience, colonial history, socioeconomic position, disability, faith, and use of traditional or biomedical care. Ask how the client identifies and which influences are relevant.

Agner, 2020; AOTA, 2020; Salimbene, 2015; UWMC, 2007.

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VI. COMMON CULTURES IN OUR REGION

Asian background and context

Communication	Preferred language, directness, eye contact, emotional expression, silence, nodding, and willingness to disagree vary widely. Confirm meaning rather than interpreting a behavior through a cultural stereotype.
Family and authority	Some clients may value family participation or show deference to clinicians; others may prefer individual decision-making. Ask who should receive information and how choices should be made.
Health and occupation	Traditional remedies, food practices, concepts of balance, faith, stigma, migration history, work, and caregiving may affect routines. Ask what has been tried and what the client believes will support recovery.

Salimbene, 2015; UWMC Chinese and Vietnamese Culture Clues, 2007; UWMC All Cultures, 2011; Agner, 2020.

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VI. COMMON CULTURES IN OUR REGION

Asian clients: clinical and self-care application

Use the client's specific identity and preferences—not the label "Asian"—to guide evaluation, teaching, and self-care intervention.

SELF-CARE AND ROUTINES

- ❑ Ask about staple foods, utensils, meal timing, oral-care practices, clothing, footwear, and bathing routines.
- ❑ Protect modesty; ask about same-gender assistance and permission before touching the head or body.
- ❑ Explore traditional practices such as herbs, therapeutic foods, massage, coining, cupping, or skin pinching without ridicule.
- ❑ Assess home setup and family routines before recommending equipment or changing task methods.

COMMUNICATION AND PLANNING

- ❑ Identify the preferred language and use a qualified interpreter for informed clinical communication.
- ❑ Use teach-back and return demonstration; nodding, smiling, or silence may not mean agreement.
- ❑ Ask whom the client wants involved while continuing to address the client directly.
- ❑ Explain procedures, prognosis, risk, adaptive equipment, and unfamiliar rehabilitation expectations clearly.

Salimbene, 2015; UWMC, 2007, 2011; Agner, 2020; AOTA, 2020.

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VI. COMMON CULTURES IN OUR REGION

Asian Communities: OT Considerations

Important: "Asian" includes many distinct communities. Country or ethnic identity, language, generation, migration history, religion, and family context are more clinically useful than the umbrella label alone.

Potential Cultural Considerations

- ❑ Language and communication preferences vary widely
- ❑ Family participation may be valued, but must be invited
- ❑ Respect for authority can mask questions or disagreement
- ❑ Traditional and biomedical practices may coexist
- ❑ Modesty, touch, food, and self-care customs may differ

OT Practice

- ❑ Ask how the client identifies and which language is preferred
- ❑ Use teach-back; do not equate nodding with understanding
- ❑ Ask who should receive information and join decisions
- ❑ Explore remedies and routines for meaning and safety
- ❑ Adapt tasks and equipment to the actual home context

Best Outcomes

Avoid pan-Asian assumptions. Individualize communication, self-care training, family participation, and intervention around the client's stated identity and routines.

Agner, 2020; AOTA, 2020; Salimbene, 2015; UWMC, 2007, 2011.

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VI. COMMON CULTURES IN OUR REGION

African American communities

African American communities include varied regional, ancestral, religious, linguistic, socioeconomic, immigration, and family experiences. Identity may be shaped by community traditions and by the continuing effects of racism, segregation, unequal access, and prior encounters with health institutions.

Culturally responsive care examines both interpersonal trust and structural barriers. Practitioners should explore valued roles and supports while asking how transportation, employment, caregiving, insurance, environmental access, or experiences of bias affect occupational participation.

AOTA, 2020; Agner, 2020; Salimbene, 2015.

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VI. COMMON CULTURES IN OUR REGION

African American background and context

Trust and power	Prior discrimination or dismissal may affect trust. Name choices transparently, invite questions, and acknowledge concerns without defensiveness.
Family and community	Family, friends, churches, faith leaders, and community networks may be important supports for some clients; ask whom the client wants included.
Health beliefs	Clients may use spiritual practices, traditional remedies, or biomedical care in different combinations. Ask what has been tried and discuss specific safety issues respectfully.

Do not explain disparities through culture alone; assess institutional and practical barriers.

AOTA, 2020; Agner, 2020; Salimbene, 2015.

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VI. COMMON CULTURES IN OUR REGION

African American clients: clinical and self-care application

Connect self-care recommendations to the client's identity, priorities, resources, and experience with the health system.

SELF-CARE AND ROUTINES

- ❑ Ask about preferred hair, skin, oral-care, bathing, clothing, and grooming routines and provide appropriate supplies.
- ❑ Protect hair and skin; avoid assumptions that standard products or schedules are acceptable.
- ❑ Explore desired family assistance, privacy, modesty, and the meaning of independence.
- ❑ Check whether equipment, home modifications, food, or supplies are affordable and available.

COMMUNICATION AND PLANNING

- ❑ Ask about past care experiences and respond to concerns about bias or dismissal.
- ❑ Explain recommendations, risks, and alternatives transparently; invite disagreement.
- ❑ Include family, faith, or community supports only with the client's permission.
- ❑ Address transportation, work, insurance, caregiver demands, and environmental access in planning.

AOTA, 2020; Agner, 2020; Salimbene, 2015.

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VI. COMMON CULTURES IN OUR REGION

African American Communities: OT Considerations

Important: African American communities are diverse in culture, religion, socioeconomic experiences, and family structure. Individual experiences with healthcare may also vary.

Potential Cultural Considerations

- ❑ Family, community, and faith may be important sources of support
- ❑ Religious/spiritual beliefs may influence coping and health decisions
- ❑ Some individuals may have concerns related to historical and personal experiences with healthcare systems
- ❑ Communication preferences vary; avoid assuming based on race
- ❑ Trust and respectful therapeutic relationships are important

OT Practice

- ❑ Establish rapport before immediately focusing on treatment tasks
- ❑ Ask about the patient's previous healthcare experiences
- ❑ Invite questions and encourage active participation in decisions
- ❑ Include family/community supports when desired by the patient
- ❑ Respect spiritual practices and beliefs
- ❑ Explain the purpose and expected benefit of interventions

Best Outcomes

Build trust + demonstrate respect + communicate transparently + involve the patient in decisions.

AOTA, 2020; Agner, 2020; Salimbene, 2015.

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VI. COMMON CULTURES IN OUR REGION

Middle Eastern communities

Middle Eastern is a broad regional label encompassing many national, ethnic, linguistic, and religious identities, including Arab, Iranian, Turkish, Kurdish, Armenian, Jewish, Christian, Muslim, and other communities. It does not identify one language, religion, migration history, or family structure.

Experiences may differ by generation, refugee or war history, faith practice, gender, and prior health systems. Ask which identities and practices influence the client's occupations, relationships, and care.

Salimbene, 2015; Agner, 2020; Kokorelias et al., 2025.

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VI. COMMON CULTURES IN OUR REGION

Middle Eastern background and context

Relationship	A formal greeting, hospitality, and time spent establishing trust may support rapport for some clients; ask how the person prefers to be addressed.
Family and privacy	Ask whom the client wants involved, how sensitive information should be shared, and whether gender concordance, modesty, or privacy affects care.
Faith and routines	Prayer, fasting, food restrictions, ritual washing, family responsibilities, and treatment ingredients may influence scheduling or self-care. Determine relevance directly.

Communication style, personal space, and emotional expression vary; clarify meaning rather than assigning it.

Salimbene, 2015; Agner, 2020; UWMC, 2011.

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VI. COMMON CULTURES IN OUR REGION

Middle Eastern clients: clinical and self-care application

Ask about privacy, gender, faith practices, family roles, and daily routines before providing hands-on self-care assistance.

SELF-CARE AND ROUTINES

- ❑ Protect modesty during bathing, toileting, dressing, transfers, and skin inspection.
- ❑ Ask whether same-gender practitioners, interpreters, or caregivers are preferred and feasible.
- ❑ Explore prayer positions, washing routines, fasting, food restrictions, clothing, and footwear.
- ❑ Determine whether equipment or task methods conflict with dress, ritual, household, or family routines.

COMMUNICATION AND PLANNING

- ❑ Use a qualified interpreter and address the client directly.
- ❑ Ask whom the client wants involved and how sensitive information should be shared.
- ❑ Explain ingredients, procedures, touch, and the purpose of unfamiliar activities.
- ❑ Do not infer anger, agreement, or discomfort from volume, repetition, distance, or indirect responses.

Salimbene, 2015; UWMC, 2011; Agner, 2020; AOTA, 2020.

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VI. COMMON CULTURES IN OUR REGION

Middle Eastern Communities: OT Considerations

Important: "Middle Eastern" represents many countries, ethnicities, languages, religions, and traditions. Do not treat the region as one homogeneous culture.

Potential Cultural Considerations

- ❑ Family involvement may be important in healthcare decision-making
- ❑ Religious beliefs may influence daily routines and healthcare practices
- ❑ Modesty and privacy may be important considerations
- ❑ Gender preferences may influence comfort with personal care or physical contact
- ❑ Dietary practices may be influenced by religious or cultural beliefs
- ❑ Language preferences may include Arabic, Farsi, Hebrew, Kurdish, Turkish, and others

OT Practice

- ❑ Ask about preferences regarding therapist/caregiver gender
- ❑ Provide privacy during dressing, bathing, and other personal-care interventions
- ❑ Ask about religious practices that affect scheduling or routines
- ❑ Consider prayer, fasting, dietary practices, and religious holidays when relevant
- ❑ Ask who the patient wants involved in decision-making
- ❑ Use qualified interpreters when needed

Best Outcomes

Respect privacy + understand religious/cultural routines + involve the family according to patient preference + individualize care.

Agner, 2020; Kokorelias et al., 2025; Salimbene, 2015; UWMC, 2011.

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VI. COMMON CULTURES IN OUR REGION

Native American/Indigenous communities

Native American and Alaska Native peoples belong to many distinct sovereign nations and communities with their own governments, lands, languages, histories, ceremonies, and healing traditions. A broad Indigenous identity cannot substitute for learning the client's preferred nation or community name.

Urban or rural residence, tribal citizenship, community connection, generation, and historical or present-day experiences with forced assimilation, relocation, and inequitable systems may influence trust and access.

Agner, 2020; AOTA, 2020; Salimbene, 2015.

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VI. COMMON CULTURES IN OUR REGION

Native American/Indigenous background and context

Nation and identity	Ask the client's preferred nation, tribal, community, or Indigenous identity; do not assume that all Native peoples share practices.
Relationships	Elders, extended family, community, spirituality, and relationships with land may be important for some clients. Ask who and what should be included.
Communication and trust	Silence, pacing, eye contact, and storytelling may carry different meanings. Allow time and explain how information will be used.

Traditional healing and biomedical care may coexist; ask what practices the client wishes to continue or accommodate.

Salimbene, 2015; Agner, 2020; AOTA, 2020.

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VI. COMMON CULTURES IN OUR REGION

Native American/Indigenous clients: clinical and self-care application

Let the client define which nation, community, family, land, spiritual, and healing connections are relevant to self-care and recovery.

SELF-CARE AND ROUTINES

- ❑ Ask about preferred foods, clothing, footwear, hair, bathing, and personal items before changing routines.
- ❑ Allow time and privacy for traditional healing, ceremony, prayer, or meaningful community practices when feasible.
- ❑ Explore distance from services, housing, water access, equipment availability, and transportation.
- ❑ Avoid positioning "independence" as separation from family or community support.

COMMUNICATION AND PLANNING

- ❑ Ask how the client identifies and which people should be involved.
- ❑ Allow silence; avoid rushing responses or interpreting limited eye contact.
- ❑ Explain procedures, documentation, and information sharing transparently.
- ❑ Coordinate with tribal or community resources only with permission and respect for sovereignty.

Salimbene, 2015; Agner, 2020; AOTA, 2020.

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VI. COMMON CULTURES IN OUR REGION

Native American/Indigenous Communities: OT Considerations

Important: Native American/Indigenous peoples represent many distinct tribal nations, each with its own traditions, languages, histories, and beliefs. Avoid treating them as one culture.

Potential Cultural Considerations

- ❑ Connection to family, community, land, and traditions may be significant
- ❑ Spirituality and traditional healing practices may influence health perspectives
- ❑ Community and family participation may be important
- ❑ Historical experiences with healthcare systems may influence trust
- ❑ Some individuals may prefer traditional healing practices alongside Western healthcare
- ❑ Communication styles and concepts of wellness may differ from Western biomedical models

OT Practice

- ❑ Ask the patient what wellness and recovery mean to them
- ❑ Respect traditional healing practices when safe and appropriate
- ❑ Ask whether family/community members should participate
- ❑ Allow time for relationship-building and trust
- ❑ Avoid assuming that traditional practices are incompatible with rehabilitation
- ❑ Incorporate meaningful cultural, community, and daily occupations when appropriate

Best Outcomes

Build trust + respect cultural identity + support patient-defined wellness + collaborate rather than prescribe.

Agner, 2020; AOTA, 2020; Salimbene, 2015.

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VI. COMMON CULTURES IN OUR REGION

Pacific Islander communities

Pacific Islander is a broad category that includes Native Hawaiian, Samoan, Tongan, Chamorro, Marshallese, Fijian, and other communities with distinct languages, political histories, island or national identities, migration pathways, and traditions. A specific island or community identity may be more meaningful than the umbrella label.

Family, church, community, land or ocean, and collective responsibilities may be important for some clients, but their form and meaning vary. Ask which relationships, roles, and places matter to the individual.

Agner, 2020; Kokorelias et al., 2025; AOTA, 2020.

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VI. COMMON CULTURES IN OUR REGION

Pacific Islander background and context

Identity and language	Ask the client's preferred island, national, ethnic, and language identity; do not treat Pacific Islander communities as interchangeable.
Relationships and roles	Family, church, elders, community obligations, and collective caregiving may influence schedules and goals. Ask whom the client wants involved.
Context and access	Migration history, work, transportation, distance, cost, and access to culturally familiar services may affect participation and follow-through.

Connect intervention with the client's actual home, family, community, faith, food, land, ocean, and recreation routines.

Agner, 2020; Kokorelias et al., 2025; AOTA, 2020.

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VI. COMMON CULTURES IN OUR REGION

Pacific Islander clients: clinical and self-care application

Ask which island, family, community, and faith contexts shape self-care rather than relying on a broad Pacific Islander label.

SELF-CARE AND ROUTINES

- ❑Ask about specific foods, utensils, meal routines, grooming, clothing, footwear, bathing, and toileting preferences.
- ❑Explore whether body size, comfort, and home space require different equipment dimensions or transfer methods.
- ❑Avoid using BMI or appearance as a substitute for individualized functional assessment.
- ❑Consider transportation, distance, household space, caregiving duties, and equipment availability.

COMMUNICATION AND PLANNING

- ❑Ask the preferred language and use qualified interpretation when needed.
- ❑Determine desired family, elder, church, or community participation while preserving the client's voice.
- ❑Use demonstration and teach-back; adapt education to preferred ways of learning.
- ❑Schedule home programs around work, worship, community events, and shared responsibilities.

Agner, 2020; Kokorelias et al., 2025; AOTA, 2020.

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VI. COMMON CULTURES IN OUR REGION

Pacific Islander Communities: OT Considerations

Important: Pacific Islander communities differ by island, nation, language, political history, migration experience, faith, and family organization.

Potential Cultural Considerations

- ❑ Family, elders, church, or community may support decisions
- ❑ Collective responsibilities may affect schedules and goals
- ❑ Food, body, clothing, and self-care practices are individualized
- ❑ Distance, cost, and transportation may affect access
- ❑ Home space and equipment fit require direct assessment

OT Practice

- ❑ Ask the client's specific island and language identity
- ❑ Invite family or community participation with permission
- ❑ Select equipment by function, fit, comfort, and home space
- ❑ Adapt training to preferred learning and real routines
- ❑ Plan around transportation and shared responsibilities

Best Outcomes

Honor specific identity, preserve the client's voice, and make self-care plans workable within the household, community, environment, and available resources.

Agner, 2020; Kokorelias et al., 2025; AOTA, 2020.

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VI. COMMON CULTURES IN OUR REGION

Avoiding cultural stereotypes

- ❑ Statements about cultural groups describe possible patterns, not rules for individual clients. Assuming that a client values family decision-making, follows a traditional health practice, or prefers a particular communication style can be as harmful as ignoring culture completely.
- ❑ A culturally responsive practitioner uses background knowledge to develop respectful questions. The client then confirms, rejects, or modifies the relevance of that information.
- ❑ The practitioner remains attentive to variation within cultures and to the way identities change across time and situations.

The clinical standard is individualized inquiry, not cultural prediction.

Agner, 2020; Odawara, 2005

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VII. APPLICATION IN CLINICAL PRACTICE

Client-centered care

- ❑ Client-centered care requires more than offering choices from a predetermined plan. It begins with the client's account of meaningful occupations, desired roles, concerns, and definition of a successful outcome.
- ❑ The practitioner contributes clinical knowledge while recognizing that the client understands the lived consequences of each option.
- ❑ Collaborative goals should describe participation that matters to the client. When priorities differ, the practitioner can identify the source of disagreement, explain clinical reasoning, and negotiate a plan.
- ❑ Documentation should distinguish the client's stated preferences from the practitioner's observations and recommendations.

Agner, 2020; Kokorelias et al., 2025

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VII. APPLICATION IN CLINICAL PRACTICE

Collaboration with families and communities

- ❑ Family participation should follow the client's preferences, communication needs, legal rights, and clinical context.
- ❑ Practitioners should ask who the client considers family, what roles those individuals hold, and how information or decisions should be shared. Family support may strengthen participation, but it should not automatically replace the client's voice.
- ❑ Community collaboration helps practitioners understand local resources, barriers, and meaningful settings for occupation.
- ❑ Partnership involves listening to community priorities and developing services with communities rather than assuming that professional expertise alone defines the need.

AOTA, 2020; Kokorelias et al., 2025

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VII. APPLICATION IN CLINICAL PRACTICE

Ethical and professional responsibilities

- ❑ Culture affects ethical questions about autonomy, safety, informed consent, confidentiality, justice, and use of professional authority. Practitioners should consider whether a recommendation protects the client, restricts the client, or reflects the practitioner's own values about independence and risk.
- ❑ Professional responsibility includes using qualified communication support, selecting appropriate assessments, documenting limitations, protecting the client's right to participate in decisions, and addressing institutional barriers when they produce inequitable care.
- ❑ Consultation is appropriate when cultural questions intersect with legal, ethical, or safety concerns.

AOTA, 2020; Agner, 2020; Kokorelias et al., 2025

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VIII. GROUP BREAKOUT

Second group breakout

- ❑ Return to the original Alex Morgan case and the plan your group developed at the beginning of the workshop. Review every evaluation priority, goal, treatment approach, discharge recommendation, and communication strategy.
- ❑ Your group will receive a role card that adds cultural, social, or family information. Conduct a brief role-play in which one participant represents Alex, one represents a family member or support person, one represents the occupational therapy practitioner, and one observes the interaction.

Revise the plan only after asking the client questions. The role card provides context for discussion, not a complete description of the client.

Agner, 2020; Kokorelias et al., 2025

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VIII. GROUP BREAKOUT

Role-play influences

Communication	Alex uses a preferred language other than English and understands some conversational English. Determine how the team will support informed communication during evaluation, education, and goal setting.
Family roles	Alex wants a family member involved in health decisions and daily care. Explore who should participate, how Alex's own preferences will remain central, and what caregiver training would be meaningful.
Health beliefs	Alex uses a traditional health practice and worries that the rehabilitation plan conflicts with it. Ask how the practice fits daily life and discuss safety without dismissing its meaning.
Daily occupations	Alex values a role or routine that the original plan did not address. Revise the goals and intervention to include the occupation and its social context.

Agner, 2020; Odawara, 2005; Kokorelias et al., 2025

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IX. COMPARE/CONTRAST

Compare and contrast the two plans

Initial plan	Identify the goals, treatment methods, communication choices, and discharge recommendations your group developed before the presentation. Name the assumptions that shaped those choices.
Revised plan	Describe what changed after the role-play. Explain which new questions, client preferences, cultural influences, or structural barriers changed the plan.
Clinical reasoning	Determine whether the revised plan improved cultural responsiveness, occupational relevance, informed choice, feasibility, or therapeutic rapport. Identify any ethical tension that remains unresolved.

Agner, 2020; Kokorelias et al., 2025

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IX. COMPARE/CONTRAST

Large-group discussion

How were the revised plans similar across groups, even when the role cards differed? Which culturally responsive practices were useful across several scenarios?

How were the plans different? Which differences resulted from the individual client's stated preferences rather than assumptions about a cultural group?

Which parts of the original plan remained appropriate? Cultural responsiveness does not require changing every recommendation. It requires examining fit, explaining reasoning, and revising the plan when the client's context changes what is meaningful or feasible.

Agner, 2020; Kokorelias et al., 2025

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X. CONCLUSION

A concrete action step

Write one action you will complete within the next month. The action should be specific enough to observe and should address clinical practice or interprofessional collaboration.

Clinical example	During every initial evaluation, I will ask who the client wants involved in decisions and how cultural or spiritual beliefs may affect the plan.
Reflection example	I will review one documentation sample each week for assumptions presented as facts and discuss one finding in supervision.
Team example	I will add a cultural humility question to case conference: What client perspective or structural barrier may be missing from our plan?

Agner, 2020; Kokorelias et al., 2025

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X. CONCLUSION

Continuous learning and reflection

- ❑ Cultural humility has no final point of mastery. Clients, communities, and cultures change, and practitioners continue to encounter perspectives that challenge their expectations.
- ❑ Ongoing reflection helps practitioners identify bias, tolerate uncertainty, and learn from difficult interactions.
- ❑ Continuing education, supervision, community partnership, feedback from clients, and interprofessional discussion can support this process.
- ❑ Organizations also carry responsibility for policies, communication resources, and practice environments that make culturally responsive care possible.

Agner, 2020; AOTA, 2020; Kokorelias et al., 2025; Suarez-Balcazar et al., 2009

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X. CONCLUSION

Role of occupational therapy practitioners

- ❑ Occupational therapy practitioners can promote culturally responsive care by connecting intervention to the client's own occupations, asking how culture and context shape participation, and sharing decisions with clients and families according to the client's preferences.
- ❑ Practitioners also influence teams and systems. They can challenge stereotyped explanations, describe structural barriers in documentation and case conferences, advocate for communication access, and help colleagues distinguish a client's informed choice from assumptions about motivation or adherence.

Cultural responsiveness becomes part of ethical clinical reasoning rather than an additional task.

Agner, 2020; AOTA, 2020; Kokorelias et al., 2025

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X. CONCLUSION

Key points

Cultural competence develops knowledge and clinical skills. Cultural humility keeps that learning open, reflective, and attentive to power.

Culture influences the meaning and organization of occupation, but cultural group membership never predicts the preferences of an individual client.

Responsive practice uses respectful communication, appropriate assessment, collaborative goals, and interventions that fit real roles, routines, resources, and beliefs.

Every participant should leave with one practical action that supports continued reflection or better collaboration.

Agner, 2020; Odawara, 2005; Kokorelias et al., 2025; AOTA, 2020

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Questions and discussion

What is one change you will make in your next clinical encounter?

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