Occupational Therapists' Racial and Ethnic Attitudes: A Replication Study

A Master's Thesis Presented to the

Faculty of the Graduate Program in Occupational Therapy

Ithaca College

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In partial fulfillment of the requirements for the degree

Master of Science

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By

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August 2016

Ithaca College

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CERTIFICATE OF APPROVAL

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Abstract

There is only a small amount of research of the effects of race, culture and ethnicity on occupational therapy (OT) practice. This study was based on a replication of the study designed in 1987 and first replicated in 1996. In all three studies, occupational therapists and occupational therapy assistants were surveyed about how they feel their own backgrounds and their clients' backgrounds affect the occupational therapy process with small modifications made to the questions to modernize language and to the format to increase return of the survey. The most significant finding from the current study was that attendance at a sociocultural (diversity) workshop or seminar had a statistically significant association with how therapists respond to a questions about how a therapist's ethnic background could interfere with treatment. Additionally, when registered occupational therapists (OTR's) were asked how a client's background interferes with and enhances therapy, multiple themes were identified. Some examples include, learning from the client, helping to establish rapport, language/communication barriers, etc. When OTR's were asked how a therapist's background interferes with and enhances therapy, again multiple themes were identified. Some examples include, increased relatability with client, therapeutic use of self and the invisibility of White privilege. These themes identified are very similar to those identified in the 1996 replication. More research needs to be done on the relationship between the attitudes occupational therapists have about race, culture and ethnicity and the effects it has on the OT process. This study leads to implications for the profession of occupational therapy, practicing occupational therapists, OT educators, OT students and clients of occupational therapy.

Acknowledgments:

Thanks to my support system for making this thesis a reality!

Jessica Valdez Taves, Advisor

Dr. Kim Wilkinson, Statistical Advisor

Dr. Ellie Fitts Fulmer, Committee

Dr. Nia Michelle Nunn, Committee

I would also like to thank my family and friends for supporting and encouraging me for the past year!

Dedication

This thesis is dedicated to my mother, Mary Giarratano, who without her I would have never heard of occupational therapy. I am continually inspired to become a better occupational therapist, researcher and person with her support.

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Chapter 1: Introduction

Occupational therapy "help[s] people...participate in the things they want and need to do through the therapeutic use of everyday activities (occupations)" (AOTA, n.d.). Occupational therapists (OTR) work across the lifespan from neonatal intensive care to end of life care. In each setting occupational therapists should ask their clients what is most meaningful to them. This could include being able to play with friends on the playground, cook a meal for their family or get dressed in the morning independently. Using purposeful therapeutic techniques, activities and adaptations, occupational therapists work with their clients as well as collaboratively with other professionals to obtain individualized goals and improve overall quality of life for their client.

Occupational therapy (OT) was formally recognized in 1917 with the founding of the National Society for the Promotion of Occupational Therapy, which three years later, in 1920, changed its name to the current American Occupational Therapy Association (AOTA) (History of AOTA accreditation, n.d). It was discovered that using occupations was successful in helping clients' complete activities of daily living (ADL's). Since its conception, OT has grown and flourished expanding the scope of practice to fit the needs of each individual client. However, the composition of professionals has not significantly changed; the majority of occupational therapists in the United States are middle class, white females (U.S. Department of Health and Human Services, 2014; Bureau of Labor Statistics, 2014). The most recent data states that only 10.2% of occupational therapists are male and 89.8% are female (U.S. Department of Health and Human Services, 2014, p.7). The U.S. Department of Health and Human Services (2014) has also compiled data that 87.2% of occupational therapists identify as White, while only 6.3% are Asian, 5% are African American, 4.3% are Hispanic, 1.2% are multiple/other races, and just 0.2% are American Indian or Alaskan Native. There was not any data on Pacific Islanders at all. This lack of racial, ethnic and gender diversity can be problematic when working with clients who have different views than the therapist

on key ideas such as independence, motivation or family roles. Awaad (2003) discusses that, "there is the potential hazard of imposing Western (principally Anglo-American) models, principles and practices upon populations whose attitudes, beliefs, values and behaviors may be very different from those of the therapist." In order to help decrease the potentially negative impacts of this lack of racial and gender diversity, cultural competence is a skill that is needed in the practice of occupational therapy. Cultural competence is defined as "the ability to understand and work effectively with patients whose beliefs, values and histories differ from one's own," (Capell, Dean & Veenstra, 2008, p. 121). Additionally, Awaad (2003) states that, cultural competence is described as, "one of the least developed features of occupational therapy" (p. 358).

Table 1 - Comparison of OTR population to US population

Race	Percentage of OTR's Population in US (2014)	Percentage of US Population (2014)
White	87.2	77.4
African American	5	13.2
Asian	6.3	5.4
American Indian or Alaskan Native	0.2	1.2
Multiple/other races	1.2	2.5
Hispanic	4.3	17.4
Pacific Islander	No Data	0.2

Information retrieved from: United States Census Bureau, 2015 & U.S. Department of Health and Human Services, Health Resources and Services Administration, National Center for Health Workforce Analysis, 2014

OT has always prided itself on being a holistic, open-minded profession (Awaad, 2003; Dillard, Andonian, Flores, Lai & Macrae, 1992). The Occupational Therapy Practice Framework (OTPF) analyzes all characteristics and contexts impacting the client in order to design and deliver a comprehensive program that results in the best possible outcome. This mindset is a very logical one. In order to meet the client's needs and goals, the therapist needs to know how the client functions in

all facets of life. Race, ethnicity and culture are prominent influences in a client's life and thus should be an integral part when planning treatment sessions (Nelson, 2007). There are many research articles that discuss the importance of culture in occupational therapy (Awaad, 2003; Capell, Dean & Veenstra, 2008; Dillard et al., 1992; Kreftling, 1991; Pineda, 1996; Skawski, 1987; Hammell, 2013) but more research needs to be done to understand the full impact it can have on each part of the OT process. Within that research, there are very limited studies looking at how race and culture impact both the therapist and the client and their interactions together. The focus of this study is three pronged: 1) to look at how currently practicing occupational therapists view their own racial, cultural and ethnic background, 2) how they view their clients' racial, cultural and ethnic background and 3) how they feel race, culture and ethnicity affects the process and outcomes of therapy.

Critical Race Theory (CRT) guides this study to explore the intersections of race and occupational therapy services. CRT is a body of literature that challenges traditional views of race, originally in the legal arena, coined by legal scholar Derrick Bell in 1985 (De-cuir Gunby & Schutz, 2014). This theory has been adopted in the fields of education, psychology and disability studies over the course of the past 30 years. CRT outlines tenets or key points in order to facilitate in depth analysis of fields of study, situations and interactions. The tenets include counter stories, the permanence of racism, meritocracy and incremental change, interest convergence and Whiteness as property (De-cuir Gunby & Schutz, 2014, p. 252-253). This theory has rarely been connected to occupational therapy, however the primary researcher has identified a correlation between the two. The one main tenet that most relates to this profession is that "Whiteness has value [in society] and...Whiteness [is] the most socially desirable identity and thus the most respectable [in society]" (De-cuir Gunby et al., 2014, p. 253-254). Health care providers who are White are inherently in a position of power due to their role as an educated clinician but also due to societal factors regarding their race, which can be particularly harmful to clients of color, even if White professionals had the

best intentions. "These ways of thinking and knowing are largely invisible to those immersed in them. Most occupational therapists and occupational therapy theory are unavoidably part of this 'invisible' white culture, which affects interactions with clients from all cultural backgrounds," (Nelson, 2007, p. 240). Working towards cultural competence, the first step is recognizing the invisibility (and power) of Whiteness and using that knowledge to make more informed decisions when treating clients of all backgrounds.

For this study, race is defined as a "social classification based on phenotype and a marker for exposure to social factors that can influence health, including socioeconomic position, lifestyle habits, and use of health care" (Hebert, Sisk, & Howell, 2008, p. 375). As a social construct, race has been used throughout history to categorize people into various hierarchies. Ethnicity, on the other hand, is defined as "that part of one's identity derived from membership, usually through birth, in a racial, religious, national or linguistic group or subgroup," (Krefting, 1991, p.6). Many individuals in society including well educated professionals cannot distinguish the difference between race (a social construct) and ethnicity (a membership in a group similar to one's self), which, as illustrated above, are distinctly different (DeCuir-Gunby & Schutz, 2014). This becomes a problem when trying to delve into discussions regarding clinical practice and race. If one cannot distinguish between the terms of race and ethnicity then the means to have an insightful, in depth discussion about the effect these concepts have on interventions, relationships and the therapeutic process is impeded. Without discussion, learning becomes more difficult and no substantial advances can be made.

Culture is "the knowledge, beliefs, values, assumptions, perspectives, attitudes, norms and customs that people acquire through membership in a particular society or group" (Hammell, 2013, p.225). When looking at culture and OT there are many different aspects that need to be considered. According to the Occupational Therapy Practice Framework (OTPF), a registered occupational

therapist (OTR) should consider and evaluate a client's values, beliefs and spirituality when looking at a "client's factors". Those factors that include "specific capacities, characteristics, or beliefs that reside within the person and that influence performance in occupations" (AOTA, 2014, p. S7). A therapist should also consider the client's cultural and personal contexts (AOTA, 2014**)**. From a holistic standpoint cultural competence is considered a core concept and therefore OTR's need to be sensitive to their client's backgrounds, roles and ideals. It is highly likely that throughout their career occupational therapists will work with clients who have different cultures than their own. Even when working with a client who has some of the same ideals or physical characteristics, it is likely that the OTR and the client will have varying opinions and traditions and go about their lives in different ways. As the OTR, there is power and privilege because of the knowledge health professionals have and the overwhelming Whiteness of the profession. However, this power remains largely invisible because of the "well-intentioned desire to 'help.' [OTR's] come from a subliminal position of superiority where [OTR's] see only the 'needs' and fail to see the assets, capabilities and gifts that clients offer," (Nelson, 2007, p. 239). It is in the best interest of the therapist, client and the profession for the OTR's to acknowledge this power and privilege and use it to help, not hinder, communication with their client in order to provide the best, culturally appropriate care,

An important aspect of the OT process is direct contact and communication with the clients. OTR's communicate constantly orally, in writing, with body language, and through facial expressions. Additionally, it is increasingly common to use technology to communicate whether that be through email, text messages or documentation (which can be on paper or electronic). One aspect of communication that is particularly important in OT is *therapeutic use of self* which is defined as the "occupational therapy practitioner's planned use of his or her personality, insights, perceptions

and judgments as part of the therapeutic process" (AOTA, 2008, 653)[1]. This concept is about using the OTR's experiences and insights to help better connect with their clients, ultimately leading to a more client centered treatment session. "Through the use of interpersonal communication skills, occupational therapy practitioners shift the power of the relationship to allow clients more control in decision making and problem solving, which is essential to effective intervention," (AOTA, 2008). Before that power shift can happen however, an OTR needs to understand his/her own perceptions and judgements. In Pineda's study (1996) it was found that "the ability to draw from personal and cultural experiences were a basis for therapeutic use of self," (p. 23). Knowing how one feels about specific topics, especially sensitive ones such as race or discrimination, needs to be explored personally by OT's as these attitudes and feelings are developed based on the unique experiences one has throughout life.

Another key point of communication is language. In the United States of America, English is the dominant language, however there are many different languages that are spoken throughout the country. For example Spanish, German, Korean, Arabic, and many others are all common languages in different sections of the United States (US Department of Commerce, 2013). Not only are different languages spoken but various dialects, such as African American Vernacular English (AAVE) are spoken throughout the country as well (Sidnell, n.d.). The language and dialect spoken by the client is a part of their cultural context and needs to be taken into account during therapy sessions. Language barriers can be challenging to overcome if there is not another way to communicate. Growing technology is helping to decrease the impacts of communication difficulties

[1] This definition comes out of the 2nd edition of the OTPF because it is more descriptive, in depth and pertains specifically to this study as opposed to the definition in the 3rd edition. The definition from the 3rd edition is, "An integral part of the occupational therapy process is therapeutic use of self, which allows occupational therapy practitioners to develop and manage their therapeutic relationship with clients by using narrative and clinical reasoning; empathy; and a client-centered, collaborative approach to service delivery."

with such tools as "Google Translate" or translator applications on cell phones and tablets. However, these methods can be slow and frustrating for both parties if it is a new program or the technology does not cooperate which can decrease the amount of time for direct interventions. Interpreters are another option to help with language barriers. There are varying state requirements for regulation and licensing of these interpreters. As of 2011, the National Council on Interpreting in Health Care has developed standards for interpreter training programs. However, there is not an accreditation process for educational programs. This means that no program has to follow the standards set by the National Council on Interpreting in Health Care (n.d) and an interpreter is not required to have any certifications. This can cause a lack of consistency in different facilities and different areas around the US. Therapists need to consider the various options available for communication in order to optimize intervention sessions.

When talking about language and communication difficulties some of the most important information OTR's give their clients is about the client's current level of functioning. In order to understand this information, the client must be healthcare literate. "Health[care] literacy is '[t]he ability to access, understand, evaluate and communicate information as a way to promote, maintain and improve health in a variety of settings across the life-course" (Levasseur & Carrier, 2010, p. 757). Being healthcare literate translates to being able to understand what medical professionals are saying about the individual's diagnosis, prognosis and treatment options. OTR's need to help their clients to understand the care that they are providing, and more importantly, how it relates to their occupational performance. A crucial part of an OTR's job is educating the client, family and caregivers, and explaining the medical jargon. In addition, OTR's explain the effects the diagnosis or condition can have on their daily lives. It has been found that when clients understand their care it positively affects compliance, safety and satisfaction (Smith & Gutman, 2004). Smith and Gutman (2004) express, "Even people who are well educated and have adequate general literacy may not

have sufficient health literacy," (p.367). Education should be a priority for all clients on an OTR's caseload to increase follow through and increase positive outcomes, such as meeting goals and increasing quality of life.

In areas of race, culture and ethnicity, educational preparedness of the clinicians also needs to be considered. For instance, how educated are clinicians on racial topics? How racially conscious are clinicians? Do they understand their own biases? OT is a White-dominated profession, therefore, an assumption can be made that those White clinicians are not generally educated on racial topics, such as institutionalized racism[2] or microaggressions[3]. It can be assumed that some clinicians (usually of color) have had some personal experiences with race, but most White people are not typically racially conscious. "I think whites are carefully taught not to recognize white privilege, as males are taught not to recognize male privilege," (McIntosh, 1989). This emphasizes the invisibility of whiteness as well as the power and privilege whiteness gives individuals; not having to think about race on a day to day basis is a privilege (McIntosh, 1989).

There is the possibility of learning how to approach these issues in formal education. Except that in the OT curriculum there are very few requirements regarding cultural competence, race, ethnicity or culture in general. Out of the 188 standards written by the Accreditation Council of Occupational Therapy Education required for a master's program, only 10 have been found by the primary researcher to possibly relate to race, culture and/or ethnicity (B.4.2, B.4.4, B.4.7, B.5.1, B.5.18, B.5.19, B.5.20, B.5.29, B.5.7, B.6.1). Many could be interpreted differently and could be met without explicit connection to cultural competence, but the primary researcher was looking for

[2] CRT presupposes a racial realist perspective in that racism remains an 'integral, permanent and indestructible component of this society' and is institutionalized throughout all economic, social, and political systems of the United States (De-cuir Gunby and Schutz, 2014, p.253)

[3] Microaggressions "are brief and commonplace daily verbal, behavioral, and environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative racial slights and insults to the target person or group," (Sue et.al, 2007, p.273)

standards that could possibly relate in any way. The most relevant standard being B.4.7 which states, "*Consider* factors that might bias assessment results, such as culture, disability status, and situational variables related to the individual and context." (ACOTE, 2011, p. 22, emphasis added). Other standards touch on therapeutic use of self, such as (B.5.7), health literacy (B.5.18), selecting appropriate evaluation tools and interventions to address various contexts (B.6.1, B.4.2, B.5.1), making an accurate occupational profile (B.4.4), teaching-learning process and interacting with clients professionally (B.5.19, B.5.20) and appropriate discharge planning in all contexts (B.5.29). Ideally education programs will embed culturally diverse case studies, labs, discussions and fieldwork experiences into the curriculum. Nevertheless specific culturally relevant standards for occupational therapy education programs will ensure that emerging therapists get appropriate chances to learn and practice being culturally competent before going out into the field.

If formal education is not where most OTR's learn about race, culture and ethnicity then the question comes up, where is their knowledge for practice gained? According to Kathryn Skawski (1987), an occupational therapist who conducted a study evaluating the racial and ethnic attitudes of OTR's (p.37), Black therapists were more likely to attribute personal experience to their preparedness. Black therapists were also more likely to feel able to deal with ethnic or racial situations when working with a client. Leah Pineda (1996), another occupational therapist, did a replication study and asked participants to rank which area had given them the most useful information about clients of varying ethnic or racial backgrounds. She found that personal and social experiences were ranked first and on the job experience was ranked second. As evidenced by these previous studies, it has been shown that the classroom is not the primary place OTR's are getting information about race, culture, ethnicity and its importance in practice. The studies are explored briefly below and in more depth in chapter two.

One possible primary source of education could be social media including Facebook, Twitter, online newspapers, etc. Social media has a significant impact on the biases people hold. It also has an influence on how educated people think about specific racial issues. For example, in 2014 the shooting of Michael Brown, an unarmed Black teenager, by a White police officer in Ferguson, MO (Buchanan et al., 2015) was brought to the attention of the general public by social media. The white police officer was eventually acquitted of all charges, spending no jail time. His acquittal resulted in protests in the town of Ferguson and across the country. The shooting, trial and protests were all talked about extensively on social media and in the news all with varying levels of in depth information. In order to be an informed citizen one must be knowledgeable about how to get information and how accurate it will be depending on the source. It is important to understand how these issues can affect people differently, whether they are occupational therapists or clients that OTR's see. The effects of social media has not been studied specifically in relation to OT but has been studied extensively in fields such as anthropology (Bonilla & Rosa, 2015). Further research is needed in this area relating current events, social media, education and occupational therapy.

Kathryn Skawski (1987) conducted a study evaluating the attitudes of OTR's. Specifically, the study was about what cultural factors of the client and the therapist interfere or enhance treatment (p.37). While the terms interfere and enhance and why they were chosen are not explained explicitly in the article, the primary researcher feels it is important to discuss what interfering and enhancing treatment means. To interfere or enhance treatment sessions, one must look at the influence both the client and the therapist have on the intervention session. It is important to note that all information is solely coming from the therapist's view because only OTR's were asked to fill out the survey. The client or their family can be seen to interfere with the session by not following the 'norms' set by the therapist, such as performing the chosen activity in a different way. The author found that "most therapists responding to the survey indicated that the client's background

was more likely to interfere with the treatment process than enhance it," (p. 44). Asian-American and White therapists both stated they felt that both the therapists' and clients' backgrounds interfered with therapy. However, Black therapists felt that their own background was enhancing but the client's' background was interfering with the therapy sessions. Throughout all responses it showed that the therapist thought they enhanced treatment but the client interfered with treatment. While these results were compelling, the study did have limitations. The response rate of this study was very low (17%) and some issues such as differentiating cultural sensitivity and cultural awareness were not discussed (Pineda, 1996). The wording of the open ended questions (specifically using the language enhance and interfere) was another limitation, revealing a potential bias on the part of the researcher. Despite the limitations, this study is unique for its time as well as for its content. Only one similar study was found after extensive research: a replication study which used the same potentially problematic survey questions.

Almost ten years after Skawski published her study in 1987, Pineda adapted that study for her Master's thesis (1996). Pineda surveyed therapists that worked primarily in the physical dysfunction setting. She used five of the same open-ended questions as the original survey as well as incorporating some new closed-ended questions to get a more holistic picture of the occupational therapists. Pineda's results improved in response rate (which went from 17% to 28%) as well as extended the content of the survey. Again only therapists were evaluated, Pineda's (1996) results had a stronger tendency to show that the client's background was a positive influence, instead of an interfering one (Pineda, 1996). This study also considered the education of the clinicians, asking them whether or not they had attended a sociocultural diversity seminar. Pineda (1996) found that if the participant had attended a sociocultural diversity seminar they were more likely to give positive responses to the open ended questions. Some limitations of the study include a relatively low response rate (28%) and the potential that therapists could have responded in a "socially desirable

way" (Pineda, 1996, p.26) because of the sensitive nature of the survey. Even when taking into account the limitations, Pineda's study found there was improvement of attitudes of therapists in the nine years since the original study. There is no evidence that another study of this type has been completed in the two decades since Pineda's study. In general these studies (Skawski, 1987; Pineda, 1996) speak to the fact that while the OT profession is working towards cultural competence and sensitivity more research needs to be done to show the impacts and importance of cultural awareness as a therapeutic outcome.

Rationale:

Skawski (1987) and Pineda (1996) found interesting and insightful results from their studies, showing that as time and the social climate of the US progressed, therapists were more likely to think of a client's influence on therapy as enhancing as opposed to interfering. Although it should be noted that the most recent study was completed in 1996 and was unpublished. Due to the time lapse and the changes in the racial climate of the country, the attitudes of health care professionals, specifically occupational therapists, need to be researched thoroughly in relation to racial and ethnic influences on the therapy process. With the recent changes in legislation, such as the Affordable Care Act, an increasingly diverse number of individuals will potentially be referred to OT to meet their health care needs. Being able to meet the needs of a more diverse clientele, including increasing the client's levels of health literacy, is vital to allow the profession of OT to continue to grow and prosper.

Race continues to be a controversial topic in healthcare (Herbert, Sisk & Howell, 2008**).** It is essential to be sensitive and aware of the client's feelings and identity as well as understanding of one's own feelings and identity. There can be many negative repercussions to approaching the client in a culturally insensitive way. Issues such as language barriers, different beliefs, or a lack of clear communication (i.e. using too much medical jargon when talking to families) have been known to

impede care (Pineda, 1996). For the purpose of this study, cultural sensitivity is understood to be, "a feature of the holistic approach, which is a core concept of occupational therapy," (Awaad, 2003, p. 358). More research needs to be done to show how cultural competence affects occupational performance and what those effects are for the profession of occupational therapy. This study will revisit Skawski and Pineda's findings and hopefully demonstrate that occupational therapist's attitudes have improved since the 1980's and 1990's. Replicating the past two studies would allow the possibility of a meta-analysis comparing the attitudes of OTR's over an almost 30 year period. This study also seeks to probe deeper into the implications of a White-dominated profession that has historically focused little attention on issues of race, culture, and ethnicity, in order to understand the factors that influence client success with treatment.

Research Problem:

Occupational Therapy is a holistic profession, meaning it emphasizes the importance of the whole individual and the interdependence of the various parts of the person, such as the contexts, relationships, previous experiences, etc (AOTA, 2014). OT also uses the social model described by the International Classification of Functioning, Disability and Health (ICF) rather than the medical model that is used by other healthcare professionals (WHO, 2002) to guide practice. Because OT emphasizes the uniqueness of an individual and the importance of the client's opinion, OT itself is a distinct profession in healthcare. There is limited evidence regarding occupational therapists' attitudes towards racial, cultural and ethnic differences and how they might impact the occupational process.

This study aims to relook at the areas of cultural competence and attitudes of OTR's across the US through replication of the previous studies. There is hope that more 'positive' results will be found because of the change in the racial climate in the US that has taken place over the past 20-30

years. A new study looking at this topic is needed because of the lack of current research and the ever increasing importance of being a racially conscious profession.

Operational Definitions:

- Race is defined as "social classification based on phenotype and a marker for exposure to social factors that can influence health, including socioeconomic position, lifestyle habits, and use of health care" (Hebert,Sisk, & Howell, 2008, p. 375).
- Ethnicity is defined as "that part of one's identity derived from membership, usually through birth, in a racial, religious, national or linguistic group or subgroup," (Krefting, 1991, p. 6).
- Culture is defined as "the knowledge, beliefs, values, assumptions, perspectives, attitudes, norms and customs that people acquire through membership in a particular society or group (Hammell, 2003, p. 225).
- Cultural competence is defined as "the ability to understand and work effectively with patients whose beliefs, values and histories differ from one's own," (Capell, Dean & Veenstra, 2008, p. 121).

Chapter 2: Literature Review

Race in Relation to Health Care:

In talking about the somewhat controversial impacts of such concepts as race, ethnicity and culture, one must have an understanding of what each of these concepts means. Racism, specifically institutionalized racism, promotes white people and devalues people of color in multiple areas such as health care, legal systems, job opportunities, etc. because it offers people of color fewer opportunities and more barriers to overcome in order to obtain the same status as white people (Hammell, 2013). Herbert, Sisk & Howell (2008) discuss the different definitions of racial disparity stating; "definitions of racial/ethnic disparities fall along a continuum from differences that have little connotation of being unfair to those that result from overt discrimination," (p.380). More research needs to be done to allow for a more concrete definition of racial disparity and its effects in healthcare. Specifically in regards to the profession of occupational therapy, more research needs to be done to show how institutional racism and unintentional bias affects the provision of occupational therapy services and the occupational performance of clients in order to better meet the needs of all clients regardless of their background.

While ethnicity and culture are intertwined, there cannot be one without the other, they are not exactly the same and should not be used interchangeably (Krefting, 1991). Ethnicity is a part of someone's culture. Hebert et al. (2008) described ethnicity as "also a social construct referring to the sharing of a culture, including ancestry, language, religion, and traditions." Therefore, the social aspects of one's upbringing and experiences greatly affect a person's ethnicity. Ethnicity is also intertwined with one's race, although they are again two different, distinct terms. "For example, African Americans and many Caribbean groups such as Jamaicans are both considered to be racially Black (at least in the United States) because of their common African ancestry. However, African Americans and Jamaicans are different ethnically because of different customs, cultural practices,

and ways of being," (DeCuir-Gunby & Schutz, 2014, p. 245). Understanding these terms and the difference between them is key to allow for in depth discussion between peers, clients and professionals.

Culture is much broader than the previous terms defined. When looking from an occupational therapy perspective, the impact of culture is more researched than ethnicity and race, however in each article reviewed the authors' state that more research needs to be done because of the heavy importance put on culture in theory but not in practice (Awwad, 2003; Dillard, 1992; Kreftling, 1991). Culture in relation to occupational therapy will be discussed about in depth in the coming section.

Williams, Lavizzo-Mourey and Warren (1994) discuss the evolution of race, racism and health care. While this article is a little outdated it gives solid background information that is relevant to how race has evolved and the impact it has on the delivery of OT. The article describes how people of color are, both past and present, at a disadvantage in the healthcare system because of social and political factors as well as lack of access to healthcare. One finding in their research was that "race is widely used in a routine and uncritical manner in the health literature to account for differences in health status and health service utilization between human populations" (p. 34). Using race alone to explain away differences is nonsensical because race has no root in biology and is a socially constructed concept. On the other hand, some researchers believe that racial disparities are a "myth" and factors such as socioeconomic status and environment are separate and not affected by race (Hebert et al., 2008). Taking race into account is important when doing research because of the societal impacts the concept has. Race should be one of many factors considered when trying to account for differences in health status and health service utilization.

In 2007, the term racial microaggressions was coined by a psychologist, Derald Sue. Sue stated that microaggressions "are brief and commonplace daily verbal, behavioral, and

environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative racial slights and insults to the target person or group," (p. 273). For example, if a white person says to a person of color something along the lines of, "There is only one race, the human race," Sue (2007) argues that the white person is denying the person of color of their racial and cultural experiences and refusing to acknowledge race (p. 276). Sue (2007) also talks about a continuum of racism in modern day society that runs from aversive racism to modern and symbolic racism finally ending with old fashioned biologic racists. Awareness and understanding of why microaggressions can be detrimental towards people of color is a big step towards racial consciousness.

Movements such as Black Lives Matter are bringing racial consciousness to the US through social media. This movement is self-described as "an ideological and political intervention in a world where Black lives are systematically and intentionally targeted for demise. It is an affirmation of Black folks' contributions to this society, our humanity, and our resilience in the face of deadly oppression," (*Black Lives Matter,* n.d.). This movement focuses on equality looking at everything from education, employment, housing, to health care. These such movements will hopefully increase the number of people of color who are able to receive adequate health care services on a regular basis leading to more appropriate referrals to OT and thus more OTR's will see clients who differ greatly from themselves in the various settings OT is provided (The Henry J. Kaiser Family Foundation, 2013).

When talking about health care one must consider not only the health care provided but the method clients use to pay for it. Health insurance is progressively becoming a necessity in the US because of the ever increasing prices of health care services. The Center for Disease Control (2014) states that in 2012 more than one in four families experienced financial burden because of medical care. Additionally, the presence of one or more family members without health insurance increased

the chances of experiencing financial burden. Alternatively, the uninsured or underinsured can decide to forgo medical care or medications due to cost alone. "Health insurance coverage rates vary significantly by race/ethnic group. Nonelderly Hispanics have the highest uninsured rate, with nearly one in three lacking coverage (32%), followed by American Indians/Alaska Natives (27%), Blacks (21%), and Asians/Pacific Islanders (18%), who are all more likely than Whites (13%) to be uninsured...Medicaid coverage helps fill in some of these gaps in private coverage, particularly for Hispanics, Blacks, and American Indians/Alaska Natives, but does not fully offset the difference, leaving these groups more likely to be uninsured," (The Henry J. Kaiser Family Foundation, 2013). This supports and updates previous findings and shows how in the current day and age people of color are still at a significant disadvantage in accessing health care services if only because of the financial burden it can cause. However, the Affordable Care Act (ACA), which was passed by President Barack Obama in 2011, is looking to change this disparity by reducing the number of uninsured in the US (Medicaid, n.d.). By insuring people who previously had no insurance, this reduces the potential financial burden health care services can cause, leading to more people seeking out services when they are sick instead of forgoing them entirely.

The ACA's goal is to give people more access to affordable insurance, which includes and makes sure they cannot get denied or have their premiums increased for pre-existing conditions. Children can now stay under their parent's health insurance until age 26, aiming to greatly reduce the number of uninsured young adults. President Obama also expanded Medicare allowing more people over 65 to get medical coverage and making medications more available and cost effective for senior citizens. Another new component under ACA is that preventive care, which has been shown to be more cost effective in the USC Well Elderly studies (Clark, 2015), is now covered by insurance. This study was the first of its kind that showed preventive OT services given to older adults had a

significant positive impact on their health allowing them to be an active member of the community longer.

In the five years since ACA was signed into law nearly 16.4 million uninsured people have acquired health insurance, which, according to the U.S Department of Health & Human Services (2015), is the largest reduction of uninsured people in four decades. This increase is a big step forward in the fight to decrease healthcare disparities and advancing on the road to equality in health care. This big increase in access to health insurance means that, OTR's will be seeing an increase in the clients who are referred to OT services. This is a positive outcome for healthcare, especially occupational therapists, as increasing individuals will be referred to OT to meet their occupational needs and the profession will continue to advance allowing for increased equity in health care (The Henry J. Kaiser Foundation, 2013).

Overall, the constructs of race, culture and ethnicity are all connected and mean something a little different to each individual based a variety of factors. These constructs have a pronounced impact on the amount of insurance a person can afford as shown by the Henry J. Kaiser Foundation (2013). They also affect the standard of care an individual receives. While society seems to be taking leaps and bounds in bringing awareness and equal access to all things especially to health care services; there is still a long way to go before there is equity in this world. Occupational therapists can help to continue this trend of increasing equal access to services by advocating for clients and teaching them to advocate for themselves regardless of their background.

Culture in Relation to Occupational Therapy:

The Occupational Therapy Practice Framework (OTPF) is a document that describes the concepts that make up occupational therapy practice (AOTA, 2014). This document outlines what is in OT's scope of practice and what each OTR should be addressing with their clients. It is the most important document in the profession and should be referred to on a frequent basis in practice

because it outlines the scope of practice for OT and provides in depth information the OT process. The American Occupational Therapy Association (AOTA) has published three revised editions to the OTPF, updating the language as it changes with the profession. One especially important aspect to this study is culture. Culture is addressed multiple times throughout the OTPF: as a client factor, a client role and the cultural context which is described as, "customs, beliefs, activity patterns, behavioral standards, and expectations accepted by the society of which a client is a member," (AOTA, 2014, p. S28). Clearly, culture is important not only to this study but also to the profession of occupational therapy because of the profound impacts it has on clients, professionals and the surrounding environment. The OTPF helps to bring culture to the forefront of occupational therapy practice.

In the literature of occupational therapy there have been a limited number of articles regarding the importance of addressing culture, cultural sensitivity, and cultural competence in everyday practice (Awaad, 2003; Dillard, 1992; Kreftling, 1991). Terri Awaad (2003) states that the profession is moving towards cultural competence but much more work still needs to be done. Awaad (2003) also brings up the point that "cultural competence has been described as one of the least developed aspects of occupational therapy," (p. 358). Some points brought up to help obtain cultural competency include an understanding of both the cultural norms and differences of one's own cultural groups and the clients as well as continuing to do research as the caseload changes (Awaad, 2003). Another key point is that OTR's need to understand that 'normalcy' is governed by Whiteness (Nelson, 2007). Nelson (2007) states it eloquently; "In Western society, whiteness is usually positioned as the 'norm' and 'others' are categorized in relation to this norm (Nelson, 2007, p.240). Continuous learning and research will help to ensure that OTR's are meeting the needs of each individual client no matter what their particular needs are at that moment.

In another article, Dillard, Andonian, Flores, Lai, & Macrae (1992) define "cultural competence...as an awareness of, sensitivity to, and knowledge of the meaning of culture" (p. 722). The authors continue to explain why occupational therapists are at an advantage to incorporate culture into everyday therapy sessions because OTR's focus on function, or the social model of disability, rather than the more medical model. The social model is defined by the International Classification of Functioning, Disability and Health (ICF) as "seeing disability as a socially created problem and not at all an attribute of an individual...disability demands a political response, since the problem is created by an unaccommodating physical environment brought about by attitudes and other features of the social environment," (WHO, 9). On the other hand, the ICF defines the medical model as "view[ing] disability as a feature of the person, directly caused by disease, trauma or other health condition" (WHO, 8). It is important not to get too caught up by language barriers or other cultural differences because as Dillard et al. (1992) state, "the development of cultural competence depends more on the attitude than on specific knowledge," (p. 723). This idea that attitude is more important is vital because it touches on a therapist's therapeutic use of self and how the OTR approaches each client using their own thoughts and feelings as part of the therapeutic process. Being willing to ask your client what their preferences are whether that be the name they preferred to be called or who they want to interpret for them is paramount.

Kreftling (1991) discusses the difference between culture and ethnicity, which is a "common misinterpretation." It is argued that the most important aspect is looking at the individual and not making blanket assumptions based on their cultural group. This article also addresses the important point that the therapist needs to understand what his or her own views are before beginning to look at a client's views. This builds off Awaad's point that an OTR should understand the cultural norms of the client and how those norms differ from their own. Having that understanding will help OTR's use their therapeutic use of self more appropriately during each session.

While the OT profession is working towards cultural competence and sensitivity more research needs to be done to show the impacts and importance of cultural awareness, competence and sensitivity as a therapeutic outcome. This study in particular is looking at culture competence of OTR's and certified occupational therapy assistants (COTA) and how it can affect the therapist's view of therapy in both planning and implementing interventions. This study asks specific questions about whether or not the OTR's think about a client's background during the planning session and whether or not they feel like their background or their client's background interferes or enhances the therapy sessions. The primary researcher is interested in looking at current cultural competence of practicing occupational therapists. Furthermore, these questions are asked in the hopes of further understanding what the impact culture can have on therapy (whether negative or positive) and adding to the current research.

Client/Therapist Interactions:

The therapeutic relationship is a very important part of the OT process; it is how the therapist and client interact with each other and use those interactions as part of therapy. An OTR's therapeutic use of self is defined as the, "occupational therapy practitioner's planned use of his or her personality, insights, perceptions and judgments as part of the therapeutic process" (AOTA, 2008, p. 653). This concept is used in every interaction an OTR has with a client whether or not it is intentional - being in a helping profession lends to the fact that social interactions will always be an integral part of the therapeutic process. Traditional OT is based on face to face client interactions further emphasizing the importance of relationships in this field. It is important to understand how the relationship between client and OTR or caregiver and OTR can positively (or negatively) affect the outcomes of therapy. While technological interactions such as telehealth, emails, text messages, etc. are increasingly becoming a part of everyday life, face to face interactions are still the most prevalent in this profession.

According to a national survey done by Michelle Gorenberg (2013), 80% of OTR's think "that the quality of the therapeutic relationship with the client was the most important determinant of outcomes. Yet, less than half felt adequately prepared in use of self by their academic education and less than 10% received consultation or continuing education regarding therapeutic use of self during their professional careers," (p. 392). This shows a large disparity between the importance of this concept and the actual practice of this concept. This is an area of OT that needs more research and more attention in the day to day life of a practicing OTR. This study is hoping to further the research out there on the importance of the therapeutic relationship by asking how the client and therapist backgrounds affect interventions, specifically asking whether they enhance or interfere with them. During OT interventions many conversations happen with the client throughout sessions. In the formal evaluation, an occupational profile is formed by asking questions about the client's family life, physical home set up and current status (or previous i.e. before accident, medical emergency, etc) are asked. As the session's progress and rapport develops the discussions turn to different, deeper topics such as the client's feelings on past experiences, current feelings and future aspirations. This shows the growth of the professional relationship and has been shown to be significant (Gorenberg, 2013).

One topic that is most discussed during a therapy session is the client's specific condition, diagnosis and prognosis. Health literacy is defined as "ability of the individual to access, understand, and use health-related information and services to make appropriate health decisions," (Smith & Gutman, 2004, p. 376). Most clients do not work in a health profession and are not as informed on medical diagnoses, treatment options, etc. It is the job of the medical staff such as doctors, nurses, etc. to explain those specifics. While most OTR's do not do the diagnosing or initial explaining of diagnosis; OTR's working in the military and in some psychiatric settings may diagnose. OTR's can help supplement information about the treatment and prognosis and relate it to their client's specific

strengths and limitations. OTR's can also contribute their own unique function based perspective, helping the client and their family to fully understand the implications of what was initially said. This profession usually has much more face to face contact with the client as sessions go for much longer than a typical doctor appointment or check-up. More, well utilized time allows for more in-depth conversations and a trusting relationship to form. Trust is key and has not always been present in the relationships of medical professionals and people of color. For example, Henrietta Lacks was a black woman whose cervix cells were taken in 1951 and used for research purposes for years after her death without the knowledge and informed consent of her or her family. This caused her family to distrust all medical professionals for many years afterwards (Skloot, 2010). Making sure the clients know and really understand their own or their loved one's condition is essential to all involved in order to form a trusting and enhancing relationship which will lead to increased participation, motivation and overall satisfaction with therapy services being received from both the client and the family.

Levasseru & Carrier (2010) did an analysis of the literature regarding health literacy in the professions of occupational and physical therapy. Overall, they found that the articles "(1) indicate the importance of health literacy in general, (2) present factors associated with low health literacy levels of the client, and (3) provide information that links health literacy to rehabilitation, emphasizing its importance for rehabilitation professionals." (p. 758). Additionally, this article compiles some possible consequences of how low levels of health literacy which could result in "poorer self-perceived health, less participation and social support, low level of empowerment, reduced likelihood of achieving life goals, poorer quality of life, underutilization of some health or information services," (Levasseru & Carrier, 2010, p. 759). All of these consequences are factors that OTR's want to avoid in practice because those are all negatives potentials for our clients. Thus OTR's must try their best to prevent any of these negative consequences from happening. The use of

one's therapeutic use of self can support more positive outcomes and increase a client's health literacy.

Overall, a client and therapist's therapeutic relationship is important to meeting the goals of both parties. How the OTR uses their therapeutic use of self is crucial to integrate in each interaction they have with a client and from the current research shows it needs more consistent consideration in day to day practice. Health literacy is an important part of education that should be provided to a client throughout each session. A therapist's understanding of their client's culture will allow the therapist to more effectively communicate with them leading to a potential increase in the client's health literacy. This study is specifically looking at taking culture, race and ethnicity into account in an OTR's interactions as well as their planning of sessions for clients.

Attitudes of Therapists:

The two studies being looked at in-depth below are the basis for the current study. The first was by Kathryn Skawski in 1987 out of Puget Sound University. This study was a questionnaire that looked at whether the clients or therapists cultural background enhances or interferes with the therapeutic process. It surveyed therapists across cultures in different regional areas in the US. It was sent by mail through an AOTA listing and had a 17% response rate. The responses analyzed were only from Black, White and Asian-American therapists because of a very low response rate from people who represent other races.

The study found that therapists who identified as either White or Asian American, felt that the client's and the therapist's background would interfere. The therapists who identified as Black felt their own background was enhancing but the clients background was interfering. This shows a very clear difference between the two group's views. Skawski also mentioned, "That the amount of time spent learning treatment theories...is worthless, if the therapist is unable to establish a therapeutic relationship in which this information can be utilized." Past research shows that

understanding, integrating and considering both our own and our client's culture is essential in establishing relationships. This again brings up the importance of a therapeutic relationship and appropriate therapeutic use of self in each session. Overall, Skawski found that more education and understanding of how to integrate culture into relationships as well as further research was needed to ensure that cultural needs are being met in occupational therapy. Her study was published in the Journal of Occupational Therapy in Health Care in 1987.

The second study was done by Leah Pineda in 1996, also from Puget Sound University in Tacoma, WA. This is an unpublished master's thesis recreating the study done by Skawski in 1987. Pineda added some additional questions to the survey as well as focusing the study on occupational therapists who work specifically in an adult physical disability setting. Pineda also used a mailed survey but had a higher response rate at 28%.

Pineda found more positive results than Skawski, giving hope that attitudes can improve. She found that most therapists do think that their own as well as the client's ethnic background enhances the therapy process. More therapists also reported that they were aware of their background no matter what ethnic group they were from. This was a significant increase from Skawski's (1986) study who found that 10% of her White participants did not have any thoughts about their own background in regards to their interactions with clients (p. 42-43).

Overall, the literature touches upon the various areas, i.e. culture, interactions, attitudes, that make up the whole. However, the literature is lacking in having more comprehensive and thorough articles looking at the relationship between race, culture and ethnicity and the profession of occupational therapy. This study hopes to enhance and add to the data for this sensitive topic.

Chapter 3: Methodology

This section will explain the methodology for this study including research questions, hypothesis, participants, exclusionary criteria, recruitment and statistical tests done using SPSS version 23 with all data collected from an online survey. The results of all statistical tests will be discussed in chapter 4.

Research Questions:

1. What do occupational therapists report as key factors impacting their sense of cultural competence when working with clients?
    a. Attitudes about race, culture and ethnicity of a client?
    b. Education of therapist?
    c. Attendance at diversity seminars or workshops?
    d. Personal experiences?
    e. Work experiences?
    f. Different primary languages of therapist or client?
2. At what frequency do occupational therapists identify with statements (see tables 16-21) about their own and others' race and ethnicity?

Hypothesis:

The primary researcher predicts that personal experiences and the attendance at diversity seminars and workshops will have the biggest impact on cultural competence as was suggested in the previous studies findings. This study will potentially have more overall 'positive' results because of the change in the racial climate in the US that has taken place over the past 20 to 30 years.

Survey Methodology:

As this is a replication study, there were minimal changes done by the primary researcher. Because of the format of the previous research a survey was implemented for the current study.

However, the survey language was updated to modernize it to some extent, more could have been changed but the primary researcher felt consistency was pertinent to the results. These studies were performed by Kathryn Skawaski, OTR and Leah Pineda, OTR, in 1987 and 1996 respectively meaning the survey was actually created almost 30 years ago and most recently updated 20 years ago. The current study was converted into an online format. This was to improve ease of access to both participants and primary researcher, increase speed of sending out survey, getting results, and simplicity in formatting (Sue & Ritter, 2012). The primary researcher also hypothesized the online format would increase completed responses and include more in depth data from the participants. The online survey helps enhance anonymity and may lead to more accurate answers because those who participate know their name will not be attached to the answers. This can decrease the feeling of having to answer in a socially desirable or politically correct way (Sue et al., 2012). A lot has changed in the time since the previous studies and one hopes that those changes are for the better, for the world of healthcare, occupational therapy, and most importantly the clients of occupational therapy.

Participants/ Recruitment:

Participants were selected by snowball sampling of convenience. The primary researcher sent it to known occupational therapists and occupational therapy assistants (networks through family in the healthcare profession, Ithaca College alumni and faculty) through email and asked them to send it on to other occupational therapists' and occupational therapy assistants they know that would be willing to respond to this survey. The primary researcher initially sent the survey to 27 different people with two reminder emails throughout the six week timeline that the survey was open. The primary researcher also put the survey on occupational therapy specific Facebook groups such as the Ithaca College Occupational Therapy Alumni group and on the American Occupational Therapy Association OT Connections forums in hopes of recruiting more participants. The survey was sent to

each of the AOTA special interest section president's (Administration & Management; Education; Gerontology; Mental Health; Sensory Integration; Work & Industry; Developmental Disabilities; Early Intervention & School; Home & Community Health; Physical Disabilities; Technology) and multicultural network groups (Asian/Pacific Heritage Occupational Therapy Association (APHOTA); National Black Occupational Therapy Caucus (NBOTC); Network for Lesbian, Gay, Bisexual and Transgender Concerns in Occupational Therapy (The Network); Network of Occupational Therapy Practitioners with Disabilities and Their Supporters (NOTPD); Occupational Therapy Network for Native Americans (OTNA); Orthodox Jewish Occupational Therapy Chavrusa (OJOTC); Terapia Ocupacional para Diversidad, Oportunidad y Solidaridad (TODOS) Network of Hispanic Practitioners). The primary researcher asked them to distribute the survey as they saw fit. Overall 211 responses were received at the end of the six week period. Because of incomplete responses some entries were removed, the final number of responses analyzed was 178. This response rate is greater than the previous two surveys. This study received approximately 24% more responses than Skawski and approximately 59% more than Pineda. However because this survey was online and used snowball sampling, there is no way of calculating the return rate as was done in the previous studies.

Exclusionary Criteria:

Participants were excluded if they did not complete the entire survey if only part one (demographics) was filled out and part two (short answer) was not or if they did not live in the United States. If the participants were not currently practicing (i.e. a student) their response was also excluded. All other responses were accepted.

Measure:

This survey was designed in two sections following the model of the previous research designs (see Appendix A for full cover letter and survey). Section one was demographics and had 12

questions. The participants were asked about their gender, age, current work setting, and length of time in the current setting. They were also asked how many hours per week they worked, what percentage of current caseload were of a different race, licensure level, highest OT degree, ethnicity, what type of area they are working in, what area of the US, and how many languages they speak. Section two was more complex and asked in depth questions regarding the current attitudes of the participants. This section had 14 questions. The participants were asked if they have ever participated in a sociocultural (diversity) workshop or seminar, if yes where, and if no would they if they could. They were also asked if they believed attending a workshop or seminar helped them deliver OT services more effectively, how often they consider the client's ethnic and cultural background and were asked to rank out of nine items which had given them the most useful information about clients of varying backgrounds. Questions 17-20 are four open ended questions asking how they feel the *client's* background enhances and interferes with treatment and how they feel the *therapist's* background enhances and interferes with treatment. Finally the participants were given 12 statements about various values and asked to check the three they felt were most important to themselves, and for each of the following ethnicities: Asian/Asian American/Pacific Islander, Black/African American, White/Caucasian/European American, Hispanic/Latino/a American, and Native American.

Analysis and Interpretation of Data:

The data was analyzed using quantitative methods. Demographic responses from part one were analyzed using IBM SPSS version 23 analyzing for frequencies, means, and medians. SPSS was used to perform a chi square goodness of fit test to determine if the population of OTR's and Certified Occupational Therapy Assistant's (COTA) who took this survey matched the US population of OTR's and COTA's in terms of racial and ethnic identity.

The four open ended questions were first color coded to sort them into positive, negative, and neutral responses. They were then coded with numbers in order to analyze the responses in SPSS. This analysis was repeated by a peer researcher to improve reliability of the coding system. For questions about client and therapist backgrounds enhancing therapy, (for example, how do you feel the therapist's ethnic background enhances the treatment process) a positive response was coded green. For example, "Broadens my thoughts regarding values/beliefs the family have that influence treatment decisions." For questions about client and therapist backgrounds interfering with therapy, (for example, how do you feel the client's ethnic background interferes with the treatment process) a positive response was again coded green but a positive response could be a negative answer because of the nature of the question. For example, "When culture encourages dependence in the elderly so they do not use their full potential" would be coded as a negative response. For the enhancing questions (for example, how do you feel the therapist's ethnic background enhances the treatment process) a negative response was coded red. For example, "it don't" was coded as a negative response (red). With the interfering questions (for example, how do you feel the client's ethnic background interferes with the treatment process) a negative response was again coded red but could be a positive answer because of the nature of the question. For example, "doesn't interfere it can be a challenge if it is different than your own" was coded as negative (red).

Once both the primary researcher and peer reviewer had color coded the responses, any differences in coding was discussed until consensus was reached. Finally with agreed upon color codes the peer reviewer changed all colors to numbers in order to allow the primary researcher to input the numbers into SPSS to do statistical testing. A one was given if it was a positive response, two if it was a neutral response and three if it was a negative response. Using SPSS a chi square test of independence was used to compare the positive/neutral/negative responses to each of the open ended questions to the following variables: 1. how many languages the participant speaks, 2. the

ethnicity of the participant and 3. whether or not they have attended a sociocultural diversity seminar or workshop.

Once all statistical tests where done, themes where identified throughout the four open ended questions. For the thematic analysis, the primary researcher looked for reoccurring buzz words or topics the participants stated in their responses. Once the responses where sorted, further analysis was done on what effect each theme could have on this topic and the implications it has for the results of this study. This method allows for further in depth analysis of each open ended question leading to more focused conclusions and implications.

Chapter 4: Results

This chapter describes the demographic and the quantitative data collected through SPSS version 23.

Section One: Demographics

For this study 212 total responses were obtained. However because of incomplete responses only 178 responses were used for statistical analysis. See Appendix C for all demographic tables. 83.9% of data collected was found to be usable. 91.6% of participant's identified as female, 6.7% identified as male. See Table 2 for breakdown of all responses. The participant's ages ranged from 21-65. The age with the greatest number of respondents was 31-35 with 18.5%, and the age with the least number of respondents was 46-50. To see a full breakdown of participants ages see Table 3. The most frequent setting for participants was a skilled nursing facility with 15.2%, followed closely by academia at 14.6%. The least common setting were a tie between community, mental health and day treatment all with 2.8%. For a full breakdown of the different settings see Table 4.

The majority of participants have been practicing for one to three years (28.4%), however there was a range of time with 21% practicing for less than one year and 18.2 practicing for ten or more years. For a full breakdown of the time practicing see Table 5. For the most part participants work full time with 52% of participants stating they work between 31-40 hours a week. For a full breakdown of the number of hours per week see Table 6.

Forty five point eight percent of participants stated that 1-25% of their caseload is a different race than themselves. 2.8% stated that none of their clients are a different race than themselves (Table 7). 90.9% of participants were registered occupational therapists while 9.1% were certified occupational therapy assistants (Table 8). When asked about the highest occupational therapy degree obtained, the majority (59.6%) stated they have earned their master's degree, 23.6% stated they have their bachelor's, 10.7% have their doctorate and 6.2% have their associate's degree (Table 9).

The majority of participants, 81.5%, identified as European-American/White/Caucasian (Table 10). 8.4% identified as Asian-American/Asian/Pacific Islander, 7.3% identified as Hispanic/Latino/a-American, 6.2% identified as African-American/Black and 1.7% identified as Native American. When asked about what kind of area the participants live in 76.4% stated urban and 23.6% stated rural (Table 11). 45.4% of participants live in the northeast while 10.9% live in the northwest (Table 12). When asked about how many languages the participants speak the majority stated they only speak one (74.7%). However 21.9% stated they speak two and 3.4% stated they speak three or more languages (Table 13). A goodness of fit test was run comparing the ethnic identification of this study's population to that of the OT population in the US with statistically significant results X^2 (2, N = 178) = .070, $p < .05$ (Table 14).

Section Two: Multicultural Competence and Attitudes

Participants were asked if they had ever participated in a sociocultural (diversity) workshop or seminar. 52.8% said yes they had and when asked where the most frequent answer was for an employment in-service (33.1%). 46.6% of participants said they have not attended a sociocultural workshop or seminar. Of that 46.6%, 33.7% said they would attend one if they could and 12.9% said they would not if they could (Table 15).

Table 15 - Have you ever participated in a sociocultural (diversity) workshop or seminar? If yes, Please indicate where (you may select more than one). If no, would you if you could?

	Frequency	Percentage
Yes	94	52.8
No	83	46.6
If yes, where?		
College Course	46	25.8
Work Orientation	18	10.1
Continuing Education	41	23
OT School Curriculum	31	17.4
Employment In-Service	59	33.1
Other	11	6.2
If no, would you if you could?		
Yes	60	33.7
No	23	12.9

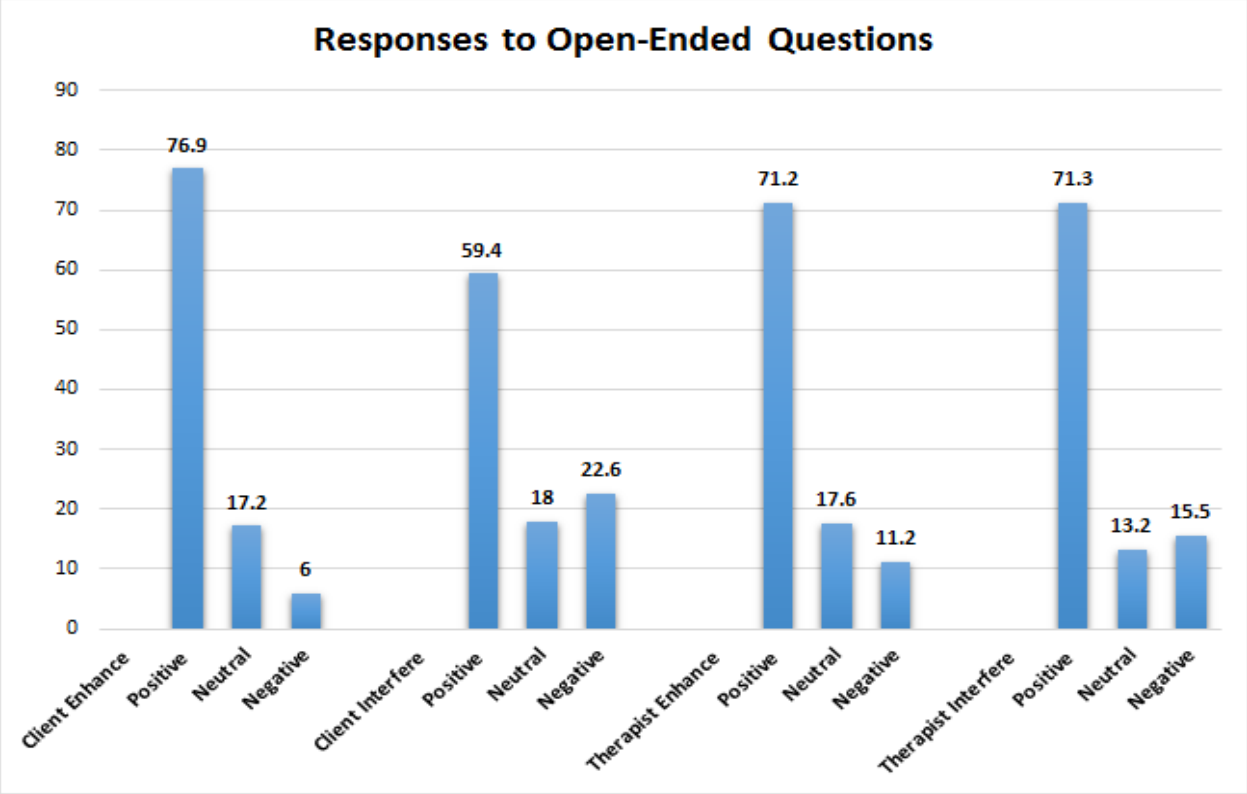
Participants were asked to rank where they have received the most useful information about clients of varying ethnic and racial backgrounds. The number one answer was personal and social experiences outside of occupational therapy (37.1%). Following closely was on the job experience at 30.3% (Table 16).

Table 16 - Which of the following has given you the most useful information about clients of varying ethnic/racial backgrounds? Number one answer

	Frequency	Percentage
Personal and Social Experiences Outside of OT	**66**	**37.1**
On The Job Experience	54	30.3
Cultural Seminar or Workshop in School	25	14
Travel	15	8.4
OT Curriculum	8	4.5
Personal Reading	2	1.1
In-Service Training at Work	2	1.1
Other College Classes	1	0.6
Other	1	0.6

The responses to the open ended questions about the influence of race and ethnicity on therapist client interactions were coded as a positive, neutral or negative response by primary research and research assistant. Below is *Figure 1* that displays the number of positive, neutral and negative response for each question (client enhance, client interfere, therapist enhance and therapist interfere).

Figure 1



For the final section of the survey, participants were asked to check which statements they felt reflected something they personally valued. The top three are: individualism and privacy are important, spirituality is important and family and kinship are important. Sharing resources and responsibilities with kin is good. The full list is below in Table 17 and the top three are bolded.

*Table 17 - Listed below are beliefs, values and practices. Please place a checkmark next to each one that reflects something **you** personally value.*

	Frequency	Percentage
Spirituality is important	**99**	**65.6**
Family and kinship are important. Sharing resources and responsibilities with kin is good	**115**	**64.6**
Individualism and privacy are important	**114**	**64**
Self-discipline and self-efficacy are important	112	62.9
I think it is important to get things done on time	110	61.8
It is important to be practical and efficient	99	55.6
It is important to respect the elders in the family	99	55.6
It is important to control one's own emotions	81	45.5
Interpersonal relationships take precedence over tasks	75	42.1
It is more important to look at the situation that is occurring now than to worry about the future or the past	67	37.6
It is ok to have a relaxed attitude about time	41	23
It is acceptable to go along with the majority's opinion	11	6.2

The participants were asked to place a checkmark next to three phrases which they believed best describe the values of Asian/Asian-American/Pacific Islanders. The top three were 'family and kinship are important. Sharing resources and responsibilities with kin is good,' 'self-discipline and self-efficacy are important' and 'it is important to respect the elders in the family.' The full list is below in Table 18 and the top three are bolded.

Table 18 - Listed below are beliefs, values and practices. Please place a checkmark next to threephrases which you believe best describes the values of ***Asian/Asian American/Pacific Islanders.***

	Frequency	Percentage
It is important to respect the elders in the family	**113**	**63.5**
Family and kinship are important. Sharing resources and responsibilities with kin is good	**85**	**47.8**
Self-discipline and self-efficacy are important	**53**	**29.8**
It is important to be practical and efficient	47	26.4
It is important to control one's own emotions	35	19.7
I think it is important to get things done on time	31	17.4
Spirituality is important	30	16.9
Individualism and privacy are important	27	15.2
It is acceptable to go along with the majority's opinion	18	10.1
Interpersonal relationships take precedence over tasks	13	7.3
It is more important to look at the situation that is occurring now than to worry about the future or the past	11	6.2
It is ok to have a relaxed attitude about time	10	5.6

The participants were asked to place a checkmark next to three phrases which they believed best describe the values of Black/African Americans. The top three values were 'Spirituality is important,' 'Interpersonal relationships take precedence over tasks' and 'Family and kinship are important. Sharing resources and responsibilities with kin is good.' The full list is below in Table 19 and the top three are bolded.

Table 19 - Listed below are beliefs, values and practices. Please place a checkmark next to three phrases which you believe best describes the values of ***Black/African Americans****.*

	Frequency	Percentage
Spirituality is important	**95**	**53.4**
Family and kinship are important. Sharing resources and responsibilities with kin is good	**92**	**51.7**
Interpersonal relationships take precedence over tasks	**59**	**33.1**
It is ok to have a relaxed attitude about time	50	28.1
It is important to respect the elders in the family	50	28.1
Individualism and privacy are important	37	20.8
It is more important to look at the situation that is occurring now than to worry about the future or the past	32	18
It is important to be practical and efficient	14	7.9
It is acceptable to go along with the majority's opinion	12	6.7
Self-discipline and self-efficacy are important	12	6.7
It is important to control one's own emotions	11	6.2
I think it is important to get things done on time	8	4.5

The participants were asked to place a checkmark next to three phrases which they believed best describe the values of White/Caucasian/European Americans. The top three were 'individualism and privacy are important,' 'it is important to be practical and efficient and self-discipline' and 'self-efficacy are important.' The full list is below in Table 20 and the top three are bolded.

Table 20 - Listed below are beliefs, values and practices. Please place a checkmark next to three phrases which you believe best describes the values of ***White/Caucasian/ European Americans****.*

	Frequency	Percentage
Individualism and privacy are important	**92**	**51.7**
It is important to be practical and efficient	**74**	**41.6**
Self-discipline and self-efficacy are important	**63**	**35.4**
I think it is important to get things done on time	62	34.8
It is important to control one's own emotions	45	25.3
It is acceptable to go along with the majority's opinion	37	20.8
Family and kinship are important. Sharing resources and responsibilities with kin is good	22	12.4
It is more important to look at the situation that is occurring now than to worry about the future or the past	21	11.8
Spirituality is important	16	9
Interpersonal relationships take precedence over tasks	13	7.3
It is ok to have a relaxed attitude about time	10	5.6
It is important to respect the elders in the family	6	3.4

The participants were asked to place a checkmark next to three phrases which they believed best describe the values of Hispanic/Latino/a Americans. The top three were 'spirituality is important,' 'family and kinship are important. Sharing resources and responsibilities with kin is good' and 'it is important to respect the elders in the family.' The full list is below in Table 21 and the top three are bolded.

Table 21 - Listed below are beliefs, values and practices. Please place a checkmark next to three phrases which you believe best describes the values of ***Hispanic/Latino/a Americans.***

	Frequency	Percentage
Family and kinship are important. Sharing resources and responsibilities with kin is good	**110**	**61.8**
Spirituality is important	**91**	**51.1**
It is important to respect the elders in the family	**71**	**39.9**
It is ok to have a relaxed attitude about time	60	33.7
Interpersonal relationships take precedence over tasks	47	26.4
It is more important to look at the situation that is occurring now than to worry about the future or the past	25	14
Individualism and privacy are important	17	9.6
It is important to be practical and efficient	13	7.3
It is acceptable to go along with the majority's opinion	13	7.3
Self-discipline and self-efficacy are important	13	7.3
I think it is important to get things done on time	7	3.9
It is important to control one's own emotions	4	2.2

The participants were asked to place a checkmark next to three phrases which they believed best describes the values of Native Americans. The top three were 'spirituality is important,' 'family and kinship are important. Sharing resources and responsibilities with kin is good' and 'it is important to respect the elders in the family.' The full list is below in Table 22 and the top three are bolded.

*Table 22 - Listed below are beliefs, values and practices. Please place a checkmark next to three phrases which you believe best describes the values of **Native Americans**.*

	Frequency	Percentage
Spirituality is important	**109**	**61.2**
It is important to respect the elders in the family	**88**	**49.4**
Family and kinship are important. Sharing resources and responsibilities with kin is good	**78**	**43.8**
It is ok to have a relaxed attitude about time	42	23.6
Interpersonal relationships take precedence over tasks	32	18
It is more important to look at the situation that is occurring now than to worry about the future or the past	23	12.9
Self-discipline and self-efficacy are important	21	11.8
Individualism and privacy are important	19	10.7
It is acceptable to go along with the majority's opinion	18	10.1
It is important to control one's own emotions	16	9
It is important to be practical and efficient	13	7.3
I think it is important to get things done on time	8	4.5

Cross Tabulations:

The primary researcher ran a cross tabulation comparing how many languages the participants spoke and their answer (positive, neutral or negative) in the open ended questions. Secondary to the small sample size of those who spoke more than one language, the primary researcher had to combine the responses from those who spoke two and three or more languages in order to meet the assumptions for a chi-square. Even with combining the two categories, some cell counts were less than five leading to a weaker statistical test. None of the chi-square tests run comparing languages spoken and open ended responses were found to have a statistically significant result. A chi-square test was run comparing degree level and open ended responses. However, because of the small sample size of those with an associate's degree and a doctorate degree some

cell counts were less than five. None of the chi-square tests run comparing degree level and open ended responses were found to have a statistically significant result.

A chi-square test was also done to compare whether or not the participants had attended a sociocultural (diversity) workshop and their answers to the open ended questions. Only when comparing attendance at a sociocultural (diversity) workshop and the question asking about if a therapist's background interferes was there a statistically significant result. All other chi-squares did not show a statistically significant result.

Table 23 - Sociocultural (Diversity) Workshop & Open Ended Questions

	Client's background enhances treatment			Client's background interferes treatment			Therapist's background enhances treatment			Therapist's background interferes treatment		
	+*	N*	-*	+	N	-	+	N	-	+	N	-
Yes	55	13	5	43	12	17	50	13	5	57	5	8
No	47	10	3**	36	12	12	38	9	9	34	12	12
Pearson Chi-Square (Asymptotic Significance)	.882			.821			.306			.031***		

*+ = positive response, N = neutral response, - = negative response
**Cell count is less than 5
***Statistically significant result

Frequencies were calculated for the number of positive, neutral, and negative responses by ethnicity. Tables 24-28 represent the five identified ethnicities and the number of positive, neutral and negative responses found for each of the four open ended questions.

Table 24 - African American/Black & Open Ended Questions

	Positive	Neutral	Negative
Client's background enhance treatment	4	4	ND*
Client's background interfere treatment	3	5	1
Therapist's background enhances treatment	5	2	2
Therapist's background interferes treatment	7	2	ND*

*ND = No Data

Table 25 - Asian American/Asian/Pacific Islander & Open Ended Questions

	Positive	Neutral	Negative
Client's background enhances treatment	6	5	1
Client's background interferes treatment	6	4	2
Therapist's background enhances treatment	8	2	ND*
Therapist's background interferes treatment	8	1	1

*ND = No Data

Table 26 - European American/White/Caucasian & Open Ended Questions

	Positive	Neutral	Negative
Client's background enhances treatment	87	15	7
Client's background interferes treatment	66	17	24
Therapist's background enhances treatment	71	19	11
Therapist's background interferes treatment	76	13	16

Table 27 - Hispanic/Latino/a American & Open Ended Questions

	Positive	Neutral	Negative
Client's background enhances treatment	7	1	ND*
Client's background interferes treatment	4	1	3
Therapist's background enhances treatment	4	4	ND*
Therapist's background interferes treatment	5	3	ND*

*ND = No Data

Table 28 - Native American & Open Ended Questions

	Positive	Neutral	Negative
Client's background enhances treatment	1	ND*	ND*
Client's background interferes treatment	ND*	ND*	1
Therapist's background enhances treatment	1	ND*	ND*
Therapist's background interferes treatment	ND*	ND*	1

*ND = No Data

Chapter 5: Theme Analysis

For each open ended question, the primary researcher analyzed the responses using thematic analysis which, "is a method for identifying, analyzing and reporting patterns (themes) within data" (Braun & Clark, 2006, p. 79). This method allows for flexibility when analyzing the qualitative data set within this study. The primary researcher used an inductive approach ensuring that each "theme captures something important about the data in relation to the research question, and represents some level of patterned response or meaning within the data set" (Braun & Clark, 2006, p. 83). Below is a discussion of each open ended question and themes identified. All identified themes are listed in Table 29. The paragraphs following will elaborate on each theme and provide direct examples from the data.

Table 29 – Themes Identified in Open Ended Questions

How do you feel the client's ethnic background enhances the treatment process?	1. Learning occurs 2. Helps establish rapport 3. Helps establish appropriate goals 4. Increases motivation
How do you feel the client's ethnic background interferes with the treatment process?	1. Different ways of dealing with illness 2. Problems with communication/Language barriers 3. Mistrust of medical professionals 4. Gender differences 5. Family "interference"
How do you feel the therapist's ethnic background enhances the treatment process?	1. Similar background helps 2. Increased relatability with client 3. Therapeutic Use of Self
How do you feel the therapist's ethnic background interferes with the treatment process?	1. Closed minded therapist 2. Language barriers 3. Invisibility of White privilege 4. Differing background hurts

The first open ended question was, "**How do you feel the client's ethnic background enhances the treatment process?**" Four themes were identified for this question. The first theme

identified was that the client's ethnic background allows for therapists learning. One participant stated, "I have learned so much from my patients in the 6 months I have been at my current position, and it has really helped me develop my rapport and therapeutic relationship with them, thus communicating more and providing the best possible care."

The second theme identified was the client's ethnic background helps establish rapport between the client and the therapist. One participant stated, "I think first it speaks to respecting all people, then it helps build trust and rapport." Another participant stated, "[The client's ethnic background] provides insight of what is relevant to them and how to establish rapport."

The third theme identified was that the client's ethnic background helps establish appropriate goals during the therapy process. One participant stated, "You are able to learn more culturally and their beliefs can help determine important areas for goals." Another participant stated, "A client's ethnic background brings pride and passion to the treatment process. It allows for the client to identify meaningful occupations in association with personal goals within their ethical belief system."

The final theme identified is increased motivation from the client. One participant stated, "Increase motivation and help to at some level relax the client and increased rapport to create buy in." Another stated, "Ethnicity impacts a person's cultural and life experience, which sets the stage for interaction, relationships, goals, priorities, and occupational engagement." Goals made with the specific client in mind will allow for the fourth theme to occur - increased motivation leading to more participation from the client and the family. All of these themes are interconnected, one leads to another and they all lead to a quality therapy session.

The second open ended question asked, "**How do you feel the client's ethnic background interferes with the treatment process?**" Five themes were identified within the responses for this question. The first theme was that the client has different ways of dealing with illness. For example,

"I have had a few clients whose background calls for staying in bed when you are sick, however many need to be up and moving very quickly following surgeries that they are in the hospital for. That can be difficult to make sure they are medically on the right course while respecting their background and lifestyle." When this happens it leads to an OTR's goals of independence and increased functional movement to potentially be at odds with the client and/or the family. A therapist can increase sensitivity by making an effort to understand the client's feelings while making sure to explain the benefits and the therapeutic reasoning why they are being asked to get out of bed, or get dressed independently can potentially ease the tension.

The second theme is that because of the issues between parties with communication and/or language barriers. One participant stated,

> When therapists and clients do not understand the differences in ethnic background, it can negatively impact communication and appropriate goal setting. I have had experiences where a client's cultural values connected to their ethnicity have been different from the assumed values in western occupational therapy and that did make working on appropriate interventions more difficult (i.e. a parent who believes children with disabilities should not be made to do hard work vs. a therapist who values building strength and skills through hard work).

One participant stated, "I do not speak much Spanish and it is difficult to communicate complicated explanations and there is a limit to the "small talk" with a client." Another participant pointed out, "While the spoken and nonverbal language may be similar, often, cultural and social scripts are tacit or not explicitly made clear - often reminding me to never assume an intervention goal, strategy, or approach has been understood and/or accepted without conversation." Each of these comments reflects how problems with communication can impact the clinical world.

The third theme identified was that the client's background or past experiences could lead to mistrust of medical professionals. Such as,

> When working in early intervention I sometimes feel like parents don't want to listen to me or assume that I come from a 'holier than thou' place rather than a place of knowledge and caring when I give advice. I often wish I was the same race as all of the kids I work with because I have good relationships with them and know that they look up to me, and I would like to be able to provide a "you can do it too" feel for them, rather than being another white person who does good as is so often portrayed by the media. I think I would be able to be a better role model for them if our skin was the same color. I don't like adding to the often internalized idea that white people are better.

and "They have learned from their background how to take care of a child and don't trust professional suggestions." One participant stated, "Greatly, because the people have mistrusts of the medical system based on backgrounds, beliefs, and previous sociocultural interactions." All of these quotes exemplify different reasons why a client could have mistrust of medical professionals.

The fourth theme is the client's background affects their outlook on gender. For example is, "when values different than school culture or when culturally men are dominant and therapist expects female clients to consent to therapist's decisions unquestionably." Another participant stated," [I] have seen some male/female concerns in regards to a male have a female care for him" and "It only interferes when the culture is one that looks down on young females when I'm working with an elder male." Gender differences can be ingrained from a cultural perspective.

Finally, the last theme identified for this question is family interference. For example, "Overbearing families will limit patient participation, distract from learning, over assistance can lead towards learned helplessness." One participant stated, "Sometimes a family feels it is their job to

care and do everything for their family member (client), it may be challenging to increase a person's independence." Another said, "Family dynamics get tricky. We had a family that did not want their mother to be told she had cancer."

The third open ended question asked was, "**How do you feel the therapist's ethnic background enhances the treatment process?**" Three themes were identified in the responses of this question. The first theme was that if the client and therapist had a similar ethnic background, it helped the treatment. Participants stated, "Having a similar ethnic background to the majority of families I work with initially helps to make a connection" and "Mostly when it matches that of the client, trust and understanding develops more easily." Other participants stated, "I think it can be used to connect with the clients in some situations. I also think it may be "easier" to make this connection if you share the ethnic background of your clients" and "Only if they match. I'm brown so the buy in from brown clients is more natural. Helps eliminate the power distance." Having a similar background as the client can be helpful because of the similarities and already presumed understood 'norms.' Although, being of a similar background is not necessary, in order to have a good therapeutic relationship between the client and therapist.

The second theme identified was that the therapist's ethnic background helps increase the relatability. Participants stated,

> "It can sometimes help the client relate to the person better. But as a Caucasian often working with people of different ethnicities than me, I think just having an open mind and trying to relate to the person on a human level is sufficient."

and "A therapist's ethnicity is just as valuable as the client's; therapists are the other half of the therapeutic process." Going along with the previous theme, the therapist's ethnic background can help increase relatability but again is not necessary.

The final theme was that the therapist's background influences therapeutic use of self. One participant stated, "Depending on the background and experiences held by the therapist, the more diverse and greater the length of treating people with different backgrounds builds a toolkit for potential intervention strategies in the future." This question is most relevant to OTR's because it talks about specific ways they can improve and enhance therapy sessions. Again these themes are all interconnected and acknowledging one leads to the others.

The final open ended question asked was, "**How do you feel the therapist's ethnic background interferes with the treatment process?**" Four themes emerged during the analysis of this question. The first theme was the therapist's background can interfere if it means they are being close minded. For example, "when one's own beliefs and judgements are what drive the goals and treatment activities versus what is truly important to the client" or "If they can only see their culture and think other cultures are inferior. But in that case that would make them a poor therapist overall." A participant also stated, "A therapist may have difficulty understanding a group's ethnicity because it may be very different from their personal ethnicity" and "Some are not as open to difference. They try to make clients adhere to western protocol as opposed to being open to adaptation." Being close minded is counterproductive and can only lead less effective outcomes.

The second theme identified was language barriers. One participant stated, "I have identified language barrier to be an issue at times. Especially if [patients] are here in US visiting with no family here or experience with our healthcare system rules."

The third theme identified is invisibility of white privilege. White privilege is defined as,

> White privilege is a set of advantages and/or immunities that white people benefit from on a daily basis beyond those common to all others. White privilege can exist without white people's conscious knowledge of its presence and it helps to maintain the racial hierarchy in this country. White privilege is having the freedom and luxury

> to fight racism one day and ignore it the next. White privilege exists on an individual, cultural, and institutional level. (University of Massachusetts, 2003)

For example responses included, "We who are of white privileged have the potential to miss many important factors that affect clinical outcomes, either intentionally or unintentionally" and "As a Caucasian I don't have the lived experiences that someone from another ethnic background has. Being the target of discrimination, stereotyping, or limited opportunities provides a different perspective." Others stated, "I haven't had that experience being a white, middle aged, female" "By making my internal bias/privilege invisible to myself at times since I am working within the system I am from" and "Maybe from having "privilege" I don't have the understanding of ethnic issues from first person experience." Being conscious of the benefits that come with being White can help one better understand all clients, the OT process and maximize outcomes.

The final theme identified was that when <u>having a differing background from the client, a therapist's background can interfere</u>. Participants stated, "I think my ethnic background interferes with the treatment process with the population I work with because it differs. If it were the same I think it would enhance the treatment process." One participant stated specifically,

> I feel like my African American and Hispanic clients are disdainful of me because of my ethnicity. I have had Spanish speaking families tell me that I have to speak Spanish, and they have become dismissive because I do not speak well enough. I frequently feel that when I arrive at some homes, they are thinking, 'Another white person to tell us what to do.' My way of gaining trust is to tell them what I do, ask them what is important to them, what they would prefer to work on.

Being an occupational therapist means working with many clients, other professionals and staff throughout the day regardless of setting; being aware of the differences and similarities one has with the people they work with throughout the day will lead to a better relationship with all.

Chapter 6: Discussion

In this chapter, each research question will be discussed in depth based on the findings of the results above. The question (or part of the question for research question one) will be bolded and the discussion below it for clarity.

What impacts cultural competence of an occupational therapist when working with clients?

Attitudes about race, culture and ethnicity of a client:

The four open ended questions and themes were explained above. From those themes the primary researcher feels there are key points to take away. From the first question it was identified that it is key to allow for learning by being an open minded therapist and seeking out the client's feelings and opinions on therapeutic activities and their overall rehabilitation plan. It is important to establish a solid rapport for each client in order to allow for the best outcomes possible. As shown in the research (Awaad, 2003; Dillard et al., 1992; Gorenberg, 2013) the therapeutic use of self is key to allowing for the relationship between client and therapist to be beneficial. As OT is holistically focused (Awaad, 2003), therapists found that the client's backgrounds can help to set realistic and meaningful goals which frame the therapeutic process. When OTR's work collaboratively with the client, the relationship can be stronger and produce more effective, efficient and personalized outcomes.

From the second question, it was identified that problems with communication or language barriers can be difficult to deal with, but with the new technology, access to interpreters and verbal check ins by the therapist; this will hopefully minimize miscommunication. Mistrust of medical professionals can be a notion that is engrained in the minds of clients, either from personal or family members' previous experiences, or media portrayals. OTR's are in a position to start to change this, because of the focus on the therapeutic relationship and client centered care and ensuring to look at all aspects of a client to meet their unique needs. In addition, if OTRs work on meeting the client's

personal goals and focus on the therapeutic relationship it can help to create respect in the relationship leading to more positive interactions and potentially outcomes of interventions. Education is a big part of the scope of practice for OT, being able to address the family in a culturally sensitive way and help them understand the therapy process will help to improve client outcomes and family satisfaction (Dillard, 1992). This question leads to more themes, all which when identified and understood, can help OTR's improve their practice.

From the third question it was identified that, having a similar background as the client can be helpful because of the similarities and already presumed understood 'norms.' Although, being of a similar background is not necessary in order to have a good therapeutic relationship between the client and therapist. Similarities in background along with one's therapeutic use of self, which is affected by the therapist's experiences, can be to positively aid the therapy process. Making a conscious effort to use one's own background as a jumping off point for therapy sessions will help increase the effectiveness of intervention sessions.

From the fourth question, it was identified that with language and communication barriers, it is important to understand what types of new technology are available. It is equally important to present material in multiple ways at different literacy levels to ensure that clients really are understanding what is being said whether it is about the current task they are going to do or discharge planning. As most OTR's identify as White, it is vital to understand White privilege and the ripple effects it has on society. Connected to that is when a client is of a differing background, it is important to understand that there will be differences and not try to change those differences. Accepting and acknowledging differences decreases the negative effects.

Education of therapist:

The education an occupational therapist receives is an important factor to consider when looking at attitudes of sensitive topics such as race, culture and ethnicity. Fifty-nine point six percent

of the participants stated their highest occupational therapy degree is a master's of science (Table 9). This is as expected because of the requirements as of 2007 to have a master's degree as the entry level for occupational therapy students before taking the National Board for Certification in Occupational Therapy licensing exam. 23.6% of the participants stated they have a bachelor's level degree. This means they are either a COTA or received their degree before the Master's requirement happened in 2007 and were grandfathered in. Very small percentages of the sample indicated they have an associate's degree (6.2%) or a doctoral degree (10.7%).

Participants were asked, "Which of the following has given you the most useful information about clients of varying ethnic/racial backgrounds?" (Table 15). They were given eight choices and a write in option. Only eight out of the 174 participants (4.5%) who answered this questions ranked the OT curriculum as the number one place where they got information regarding clients of varying ethnic/racial backgrounds. In addition, only one out of the 174 participants (0.6%) stated the number one place was in other college courses. All together that is only 5.2% of participants who stated schooling was the number one place they got this information. This supports the notion that formal education is not the main place where OTRs are getting this information.

A chi-square test was run looking at the degree level compared to the opened ended question responses (positive, neutral and negative). No statistical significance was identified for any question. There was a small sample size of those who have an associate's degree and a doctorate and multiple cells were identified to be less than five impacting the results of the chi square tests. More research needs to be done with a larger sample size of participants with an associates and doctoral degree to identify if there is a correlation between degree level and attitudes of occupational therapists on race, culture and ethnicity.

Attendance at diversity seminars or workshops:

52.8% of the participants have participated in a sociocultural (diversity) workshop or seminar. The top three places where they attended the workshop or seminar is employment in-service (33.1%), college course (25.8%) and continuing education (23%). Of the 46.6% that said they have not attended one 33.7% stated they would if they could while 12.9% said they would not take that opportunity if it was presented to them (Table 14). When comparing the statistics of attending the survey (yes/no) to the responses of the open ended questions (positive, neutral, negative) it was identified that it was statistically significant only when comparing the answers of the last open ended question; asking if the therapist's ethnic background interferes with treatment. All others were not statistically significant and one cell was under five when comparing "client enhance" (Table 27).

A little more than 50% of the participants have attended a sociocultural (diversity) workshop or seminar. The National Board of Certification in Occupational Therapy requires 36 competency assessment units (CAU's) or professional development units (PDU's) every three years. One PDU that is acceptable is attending "workshops, seminars, lectures, professional conferences, or online courses," (National Board for Certification in Occupational Therapy [NBCOT], n.d). This aligns with two of the top three places participants stated where they had attended the diversity workshop or seminar (in-service and continuing education).

The only statistically significant association found among the open ended questions occurred when comparing attendance at a sociocultural (diversity) workshop or seminar and how the therapist's background interferes with treatment. There could be many reasons for this but the primary researcher hypothesizes it is related to racial identity theory. Chalmer Thompson and Robert Carter (1997) discuss Helms' (1990) racial identity theory looking at both the Black and People of Color identity development theory and the white identity theory (p.15-32). There are different stages that each individual goes through during the time they develop their own racial identity. One can be

in a stage for long periods of time before moving on to the next stage depending on experiences and reflection. One can take extended periods of time for each stage and the whole process is experienced over multiple years.

The White identity theory is identified to be applicable to this study because of the majority of participants who identified as White. There are six stages - contact, disintegration, reintegration, pseudo-independent, immersion/emersion and autonomy. It appears that a number of participants are in the pseudo-independent phase meaning there is a, "tendency to simultaneously reshape reality and selectively perceive racial stimuli, the reintegration-status White confronts the distortions that perpetuate racism, but has not yet overcome these distortions in his or her personal life," (Thompson & Carter, 1997 p. 24). Some examples include, "…I treat each individual individually," and "To say that it interferes is shocking to me. If anything, a clinician who would think that it interferes isn't fully respecting the difference and hopefully isn't making assumptions based on a client's ethnic background." These two responses are from two different participants but both exemplify the pseudo-independent phase of the White identity theory because the first participant is perpetuating this divide by treating each individual individually instead of treating each individual with equity. The other participant is not acknowledging the fact that there will be a difference and accepting it. They are ignoring it by saying it doesn't exist. Because these participants have not gone through all stages of the racial identify theory this could have a significant impact on how they believe a therapists background interferes with treatment.

Personal experiences:

When asked to rank where the participants had gotten the most useful information about clients of varying racial and ethnic backgrounds, the number one response was personal and social experiences outside of OT (37.1%). This is consistent with the previous study in 1996. Pineda (1996) identified that, "personal and social experiences (47%) were ranked first by respondents, and on-the-

job experience (20%) was ranked second as resources having provided the greatest amount of knowledge about clients' ethnic and cultural backgrounds," (p. 13).

Knowing that personal experiences outside of the occupational therapy realm has the biggest reported influence has implications. Educators can potentially help facilitate interactions revolving around race, culture and ethnicity in the classroom. In general, individuals who know this may also open themselves to opportunities and diverse experiences in the social context.

Work experiences:

In the open ended questions participants responded with specific and general work experiences. One participant stated,

> I have seen it [the client's background] as a barrier when other team members make certain assumptions based on a client's ethnic background. For example, assuming that a client is receiving state assistance, like WIC, because of her ethnicity. I have also seen some clients who come to the session with an us/them attitude--assuming that we won't understand them because we are different. It is a key area to building respect and trust.

This participant exemplifies how work experiences can have influence over a person's mindset. Especially as a new inexperienced clinician it can be very easy be influenced by co-workers notions and internalize them as one's own. It also shows that this participant is able to identify racially charged interactions but disassociates themselves from it exhibiting that they are further along the spectrum of racial identity development than some of his/her peers as discussed in the earlier section.

On the job experience was the second highest response (30.3%) where participants stated they had received information about clients of varying racial and ethnic backgrounds (table 15). Employment in-services (33.1%) was the most frequent place participants stated they had attended a sociocultural (diversity) workshop or seminar. The third most frequent was continuing education

(23%) which could have happened at the workplace or have been funded by the workplace. This data along with the participant responses support that work experiences influence cultural competence.

Different primary languages of therapist or client:

As discussed in the literature review, languages and communication are vital parts of the occupational therapy process. 21.9% of participants stated they spoke two languages and only 3.4% stated they spoke three or more languages (Table 13). A chi-square test was performed comparing number of languages and responses to open ended questions. No comparison was identified to be statistically significant (Table 26). The sample size of those who spoke two or more languages was very small and thus no association can be identified between the two.

However, when doing theme analysis of the open ended questions the primary researcher identified multiple times that language barriers or barriers of communication surfaced. This indicates there is clinical significance related to spoken languages and cultural competence.

At what frequency do occupational therapists identify with statements about their own and others race and ethnicity?

OTR's are a distinct group of people with their own specific values. The top three statements participants selected as something they personally value can be summarized as individualism and privacy, spirituality, and family and kinship. This is telling of the culture of occupational therapy. It is also prudent to point out that the top three for the overall OT sample are in line with what they assume to be the values of multiple "other ethnicities". This may allow OTR's to relate to their client's in a stronger way even if they are of a different race or ethnicity.

The top three statements participants stated Asian/Asian-American/Pacific Islanders value were family and kinship are important, self-discipline and self-efficacy are important and it is important to respect the elders in the family. These correspond to two of the top three in Pineda's study (1996) (family and kinship is important and it is important to respect elders). In occupational

therapy evaluation many questions are asked, contexts looked at and assessments given. When working with a client that identifies as Asian, these values are something that should be taken into account as they could be potentially helpful. Involving family and kinship into therapy sessions or discharge planning to ensure they have the support they need. Understanding the need for self-discipline and self-efficacy, and respecting of elders whether the elder is the client or not. While these values should be taken into account, it is important to assess each client thoroughly to understand what is specifically important to them.

The top three statements participants stated Black/African Americans value were spirituality is important, interpersonal relationships take precedence over tasks and family and kinship are important. These correspond to two of the top three in Pineda's study (1996) (spirituality is important and family and kinship are important). These values can be taken into account when working with a client who identifies as African American. Identifying that spirituality is important can help set and meet goals such as getting dressed for church, or walking into synagogue independently. An OTR can focus on the therapeutic relationship with the client before focusing on specific tasks, in order to better understand the client and what is important to them. As well as involving family and kinship in the therapy process can help increase motivation and compliance from the client. While these values should be taken into account, it is important to assess each client thoroughly to understand what is specifically important to them.

The top three statements participants stated White/Caucasian/European Americans value where individualism and privacy are important, it is important to be practical and efficient and Self-discipline and self-efficacy are important. These correspond to two of the top three in Pineda's study (1996) (individualism and privacy are important and it is important to be practical and efficient). Understanding that individualism and privacy are valued can help identify goals and can gage how hands on the therapist is (depending on the safety level of the client, of course). Being practical and

efficient during a therapy session will help respect the client's ideals and potentially increase compliance if they do not see therapy as a waste of time or effort. Utilizing the past two values can increase the client's self-discipline and self-efficacy by allowing the client to be successful and want to continue with therapy and the recovery process. While these values should be taken into account, it is important to assess each client thoroughly to understand what is specifically important to them.

The top three statements participants stated Hispanic/ Latino/a Americans value where spirituality is important, family and kinship are important and it is important to respect the elders in the family. These correspond to two of the top three in Pineda's study (1996) (spirituality is important and family and kinship is important). Taking into account spirituality (whatever that means for the specific client) can help increase motivation by using spiritual activities or tasks during therapy sessions. Family and kin can help the client stay motivated and help with follow through (home exercise plans or ensure that the client really is using a walker and not furniture walking). As an OTR, knowing the family dynamics, and that the elders are respected (whether the elder is the client or part of the family) can be very helpful when planning sessions. While these values should be taken into account, it is important to assess each client thoroughly to understand what is specifically important to them.

The top three statements participants stated Native Americans value where spirituality is important, family and kinship are important and it is important to respect the elders in the family. Pineda's study did not look at Native American's so no similarities can be drawn. Incorporating spirituality into therapy sessions or just acknowledging the importance of it can help improve the therapeutic relationship. Also involving the family whenever possible can help the client feel more comfortable with the OTR and help increase motivation to be present during therapy sessions. Respecting the elders of the family such as incorporating them in all decisions regarding therapy while still ensuring the client is getting the best possible care can again help the therapeutic

relationship become stronger and more effective. While these values should be taken into account, it is important to assess each client thoroughly to understand what is specifically important to them and not make assumptions about a client because of their background.

Table 30 – Value Statements

1. Individualism and privacy are important
2. It is ok to have a relaxed attitude about time
3. I think it is important to get things done on time
4. Spirituality is important
5. It is important to be practical and efficient
6. Interpersonal relationships take precedence over tasks
7. It is more important to look at the situation that is occurring now than to worry about the future or the past
8. It is acceptable to go along with the majority's opinion
9. Family and kinship are important. Sharing resources and responsibilities with kin is good
10. Self discipline and self efficacy are important
11. It is important to respect the elders in the family
12. It is important to control one's own emotions

Table 31 – OTR's Perceptions on Value Statements

Statements	1	2	3	4	5	6	7	8	9	10	11	12
OT's	X			X					X			
Asian/Asian American/Pacific Islander									X	X	X	
Black/African American				X		X			X			
White/Caucasian/ European American	X				X					X		
Hispanic/Latino/a American				X					X		X	
Native American				X					X		X	

All of this information should be taken into account when working with clients of all backgrounds. However, it needs to be understood that the above statements were the opinions of therapists and are not always true for every person of that ethnicity.

Previous Studies:

The primary researcher has found many similarities between the two previous studies and the current one. For example, all three studies found there was a disconnect in the discussion of sociocultural factors that affect treatment in OT curriculums. Skawski (1987) reported that "the relevance of sociocultural factors to treatment has not been adequately stressed in occupational therapy education" (p. 46) and Pineda (1996) found that only 1% of her participants stated that the OT curriculum gave them resources/information on how to acquire greater cultural sensitivity (table 2, p. 34). This is continually supported with the data from this study as only 5.2% of participants stated they got adequate information from the OT curriculum (table 15).

Pineda (1996) also did a theme analysis of the open ended responses and found similar themes to those found in this study. When looking at client's background enhancing treatment some themes identified in both studies were that it can help promote participation, increase motivation, and establish rapport. When looking at a client's background interfering with treatment Pineda identified themes of gender issues, communication barriers, ethnic/cultural differences regarding goals, and views of illness/independence. When looking at therapist's background enhancing treatment some themes Pineda identified were trust with clients of the same ethnicity, therapeutic use of self, and empathy/sensitivity to clients of the same ethnicity. When looking at a therapist's background interfering with treatment some themes identified were communication barriers, therapist's personal prejudices/bias and ethnocentric view of treatment. These themes are almost identical to the themes identified in this current study.

When compared to Pineda's study (1996), most of the values picked by participants about specific ethnicities are the same. Each ethnicity (except for Native Americans because Pineda did not evaluate that ethnicity) had two of the same value statements in the top three. This shows that there has been little change in the past 20 years regarding how OTR's think about other ethnicities. Skawski did not look at these value statements so no data can be compared.

In the conclusion of Skawski's article, she stated what is still true.

> "Therapists of different ethnic and racial backgrounds display varying levels of the cultural awareness and sensitivity necessary for meeting the needs of clients. Most occupational therapists currently practicing in the United States are part of an unquestioning majority. This can negatively affect the provision of health care services to culturally-distinct clients if occupational therapists are not aware of their own values and those of their clients" (p. 47).

As evidenced by this and the previous data it is clear that there have been no drastic changes in the way therapists think about race, culture and ethnicity and its effects on intervention in the last 20-30 years since the original studies were performed.

Chapter 7: Limitations and Implications

Limitations:

This study as a replication study comes with some inherent limitations. This study did allow for informative descriptive statistics which can be theorized to generalize because of the statistically significant goodness of fit test. However, the design was not conducive to using inductive statistics to make broader claims about the larger population of OTR's across the United States.

For this study three chi-square tests of independence were run to look for associations. Because of small sample sizes of those who identified as bilingual/trilingual and those with an associate's degree or doctorate degree had less than five in the category. Though chi square can still be run under these conditions, this may create more opportunity for a type II error, where significant results are not identified though there is a true association. In this case, no statistically significant association was found for either when comparing it to the open ended responses.

Another possible limitation was coding of the open ended questions. Coding was done by the primary researcher and one peer researcher both of whom were student level researchers who had not had significant clinical or research experience. Although care was taken to ensure inter-rater reliability and validity the initial coding could be looked at as subjective.

The thematic analysis that was done with the open ended questions can also be looked at as subjective. As this method is very flexible and fluid with no set guidelines, it is up to the researcher to outline what qualifies as a theme and what impact that theme has on the results of the study.

Another limitation of this study was that the survey was first developed in 1987, the language revolving around this sensitive subject has changed and developed. The primary researcher made the decision to keep most of the same language as this was a replication study. However, some language, specifically using the words interferes or enhances when talking about a clients or therapist's background could be seen as problematic for some participants. This could have led to

some participants not answering the open ended questions or responding in a different way than if the wording had been updated.

This was an anonymous survey in part to help ensure participants felt comfortable sharing their honest feelings. However, due to the sensitivity of the topic and vagueness of the open ended questions it is possible the participants could have answered in a way they feel is 'socially acceptable' rather than their true feelings about the topic. Due to the anonymity of the survey, follow up with participants was not feasible. Overall, a few limitations exist but the findings indicate further research is recommended in this area.

Implications for occupational therapy practice:

This topic of race, culture and ethnicity is under researched in the field of occupational therapy. Specifically investigating the role cultural competency has in occupational therapy and its effects on clients as well as therapists is essential. More research is needed to establish where therapists are getting information on race, culture and ethnicity. Knowing where OTR's are getting this information will be key to understanding and outlining how they should be effectively trained to ensure competence. Finally research is needed to understand the connection between number of languages spoken and attitudes about race, culture and ethnicity. For the theme analysis, language barriers and difficulty with communication come up more than once, showing clinically there could be some significance. Unfortunately, in this survey there was a very small sample size of those who spoke more than one language.

The profession of occupational therapy as a whole must be more racially conscious. There are many participants who showed how they are working on being aware of white privilege, the power that comes with being a health care professional and implications of institutionalized racism. For example, one participant stated,

> Working in a highly segregated region of the country, there can be a lot of baggage and distrust to overcome when initially meeting new families. I don't want to be just another white lady coming over to tell you how to raise your kids, therapeutic use of self is essential to avoid that trap.

Another stated,

> Therapists need to be very aware of their own experiences related to their ethnicity because it can be a benefit or an interference. For example, it isn't appropriate to assume that everyone from the same ethnicity has had the same experiences. So as a Hispanic woman, I shouldn't assume that my life experiences mirror those of other Hispanic women.

These two participants are acknowledging their position and expressing the importance of awareness of one's own self and how they present to their clients. However, there are many who did not identify that they are even aware that race, culture and ethnicity could have effects on their practice. For example one participant stated, "I do not know [how a therapist's ethnic background could enhance treatment], I am white and have not experienced any enhancement from my ethnicity." Another stated, "…I treat each individual individually." Both of these participants are not acknowledging the impacts of race, culture and ethnicity in practice. Cultural awareness is needed to help meet the needs of all clients regardless of their background.

It should be noted that through this project, a culture of occupational therapists has emerged; a micro-culture within the macro-culture of the US. There are specific values OTRs hold dear; three that were elicited by this study were individualism and privacy, spirituality, and family and kinship. Since this sample accurately represented the ethnic and racial breakdown of OTRs in the United States, we can hypothesize that these values would be found to be important in the larger population of OTRs. Acknowledging that there is a collective thinking is important to preserving and enhancing

this specific group, as well as realizing how this particular culture can help OTRs have better connections with their clients. It is prudent to point out that the top three for the overall OT population are in line with multiple other ethnicities. OTRs are a distinct group of people with their own specific values. OT is a unique and amazing profession that can do a lot to help clients realize their full potential in therapy and in life. Using the information from this study as well as expanding and researching on one's own will help the whole profession become more racially conscious and, in turn, provide better therapy to all outcomes.

Implications for occupational therapy educators:

From this study and previous data it is evident that OTRs are not learning to their full potential about cultural competence and how to be racially conscious in the classroom. This is evidenced by the fact that only 4.5% of participants stated that they learned about clients of varying race or ethnicities from the OT curriculum. This could indicate educators are in a very important position and have the ability to cause change and awareness in this area. Continuously educating the next generation of occupational therapists is a valuable opportunity. As educators it is vital to be racially conscious in everyday life and bring that to the classroom by utilizing the OTPF and the ACOTE standards (there are 10 that relate to this topic talked about in chapter one) that encourage looking at race, culture and ethnicity in case studies, assessment results, appropriate discharge planning, therapeutic use of self, etc. Another very useful tool is *A guide to cultural competence in the curriculum: Occupational therapy* by the Center for International Rehabilitation Research Information and Exchange (Nochajski & Matteliano, 2008). It lays out objectives, references, classroom activities, web resources, self-tests, questionnaires, case studies specifically for occupational therapy students. Nochajski & Matteliano (2008) state that, "integrating cultural competence into existing courses [so] that students have an opportunity to see its implications and apply its principles in a variety of contexts. When it reappears in their coursework each semester,

their knowledge, attitudes, and skills in this area develop and deepen." Educators can bring race, culture and ethnicity to the forefront of the classroom and acknowledge its importance in everyday practice.

Implications for occupational therapy students:

Occupational therapy students (OTS) also have a responsibility to become culturally competent individuals. One's therapeutic use of self starts to develop as a student. To help this development, a student needs to be inquisitive, open minded and committed to being the most skilled OTR they can be. OTSs should ask questions, explore their own feelings about their own race, culture and ethnicity and work to understand concepts such as institutionalized racism and white privilege. Being aware of race, culture and ethnicity is the first step towards cultural competence needed when working with those who are different in varying ways. OTSs should also be racially conscious when working with clients in clinic, on fieldwork and when out in practice. "The therapist [or student] should seek a comprehensive understanding both of the cultural norms and variances of the societal group(s) with which he or she is working" (Awaad, 2003, p. 357). As found in the literature review and the thematic analysis one's therapeutic use of self is vital to the therapy process and having a good therapeutic relationship with clients, family and other professionals. Overall, everyone has a responsibility when it comes to education about cultural competence. The more individuals who take on that responsibility the better the outcomes will be for all involved; clinicians, educators, students and clients.

Implications for future research:

Race, culture and ethnicity and their impact on the profession of occupational therapy is still an emerging area of research. It is clear more research needs to be done to look at the education of new therapists and continuing education of current OTR's and the development of cultural competency. More research also needs to be done with a larger sample size of bilingual and

multilingual therapists to identify if there is a correlation between languages and attitudes of occupational therapists on race, culture and ethnicity.

Overall conclusions:

Race, culture and ethnicity and overall cultural competence is a sensitive topic for all. However there are notable effects on the profession of occupational therapy that need to be further studied. A goodness of fit test was run comparing the ethnic identification of this study's population to that of the OT population in the US with statistically significant results (Table 14). This shows that the ethnic breakdown of this study was comparable to the ethnic breakdown of OTRs in the US. This was an important finding because often research is done without the appropriate representation of ethnic identifies. There is a statistically significant relationship when comparing attendance at a sociocultural (diversity) workshop and how a therapist answers the question asking about if a therapist's background interferes with treatment (Table 23). When OTRs are asked how a client's background interferes and enhances therapy, multiple themes were identified. Some examples include, learning from the client, helping to establish rapport, language/communication barriers, etc. When OTRs are asked how a therapist's background interferes and enhances therapy, again multiple themes were identified. Some examples include, increased relatability with client, therapeutic use of self and the invisibility of White privilege.

This replication study allows, once more, to look at how occupational therapists and occupational therapy assistants feel their own backgrounds and their clients' backgrounds affect the occupational therapy process. This study provides updated data on this topic, showing there have been very few significant changes in the last 20-30 years. The implications for practicing OTR's, OT educators, OT students and even clients of OT can help the profession move forward to be more racially conscious and active about exploring one's own background and one's clients leading to more individualized therapy sessions and potentially overall better outcomes.

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Appendix A: Online Cover Sheet & Survey

Hello – I am studying occupational therapists' racial and ethnic attitudes and how they feel it affects their practice. In the following survey, you will be asked for demographic data and then about some of your experiences and feelings about how race affects therapy. After the survey you will have the option of submitting your name and contact information for a drawing of two $25 Amazon gift cards. This contact information will not be in any way connected to your responses. I ask that you send this survey on to any other occupational therapists you know who would be willing to participate.

This survey has minimal risks including the potential to feel uncomfortable with some questions asked. If you do feel uncomfortable at any point you can skip questions or withdraw without penalty from this survey at any time. You will still be eligible for the $25 Amazon gift card.

To clarify, here are some definitions:

- "**Race** is defined as a socially constructed category that influences people's decisions and has consequences" (Whalley Hammell, 2013).
- **Ethnicity** is defined as "that part of one's identity derived from membership, usually through birth, in a racial, religious, national or linguistic group or subgroup," (Krefting, 1991).
- **Urban:** "The Census Bureau's urban areas represent densely developed territory, and encompass residential, commercial, and other non-residential urban land uses. The Census Bureau delineates urban areas after each decennial census by applying specific criteria to decennial census and other data (Urban and Rural Classification)."
    - "The Census Bureau identifies two types of urban areas:"
        - "Urbanized Areas (UAs) of 50,000 or more people;"
        - "Urban Clusters (UCs) of at least 2,500 and less than 50,000 people."
- '"**Rural**' encompasses all population, housing, and territory not included within an urban area" (Urban and Rural Classification).
- **Cultural competence** is defined as "the ability to understand and work effectively with patients whose beliefs, values and histories differ from one's own," (Capell, Dean, Veenstra, 2008).

The survey should take no more than 20-30 minutes to complete. If you are interested, please click the link below:

By clicking the link and taking the survey, I am acknowledging that I am 18 years of age or older.

LINK HERE

If you have any questions, concerns or feedback, please feel free to contact me at:

Susan Giarratano

Graduate Student at Ithaca College

(203) 364-6350

sgiarra1@ithaca.edu

Or my faculty advisor at:

Jessica Valdez Taves

Occupational Therapy Professor at Ithaca College

(607) 274-3792

jtaves@ithaca.edu

Survey:

Section 1: Demographics

Gender:

- Male
- Female
- Other
- I do not wish to disclose

Age:

- 21-25
- 26-30
- 31-35
- 36-40
- 41-45
- 46-50
- 51-55
- 56-60
- 61-65+

In what type of setting are you predominantly working in now?

- Rehab
- Acute Inpatient
- Outpatient
- Day Treatment
- Skilled Nursing Facility
- Home Health
- Mental Health
- School Based

- Community
- Early Intervention
- Academia
- Other

How long have you worked in your current setting?

- less than 1 year
- 1-3 years
- 4-5 years
- 6-7 years
- 8-10 years
- 10+ years

How many hours a week do you work?

- 0-10 hours
- 11-20 hours
- 21-30 hours
- 31-40 hours
- 41-50 hours
- 51+ hours

What percentage of your current caseload (clients that you work with directly) are of a different race than you?

- 0%
- 1%-25%
- 26%-50%
- 51%-75%
- 76%-100%

What is your licensure level?

- Registered Occupational Therapist
- Occupational Therapy Assistant

What is the highest occupational therapy academic degree you currently hold?

- Associates
- Baccalaureate
- Masters
- Doctorate

What is your ethnicity? **Please select all that apply.**

- ☐ African-American/Black
- ☐ Asian-American/Asian (including Pacific Islander)
- ☐ European-American/White/Caucasian
- ☐ Hispanic/Latino-American
- ☐ Native American

What type of area do you work in?

- ○ Rural
- ○ Urban

What area of the United States do you live in?

- ○ Northeast
- ○ Midwest
- ○ South
- ○ Northwest
- ○ Southwest

How many languages do you speak?

- ○ 1
- ○ 2
- ○ 3+

Section 2: Multicultural Competence and Attitudes

Have you ever participated in a sociocultural (diversity) workshop or seminar?

- ○ Yes
- ○ No

Please indicate where (you may select more than one):

- ☐ College course
- ☐ Orientation
- ☐ Continuing edu
- ☐ OT school curriculum
- ☐ Employment in-service
- ☐ Other, please specify

Would you if you could?

- ○ Yes
- ○ No

Do you believe that attending a social cultural/diversity workshop or seminar would help you to interact and administer OT services more effectively to people that are a different race than you? (please select only one answer)

Strongly disagree	Disagree	Agree	Strongly agree
○	○	○	○

How often do you consider your clients ethnic and cultural background when planning clinical treatments and goals? (please select only one answer)

Never	Sometimes	Usually	Always
○	○	○	○

Which of the following has given you the most useful information about clients of varying ethnic/racial backgrounds? (Rank from "1" - has given you the most information, "2" has given you the second most information, etc and "9" has given you the least information).

Cultural seminar or workshop in school

In-service training at work

OT curriculum

On the job experience

Other college courses

Personal reading

Personal and social experiences outside of OT

Travel

Other (Please specify)

How do you feel the clients ethnic background **enhances** the treatment process?

How do you feel the clients ethnic background **interferes** with the treatment process?

How do you feel the therapists ethnic background **enhances** the treatment process?

How do you feel the therapists ethnic background **interferes** with the treatment process?

Listed below are beliefs, values and practices. Please place a check mark next to each one that reflects something **you** personally value.

- ☐ Individualism and privacy are important
- ☐ It is ok to have a relaxed attitude about time
- ☐ I think it is important to get things done on time
- ☐ Spirituality is important
- ☐ It is important to be practical and efficient
- ☐ Interpersonal relationships take precedence over tasks

- ☐ It is more important to look at the situation that is occurring now than to worry about the future or the past
- ☐ It is acceptable to go along with the majority's opinion
- ☐ Family and kinship are important. Sharing resources and responsibilities with kin is good
- ☐ Self discipline and self efficacy are important
- ☐ it is important to respect the elders in the family
- ☐ It is important to control one's own emotions

Listed below are beliefs, values and practices. Please place a check mark next to 3 phrases which you believe best describes the values of **Asian/Asian American/Pacific Islander's.**

- ☐ Individualism and privacy are important
- ☐ It is ok to have a relaxed attitude about time
- ☐ I think it is important to get things done on time
- ☐ Spirituality is important
- ☐ It is important to be practical and efficient
- ☐ Interpersonal relationships take precedence over tasks
- ☐ It is more important to look at the situation that is occurring now than to worry about the future or the past
- ☐ It is acceptable to go along with the majority's opinion
- ☐ Family and kinship are important. Sharing resources and responsibilities with kin is good
- ☐ Self discipline and self efficacy are important
- ☐ it is important to respect the elders in the family
- ☐ It is important to control one's own emotions

Listed below are beliefs, values and practices. Please place a check mark next to 3 phrases which you believe best describes the values of **Black/African American's**.

- ☐ Individualism and privacy are important
- ☐ It is ok to have a relaxed attitude about time
- ☐ I think it is important to get things done on time
- ☐ Spirituality is important
- ☐ It is important to be practical and efficient
- ☐ Interpersonal relationships take precedence over tasks
- ☐ It is more important to look at the situation that is occurring now than to worry about the future or the past
- ☐ It is acceptable to go along with the majority's opinion

- ☐ Family and kinship are important. Sharing resources and responsibilities with kin is good
- ☐ Self discipline and self efficacy are important
- ☐ it is important to respect the elders in the family
- ☐ It is important to control one's own emotions

Listed below are beliefs, values and practices. Please place a check mark next to 3 phrases which you believe best describes the values of **White/Caucasian/ European American's**.

- ☐ Individualism and privacy are important
- ☐ It is ok to have a relaxed attitude about time
- ☐ I think it is important to get things done on time
- ☐ Spirituality is important
- ☐ It is important to be practical and efficient
- ☐ Interpersonal relationships take precedence over tasks
- ☐ It is more important to look at the situation that is occurring now than to worry about the future or the past
- ☐ It is acceptable to go along with the majority's opinion
- ☐ Family and kinship are important. Sharing resources and responsibilities with kin is good
- ☐ Self discipline and self efficacy are important
- ☐ it is important to respect the elders in the family
- ☐ It is important to control one's own emotions

Listed below are beliefs, values and practices. Please place a check mark next to 3 phrases which you believe best describes the values of **Hispanic/Latino American's.**

- ☐ Individualism and privacy are important
- ☐ It is ok to have a relaxed attitude about time
- ☐ I think it is important to get things done on time
- ☐ Spirituality is important
- ☐ It is important to be practical and efficient
- ☐ Interpersonal relationships take precedence over tasks
- ☐ It is more important to look at the situation that is occurring now than to worry about the future or the past
- ☐ It is acceptable to go along with the majority's opinion
- ☐ Family and kinship are important. Sharing resources and responsibilities with kin is good
- ☐ Self discipline and self efficacy are important
- ☐ it is important to respect the elders in the family

- ☐ It is important to control one's own emotions

Listed below are beliefs, values and practices. Please place a check mark next to 3 phrases which you believe best describes the values of **Native American's**.

- ☐ Individualism and privacy are important
- ☐ It is ok to have a relaxed attitude about time
- ☐ I think it is important to get things done on time
- ☐ Spirituality is important
- ☐ It is important to be practical and efficient
- ☐ Interpersonal relationships take precedence over tasks
- ☐ It is more important to look at the situation that is occurring now than to worry about the future or the past
- ☐ It is acceptable to go along with the majority's opinion
- ☐ Family and kinship are important. Sharing resources and responsibilities with kin is good
- ☐ Self discipline and self efficacy are important
- ☐ it is important to respect the elders in the family
- ☐ It is important to control one's own emotions

Appendix B: IRB Application and Approval

Please save and email copy to hsrlog@ithaca.edu

A complete application includes all of the following:

- A brief project description (adequate to evaluate risks to subjects.)
- Copies of all instruments to be used.
- The consent form that you will use in the study (see part 2 for more information.)
- If this proposal is part of a grant proposal, include a copy of the proposal and all recruitment material.

Please be advised that if your study is not granted an exemption, you may be requested to submit an expedited or standard review form which will require further review.

Submission Date: 8/9/15 Primary Investigator: Susan Giarratano

Title: Graduate Student

If other, please explain: ____

If Student, Faculty Advisor Name: Jessica Valdez Taves

Department: Occupational Therapy

School: HSHP

Telephone/E-Mail: 203-364-6350/sgiarra1@ithaca.edu

Additional Investigators-Names and E-mail:

Dr. Ellie Fitts Fulmer (Committee Member) efulmer@ithaca.edu

Dr. Nia Nunn Makepeace (Committee Member) nmakepeace@ithaca.edu

Project Title: Occupational Therapists' Racial and Ethnic Attitudes: A Replication Study

External funds being used? No.

If yes, please list CITI certification dates for **ALL** researchers on project:

If you are conducting research that will receive external funding from NIH or NSF, undergraduate and graduate students as well as faculty and staff involved must complete CITI training which can be accessed at the following link:
https://www.ithaca.edu/provost/docs/hsrdocs/hsrresearchtrainingm/.

The Board will not approve projects until all participants have been certified

Subject Pool: Licensed and registered occupational therapists around the country who are currently practicing and between the ages of 21-75.

Brief Project Description:

This study is a quantitative survey design with some open ended questions and will assess the personal attitudes of practicing occupational therapists regarding race/ethnic attitudes and how they feel it impacts treatment.

Participants will be selected by snowball sampled of convenience. The primary researcher will send it to occupational therapists' through email (known through school such as professors, alumni, previous fieldwork supervisors and family) and ask them to send it on to other occupational therapists' they know would be willing to answer the survey. The primary researcher will also post the survey on occupational therapy specific Facebook groups in hopes of getting more participants.

The risks of this survey are minimal. However, there is some potential for the participants to feel uncomfortable while taking this survey. The participants can choose to not answer any questions that make them uncomfortable and can stop taking the survey at any time without ramifications

This survey will be anonymous and online. No identifying data will be collected. Demographic data will be collected but nothing more specific than the region of the United States that they live in

PART 1: EXEMPTION CRITERIA FOR RESEARCH PROJECTS

Please select any and all categories that relate to your research. Research is exempted when all research methods fall in one or more of the following six categories. Check all statements that apply to your study:

1. Research in an education setting to evaluate normal educational practices.

2. Research not involving vulnerable participants to observe, do interviews, surveys, or educational tests MUST also comply with one of the following (please check all that apply):

_X_ A. The participants cannot be identified, directly or statistically.

____ B. The responses/observations could not harm participants if made public.

C. Federal statute(s) completely protect all participants (confidentiality.)

3. Research to observe public behavior - interviews, surveys, or educational tests when all respondents are elected, appointed, or candidates for public office

4. Research only using existing data, documents, records, or specimens properly obtained MUST also comply with one of the following (check all that apply):

__ A. Subjects cannot be identified in the research data directly or statistically and no one can trace back from research data to identify a participant.

___B. The source(s) is publically available

5. Research for demonstration service/care programs (e.g. health care delivery) MUST also comply with **ALL** of the following:

A. It is directly conducted or approved by the head of the US Government department or agency: AND THAT

B. It concerns only issues under usual administrative control (48 Fed Reg 9268-9), e.g. regulations, eligibility, services or delivery systems; AND THAT

C. Its research/evaluation methods are also exempt from HSR review.

6. Research involving food and not involving vulnerable participants- to evaluate quality, taste, or consumer acceptance - MUST also comply with **one** of the following:

A. The food has no additives.

__B. The food is certified safe by the USDA, FDA, or EPA.

PART 2: CONSENT FORMS

The consent form must be written in non-technical language which can be understood by the subjects. It should be free of any exculpatory language through which the participant is made to waive, or appears to be made to waive any legal rights, including any release of the investigator, sponsor, institution or its agents from liability for negligence. (Note: the consent form is not a contract.)

For example consent forms, please refer to our website, www.ithaca.edu/provost/research/hsr/.

The HSR prefers using signed informed consent. However, if that is impractical, an application to waive signed consent can be requested below. However, even if this waiver is requested, **the HSR must be provided with the consent script that will present the information to human subjects regarding the study/research.**

I am requesting a waiver of signed Informed Consent because:

___A. Having a participant sign the consent form would itself be the principal risk of participating in the study.

__X__ B. The research presents no more than minimal risk of harm to subjects and involves no procedures for which having signed consent is normally required.

Note: Minimal risk - risks of harm anticipated in the project are not greater, considering probability and magnitude, than those ordinarily encountered in daily life or during the performance of routine physical or psychological examinations or tests.

If one of the above applies, you must still fill out the consent script below. If a waiver does not apply, please fill out the Informed Consent Form found at ithaca.edu/provost/research/hsr/ and e-mail form to hsr@ithaca.edu

If waiver is requested, please provide the script that will be used to present information to participants:

Electronically submitted protocols **must be sent from an Ithaca College e-mail account**. Original signatures are not required. Ithaca College e-mail IDs have been deemed by the College to constitute a legal signature.

PLEASE NOTE THAT YOUR PROPOSAL WILL BE DEEMED INCOMPLETE UNLESS COPIES OF ALL INSTRUMENTS TO BE USED (SURVEYS, ETC.) AND INFORMED CONSENT FORM (IF NECESSARY) ARE SENT TO hsrlog@ithaca.edu.

_X_ certify my responses are accurate and complete. If the project scope/design is later changed I will resubmit for review.

_X_ I will obtain written approval from the authorized representatives of all non-IC institutions in which the study is conducted.

ITHACA COLLEGE
Sponsored Research

August 17, 2015

Susan Giarratano, Graduate Student
Department of Occupational Therapy
School of Health Sciences and Human Performance

Re: IRB 0815-01, Occupational Therapists' Racial/Ethnic Attitudes: A Replication Study - Exemption

The Institutional Review Board for Human Subjects Research (IRB) has reviewed your proposal and has determined that by the IRB Guidelines, this project can be approved for an exemption from ongoing oversight.

In certifying that your research is exempt, the IRB indicates that there will be no continued oversight. Since the IRB is not approving the project, there also is no approval time frame. Should the project be continued beyond the semester, you may do so without additional involvement with IRB provided that the same procedures as described in the application are followed. If there are changes in design, the application would have to be resubmitted to the IRB.

Please note that if there are any adverse events resulting from this research, they must be reported to the IRB.

This approval is issued under the Ithaca College's OHRP Federalwide Assurance #00004870. Please feel free to contact the IRB at irb@ithaca.edu with any questions or concerns.

Sincerely,

Wade Pickren, PhD
Director, Sponsored Research
Institutional Review Board for Human Subjects Research

/mat

c: Jessica Valdez Taves, Assistant Professor

Appendix C: Tables

Table 2 - Gender

Gender	Frequency	Percentage
Male	12	6.7
Female	163	91.6
Other	1	0.6
I do not wish to disclose	2	1.1

Table 3 - Age

Age	Frequency	Percentage
21-25	26	14.6
26-30	32	18
31-35	33	18.5
36-40	31	17.4
41-45	14	7.9
46-50	8	4.5
51-55	12	6.7
56-60	13	7.3
61-65	9	5.1

Table 4 - In what type of setting are you predominantly working in now?

Setting	Frequency	Percentage
Rehab	12	6.7
Acute Inpt	21	11.8
Outpt	20	11.2
Day Treatment	5	2.8
SNF	27	15.2

Home Health	15	8.4
Mental Health	5	2.8
School Based	19	10.7
Community	5	2.8
EI	10	5.6
Academia	26	14.6
Other	13	7.3

Table 5 - How long have you worked in your current setting?

Length of Time	Frequency	Percentage
<1	37	21
1-3	50	28.4
4-5	27	15.3
6-7	13	7.4
8-10	17	9.7
10+	32	18.2

Table 6 - How many hours a week do you work?

Number of Hours	Frequency	Percentage
0-10	10	5.6
11-20	12	6.8
21-30	17	9.6
31-40	92	52
41-50	39	22
51+	7	4

Table 7 - What percentage of your current caseload (clients that you work with directly) are of a different race than you?

Percentage of Difference	Frequency	Percentage
0	5	2.8
1-25	81	45.8
26-50	40	22.6
51-75	30	16.9
76-100	21	11.9

Table 8 - What is your licensure level?

Licensure Level	Frequency	Percentage
OTR	160	90.9
COTA	16	9.1

Table 9 - What is the highest occupational therapy academic degree you currently hold?

Degree	Frequency	Percentage
Associates	11	6.2
Bachelors	42	23.6
Masters	106	59.6
Doctorate	19	10.7

Table 10 - What is your ethnicity? Please select all that apply.

Ethnicity	Frequency	Percentage
African American/Black	11	6.2
Asian-American/Asian/Pacific Islander	15	8.4
European-American/White/ Caucasian	145	81.5
Hispanic/Latino/a-American	13	7.3
Native American	3	1.7

Table 11 - What type of area do you work in?

Area	Frequency	Percentage
Rural	42	23.6
Urban	136	76.4

Table 12 - What area of the United States do you live in?

Area	Frequency	Percentage
NE	79	45.4
MW	24	13.8
South	25	14.4
NW	19	10.9
SW	27	15.5

Table 13 - How many languages do you speak?

Number of Languages	Frequency	Percentage
1	133	74.7
2	39	21.9
3	6	3.4

Table 14 - Goodness of Fit Test

Ethnicity	Observed N	Expected N	Residual
African American	9	8.4	.6
Asian	12	10.6	1.4
White	139	147.3	-8.3
Hispanic	9	7.3	1.7
Native American	1	0.3	0.7
Biracial/Multiracial	6	2.0	4.0
Chi-Square (Asymptotic Significance)		.070*	

* Statistically significant result