Minority is the New Majority: Strategies to Combat Racism, Address Micro-aggressions, and Promote Healing in the Therapeutic Setting

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- [Host] I'm very honored to introduce today's speaker, Dr. Aditi Mehra joining us to speak on minority is the new majority strategies to combat racism, address microaggressions and promote healing in the therapeutic setting. Dr. Mehra graduated with a bachelor's in occupational therapy from Western Michigan University in 1998, and has a doctorate in health sciences from Midwestern University in Illinois. She has practice as a pediatric occupational therapist for the past 22 years in various settings, including early intervention hand therapy, inpatient and outpatient rehabilitation and school settings. During her doctoral studies, Dr. Mehra also pursued a certification in Applied Behavior Analysis to improve and enhance collaboration within multidisciplinary teams. Once she delved deeper into this field of ABA, Dr. Mehra uncovered fit learning, which is an academic program based on the principles of ABA designed to build fluency and address all differences in learning. Dr. Mehra is currently the Director of fit learning labs in the Chicagoland area and Denver Colorado. She continues to practice occupational therapy in the school setting and private teletherapy services. Her passion is rooted in interprofessional education and aims to foster multidisciplinary collaboration with the field of occupational therapy and other allied health professions. She provides continuing education presentations to various allied health groups in the community, and as an adjunct professor at Elmhurst University. Welcome Dr. Mehra and thank you so much for joining us today.

- [Mehra] Thank you so much, I'm delighted to be here to talk about sort of the elephant in the room these days. This is one of my favorite topics because it was actually part of my dissertation in my doctorate program, and it was specifically for early intervention, but there's no doubt the landscape, culturally is changing in the United states and racial issues and cultural issues are paramount currently in our healthcare profession. So I'm really excited to talk about it. And I'm gonna start off just by talking about some statistics, because that's always a good place to start. In the

research shows, Pew Research Center really is where I got all this information from. It indicates that the proportion of immigrants in the United, in the US population is actually approaching a record term high. It's about 13.6% of the population, so that's the highest since gosh, like 1910, I believe. So it's really quite major, as far as statistics goes. The household income in the United States is also near high. However, there's some inequity in Amongst racial and ethnic groups, so that plays a factor into racial disparities. Also, more broadly, the public also sees differences by race and ethnicity, when it comes back to getting ahead in the United States and access to services, and these statistics on the slide sort of indicate that. The majority of Americans, 56% say that being black hurts, the person's ability to get ahead and access. And then 51% say being Hispanic as a disadvantage, and 59 say that, being white is an actual advantage.

So, I wanted to start off with statistics so we can use that to base some of what we're seeing in the health care related to disparities. I do want to point out President Clinton's advisory board and they're sort of conclusion when they had done an analysis, that racism is one of the most divisive forces in our society, and the racial legacies that have preceded the current situation continue to haunt us and create the sort of disparity in healthcare for us too between a minority and majority groups. They're also very deeply ingrained, and they're quite invisible. And lastly, which is the most important part of all, and you'll see this theme sort of resonate throughout the presentation is that most white Americans are unaware of the advantages of being simply being white. So I just thought this was a really nice, comprehensive, sort of conclusion from a very knowledgeable advisory board. And it sort of sets the pace of why we're here today and why we're talking about this. So based on all that our learning outcomes today are going to be really talking about cultural competency and identifying those three terms cultural humility, racial microaggression and ethnocentrism. Identifying the differences between microaggressions, listing types of microaggressions, specifically their impact on practice, describing the core concepts and importance of humility versus competency in cultural. And then identifying

challenges and strategies to combat racial microaggression, especially its application to delivering culturally confident care. So let's get started, I'm gonna just start off with terminology because there are so many terms. It just seems like we've been talking about cultural competency for ages. And during this time, they've been so many terms that have been thrown out. I think I've been reviewing the literature for, so I did my doctorates about four years ago so I've been reviewing the literature since then. And there's so many different terms, so culture basically there's a sort of the thoughts, communication, beliefs, values of a specific racial, social group, race is actually the physical characteristics, such as your skin color, et cetera. Ethnicity is actually refers to a particular social group in like a society and it's because they share a specific value or belief. And it's also based on social attitudes and economics and those aspects.

Ethnocentrism, you've probably heard this a lot also, this is when we evaluate other cultures according to preconceived notions of our own. And then racial microaggression, this is sort of a newer term that I've seen in the literature and it's really about Understanding that there are brief and very commonplace, somewhat seemingly nocuous, behavioral and environmental indignities that happen, and sometimes they're unintentional, just because we're just so used to speaking this way, but they have a very negative impact on a specific racial group. So it's like a racial insult that is very subtle, and yet can be very harmful. And the last term, which we'll go into a lot more is cultural humility, and the research really shows that this is a new term that was coined in mostly recent literature in cultural competency, and it's all about reflecting on oneself, critiquing oneself, and really learning to be aware of what your biases and notions are, and starting there and sort of examining that while learning about another culture. And I wanted to put this in because I think often we talk about cultural competency, and we get a little focused on race, but it's not always about race, right? Culture refers to various things, in this presentation, we are sort of focusing on race. However, it's all about that ism, right? And I found this interesting in the literature, Isms are really general term that refers to sort of a theory or practice or

doctrine. And it describes something that really denotes oppression of a group based on the characteristics of its members. So racism, sexism, ageism, all these and isms of any kind really impose limits on a macro societal level. And we obviously have already seen a lot of this in our health care literature.

So are they really health disparities based on race? A lot of practitioners may not realize that they are or may not have given it consideration, because again it's under the radar of you know only what you know, but the research shows there is indeed a significant disparity, personal factors of our clients for example, education, respect, affordability, cultural sensitivity, all these aspects impact health care and accessibility. So culture is a very important part of health care accessibility, so that creates a disparity right there. The research shows that Hispanics feel disrespected by health professionals all the time and this creates a general mistrust, which in turn creates a health disparity. Another research article in 2014 believe that people from diverse backgrounds experienced microaggressions in all areas of life, including therapy and schools, this was highlighted very specifically in the literature. So yes, it is very alive and rampant. A little bit more about health disparities, Hoffman et al in 2017 indicated that medical students believed that black skin was thicker than white skin, and therefore presented a higher pain tolerance, right? Instead, it seems a bit unbelievable, doesn't it?

Like in 2017 that medical students would have this notion you think that, that was somewhat archaic belief. And then in 2017, there was another article talked about Roma women who are basically indigenous to darker skin, they've reported being mistreated, not getting proper communication being abandoned, abused even, so, it again, you wouldn't know until you research it. And so now having done the research, it's quite eye opening to see that this is still happening. So racism is changing, it is not the same, right? It's just everything evolves like changes inherent, it's part of life. So many studies in healthcare, education, employment, et cetera, et cetera, indicate that

there's such a difficulty in describing and actually defining racism, that's one of the hardest aspects of it. There's aversive racism or implicit bias, all these types of terms, it's really hard to quantify, because they're so subtle and somewhat nebulous, sometimes very, insidious nature. But without this classification and understanding of these terms, it kind of adds another layer of difficulty for practitioners like us. So I don't think that's something we could solve right away, but it's important to understand what racism looks like right now, regardless of various terms that are used. So racism, contemporary wise, is more likely than ever to be very covert. I grew up in, so I am Indian by nature or by birth, and I grew up in England. And racism, when in the 80s, when I was going to high school was very overt at least in England. And now there's the shift of being very covert where someone may not obviously say something to you, but outwardly, but they may imply it. And it has evolved from the old fashioned form, where it was an overtly racial hatred and bigotry, it was very public.

So that's what makes it so difficult to recognize and identify. So it is subtle, we've discovered that, but just because it's subtle does not mean that it's not impactful. It's easy to say, well, they're not saying it to your face, at least they're not saying it to you, so don't worry about it. Well, the literature shows that common daily experiences of these subtle racism or racial instances actually are considered aversive racism and have a significantly more influence on racial behaviors, like it impacts the person receiving this in a very, very significant way. So furthermore, these sort of invisible impacts or subtle racism encounters have major issues in that it prevents the perpetrators from realizing and confronting their own problem with racial issues and their practice and their role in how they're creating this disparity in health care, which ends up impacting everyone globally. So it's sort of that butterfly effect, right? You start with this little well, I'm not really recognizing what I'm doing, and then that sort of builds up and causes a grantor effect. So this several forms of micro-aggressions, as I said they're very subtle, stunning, very automatic, often there can be nonverbal exchanges, like put downs. Also, sometimes it can be awfully jokingly, right? So it's

really disguised, subtle insults directed, towards people of color. And sometimes it's very own automatic and not conscious, like you're not thinking about it. They can be brief, everyday exchanges that are towards a minority group. But then not just limited to verbal exchange and behavior and encounters, it's actually can be very environmental.

So if I go to see a counselor, let's just say and I'm of Indian origin and I go there and all her literature is based on Caucasians or the posters I see in the waiting room are all Caucasian, it may not be an overt thought, but it might be a very subtle sort of, hmm, I don't know if this is the right counselor for me, because it seems like she doesn't have a lot of exposure to my type of people in my background perhaps. So that may be an assumption I might make as a client. So that three types of microaggression, there's micro-assalt, this is very old fashioned sort of racism, when you call someone like colored or oriental. Generally this happens more in private situation, and hence micro, and the thing about it is the perpetrator can get to be anonymous, right? This really is the advantage for the perpetrator. So an example might be when a white employer tells a candidate of color, I believe that the most qualified person should get the job regardless of race, or when the employee of color is asked, how did you get your job and the underlying message from the recipient may be all people of color are not qualified for example, things like that. So they can micro-assaults happen, I'm sorry, I just described micro-insults, not assaults. So I moved on to micro-insults without saying that, so micro-insult is basically subtle snuffs, micro-assaults are more overt, micro-insults are more subtle snaps and they are hidden, they're conveyed but not very directly.

As I said, when a white employer says, how did you get your job, that sort of thing. And then there are micro-invalidations. This is characterized by communications that exclude or negate the feelings of someone who might be experiencing in their mind racial microaggression. So when you might say to someone, oh, don't be so over

sensitive, don't be petty, it's all in your head, I can tell you as a therapist of color, I have definitely experienced that. So that's another form of microaggressions. So these three forms are really important to understand because they really are very inherent in our society right now, and are extremely insidious in that they can really be detrimental to practice. There are actually nine versions of micro aggressions, the literature shows and I really like this because it's sort of characterized aspects of racial issues, right? So let's start with alien in our own land, what that is, it is belief that a visible racial minority, even though they're citizens are actually foreigners.

So I'm a citizen, but sometimes people still see me as a foreigner, because I'm not white, for example, and my accent is not very American. Number two would be color blindness, this is when you say, I don't see color, that and you may or may not, I'm not here to descend that but it's about being aware of what you may not be aware of, right? Third is myth of meritocracy, I can't say that word to save my life. And these are statements which assert that race plays a minor role in life success. It's not that way, it's a minor thing, it's not because of race. And the denial of individual racism, that I'm not racist at all, because I have a friend who's African American, or I have a friend who's Indian, for example. Ascription of his intelligence, this happens all the time. To me I know, I can speak to it firsthand, because I'm Indian people assume that I'm good at Science, that's sort of the general assumption. And then second class citizen, this is that they're treated as a lesser person of group. And then pathologizing cultural values and communication styles. This is the notion that values and communication styles of people of color are not typical or abnormal, for example.

So these are some variations of racial microaggressions and the interpretation in daily life. Two more, the assumption of criminal status, just because you're a specific ethnicity that you might be more prone to criminal activities, environmental microaggressions which is more apparent, this happens more in a systemic sort of level, like I mentioned the doctor's office or a certain area that typically white people go

to vice versa. So those sorts of aspects. So is it really that serious? We know that the literature we know that health disparities, are not good. But it is serious on even a personal level, because microaggressions have major implications for both the perpetrator and the targeted person. So the person who's actually doing it may not realize it, that it's very harmful to them too. Because the literature shows it creates psychological dilemmas that unless they're adequately resolved lead to increased levels of frustration stress, mistrust, just a generally not a good feeling I guess. It just creates really bad karma between races and society in general. So, if you're thinking, why do I need to worry about it? This is why you need to worry about it because it is so detrimental. So as therapists what is our responsibilities? Well, as practitioners, we have an opportunity to play a really vital role here.

As OTs specifically, we want to address the role in addressing occupational injustice, which is basically promoted by acts of micro aggression, right? Occupational injustice really happens when participation in an occupation is bought, segregated or prohibited, restricted in any way. So as OTs our goal is obviously to improve participation and quality of life, and so if we are not addressing these microaggressions we are inherent contributing to it. I think that's what this article in 2017 said, by Aldrich et al, that OTs in the US have yet to take on this responsibility of decreasing occupational injustice in practice. And why is that? It's because, again, you know what, you know, if you're white therapists you may not be aware of what you're not aware of. And there is definitely a power dynamic going on. When I looked at the literature, prejudice, privilege and power are the three main areas that are limiting our progress in cultural competency. Professional power, white privilege and biases is the three tiered problem.

Power hierarchies like this are present between clinicians and their patients or caregivers in healthcare, they're very prominent. So if you look at a traditional relationship between a patient and a provider, it tends to be very sort of paternalistic,

right? Where the provider is directing the patient on a treatment plan. You need to do x, y, and z to mitigate a health concern. However, a balanced approach to this would be, a patient and a provider relationship that's sort of shared, right? It's a shared decision making. So we make the decision based on clinical expertise, but also consider the patient's lifestyle needs some values and preferences, that is really going to be very important in this situation. So I wanted to sort of bring up some examples of professional privilege and control because again, this is very prominent to be being unaware of, right?

So the first is direct coercion, when you are in a position of professional privilege, like I'm the OT, I'm the considered expert. We would definitely do some, something that may be perceived as direct coercion. For example, if a patient is having pain, I would say, okay I would like you to do these exercises to eliminate the pain. And there is a sort of direct coercion there because I have not taken into account any sort of environmental situation, cultural situations, I've said, This is what you need to do to get rid of the pain. And the patient complains to me, I can't get rid of the pain well, because you're not doing x, y and z. So because I'm the professional, the expert, I'm sort of forcing them to do these activities in a way to achieve the goal they want. Then there's idiologic hegemony. This is more nuanced and subtle, it may involve pressuring clients to change their behaviors, or make specific choices based on what provider deems is necessarily good.

So an example might be, I see a client who wants OT but doesn't have a car, for example, so has to borrow car and come to therapy for her child, let's just say, and I, she cancels sessions and all that, and then I get upset at her and I say, well, we can't continue because you can't make the sessions, why? And, we have this exchange and I sort of stopped making assumptions, well, why can't you do this, why can't you borrow the car from your family members? Why, if this was important to you, so all that stuff really is very nuanced and subtle, because I might say, well, I understand that you

don't have a car, but da, da, da, da. But am I really understanding her position and taking into account what's going on. So these two aspects, they're really hard to understand honestly, when I was reading the literature, it was really hard to sort of tease it apart. But the important thing to remember here these perspectives are culturally informed, and they're not necessarily negative, right? If a client does not bring in their child to therapy, for whatever reason, my intention is not negative. It's true that I can't really make, I can't help if you don't show up, but it's making sure I am addressing this subtle nuances.

So let's really look at the OTPF as a guide here, because that's what we do, right? We as therapists look at that and go okay, what do we care about, what are we trying to achieve here? So if you look in the center of everything is the client, their factors, their performance patterns, their skill set, right? We all know that, and then we also look at the domain of occupational therapy, and what aspects we address. So social education, play work, ADLs, IADLs, leisure, et cetera, et cetera. How does this all apply within the context of racial microaggressions? So what client factors, for example, might be impacted when there's some racial issues going on? And are you as a therapist considering these? And then the other facet here is that context and environment are pertinent, pertinent factors, right? Because if there's racial microaggressions, that's going to really impact the context environment. So if you're just looking at the center of these client factors and all that and disregarding the context environment, then there will be a disparity in your delivery of health care.

So, like the literature indicates racial microaggressions have a very significant impact that may not be apparent to you and I, it can be very subtle, but it creates self doubt, isolation, anger, exhaustion, frustration and really does impact overall participation, so it's a very core topic for us in OT. So let's look at some of these racial microaggressions. Before I go there, I do wanna talk about stress in general. I can tell you that stress is a very key component of racial microaggression, actually, of any

microaggression, stress is very real and anxiety can be very real. It's very important to acknowledge any stress you have, or your client has experienced due to microaggressions. Because we have to think about stress as the same way as we think of like something bad happening physically in the environment, right? Stress is actually our response to conditions of stimuli in the environment. So if a client is experiencing stress, you need to sort of look at the environment go what's going on? There are several types of stress also that are encountered in, microaggressions is positive, tolerable stress, and then there's really toxic response, stress response. And positive stresses, it's fairly normal, it's very healthy, it's like when you are about to do a presentation, you have sort of butterflies in your stomach, that's sort of the positive stress. Tolerable stress is activates sort of the alert system and we do sort of need that because it's for like severe long lasting events, that sort of mixed tolerable stress. But then the most harmful is the toxic stress, and that happens when we have strong, frequent and prolonged adversity in our lives. And even if the access subtle, it doesn't matter or overt, it's just toxic because it's like an illness, it just keeps, it's pervasive and keep staying there.

So stress is a really important part that we need to look at when we are considering participation of clients. So going back to ADLs, how does, how do racial microaggressions impact ADLs? Studies show that investigating sleep and reduced sleep for individuals who have experienced discrimination, that they have shorter people of sleep. So this obviously impacts their everyday living activities. IDLs of less sleep, leisure, play all that. Then we have impact on child rearing. So I saw articles where African Canadian women, were dealing with racism, like imagine that. Imagine that if you've not dealt with it, like you might send your child out to go, your teenagers go out, and you might say, just make sure you're careful about driving and texting and make sure this, but most of us are not going okay, we need to worry about race and make sure that you don't say anything wrong or you don't drive here or you don't, you and I probably don't think about that, but this is very real conversation, and impacts

child rearing for so many families. That was very apparent in the literature. It also impacts leisure, who would have thought, right? But yeah, if you feel snubbed in any way or I mean, the reality of human beings in nature is we want to feel reinforced, right? We wanna feel good, and we're going to do things that make you feel good. So if I go and hang out with my friend, and her sister, is says makes these little subtle comments that are racist and all that, am I going to want to hang out with her again? Probably not, because that's going to have an impact on me.

So the research shows that African Americans and African Canadian women this particular study showed that we're avoiding activities like watching TV or going to restaurants and things like that because of these microaggressions. Also, African American women did it identify, our customers identified that they were monitored, scrutinized more, and I think I recently saw something on YouTube, that a company had done the sort of research on it, a journalistic approach or whatever "Dateline" or one of those type of shows. Anyway, so it is very real and it's happening, if you look on YouTube, you'll probably find some videos to share that viewpoint. Okay, so that's life, right? That all refers to a client's participation, but how does racial microaggression impair our therapeutic alliance? Well, that's the big nut here, that's what's sort of going on. How, it happens is, there's several barriers, the first one I already identified, your environment.

So if you have a therapeutic clinic, you need to have diverse brochures, diverse pictures. We might be like, well, how does that do anything? Well, obviously it does, because those subtle microaggressions that people of different cultures face. But for effective therapy to occur, there has to be sort of a therapeutic alliance, right? A therapeutic relationship is the most important part of what we do with our clients, especially when they come from a different race or color or have different values. The licks just states that white therapists who are products of their cultural conditioning, so it's not necessarily a fault, it's just cultural conditioning may be prone to engage in

microaggressions. And this is why when we look at therapeutic alliance, it is tends to focus more on white therapists, and therapeutic alliance is likely to be weakened or terminated when clients of color perceive therapist clients to be prejudice biased or unlikely to understand them, this really does corrode the therapeutic process. It has been postulated that, a therapist biased, biased might be the partial account for the low use of mental health services in literature, and also premature termination of therapy by minorities. So it's really important that we understand what the client's perceptions are, and understand that there might be some microaggressions we are not recognizing.

So, now we're gonna go through all the examples of microaggressions into therapeutic practice. If you are interested in this more, please do read the article cited below it is brilliant. This is where I got most of this literature for therapeutic alliances with consideration to microaggressions because it was brilliant. It was really brilliantly done and laid out. So we're gonna go through this, I'm gonna use slides 27 to 36. And we're gonna start with a case scenario. So the case scenario is, this was highlighted in this journal, there is an Asian American traveling with an African American colleague, and they're on a plane flying from New York to Boston, a small plane, and a single row of seats, right? So it's one seat on one side and then two on the other, so it's a very small plane. So the Asian American and African Americans get on the plane and since they weren't many passengers, the flight attendant says you know what, go ahead and sit anywhere because we don't have any passengers. So they go ahead and they sit in the front across the aisle from each other, right? So one seat and then across the aisle the other seat. They just figured this is the best way they can chat and all that. So then the attendant was about to close the hatch, and then before she did that three white men in suits entered the plane, and they were informed they could sit anywhere, which was the same thing, right? So they promptly seated right in front of the Asian and African American colleagues. Then what happens is, the flight attendant sort of looks at everyone, well, there's not many people there. And then she sort of scans the purview

and goes, okay, she leans over to the African American and Asian American colleagues and says, would you mind sort of moving to the back because you want to distribute the weight on the plane evenly because there are not many passengers. So, in this situation, both the passengers of color have a semi similar sort of negative reaction.

First balancing the weight, it certainly seems reasonable, but why would they asked to do that when they boarded the plane first? So that was a little bit weird, but then they were like, well, are we being petty or sensitive? Don't know, right? So if you think if you were in that situation, I know being a therapist of color, if I was in that situation, yes, it might occur to me that is she possibly being racist, that's why she asked us to move. So in this situation, the Asian American and African American decided, okay, they didn't feel right about it they did ask her about it. So they said, why did you ask us? It feels like, because you're asking us because we're people of color and asking us to sort of go to the rear of the bus, so to speak. And the flight attendant was horrified, and she said, I have never been excused of that, how dare you, I don't see color. I only asked you to, distribute the weight. So, this is the case scenario, I just want you to keep this in mind for as we go through this, and we're gonna talk about it a little bit more. So, in this situation, it's very hard to tell who's right and wrong because there's no way to know, right? But this happens a lot, the concept happens a lot where people of color have this doubt in their mind. Am I really hearing this am I not, and that itself can be very detrimental.

As I said, we'll go through it more again, but before we do that I want to, again go through the racial microaggressions in practice, so let's start with alien and own land. This is where they're assumed to be foreign born just because they're of color. So an example might be a white client does not want to work with an Asian American therapist because she doesn't feel like she would understand. A white therapist tells a Latino client that she should seek a Spanish speaking therapists. So the message it was really giving is alien in your own land that you are not American. This actually I

have experienced this myself, where a white parent did not feel that I understood the culture in early intervention when we were working with her and a baby, so I certainly felt it. Not that I disagreed with her and her perception but I felt that microaggression. Another example here is ascription of intelligence, we talked about this before is assigning a degree, right, of intelligence, yeah and I get this all the time that it must be, you must be good at science, you must be good at math because you're Indian. And I don't know how much of it in therapeutic practice that I've seen, but I've just seen it in general. Then we've got color blindness, this is very prominent in therapeutic practice where therapists might say, I think you're being paranoid. And now referring back to that airplane situation, the flight attendant was also inferring that the clients or the patrons were being paranoid, right?

So in a therapeutic setting, a client of color might say you're being paranoid when a client of color discusses her feelings. This is very, very prominent, happens all the time, and often it happens, because we just don't want to deal with the conversation, and so we might just say, well no, you're probably just being paranoid. And also because maybe you just like to see the good in people, right? And it doesn't have to be an aversive situation. And the message they're really getting is that race and culture are not important variables that impact people's lives, and that your racial experiences are not valid. So instead of doing that, it's really about asking them why they felt that way, and yes, I can certainly see how you would perceive that. Criminality, I think this is pretty obvious, I think this is probably the most common and overt one of them all. Like client shares that when she was accused of stealing at work, the therapist encourages this client to ponder if she may have contributed to the employees trust by doing something or saying something. A therapist takes great care to ask all substance abuse questions in an intake with a Native American client and is suspicious of the client's non existent history with substances. Again, this is a very subtle nuance, right? Because you don't know I mean, could be true, maybe they don't have any experiences. But your knowledge of what you think Native Americans do and believe

may make you question whether they're telling the truth. So the message really becomes that you're a criminal in the first situation and you are a deviant in the other one. Denial of individual racism, this is why the statement made when whites renounce their racial biases, right? A client of color asks his or her therapist about how race affects their working relationship, and the therapist goes, oh, not at all, the race doesn't matter at all, I treat you the same. The message you're giving is that racial and ethnic experience is not important. That's really interesting, isn't it? Because I think a lot of us do say that, and we mean it in we are not intending to treat them any different, but the reality is, everyone comes from a different experience, and everyone comes from different background, so race and ethnicity does play a role here.

So instead of saying that I don't treat you any different, it might be well I do like to consider individual person's values, beliefs and experiences, and I try not to assume, and I try to ask what their values are, so that I am treating everybody fairly regardless of their color. The client of color expresses hesitancy in discussing racial issues with his white female therapist. And she replies I understand, because as a woman, I faced discrimination also. So the message here you're giving is that your racial oppression is no different than my gender oppression. Oppression has some commonalities, there's no doubt, but equating your experience with somebody else's that may be a little bit difficult for the recipient. Because obviously, there are different degrees and different situations. So there is some commonality and you could say that, I think I may have some understanding of what you've been through, but I certainly can't, I'm not in your shoes, so I can't see, I can't tell what degree it has impacted you and accept it, and then refer them possibly to someone else. Myth of meritocracy, I can't say this meritocracy, there we go.

These are statements which assert that race does not play a role in succeeding in career advancement at all, it has nothing to do with race. A school counselor tells a black student that if you work hard, you can succeed like everyone else. A career

counselor might say that when he's working with a client of color, who's concerned about not being promoted at work, despite being qualified, the counselor might say, well, maybe if you worked harder, you can succeed like your peers, the message we give them here is people of color are lazy, or incompetent or need to work harder. Now, we do have to be careful here, like we might do parent education or we might give exercises and be careful when we say, well, you're not really doing the exercises like I requested, so it doesn't have this sort of implication that because you're of a certain ethnicity, you're not gonna follow through. And that it truly is because you feel they haven't done the recommended homework. Then number seven is pathologizing cultural values, communication styles. This is the notion that values and communication of the white or dominant culture are ideal, and everybody else's is rubbish, right? This is when a black client is loud, emotional or confrontational, and the white therapists she sees, may suggest, oh, maybe she has borderline personality disorder, no, maybe that's just who she is. Asian client doesn't make eye contact much, and the therapist might say, well, maybe she's got sensory issues, maybe she does, but maybe that's just how she was brought up.

So, assimilation to the dominant culture is the message you're giving is that basically, if you don't assimilate, then you're not good enough. Racial microaggressions in therapeutic practice, communications styles, oh, I'm sorry, we did this already, apologize. Second class citizen, this is when a white person is given preferential treatment over consumer based on color, right? Again, this happens a lot, and we've heard about it a lot. But in the therapeutic environment, a therapist might limit the amount of therapy sessions to provide a person of color. So for example, if a student is providing early intervention home services, and she has to see a family of color, and African American, and it's a poor neighborhood when they're all African American, and she doesn't really want to see this family, doesn't feel comfortable, she might discharge services or suggest just reducing frequency, for example. Is it because whites are more valued than people of color? Is there a bias there, that is that the

reason? Clients of color are not welcome or acknowledged by receptionist, if you're sitting at the reception desk, but you don't feel acknowledged compared to a white patron. These white clients are more valued than people of color. Again, you're sending the same message, so we have to be very careful of what message we're sending. Example 10 is environmental microaggressions.

Again, I think we've talked about this, if every counselor is white, and I will tell you that I sort of saw this, a lot of faculty positions I've noticed, when I was applying for Job sometimes I had, I wouldn't, it wouldn't bother me, but it would be I would recognize and go, oh, wow, they don't have much diversity on their staff. So, I do think that is very, very true and something we do need to consider on a macro level, that are we representing the cultural landscape that is up and coming in healthcare. So if we go back to our story about the flight attendant and the two patrons of color. I just want to talk about some of the dilemmas, because these are very apparent in that situation and can be applied to the therapeutic setting. So the first dilemma was clash of racial realities, right? The question we posed is, did the flight attendant engage in microaggression or did the patrons of color and his colleague just misinterpret the action, how do we know? This is so hard, there's just no right answer, because everyone has their own perception, right?

Right, so if we look at studies literature shows that racial perceptions of people of color differ remarkably from those of whites, like what your perception is, is very different than mine, mine is very different than an African Americans, because we've all had different life experiences. However, the literature also shows that white Americans tend to believe that minorities are doing better in life and discrimination is on the decline. I had a client once who said to me, this is when Obama was president, she goes, well, now that Obama's president, I'm sure you're happy that they're not as many racial issues. And it was just, there was so much to that phrase or that conversation, I couldn't even pass through it. But anyway, my point is that she just believe that things

are better because somebody who's African American is president, that means everything's much better. And the majority of whites do not view themselves as racist, and I will tell you with full authenticity, this lady had absolutely no thought whatsoever that she was being racist or making comments, she was just a lovely lady who just said what she thought. But it is important for us to know that 96% of the African Americans are reporting they're experiencing racial discrimination in a one year period, and many instance, things like they have been mistaken for a service worker, being ignored, given poor service, treated rudely, experiencing major issues when they're shopping or criminality and all that.

So this is huge, and I'm gonna share an experience that I had, this was just funny. So I'm married to a white American, well actually he's half Indian and half white, but he practically looks white. And so when I had my child, I taken him to, my son took him to swim classes, and my son is obviously a little lighter than me, he looks more white than I do. And I was getting him changed in the locker room, and there was a white lady there with her child. I'm sorry, not white lady or Latino lady with her child. And she looks at me and she says, how long have you been taking care of them? And, I said, since they were born, like just jokingly because yeah, that was truth, but also like she assumed that I was the help because of the color differentiation. So this clash of racial reality is so apparent in the real world and in practice. Now, let's look at the second dilemma, which is the invisibility of unintentional expressions of bias. The flight attendant her actions, their meaning were invisible to her, right? She had no idea what she was doing, or that it could have been construed that way. And how do we know, that she was so stunned that anyone would, think of her as being racist in any way shape or form that she was only, she only had the best of intentions. And there is considerable empirical evidence that shows racial microaggressions do become automatic because people experience cultural conditioning.

This is so interesting, they become connected neurologically with the processing of emotions that surround prejudice, that was actually in a very old article in 1998. So isn't that I mean, that's just a fascinating, it's like we are conditioned, we become so conditioned and automatic. That really is a profound statement that it changes our neurological connection in the brain, microaggressions are that detrimental. So how does one actually prove that microaggression has occurred, right? In that situation with the flight attendant, it was so subtle, it was so indirect and unintentional how, what do we do, like if those patrons of color if they felt slighted, how do they even prove that? It's very, very difficult, that is the, that is the main dilemma, but there's also a third dilemma here, there's a perceived minimum harm of racial microaggression.

So whether we can prove it occurred or not, is a whole different story, we also need to ponder that was it really a bad thing? Is it really? So in most cases when individuals are confronted with micro-aggressive acts like in the story of the flight attendant, the perpetrator, the flight attendant typically believes that the victim is overreacting. So she inferred that they were overreacting being petty and oversensitive, now, that whole repertoire right there actually changes how minorities psychologically perceive themselves. Like when I have a racial encounter, I do doubt myself, go am I just being petty or silly? Because I have been told that in the past, or did something really happened that was a racial issue. That's really hard.

We have this sort of cultural belief that we should just let it go, right? Like that's a very, and there's nothing wrong with that. But the evidence also supports that the detrimental impact of more subtle forms of racism, they are very, very detrimental not only to the perpetrator, but also to the recipient, because it's this perception of minimal harm. Researchers have also found a positive association between happiness, life satisfaction, self esteem, mastery of control, and health, overall general health and discrimination. So, it does take a toll on a recipients well being, and also the perpetrators, although we fail to believe that. Then we've got the fourth dilemma, gosh,

there's so many dilemmas here, right? The fourth dilemma is that the person must determine if a microaggression is happening, right? So there's no way to know was it deliberate, was it unintentional, how should I respond, should I just bring it up, or should I just let it go, should I just drop it? I don't know, it's very, people of color they basically rely very heavily on experience to decide what to do in these situations. Like even in the past, I've brought it up and it's become a big issue, then I might not bring it up again. So responding with anger, striking back, all those things can have a lot of negative consequences, so it really depends on you as a person and your experiences. So where do we go from here? This is really difficult, because we don't know when we are being aggressive, or engaging in this racial micro aggression because it is so subtle and unintentional often.

So the greatest challenge in society and health professionals face is making the invisible visible, that is so difficult. But the literature shows that education and training is critical. Studies do suggest that white clinicians do, are not receiving any supervision experiences education or anything on this matter, and that they're afraid of it. They afraid of talking about it, they're afraid to bring it up. And I think partly it's because inevitably it ends up leading to politics and they'd say like, stay away from those topics. But we do have to address race in the environment of healthcare, especially within OT, because it impacts participation, right? So this is where I wanted to go into cultural competency. And so we've been talking about cultural competency for lasted ages, ages, ages ages, because it's like we know we need to address it, but nobody knew how and everyone kept coming up with models on how to do it, and everybody knew education was a key component, everybody. We need to educate our professors, our students, we really need to make them understand it's a problem, tell them about all these cultures et cetera, et cetera.

However, if we are truly going to address culture, in the healthcare field, cultural competency programs and racial microaggressions if we truly want to crack that nut,

we need to a, support trainees to overcome their fears of just discussing it. Like if we're going to talk about it, there's not much else we can do, right? We need to promote and celebrate inquiry, I'm so glad you asked me that, like I had a clinician friend who was white, and we had an African American client. And she said to me, the client, was not following through for whatever. And my friend said to me, if I say something to her, I'm afraid she's gonna think it's racial, because I'm white. And so she said, can you bring it up because I was the treating OT, and I said, you know what, why don't we go in together and let's start the conversation off with that where we just say, I have to bring this up from a therapeutic standpoint, but I don't want you feel offended in any way, shape or form, this is just because we as a team feel that this would be in the best interest for your child. So really processing what you can do, problem solving together. And we all have to understand microaggressions.

Self awareness is key, if we aren't aware, if you don't know what you don't know, you're really going to be in trouble long term, and it has a global effect. There is going to be a shift from knowledge based training, the most recent literature that I saw in the last two years, two to three years, it's there's a huge shift from being knowledge based because knowledge base can really bring other aspects into play, and we'll discuss that later. So, again, do we really need culture competency and racial microaggressions training? Yes, we talked about this again, I'm just going to reiterate it because I really want to make sure that everyone's on the same page here, has huge social benefits makes the world a better place. I know sounds like an awful cliche but it's true. Health benefits, I think we already went over that. But business benefits, right? It improves everything if you have a practice, improves business decisions, and on a global scale, or actually national scale, state scale, whatever you want to say it, it reduces cost of health care for all of us, which has tax implications, and various other implications. So yes, it's very important, so please don't ignore it and just sort of poopoo it.

Okay, as I said, we've been talking about culture competency for ages, I do wanna talk about the terms here. Cultural competence is a very broad term, and it includes awareness, knowledge, sensitivity, skills and cultural encounters, which this is from Callister in 2005. However, I do want to say cultural competency is not about being colorblind, this was definitely identified in the racial microaggressions literature that we don't see any difference. Okay, so here's an exercise for you, if you've got a piece of paper and pencil handy, I'd like to just look at this picture, this is she's your client, and I'd like you to sort of jot down some assumptions you might make. Now, nobody's going to see this except you, so I hope that makes you a little bit more open and willing to be as honest and candid as possible. So go ahead and write a few things that you might consider if this client walks into your clinic and you have to take her medical history, what are those sort of immediate stereotypes that you might go towards?

So, the first one, I think I've sort of hate this over and over again, she must be good at math and science. She must be a stem person because she's Indian. Probably eats spicy food foods or smells all spicy foods and curries and spices, right? Must have a thick Indian accent. She's probably very passive in nature and must be married to a doctor or have a doctor in the family. So these are some of the stereotypes that I faced personally, but also I've read in the literature towards Asian Indians. So, you know, this is the first step two self awareness, I want you to look at your list of whatever you wrote, and most of the things probably do coincide with what I just stated, because these are stereotypes that are very, very rampant in everyday life. They're just there, and you can't help it, it's just there. So it's not your fault if you did come up with these sort of stereotypes, it happens, it's just part of who we are, and the context of the environment we live in. However, this is a picture of me, I'm just wearing my Indian garb for the purposes of this activity.

As you know, I'm not good at math at all, actually, and science, yeah, that's debatable. I do love spicy food, so you're quite accurate there, I don't have a thick Indian accent, I

actually have more of an English accent because I went to school in England, must be passive in nature, I would certainly say I am not, ask my children, they tell you I'm far from passive, and must be married to doctor, I'm actually not married to a doctor, however, I do have doctors in my family. So, that's just an example there have to show you that just because you have stereotypes in your head, doesn't mean a, they're true, but some of them might be true, right? Because stereotypes actually exist for a reason, they didn't just come about from nowhere they happen because we see a resonating theme with a specific group of people. But the point here is, you need to be aware of your stereotypes before they occur. So let's take another activity here, what are some things you might assume?

Again, this parent comes into your clinic with her child and is seeking OT services, what are some stereotypes, and again, be as brutally honest with yourself as you possibly can because nobody's going to see this other than you and this is the first very, very, very first step towards cultural competency and humility. I'm gonna tell you a few things that I may have thought of. She's probably very argumentative, right? I have to be a little more passive with her. She won't be easily persuaded because there's the stereotype that African American women are, very gung ho very powerful. She's probably from a lower income household, no way of knowing that, but that may be an assumption made. Probably a single mother, another assumption that's made due to stereotypes, and may not be very educated. Now, it's okay, maybe you had worse stereotypes than this. Maybe you had worse nuances than, it's okay. Give yourself a break and be like it's all right, because that's you have to recognize it before you can deal with it.

Next time a client comes in, you're probably going to have the same stereotypes in your head, and it's okay. But maybe once you have those stereotypes, start crossing them off as you start interviewing the client and talking to them and asking open ended questions, maybe you'll be able to check off some of those stereotypes, and try not to

make decisions until you've done that. So there's several pitfalls of cultural competency. Past research in OT is primarily focused on cultural competency as a sort of conceptual roadmap of working in diverse contexts. If you look at the scoping review of literature on this, it's knowledge that is specific to each culture is very important. However, there's an argument that we need to shift from this emphasis of knowledge, and shift it to a more finite construct that has to be really understood and mastered to, and that is to practice cultural humility, right? Because knowing leads to misunderstanding and stereotyping. Now, because I'm Indian, you might assume, in this case, Japanese lady you might assume that I'm strict, and actually I am, I'm very strict with my boys. But also, there's an assumption if the family's Filipino, they are gonna take care of them. These are assumptions, but the world is changing with globalization and migration. All this is changing, cultures are no longer static, they're evolving and dynamic.

So it's really important that we don't stay in this stance. So cultural competency or cultural humility, well, just to recap, humility is defined by a lifelong learning orientation approach to working with people with cultural backgrounds, and it really recognizes the power dynamics in healthcare. So it's not only about learning about culture, but it's also evaluating your own culture throughout and being very dynamic in that situation. So cultures are not monolithic, right? But they're, they tend to be most easily understood in that way. If you look at cultural psychology, and there was an article I read, oh, I think it was in 20, was it Raynaud, I can't remember, anyway she, it was in 2015, so very recent, she found that over the course of a 43 years over the course of 43 years, it was a Mayan community in Mexico, children's cognitive abilities changed along with their occupation and environment. So cultural psychology, cultural evolution is dynamic and ever evolving. There's evidence that cultural roles cognitive, and related cognitive abilities, morph and collectively change, over generations. And this suggests that cultural humility is more useful than ever in OT, because it emphasizes having the perspective of a lifelong learner with no sort of fixed viewpoint. It's really about a very

process oriented, ongoing, evolving, dynamic approach, that's the key to being better as a therapist in a very racially diverse world. But they are differences and I do you want to talk about cultural humility and cultural competence, and it's really important to understand the differences, because then you know which one you really need to gravitate towards. Cultural humility, in contrast to competence really allows inconsistencies. I do want to say that for sure, that is probably one of the most prominent things that I saw in literature.

You know, it's a constant process in humility, whereas competence is about knowing about specific cultures. And that would be great if those cultures were not evolving at all, right? But they are, and cultural humility recognizes gaps in knowledge without shame, and it's about deeper engagement, understanding and humility, whereas in competence, there's this expectation that we should just know and we should be good at it. Then in humility, it creates an expectation for differentiation between cultures, that yes understanding the differentiation, whereas in competence focuses on differences between cultures. So, let me clarify that for that cultural humility is differentiation between and within cultures, and then competence is differences between cultures. Humility, it really acknowledges the implicit and explicit prejudice, right? Things that are subtle and nuances to promote a positive change, whereas competence, cultural competence is really about personal culture and how it differs from others, but they don't really go into the prejudices and implicit biases that's actually separate. Cultural humility recognizes the power dynamics and healthcare and cultural competence, I mean, it sort of grazes on the concept but does not really address privilege and white power professionally.

Cultural humility and professional power, I do want to go over this again because this, again is very important because it's happening all the time. Humility is knowing that you're smart, because you have gone to school, you've got a degree in this, you've got tons of experience. So yes, you are smart, but humility is that you're not all knowing,

there's absolutely not one person on this planet who knows everything, there isn't. Your mother in law may think she does, but she doesn't, right? Nobody knows everything. So it is accepting that you have personal power, but there's more to learn. Also, it does not prescribe specific changes but encourages professionals to see how their power might be impacting the lives of their patients. So, opening that door of this is what I would recommend, however, I'd like to hear from you if this is even feasible or if this how this feels to you, right? It's really opening that door, is so paramount. So what should cultural competency training include? We have to aid specifically white clinicians to achieve more of the following in our cultural competency programs. And I say cultural competency loosely, I also mean humility, all tied in there, because cultural competency had some great components to it. And we're gonna look at that later on. But it should have, it should increase their ability to identify racial microaggressions, in general and in themselves.

Most people do not know what racial microaggressions are. I had not heard that term until recently, and I've experienced them myself. So I do think it's important to look into that, also understand how these aggressions including their own detrimentally impact clients of color. So maybe like this is one activity that I do with my students is I want you to think about an encounter you had with a patient of a different color, and just relive that scenario. Now, I want you to be the person of color, and every statement that you made, how do you, every statement that the therapist made, how do you think you would have perceived it being on the other end, right? It's set, it's going in their shoes, and looking at things from a different perspective. It means to have a shift towards cultural humility, we already talked about that, that it's a very dynamic process and that I need to evolve and learn not only about other cultures but self evaluate. And the literature shows that journaling, right? I did not think this was going to be included in the research. But journaling is a very effective means of achieving cultural humility, it sort of makes sense, right? Like if you are journaling your encounters, if I sat down and wrote about my encounters, I think it would be very cathartic a, and also revealing as

to what I'm doing. I do, do that even in other areas. I think journaling is a very powerful tool. As OTs we always talk about how handwriting is so important, well, that connection between the motor act of writing and your brain and the neurology and the psychology and the attention, I mean, it's just so powerful. So it's happy to see the research actually support that as a way of addressing cultural competency education. Oh, but you're going to say, oh, it's so uncomfortable, and I know it is. I know it is, I'm not going to pretend it isn't. It's uncomfortable for me and I'm a person of color. But if I have to bring something up to a therapist who's white or a person who's white, or if I have to bring something up, that's with a person who's African American, now, this is another elephant in the room that I want to address.

A lot of people think because I am of color, or people of color, Asian ethnicity or whatever, are not racist towards other people of color, that is not true. Not true, there are plenty of Indians that I have encountered who are racist towards African Americans, or are racist towards white people. It works in many ways, I think, and this is just a personal opinion, this is not based on research that people don't, we don't talk about it. And culturally, we tend it's sort of just accepted. There's the difference, there and I think we'll go into that later too. But it is so uncomfortable, and the literature shows that, it says that avoidance, really hinders the learning process and a movement towards multicultural competence. We have to explore it, we have to understand it, I've seen this firsthand, working in the school system in a neighborhood that predominantly white, I'm the only non white for example, it would be very difficult to bring up color, racism, it would be very difficult.

So I'm not belittling the fact that it is uncomfortable, but if we are going to learn we have to conquer that. There is this paradox, now this is interesting 'cause I as my bio indicates, I really like to look cross referencing literature in allied fields, and I found this in a psychology journal, and it was all about, the race obsession avoidance paradox. Sounds like an awfully serious problem, right? And actually is, obsession and

avoidance are common themes, right? Racial inequality persists in the United States. Even if it doesn't have an urgent place or national agenda, It is not fashionable to discuss it, this again goes along with, why do we have to talk about it, right? We have this obsession with race, but we avoid it, and this paradox does not help our professions at all. There is a, Bronfenbrenner, do you guys remember this? This probably you've learned it in child development classes or even in the OTPF sort of model. It's the ecological systems theory, it was created a long time ago in like 1979, but I really love it because it really helps us understand the significance of human development within the context of these sort of multi layer situations and environments, right? What he articulated is that bi directional interaction between these environmental layers, and between the individual and the environment are really important.

So therapists, as therapists we are going to work with people who have very varying systems, and microaggressions actually do start. Microaggressions are very prominent in these layers, so the Exosystem, I'm sorry, let's look at that. It's includes safe social settings or broader community where individuals live right? Like workplace school, for example, the macro system is where they live and includes values and customs, and the Chronosystem is referred to environmental and so socio historical circumstances like me earthquake occurs, et cetera. So this paradox, is described when in an ecological model like this, it's an element which exists in this some sort of macro system, and then also in the Chronosystem, but really, it's equating to the macro system because it is so inherent in our communities. What are the other barriers to cultural competency or humility, faculty members feel unprepared, and staff they make, if they do not have a diverse staff that may not come up. And now it doesn't mean that you have to have diversity on the staff to teach these aspects, but it does bring a unique perspective that may not be present. Lack of time, ethnocentrism, prejudice, cultural biases, judgmental attitude, lack of training and resources, and simply being unaware that we are unaware, right? Just, we just like if it's not an issue, I don't see

color, it's it doesn't bother me. Well, it may not bother you, but it's still there, it's there in the environment and ignoring it is not solving the problem.

So, we are going to use a cultural competency model, because not everything is bad about it. The only area that I have adapted, this is a model by Campinha Bacote and I did adapt where it says cultural humility, that was cultural knowledge. So it's the only thing I changed, but really, it starts with cultural desire and it has these four components. So the other thing that's really important to know is that it's dynamic again, and it's not a static place to be, so it starts with a journey. It's about becoming culturally competent, and not being, right? So cultural desire is what starts you on the journey. And this was the process, it's a model of care that was highlighted in the literature, it shows you that the desire starts in this volcano eruption, where you have this desire to learn and perhaps that's why you're here listening to me today on this topic. And then you look into cultural skills, cultural awareness, encounters and again cultural humility is something I added into replace knowledge, again, this is an adapted version. So cultural desire again, we all come from the same place.

So, we need to make sure that we have this desire to learn and, are willing to talk about the uncomfortable. Cultural awareness, recent systemic review of studies on implicit and explicit ethnic bias and healthcare really talks about the disparities and we talked about earlier, skin color being a difference, but there's definitely more research that needs to be done in this area and healthcare. But we start by being aware of it. This was a checklist that I found online and if you can find out, if you go to this link, and it's just sort of a self assessment, I thought it was really nice as a start. Again, you can do it in the privacy of your home, just download it, and it can give you an idea of what's, where you're at. Cultural humility, again, we talked about this a lot, I think I've ingrained it several times. But there is more variation within the culture than across a cultural group now, 'cause it's so dynamic and different, right? Cultural encounters, interacting with patients from diverse cultural groups will refine or modify one's existing

beliefs about a cultural group and prevent stereotyping. I cannot tell you how important this is, not only as a therapist, but as a parent, I practice this, I make sure that my children do not only associate with Indians or white students, I tell them, you can learn from everyone. And I want you as long as you know the right and wrong thing to do, you need to make sure that you expose yourself because there's such a rich world out there. But when we take our biases and limit our children, we're not helping them at all.

Oh, this is something I really want to talk about because, it's translation, nobody talks about this. But we have so many OT assessments, evaluations, materials, plethora of information that we disseminate to our clients. However, there's not always translation available, and this can really impact, impact healthcare, and it can increase health disparities, right? So the importance of translation procedures is overlooked, that's what was shown in the research. And there's a lack of rigor in these translation services, especially for instruments of assessment. And it does affect our results and it causes us to generalize and not, I apply it to a culture. The literature has not addressed this at all, I found very limited literature on this, so if you are an OT student, looking to do some research, this may be your hot area right here. Cultural translation is a term that is used to replace words or phrases in the source language, with phrases that are culturally appropriate for that target culture. What this really means is, let's just take the sensory profile, right? They may be terms that we use, but a different culture may not understand, and so you would want to replace those phrases with more culturally appropriate phrases, so that you get a more accurate representation of the child's assessment.

That translation method has been used, that's when two bilingual translators are familiar with the resource, and targeted languages, they will translate and then give it to each other, so that's just not one perspective. Again, we're trying to make sure, we understand the dynamics of a culture and the variations within one culture. So this is an area I would definitely suggest looking into and be mindful of when you are opening

a clinic or if you're working at a clinic, that the change in the demographics will require you to change how you present your brochures and material. So I did want to just mention a few articles that I read on this, this was a case example of translating evaluation of sensory processing from English to Chinese. If you're interested in this, please do look into this, but we cannot use this data and apply it to a different culture like Taiwanese, we would only be able to apply it to Chinese children and the culture and the values how are they accounted for? Especially with a sensory processing form which has such so much subjective sort of participation questions, right? And it does depend on values and beliefs. So please look into this literature if you're interested in this.

Another example is sensory behaviors in autism, this was there was an examination in two countries, and I believe the other country is Israel. So just examining the differences, again, what cultural aspects taken into consideration. If I say he's recluse in the US, what does that mean compared to in Israel? Do they expect their children to be engaging more? Eye contacted is a big one, that's a big one in sensory processing, right? Do they make eye contact? Well, in certain cultures, children are not supposed to make eye contact with parents, certain families, that may happen. So again, be careful of that when you're working with this population. So going back to the OTPF, we want to really look at culture and values and all that in respect to a client. If we look at client and their factors or performance patterns and skills, one of the things we need to do is especially look into parent education, working with families with early intervention, values, beliefs and culture is so important for us to ascertain. So there is a Culture-Parenting Nexus, culture really helps to construct parents and parenting and is maintained and transmitted by influencing parental cognitions. So what that really means it's a fancy way of saying is that the culture the parents live in, will be infused into the child and move on and move on more.

So it is very important that we addressed that elephant in the room, the context of parenting, the environment is going to be very important. I want to just share some contrasting beliefs, now this is not specific to a culture. But Oops, sorry, contrasting perspectives on birth and infant care, there's so many contrasting perspectives. And it depends on which part of the country you are, depends on what your values or beliefs are, what culture ethnicity you started from, but it's constantly changing, right? So we do need to make sure we are cognizant of that. Obesity is a big thing, certain people value children to be, I wouldn't say obese but maybe weigh more than your average or typical child on the scale in Western culture. So, I know like Indian culture, moms are always feeding their babies like that. Food is means that if you have a child who's plump and healthy, that means you want to record and feeding. So messy play is going to be really important to consider. Also think about what type of foods. So I was working in early intervention, and I was brought on because another therapist was fired, because she had encouraged the child or should given the child marshmallows, no, no, sorry, marshmallows or jello it can't remember anyway and that family was not happy because they're Muslim. So she didn't know, you don't realize it was a big issue.

So, I was told I was taking over and I was sort of given this information, so some things like that and you wouldn't know maybe they're Muslim but maybe some Muslims don't are not practicing that strictly, so you just want to ask in that situation, right? Are there any food restrictions, preferences, whether it's dietary, or values or beliefs, religious beliefs that need to be aware of, that's it. Contrasting perspectives on feeding, this is a hot one for me, because in OT, when I work with Early Intervention, a lot of Indian parents, they will feed the child until they're five years old. That was the cultural norm, and I didn't know of that because I haven't lived in India, I sort of grew up everywhere except India. So I was not aware of that cultural norm, so here is an example of the opposite. But to me, it was like well, well, they should be eating on their own, why feeding them? And why isn't that a goal? So you have to step back from that judgment

and really meet the family where they are. Contrasting perspectives on sleeping, co sleeping is a huge thing.

I think my parents, when I had my first child, were talking about sleeping and they were like, why are you letting I was doing the Ferber method. And they were so bothered because they're very traditional Indian, and I'm so not. And we had this sort of clash where I understood the science and the importance of it where they are like, no, we basically hold the baby until they're seven, eight years old, try to get them to sleep. So, and there's nothing wrong with it, it's just different, contrasting perspectives on play, how important is it to certain cultures and certain people. Some people are, don't really understand it as being important, others may understand it. Contrasting perspectives on traditional medicine. I know like in the Indian culture, many people use homeopathic organic rather than medication and various other cultures do. So again, it's not about assuming it's just about asking what preferences are like. So, what I wanted to really ganner here is that there are some predominant Western American values and assumptions, right? That's good knowledge to have, because it's about self awareness.

Most of us therapists who are working here may have these values, individualism and privacy may be very important or is important in the Western culture. Equality is very important to us as Americans in formality. The future looking at change progress, it's so important to ask, we look at a disability, or a condition with a child or a patient, and we are constantly trying to figure out how to change things or progress. There's also value in goodness and humanity, we really value humanitarian work time is very valuable to us, we don't we try not to waste it, right? Achievement we're very goal oriented, materialism is really important, the big car, the fancy car, the name brands, right? Directness and assertiveness is very important in the American culture, we just say it, if we're not happy with something. That's a culture I had to get used to when I came from England because it was a little, there were some differences there for sure.

There is another perspective, that's what we need to be mindful of is that even though we're in this culture, things are changing, even this culture is changing, right? So we need to accept with grace, and be open to it and then understand that some cultures value balance and harmony, right? Some have a wait and see approach, a lot of families I've encountered who may have a child with Down syndrome, they're not worried about it. They're like, it is what it is and I'm okay with that. And I am the one going, oh, but they could do this and that, and it's okay, and it's a different perception. So some cultures have more of a gentle approach rather than sort of assertive, let's do this and achieve this. Those are the aspects that we need to really think about, individualize attention and time is very important to certain cultures, like time is not, I'm not worrying about wasting my time. I know there's a big joke in the Indian community where it's Indian standard time or you're always late.

So there are stereotypes like that happened, and then there are other cultures that believe in collectivism, right? It's about being community not about individual growth and strength and exceeding and really competing with each other, it's about being collective and coming together as a community. So the mainstream culture is really mastery of nature, personal control, optimism, self assertiveness, gratification, materialism, independence, challenges, equality, independence, marital bond, child has given many choices. These are just what's happening right now in our culture, but it doesn't mean that everybody we will encounter in this culture in the United States feels that way, so you need to be mindful of that of that and know that there is no cultural transcript here, or script, there isn't one. We, the best thing we can do is ask open ended questions, consider what systemic pressures may affect the client, like look at the context, environment, values, all those client factors.

When you ask a client more pressing questions, and in depth questions that are pertinent to their environment and culture, like, if that client was telling about who was who didn't have a car, okay? If I'm asking her to come in for therapy, how does public

transportation affect her? And also, what assumptions am I making? So again, being aware that you are unaware and always being aware. This is a model I actually created for my dissertation, it is based and adapted from the Bronfenbrenner model of ecological systems and child development theory. It was a way to make early intervention providers more cognizant of the differences in child rearing. So for example, you would take this when you see a new client and just circle, what the family was, what their values are by asking them open ended questions. Would they prefer to suits, if the child self suits asleep or would you prefer co sleeping, just asking them because this will be a more individualized way of addressing cultural competence. Telehealth so with this new arena of telehealth, well, it's actually not new, it's been there for a while, it's just that we have had to adapt it more. We are reducing the distance as a barrier to treatment but it has other implications, right? We need significant effort to both translate the best practices, when we are servicing rural service areas.

So telehealth is enabling us to reach these rural areas, but are we equipped to culturally be responsive in these areas, and that's what we need to really ascertain. There are certain barriers to culturally appropriate care in rural areas currently, there are differing attitudes towards technology. African American, Hispanic families tend to report more affinity for information technology than whites do, but tend to have lower access to it, right? And perhaps poorer skills to use it effectively. Poverty and low socio economic status are taken into account, studies found that, Latinos had significantly poorer access than any other group. Then there's also Asians, right? If you think about Asians and Koreans, they're more likely to form online relationships than whites, that's what the literature shows. The differences is in the affinity for the use of technology, maybe they again, we can go back to the stereotype, maybe they're more into STEM type professions and therefore are more comfortable with technology.

So, this is something we need to ponder and consider. Individuals living in rural locations, commonly lack privacy, and they are concerned about this, so what do I mean by this? In the literature, I saw that, if they live in rural areas, often it's in small communities or maybe extended family communities and they don't want everyone to know that their child is getting services or they're needing any help. So if you're on telehealth, it may be in a room and it's a community setting where people are coming and going, so you need to be fairly cognizant of that too. They also don't want to be the subject of gossip, or being marginalized because they're receiving therapy services. This is also very apparent in the literature. Other considerations for telehealth, if you're going to establish this virtual therapeutic connection, clinicians need to think about replacements for behaviors of like if in a clinic you might hand someone a tissue box, or you might tap their hand to show support. What are you going to do in this situation, into telehealth situation, how you going to be supportive? You need to come up with some phrases, things like that to really convey that. Also consider how a patient's cultural background influences her comfort with technology, also that patient provider connection and relationship, how's that gonna be impacted by video conferencing? Asking open questions prior to initiating services is really going to be important. Also respecting cultural modifications in this medium.

So an example might be, if I'm working with a Muslim family, and, they cannot be seen without a headscarf, women in that culture in that family that's important. So making sure that I text her beforehand before starting the zoom session to say, hey, I'm gonna be on in about five minutes, are you ready? That sort of thing. The BPSC models, bio-psycho-social-cultural model, this is where cultural issues may be lumped into social history, for convenience. So when you're taking the history, maybe you won't really review it, you just sort of dump it in there but not really pay attention to it. So the social history competes with the problems that we're looking at if the patient's there because she's got breast pain or whatever, I'm focused on that, but I'm not really even paying attention to social history. So, they need to have a very general approach to

taking this type of history and information. And checklists, be very careful of checklists, they do not always capture the complexity of cultural issues, and may inadvertently simplify and stereotype, this was also apparent in the literature.

Okay, so one thing I did want to go over is the CLAS guidelines, this is the national standards on culturally and linguistically appropriate services. This was set out there by the US Department of Health and Human Services to sort of address culture. And, the thing is, things have changed so much as we talked about, it's really evolved from purely cultural competency, which is knowledge base, to now really taking into account some of those racial microaggressions. So, please do look into the guidelines as they are very helpful, they did recently update it and I found it a lot more pertinent to the environment today. So some of the aspects that we need to consider when we are considering these guidelines related to telehealth specifically, we need to have cultural competent care not only as a therapist providing the services, but also the mid level staff whose say is monitoring, and managing the services.

So you have somebody who does that for you, that needs to be considered also and needs, make sure that they are culturally sensitive also in collecting and disseminating information. Language services, language access services, which basically means that there are options of preferred language, whether it's Spanish or other languages, brochures or anything that you might be sending digitally, make sure there is some feasibility there. Organizational support, this is really about making sure that you are accessing information which is culturally sensitive across various support groups, social networks, that you are sharing it and making sure the information you do share has a cultural component when it's applicable.

An example of this as somebody put standards for, back to school mask wearing and all that and I thought it was brilliant, really nice guideline. But one of my clients who is, the mum only speak Spanish and dad speaks English, the mum had, and dad had

called me and said, well, is there anyone who can translate this? So really being cognizant of that, that not everybody is going to be English speaking and may have different needs when it comes to linguistic material in healthcare. And then considering the individuals patient health related information. When you are taking in information, whether the health history and all that sometimes, we can get a little focused on the problem, rather than really considering, what the patient's values and cultural aspects they are that we need to be considering. I know I've done this, guilty as charged for sure, like I see a client to has hemiplegia, and I'm so focused on I'm already thinking about all my hemiplegia articles, the research and I may not necessarily go back and look at their history patient, gender, patient, race, family values, all that, so really making sure that you are doing that. Once again, I would refer you to that website with the CLAS guidelines.

Okay, so integrating culture into telehealth, it's quite interesting 'cause there's not a lot of information and research on this topic as yet. However, I did find this article which was quite eye opening, it talks about really looking at three aspects when you are trying to integrate, the rural aspect, cultural aspect of telehealth. So, culture and diversity, really celebrating and understanding the uniqueness, sharing best practices and supporting the interest of that community based on their culture, right? So depending on what's important to that culture, that's what you want to highlight or that community. Rural settings, this can be, a very different way of thinking because their paradigm may be very limited compared to what you might experience. So it's really important to really take into context of specific local and regional aspects, and are these individuals, the type who will be seeking help in independently and what resources do they have in the community, thinking about advocacy for patients in the rural setting, especially if they're minority related because they may have access but being, first of all, if you're in a rural setting, you may have limited access. And then if you're a minority, you may have even more limited access, so that's something to really think about. And then, just generally tele behavioral Health, basically, this means

really mapping out to the community, building those partnerships, building a community of telehealth services for this very rural setting and possibly a diverse setting.

So you're really looking at rural setting and cultural setting as two limitations and bringing it together. So this was a great article to read up on that. So how can we combat racial microaggression towards our patients? You might see that when you are with a patient and they expressed this to you. So the biggest thing that I found in the literature was being consistent and appropriate in describing, the race of patients, when you are in the waiting room, when you are talking to the receptionist or another staff member, always use appropriate language, and also in your reports in your education, I'm sorry, medical history all that, you need to be very cognizant of how you're describing the race. Be an advocate, so if your patient tells you that she felt x, y and z because of this aspect of microaggression that you may feel is happening, make sure you advocate it, make sure you make the front desk aware, the personnel of aware that this is a concern, we need to ponder. Always convey respect, obviously that goes without saying, but don't avoid the topic, I think this happens a lot where especially, just in my opinion, I don't have any scientific basis for this. But if you are have white privilege or professional power, you may have a tendency sort of recoil from these sorts of conversations and situations 'cause it's uncomfortable, let's face it, it's not a fun topic for anybody, right? So we really need to be aware of our power and perspective and realize that ignoring it does not mean it goes away, and we're actually hurting ourselves, by limiting our own potential for growth in this area. And then lastly, cultural humility, I mean, I think we've gone over this quite a few times in this presentation, I think this is the key to everything we do, it's not having this very stagnant perspective that I know everything, I'm not racist, so it doesn't apply to me, really taking a step back, introspecting and figuring out where you truly are in this plane of racial microaggression. So that's helping all patients, but we as therapists also encounter racial microaggressions, right?

So if a therapist has a patient to shares with her that you know what, this is the sort of situation I'm facing, what do you suggest to her? In OT, we pride ourselves on being very holistic, we certainly don't know all the answers, but one of the unique aspects in our profession and scope and sequence is having a very holistic mindset of knowing resources that can address the person as a whole. And one of these factors or not factors, resources I would say is mindfulness. When a patient talks to me about some sort of microaggression they have encountered, obviously I can offer my opinion on what I might do. But I always suggest you need to take care of yourself and how that impacts you, that's really important. Microaggressions we face them sometimes on a day to day basis, without realizing the potential harm. In your mind, you might think it's innocuous and it truly isn't, the research shows that it impacts daily life skills and really impacts them to the core. And to address some of those things, the research has shown mindfulness is an effective strategy.

So what is mindfulness? Just briefly, I wanted to go over this, it's really a state of awareness of practice, it is not a cult, it is not a religion, it is not something that unless you're sitting Indians style and closing your eyes that you can't do it. It is definitely something that you need to consciously do, but it's really about being present in the moment, and it actually goes hand in hand with cultural humility, like really being present of your own biases, and not just ignoring them. But it involves being present and intentional. And there's lots of research out there to show you this technique but the research has also shown that it helps with physical rehabilitation and microaggressions. So, to further elaborate on mindfulness and how to cope with racial microaggressions, in the research shows it can be a benefit for at risk populations. I think minorities disabilities et cetera, it has also been shown to build resilience and coping skills for everyday stress factors. And of course, racial microaggression falls right into that alley, right?

So that's why it can be a really powerful tool, I have included a link here to a citation for article I found specifically on addressing microaggressions with mindfulness, and it's very recent article, so if you get a chance do read that. So, the other aspect that mindfulness and microaggressions address, is they remove the person from the interaction, right? So it's about saying, I'm here and I'm scrolling through in my mind, what's happening out, it's sort of like an out of body experience. So it creates space between what you're feeling and what's actually happening. It has also shown to develop self growth and really empower self acceptance and acceptance of others. That's why I think it's important not only for the person receiving the microaggressions, but also the person who has the potential or propensity to deliver it. So as a therapist, mindfulness is really important for me, so that as a health care provider, I'm not engaging in those behaviors too. So again, there's another article here that you can read on that, but I found it very enlightening. So what is our responsibility as researchers?

One of the major obstacles in research that I found is, there's this continuation of how we admit subtle racism and microaggressions. We think it's innocuous and therefore it's not always included in the research agendas, and therefore there's a huge gaping hole. And this absence conveys the notion that these sort of covert forms of racism are not valid and are not important in healthcare, and therefore, they can't be quantified or proven. So in fact, emitting microaggressions from these studies on racism on the basis or the belief that they're less harmful, actually encourages our profession as a whole, to look the other way. So avoiding the subject itself is actually a microaggression that we are delivering without being aware that we are. So definitely need more research in this area. Oops, sorry, so I'm just going to leave you with that thought is that, as you are students or practitioners or perhaps you're delving into the realm of research, I think it's really important that we need to look into racial microaggressions and the research on it, the lack of it, but also I want you to start pondering this, this would be a great topic for anyone who is interested in research.

Think about the tools that are used for research in microaggression, racial microaggression, what do I mean by that? So they are not adequate assessment tools to measure microaggression in healthcare.

So there's some prominent ones that I can think of, first of all, race related stress and discrimination measures are there, I think it's called the PEDQ, which is the perceived ethnic discrimination questionnaire. Then there's the colorblind racial attitude test. So there are some out there, but none of them are directly aimed at distinguishing between categories of racial microaggression, and whether those are intentional or unintentional, so really trying to measure that implicit racial microaggression, just something to think about. And lastly, I'm going to leave you with this thought, we as therapists and healthcare providers educators, we certainly know what we know. I know a lot about pediatric OT, for example, but we don't know what we don't know, or we know what we don't know. So I know that I don't know enough about cancer research, but there's a whole realm out there where we don't know what we don't know. There is this absolute entity that we are unaware of being unaware of, and that's what racial microaggression is too. Oftentimes than not we are unaware of being aware of our own biases, and that's what I would like to leave you with, to really ponder for yourself. Lastly, we just have references and questions.