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PROPOSALS TO ADDRESS HEALTH DISPARITIES IN OCCUPATIONAL THERAPY

by

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A thesis submitted to the faculty of The University of Mississippi in partial fulfillment of the requirements of the Sally McDonnell Barksdale Honors College.

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DEDICATION

To anyone and everyone who has ever doubted their ability to succeed.
Keep going!

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I want to thank my advisors—Dr. Timothy Yenter and Dr. Jennifer Parsons—for believing in me when I did not believe in myself. They have taught me everything there is to know about grit, resilience, and determination, and I will cherish their guidance for the rest of my life. Without them, this project would have been nothing more than a silent "what-if." I would also like to thank Dr. Matthew Jessee for his contributions as my third reader.

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ABSTRACT

PROPOSALS TO ADDRESS HEALTH DISPARITIES IN OCCUPATIONAL THERAPY

Health disparities, “preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health,” are infamous for their effects within both general healthcare and occupational therapy settings (Centers for Disease Control and Prevention [CDC], 2008). Though existing literature establishes a need for the widespread adoption of anti-discrimination measures, specific recommendations for occupational therapy schools remain limited. This project aims to remedy this gap in knowledge by serving as an initial overview of healthcare disparities within occupational therapy and by addressing the potential value of incorporating diversity courses into the curriculum of occupational therapy schools. Through the presentation of data from a wide variety of sources, this project identifies understanding and experiential learning as two valuable options for effective diversity courses within the curriculum of occupational therapy schools.

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INTRODUCTION

At the very heart of healthcare lies the relationship between providers and their patients, a bond that provides the foundation on which all future interactions are built—whether they be as tangible as physical care or as conceptual as proper bedside manner. In theory, this connection is created and preserved by the leading promises within medical pledges. Though vows of service are not limited to physicians, the Hippocratic Oath is perhaps the most well-known example; it declares "that there is an art to medicine as well as science, and that warmth, sympathy, and understanding may outweigh the surgeon's knife or the chemist's drug" and "that [physicians] do not treat a fever chart, a cancerous growth, but a sick human being, whose illness may affect the person's family and economic stability" (Lasagna, 1964). Despite these commitments, a healthcare provider's quality of care is likely to worsen disproportionately if the patient is not Caucasian, cisgender, heterosexual, male, or below the age of 65 (Penman-Aguilar et al., 2016). Implicit bias, the root of this problem, refers to one's action upon "the basis of prejudice and stereotypes without intending to do so," inherently perpetuating the roles of such generalizations within modern society (Brownstein, 2019). To better care for all groups, then, healthcare providers must undergo proper training and practice to develop the skills necessary in providing equitable care to all who may enter their places of service.

The issue of race inequality has become increasingly visible to the citizens of the United States of America, emphasized by the wrongful deaths of Black men and women such as George Floyd, Elijah McClain, and Breonna Taylor. Their stories, horrific beacons of the racist systems still implemented by their country's government today, demonstrate that, "when racial discomfort arises, Whites typically respond as if something is 'wrong,'" unleashing an "array of countermoves against the perceived source of the discomfort, including: penalization; retaliation; isolation; ostracization; and refusal to continue engagement" (DiAngelo, 2011). Unfortunately, such discrimination is not condemned enough by those in positions of power and is often harnessed as a means by which to enforce the very regime that they swore to overcome. In certain cases, the influence of implicit bias is silent, seizing an individual's explicit beliefs and desires (e.g., treating all patients equally) and replacing them with the unseen authority of negative implicit affiliations on thoughts and action.

The color of one's skin is not the only source of discrimination from which people may fuel their attitudes and actions; gender identity plays a near equal role, with women often getting the lesser end of an already unequal arrangement. Outside of the healthcare world, "37% of women who say their workplace is mostly male report they have been treated as if they were not competent because of their gender," compared to the 20% of women who work mostly with other women that report the same experiences (Parker, 2020). Inequity of this degree becomes increasingly dangerous when introduced to any area of the healthcare industry, immediately placing the lives of anyone involved at risk; despite this high likelihood of complication, however, misogynistic behavior is an all-too-common occurrence in healthcare.

Similarly, anyone with an identity or sexuality that is not considered to be "natural" (i.e., cisgender and heterosexual) immediately places a target on one's back.

By falling into this category, individuals are automatically seen by many as threats to the "proper order" of society. In fact, studies have proven that "46% of heterosexual first-year medical students in a large U.S. sample expressed at least some explicit bias, and 82% held at least some degree of implicit bias against gay and lesbian individuals" (Fallin-Bennett, 2015). It is because of this lack of consideration that minorities fear disclosing controversial information pertinent to their wellbeing. Concerns of this nature are not limited to patients, however; through an inquisitive study of individuals pursuing a career in general surgery, colorectal surgery specialist Kathreen P. Lee, MD and her colleagues discovered that "over one-third of LGBT residents had not revealed their sexual orientation when applying for residency because of concerns about being rejected for that reason, and over one-half reported actively concealing their sexual orientation from fellow residents and attendings" (Fallin-Bennett, 2015).

Patients may also experience discrimination because of the conditions with which they present. A recent study found that—though the explicit attitudes of healthcare providers indicated "no preference for people with disabilities (PWD) or nondisabled people"—their implicit attitudes revealed a moderate preference for nondisabled people (VanPuymbrouck et al., 2020, p. 6). In turn, the quality of their care for individuals with disabilities was significantly lower than that for individuals without disabilities. This study also suggested that female providers, younger providers, multiracial providers, politically liberal providers, and/or providers with disabilities are expected to earn lower explicit and implicit scores than male providers, White providers, older providers, nondisabled providers, and/or politically conservative providers. Because the latter groups dominate the American healthcare system, their affinity for ableist attitudes is particularly concerning.

While each of the aforementioned fuels of bias—race, gender identity, sexuality, and disability—are of equal importance in the fight to ensure equity for all patients in need, there exists another stage that cannot be avoided by any living creature on Earth: old age. Many assert that, because the process of aging affects all people without care of status or experience, it is possibly the most concerning cause for discrimination in healthcare today. At any rate, improvement must be made in the ways by which elderly patients are currently treated in clinical settings; lack of representation for these men and women in biomedical research, for instance, actively contributes to "uncertain efficacy and unpredictable harms of therapies, potentially preventable health decline during ineffective care, wasted healthcare resources, and unnecessary costs" (Stone, 2012). Additionally, elderly individuals are often subjected to older, less "aggressive" (and, by affiliation, less effective) methods of care, a decision often made by healthcare providers on the grounds that their patients' odds of survival are not favorable enough to justify any further action. When any man or woman is alive, he or she deserves to be treated as such by being granted the highest quality of care that he or she can obtain—unless explicitly notified that advanced methods would prolong or worsen suffering. In any case (even when death is imminent), there is absolutely no place for ageism within the walls of any treatment facility or the heart of any medical professional.

Though the past actions and thoughts of biased healthcare workers cannot be erased from the memories of affected patients, the implementation of preventative training programs could reduce the normalcy of such behaviors by a considerable margin; ideally, the public opinion of healthcare would improve in response, encouraging more diverse groups of people to rely on medical professionals in a way that may now seem disheartening. This project aims to promote positive change through the development and presentation of diversity training courses for occupational therapy schools.

CHAPTER I: HEALTH DISPARITIES IN GENERAL HEALTHCARE SETTINGS

Despite recent efforts to promote health equity, health disparities continue to adversely affect patients in general healthcare settings (e.g., acute care hospitals, urgent care centers, and long-term care facilities) across the world. This chapter identifies five contributing factors to health disparities: socioeconomic status, race and ethnicity, gender identify and sexual orientation, age, and language barriers.

Socioeconomic Status

Ju et al. (2021) explore the social determinants of oral healthcare in the United States. They found that age, race, gender, income, language skills, citizenship status, and educational attainment affect an individual's likelihood of receiving oral healthcare services. For instance, over "60% of participants with less than a high school education reported not visiting a dentist in the past year, whereas only 22% of participants with at least a college education reported no dental visits during the same time" (Ju et al., 2021, p. 4). Moreover, participants with the lowest levels of income and education had a probability of not visiting a dentist that was "15% higher than what would be expected . . . given their need" (Ju et al., 2021, p. 5). The authors state that efforts to remove the inequalities and inequities in oral healthcare services must begin with action in both social and political spheres. To examine the inequalities and inequities in oral healthcare services, the authors reviewed 4,745 responses to the National Health and Nutrition Examination Survey

(NHANES). Of these responses, 29.3% came from individuals with fair/poor self-rated oral health, 52.4% came from females, and 65.9% came from non-Hispanic Whites (Ju et al., 2021, p. 5). Though this study referenced a large and representative sample size, it did not incorporate clinical data into its analysis; future studies may benefit from the inclusion of clinical data to paint fuller pictures of their participants.

Hoover et al. (2022) evaluate the stigmatization of substance use disorders (SUD) in hospitals. Both patients with SUD and hospital-based providers described a sense of mutual mistrust that promoted stigmatization; after serving as a "punching board" for a patient in opioid withdrawal, one nurse developed a dislike for treating all patients with SUD (Hoover et al., 2022, p. 6). Likewise, one patient criticized her medical team for "[giving] her something [she] was going to get addicted to and [taking] it away cold turkey" (Hoover et al., 2022, p. 6). Similar negative interactions are often documented in medical charts, influencing the opinions of future providers before they ever meet their patients. Because people who anticipate stigma within healthcare settings "have lower self-worth . . . and engage in higher health risk behaviors," the authors advocate for the integration of clinical education into the practices of all providers who interact with patients (Hoover et al., 2022, p. 11). To identify the stigma of addiction, the authors conducted interviews with 20 patients and 62 hospital-based providers, including "20 hospitalists, 18 pharmacists, 13 nurses, and 11 social workers" (Hoover et al., 2022, p. 5). The generalizability of their data is limited by their structure, location, and sample size. Because the authors relied only on their participants' responses to qualitative questions, the inclusion of quantitative data (e.g., the length of stay of each patient) would better reveal the effects of stigmatization on the patient experiences of individuals with SUD.

Bell et al. (2020) evaluate the implications of socioeconomic status (SES) on health inequities among Black and White college graduates in the United States. Though educational attainment did not significantly interact with the self-rated health of Black women, Black men experienced “diminished returns of education on self-rated health” (Bell et al., 2020, p. 4). Adjusting for all covariates (e.g., homeownership, household income, and investment income) only partially mediated race inequities in self-rated health. In other words, wealthy, educated Black people would still be expected to experience more health inequities than White people of similar backgrounds. The authors evaluated 14,823 responses to the National Health and Nutrition Examination Survey (NHANES). They identified self-rated health as their dependent variable and race as their independent variable. Because they only referenced the responses of Black and White individuals, they could not fully establish the relationship between SES and health inequities among all ethnicities. Moreover, the authors did not include actual measures of wealth in this study; rather, they only included proxy measures of wealth (e.g., homeownership and investment income). Despite these limitations, the authors strongly believe in the ability of social justice efforts to reduce the racial inequities that were discussed in this study.

Race and Ethnicity

Tambling et al. (2023) evaluate the presence of demographic differences in mental health, mental health literacy, and insurance literacy in the United States. Their findings suggest that mental health literacy is highly negatively correlated with mental health, internalized stigma, and insurance literacy. Because Black and Asian respondents displayed the lowest levels of mental health literacy, they are more likely to face additional health disparities than other ethnic groups. For instance, they often possess a greater need for mental health interventions, but their insurance and mental health illiteracy frequently impede their ability to receive prompt care. The authors administered a variety of surveys (e.g., the Generalized Anxiety Disorder scale, the Perceived Stress Scale, the Burden Scale for Family Caregivers, and the Mental Health Literacy Scale*)* to 615 participants. The survey responses were evaluated in relation to each of the following demographic characteristics: race, gender identity, education level, and household income. Though slight relationships were found between an individual's gender identity, education level, and household income and his/her mental health literacy, they were less significant than that between race and mental health literacy. The external validity of this study is limited by the authors' use of a paneling company for participant recruitment. Furthermore, cross-sectional studies are limited in their ability to determine causal elements. Nevertheless, it provides substantial evidence of the need for the expansion of health literacy in the United States.

Womersley et al. (2021) discuss the effects of race and socioeconomic status on postpartum care in the United Kingdom. Though Black, Asian and minority ethnic (BAME) women are disproportionately affected by perinatal mood and anxiety disorders (PMAD), white British women are significantly more likely to receive treatment for them. BAME women also experience higher rates of preeclampsia and gestational diabetes mellitus (GBM), risks that are compounded by "pre-existing obesity that is itself linked to deprivation" (Womersley et al., 2021, p. 32). When first-line treatments (e.g., lifestyle changes) are prescribed to these populations, "differences in diet and nutritional education and limitations in English language proficiency" often hinder their success (Womersley et al., 2021, p. 32). The authors review 45 articles about maternal health in the United Kingdom. They then acknowledge three major pathways for improvement in the National Health Service (NHS): “proactive screening programs, opportunistic review of women who come into contact with primary or secondary care, and targeted research into effective postpartum interventions” (Womersley et al., 2021, p. 34). Ideally, the implementation of these strategies would lead to the proactive detection and management of prenatal and postnatal medical conditions for all women.

Groskaufmanis et al. (2022) compare the use of preventive services among Black, White, and Hispanic individuals with cerebral palsy or spina bifida (CP/SB). Though “the rate of recommended services for all subpopulations of adults with CP/SB was low,” White adults possessed higher odds of receiving bone density screenings and annual wellness visits than both Black and Hispanic adults (Groskaufmanis et al., 2022, p. 430). The authors found no significant racial/ethnic inequities in the use of office visits, cholesterol assessments, and diabetes screenings. Moreover, the use of preventive services increased across all subgroups as time progressed. The authors evaluated the 2007–2017 private claims data of 11,635 adults with CP/BS; of these adults, 1,243 were Hispanic, 1,457 were Black, and 8,935 were White. The authors based their study on six outcomes of interest: “any office visit, any physical/occupational therapy, wellness visit, bone density screening, cholesterol screening, and diabetes screening” (Groskaufmanis et al., 2022, p. 430). Because this study only included adults with private insurance, its results cannot be generalized to all adults with CP/SB. Nevertheless, the authors claim that “improved physical accessibility of healthcare settings, greater adoption of telehealth, and increased clinician education regarding the healthcare needs of individuals with disabilities" could benefit the vast majority of adults with CP/BS (Groskaufmanis et al., 2022, p. 436).

Morrison et al. (2021) investigate the assessment and documentation of nonverbal pain behaviors among newly admitted nursing home residents across the United States. Using the Minimum Data Set 3.0 (MDS 3.0), they divided 994,510 residents into three categories: Hispanic (n = 63,673), non-Hispanic Black (n = 146,058), and non-Hispanic White (n = 784,779). Staff members documented nonverbal sounds, negative facial expressions, and protective body movements as positive signs of pain. The respective percentages of daily pain documentation for non-Hispanic Blacks, Hispanics, and non-Hispanic Whites were as follows: 7.0%, 7.2%, and 12.2%. Moreover, non-Hispanic Blacks and Hispanics were significantly less likely than non-Hispanic Whites to receive pain medication. As noted by the authors, this study faced several limitations. Pain behaviors were assessed by nursing home staff during a five-day period, so human error (i.e., failing to properly observe and document behavior) may have prevented the results from accurately representing the experiences of the residents. Furthermore, the MDS 3.0 did not account for the race or ethnicity of staff members; consequently, the effects of racial or ethnic concordance between residents and staff members could not be determined. Future studies may evaluate the treatment outcomes of patients and providers that are racially and/or ethnically matched; additionally, identifying the stigmas that are associated with outward emotion in different communities would provide vital insight into the pain expression of their members.

Sun et al. (2022) discuss the disproportionate rates at which healthcare providers assign negative descriptors to non-White patients. They defined a "negative descriptor" as any word that alluded to patient difficulty (e.g., “aggressive” and “resistive”). Reviewing the electronic health records (EHRs) of 18,459 patients in Chicago, Illinois, the authors found that Black patients had “2.54 times the adjusted odds . . . of having one or more negative descriptors in their EHRs compared with White patients” (Sun et al., 2022, p. 207). The EHRs of unmarried patients and patients with federal health insurance also possessed higher likelihoods of containing stigmatizing language. Because prior documentation accounts for roughly 90% of EHRs, negative descriptors are often copied into subsequent notes and shared with multiple healthcare providers. This practice amplifies systemic biases across a variety of medical specialties, preventing affected patients from escaping their influences. As noted by the authors, this study faced several limitations. It collected patient information from a single medical center in an urban area, hindering the generalizability of its results. Moreover, the racial and ethnic heterogeneity of the sample was limited. 29.7% and 60.6% of patients were White and Black, respectively; other races and ethnicities accounted for only 9.7% of the sample. To better understand the attachment of negative descriptors to other racial and ethnic minorities (e.g., Hispanics and Latinos), future studies may recruit patients from multiple medical centers in various settings.

Gender Identity and Sexual Orientation

Harless et al. (2023) explore the patient experiences of transgender or nonbinary (TNB) individuals living in Appalachia. When compared to the general population, TNB individuals face increased rates of stigma, poverty, and health disparities. The authors note three themes that were present in each of their participants’ responses: “the experiences of stigma related to gender, the impact of stigma on personal wellbeing and perception of health, and the need for affirming TNB healthcare services" (Harless et al., 2023, p. 1). Every participant identified the cultural and political landscape of Appalachia as fuel for discrimination; most notably, the "social conservancy" of the South contributed to the removal of several participants from their social support networks (Harless et al., 2023, p. 3). This isolation often contributed to the development of self-injurious behaviors (e.g., substance abuse). To improve patient experiences for TNB persons, the participants encouraged healthcare providers to outwardly respect their gender identities. To locate potential participants, the authors asked community partners that serve the TNB population to share information about their study; they effectively recruited "ten participants from four different Appalachian states within three different Appalachian sub-regions" (Harless et al., 2023, p. 3). They then conducted semi-structured interviews with each participant, recording their responses on a handheld device. Because most participants were white and assigned female at birth (n = 9 and 8, respectively), a larger, more diverse sample would provide a deeper context of the patient experiences of all TNB individuals living in Appalachia.

Jackson et al. (2016) investigate the relationship between health and sexual identity among sexual minorities in the United States. They first identify sexual minorities as "individuals who self-identify as gay, lesbian, or bisexual and who engage in same-gender sexual behavior or report same-gender sexual attractions but do not self-identify as such" (Jackson et al., 2016, p. 1). When compared with heterosexual men and women, sexual minorities are more likely to develop depression, hypertension, obesity, and alcoholism; not only do they possess more risk factors for chronic illness, but they also possess a lower likelihood of seeking medical treatment for their condition(s). Jackson et al. theorize that these trends arose from the stigma, discrimination, and victimization that are often experienced by sexual minorities. The authors recorded information about the health outcomes, health behaviors, and sexual identities of 69,270 individuals in the United States. Though they promoted the reliability of their results with a large sample size, sexuality is notoriously fluid; as a result, their study would benefit from longitudinal studies that are designed to examine shifts in sexual orientation over the lifetime.

Other Factors

Neal et al. (2022) discuss the effects of patient age on recommended treatment modalities. Though treatment guidelines for breast cancer state that "patient health and patient choice are the only acceptable reasons to deviate from guideline compliant care," the results of four methods—an Implicit Associations Test (IAT), a questionnaire about treatment recommendations by age, a questionnaire about age-related assumptions regarding older patients, and a semi-structured interview about treatment recommendations for older patients with breast cancer—suggest that the majority of responding healthcare professionals possessed an "anti-old" implicit association and altered treatment plans accordingly (Neal et al., 2022, p. 2401). Consisting of surgeons, oncologists, and breast care nurses, 90% of respondents reported that age bias significantly decreases the quality of care that is received by older patients. For instance, healthcare providers are significantly less likely to recommend surgery, chemotherapy, or radiotherapy to older patients; instead, they promote primary endocrine therapy, a treatment modality that is both less aggressive and less effective than traditional methods. These biased decisions harm patients mentally, physically, and emotionally, worsening their treatment outcomes.

Language barriers often lead to treatment delays, poor patient-provider relationships, and low patient confidence during healthcare encounters. Without language access services, language minority (LM) persons frequently ask friends or family members to accompany them to their appointments for interpretation purposes. This practice raises concerns regarding both accessibility and confidentiality, calling attention to the need for bilingual providers within all healthcare settings. De Moissac & Bowen (2019) found that—though the provision of language access services (e.g., on-site interpreters) would greatly benefit LM persons—the costs associated with these measures frequently deter healthcare settings from implementing them. As noted by the authors, this study faced several limitations. The selection of participants was both non-random and non-stratified, skewing the data to best represent certain provinces. Additionally, the authors' reliance on language advocates as recruiters may have biased their sample. Future studies may evaluate the impact of language barriers on the average length of stay and readmission rates among hospitalized minority Francophones.

CHAPTER II: HEALTH DISPARITIES IN OCCUPATIONAL THERAPY

Because occupational therapy aims to promote health and wellbeing through personal occupation, its success relies heavily on the degree to which it can appeal to individual identity (“About occupational therapy,” 2024). When presented with certain identities, the quality of care that is provided by occupational therapists significantly worsens, deterring their patients from regularly seeking therapeutic services. Thus, it would be preferable for occupational therapists and occupational therapy students to view differing identities as opportunities for growth rather than undesirable barriers. This chapter identifies three contributing factors to health disparities in occupational therapy: age, gender identity and sexual orientation, and race and ethnicity.

Age

Friedman & VanPuymbrouck (2021) assess the presence of implicit ageist and ableist attitudes among second-year occupational therapy students in the United States. They found that 70.37% (n = 28) of their participants preferred younger adults over older adults, whereas only 20.37% (n = 11) of their participants preferred older adults over younger adults. The authors also identify a statistically significant relationship between implicit age attitudes and implicit disability attitudes; according to their predictions, an individual who expresses a high level of implicit age bias is also expected to express a high level of disability bias. Because occupational therapists are expected to work with a variety of special populations, the presence of implicit ageist and ableist attitudes are not conducive to positive patient-provider relationships. The authors recruited 54 second-year occupational therapy students from three large universities in the Midwestern United States. They then administered the Age Implicit Association Test (IAT) and the Disability Attitude Implicit Association Test (DA-IAT) to each student. The vast majority of respondents were White (75.93%) and women (84.07%), so the authors recommend that future studies evaluate a wider, more representative sample. The authors also advocate for educational reforms to better represent age in disability in occupational therapy curriculum; because current discussions of age and disability in are "commonly negatively framed and tend to focus on inability, dependence, and frailty," changes should be made to highlight age and disability as a natural part of the human condition (Friedman & VanPuymbrouck, 2021, p. 12).

Pergolotti et al. (2014) examine the tendencies of older adults (age ≥ 65 years) with cancer to seek occupational therapy services. Though occupational services could significantly improve their quality of life, only 32% of adults who were diagnosed with breast, prostate, or skin cancer used them within the first two years of their cancer diagnosis (Pergolotti et al., 2014, p. 600). Moreover, older adults who eventually received occupational therapy services "were significantly older (77 years vs. 75 years) and disproportionately female (55% vs. 43%)" (Pergolotti et al., 2014, p. 600). The authors identify previous use of occupational therapy services as the strongest predictor of post-diagnosis use of occupational therapy services; adults who used occupational therapy services within 1 year before their diagnosis were "35% more likely to use occupational therapy after diagnosis" (Pergolotti et al., 2014, p. 602). The authors evaluated the claims of 21,131 Medicare beneficiaries who were diagnosed with breast, prostate, lung, colorectal, and melanoma cancers in 2004–2007. These cancer diagnoses are the five most common in North Carolina, the state in which this study was conducted. The authors excluded adults who "(1) qualified for Medicare because of end-stage renal disease or disability, (2) were diagnosed at death or during an autopsy, (3) were diagnosed before their 66th birthday, (4) had a previous diagnosis of cancer, or (5) were not enrolled in Medicare Part A or Part B" (Pergolotti et al., 2014, p. 598). Because Medicare billing codes do not include diagnosis codes, the adults included in this study may have been receiving occupational therapy services for reasons unrelated to cancer; thus, the results of this study are limited. Future research is needed to determine the most effective ways to increase awareness of occupational therapy services among older adults with cancer.

Gender Identity and Sexual Orientation

Liedberg & Hensing (2011) reveal the effects of gender bias on by occupational therapy students in Sweden. They found that the majority of occupational therapy students tend to follow traditional gender roles when prescribing activities to clients. For instance, 28% of students chose fishing for their male client; conversely, only 2% of students chose fishing for their female client (p. 280). "Feminine" activities included cleaning (10% male vs. 17% female), riding horses (2% male vs. 30% female), and aerobics (0% male vs. 21% female). "Masculine" activities included weight training (37% male vs. 15% female) and car maintenance (56% male vs. 45% female). The gender of the students did not appear to influence their activity prescription, regardless of the gender of their clients. The authors assigned fictional case studies to 107 occupational therapy students; after receiving their case studies, the students were instructed to select three activities for their client to perform. 54 students received a fictional male client (Eric), whereas 53 students received a fictional female client (Erica). To collect the initial perceptions of each student, the authors encouraged them to "make their choices without too much reflection (Liedberg & Hensing, 2011, p. 281). Though intentional, this instruction may have prevented certain students from expressing their best judgements. Future studies should evaluate gender construction within occupational therapy; once this is understood, progress can be made toward the elimination of gender bias.

Bolding et al. (2020) examine the perceived clinical preparedness of occupational therapy students and recent graduates for treating LGBT patients. Though 62.8% of respondents reported receiving some education on respectful communication, several indicated that these lessons were not sufficient for daily use. For instance, one respondent stated that his/her curriculum "'[addressed] diversity in a general sense . . . and [did] not specifically address issues related to sexual and gender minorities'" (Bolding et al., 2020, p. 5). Moreover, 61.1% of respondents reported receiving between zero and two hours of education on the specific needs of LGBT patients. As a result, the majority of respondents ranked themselves poorly (between three and four on a seven-point scale) on questions about clinical preparedness for treating LGBT patients. To increase the confidence of occupational therapy students and recent graduates, the authors recommend that they receive additional training on "terminology, stigma and discrimination, LGBT-specific health disparities, sexuality and sexual dysfunction, . . . [and] intersectionality" (Bolding et al., 2020, p. 9). The authors evaluated the responses of 435 occupational therapy students and recent graduates to a 31-question survey; of these questions, 18 were taken from the Lesbian, Gay, Bisexual, and Transgender Development of Clinical Skills Scale (LGBT-DOCSS). Though the LGBT-DOCSS was "validated through research with a large multinational and interdisciplinary sample," it is not immune to the effects of self-selection bias (Bolding et al., 2020, p. 4). The results of this study were further limited by the unequal representation of the United States's four geographical regions; response rates were higher from the South and West than the North and East.

Leite & Lopes (2022) gather existing literature about occupational therapy and the lesbian, gay, bisexual, transgender, queer, intersex, asexual, and other dissident gender and sexuality (LGBTQIA+) population. They divided their search into three axes of analysis: "(1) demands for occupational therapy, (2) professional education, and (3) interventions" (Leite & Lopes, 2022, p. 4). Discrimination in the workplace is commonly experienced by members of the LGBTQIA+ population, a trend that promotes occupational injustice. Though they cannot prevent these unpleasant experiences, occupational therapy practitioners can lessen their severity by developing interventions to build the confidence of their LGBTQIA+ patients (e.g., gender-affirming care). Leite & Lopes also call attention to the shortcomings of occupational therapy school, as "occupational therapy students have the lowest workload including content regarding LGBTQIA+ people" (Leite & Lopes, 2022, p. 6). They believe that the inclusion of LGBTQIA+-related courses would prevent students from "maintaining a biomedical perspective on the bodies of [LGBTQIA+] people," an approach that would save patients from the damaging effects of heteronormativity (Leite & Lopes, 2022, p. 7). During their scoping review, Leite & Lopez identified 43 relevant articles: "28 research articles, 9 reflection articles, 3 experience reports, and 3 literature reviews" (Leite & Lopes, 2022, p. 3). These articles, published between 1987 and 2021, exhibit a noticeable gap in existing literature about occupational therapy and the LGBTQIA+ population. Despite this obstacle, the authors constructed a thoughtful article on the needs of LGBTQIA+ patients and the responsibilities of occupational therapy practitioners. Their acknowledgement of their positionality (Leite = gay, cisgender, and Latino man; Lopes = heterosexual, cisgender, and Latino woman) contributed to the credibility of their work. Further research is needed to develop specific occupational therapy interventions for members of the LGBTQIA+ population.

Race and Ethnicity

Breland & Ellis (2012) encourage researchers to report the race and ethnicity of their participants. Because "race and ethnicity are associated with biological factors and social determinants that contribute to health-related outcomes," they may provide valuable context for the results of any given study (Breland & Ellis, 2012, p. 116). For instance, some conditions disproportionately affect individuals from certain racial and ethnic groups; if these conditions were to be studied, failure to report participants' race and ethnicity would prevent affected individuals from learning vital information about their health. Moreover, occupational therapy practitioners cannot properly address health disparities without understanding the ways by which race and ethnicity affect everyday life. Though the benefits of reporting race and ethnicity are well-reported, researchers often fail to do so; after evaluating 342 articles published in the *American Journal of Occupational Therapy* from 2000 to 2008, Breland & Ellis discovered that only "118 articles (34.5%) reported race and ethnicity" (Breland & Ellis, 2012, p. 116). Consequently, the race and ethnicity of 41,035 participants (75%) were unknown. To select sources for this study, Breland, Ellis, and three graduate students "independently reviewed the full text of participant-oriented research articles published in Volumes 54–62 of the *American Journal of Occupational Therapy*" (Breland & Ellis, 2012, p. 116). They excluded editorials, meta-analyses, literature reviews, and articles with occupational therapy practitioners as the primary participants. In doing so, they highlighted the importance of race and ethnicity from a patient perspective (rather than a provider perspective). Further research is needed to address two uncertainties: the types of studies that typically report race and ethnicity and the prevalence of reporting race and ethnicity in other countries.

Bass-Haugen (2009) identifies income level and racial/ethnic identity as causes of health disparities in the United States. When evaluating the health and behavioral characteristics of adult American citizens, she found that Black, Hispanic, and multiple race citizens "were more likely to report negative emotions, difficulty and limitations in performing activities, and infrequent participation in physical activities" (Bass-Haugen, 2009, p. 32). Similarly, "poor" citizens (income < poverty threshold) expressed higher levels of depression and avolition than "nonpoor" citizens (income ≥ 200% of poverty threshold). These findings were not limited to adults; poor and/or non-White children reported decreased feelings of safety in their schools and neighborhoods. Consequently, White children were less likely than their non-White peers "to have 4 or more hours per week of TV, video, or video games and more likely to engage in activities outside of school" (Bass-Haugen, 2009, p. 29). White children were also less likely to experience social, behavioral, or developmental delays than non-White children (22.2% and 24.2%–33.5%, respectively). Bass-Haugen performed a retrospective analysis of various surveys, including—but not limited to—the Behavioral Risk Factor Surveillance System, the National Health Interview Survey, the Home Health Outcome and Assessment Information Set, the Nursing Home Minimum Data Set, the National Survey of Children's Health, and the National Survey of Children's Health with Special Needs. These surveys include respondents from every county in the United States, promoting the applicability of Bass-Haugen's findings. However, her work is limited by the nature of her data; because she only referenced secondary sources, she was unable to modify the scope of her research. Future studies may benefit from the inclusion of primary data.

Côté (2013) evaluates the barriers to occupational rehabilitation that are faced by immigrant and/or minority workers. He first acknowledges cultural influences on pain perception and management; among certain populations (e.g., Hispanic and Latinx people), pain is often "described as an ordeal or attributed to fate or God's will" (Côté, 2013, p. 159). Treatment for these patients would vary significantly from that of atheists, and occupational therapy practitioners must learn to consider this nuance. It is also imperative that occupational therapy practitioners refrain from allowing their own cultural backgrounds to "influence their representations of pain and subsequent interventions" (Côté, 2013, p. 159). Additional barriers include non-universal cultural norms. For instance, occupational therapy practitioners from Western nations typically anchor their rehabilitation programs on the concepts of autonomy; meanwhile, specific cultural areas (e.g., Southeast Asia) prioritize interdependence, family hierarchy, and community belonging. Though Côté encourages occupational therapy practitioners to honor their patients' cultural beliefs, he also reminds them that "every individual case expresses a complex situation at the interplay of personal factors . . ., social/environmental factors . . ., and structural factors" (Côté, 2013, p. 161). Côté searched for existing literature by using the following keywords: "insertion; rehabilitation; occupational rehabilitation; return-to-work; treatment AND intercultural (and cross-cultural) communication; cross-cultural comparison; cultural characteristics; cultural competence, cultural diversity; ethnic groups; ethnic minorities; work and immigrant workers; occupational diseases; occupational health; and occupational medicine" (Côté, 2013, p. 154). Though he found 783 relevant articles, he chose to retain only 27. He reported that his search was limited by several researchers' inability to report sufficient demographic information about their participants; one article, for instance, consistently confused phenotypes, national identities, and religious identities (Côté, 2013, p. 161). To overcome these shortcomings, Côté asks future researchers to carefully document their participants' data; failure to do so slows progress for patients and practitioners alike.

Gibbs (2017) addresses racial disparities in the detection of autism spectrum disorder (ASD) by occupational therapists. White children are significantly more likely to receive an ASD diagnosis than Black and Hispanic children. White children also receive their diagnosis at a younger age; though the Centers for Disease Control and Prevention (CDC) recommends that ASD be diagnosed by two years of age, most White children are not diagnosed until after four years of age (Gibbs, 2017, p. 2). The age of diagnosis is even older among racial and ethnic groups. Consequently, the parents of minority children with ASD are delayed from "[learning] about their child's developmental challenges, [coping] with caregiving demands, [seeking] appropriate services, and [obtaining] counseling" (Gibbs, 2017, p. 2). Because occupational therapists typically spend a considerable amount of time with each of their patients, they can detect symptoms of ASD that other individuals may overlook. The author evaluated existing literature to determine the potential roles of occupational therapists in the early detection of ASD in various racial or ethnic groups. Though her included studies are well-focused on ASD detection in Black, White, and Hispanic children, they do not evaluate the experiences of other ethnic groups (e.g., Asians and Native Americans). Thus, future studies may benefit from the evaluation of a more diverse sample. Additionally, the author noted a need for additional research on the specific responsibilities of occupational therapists in these scenarios.

Imm et al. (2019) assess disparities in the diagnosis and documentation of autism spectrum disorder (ASD) in Black and Hispanic children. They found that Black and Hispanic children were "more likely than White children to have only education records for review" (Imm et al., 2019, p. 7). Without adequate health records, a clinician cannot confidently diagnose a child with ASD; thus, the ASD cases of Black and Hispanic children were more likely to be classified as "suspected" or "possible" than those of White children. The authors hypothesize that this discrepancy stems from the Black and Hispanic children's limited access to healthcare, a problem that may be promoted by any of the following obstacles: "language barriers; limited economic resources, knowledge and schedule flexibility required of parents to access comprehensive autism assessments for their children; limited parental awareness of ASD and ability to report autism symptoms; and/or socioeconomic disadvantage" (Imm et al., 2019, p. 8).The authors evaluated records from the Colorado and Wisconsin Autism and Developmental Disabilities Monitoring (ADDM) Network. Because they only studied children with confirmed residency in their surveillance area, several Hispanic children were not included in this study; it is possible that confirming residency within their surveillance area was significantly more difficult for immigrant populations (Imm et al., 2019, p. 8). Their study is further limited by the assumption that, “by the age of eight years, . . . documentation of behaviors and developmental histories consistent with ASD [should] be available in administrative records for children with ASD” (Imm et al., 2019, p. 9). It is not uncommon for ASD diagnoses to be delayed (especially in female children), delegitimizing this assumption.

CHAPTER III: PROPOSALS FOR CHANGE

To address the limitations that were discussed in Chapter II, occupational therapy schools should incorporate diversity training courses into each of their nine semesters. Examples of relevant material include the adoption of cultural humility and the promotion of occupational justice. However, the modernization of curricula is not sufficient to ensure that occupational therapists and occupational therapy students maintain culturally sensitive attitudes throughout their entire careers; thus, methods to encourage positive progress (e.g., requiring a certain number of diversity-related Continuing Education Units [CEUs]) should also be considered.

Agner (2020) implores occupational therapy practitioners to replace their passive understanding of cultural competence with an active pursuit of cultural humility. As the first widespread attempt to increase the sensitivity of occupational therapy, cultural competence fails to represent a modern understanding of culture; that is, it presents culture as “a finite construct to be understood or mastered” (Agner, 2020, p. 1). Cultural humility, however, acknowledges the fluidity of culture by emphasizing the “constant process of learning” it requires (Agner, 2020, p. 2). Moreover, cultural humility encourages healthcare providers to utilize their position of power for the well-being of their patients. To instill this framework in the minds of healthcare students, Agner supports the inclusion of “several experiential aspects, reflective exercises, and didactic training on racism and bias in healthcare” in their respective curriculums (Agner, 2020, p. 5). To differentiate between cultural competence and cultural humility, Agner evaluated 30 relevant studies that were published from 1992 to 2018. She sourced these articles from a variety of journals, including the *American Journal of Occupational Therapy*, the *British Journal of Occupational Therapy*, the *Canadian Journal of Occupational Therapy*, the *Journal of Experimental Social Psychology*, and the *Journal of General Internal Medicine*. By highlighting the importance of cultural humility in several healthcare fields, Agner emphasized the generalizability of her argument; in other words, she proved that the need for cultural humility is not specific to occupational therapy. However, her work is limited by its subjective nature; though Agner referenced several relevant studies, she only presented the hypothetical value of cultural humility. Future studies may benefit from examining the effects of cultural humility on patient-provider relationships in various locations (e.g., clinics and hospitals).

Braveman & Bass-Haugen (2009) call occupational therapy practitioners to action by unveiling the relationship between social justice, health disparities, and occupational therapy. Designed to "'[enable] people to participate as valued members of society despite diverse or limited occupational potential,'" occupational therapy pragmatically promotes social justice (Braveman & Bass-Haugen, 2009, p. 8). Occupational justice, an occupational therapy-specific branch of social justice, refers to an individual's right to participate in occupations without feeling "barred, confined, restricted, segregated, prohibited, undeveloped, disrupted, alienated, marginalized, exploited, [or] excluded" (Braveman & Bass-Haugen, 2009, p. 8). When occupational justice is not realized, health disparities are often present. These variables negatively impact at least one of the following: health status, healthcare access, and quality of care. Within occupational therapy, health disparities disproportionately affect women, people of color, members of the LGBT community, and patients with "taboo" diagnoses (e.g., HIV/AIDS). Braveman & Bass-Haugen provided brief summaries of eight articles about social justice and health disparities in occupational therapy. These articles, sourced from the *American Journal of Occupational Therapy*, reflected the applicability of occupational therapy to a wide variety of clinical cases. They also "[fostered] the development of emerging practice areas to help meet society's health, wellness, and quality-of-life needs," fulfilling a goal set by the American Occupational Therapy Association (Braveman & Bass-Haugen, 2009, p. 11). However, the field of occupational therapy has changed substantially in the last 15 years. Further research is needed to adapt Braveman & Bass-Haugen's findings to best suit the needs of current and future occupational therapy patients.

Lindsay et al. (2014) examine how occupational therapy practitioners act as cultural brokers to provide culturally sensitive care to immigrant children with disabilities. They define cultural brokerage as the act of "'bridging, linking, or mediating between groups or persons from different cultures'" (Lindsay et al., 2014, p. 115). This important task cannot be completed without first addressing cultural and socio-structural constraints. As residents of either Toronto or Quebec City, the occupational therapy practitioners who participated in this study were subjected to specific "assumptions [that were] embedded within the Canadian healthcare system" (Lindsay et al., 2014, p. 117). One such assumption was that independence is the optimal goal of therapeutic intervention; however, certain cultural groups do not encourage independence, especially among children with disabilities. The cultural connotation of play serves as another constraint; though play is known to facilitate the development of social and cognitive skills in children, parents of certain cultural backgrounds do not regularly engage in play with their children. Lastly, many clinicians struggle to overcome gender relations within certain cultures. For instance, a father may act as an authority figure and prevent his wife from speaking during their child(ren)'s assessments; this is especially problematic when the mother serves as her child(ren)'s primary caregiver (Lindsay et al., 2014, p. 117). To overcome these barriers, many occupational therapy practitioners emphasize the importance of "listening to clients, being respectful, and involving [them] in [their child(ren)'s] therapy" (Lindsay et al., 2014, p. 119). Lindsay et al. (2014) recruited 17 occupational therapy practitioners who had "at least 2 years of experience providing rehabilitation services to children with disabilities and at least 1 year of experience in working with immigrant families raising a child with a disability" (Lindsay et al., 2014, p. 116). All of these participants were female; though this lack of diversity limits the generalizability of the authors' findings, it accurately represents the demographics of the occupational therapy profession. Lindsay et al. prompts future researchers to study the ethical implications of altering therapy for clients from minority backgrounds. Additional projects should recreate this study with an expanded recruitment area.

The American Occupational Therapy Association (AOTA) (2021) outlines the minimum standards of practice for occupational therapists and occupational therapy assistants in the United States. It describes five standards: "Professional Standing and Responsibility," "Service Delivery," "Screening, Evaluation, and Reevaluation," "Intervention Process," and "Outcomes, Transition, and Discontinuation." These standards are then divided into 45 specific requirements; within these requirements, the need for cultural humility among occupational therapy practitioners is only addressed once.

Referencing Agner's definition of cultural humility, the AOTA states that occupational therapy practitioners should "[maintain] a constant process of learning" and "[understand] differentiations between and within cultures" to preserve their professional standing (AOTA, 2021, p. 3). To improve quality of care, AOTA should incorporate cultural humility into each of their five standards. Though cultural humility certainly affects professional standing and responsibility, it plays a larger role in determining an individual's ability to care for his/her patients. AOTA should also work alongside the Accreditation Council for Occupational Therapy Education (ACOTE) to establish new educational requirements for occupational therapy students; currently, ACOTE does not mandate the inclusion of cultural humility training in occupational therapy curricula. Instead, it requires only introductory psychology, abnormal psychology, and introductory sociology or introductory anthropology.

Brown et al. (2011) address the shortcomings of multicultural training curricula in occupational therapy programs across the United States. Of the 78 programs they evaluated, only 38 "agreed that they provide training opportunities for professional development in cultural competence" (Brown et al., 2011, p. 9). Even fewer programs (n = 25) implemented a method to evaluate the efficacy of their multicultural coursework and/or training. Brown et al. present multiple reasons for these weaknesses, with the most common being "lack of diversity in the student body, faculty, or context" (Brown et al., 2011, p. 10). Lack of time, the second most common challenge, is the most easily remedied; opportunities for multicultural training could be implemented into existing learning opportunities (e.g., Fieldwork I and service-learning projects). To overcome a lack of diversity, Brown et al. encourage students and faculty members to broaden their definition of diversity; instead of limiting themselves to race and ethnicity, they should also consider "persons of different socioeconomic standing or who are homeless, persons with disabilities, [and/or] persons of a different religion or sexuality" (Brown et al., 2011, p. 11). Though useful, these solutions only apply to individuals who are already enrolled in occupational therapy programs; for lasting change, programs should aim to "[increase] targeted student recruitment and awareness campaigns to under-represented populations, as well as additional dedicated scholarship monies to increase access to entry-level graduate education to those from diverse backgrounds" (Brown et al., 2011, p. 13). Brown et al. administered a 68-item survey to 144 occupational therapy programs in the United States and received 78 responses. This survey aimed to address four interrelated dimensions: "multicultural knowledge, multicultural skills, teaching methods, and contextual supports for multicultural training" (Brown et al., 2011, p. 5). Because it was developed specifically for this study and could not undergo previous testing, its validity and reliability cannot yet be guaranteed. This study is further limited by its response rate; because only 54% of occupational therapy programs responded, the authors' findings lack generalizability. Future studies may evaluate the multicultural training curricula at individual occupational therapy programs in various countries.

Castro & Mårtensson (2016) present a new scale for the assessment of cultural awareness among Latin American occupational therapy students. Prior to the authors' efforts, only two instruments—the Cultural Competence Assessment Instrument (CCAI-UIC) and the Cultural Awareness and Sensitivity Questionnaire (CASQ)—had been identified as "possible tools for exploring culture in occupational therapy practice and training" (Castro & Mårtensson, 2016, p. 197). Both of these assessments were developed in the Western World, a fact that may limit their usefulness in non-English-speaking countries. After consulting with occupational therapy practitioners from Chile, Mexico, Argentina, Columbia, and Venezuela, Castro & Mårtensson developed a 30-item scale to gauge "personal, professional, and political" interpretations of culture among occupational therapy students (Castro & Mårtensson, 2016, p. 202). They plan to conduct a follow-up study to test the functionality and reliability of their scale; for now, they consider it to be "one step, among many others, that is needed to support a multiplicity and diversity of occupational therapies worldwide" (Castro & Mårtensson, 2016, p. 203). Castro & Mårtensson required each of their contributors to be "a faculty member or a department head of an occupational therapy program approved by the World Federation of Occupational Therapists (WFOT) in Latin America and working in a Spanish-speaking country in the region" (Castro & Mårtensson, 2016, p. 198). By doing so, they ensured that their scale would successfully serve a population that was previously overlooked by the occupational therapy profession. Moreover, their use of a Delphi design maintained anonymity among participants, protecting their data from biased responses; however, it also led to participant dropout throughout each round of their study. Once the functionality and reliability of their scale has been tested, further research should be conducted to test its replicability in various settings.

CHAPTER IV: PROPOSED CURRICULUM

Inspired by the issues and suggestions that were addressed in Chapters II and III, the following lesson plan is designed to promote the development of cultural humility among occupational therapy students. It emphasizes both understanding and experiential learning, two educational approaches that are crucial to the long-term success of students. With a specific goal of addressing ageism and ableism, this lesson plan builds upon Friedman and VanPuymbrouck's 2021 study, "Ageism and Ableism: Unrecognized Biases in Occupational Therapy Students." Additional lesson plans are needed to address racism, sexism, transphobia, and homophobia (among other factors that exacerbate health disparities).

Objective

Through diversity training, students will become active, thoughtful learners who are well-prepared to participate in a heterogeneous society.

Understanding

Teaching for understanding aims to build a bridge between students' past and present knowledge and experiences. It allows students to move beyond mere reproduction and memorization, educational fads that have become increasingly common since the rise of standardized testing. Indeed, Hounsell (1997) states that—when "the mastery of factual or procedural details . . . becomes an end in itself, dislocated from meaning—then to have [learned] is not to have partially understood but to have not understood at all" (Hounsell, 1997, p. 240). This concept is particularly relevant to the success of occupational therapy students; to best treat their future patients, they must internalize the value of individualized, culturally humble care. Failure to do so would likely result in a mismatch between their interventions and their patients' desired outcomes.

To ensure that lessons take root in the brains of learners, teachers should recognize and build upon their students' existing conceptions. This may require the "unthinking" of an idea or concept, a difficult task through which teachers "put themselves in the frame of mind of students who are encountering [a subject] for the very first time" (Hounsell, 1997, p. 242). When giving lessons about diversity, for instance, teachers may have to forego their own understanding and look through fresh eyes; though certain views may seem like second nature to some students, not everyone will have been able to interact with diverse populations before occupational therapy school. It is the job of teachers to level the playing field between students through the provision of experiential learning opportunities.

Experiential Learning

In its simplest form, experiential learning can be defined as "learning by doing" (Lewis & Williams, p. 5, 1994). It encourages teachers to trade active direction for passive facilitation, and—in doing so—identifies education as a student-centered affair. By "[requiring] students to cooperate and learn from one another through direct experiences," experiential learning reinforces the notion that learning is a continuous process (Bartle, 2015, p. 2). Put differently, no two individuals will ever live identical lives; as a result, there will always be room for students to grow as both people and providers.

The provision of experiential learning opportunities would be a major asset to all occupational therapy schools. Allowing students to participate in relevant hands-on activities would promote the maturation of their clinical reasoning and critical thinking skills (Coker, 2010, p. 280). Moreover, students would also develop levels of compassion and empathy that could not be achieved through traditional lessons alone.

Addressing Ageism and Ableism

Day 1

Upon entering the classroom, students will be instructed to complete the Age Implicit Association Test (See Appendix A). This test will take approximately 10 to 15 minutes to complete. Following the conclusion of the test, students will be given a short period of time (e.g., 5 to 10 minutes) to analyze their results and collect their thoughts for discussion. They will then be separated into randomly assigned breakout groups, where they will participate in unstructured discussion for 10 minutes. After this, they will leave their breakout groups and return to one large group. The teacher(s) will then lead a semi-structured discussion for the remainder of class. The following questions may be asked:

1. Did your results surprise or unsettle you? Why or why not?
2. In what ways have your past experiences shaped your results?
3. How might your results affect your ability to care for future patients?

Day 2

Upon entering the classroom, students will be divided into three randomly assigned breakout groups. Each of these groups will review different examples of relevant media and literature (e.g., memoirs, podcasts, and peer-reviewed articles), carefully chosen to represent the experiences of various older adults. The groups will rotate in 10- to 15-minute intervals until every student has reviewed all three materials. For the remainder of class, students will write journal entries that reflect on their experiences. If resources allow, the teacher(s) may establish partnerships with older adults and anti-ageism advocacy organizations to allow their students to learn in community-based, non-clinical settings.

Day 3

Upon entering the classroom, students will be instructed to complete the Disability Attitude Implicit Association Test (See Appendix B). This test will take approximately 10 to 15 minutes to complete. Following the conclusion of the test, students will be given a short period of time (e.g., 5 to 10 minutes) to analyze their results and collect their thoughts for discussion. They will then be separated into randomly assigned breakout groups, where they will participate in unstructured discussion for 10 minutes. After this, they will leave their breakout groups and return to one large group. The teacher(s) will then lead a semi-structured discussion for the remainder of class. The following questions may be asked:

1. Did your results surprise or unsettle you? Why or why not?
2. In what ways have your past experiences shaped your results?
3. How might your results affect your ability to care for future patients?

Day 4

Upon entering the classroom, students will be divided into three randomly assigned breakout groups. Each of these groups will review different examples of relevant media and literature (e.g., memoirs, podcasts, and peer-reviewed articles), carefully chosen to represent the experiences of people with disabilities. The groups will rotate in 10- to 15-minute intervals until every student has reviewed all three materials. For the remainder of class, students will write journal entries that reflect on their experiences. If resources allow, the teacher(s) may establish partnerships with people with disabilities and disability advocacy organizations to allow their students to learn in community-based, non-clinical settings.

Day 5

Having completed age-related and disability-related activities, students will be instructed to retake both the Age Implicit Association Test and the Disability Attitude Implicit Association Test (See Appendices A and B). These tests will take approximately 20 to 30 minutes to complete. Following the conclusion of both tests, students will be given a short period of time (e.g., 5 to 10 minutes) to analyze their new results and collect their thoughts for discussion. They will then be separated into randomly assigned breakout groups, where they will participate in unstructured discussion for 10 minutes. After this, they will leave their breakout groups and return to one large group. The teacher(s) will then lead a semi-structured discussion for the remainder of class. The following questions may be asked:

1. How did you feel about the in-class activities?

2. Did you expect your results to change?
    a. If yes, why?
    b. If no, why not?
3. Did your results change?
    a. If yes, why?
    b. If no, why not?
4. How might your results affect your ability to care for future patients?

CONCLUSION

This project contributes to existing literature about the integration of diversity courses into the curriculum of occupational therapy schools. It arose from questions about (a) the existence and severity of health disparities in occupational therapy and (b) the degree to which diversity courses may mitigate the effects of these disparities. It suggests that, when diversity courses include both understanding and experiential learning, they will lead to increased cultural humility among occupational therapy students. In turn, their ability to provide high-quality care to future patients will improve. Future research is needed to determine the long-term benefits and drawbacks of integrating diversity courses into the curriculum of occupational therapy schools.

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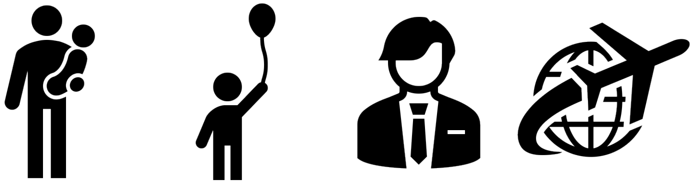
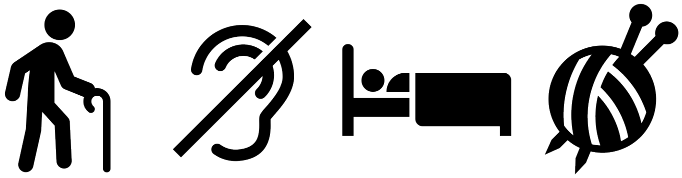
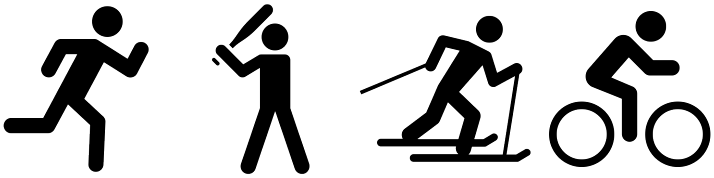
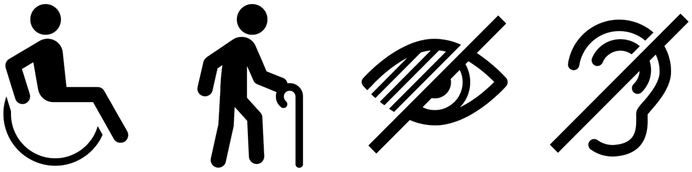
APPENDIX A

Category	**Items**
Good	Adore, Pleasure, Lovely, Delightful, Glad, Friendship, Attractive, Excellent
Bad	Dirty, Abuse, Annoy, Scorn, Gross, Hatred, Awful, Detest
Young people	
Old people	

The Age Implicit Association Test

APPENDIX B

Category	**Items**
Good	Adore, Pleasure, Lovely, Delightful, Glad, Friendship, Attractive, Excellent
Bad	Dirty, Abuse, Annoy, Scorn, Gross, Hatred, Awful, Detest
Non-disabled people	
Disabled people	

The Disability Implicit Associations Test