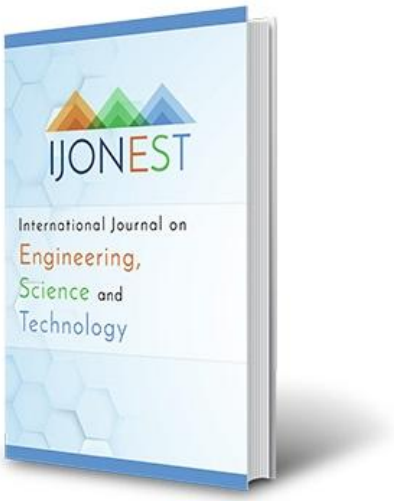

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A Social Work Centered Approach to Culturally Appropriate Healthcare

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Abstract

Navigating the healthcare system could prove arduous for the average person, and even more daunting for immigrants, minority and vulnerable persons. Similarly, the proficient delivery of healthcare services that promotes total well-being to help achieve desired health outcomes can also be a cumbersome process for healthcare providers attributable to the enormous task of ensuring equitable access to healthcare. Prevailing impediments in accessing healthcare include language barriers, lack of transportation, low health literacy, payment access, cost of accessing healthcare, culture, gender disparities and mistrust of healthcare providers. The increasing impact of culture on accessing healthcare cannot be overemphasized. While several scholarly works expound on culturally appropriate healthcare and endeavor to address the barriers to accessing healthcare through a clinical or public health lens, a social work-centered approach has not been adequately used in the existing literature on culturally appropriate healthcare. This article introduces a unique viewpoint and framework by exploring culturally appropriate healthcare through a social work centered lens. It offers insights on how healthcare providers, clinicians, and social workers can position themselves to foster culturally responsive healthcare through grounding holistic assessments to help clients access healthcare that honors client identity, mitigates disparities, and fosters trust.

Introduction

Culturally appropriate healthcare can be described as the intentional effort by healthcare providers to deliver excellent care with careful consideration of the patients' diverse cultural backgrounds. It is the commitment of the clinician to endeavor to understand how the patient's culture influences their understanding of the presenting symptoms to avoid stereotyping and seek to provide care that is respectful of patients' cultural beliefs. Nair and Adetayo (2019) have observed that "health is determined by many factors outside the traditional healthcare setting" (p.1) and it is imperative for healthcare providers to "collaborate effectively with individuals from different cultures; and such competence improves health care experiences and outcomes" (Nair & Adetayo, 2019.p.1; Stubbe, 2020).

Low socio-economic status is a key factor for poor health outcomes and is common among marginalized groups such as immigrants and minorities (Chang-Muy & Congress, 2023). A substantial portion of these groups are employed in low wage jobs that do not often provide health insurance coverage (KFF, 2022). This consequently

leads to reduced screening and preventive health visits, restorative care and disease management (Hendi & Ho, 2021). These marginalized groups and communities are also confronted with an array of systemic and logical challenges such as language barriers, stigma and marginalization, lack of transportation and health insurance, lack of adequate childcare, and many more (Moore, 2024). Salhi et al (2019) assert that " it is impossible to provide effective, appropriate, and compassionate care without consideration of the obstacles and conditions" (p. 90). According to Padela et al (2018), healthcare interventions that incorporate the cultural and unique needs of such individuals are lacking.

It is important for healthcare providers to recognize and assess the diverse cultural factors that impact the overall health and well-being of the client and commit to refine their expertise in the provision of services while being sensitive to the client's culture. Cultural consideration in the provision of healthcare is important because culture determines how one defines health (Chang-Muy & Congress, 2023). The clinician needs to also understand that client preferences differ, moreover, the expectations inherent to each client in accessing healthcare services are influenced by their unique cultural background or experiences.

Existing literature has predominantly examined culturally appropriate healthcare through a clinical or public health lens. These literature (Betancourt et al., 2002; Betancourt et al., 2003; AHRQ, 2016 ; Bowker & Kerkove, 2024; Hall et al., 2016; Metzl & Hansen, 2014; Soto et al., 2018; Troung et al., 2014) conceptualize culturally appropriate healthcare with an emphasis on applying cultural competence at multiple levels (clinician, institutional, and policy levels) to decrease ethnic and racial disparities in healthcare delivery to bring about systemic changes. Curtis et al (2019; 2025) critique the cultural competence framework and suggests a framework based on cultural safety to address systemic disparities.

Earlier scholars such as Tervalon & Murray-Garcia (1998) proposed culturally appropriate healthcare through cultural humility rather than cultural competence to emphasize a continuous self-reflection and recognition of relational dynamics. From these conceptual theories, the United States Department of Health and Human Services Office of Minority Health introduced the National Standards for Culturally and Linguistically Appropriate Services (CLAS) framework in the year 2000 which was later modified in 2013 (DHHS OMH, 2013).This framework which is prevalent in clinical and public health setting underscores culturally appropriate healthcare through organizational governance, policy analysis and implementation, advocacy, workforce diversity and systemic reflection.

While the literature and frameworks have expanded from cultural competence to cultural humility and cultural safety, few explicitly situate these frameworks within a holistic and social work centered lens. This study identifies the strengths and limitations of existing conceptual frameworks such as cultural competence and cultural humility and introduces social work values to address the gaps in shaping culturally appropriate healthcare. This study seeks to elucidate and expound on previous work on culturally appropriate healthcare to introduce a unifying framework across micro, mezzo, and macro levels. Through the evaluation of existing literature, this study will introduce a culturally appropriate healthcare framework through a social work lens. The new framework is unique with integrative approach that incorporates the ecological systems theory, and other social values concepts such

as empowerment across the multiple levels (micro, mezzo and macro levels). This multidimensional orientation and integrative approach are imperative to position healthcare providers including social workers to deliver culturally appropriate healthcare that produces positive health outcomes.

The social work profession mandates the application of standards and indicators that promote cultural sensitivity and competence in social work practice; These standards encompass without being restricted to 1. standard 2:- self-awareness-which urges social workers to be aware of their own personal cultural identities and that of their clients, and be culturally sensitive to their clients standard 3:- cross cultural knowledge-mandates social workers to further their knowledge of the diverse cultural components of different groups, standard 4:- cross cultural skills:- encourages social workers to apply skills that demonstrate comprehension and respect of culture, standard 5:- service delivery-encourages social workers to make referrals that are culturally appropriate and endeavor to address gaps in services that affect people within different cultures standard 9:- language and communication-mandates social workers to ensure and advocate for effective communication on behalf of clients from different cultural backgrounds and unique needs (NASW, 2015).

This study will discuss the conceptual foundations underlying the proposed framework while highlighting their strengths. It will introduce social work values and provide guidance on how these values can be integrated into providing culturally appropriate healthcare. A variety of case vignettes will be presented and explored to aid the reader in the comprehension of skills and techniques introduced. The social work centered approach to culturally appropriate healthcare framework will be presented with discussions, conclusions and further directions

Conceptual Foundations

Cultural Humility - Cultural Safety - Cultural Competence- Ecological Systems Theory

The framework for culturally appropriate healthcare through a social work lens will be grounded in key social work values and standards such as cultural humility, cultural safety, cultural competence, and ecological systems theory.

Cultural Competence

The term cultural competence which has become an ubiquitous term in the healthcare and human service sector, was introduced by Cross et al (1989) as “a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enable that system, agency, or those professionals to work effectively in cross-cultural situations” (p.13). According to (Lin et al., 2017; Bowker & Kerkove, 2024), cultural competence transcends the awareness of other cultures to develop effective skills and values to engage appropriately with persons and circumstances across cultures. For one to be culturally competent, one must recognize, comprehend, and appreciate the different cultural values that shape the individual, and endeavor to cultivate the requisite skillset to ensure a meaningful and effective relationship.

The national association of social workers reverberates that “cultural competence requires social workers to examine their own cultural backgrounds and identities while seeking out the necessary knowledge, skills, and

values that can enhance the delivery of services to people with varying cultural experiences" (NASW 2015, p.65). Cultural competence is however critiqued for envisioning a static outcome where one becomes an expert through the knowledge of skills and cultural beliefs (Duke et al., 2009; Kumagai & Lypson, 2009), "a catchphrase and an international flag of convenience" (Danso, 2018, p.415).

Cultural Humility

Cultural humility coined by Tervalon et al. (1998) is a process of continuous self-reflection and critique of the clinician's own biases and assumptions, while learning to understand the values of other different cultures. Cultural humility aspires to comprehend how one's own cultural values have shaped their biases and values (Foronda et al., 2015; Stubbe, 2020). The national association of social workers define cultural humility as "the attitude and practice of working with clients at the micro, mezzo, and macro levels with a presence of humility while learning, communicating, offering help, and making decisions in professional practice and settings" (NASW 2015, p.16). Gottlieb (2021) echoes that: "to practice cultural humility means to always consider the ways that the systems with which our clients interact have shaped their lives, their belief systems, their relationships, their sense of self, and the conditions that have brought them to our services." (n.p.). She emphasizes that social workers have to be willing to be "a student of the client rather than an expert" (Gottlieb 2020, p.4) teachable and accept missteps.

Cultural Safety

Cultural safety is effectively ensuring that persons we work with feel safe and respected especially in healthcare settings. A key emphasis of cultural safety is the power differences between clinicians and clients. Proposed in the 1990's by Ramsden (2015), they define cultural safety as "a focus for the delivery of quality care through changes in thinking about power relationships and patients' rights" (Papps & Ramsden 1996, p.493). Beyond merely understanding other cultures, cultural safety emphasizes the need for clinicians to recognize the power imbalances between them and patients (Papps & Ramsden, 1996); Laverty et al., 2017) and "allow the patient to determine whether a clinical encounter is safe" (Curtis et al. 2019, p.16). Clinicians need to understand how their own cultures, assumptions and biases influence service delivery.

Comparisons and Contrasts: Cultural Humility-Cultural Safety and Cultural Competence

Cultural competence emphasizes a goal where one becomes an expert of other cultures (Duke et al., 2009; Bowker & Kerkove, 2024) whereas cultural humility underscores a lifelong process with no end point, where one is continuously learning (Lekas et al., 2020). While cultural competence assumes the social worker understands the values of the client, cultural humility presupposes the client is an expert of their circumstances. Again, as cultural competence utilizes an objective approach to practice, cultural humility uses a subjective approach (Patros & Grosky, 2024; Wheeler, 2018). However, both cultural humility and cultural competence focus on understanding the culture of the client, while cultural safety prioritizes accentuation of the social worker's own culture (Curtis et al., 2019). Surpassing a goal [cultural competence] or an ongoing process [cultural humility], cultural safety is

argued to be a paradigm shift, a more dramatic change of approach (Bowker & Kerkove, 2024). Cultural safety is proactive and radical, "effectively rejecting the more limited culturally competent approach for one based not on knowledge but rather on power" (HQSC, 2017, p.10). It is worth mentioning that cultural humility [a process] combined with cultural competence [a product] results in cultural safety [a paradigm shift] which automatically improves the health outcomes of the client. Juxtapose to that, the social worker needs cultural humility and cultural safety to be culturally competent (Bowker & Kerkove, 2024).

Ecological Systems Theory

The Ecological Systems Theory (ecosystems) which is grounded in the Person In Environment Theory (PIE) asserts that individuals are continuously impacted by their environment and vice versa. Developed by Bronfenbrenner in 1979, the ecosystems theory describes the five systems within the environment, which are the microsystem, mesosystem, exosystem, macrosystem, and chronosystem (Patros & Growsky, 2024; Snyder & Duchschere, 2022). The microsystem consists of the individual's immediate environment, where most interactions occur like family, school, peers, religious organization, etc. (Brofenbrenner, 1979; Hoskin & Ellis; 2015; Lim et al., 2019).

The mesosystem is the connections and relationships between the microsystem and the larger environment (Bronfenbrenner, 1979). Examples include the family's interaction with the school, family and court system, family and healthcare system, among others (Snyder & Duchschere 2022). The exosystem is the indirect environment of the individual (Bronfenbrenner, 1979) and comprises of extended family members, parents' economic situation, neighbors, social services, school board, mass media. The macrosystem is the larger environment like social and cultural values, policies, laws, etc. that impacts the individual (Bronfenbrenner, 1979; Patros & Growsky, 2024).

The chronosystem is the history and timing of events over time during one's life. Examples are the stages between birth to childhood, the teenage stage, the youthful stage, young adult stage, adulthood, puberty, etc. All the environmental systems according to Bronfenbrenner (1979), are fluid and are constantly interacting with each other. For clinicians to engage in impactful interventions and foster the well-being of clients, the clinician must first discern the critical elements of the surrounding milieu that affect the individual since persons are shaped by their environment (Patros & Grokowsky, 2024; Tyler, 2024).

Integrating Social Work Values in Culturally Appropriate Healthcare

Social workers core function revolves primarily around the vulnerable, oppressed, and marginalized persons (NASW, 2021). Thus, in any therapeutic relationship, social workers are cognizant that the client's presenting symptoms are influenced by multiple factors linked to their physical and social environments. Therefore, in working with clients to access healthcare, social workers utilize broad problem-solving processes to intervene at multiple levels. The multiple levels are 1) micro level 2) mezzo level and 3) macro level. Working across multiple levels is a fundamental principle of the ecosystem theory which also stresses that one should not work with an

individual exclusive of their environment (Pomeroy & Garcia, 2018) since individuals are shaped by their environments and vice versa.

Several problem-solving processes and techniques available to social workers at the micro level as they engage with clients are empathy, building rapport, motivational interviewing, communication [verbal and nonverbal], affirmation, compassion, seeking concreteness, patience and silence, authentic connection, summarizing response, acknowledging client's feelings, minimal encouragers, humor, starting where ethe client is, self-disclosure, etc. These techniques forge a solid foundation to foster strong relationships (Blundel, 2023). Tools such as ecomap, genogram, culturagram, and many more are also effective family assessment and visual tools for social workers to utilize as they engage with clients in accessing healthcare services (Hepworth, et al., 2023).

These family assessment tools help the clinician gain different perspectives on a client's family dynamics and unique environment. Culturagram, originally introduced by Dr. Elaine Congress (Congress, 2008) goes a step further than ecomap and genogram to enable clinicians gain a clearer understanding of a client's cultural background and its influence (Rapp-McCall et al., 2022). Culturagram is an indispensable tool for clinicians in helping individuals access appropriate healthcare and subsequently guides the decision and selection of suitable and effective interventions and treatment options. The posture of humility and readiness to learn from the client [cultural humility] enables the clinician to understand the health needs of the individual using culturagram.

It is imperative to highlight how some individuals may have multiple cultural backgrounds, and it is incumbent upon the social worker to identify these multiple cultural backgrounds and their influence. For example, an individual can be born in the United States to an Asian father and Middle Eastern mother. The individual's values, beliefs, and opinions consequently will be shaped by both [Asian and Middle Eastern] cultures. With a person in environment focus, the social worker transcends mere identification of the person to discern environmental and cultural dynamics that impact the individual and seeks interventions that improve the total wellbeing of the individual including spiritual, mental, physical and emotional wellbeing (Hardee et al., 2019).

As noted in the preceding discussion, persons from marginalized communities are often not comfortable sharing their personal information about their health when asked by healthcare providers (LaMotte et al., 2022) owing to frequent negative experiences in accessing healthcare which leads to mistrust in the healthcare system (Hardee et al., 2019). The initial approach to addressing this necessitates the application of welcoming skills such as a warm greeting accompanied by a broad smile, and using the client's name which makes the client feel welcome and at ease. Similar approaches such as building rapport and communicating empathy through active listening, attentive posture, body language, starting where the client is, (Pomeroy, & Garcia, 2018; Trevithick, 2000; Voutilainen et al., 2018) are all basic skills social workers can utilize to establish a conducive atmosphere for engagement and fruitful discussions, and create a positive and authentic trusting connection with clients (Fuehrer et al., 2024).

This authentic and trusting relationship enables the client to open up and willingly divulge personal information about any health challenges as they feel valued, seen, and heard. When we communicate empathy, clients feel validated instead of feeling judged as we are conveying support, care and understanding. Additional practical

techniques include patience and compassion. When health diagnosis is complex, longer duration of treatment is needed, and clients are encountering barriers to accessing healthcare, social workers can use patience to demonstrate compassion (Sinclair et al., 2016) and help clients navigate the complex conditions they face. For instance, giving enough time for client to process information and asking questions, gently repeating information to ensure client understands diagnosis, allowing clients to fully express themselves without interruptions even when concerns seem minor. Patience allows the social worker to guide the client to have clarity and desist from making hasty health decisions. Patience also allows the social worker to see the medical situation through the client's eyes.

Compassion can be expressed by "acknowledging client's feelings" (Pomeroy & Garcia, 2018, p. 67) and "responding to their nonverbal cues" (Hepworth et al., 2023, p. 170). Nonverbal cues such as furrowed brow, avoiding eye contact, grimacing, fidgeting and tense jaw can reveal information that might not be explicitly stated. Responding to such cues by using warm and reassuring body gestures such as eye contacts, asking genuine questions about how diagnosis impacts daily life, and following up after appointments to check on how clients are coping are practical ways of showing compassion which promotes healing and total wellness. Compassion allows social workers to see clients beyond their presenting circumstances to provide dignified support.

Clients need to feel supported by their healthcare providers. This builds trust which enables clients to be forthcoming with sensitive health and personal health information. This, however, requires an intentional effort from social workers to encourage clients to articulate relevant details to ensure thorough understanding of health challenges and provide effective solutions. To do this, skills such as minimal encouragers and minimal prompts, leading questions, motivational interviewing (Blundell, 2023; Hepworth, 2023; Reiter, 2022), affirmations (Hepworth et al., 2017) probing for more information through clarification , normalizing can be utilized. Expressions such as "oh I see", "mmm" "tell me", "tell me more", "mmm hmmm", "really?", (Hepworth et al., 2017, p.148) and body gestures like leaning slightly forward, nodding, eye contact, a smile, are all useful in creating a safe space and encouraging the client to speak. This conveys to the client that the social worker is present and is interested in what they're saying. It gives the client a reassurance of being understood, providing a conduit for the elucidation of the true extent of their challenges.

Affirmations such as "you are strong", "you're making the right choices", "you can do this", "you are surrounded by a skillful and dedicated team", "you are capable", "you are resilient", "healing takes time and you'll get through this", "your illness does not define you", all have a positive impact on the client's health and total wellbeing. Humor and self-disclosure (Blundell, 2023; Hepworth et al., 2017, p. 109.) when used appropriately by social workers can ease any tension and create a sense of camaraderie between them and clients. For instance, when a client is expressing fear with a treatment, surgery or diagnosis, the clinician can share their own fear, or anxiety with similar situations in the past to reassure the client and connect with them. Self-disclosure is an effective tool in bridging cultural gaps between social workers and clients, and normalizes struggles (Walters, 2007; Dewane 2006; Edwards & Bess, 1998). It dismantles power imbalances and facilitates healing.

Humor also helps shift the client's focus on stress emanating from difficult diagnosis and offers a fresh perspective

on viewing the situation. Carefully thought-out humor like commenting on the lengthy paperwork to be filled out, social worker sharing spilling of coffee on themselves before starting day, etc. Humor significantly reduces stress and helps clients gain control of their situation which fosters resilience (Blundell, 2023).

It is pertinent to highlight that common communication styles have cross cultural semantic variation and social workers have to ensure that their communicative intent are perceived and understood by the client correspondingly and vice versa. Communication gestures such as facial expressions, eye contact, silence, tone and volume of speech, directedness, and many others have contextual differences in interpretation (Hepworth et al., 2023; Pomeroy & Garcia, 2018). Some examples of these include; While maintaining eye contact is encouraged in the American culture during communication, this is perceived to be very disrespectful in some Asian cultures. Even though the social worker might offer to shake hands with a client to let the client feel welcome, shaking of hands with the opposite sex is eschewed in the Moslem and some cultures. In some Latin American and Asian cultures, difficult medical diagnosis or negative issues are not communicated directly to the patient while it is perfectly normal to disclose such information directly to the patient in the US culture, and a thumbs up may be perceived as offensive behavior by other cultures.

To avoid ambiguity and ensure aptness of communication, skills such as clarification, furthering responses, seeking concreteness, seeking client feedback, closed-ended question, and summarizing (Hepworth et al., 2023; Pomeroy, & Garcia, 2018; Hepworth. et al., 2023, p. 143) can be utilized. By way of illustration, politely asking clients to repeat or summarize what has been said to confirm understanding, asking clients "what their thoughts are" on what is being said, asking closed ended or targeted questions like are you "comfortable with this option?" can be effective tools for social workers to ensure full comprehension and clarity of client's needs [and vice versa] and avoid ambiguity. Applying these skills ensures that the social worker has a clear and accurate understanding of the client's situation, resulting in a strong therapeutic relationship and providing accurate intervention and treatment.

As previously mentioned, culturally appropriate healthcare through a social work centered lens necessitates a holistic approach where social workers not only work with clients at the micro level but also at the mezzo and macro levels. The PIE theory postulates that an individual is affected by their environment, similarly as the environment is affected by the individual. Hence, considering environmental factors in a therapeutic relationship is imperative for effectual results (Salhi et al., 2019; Snyder, & Duchschere, 2022). At the mezzo level, social workers need to assess the client's family and social functioning, and additionally assess the supports available within the family, religious and local community. As an illustration, the social worker might need to know of client's relationship with spouse, parents, siblings, etc. and their ability to provide support, and more importantly how the current diagnosis impacts the family. Client's relationship with neighbors, community members, religious affiliation, and other group memberships are all vital in identifying the supports and resources available to the client. In most cases, community discouragement of disclosures, lack of family support for medical treatment, lack of understanding of the purpose of treatment, and childcare are a few barriers to address at the mezzo level. The social worker can partner with the family and local support or religious groups to ensure that the client is receiving holistic care. Additional roles at the mezzo level are for the social worker to act as a broker and connect

the client with needed resources, and advocate for Culturally and Linguistically Appropriate Services (CLAS) to ensure services provided are respectful of client's cultural beliefs and practices.

At the macro level, the social worker should promote organizational and institutional changes, and advocate for responsive and social policies to address barriers such as lack of transportation, lack of health insurance, stigma, marginalization, poor housing conditions, and linguistic barriers. Social workers can initiate trainings for interdisciplinary providers in addressing linguistic barriers to ensure cultural sensitive care. Furthermore, social workers can partner with local community clinics and organizations to provide screenings, disease management, health education, and basic preventative care. They can also advocate for resources to address service gaps, and educate service delivery systems to better meet the needs of clients.

To fully comprehend all the techniques and skills mentioned above, let us delve deeper into a few case vignettes.

Micro level Case Vignettes

1. **Focus Skills: Patience, Compassion, Empathy, and Cultural Sensitivity.** Mrs. Abiola is a middle-aged woman originally from Nigeria who just got divorced by her husband of 30 years of marriage. She has no children with her former husband. She has undergone multiple hospitalizations after the divorce for chest pains, frequent headaches and extreme fatigue. Her primary care provider suspects depression but Mrs. Abiola refuses this diagnosis and reluctantly meets with the behavioral health social worker at the behest of the primary care provider. Obviously guarded, the social worker, rather than imposing any labels or judging, patiently listens while validating Mrs. Abiola's pain. She articulates to Mrs. Abiola, "it must be so hard for you to experience this pain, and I'm here to support you". With empathy, patience and compassion from the social worker, Mrs. Abiola willingly divulges about her loneliness and expresses her desire for a local community or church group. She also asks for faith-based counselling. The social worker connects her to a colleague who has a private Christian counselling practice and a local community networking group. There have been no documented hospitalizations since then. This case demonstrates how patience, empathy, compassion and cultural sensitivity help bridge cultural gaps, creating cultural safety and leading to a trusting therapeutic relationship (*This case vignette is hypothetically constructed by author for illustration purposes only. All characters are imagined and not real).*

2. **Focus Skills: Cultural Humility, Seeking Concreteness, Clarification, and Summarization.** Ajara is a young Azerbaijani American woman. She has been seeking treatment with multiple providers but no diagnosis has been found. She complains of fatigue and not "able to think straight". She uses terms such as "I feel like a broken phone," "I can't explain it", "life is heavy", etc. Applying cultural humility, the social worker uses clarifying questions and asks Ajara respectfully, "when you say I feel like a broken phone, what do you mean"?, when you say 'heavy,' do you mean physically, emotionally, or something else? As Ajara expounds on this, the social worker seeks concreteness by asking "how does a typical day look like for you?" The social worker having synthesized the various aspects of the conversation,

summarizes and expresses“ so what I'm hearing is that you're navigating a lot between your family, work, and school, and that is causing you a lot of stress". Ajara confirms this and the social worker recommends relaxation techniques, healthy lifestyle habits, and therapy, to which Ajara is thankful. This case exemplifies how social workers use clarifying questions and seeking concreteness to understand the client. This also helps the client to connect emotional stress to physical symptoms (*This case vignette is hypothetically constructed by author for illustration purposes only. All characters are imagined and not real*)

3. **Focus Skills: Minimal Encouragers, Humor, Motivational Interviewing, and Self-Disclosure.** Sharniece is in her senior year of high school. She was involved in an alcohol incident and altercation with her friends. She is resistant, hardly answers any questions and tells the school social worker she has everything under control. The social worker responds by saying " I wasn't a saint at age 18 either". With this humor, the emotional temperature of the room is lowered and cultural safety is created. Sharniece feels at ease and expresses her frustration of being frequently judged. The social worker uses minimal encouragers such as ", mmmm, I hear you" and appropriate body posture (leaning slightly forward) to encourage her to keep talking. The social worker continues to use motivational interviewing techniques through reflective listening, "on one hand, you're saying you've got this under control, and on the other hand, your colleagues seem very worried. How do you make sense of that?" After much conversation, the social worker uses self-disclosure which helps Sharniece with tips on navigating peer pressure. Sharniece is content and satisfied, and states that finally someone "gets me". This case vignette illustrates how humor, self-disclosure, and reflective listening reduces power imbalances to create cultural safety. *(This case vignette is hypothetically constructed by author for illustration purposes only. All characters are imagined and not real).*

Mezzo Level Case Vignettes :Focus Skills: Broker, Educator, Advocate, Coordinator, Liaison

1. A middle-aged Afghan refugee mother (Zarina) of four came to the hospital today with her 4 year old daughter with speech and social-emotional delay. As with hospital policy, an interpreter is used by phone as the mother understands very little English. Zarina verbalizes concern that her child would be taken away from her, and fears that her child is being labeled "abnormal." The social worker assures her that her child will not be taken away from her and takes her through culturally sensitive psychoeducation session about child development, highlighting family strengths. At the next visit, the social worker advocates and arranges for an in-person interpreter. She connects Amina with a bilingual case manager and introduces her to a local Somali mothers' support group. Amina thanks the social worker and conveys to her that she now feels at peace and comfortable. *(This case vignette is hypothetically constructed by author for illustration purposes only. All characters are imagined and not real).*
2. The occupational therapist informs the school social worker of Yussef's frequently missed therapy sessions. The social worker is concerned and schedules a home visit with a bilingual community liaison. During the visit, they realize that Yussef's mother is having a difficult time with caregiving and navigating resettlement systems, afraid of public transportation, and lonely. Together with the community liaison, they partner with the local mosque's women's group to check on her frequently and

help with transportation. They also connect her to a nonprofit organization to address housing instability and access interpretation services. Yussef now attends therapy sessions regularly and her mother feels empowered. (*This case vignette is hypothetically constructed by author for illustration purposes only. All characters are imagined and not real).*

The above mezzo level cases underscore the importance of how social workers serving as brokers, educators, liaison, advocates and community connectors can activate culturally congruent support systems and foster resilience.

Macro Level Case Vignette- Focus Skills- Assessment, Research, Advocacy, Lobbying, Policy Reform

1. Mr. Stefan Miller is a 75 year old African American man living in a rural town where public transportation is limited. He has chronic heart disease, limited mobility and digital literacy challenges. He frequently misses cardiology appointments as he has no means of transportation even though he is eligible for Medicare. He also expresses mistrust of medical providers based on a long history of racial discrimination in healthcare. He's not the only one to express such concerns so the clinical social worker conducts a needs assessment and presents the findings to the county health board. She collaborates with local faith-based organizations and a transit agency to pilot a community seniors shuttle program for medical appointments. At the policy level, she works with an aging advocacy network to lobby the state legislature for increased funding to expand mobile health clinics and digital inclusion programs for rural seniors. Mr. Miller now consistently attends all appointments, and his heart disease is being better managed now. This case demonstrates how social workers can empower systems to be more inclusive especially for historically marginalized populations (*This case vignette is hypothetically constructed by author for illustration purposes only. All characters are imagined and not real).*

Case Vignette That Integrates All Levels of Practice: Micro, Mezzo and Macro Level.

Mrs. Kayla Gomez is a 65 year old Afro-Caribbean woman living with her daughter and teenage grandchildren. She has been diagnosed with ovarian cancer but has an issue with medical mistrust. She has very limited access to oncology services as they live in a predominantly black and immigrant neighborhood. She is considering prayer and natural herbs rather than chemotherapy for treatment. At the micro level, the clinical social worker uses empathy and authenticity to build rapport. She tells Mrs. Gomez, "It's completely normal to feel anxious about starting chemotherapy. Many patients share similar concerns, and we'll support you every step of the way" She continues to use motivational interviewing techniques and cultural humility to validate her fears while gently exploring her health beliefs: "On one hand, you believe in natural healing, and on the other, you're worried the cancer may spread. How are you holding both?" As the conversation continues, the social worker uses compassion and minimal encouragers like " I hear you" while gently nodding to show understanding. She adds self-disclosure to build trust and shares that feeling conflicted when navigating multiple health belief systems is common with many clients. Through clarification and summarizing, the social worker helps Mrs. Kayla to articulate her treatment challenges more clearly, allowing for shared decision-making with her care team.

Recognizing the importance of community and religion to Mrs. Kayla, the social worker at the mezzo level, partners with Mrs. Kayla's pastor to organize a family meeting to discuss how she can be supported and substantiate collective understanding. The social worker connects Mrs. Kayla to a local ovarian cancer support group for black women, reinforcing cultural identity and reducing isolation. The social worker realizes systemic patterns of rejecting treatment due to cultural mistrust and brings this to the attention of the management of the hospital. She proposes culturally responsive oncology orientation sessions in partnership with trusted community leaders. She also advocates for transportation vouchers and interpretation services to reduce access barriers for non-native English speakers. Mrs. Gomez has started chemotherapy treatments while attending prayer services at church. Her progress is demonstrably significant and her family is thankful.

The above case vignette provides compelling evidence on how social workers can apply therapeutic and clinical skills to intervene at multiple levels to address complex issues to bring holistic care while addressing the root cause of disparities. (*This case vignette is hypothetically constructed by author for illustration purposes only. All characters are imagined and not real).*

Proposed Social Work Centered Framework for Health Care

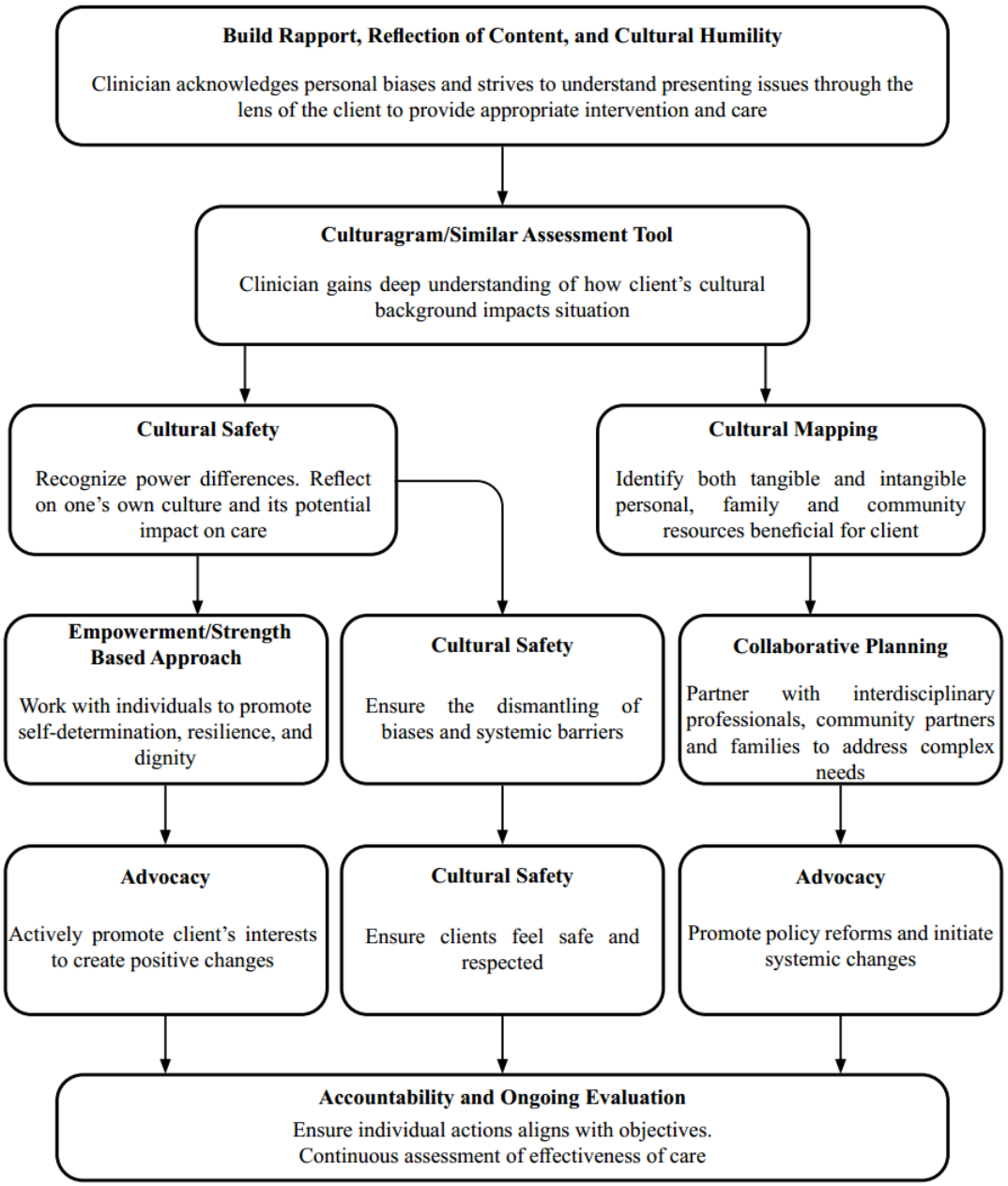
Society is rapidly converging toward a global community of culturally and ethnically diverse groups. The need for integrative models of healthcare that responds and addresses the psychosocial, cultural, and structural needs of persons cannot be overemphasized (Govere & Govere, 2016; Stubbe, 2020). The *Social Work–Centered Cultural Care Framework* grounded in cultural humility, cultural safety and advocacy is being proposed for social workers, clinicians, and all healthcare providers to aid in providing holistic care that bridges cultural divides and dismantles systemic inequities while fostering person centered care. Integrating a generalist stance with interventions across micro, mezzo and macro levels, this framework provides a practical roadmap for a culturally appropriate healthcare that brings human dignity and total wellness to individuals.

The proposed framework (see Figure 1) depicts the roadmap to culturally appropriate healthcare through a social work centered lens. The arrows pointing down shows how each stage of the framework progresses to the next. At the initial clinician/patient encounter, it is incumbent upon the clinician to build rapport with the patient to cultivate trust [Build rapport]. The patient is most likely to divulge pertinent health information to their providers when they feel safe, supported and comfortable. It is crucial for the clinician to contextualize symptomatology within the patient's comprehension by reflecting on information provided and asking any clarifying questions [reflection of content]. This will necessitate the clinician assuming the position of student learner whiles being aware of their own biases(Lekas et al., 2020; Stubbe, 2020) as the patient explains presenting symptoms [cultural humility]. This effort will establish a solid bedrock for an excellent therapeutic relationship between the clinician and patient.

In accordance with our prior discussion on the ecosystems theory, several environmental factors impact the overall wellbeing of the individual (Moore, 2024; Salhi et al., 2019). Hence, utilizing a strengths-based assessment tool such as culturagram enables the clinician to gain full comprehension of how client's cultural, social and other

external factors impact not just presenting symptoms but client's understanding of them. With a meticulous understanding of the multidimensional facets of symptomatology, the next step for the clinician is to dismantle any power imbalances by ensuring the patient is comfortable to share any differing views or ask questions without hesitancy [cultural safety]. Any power differences should be addressed appropriately whilst paying attention to patient's interests (Stubbe, 2020). It is imperative for this to be enforced throughout the therapeutic process to ensure patients feel safe and respected. The clinician's awareness of patient's strengths and choices, and recognition of working *with* the patient and not *for* the patient, [empowerment/strengths based approach] is crucial.

Social Work–Centered Cultural Care Framework



Source: Model designed by author with ideas from Bowker & Kerkove, 2024

Figure 1. Social Work-Centered Cultural Care Framework

Utilizing an assessment tool such as culturagram as aforementioned helps the clinician gain a holistic understanding of clients' complex needs and the various systems withing the client's environment that needs intervention. Informed by that knowledge, the ensuing action is to identify resources [both tangible and intangible] beneficial to clients total health and wellness [cultural mapping]. These resources in addition to appropriate medication include local community health centers for follow up health maintenance and wellness programs, local organizations that provide services such as local meal delivery, non-emergency transportation, etc. to address social determinants of health, family members, local support groups, religious groups, and friends. All these resources and inputs are important in the delivery of holistic and culturally appropriate healthcare. Where necessary, the clinician must work together with community partners and other interdisciplinary professionals such as physical therapists, dieticians, social workers, occupational therapists to ensure that all aspects of the patients' needs are addressed [collaborative planning].

Collaborating with interdisciplinary professionals and community partners can be challenging, as each function under different guiding policies, values and standards. This can be a precursor to compromise patients' needs and interests. To mitigate against this possibility and guarantee that patients' needs are addressed, the clinician must actively promote the patient's interest [advocacy] concurrently guaranteeing that the patient feels respected and heard [cultural safety].

Culturally appropriate healthcare through a social work centered lens is not merely the clinician's imagined destination, but a deliberate and continuous endeavor in the delivery of healthcare, where the healthcare provider continually evaluates interventions being provided to substantiate their effectiveness and compatibility with the patient [Accountability and Ongoing Evaluation]. Total patient satisfaction is achieved when healthcare services are accessible, and addresses patients' complex needs. Utilizing the social work-centered cultural care framework is a positive stride to enable healthcare providers to deliver sound, holistic healthcare that aligns with the patient's cultural and social values.

Conclusion and Future Directions

Culturally appropriate healthcare has made significant strides evolving from cultural competence to cultural humility with contributions from public health and other clinical disciplines with the passage of time. The integration of a social work lens is however important for improving health outcomes, promote health equity, and foster justice within healthcare systems as it addresses the lived experiences of patients, challenges systemic inequities, and promotes health equity which is much needed in today's society of diverse cultures . This multidimensional orientation ensures that patients are not just recipients of healthcare services, but collaborators in ensuring patient centered interventions and creating culturally responsive environments. This offers a unique opportunity for social work to serve as bridge discipline and critical leaders in influencing systems to bring about policy changes to reduce health disparities.

The proposed social work–centered cultural care framework provides profound and practical insights to transform healthcare environments, foster community engagement and policy reform. True cultural responsiveness is

multidimensional, and social workers must strive beyond individual solutions to challenge institutional discrimination and promote equity. The proposed framework provides a pathway to utilize broad system-based approaches to intervene at all levels to improve health outcomes and restore dignity for marginalized populations. The integration of ecological systems theory, cultural humility, cultural safety, and empowerment approaches makes the social work centered culture care framework an excellent tool for healthcare providers, clinicians and social workers. Culturally appropriate healthcare is not just a static point or best practice, but a continuous reflection, acclimatization and systemic restructuring. It is an ethical imperative that involves a deep humility and commitment to practice that transforms every level.

Educational curriculums should be expanded to encompass the social work centered approach to culturally appropriate healthcare. It is imperative for this framework to be included in training programs and modules for clinicians, social workers, and healthcare professionals. Institutional policies should integrate this framework to reflect interdisciplinary collaboration and leadership accountability. Research efforts steered by social workers should be conducted to evaluate the outcomes of culturally integrated interventions in healthcare settings and beyond. With the ever-increasing diversity in communities and societies, culturally grounded practices will become the norm rather than an exception

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References

Agency for Healthcare Research and Quality (AHRQ). 2016. *Cultural Competence Resources for Health Care Providers*. https://www.ahrq.gov/topics/cultural-competence.html

Betancourt, J. R., Green, A. R., & Carrillo, J. E. (2002). *Cultural Competence in Health Care: Emerging Frameworks and Practical Approaches.* The Commonwealth Fund.

Betancourt, J. R., Green, A. R., Carrillo J. E., & Ananeh-Frimpong, O. (2003). *Defining Cultural Competence: A Practical Framework for Addressing Racial/ethnic Disparities in Health and Health Care.* Public Health Reports, 118(4), 293–302. doi:10.1093/phr/118.4.293.

Blundell, P. (2023). *Humour as a Boundary-Breaker in Social Work Practice. Ethics and Social Welfare,* 17(2), 206–220. https://doi.org/10.1080/17496535.2023.2204448.

Bowker, D. M., & Kerkove, K. S. (2024). *Social Determinants of Health in Nursing Education: Integrating into Curriculum and Practice*. Iowa State University Digital Press.

Bronfenbrenner, U. (1979). *The Ecology of Human Development: Experiments by Nature and Design.* Harvard University Press.

Chang-Muy, F., & & Congress, E. P. (2023). *Social Work With Immigrants and Refugees: Legal Issues, Clinical Skills, and Advocacy* (3rd ed.). Springer Publishing Company.

Congress, E. (2008). *The Culturagram*. In Roberts, A. (2008). *Social Work Desk Reference* (2nd ed., pp. 969-

973).New York: Oxford University Press.

Rapp-McCall, L., Roberts, A., & Corcoran, K. (2022). *Social Workers' Desk Reference* (4th ed.). Oxford University Press.

Cross, T. L., Bazron, B. J., Dennis, K. W., & lsaacs, M. R.(1989) *Towards a Culturally Competent System of Care: A Monograph on Effective Services for Minority Children Who Are Severely Emotionally Disturbed.* CASSP Technical Assistance Centre. Washington DC: Georgetown University Child Development Center.

Curtis, E., Jones, R., Tipene-Leach, D., Walker, C., Loring, B., Paine, S. J., & Reid, P. (2019). *Why Cultural Safety Rather Than Cultural Competency is Required to Achieve Health Equity: A Literature Review and Recommended Definition.* Int J Equity Health;18(1):174. doi: 10.1186/s12939-019-1082-3. PMID: 31727076; PMCID: PMC6857221.

Curtis, E., Loring, B., Jones, R., Tiene-Leach, D., Walker, C., Paine, S. J., & Reid, P. (2025). *Refining the definitions of cultural safety, cultural competency and Indigenous health:* lessons from Aotearoa New Zealand. Int J Equity Health.;24(1):130. doi: 10.1186/s12939-025-02478-3. PMID: 40346663; PMCID: PMC12063315.

Danso, R. (2018). *Cultural Competence and Cultural Humility: A Critical Reflection on Key Cultural Diversity Concepts.* Journal of Social Work, 18(4), 410–430. https://doi.org/10.1177/1468017316654341

Dewane, C. J. (2006). *Use of self: A Primer Revisited*. Clinical Social Work Journal 34(4), 543-558. https://doi.org/10.1007/s10615-005-0021-5

Duke, J.A.N., Connor, M., & McEldowney, R. (2009). *Becoming a Culturally Competent Health Practitioner in the Delivery of Culturally Safe Care: A Process Oriented Approach.* Journal of Cultural Diversity, 16(2):. 40–49.

Edwards, J. K., & Bess, J. M. (1998*). Developing Effectiveness in the Therapeutic Use of Self*. Clinical Social Work Journal, 26, 89-105. https://doi.org/10.1023/A:1022801713242.

Foronda, C. , Baptiste, D- L., Reinholdt, M. M., & Ousman, K. (2015). *Cultural Humility: A Concept Analysis*. Journal of Transcultural Nursing. 2015;27(3):210-217. doi:10.1177/1043659615592677

Fuehrer, S., Weil, A., Osterberg, L. G., Zulman, D. M., Meunier, M. R., & Schwartz, R. (2024). *Building Authentic Connection in the Patient-Physician Relationship*. Journal of Primary Care & Community Health,15. doi:10.1177/21501319231225996

Gottlieb, M. (2020). The Case for a Cultural Humility Framework in Social Work Practice. *Journal of Ethnic & Cultural Diversity in Social Work*, *30*(6), 463–481. https://doi: 10.1080/15313204.2020.1753615

Gottlieb, M. (2021). *What is cultural humility ? 3 Principles for social workers*. The New Social Worker .https://www.socialworker.com/feature-articles/practice/what-is-cultural-humility-3-principles-for-social-workers/

Gover, L., & Govere, E. M. (2016). *How Effective is Cultural Competence Training of Healthcare Providers on Improving Patient Satisfaction of Minority Groups?* A Systematic Review of Literature. Worldviews Evid Based Nurs;13(6):402-410. doi: 10.1111/wvn.12176. Epub. PMID: 27779817.

Hall, G. C., Ibaraki, A. Y., Huang, E. R., Marti, C. N., Stice, E.(2016). *A Meta-Analysis of Cultural Adaptations of Psychological Interventions;* Behav Ther;47(6):993-1014. doi: 10.1016/j.beth.2016.09.005. Epub. PMID: 27993346.

Hardee, S. K., Sanford, G., Burnes, D.,(2019). "Historic and Current Health Care Struggles for the Homeless and Skills for Providers to Improve Care". *Archives of Family Medicine and General Practice*. **4** (1). doi:10.36959/577/486.

Health Quality & Safety Commission. (2017). *A Window on the Quality of New Zealand's Health Care.* Wellington, New Zealand.

Hepworth, D. H., Rooney, R. H., Rooney, G. D., & Strom-Gottfried, K. (2017). *Direct Social Work Practice : Theory and Skills* (10th ed.). Cengage Learning.

Hepworth, D., Vang, P. D., R., Blakey, J., Schwalbe , C., Evans, C., Dewberry-Rooney, G., & Strom-Gottfried, K (2023). *Empowerment Series: Direct Social Work Practice.* Cengage Learning

Hendi, A. S., & Ho, J. Y. (2021*). Immigration and Improvements in American Life Expectancy*. *SSM—* Population Health, 4;15:100914. doi: 10.1016/j.ssmph.2021.100914. PMID: 34522764; PMCID: PMC8426263.

Hoskin, A. W., & Ellis, L. (2015*). Fetal Testosterone and Criminality: Test of Evolutionary Neurocardiogenic Theory.* Criminology, 53(1), 54–73. https://doi.org/10.1111/1745-9125.12056

Kaiser Family Foundation (KFF). www.kff.org

Kumagai A., Lypson, M.(2009). *Beyond Cultural Competence: Critical Consciousness, Social Justice, and Multicultural Education*. Acad Med. 2009 Jun;84(6):782-7. doi: 10.1097/ACM.0b013e3181a42398. PMID: 19474560.

LaMotte, J. E., Hills, G. D., Henry, K., & Jacob, S. A. (2022). *Understanding the Roots of Mistrust in Medicine: Learning from the Example of Sickle Cell Disease*. J Hosp Med. J;17(6):495-498. doi: 10.1002/jhm.12800. Epub. PMID: 35535934; PMCID: PMC9303871.

Laverty, M., McDermott, D.R., & Calma, T.(2017). *Embedding Cultural Safety in Australia's Main Health Care Standards*. Med J Aust;207(1):15-16. doi: 10.5694/mja17.00328. PMID: 28659104.

Lekas, H. M., Pah, K., Lewis, C. F. (2020). *Rethinking Cultural Competence: Shifting to Cultural Humility*. Health Services Insights, 13:1178632920970580. doi: 10.1177/1178632920970580. PMID: 33424230; PMCID: PMC7756036.

Lim, S., Lambie, I., & Van- Toledo, A. (2019). *Characteristics of female youth offenders in New Zealand.* International Journal of Offender Therapy and Comparative Criminology, 63(2), 198–217.https://doi.org/10.1177/0306624X18799002

Lin, C. J., Lee C. K., & Huang, M. C.(2017). *Cultural Competence of Healthcare Providers: A Systematic Review of Assessment Instruments.* J Nurs Res. 2017;25(3):174–86. doi: 10.1097/JNR.0000000000000153. PMID: 28481813.

Metzl, J. M., & Hansen, H. (2014). *Structural Competency: Theorizing a New Medical Engagement with Stigma and Inequality.* Soc Sci Med;103:126-133. doi: 10.1016/j.socscimed.2013.06.032. PMID: 24507917; PMCID: PMC4269606.

Moore, P. L. (2024). *The Impact of COVID-19 on Diverse Communities During the Pandemic: A Case for Culturally Competent Intervention Strategies*. Journal of Health and Human Services Administration, *47*(1-2), 6-22. https://doi.org/10.1177/10793739241274839

Nair, L., & Adetayo, O. A. (2019). *Cultural Competence and Ethnic Diversity in Healthcare.* Plastic and reconstructive surgery. Global open, *7*(5), e2219. https://doi.org/10.1097/GOX.0000000000002219

National Association of Social Workers. (2015). Standards and Indicators for Cultural Competence in Social Work Practice.

National Association of Social Workers. (2021). *Code of Ethics*. https://www.socialworkers.org/About/Ethics/Code-of-Ethics/Code-of-Ethics-English

Padela, A. I., Malik, S., Ally, S. A., Quinn, M., Hall, S., & Peek, M. (2018). *Reducing Muslim Mammography Disparities: Outcomes from a Religiously Tailored Mosque-Based Intervention.* Health Education & Behavior*; 45*(6), 1025–1035. https://doi.org/10.1177/1090198118769371

Papps, E., & Ramsden, I.(1996). *Cultural safety in nursing: the New Zealand experience*. International Journal for Quality in Health Care, 8 (5), 1996, 491- 497, https://doi.org/10.1093/intqhc/8.5.491

Patros., A. & Grokowsky, K. (2024). *Introduction to Human Services*. Western Technical College. Open Education Resource (OER). LibreTexts

Pomeroy, E. C., & Garcia, R. G. (2018). *Direct Practice Skills for Evidence-Based Social Work: A strengths-Based Text and Workbook*. New York, NY: Springer Publishing.

Ramsden, I. (2015). *Towards Cultural Safety*, In Wepa, D. (2015). *Cultural Safety in Aotearoa New Zealand, (2nd ed.)*,5-255 Cambridge University Press: Melbourne.

Reiter, M. D. (2022). *Therapeutic Interviewing: Essential Skills and Contexts of Counseling*. Routledge: NY

Salhi, B.A., Tsai, J.W., Druck, J., Ward-Gaines, J., White, M.H., Lopez, B. L.(2019). *Toward Structural Competency in Emergency Medical Education.* AEM Educ Train.:S88-S97. doi: 10.1002/aet2.10416. PMID: 32072112; PMCID: PMC7011420.

Sinclair, S., McClement, S., Raffin-Bouchal, S., Hack, T. F., Hagen, N. A., McConnell, S., & Chochinov, H. M. (2016). *Compassion in Health Care: An Empirical Model*. Journal of pain and symptom management, 51(2), 193–203. https://doi.org/10.1016/j.jpainsymman.2015.10.009

Soto, A., Smith, T. B., Griner, D., Domenech- Rodríguez, M., & Bernal, G (2018). *Cultural Adaptations and Therapist Multicultural Competence: Two Meta-Analytic Reviews*. J Clin Psychol;74(11):1907-1923. doi: 10.1002/jclp.22679. PMID: 30091201.

Snyder, S.E. & Duchschere, J. (2022). *Revisiting Ecological Systems Theory: Practice Implications for Juvenile Justice Youth*. Translational Issues in Psychological Science*, 8*(2), 234-245. https://doi.org/10.1037/tps0000324

Stubbe, D. E. (2020). *Practicing Cultural Competence and Cultural Humility in the Care of Diverse Patients*. 18(1):49-51. doi: 10.1176/appi.focus.20190041. PMID: 32047398; PMCID: PMC7011228.

Tervalon, M., & Murray-García, J. (1998). *Cultural Humility Versus Cultural Competence: A Critical Distinction in Defining Physician Training Outcomes in Multicultural Education.* J Health Care for the Poor and Underserved, 9(2):117-25. doi: 10.1353/hpu.2010.0233. PMID: 10073197

Trevithick, P. (2000). *Social Work Skills: A Practice Handbook*. Open University Press.

Truong, M., Paradies, Y.,& Priest, N. (2014). *Interventions to Improve Cultural Competency in Healthcare: A Systematic Review of Reviews*. BMC Health Serv Res.; 14:99. doi: 10.1186/1472-6963-14-99. PMID: 24589335; PMCID: PMC3946184.

Tyler, B. (2024). *Person- in -Environment (PIE)Theory*. EBSCO Host. https://www.ebsco.com/research-starters/social-sciences-and-humanities/person-environment-pie-theory

Voutilainen, L., Henttonen, P., Kahri, M., Ravaja, N., Sams, M., & Peräkylä, A. (2018). *Empathy, Challenge, and Psychophysiological Activation in Therapist-Client Interaction*. Frontiers in psychology, 9, 530. https://doi.org/10.3389/fpsyg.2018.00530

United States Department of Health and Human Services (DHHS) Office of Minority Health (2013). *National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care* (+ Blueprint). Policy Backbone for Culturally and Linguistically Appropriate Care

Walters, H. (2007). *An Introduction to Use of Self in Practicum Placement.* Social Worker: The New Social Worker Online Magazine. https://www.socialworker.com/feature-articles/practicumplacement/An_Introduction_to_Use_of_Self_in_Practicum_Placement/

Wheeler, M. (2018). *Cultural Competence and Cultural Humility***.** A Literature Review for Understanding and Action. Central Florida Diversity Learning Series

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