Shifting our Gaze: Thinking Critically about 'Culture'

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Abstract

The complexity of 'culture' and its expression in occupational therapy practice and education continues to be explored and debated extensively within our profession. A pervasive feature of this discourse is the notion of cultural competency as an ideology and approach that is aligned with multiculturalism. This paper critically examines and problematizes the culturalist assumptions that underpin the predominant way in which culture continues to be conceptualized and enacted in occupational therapy. This analysis draws attention to the inherent risks of engaging in uncritical theorizing on issues of culture and diversity and to the ideological processes of 'Othering' and racialization that underlie culturalist perspectives. The concept of cultural safety is introduced as an alternative critical analytical lens that brings postcolonial theorizing into the practical realm of occupational therapy practice and education. This lens shifts our gaze away from cultural differences and directs our attention to the socio-political and historical contexts of peoples' health and healthcare experiences. This paper concludes that cultural safety is consistent with growing calls within our profession to engage with critical perspectives on issues related to culture, diversity, and injustice in order to advance socially transformative and responsive forms of occupational therapy practice and education.

Introduction

What 'culture' is, and what culture means in the context of occupational therapy has been explored and discussed for decades (Bonder, Martin, & Miracle, 2004; Castro, Dahlin-Ivanoff, & Martensson, 2013; Engel-Yeger, Jarus, & Law, 2007; Fitzgerald, Mullavey-O'Bryne, & Clemson, 1997; Iwama, 2003, 2007; Jungersen, 1992; Wells & Black, 2000). This literature has portrayed diverse perspectives and expressions of culture in occupational therapy discourses, but has failed to come to any consensus regarding how conceptualizations of 'culture' intersect with occupation and occupational therapy (Beagan, 2015; Castro et al., 2013). A recurring feature in this literature is 'cultural competency' – demonstrated when an occupational therapist "understands and appreciates differences in health beliefs and behaviors, recognizes and respect variations that occur within cultural groups, and is able to adjust his or her practice to provide effective interventions for people from various cultures" (Suarez-Balcazar et al., 2009, p. 499).

As a Euro-Canadian occupational therapist who has been working with and learning from Indigenous[1] clients and colleagues for many years, a cultural competency viewpoint proved inadequate in informing my theorizing on how my occupational therapy practice could be responsive to the historical, socio-economic, and political realities of Indigenous communities, families, and children's lives. In recent years, I have been drawn to critical theoretical perspectives for their potential to generate reflexive, multidimensional, and nuanced analyses of peoples' occupational realities and inform socially responsive policy and practice interventions (Gerlach, 2015; Farias & Laliberte Rudman, 2014).

In this paper I call for a critical shift in our professional discourse on the complex and political concept of culture. The specific objectives of this paper are to: (a) problematize the predominant way in which culture continues to be conceptualized in occupational therapy; (b) introduce the concept of cultural safety as an alternative critical lens for examining issues of culture, health, and health inequities and, (c) explore the relevance of cultural safety in the context of socially transformative occupational therapy education and practice. This paper is influenced by my occupational therapy practice and research with Indigenous families in Western Canada, and by critical approaches to issues of culture, diversity, and difference primarily in nursing scholarship (Browne, Smye, & Varcoe, 2005; Browne & Varcoe, 2006; Browne et al., 2009; Reimer Kirkham & Anderson, 2002).

1. In this paper, 'Indigenous peoples' refers to the original inhabitants of a region or territory, which in Canada is inclusive of First Nation, Métis, and Inuit peoples.

Culturalist Perspectives in Occupational Therapy

Culturalism refers to a process whereby ideologies and practices use narrow and stereotyped representations of culture as the primary lens for understanding assumed differences about various individuals or groups of people (Browne et al., 2009). Culturalist perspectives are deeply embedded in Western societies, including in healthcare and academic institutions, and are grounded in ideologies of multiculturalism and neoliberal individualism. Since the 1980's, culturalist perspectives, frequently framed interchangeably as cultural awareness, sensitivity or competency, have been, and continue to be pervasive in international occupational therapy discourses (Awaad, 2003; Heigl, Kinebanian, & Josephsson, 2011; Humbert, Burket, Deveney, & Kennedy, 2011; Sood, Cepa, Sebestina, & Shovan, 2014; Suarez-Balcazar et al., 2009; Wray & Mortenson, 2011). This literature emphasizes the ongoing development of therapists' cultural awareness, knowledge, and skills in order to improve occupational therapy outcomes for clients that are perceived as being different from the dominant cultural norm (Heien, 2012; Lindsay, Tetrault, Demaris, A, & Peirart, 2014; Wray & Mortenson, 2011). Culturalist perspectives focus on working effectively with clients who therapists perceive as being 'different' from the dominant society, and in which 'difference' is frequently equated with ethnicity or race[2]. A tacit underpinning of perceiving clients in this way is that 'culture' is viewed as a problem that challenges 'practice-as-usual' (Beagan, 2015).

Cultural competency in occupational therapy can provide a starting point for understanding how an individual's or family's health and occupational engagement *may* be influenced by particular values, beliefs and practices that are assigned as being 'cultural' (Bonder et al., 2004). This approach has also drawn attention to issues of diversity and the socio-cultural context of occupational therapy (Beagan, 2015; Kinebanian & Stomph, 2009). However, occupational therapists have also expressed concerns about the significant limitations of culturalist perspectives in our professional discourse (Beagan, 2015; Castro et al., 2013; Gerlach, 2012; Hammell, 2013). There also remains a lack of evidence to support the effectiveness of culturalist approaches in improving health outcomes for individuals and population groups who experience structural forms of social marginalization (Truong, Paradies, & Priest, 2014). In the following section, I examine why culturalist perspectives are problematic.

2. It is important to acknowledge that 'race' is not a biological category or phenomenon. Rather all categories of difference, including race, class, and gender are socially constructed and historically specific.

Othering & Racialization

It is important to recognize that "cultures and cultural differences are not 'discovered', they are constructed" (Allen, 1999, p. 230). Prevailing Western views of culture frequently conflate 'culture' with ethnicity and race and promote ideological processes of 'Othering' and racialization[3]. These culturalist discourses reproduce simplistic and homogenous categorizations of people and simplistic binaries of 'us' and 'them' (Narayan, 2000). For example, Lynch and Hanson (2002), in their text on 'developing cross-cultural competence' with families and children, provide a list of contrasting beliefs, values, and practices for 'Middle Eastern' families versus 'mainstream culture'. A feature of Othering is that individuals who identify with, and are embedded in dominant culture may perceive themselves as not having a 'culture'. In the context of occupational therapy, Beagan (2015) notes, "culture is seen as something in or possessed by the ethnic Other [while the therapist] is depicted as culturally neutral, as is the profession more broadly" (p. 275).

Othering and racialization are central features of colonial discourses as they tacitly (re)produce assumptions of Western superiority and dominance over an essentialized, inferior, and subordinate Other in order to legitimize colonial governance (Said, 1994; Young, 2001). Different individuals or population groups continue to experience racialization as a feature of contemporary social dynamics in many countries. Racialization may be conscious and deliberate, an act of racism that discriminates openly, or unconscious and unintended (Browne et al., 2005). Racialized stereotypes often become so pervasive that they become unquestioned, taken-for-granted truths that influence how various population groups are viewed within a society. The consequences of the multifaceted processes of Othering, racialization, and systemic discrimination in the healthcare system are increasingly recognized as serious structural barriers to health equity, which risk being overlooked unless a broader perspective of culture is employed (Browne et al., 2009).

An 'Unreflexive Stance towards Difference'

In my early work with Indigenous communities, I employed a lens of cultural sensitivity that implicitly focused on identifying beliefs, values, and behaviors that I perceived were different from my own Eurocentric worldview and which I then constructed as 'Indigenous culture' (Gerlach, 2003). Albeit unknowingly at that time, I was participating in a process of culturalism, by using a narrow and simplistic lens of culture to interpret Indigenous families and colleagues' interactions and behaviors. A concern in

3. Interrelated with the process of Othering is an ideological process of racialization whereby racial identity is assigned to an individual or population group based on presumed genetic, physical, or biological differences, and then treated in accordance with these beliefs (Fanon, 1967).

bringing what Razack (1998) describes as an 'unreflexive stance towards difference' is an emphasis on culture to the extent that other facets of human existence and the influence of broader social and structural factors are ignored. As Razack (1998) notes:

> *"The notion of culture that has perhaps the widest currency among both dominant and subordinate groups is one whereby culture is taken to mean values, beliefs, knowledge, and customs that exist in a timeless and unchangeable vacuum outside of patriarchy, racism, imperialism, and colonialism. Viewed this way, culture maintains a superautonomy that reduces all facets of social experience to issues of culture" (p. 58).*

Recognizing and responding to diverse cultural meanings and experiences of health and healthcare is important. However, using 'culture' as the primary lens through which to understand and be responsive to clients who are perceived as being 'different' risks that cultural characteristics, particularly when they conflict with routine practices and expectations, are assumed to be the primary explanatory reason for issues such as healthcare access and compliance or poor health outcomes (Smye & Browne, 2002). This perspective is not supported by evidence; as Browne and colleagues (2009) assert:

> *"It is not primarily cultural beliefs or cultural barriers that influence how people manage health, illness, or access to care. Rather, it is the structural constraints and limitations on life opportunities that influence people's abilities to manage illness or access services, leading to health and health care inequities" (p. 171).*

Employing culturalist perspectives in healthcare contexts is aligned with neoliberal and biomedical ideologies, which reduce learning about 'cultural differences' to a skill for which we can develop expertise (Kleinman & Benson, 2006). The focus is on culture at the level of the individual while the complexity of both our own and our clients' social identities (including gender, sexuality, age, socio-economic status and so forth), histories, and lived experiences are disregarded. An unreflexive stance towards difference therefore draws our attention away from the ways in which occupational therapy and peoples' occupational realities are bounded by broader socio-economic, political, and historical dynamics and contexts (Gerlach, 2015).

It is not my intention to suggest that occupational therapists engage in a process of Othering or racialization intentionally. Rather, I am concerned that how 'culture' is taken up in occupational therapy curricula and practice means that therapists are complicit, albeit unknowingly, in processes that fail to be respectful of and responsive to the complexities of people's social identities and lived realities. There are growing concerns within our profession that increasing globalization has amplified the largely uncritical uptake of occupational therapy theories and models that reproduce Western, Anglophone, middle-class, female,

urban, and Judeo-Christian values and worldviews (Gerlach, 2015; Hammell, 2011; Kantartzis & Molineux, 2011; Whiteford & Hocking, 2012). By employing culturalist perspectives and focusing our gaze on clients as the 'ethnic Other' (Beagan, 2015), we fail to turn our gaze inward to the socio-cultural, historical, and political nature of our taken-for-granted occupational therapy knowledge, practices, and agenda, and the academic and/or healthcare institutions in which we are socialized and located (Gerlach, Sullivan, Valavaara, & McNeil, 2014; Kantartzis & Molineux, 2012). Narrowing our gaze in this way reinforces the cultural division that cultural competency claims to bridge and perpetuates the dominance of prevailing occupational therapy practices. Ultimately, approaches that are underpinned by culturalist assumptions limit the potential of occupational therapy to be responsive to individuals and populations groups who experience varying structural forms of marginalization and racialization.

In a recent review of the literature on 'occupational therapy and culture', Castro and colleagues (2013) propose that our profession is at an intellectual crossroads in our theorizing on 'culture'. We can choose to stay with a reductionist viewpoint of culture which may be 'easier to reach', or build on the emergence of critical perspectives in our profession (Castro et al., 2013). In the following section of this paper I provide an overview of cultural safety as an alternative concept that promotes critical theorizing and reflexivity in relation to the intersections of culture, health and healthcare, and structurally rooted health inequities. This is followed by a discussion on the implications of cultural safety for occupational therapy education and practice.

Cultural Safety

The failure of culturalist approaches in healthcare and health policies to address the significant health inequities experienced by Māori, in the contemporary settler-colonial context of Aotearoa/New Zealand, led to the conceptualization of cultural safety in the early 1990's by Maori nurse-leaders and educators (Papps & Ramsden, 1996; Ramsden, 1993; Wood & Schwass, 1993). The Nursing Council of New Zealand (2011) currently defines cultural safety as:

> *"The effective nursing practice of a person or family from another culture, and is determined by that person or family. Culture includes, but is not restricted to, age or generation; gender; sexual orientation; occupation and socioeconomic status; ethnic origin or migrant experience; religious or spiritual belief; and disability" (p. 7).*

Cultural safety aimed to disrupt culturalist assumptions that conflated Māori 'culture' with chronic cycles of poverty and poor health outcomes, and failed to recognize the ongoing impact of over a century of colonial oppression (Ramsden, 1993). The purpose of cultural safety was to improve Māori health outcomes by "reorient[ing] the training of health professionals towards a more critical understanding of colonial structures and their impacts on contemporary Māori" (Dyck & Kearns, 1995, p. 141).

Since its inception, cultural safety has evolved in diverse international contexts and with an increasing range of health disciplines who are seeking to transform individual and institutional level policies and practices in relation to diverse Indigenous and non-Indigenous populations who experience social and health inequities (Beavis et al., 2015; De Souza, 2015; Nayar, 2005; Pauly, McCall, Browne, Parker, & Mollison, 2015). In this way, cultural safety is increasingly being viewed as an essential starting point for effective healthcare interventions with individuals and population groups who experience varying forms of structural oppression, including long-term poverty and systemic racism (Browne, Varcoe, Ford-Gilboe, & Wathen, 2015). Thus, the applicability of cultural safety has moved beyond its Indigenous roots, as it brings a broader and nuanced analysis of issues of culture, diversity, oppression, and health inequities that have wide international relevancy (Arieli, Mashiach, Hirschfeld, & Friedman, 2012; Cox & Simpson, 2015; Nayar, 2005; Pauly et al., 2015).

A Critical Analytical Lens

As a critical analytical lens, cultural safety is rooted in postcolonial[4] theoretical perspectives that emphasize a social, political, and moral critique of the history and legacy of colonialism and its manifestations in contemporary contexts (Said, 1978; Young, 2001). Postcolonial perspectives expose and contest the complex process by which a dominant social group privileges its own norms and values by marginalizing and excluding social groups with less power (Gandhi, 1998; Said, 1978). Theorizing from this perspective also provides 'a window for understanding' and contesting how race and culture continue to be constructed in ways that reproduce and sustain intersecting forms of oppression in contemporary societies (Anderson, 2002).

Cultural safety brings postcolonial concerns into the practical realms of healthcare services, research, and education to address issues of social justice and health equity (Anderson et al., 2003; Beavis et al., 2015; Browne et al., 2009; Downing & Kowal, 2011). As a critical analytical lens, cultural safety recognizes that healthcare services, research, and education are not neutral or ahistorical, but are bounded by particular socio-cultural, historical, and political contexts (Anderson et al., 2003; Browne et al., 2009). Thus, this lens provokes a critical examination of how social relations of power in society and healthcare specifically influences what counts as knowledge and evidence. Central to this process is the recognition that health beliefs and practices that differ from the dominant society are viewed as equally valid and relevant as mainstream healthcare approaches (Papps & Ramsden, 1996).

Consistent with postcolonial theorizing, and foundational to the concept of cultural safety, is a critical conceptualization of culture

4. The 'post' in postcolonial does not imply that we have moved beyond inequitable social and power relations; rather that new forms of inequities continue to emerge (Ashcroft, Griffiths, & Tiffin, 2007).

as a dynamic, power-laden relational process that is shaped by and embedded in particular sociopolitical, temporal and historical contexts (Browne et al., 2009). Thus, cultural safety shifts our gaze away from ethno-cultural characteristics or differences and brings into focus the influence of wider socio-economic, historical, and political determinants on people's overall health, healthcare access, and experiences of social and health inequities (Browne & Varcoe, 2006; Browne et al., 2009). Connecting people's health and healthcare experiences to broader socio-political contexts is particularly salient for individuals and population groups who have endured long-standing and historically-constituted forms of marginalization, racialization, and systemic discrimination (Browne, 2007). In the context of Israel, for example, nurse researchers' use of a cultural safety lens revealed how Arab Israeli nursing students' relationships and experiences with their Jewish Israeli peers and faculty were shaped by historically-entrenched and politically charged social relations, power imbalances, and conflicts in this society (Arieli et al., 2012).

Shifting our Gaze

In contrast to egalitarian notions of 'treating everyone the same', cultural safety provokes a critical examination of how practice-as-usual can lack relevancy, or worse inadvertently reproduce social relations of power or recreate people's lived experiences of trauma (Smye & Browne, 2002). As highlighted by nursing scholars, Browne et al. (2005):

> *"By intentionally shifting the focus of analysis away from cultural characteristics or cultural differences as the source of the problem, cultural safety has been instrumental in directing us to shift our gaze onto the culture of healthcare and in showing us how practices, policies, and research approaches can themselves create marginalizing conditions and inequities" (p. 32).*

Importantly, from a cultural safety perspective, the clients/patients are the only ones who have the power to comment on care; deciding whether they feel safe with their healthcare and involved in a change process at individual and organizational levels (Cox & Simpson, 2015). Thus, cultural safety emphasizes that it is healthcare systems that need to change and adapt rather than the users of these systems (Cox & Simpson, 2015).

The provision of culturally safe care requires that all healthcare providers accept and reflect how they are bearers of culture; that they are socially powerful, privileged and positioned; that their status is historically and politically constituted; and that it is their own personal and professional values, beliefs, and assumptions that require examination to shift power relations and structural inequities (Cox & Simpson, 2015; Gerlach, 2015). Only by providers becoming self-aware of how they are located in healthcare and the wider society, can they begin to develop equitable relationships in which differences are acknowledged but in which power, biases, and privilege are not perpetuated (Anderson et al., 2003). This involves a

radical shift away from hierarchical and expert driven approaches and addressing how power imbalances are entrenched in and reproduced through routine practices and policies at individual and organizational levels (Browne et al., 2012).

Discussion

In order for occupational therapy to contribute in a meaningful way towards addressing escalating issues of social injustices and health inequities, we need to shift our professional gaze beyond culturalist perspectives and engage in critical theorizing and reflexivity (Dickie, 2004; Gerlach, 2015). In this final section of the paper, I discuss the relevancy of cultural safety to socially transformative occupational therapy practice and education.

Cultural safety is well aligned with a growing call within our profession to move beyond individualistic analyses and engage with critical perspectives on issues related to culture, diversity, and injustice in order to advance socially transformative and responsive forms of occupational therapy practice and education (Dickie, Cutchin, & Humphrey, 2006; Gerlach, Teachman, Laliberte Rudman, Huot, & Aldrich, in review). However, there are no neatly packaged guidelines on how to provide occupational therapy in ways that are culturally safe and translating this into practice is not straightforward (Gerlach, 2012).

As a critical analytical lens, cultural safety fosters socially responsive occupational therapy by broadening our clinical gaze and focusing our attention on how intersecting socio-historical, political and economic factors limit people's occupations and occupational opportunities. By simultaneously turning our gaze inward, cultural safety also provokes a critical examination of how our professional relationships and taken-for-granted occupational therapy concepts, models, and practices are socially, culturally and historically located in ways that privilege and (re)produce Western power and knowledge (Hammell, 2011; Iwama, 2007).

Consistent with critical theorizing, working towards the provision of cultural safety in occupational therapy requires that we challenge the assumptions, relevancy, and unintended consequences of our taken-for-granted theories, models, and practices - our 'sacred texts' (Hammell, 2009). Cultural safety also requires that we are open, adaptable and responsive to clients' occupational realities rather than our own professional, practice or organizational agendas. Thus, it is our responsibility – not our clients', to adapt and transform how we think about and provide occupational therapy in different social contexts (Gerlach et al., 2014; Kinebanian & Stomph, 2009). This disrupts practice-as-usual and universal claims of being 'client-centered' (Hammell, 2015).

In contrast to the individualism perpetuated through culturalist perspectives, cultural safety, as it locates health within the broader social, historical and political contexts of peoples' lives – has the potential to radically shift the focus of our

interventions. For example, in my research with an Indigenous early child development (ECD) program in Canada (Gerlach, 2015), utilizing cultural safety as an analytical lens revealed how the taken-for-granted practice of screening a child's development, frequently created conditions of cultural unsafety or risk for Indigenous caregivers. My analysis demonstrated that this taken-for-granted practice unintentionally reinforced caregivers' concerns about historical and ongoing forms of over-surveillance which have resulted in high numbers of Indigenous children being removed from their homes and placed in state 'care' in the child welfare system. Providing culturally safe intervention in this context, required a tacit shift in power relations, as ECD workers' understanding of the socio-historical contexts of families' lives resulted in them deferring or delaying developmental screening in order to focus on (re)building trusting relationships (Gerlach, 2015).

Bringing a cultural safety analysis to my occupational therapy practice with Indigenous families shifted and broadened the focus of my intervention. As a result, I prioritized relational practices in which I learnt *from* caregivers about their everyday lives and the ongoing, multifaceted impacts of colonization on their children's health and occupational engagement.

In the context of Israel, cultural safety requires that occupational therapists critically reflect and understand how individuals' and population groups' health outcomes and healthcare experiences are located in and shaped by the historical and ongoing political actions and conflicts particular to this country. Also, how the historical and contemporary context of relations between the various populations groups within the state of Israel, and wider popular discourses in this society, influence therapy-client encounters and peoples' access to equitable health outcomes.

In disrupting an expert-drive model, cultural safety implicitly positions us as learners in the intervention process (Gerlach et al., 2014); opening up a critical, reflexive, intellectual space in which we might learn about the contexts and complexities of our clients' occupational lives while constantly questioning our social identities, position of power and privilege, and the cultural bias of our interventions. Questions raised by reflecting from a viewpoint of cultural safety include: How does my position of power and privilege as an occupational therapist influence my relationships with my clients? What are the values, assumptions and biases that underpin how I think about and provide occupational therapy? How can my practices be responsive to the unique socio-cultural identities, histories, and contemporary contexts of my clients' lives?

As an educational framework, cultural safety shifts our dialogue beyond the comfort of cultural awareness, education, and practice skills. Cultural safety necessitates creating time and safe spaces within occupational therapy curricula for students to critically reflect on, question, and discuss how their social identities, lived experiences, and education shape their positioning within prevailing power

structures in society and in the healthcare system. Students also need to engage with critical scholarship that links broader structural determinants, such as systemic racism, with social and health inequities (Ramsden, 2015). This requires a critical stance from educators on issues of diversity and culture in order to avoid unintentionally perpetuating ideological processes that contribute to the structural forms of oppression and injustice we aim to address.

Conclusion

Responding to the occupational wellbeing of *all* our clients requires that occupational therapy education and practice moves beyond the comfort of a reductionist viewpoint of culture and confront how Othering, racialization, and discrimination are tacitly embedded in policies, practices and curricula in ways that limit the reach of occupational therapy and risk that we are unwittingly complicit in perpetuating relations of power and oppression. In this paper I offer cultural safety as an alternative critical analytical lens that is commensurate with a growing international interest in socially transformative occupational therapy practice and education. Further research is needed on what cultural safety looks like, and how it is experienced, in diverse occupational therapy practice and educational contexts.

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