Article

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Approaches to culture and diversity: A critical synthesis of occupational therapy literature

Des approches en matière de culture et de diversité : une synthèse critique de la littérature en ergothérapie

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Key words: Critical reflexivity; Cultural competency; Cultural diversity; Cultural humility; Cultural safety.

Mots clés : compétence culturelle; diversité culturelle; humilité culturelle; réflexivité critique; sécurité culturelle.

Abstract

Background. The 2007 position statement on diversity for the Canadian occupational therapy profession argued discussion was needed to determine the implications of approaches to working with cultural differences and other forms of diversity. In 2014, a new position statement on diversity was published, emphasizing the importance of social power relations and power relations between client and therapist, and supporting two particular approaches: cultural safety and cultural humility with critical reflexivity **Purpose.** This paper reviews and critically synthesizes the literature concerning culture and diversity published in occupational therapy between 2007 and 2014, tracing the major discourses and mapping the implications of four differing approaches: cultural competence, cultural relevance, cultural safety, and cultural humility. **Key Issues.** Approaches differ in where they situate the "problem," how they envision change, the end goal, and the application to a range of types of diversity. **Implications.** The latter two are preferred approaches for their attention to power relations and potential to encompass a range of types of social and cultural diversity.

Abrégé

Description. La Déclaration de principes conjointe sur la diversité pour la profession de l'ergothérapie au Canada de 2007 arguait qu'une discussion était nécessaire afin déterminer les conséquences des approches guidant le travail avec les différences culturelles et autres formes de diversité. Une nouvelle déclaration de principes concernant la diversité publiée en 2014 met l'accent sur l'importance des relations de pouvoir social, de même que des relations de pouvoir entre le client et le thérapeute, et soutient deux approches en particulier : la sécurité culturelle et l'humilité culturelle avec réflexivité critique. **But.** Cet article révise et synthétise de manière critique la littérature relative à la culture et à la diversité publiée en ergothérapie entre les années 2007 et 2014, en retraçant les références majeures et en illustrant les conséquences de quatre différentes approches : compétence culturelle, pertinence culturelle, sécurité culturelle et humilité culturelle. **Questions clés.** Les approches diffèrent dans leur localisation du « problème », dans leur façon d'envisager le changement et l'objectif final, de même que leur mise en œuvre auprès de différents types de diversité. **Conséquences.** Les deux dernières approches sont privilégiées en raison de l'attention portée aux relations de pouvoir et de la possibilité de couvrir un éventail de types de diversité culturelle et sociale.

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In 2007, a position statement on diversity for occupational therapy in Canada was jointly released by five national associations (the Association of Canadian Occupational Therapy Regulatory Organizations, the Association of Canadian Occupational Therapy University Programs, the Canadian Association of Occupational Therapists [CAOT], the Canadian Occupational Therapy Foundation, and the Occupational Therapy Professional Alliance of Canada; CAOT, 2007). It stated that "multiple definitions of and approaches to diversity" existed within the profession without consensus on definitions or best practice and recommended therapists and organizations encourage discussion and debate. Seven years later, the same five professional bodies jointly released a new position statement that committed the profession to approaches that "attend to the full range of social and cultural diversity, critically examining biases embedded in the profession, power relations between clients and therapists, power relations within the profession, and connections between individual experiences and broader social structures" (Occupational Therapy Professional Alliance of Canada, 2014). It argued in favour of two approaches to diversity: cultural safety and cultural humility with critical reflexivity. This paper provides an analysis of the discussions that occurred in the literature between 2007 and 2014 that led to a significantly more specific position being taken in the latter statement.

What Is "Diversity" and Why Does It Matter?

Humans differ from each other on every imaginable characteristic. As used in this context, however, *diversity* refers to those human differences that are noticed and deemed to matter within specific social structures, becoming matters of power inequalities (Kinébanian & Stomph, 2009). It is their connection with inequities in occupational opportunities and engagement, health and well-being, and everyday life chances that determines which social and cultural differences matter in any given place and time. Common categories are gender, social class, caste, age, religion, ethnicity, sexual orientation, race, and ability/disability.

Diversity is often discussed alongside the concept of culture, which arises from anthropology. *Culture* refers to shared ideas, beliefs, systems of concepts and meanings, values, knowledge, ways of being, customs, and often, language that arise over time within a particular group (Hammell, 2009; Kinébanian & Stomph, 2009). It includes implicit assumptions, beliefs, and unwritten rules as well as taken-for-granted notions of what is normal. The less conscious elements of culture are often most emotionally loaded. Anthropologist Linda Hunt (2001) has argued, "Culture does not determine behavior, but affords group members a repertoire of ideas and possible actions, providing the framework through which they understand themselves, their environment, and their experiences" (p. 3). Culture provides a ready-to-hand way of being in the world that is familiar and feels normal. It is not static but, rather, constantly changing, though often slowly.

Culture does not refer solely to ethnicity; cultural differences arise in connection with all intersecting aspects of diversity. Every human being is affected by cultural affiliations, though often effects are subconscious. For example, the values, beliefs, and assumptions of a working-class gay Iranian may differ from those of an upper-class heterosexual Iranian. In every occupational therapy encounter, both therapist and client are always thoroughly immersed in their own social and cultural contexts, which may differ by gender, class, ethnicity, and so on.

In most societies, and certainly in Canada, human differences are organized hierarchically, both reflecting and creating disparities among groups. Diversity is not simply a range of pleasing differences; some groups tend to be established as "better than" and others as "lesser than" (Pease, 2010). Differences among groups frequently become the basis for stereotyping as well as rationalizing poor treatment for some and preferential treatment for others. Attention to diversity, then, is attention to social inequities and attention to patterned differences in expectations, experiences, opportunities, access to resources, life chances, and health outcomes (Bass-Haugen, 2009). In other words, it means attention not only to difference but also to power relations and inequities among groups.

The omnipresent effects of diversity are least evident within groups that are socially dominant (Steggles & Gerlach, 2012). Members of groups that experience social and cultural privilege and advantage tend not to even notice that they are part of social or cultural groups. Culture is understood as something those "other," "different" people have; people from socially dominant groups often see themselves as culturally neutral (Pease, 2010). The invisibility of dominant groups in discussions of diversity means the inequitable effects of differences can operate unchecked. Occupational therapy's commitment to all people's ability to participate to their fullest potential in everyday life (World Federation of Occupational Therapists [WFOT], 2006) requires taking into account all aspects of social and cultural diversity, particularly as they affect therapy encounters. Multiple approaches to understanding diversity have emerged in the literature, each with distinct assumptions, goals, and implications. These approaches will be analyzed below, in an integrative review of the literature (Whittemore & Knafl, 2005).

Searching the Literature

As the 2007 position statement called for greater discussion and debate around diversity in occupational therapy, for this analysis, all occupational therapy literature concerning diversity from 2007 to 2014 was examined. The main database for occupational therapy, CINAHL, was searched using three main keyword search terms (*diversity* or *culture* or *cultural*) combined with *occupational therap** as a keyword. A total of 362 articles were retrieved. A separate search combining *occupational therapy* with terms specific to sexual orientation, race, ethnicity, and social class returned an additional 93 citations. After

Table 1
Cumulative Index to Nursing and Allied Health Literature Citations of Occupational Therapy and Culture/Diversity Over 21 Years

Year	Number of citations
1994–1996	59
1997–1999	80
2000–2002	95
2003–2005	121
2006–2008	159
2009–2011	195
2012–2014[a]	181

[a]To October 2014.

skimming titles and abstracts, items were excluded if they were reporting on a cross-cultural fieldwork experience, cross-cultural validation of an instrument, or the occupational specificity of a particular sociocultural group; if the term *culture* referred to professional or research culture; or if they simply used race, ethnicity, or class as research variables. Articles were retained if they promoted or reported on an approach to working with diversity in occupational therapy. In total, 110 articles were read in full and formed the basis of this analysis. This review also incorporates a few key sources that predate 2007, if they were central to establishing an approach to diversity and were widely cited.

Emerging Trends in the Literature

Occupational therapy literature about culture and diversity is steadily increasing (see Table 1). In reviewing the current literature, an unfortunate pattern becomes apparent: Both diversity and culture tend to get reduced to an overly narrow focus on ethnicity. While attention to ethnicity is important in a globalizing and internationalizing context, it does a disservice to other forms of diversity that are equally important (e.g., race, social class, ability, age, religion, sexual, and gender identity). There is very little occupational therapy literature on race or racism, on social class or poverty, or on gender or sexual identity, except as variables (for exceptions, see Andrews, Griffiths, Harrison, & Stagnitti, 2013; Beagan, 2007; Beagan & Etowa, 2009; Beagan et al., 2013; Breland & Ellis, 2012; Javaherian, Christy, & Boehringer, 2013).

In discussions of diversity, a wide range of terms and concepts has been employed, though three approaches have predominated in the occupational therapy literature: cultural competence, cultural relevance, and cultural safety. A fourth approach is emerging based on cultural humility and critical reflexivity. Each shall be discussed below.

Cultural Competence

The dominant approach to addressing diversity in the health professions is cultural competence. Related terms are also used, such as *cultural sensitivity*, *cultural awareness*, *culturally responsive*, and *transcultural competence* (see Haltiwanger, 2010; Kirsh, Trentham, & Cole, 2006; Lindsay, Tétrault, Demaris, King, & Piérart, 2014; Muñoz, 2007; Trentham, Cockburn, Cameron, & Iwama, 2007). While definitions vary, there are important consistencies. Balcazar, Suarez-Balcazar, and Taylor-Ritzler (2009) argue that culturally competent therapists "understand and appreciate differences in health beliefs and behaviours, recognise and respect variations that occur within cultural groups, and are able to adjust their practice to provide effective interventions for people from various cultures" (p. 1153). Others define cultural competence as being able to work effectively with clients unlike oneself (e.g., Kinébanian & Stomph, 2009; Trentham et al., 2007).

Cultural competence centres on the development of awareness, knowledge, and skills (Balcazar et al., 2009; Black & Wells, 2007; Haltiwanger, 2010; Lindsay et al., 2014; Quereshi, 2004; Suarez-Balcazar & Rodakowski, 2007; WFOT, 2010). Awareness includes developing insight into one's own cultural values, attitudes, and biases as well as developing awareness of and sensitivity to the potentially distinct values, beliefs, and attitudes of clients unlike oneself. Knowledge entails learning about other cultures, in particular in relation to health, illness, and disability. Openness and curiosity are key. Skills for cultural competence are not often well delineated, but synthesizing across the literature reveals that they include effective communication, rapport building across differences, respect, active listening, advocacy, ability to explain the local health care system, ability to explain what occupational therapy is, use of open-ended processes of inquiry, use of culturally appropriate occupations, and thinking outside the box to adapt practices, assessments, and interventions (see Lindsay et al., 2014; Muñoz, 2007; Pooremamali, Persson, & Eklund, 2011; Thorley & Lim, 2011; Wray & Mortenson, 2011). Often, cross-cultural encounters are identified as the means for improving knowledge and skills (Kinébanian & Stomph, 2009; Muñoz, 2007) "through repetitive engagements with diverse groups" (Balcazar et al., 2009, p. 1153).

At their worst, cultural competence models become a kind of "laundry list" of cultural attributes that pertain to specific ethnic groups (e.g., which hand is used for greeting; Qureshi, 2004; or social manners; Haltiwanger, 2010). Clinicians are encouraged to learn about the culture of the client and adapt assessment and interventions. Increasingly, however, theorists insist that to avoid stereotyping or casting culture as static and unchanging, it is necessary to understand that people experience their own cultures in multiple and fluid ways (Muñoz, 2007; Trentham et al., 2007; WFOT, 2010). This view shifts the focus to ascertaining each person's individual occupational meanings and preferences without any cultural assumptions (Bonder, Martin, & Miracle, 2004).

In recent years, most authors who use the cultural competence approach emphasize that cultural competence is not an end state that can be achieved but, rather, a constant learning process (e.g., Black & Wells, 2007; Kinébanian & Stomph, 2009; Muñoz, 2007). This emphasis on process, rather than achieving a state of competence, is undermined when

accompanied by hierarchically ordered lists that suggest cultural competence is an "advanced" state relative to other approaches (e.g., Boggis, 2012). For example, one author presents a developmental continuum: "(1) cultural destructiveness, (2) cultural incapacity, (3) cultural blindness, (4) cultural pre-competence, (5) cultural competency, and (6) cultural proficiency" (Haltiwanger, 2010, p. 9). Despite the insistence on process, most writing in the cultural competence approach assumes a "state" of competence can be achieved (Balcazar et al., 2009; Black & Wells, 2007; Boggis, 2012; Suarez-Balcazar & Rodakowski, 2007). This assumption is most evident in the wealth of literature concerning education and assessment (see Brown, Muñoz, Powell, 2011; Cherry et al., 2009; Costa, 2009; Gupta, 2008; Kale & Hong, 2007; Lewis, Bethea, & Hurley, 2009; Murden et al., 2008; Scheer & Kearney, 2008; Suarez-Balcazar et al., 2011). The tools used for assessing cultural competence—including one developed specifically for rehabilitation professions (see Suarez-Balcazar et al., 2011)—typically measure self-reported levels of comfort and confidence working across cultural differences (Kumaş-Tan, Beagan, Loppie, MacLeod, & Frank, 2007).

Despite its popularity, there are some overarching concerns regarding the cultural competence approach (see Baker & Beagan, 2014; Carpenter-Song, Schwalie, & Longhofer, 2007; Hammell, 2013b, 2014; Kirmayer, 2012; Kumaş-Tan et al., 2007):

- It typically reduces the range of diversity and culture to ethnicity and sometimes race. Gender, social class, caste, age, religion, ethnicity, sexual identity, and ability are ignored.
- Culture is seen as something in or possessed by the ethnic Other; the (presumably dominant-group) therapist is depicted as culture neutral, as is the profession more broadly. Generally, clients from nondominant groups are seen as posing problems for practice-as-usual.
- Cultural "incompetence" is cast as a failing of the individual therapist rather than a systemic societal feature. It is assumed to be due to lack of awareness-knowledge-skill or incorrect attitudes.
- Greater contact with Other ethnic groups is assumed to enhance cultural competence. Contact does not always reduce negative attitudes or beliefs; in fact, it gave rise to apartheid, Nazi extermination policies, and effective colonization of Aboriginal peoples. One study with rehabilitation counselors found the more "minority clients" on their caseloads, the *less* culturally competent they were (Cumming-McCann & Accordino, 2005).
- Cultural competence is measured through self-report of comfort and confidence working across cultures. Yet, people often become *less* comfortable and confident as they learn more about diversity and begin to see what they do not know and recognize entrenched biases and assumptions. Comfort and confidence may indicate arrogance rather than competence.
- Social power relations are ignored, particularly issues of power and privilege. Some have called this the "3-D approach" to multiculturalism, "one that celebrates dance, dress, and dining, but fails to take into account the multiple dimensions of racial and social inequality" (Srivastava, 2007, p. 291).
- Despite emphases on process and ongoing learning, the very notion of competence suggests one can reach a testable end point, when one has become a culturally competent practitioner. Regardless of the fit with competency-based education, this is troubling.

Culturally Relevant Occupational Therapy

The culturally relevant model of occupational therapy, championed by Michael Iwama (2003, 2005, 2006), is less an approach to culture and diversity than it is an approach to occupational therapy that makes space for cultural differences. Emerging from Eastern cultures and philosophies, it rejects some fundamental constructs in Western occupational therapy theories. For example, Iwama argues that in Eastern worldviews, persons cannot be understood to engage with their environments through occupations, because people are indivisible from their environments. There is no person distinct from environment.

Along with Iwama, other scholars and practitioners have noted that occupational therapy as a profession is not culture neutral; rather the dominant professional culture is closely aligned with Western middle-class cultural values, beliefs, and assumptions (Hammell, 2009, 2011, 2013a; Hopkirk, 2012; Laliberte Rudman & Dennhardt, 2008; Nelson, 2007). Emphasis on personal independence and autonomy, performance and achievement, and goal directedness may limit the relevance of occupational therapy models for those who do not share such cultural values. Even sense of time—orientation to the future or the past—may differ culturally, affecting goal-directed occupational therapy (Chiang & Carlson, 2003; Laliberte Rudman & Dennhardt, 2008).

The Kawa Model (Iwama, 2006; Iwama, Thompson, & MacDonald, 2009) uses the metaphor of a river (*kawa*) to explore interconnections among energy or flow, physical and social environments, obstacles and life circumstances, and personal attributes and resources. Iwama has noted,

> Rather than foisting a universal framework or model, with its predetermined concepts, principles, socio-cultural norms and rigid protocols on to each unique client, the client's emergent narrative- or "river" is drawn out, centralised, and made to form the basis for the ensuing rehabilitation process. (Iwama et al., 2009, p. 1134)

The Kawa Model has proven useful for some practitioners. Nelson (2009) reports varying outcomes using it with young, urban Indigenous people in Australia. Carmody et al. (2007) found the model effective in working with two clients in Ireland, though interestingly, the process still resulted in a focus on performance and goal setting. They argue that much rests on interviewer skill in eliciting client narratives. In addition to raising several important critiques of the Kawa Model,

Mineko Wada (2011) notes that its implementation appears much like a client-centred occupational performance process (p. 231).

While the culturally relevant approach to occupational therapy continues to be developed and refined, it has already demonstrated one clear benefit: a shift away from focusing on the cultural Other ("those people") to recognizing cultural biases and assumptions operating within occupational therapy as a profession (Hammell, 2011; Hopkirk, 2012; Iwama, 2006; Martin, 2008). As long as (Western) occupational therapy is perceived as culturally neutral (as in most cultural competence approaches), its conceptual constructs can be imposed on others without awareness (Hammell, 2011). Focusing on culture *within* allows occupational therapy to move away from conceptualizing culture and diversity as problems that lie within some clients (who fit least well with existing systems, concepts, and processes) and more as a *clash* of cultures—between the (cultural) values, beliefs, and priorities of any individual client and the cultural values, beliefs, concepts, and assumptions of the profession. It becomes clearer that diversity is a two-way street. This perspective may also aid in moving away from exclusive focus on ethnicity toward incorporating other aspects of sociocultural diversity.

Cultural Safety

Cultural safety is an approach that appears most commonly in literature from New Zealand, Australia, and Canada (see Gerlach, 2012; Gray & McPherson, 2005; Jull & Giles, 2012; Nelson, 2007, 2009; Stedman & Thomas, 2011; Thomas, 2008; Thomas, Gray, & McGinty, 2011). Originally conceptualized by Maori nurses in New Zealand (Papps & Ramsden, 1996; Ramsden, 1990, 1993), it has been built into the Australian Minimum Competency Standards for New Graduate Occupational Therapists (Thomas et al., 2011) and is a component of occupational therapy education and standards of practice in New Zealand (Gerlach, 2012). As Gerlach (2012) notes in her recent review of the concept, the

> rationale for cultural safety was the belief that the significant health disparities experienced by the Maori people of New Zealand were a direct outcome of over a century of colonialism and chronic cycles of poverty, which were misconstrued by many as being synonymous with Maori culture. (p. 152)

Cultural safety has been promoted primarily for use in the context of Aboriginal health (Jull & Giles, 2012). Jull and Giles (2012) argue that cultural safety

> is felt or experienced by a client when a healthcare provider communicates with the client in a respectful, inclusive way, empowers the client in decision making, and builds a healthcare relationship in which the client and provider work together as a team to ensure maximum effectiveness of care. (p. 72)

While this explanation could describe effective client-centred practice, cultural safety holds central a focus on power relations, particularly, a critical recognition of colonialism and its ongoing effects on the social, economic, political, and health inequities faced by Indigenous peoples (Gerlach, 2012; Hammell, 2013b; Jull & Giles, 2012; Nelson, 2009). Cultural safety moves beyond sensitivity to and awareness of cultural difference to analyzing power imbalances, discrimination, and the lasting effects of colonization. Rather than attending to cultural practices, it emphasizes the social, economic, and political contexts that shape current social realities. It is clear that dominant groups and dominant health care cultures are expected to change and adapt, not Indigenous peoples (Gerlach, 2012).

At the same time, cultural safety recognizes that power and authority are also embedded in the policies, practices, and everyday procedures of heath care (Gerlach, 2012; Gray & McPherson, 2005; Thomas et al., 2011). There is explicit recognition that health care providers wield professional power; cultural safety demands that health professionals critically examine their professional assumptions and beliefs as well as their own personal cultural and colonial heritages. Clearly, self-reflection is required, as is reflection on the profession's core assumptions. This approach, however, is motivated by and directed toward health equity and social justice (Jull & Giles, 2012).

A central critique of the cultural safety approach is that it provides little guidance for therapists about what to *do* (Gerlach, 2012, p. 154), beyond collaborating and engaging with Aboriginal partners (Nelson, 2009). In addition, although proponents insist that *culture* is defined broadly, encompassing dimensions such as age, gender, sexual orientation, socioeconomic status, ethnicity, religion, ability, and race (Gerlach, 2012; Hammell, 2013b), there is little evidence of the concept actually being employed so broadly. It has been used almost exclusively in the context of Indigenous health (Kirmayer, 2012). Cultural safety has, nonetheless, made several very important contributions:

- It refuses to reduce diversity in experiences and outcomes to cultural "difference," shining the light instead on social, political, and economic power relations that shape and determine experiences and outcomes. This perspective moves away from casting "minority groups" as the problem to understanding dominant groups, and particularly, their (largely unconscious) wielding of power and privilege, as the problem.
- It has the potential—at least on the surface—to be applicable to a range of diversity, beyond ethnicity.
- It demands critical self-reflection, not only on professional assumptions and biases (as in the culturally relevant approach) but also on personal relationships to culture and to social power relations, such as colonization. This self-reflection helps practitioners to avoid imposing their cultural values and avoid reproducing inequitable social relations.
- As with cultural competence approaches, it requires awareness and knowledge—particularly about historical and current social inequities—but these are as much about advantage as disadvantage, as much about power as oppression, as much about privilege as discrimination.

- It is grounded in a moral discourse that promotes social change toward equity and justice.

Cultural Humility and Critical Reflexivity

The concept of cultural humility was coined by Melanie Tervalon and Jann Murray-García (1998), challenging the notion of competence as "demonstrable mastery of a finite body of knowledge" (p. 118). Rather than seeing cultural difference as something that resides in the client unlike oneself, they cast it as inherent in the relationship between two equally valid worldviews, the therapist's and the client's. They urge health care providers to be "flexible and humble enough" to avoid the complacency of stereotyping, to assess the cultural narratives of each new patient/client, to admit when they lack knowledge, and to be willing to seek out appropriate resources (Tervalon & Murray-García, 1998, p. 119). Cultural humility requires lifelong commitment to ongoing, courageous, honest self-evaluation and self-critique, examining how one is implicated in patterns of intentional and unintentional advantaging and disadvantaging by ethnicity, race, class, ability, gender, and sexual identity. It demands systematic reflection on enactments of professional power, challenging professional authority through recognition of client expertise, and advocacy guided by community. Humility is a prerequisite in challenging professional authority.

First introduced in occupational therapy by Beagan and Chacala (2012; see also Kumaş-Tan, 2005), cultural humility has been most fully championed by Hammell (2013b), who notes, "Cultural humility challenges occupational therapists to recognize the ways in which their own perspectives may differ from those of others and to acknowledge the advantages that derive from their own professional and social positions" (p. 5). It asks therapists to attempt to redress the power imbalances that attach to professional status as well as to race, gender, class, sexual orientation, ethnicity, and so on. Cultural humility resonates with Nelson's (2009) description of her work with Indigenous communities in Australia:

> We need to be humble in our approach to Indigenous people. Knowing my history also helps me have an attitude of humility with Indigenous people, not assuming that I am the expert and being keen to learn from Indigenous perspectives about health and experiences of disability. (p.100)

In many ways, cultural humility parallels other approaches to diversity. As with cultural competence, it asks therapists to practise self-awareness and sees cultural difference as emergent in interactions. As with culturally relevant occupational therapy, it emphasizes client-centred process and critical reflection on power and cultural assumptions embedded in the profession. As with cultural safety, it links self-reflection with understanding of history and societal power relations.

Importantly, in occupational therapy, cultural humility has been coupled with critical reflexivity (see Beagan & Chacala, 2012; Hammell, 2013b), which insists that self-reflection examine individual practices in relation to social structures and power relations (Kondrat, 1999). Critical theory seeks to understand and confront social inequities. Social structures and power relations are theorized not only as determining people's experiences and outcomes but also as continually recreated, undermined, or transformed through human actions and discourses. Kondrat (1999) insists we all have "day to day involvement in the ongoing construction, maintenance or renewal of the structures of society" (p. 465). Thus, critical reflexivity requires examining how everyday interactions, including with clients, maintain or transform social structure and power relations.

Table 2
Examples of Critically Reflexive Questioning

How is that client's adherence to therapy affected by her poverty?
How does available public transportation affect her?
How does our clinic come to be located where there is little access to public transportation? How does that affect our client base?
How do staff unintentionally enact middle class–ness?
What assumptions do I make that may not fit for working-class or impoverished clients?
Who is likely to feel welcome in this clinic, and why?
How might clients display resistance to middle-class biases in our clinic?
How might we alter clinic culture to be more welcoming?

Critical reflexivity can be a path to identifying and "unlearning" worldviews and behaviours that are systematically harmful to particular groups. It begins with questioning how one is implicated in structures of power (see Table 2 for an example of critically reflexive questioning.) Rather than stopping with reflection on personal feelings or biases, it interrogates "the *relationship* between seemingly unproblematic, everyday behavior and structured outcomes" (Kondrat, 1999, p. 468, italics added). Critical reflexivity understands the individual as always in relation to the social. It sees social inequities as part of the social fabric; while individuals are not at fault for those, individuals are responsible for their ongoing contribution to or transformation of inequities. Critical reflexivity makes "attention to power central, rather than peripheral, to explorations of culture and diversity in occupational therapy" (Beagan & Chacala, 2012, p. 150).

Cultural humility and critical reflexivity are more likely to leave therapists feeling humble and uncertain than comfortable and confident; this is a good thing. Rather than having right answers—as measured in cultural competence—cultural humility and critical reflexivity emphasize asking good questions. Awareness and knowledge give way to critical analysis. Moreover, the need for reflexivity increases with increasing social and professional power. As Nelson (2007) says of her work with Indigenous Australians, "The responsibility for critical self-reflection lies with the representative of the dominant culture" (p. 242).

Importantly, Hammell's (2013b) examination of cultural humility is one of very few publications in occupational therapy to address race, class, sexual orientation, gender, and ability within the framework of culture and diversity. Kirsh et al.'s (2006) study of "minority" client experiences incorporates ethnicity, sexuality, and gender identity. Though they label their approach *cultural competence*, they stress co-expertise between therapist and client, grounded in explicit recognition of structured power relations, processes of discrimination, and historical and contemporary oppression. Similarly, Trentham et al.'s (2007) curriculum analysis attends to a range of aspects of diversity, in an approach they call "trans-cultural competence." Nonetheless, they insist it go "beyond the individualistic notion of cultural sensitivity to consider the systemic and structural barriers" (p. S51) to reach solutions that are political rather than individual. These works suggest that an approach rooted in critical reflexivity may have applicability beyond ethnicity. Finally, Beagan and Chacala's (2012) study is one of the only ones to have examined the experience of "minority-group" occupational therapists, suggesting cultural humility encompasses multidirectional power relations and cultural differences.

Discussion

This review of existing literature is inevitably limited, both in scope and in interpretive analysis. Searches using keywords may miss literature that addresses relevant content using different language. The search also focused only on peer-reviewed articles indexed in CINAHL. More importantly, the interpretive analysis focuses on identifying and critiquing predominant approaches in the literature, which risks running roughshod over nuances within each approach and leaves little space for unique outliers that may in fact pose different and valuable approaches to the field. Nonetheless, within these limitations, some principles appear common to all of the approaches to culture and diversity in occupational therapy: self-awareness, knowledge about other sociocultural groups, and respect for others. There are also important differences and some remaining gaps.

The four approaches are compared in Table 3. They differ in identification of the problem or issue; relationship to existing power structures, both in solutions posed and in ultimate goals; the degree to which they have encompassed multiple forms of diversity, beyond ethnicity; and how well established they are in occupational therapy. Although the most established, the dominant cultural competence approach falls short in its lack of attention to cultural assumptions in the profession itself and lack of attention to issues of power. While objective measures of cultural competence abound—which makes this approach tempting—the reduction of racism, poverty, colonialism, and ethnocentrism to "cultural difference" is alarming. The other three approaches attend to power between therapist and client and cultural biases within the profession, but only cultural safety and cultural humility make broader social power structures central, with a goal of ceasing to perpetuate oppressive relations.

Future Directions and Implications

The absence of attention to other aspects of social diversity, beyond ethnicity, is alarming. There is very little published in occupational therapy on poverty or other aspects of social class, racism or ethnocentrism, gender or gender identity, sexual orientation, religion, or the effects of ableism. There is also surprisingly little research on client experiences of culture and diversity in the therapy context and on minority therapists' experiences. Attention to these gaps may help clarify and deepen conceptual understandings of culture, diversity, competent practice, cultural relevance, cultural safety, cultural humility, and critical reflexivity. Meanwhile, theory, education, practice, and scholarship that employ cultural safety—particularly, extending its use beyond Indigenous contexts—or employ cultural humility and critical reflexivity appear to be most valuable for occupational therapy. Any approach that ignores power relations within the profession suggests an end point of competence can be achieved or suggests incompetence in working with diversity is the fault of the unskilled or unaware therapist should be abandoned or significantly altered, regardless of ease of measurement or fit with competency-based education.

Conclusion

Since the 2007 position statement on diversity was published, there has been an exciting increase in discussion about culture and diversity within occupational therapy. Whereas in 2007 there was insufficient evidence to conclude one approach to working with diversity was superior to another, the wealth of literature published since does allow analysis of the foundational assumptions and implications of various approaches. While cultural competence has the benefit of being well established, measureable, and familiar across professions, it falls short in attention to power relations and application beyond ethnicity. Cultural relevance adds important insight into the ways cultural assumptions are embedded in the theoretical frameworks of the profession, while cultural safety insists that too often, the results of social, economic, and political power structures are misread as cultural difference. Though new in occupational therapy, cultural humility and critical reflexivity offer considerable promise in their attention to structured power relations, application beyond ethnicity, and insistence that the "problem" of diversity is not individual in scope but is always an instantiation of historical and current structural relations.

Table 3
Comparing Approaches in Occupational Therapy

Question	Cultural competence	Culturally relevant	Cultural safety	Cultural humility and critical reflexivity
How is the issue or problem understood?	Difference resides in "minority" clients who need understanding and better practice. "Incompetence" is an individual failing—lack of knowledge, poor attitudes or skills.	The issue is imposition of Western cultural assumptions entrenched in occupational therapy theory and practice.	Cultural "differences" are often the outcome of colonialism and chronic poverty. "Incompetence" is unexamined (colonial) power and privilege.	Clients and therapists are both affected by and part of constructing social and cultural differences, which are hierarchically ordered.
How is better practice to happen?	Awareness (of own and client cultures), knowledge (of client culture), and skills (communication, respect, active listening, adaptation) acquired mainly through contact with "minority" groups	Invite client narratives to avoid irrelevant cultural assumptions and ground therapy in their cultural realities; relies heavily on interview skills	Analysis of power relations, especially social, economic, and political legacy of colonization; attention to power relations within therapy encounters; collaboration with Indigenous communities	Humility, flexibility, openness to learning from the "expert" client; constant questioning of the effects of power structures on client, self, and own practice; critical reflection on power in therapy
What is the goal?	Achieve competence, ability to work effectively with clients unlike oneself; some say an ongoing process of learning	Open process to let worldviews emerge, ensure relevance of therapy process to each client; eventually, alter occupational therapy theory	Ameliorate health inequities and social injustices	Lifelong process of examining own implication in power structures, to effect social change and redress power imbalances in client–therapist encounters
Can it be assessed?	Multiple assessments, some occupational therapy ones; tend to measure attitudes and knowledge, not practice; focus on comfort and confidence	Primarily by clients, though can critically interrogate own practice	Primarily by clients, though can critically interrogate own practice	Primarily by clients, though can critically interrogate own practice
Applicable to multiple forms of diversity?	Almost always reduces diversity to ethnicity, sometimes race	Focus on ethnicity, though potentially open to any form of diversity; no evidence yet	Focus on Indigenous people, though claims applicability to other forms of diversity	Addresses any form of diversity where structured power relations are involved
What are the gaps?	Ignores power relations and social structures, assumptions embedded in the profession	Ignores power relations and social structures, not clear how it differs from truly client-centred practice	Little guidance on what therapists actually do, not clear how it would apply beyond Indigenous groups	Unclear how critical reflection and humility lead to changed practice, especially given institutional constraints
Established in occupational therapy?	Very well established; the language has resonance across multiple professions, institutions	Most literature is from the author of the Kawa Model: critique just beginning to emerge	Well established in New Zealand and Australia, growing in Canada, especially in Aboriginal health and in nursing	Very new, more common in medicine

Key Messages

- Occupational therapy discussions of culture and diversity increased rapidly between 2007 and 2014.
- While cultural competence is the dominant approach promoted in the literature, it has significant limitations.
- With their focus on social power relations, cultural safety and cultural humility with critical reflexivity hold the most promise for the profession.

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Book Review

Hinojosa, Jim, and Blount, Marie-Louise. (Eds.). (2014). *The texture of life: Occupations and related activities* (4th ed.). Bethesda, MD: AOTA Press. 457 pp. US$126.00. ISBN: 978-1-56900-352-7

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The title of this book intrigued me when I was shown the list for review, and I was not disappointed. This fourth edition of *The Texture of Life* presents the art and science of occupational therapy in a unique and compelling way. As noted in the foreword by Barbara Boyt Schell, there have been so many changes in occupational therapy literature, practice, and research (since the previous edition of this book) to warrant a fresh view on where the profession is heading.

The emergence of occupation-centred practice has become a major focus and continuing thread throughout this text. Similarly, spirituality and care of others have joined the ranks in occupational clusters of more traditional company, such as work, self-care, and leisure. From a Canadian perspective, the chapter "The Occupational Profile" is an exceptional resource that provides clarity to and understanding of the core of occupational therapy practice in the United States.

The resources that accompany the narratives are rich and broad in their scope. Accompanying concepts, such as occupational performance and clinical reasoning, are explored in depth and linked strongly to the multiple facets of practice evolving in 21st-century occupational therapy. And this is all accomplished through accessible narrative, with interesting questions woven together with enlightening tables and informative photographs. It is well worth making this book an addition to any library.

Susan Baptiste