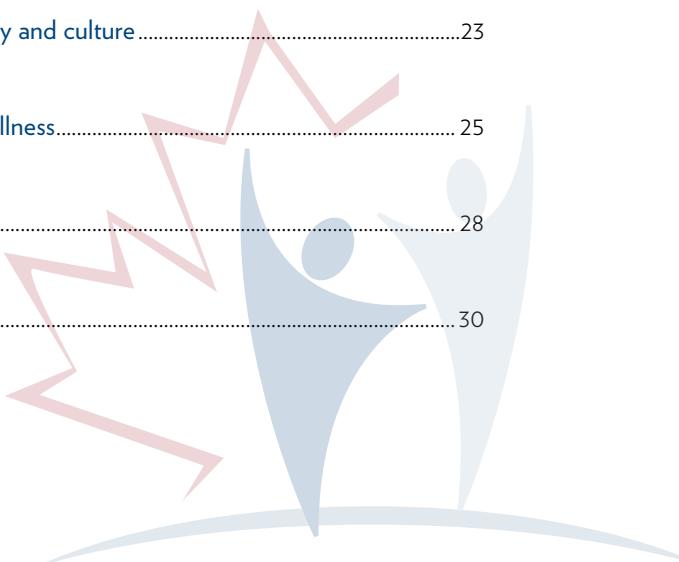


# OCCUPATIONAL THERAPY NOW

OCCUPATIONAL THERAPY NOW VOLUME 14.1

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# Broadening our view of culture in occupational therapy

Elizabeth Steggles and Alison Gerlach

This is a conversation between guest editors Alison and Elizabeth about why they were drawn to edit this special issue of *OT Now* on the topic of culture, and why they think this is an important concept for occupational therapists to explore and expand.

*Elizabeth:* We have been working on this special edition of *OT Now* for almost a year and have only met face-to-face once. I don't think I ever asked you why you developed an interest in culture.

*Alison:* My interest in notions of 'culture' goes back to 1998 when I was invited by the Lil'wat First Nation in British Columbia to provide early intervention and school therapy services in their community. At that time I couldn't find the answers I was looking for to help me make sense of what I was seeing and experiencing, and I remember feeling vulnerable, confused and frustrated. Existing concepts of cultural awareness and sensitivity were limited in addressing my relational and practice issues, so I started reading, learning and developing inter-professional and community relationships to develop my understanding. This learning continues both in community and more recently through my doctoral studies as I explore more critical perspectives on 'culture' and how these translate to practice. What about you? Why did you develop an interest in this topic?

*Elizabeth:* Through the Occupational Therapy Examination and Practice Preparation (OTepp) project, I am working with internationally educated occupational therapists (IEOTs) who wish to transition into practice in this country. One of the findings is that cultural differences have a much greater impact on the transition process than differences in occupational therapy training. This has led us to consider how we can raise awareness and understanding of cultural differences, not only for IEOTs, but also for clients, domestically trained colleagues and employers.

As guest editors we come from different occupational therapy backgrounds and experience. How do you think this has affected our approach?



Alison Gerlach

*Alison:* Interesting that you focus on our differences when what comes to mind for me is what we have in common! I think we both saw this special issue as an opportunity to encourage a much broader discussion on wide-ranging issues that we both see as being 'cultural' and as having relevance for contemporary occupational therapy in Canada. I saw this special issue as an opportunity for occupational therapists who share this interest as a way of having a voice – I was then really curious to see the response. Would submissions reflect the diversity that we have in Canada and hopefully increasingly in our professional membership?

*Elizabeth:* My question was prompted by the fact that you have made a more academic exploration of the nature and impact of culture, but it's true that we have both been led by experiences in our occupational therapy practice that have prompted us to take a closer look. Our discussions and my reading have helped to make my implicit thinking about culture more explicit, although I still have difficulty defining culture. Lionel Laroche (2007) provides a simple, graphic description: "Like water to a fish. A fish does not know that water exists until it jumps out of it." This may sound naïve, but just like the fish, I hadn't truly realized that I view the world through my own individual lens with all its ingrained biases and unrecognized interpretations that are based on my multitude of life experiences. They cannot possibly be the same as anyone else's. I'd like to know how you define culture.

*Alison:* We all love definitions and categories but I have yet to find a description or definition of 'culture' that truly reflects its complexity when you consider how, for each of us, our cultural identity is also influenced by varying degrees in relation to our class, Nation, religion, gender, sexual orientation and the effects of migration and acculturation and so forth, and that it is ever-changing. I think the fish analogy is particularly relevant for White therapists, like us, whose privileged position and culture is largely invisible, unquestioned and often assumed to be universal.



Elizabeth Steggles

In occupational therapy and other health care professions, the concept of culture – as synonymous with, or inadvertently disguised as ‘difference’ in relation to race or ethnicity – seems to be amazingly resilient and I think this says more about who we are as a profession than it often does about a client’s ‘culture’. I think in this special issue we have made a step in the right direction by including papers that explore what the complex concept of ‘culture’ can represent for new graduates, seasoned clinicians and scholars.

*Elizabeth:* What did we hope to get out of this issue?

*Alison:* I hope this special issue gives readers pause for thought. To the readers, I would like to say: While reading the different perspectives of how the concept of culture has been interpreted by the writers, give yourself some time to think about what the word ‘culture’ conjures up for you. Ask yourselves: How would I describe my culture and how does this intersect with other personal factors such as my gender, sexuality, class, race and Nation? What are some of the cultural beliefs, assumptions and values that inform our profession? I know that turning the lens inward – thinking about the unquestioned cultural assumptions that underlie much of our profession – is a tough thing to do. Sometimes we need to experience being the ‘other’ in a foreign environment to do this, and the paper by Kaitlynn Dewhirst and Ashley Whittaker on their experiences in Bolivia is a great example of this.

I am also really excited that we have articles that explore the cultural nature of occupational therapy, as in the paper on mentorship by Leah Dix and Sue Baptiste, and the two papers on mental health, one by Regina Casey, Shalini Lal and Mineko Wada and the other by Shirley Ramos. The influence of gender and sexuality in our profession is dealt with both in Brenda Beagan, Anne Carswell, Brenda Merritt and Barry Trentham’s paper on lesbian, gay, bisexual and queer (LGBQ) experiences, as well as in *The male occupational therapist* by Alexandra Biriukova, Kenneth So and Donna Barker. We also have the opportunity to read how our profession is experienced by occupational therapists who do not self-identify as being members of the dominant White society in the papers by Kaarina Valavaara and by Shaminder Dhillon and Rajni Dhiman.

*Elizabeth:* I think some of the issues you raise relate to the fact that our profession itself lacks cultural diversity and, as a result, we tend to have a narrow view of the world. One of the things we both wanted to address in this issue was the need for greater diversity

within our profession. On one level increased diversity would be more reflective of our client base but, more importantly, I believe increased cultural diversity would broaden our perspective, enrich our creativity and enable us to do things better. I was surprised that we did not receive any insights about disability and culture. I had hoped that we would hear from occupational therapists or students with disabilities about their experience of the culture of academic institutions and employers. Having spent many years advocating for people with disabilities and seeing the challenges faced, it is my perception that our profession is not as accepting as we would like to think. I was, however, very pleased to hear from Lauren De Souza, Yingbo Guo and Olivia Hanson about the simple and effective strategies being implemented at Dalhousie University to reduce bias and ensure equity.

*Elizabeth:* We certainly received a broad range of interesting perspectives. For the most part they related to individual experiences but Susan Wilberg’s description of working with an immigrant family also indicates beautifully how occupational therapy is positioned well to enhance lifestyle transitions whatever they may be. As you say, Alison, I don’t think we began to scratch the surface of the cultural nature of our profession, but there is obvious interest in pursuing this topic further. The *Joint position statement on diversity* (2007) gives us a good starting place. I’d be interested to know how you think we can move forward.

*Alison:* I’m not sure we have enough space to answer that here! I think we need to consider some of the ways in which culture in its broadest sense intersects with occupations and health outcomes in relation to all client populations – rather than it being something to consider when we perceive a client as being ‘different’. I think we need a more critical discourse on culture, including the cultural bias of occupational therapy knowledge, in order to authentically call ourselves a client-centred profession.

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## About the guest editors

**Alison Gerlach** has 20 years of clinical experience in supporting and learning from families, children and colleagues as a community-based occupational therapist in the public and private sectors. Since 1998 Alison has partnered with Aboriginal communities and agencies on a diverse range of projects, including the publication of *Steps in the Right Direction: Connecting & Collaborating in Early Intervention Therapy with Aboriginal Families & Communities in British Columbia*. Alison is a clinical instructor in the Department of Occupational Science & Occupational Therapy at the University of British Columbia, where she is also currently undertaking doctoral studies. Alison’s research interests include promoting health and health care inequities for children living in conditions of vulnerability through critical inquiry, and the development of more inclusive epistemologies and practices in occupational therapy. Alison can be reached at: ag.consulting@telus.net.

**Elizabeth Steggles** is an assistant clinical professor at the School of Rehabilitation Science, McMaster University. Currently she is employed by CAOT and manages the Occupational Therapy Examination and Practice Preparation Project for internationally educated occupational therapists. Elizabeth’s clinical work has focused on accessibility and the use of assistive technology to enhance autonomy for people with disabilities. Most recently, she has served on the McMaster University President’s Advisory Committee on Building Inclusive Communities. She has also led the McMaster campus accessibility audit. Elizabeth has developed and managed services in both public and not-for-profit organizations. She may be reached at: steggl@mcmaster.ca.

# What's new



## Resource Sheets

CAOT is pleased to offer many varieties of resource information for occupational therapists. Resource sheets provide a brief summary of a particular topic area related to occupational therapy practice. NEW 'professional image guidelines' are available at: [www.caot.ca](http://www.caot.ca) > CAOT Members > Professional Practice > Practice Resources > Resource Sheets ([www.caot.ca/default.asp?pageid=119](http://www.caot.ca/default.asp?pageid=119)).

## Job finding strategies

CAOT offers career listings and job finding strategies at: [www.caot.ca](http://www.caot.ca) > CAOT Central > Professional Practice > Careers in Canada. CAOT would also like to tap into members' experiences and successes of finding a job in our exciting profession and invites members to post success stories in finding employment, job search strategies and resources on the CAOT Facebook page. Visit CAOT's Facebook page (Canadian Association of Occupational Therapists) and enter into the Discussions. The topic is listed as "OT Job Search Strategies". We look forward to hearing your stories!

## All New CAOT benefits!

- Eligibility for access to a Member Assistance Program (MAP) whereby you are eligible to receive legal counselling, referral and information services for you and your family.
- Access to the HT Health Works website to allow you and your family or clients to monitor personal health information at: [www.hthealthworks.com](http://www.hthealthworks.com) (Referral ID: CAOT).

- Now available! A revised edition of *Living with Alzheimer's Disease and Related Dementias: A manual of resources, references and information*, 2nd Edition. Also new is *Spirituality and Occupational Therapy*, 2nd Edition. Visit the online store at [www.caot.ca](http://www.caot.ca) to purchase these or other exciting CAOT publications.
- Access to social media services including a profile on Facebook and Twitter where breaking news is brought directly to your fingertips.
- Coming in 2012 – Free online access to the *Australian Occupational Therapy Journal*.

## CAOT-BC

The British Columbia Society of Occupational Therapists (BCSOT) announced their impending closure in August and officially closed their doors on September 30, 2011, despite a number of recruitment initiatives. In response, CAOT has formed a provincial chapter of the Association, CAOT-BC. CAOT-BC is led by a transition planning team. The team has developed a strategic plan that will focus on priorities specific to the needs of British Columbia occupational therapists and encourage a strong voice on provincial professional affairs. In addition to promoting and representing occupational therapy within the province, priorities within the plan include building infrastructure and engaging BC therapists in new initiatives to advance practice and influence health policy.



COLUMN EDITORS:  
ALISON GERLACH & JANET JULL

*"We must cherish our inheritance. We must preserve our nationality for the youth of our future. The story should be written down to pass on."*

Louis Riel (Racette & Ross, 2010)

My journey in occupational therapy began in 2009 when I walked into the first class of the Master of Science in Occupational Therapy program at the University of Alberta. Like many of my peers I was excited, nervous and filled with a passion for helping people, but I had only a vague idea of what occupational therapy would hold for me.

Before I share my story, it is important that I introduce myself and emphasize that this story is mine alone. I cannot and do not speak for the experiences of other Aboriginal occupational therapists. I can only share my story and hope that, through it, I can contribute a unique voice to the profession.

I am Métis through my mother and Finnish through my father. Like many Métis people, I grew up close to my large extended family and spent much of my childhood learning about our family values and history. I grew up aware of my Aboriginal heritage but was always cautious about sharing this part of me. As my family and I begin to shake off generations of colonialism that taught us to be ashamed of our Aboriginal status, I now feel empowered to share my story to help the Métis culture remain vibrant and alive (Iseke-Barnes, 2009).

### **Loneliness as a minority student**

Before entering occupational therapy, I completed a Bachelor of Arts degree in Native Studies and participated in an innovative Aboriginal youth leadership internship with the British Columbia Public Service. I had the privilege of being surrounded by Aboriginal friends, family and colleagues who unwaveringly encouraged me in my journey as an academic, a professional and a young Métis woman. As I entered into

## Finding my own path to travel: An Aboriginal student's journey in occupational therapy

Kaarina Valavaara

occupational therapy with the intention to use my new career to improve the health and well-being of Aboriginal people, I knew I had their full support.

During my first semester, in addition to the whirlwind of learning transfers, occupational therapy theory, anatomy and research methods, I soon found myself in a new position I had not yet experienced as a Métis woman: I felt alone. In my head I knew I had the support of my loved ones, but I had never felt such isolation as I did during some of those early days of my occupational therapy program. I felt this loneliness when I was routinely the only one to introduce Aboriginal health and social perspectives into class discussions. I also felt very alone when I saw Aboriginal clients being treated with prejudice in the health care system during fieldwork, as, for example, when I heard negative stereotypes of Aboriginal people during patient rounds in the hospital.

My classmates and faculty often responded to my contributions and concerns with interest and honest questions about Aboriginal history, health and the role of occupational therapy in Aboriginal communities. However, as many minority students have experienced in higher education, it can be isolating to continually educate and advocate on behalf of your people (Jones, Castellanos, & Cole, 2002). During some long study sessions and group discussions, I did not always have the energy or the words to explain that being Aboriginal means that I might view research and practice through a different cultural lens, or to explain how difficult it is to handle prejudiced attitudes while doing fieldwork.

### **Speaking the same language**

It was not until the fall of my second year when a First Nations woman came and shared some teachings in a class on cultural competency that I was able to articulate some of the tension and loneliness I was experiencing. I was shaken to the core during her presentation as it was the first time in almost a year

### **About the author**

**Kaarina Valavaara, MScOT, BA (Hons)** is a member of the Métis Nation of British Columbia. She is a new graduate from the University of Alberta with a Master of Science degree in Occupational Therapy, currently working in acute care at the Royal Alexandra Hospital in Edmonton, Alberta. You can contact her at: [kaarina@ualberta.ca](mailto:kaarina@ualberta.ca).

and a half that someone at the front of the room was speaking the same language as me; she was using phrases and jokes that felt like home. Speaking with her afterwards, I shared my fears and frustrations about being the only Aboriginal student in my cohort. She gently and firmly reminded me that I should be neither indifferent nor angry with anyone who I felt should know more about Aboriginal people. She instead encouraged me to respond positively by advocating for the inclusion of Aboriginal perspectives in my occupational therapy education. She also encouraged me to continue to work towards being the best occupational therapist I could be so I could advocate for the health and well-being of our communities.

That experience was a turning point in my education as I learned that, even as a student, I had a responsibility to use my privilege, education and knowledge towards positive action for Aboriginal communities (Kovach, 2009; Wilson, 2008). To do so, I needed to ground my occupational therapy education and practice in my cultural values and principles. Aboriginal cultural values are, in general, founded in a worldview emphasizing relationships, accountability and interconnectedness of people with the natural and spiritual world (Wilson, 2008). As such, it is nearly impossible for Aboriginal people to separate cultural knowledge and values from everyday practice as clinicians and researchers (Kovach, 2009; Wilson, 2008).

### Sharing Aboriginal perspectives

After that pivotal experience, I made an effort to connect with other Indigenous health care students to share my thoughts and experiences with and alongside them. Their support provided me with the energy and motivation to continue on the challenging journey of learning how to live my cultural values in my education and career.

I also realized that if I wanted more Aboriginal perspectives represented in the occupational therapy profession, I had to do my part to contribute to occupational therapy literature. I decided to base the research for my capstone literature review in Indigenous methodologies rather than in modern scientific research methods. This process provided the opportunity to explain and defend the use of Aboriginal values and knowledge in the process of reading, evaluating and writing about occupational therapy practice in Aboriginal communities.

I was fortunate to join the Occupational Therapy and Aboriginal People's Health Network through the Canadian Association of Occupational Therapists. By connecting with occupational therapists with similar experiences and interests I can contribute to the development of occupational therapy practice with Aboriginal peoples on a national stage.

### Making our voices heard

As I now reflect on my occupational therapy education, I realize that my experiences there have contributed positively to the development of my voice as a Métis woman. It was through my difficult days that I joined a long history of Indigenous scholars who have persevered to make our voices present across many academic disciplines and professions

(Deloria Jr., 2004). I can only hope that through some of my experiences and decisions, whether it was making sure Aboriginal perspectives were brought into class discussions or introducing Aboriginal methodologies into a literature review, I have honoured those who have come before me. I also hope that my classmates and colleagues are more informed about Aboriginal people in their practice because of our conversations.

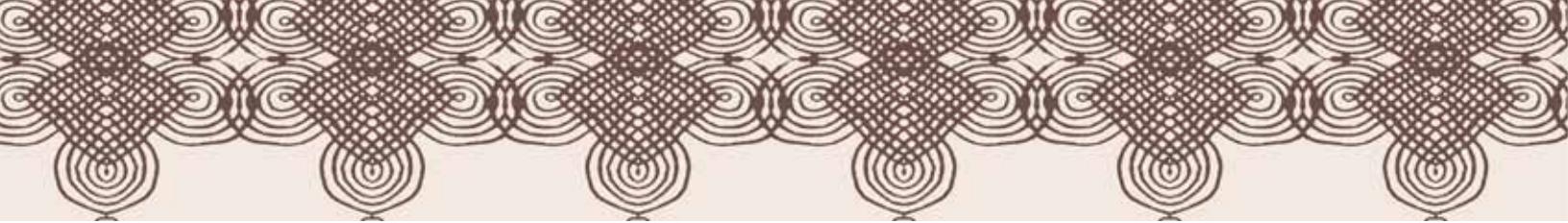
As I enter the professional world, I am excited and overwhelmed by the challenges and opportunities that lie ahead. I am thankful to have the support of friends, family and faculty behind me as I continue to grow as an occupational therapist and Métis woman. I hope to step into a role that advocates for occupational therapy in Aboriginal communities, and to encourage other Aboriginal people to consider careers in rehabilitation so that we can contribute to the mosaic of voices in health care for many generations to come.

While I cannot know exactly how my career will unfold I look forward to being able to support Aboriginal people and communities through my practice as an occupational therapist. I truly believe that “through engagement in meaningful occupations health, well-being and justice are realized” (CAOT, 2011, p.1), and that occupational therapists can contribute to the ongoing healing of Aboriginal people and communities.

During my final defence of my capstone literature review of occupational therapy services in Aboriginal communities, one reviewer said, “I can't imagine you not doing this kind of work.” Me neither.

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## ENHANCING PRACTICE: MENTAL HEALTH



COLUMN EDITOR: REGINA CASEY

# Promoting a culture of family involvement in mental health

Regina Casey, Shalini Lal and Mineko Wada

Several factors have led to this family exclusion, including the era of institutionalization, privacy and confidentiality laws, and unproven beliefs that families cause mental illness. Fortunately, in recent years, this culture has been changing and we see family members becoming involved in the mental health care of their loved one and also in service development, evaluation and research. This shift is in part due to three factors: family advocacy, increased evidence supporting positive effects of family interventions on the outcomes of individuals with mental illness, and valuable contributions by families in service development and delivery. Consequently, we now see sustained efforts to involve families at the broader level of mental health system reform, such as, for example, the extensive consultation processes that the Kirby Commission undertook, and in the ongoing community consultation efforts of the Mental Health Commission of Canada (MHCC).

Given these recent developments, it is timely to consider how occupational therapy practice in mental health supports a culture of family involvement. Culture is comprised of three levels: artefacts (policies/models/frameworks); values (goals and philosophies that are apparent within a system); and tacit assumptions (individuals' thoughts/feelings) (Schein, 2010). Using this framework, this article asks: to what extent do our societal contexts, policies, models, and systems promote a culture of family involvement? And what lessons regarding family inclusion can be learned from other practice settings locally and internationally? In reflecting upon these questions, the authors draw from their collective local and international experiences working in occupational therapy mental health practice as well as from the broader literature. We consider three areas in particular: societal contexts; frameworks, positions, and practice models; and an illustrative example of family involvement in a Canadian regional mental health care system.

## Societal contexts

It is possible that a societal context that promotes a culture of individualism (vs. collectivism) and a biomedical culture of practice have unintentionally contributed to families being excluded by our Canadian mental health care system. Reflecting upon how families are involved in health care contexts within other societies can deepen our understanding of the extent to which social influences support and/or hinder the promotion of a culture of family inclusion within health care systems. In Japanese mental health care, for example, disability is understood to not only stem from illness, but also to be influenced by the social environment. This perspective implies that the experience of disability may be impacted by a family's lack of understanding of the illness. In this instance, service goals might be to lessen the impact of disability by providing the necessary education to family members. Given that family is a fundamental group in Japanese society, family involvement in mental health care is important throughout clients' recovery process (Yamane, 2007).

## Frameworks, positions, and practice models promoting a culture of family involvement

Supporting family involvement in fostering recovery and supporting loved ones who are receiving services from the mental health care system is a key goal outlined in the proposed framework for a Canadian Mental Health Strategy (MHCC, 2009). Goal four is "the role of families in promoting well-being and providing care is recognized, and their needs are supported" (MHCC, 2009, p. 6). Broadening the concept of family involvement further, the Canadian Association of Occupational Therapists' position statement (CAOT, 2008) recommends that occupational therapists collaborate with consumer, family and caregiver organizations, acknowledging:

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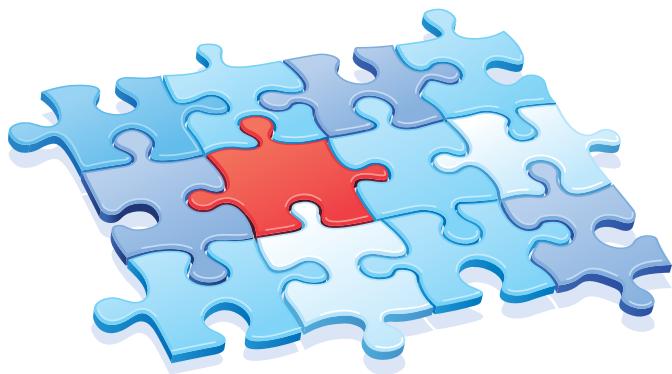
*Service gaps exist, causing families to assume greater responsibility for client care so it is critical to involve consumers and families when planning, implementing and evaluating mental health and mental illness services ... [and to formally recognize] the roles of families and caregivers and provide sustainable funding for support networks and services.*  
*(Background section, para. 5)*

These documents may be seen as artefacts that aim to promote a culture of family involvement.

In our exploration of practice models specific to occupational therapy that can be used to promote a cultural practice of family involvement in mental health, it is helpful to consider those that have been developed within collective contexts where families are valued as a fundamental group in society. The Kawa (river) model serves as one such example. This model is used as a tool to help clients portray their life circumstances by drawing their rivers. The Kawa model uses a culturally relevant metaphor for life to help clients address their challenges, attributes, environmental conditions and well-being in a culturally responsive way (Iwama, 2006). One of the Kawa model's unique assets is its capacity to convey clients' relationships in their social context. Iwama (2006) indicated that sustaining harmonious relationships with family members, colleagues and friends is the most critical determinant of well-being in Japan because Japanese culture is collective in nature. In using the model, therapists therefore encourage clients to reflect upon and capture in their river, how they perceive their relationships with family members and what hinders and facilitates their well-being in these relationships. A shared understanding of the client's perception of the family will help the client and the therapist to determine how family members will be involved in mental health care programs. Thus, this artefact (in this case, a model) serves to make explicit clients' implicit values and philosophies.

### **Family involvement in a Canadian regional mental health care system**

It is also helpful to consider concrete examples of how families are involved in the mental health care system. Approximately 10 years ago, management within Vancouver Mental Health Services developed an initiative to make family involvement a priority or, in organizational cultural terms, 'just the way we do things'. To that end, a coordinator staff position was established at the management level to bring families of clients together to articulate their strengths and needs; thus, ensuring family involvement became valued and expected. Under the stewardship of the Regional Manager of Rehabilitation Services, Consumer, and Family Involvement (an occupational therapist), a comprehensive system-wide family involvement plan was developed. This plan served to lay the foundation for the development of the Family Advisory Committee — a vital group of family members who meet regularly and participate actively throughout the system. The general goal of this committee is to ensure that families are able to voice their



perspectives throughout the different service related areas of the organization. Family members also volunteer their services for a variety of activities including:

1. Taking part in educational and research endeavours including the sixth successful interagency annual conference,
2. Facilitating dialogues in the community on topics such as spirituality and recovery,
3. Representing families on a number of committees including the organization's Policy and Procedure Committee, and
4. Joining interview panels to help select staff.

At the level of service delivery, family support and education sessions are available at different locations in the city. Families seek support and education from professionals and peers on a range of issues.

Thus, family members are involved in service development, delivery, evaluation and research throughout the organization. The organizational culture is influenced both from the 'bottom up' and the 'top down'. The vision to ensure continued involvement of family members at the organizational level is being realized, which is a major accomplishment considering the challenging nature of changing culture (Schein, 2010). This example serves to make explicit the artefacts, values and tacit assumptions that serve to create a culture of family involvement over a 10-year period.

### **Conclusion**

The examples of frameworks, positions, and practice models we have offered here are strong evidence that our mental health care system and our profession are acknowledging the need to ensure a culture of respect and inclusion of families, and that we are recognizing the expertise of families as well as their individual and collective needs. We also have evidence of emerging, promising practice examples of how such broader level frameworks, positions, and models might be implemented to guide our individual values/actions and organizational structures to promote a culture of family inclusion. The example from Vancouver Mental Health Services of how families are involved in a system of care briefly illustrates that creating and promoting a culture of family

inclusion involves consideration and development of artefacts, values and tacit understandings (Schein, 2010) at every point in the system over considerable time.

However, while these examples are promising, the extent to which recommended policies and system level practices for family inclusion are widespread and how success related to these efforts is measured remains less clear. This suggests a potential direction for future research. In the meantime, however, we can continue our critical reflections about the extent to which families are included in day-to-day practice. Moreover, we can also begin to more formally engage in a process of partnering with families in shared reflection on the barriers, facilitators, and solutions to developing and sustaining a culture of family inclusion.

### Acknowledgements

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# Diversity among occupational therapists: Lesbian, gay, bisexual and queer (LGBQ) experiences

Brenda L. Beagan, Anne Carswell, Brenda K. Merritt and Barry Trentham

## Sexual orientation in occupational therapy

Sexual orientation has received scant attention despite recent attention to cultural diversity in occupational therapy. There is very little published literature exploring the experiences of clients and therapists who identify as lesbian, gay, bisexual or queer (LGBQ). (The marginalization of trans-people is even more extreme, but the issues they face are distinct from those of LGBQ persons and warrant a more focused and in-depth discussion than this article can provide.)

In 2000, Clare Taylor argued: "There is a need to demonstrate openness and acceptance so that lesbian and gay colleagues can feel comfortable in what is often a heterosexist world" (2000, p. 411). She noted that sexual orientation is not simply an individual's sexual preference, but as much a cultural identity as race, ethnicity, religion or social class. The same year, Jeanne Jackson (2000) released the only published account of the work experiences of LGBQ occupational therapists. The lesbian therapists in her study reported that their interests and values differed from those of their predominantly heterosexual colleagues. They rarely experienced outright discrimination, but rather struggled with everyday assumptions that left them feeling marginalized, not quite belonging. For example, staff room conversations centred on marriages, babies, struggles with male partners about housework and so on. When lesbians tried to enter into those conversations, they were often met with bewilderment. And when they talked about their relationships or outside-of-work events, this was seen as 'flaunting' their sexual orientation. The lesbian therapists tended to withdraw from casual conversations at work, losing personal and professional connections.

## Heterosexism versus homophobia

Jackson's (2000) work highlights that heterosexism may be more damaging than homophobia in an occupational therapist's

work environment. Homophobia is fear of and/or dislike/hatred for LGBQ people, their sexual desires and relationships. It may manifest as discrimination, intolerance, verbal or physical abuse. Heterosexism is the belief that everyone is (or should be) heterosexual, ignoring other sexual orientations or seeing them as lesser. It is the conscious or unconscious (often unintentional) exclusion of LGBQ existence and realities. The everyday occupational meanings and engagements of LGBQ people are marginalized and made invisible when everyone is unquestioningly presumed to be heterosexual.

Heterosexism is usually unintended. When we are part of a statistical majority or socially dominant group, we easily forget that we see the world through a particular lens or world view not shared by all. We make assumptions and act out of unexamined biases. Nonetheless, heterosexist assumptions, though unintentional, make the environment less safe for those who identify as LGBQ.

## Sexual orientation as cultural

One of the tricky things to grasp is that sexual orientation is not just private or individual, and not just about sex. Certainly gay or lesbian identity is partly about same-sex desire and romantic love, and bisexuality is partly about attraction to either sex, just as heterosexuality is partly opposite-sex attraction. But beyond attraction and romance there are cultural aspects to sexual orientation. Those who identify as LGBQ often identify as having shared history, activities, art, music, celebrations, poetry, fiction, heroes and so on. Despite diversity within LGBQ communities, there are common cultural experiences, ways of being, norms and values. When LGBQ realities and worldviews are marginalized in a workplace, it is not just sexual lives that are rendered invisible; it is whole lives, whole selves and cultural realities.

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## Experiences of LGBQ occupational therapists

We have gathered a few examples of everyday work experiences of LGBQ occupational therapists, from our own lives, and those of people we have talked with:

*"For a number of years I lived in two different and separate worlds – my professional world and my personal world. Coming out to my professional friends and colleagues was scary. I did not look or act different, but I sure felt different. I fit better in my skin and was happy...but I was concerned about how 'coming out' would change my professional image and acceptance."*

*"I am comfortable with who I am as a lesbian. I have a partner of 14 years, great friends and community. I've just never told anybody at work about that stuff."*

*"I was an eager, passionate new faculty member, somewhat conflicted about whether or not to be 'out' with students, though I had always been out in previous work settings. How could I be out and authentic while not conveying to students that I was sharing with them a deep, dark secret? When I discussed my dilemma with a more experienced gay faculty member the response was, 'Why do students need to know your private business?' I felt very let down."*

*"While sitting around the lunch table at the hospital cafeteria, one of my occupational therapy colleagues asked me if I had a husband or boyfriend. When I said no, my colleagues immediately started talking about plans for their 'single girls night on the town' and invited me along. There was little opportunity in the conversation to 'come out' and correct their assumptions about my sexual orientation. The situation felt uncomfortable and threatening. In five years at that hospital, I never came out to my colleagues and avoided personal conversations. In all other aspects of my life I was open about my sexual orientation – this situation left me feeling like a coward and a liar."*

*"Entering a client's room in an acute care facility, I heard some nurses making jokes about gays and lesbians at the nurses' station. I knew this client identified as gay, but I was afraid to challenge them, lest he receive poorer quality care."*

*"I was a new grad, co-facilitating a life skills group on sexuality with a small group of men. Shortly into the session, one of the participants bellowed out, slamming his fist on the table, 'This better not be about faggots – who gives a shit about god-damned faggots. If I ever found one of them, I'd cut their balls off. There better not be any faggots here!!"*

*"A very 'out' gay student approached me knowing that I am lesbian. He had a fieldwork placement coming up in a remote rural area. He knew his presentation of self was pretty effeminate – he looked, sounded, acted gay. He wanted advice on how to handle potential homophobia in his rural placement."*

*"A client saw a photo of me and my partner on my desk at the private clinic where I work. She asked in belligerent tone, 'Who's that?' I avoided the topic somehow, but later talked with a colleague at lunch who said, 'Perhaps you shouldn't have that photo in your office.'"*

## Why does this matter for occupational therapy?

The exclusion and marginalization of LGBQ occupational therapists and their realities matter because it is very difficult to create an authentic relationship with clients, colleagues or students if a major part of who you are is hidden and silenced. How do you connect with clients meaningfully if you feel you must hide important parts of yourself? How much more effort does it take to be always guarded? How engaged can you be? We suggest the toll can be considerable.

Furthermore, we believe that when LGBQ therapists feel pressure to render themselves invisible at work, the therapy environment is also rendered less safe for LGBQ clients. How well can you advocate for clients' safety if you yourself do not feel safe to be 'out' at work? Does the presence of 'out' colleagues help shift the workplace climate to make things safer and more comfortable for clients, too? Does it help encourage everyone to think about non-inclusive language, forms, assumptions and so on?

Occupational therapy has always championed the disadvantaged and cared about diversity. This sentiment is stronger than ever in the profession. But we cannot ask diverse people to enter a profession and then keep hidden those things that mark them as different. It means the whole profession fails to benefit from existing diversity amongst its practitioners. Currently the profession may not be learning from its LGBQ members, wherever those members feel unsafe and silenced.

It is not sufficient to say that LGBQ therapists should simply be 'out' about their sexual orientation and everything will be fine. This puts the onus for change on the group at greatest risk of rejection, marginalization and discrimination. The responsibility for change lies at least equally with those who identify as heterosexual to find ways to be allies to LGBQ colleagues. Even if you don't know whether any of your colleagues are LGBQ, routinely using inclusive language, challenging thoughtless assumptions and trying to alter your own worldviews can help create safer workplaces. Assume 10% of your students, colleagues, and clients are LGBQ and see if that makes a difference!

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# To boldly go.... a new frontier for occupational therapists in Canada

Susan Wilberg

Right here in our own backyard there exists an arena for intervention, where culture has an immense impact on all areas of occupational performance, and for which Canadian occupational therapists are uniquely qualified, critically needed and rarely utilized. This untapped area for occupational therapy intervention and contribution is in the realm of refugee sponsorship, settlement and support.

As a young occupational therapist I often envisioned practicing my profession in a developing country, possibly in Africa. Life's path led in other directions and my vision was not realized. A few years ago, however, a similar opportunity presented itself; Africa, in a sense, came to me. I volunteered to chair a church committee sponsoring a refugee family of five (a mother and four children) from Somalia. I assumed a role for which my skills as an occupational therapist had uniquely prepared me. Through this experience, I became convinced that the process of refugee sponsorship and successful settlement in Canada would benefit enormously from the involvement of more occupational therapists, and provide an exciting and challenging new frontier for occupational therapy practice.

In more than 20 years of experience as a home care occupational therapist/case manager, which included working in a downtown core, working with this Somalian refugee family proved the most challenging case management involvement of my career. The family members had all suffered extensive trauma, spoke no English, had minimal formal education and their physical health status was unknown upon arrival. My role in the context of the team (our church committee) required ongoing assessment of the family's needs in all areas of occupational performance (self-care, productivity and leisure, as impacted by their mental, physical, sociocultural and spiritual health status). We provided direct intervention to teach and coach development of necessary skills. We also identified and liaised with the community resources that could best meet the family's needs and help them successfully adapt to their new Canadian environment.

## Learning culture and coping strategies

Understanding of culture was imperative for this family and impacted all interactions and areas of their function. We learned much in the first weeks following their arrival, when language was a barrier and they were struggling to recover from their journey and adjust to their new reality. For example, we found that music proved an effective and comforting medium, whereas bringing in a gentle therapy dog, rather than easing stress, aroused terror. We later learned that dogs are often feared in Muslim and many African cultures. Basic tasks such as using electric appliances, controlling thermostats, vacuuming, refrigerating food, shopping, money management and using public transit were all unfamiliar to them. Learning these basic skills helped them build confidence and feelings of self-reliance. Later, we also discovered that disclosure during medical or counselling sessions of relevant information such as rape in the refugee camp (an unfortunately common occurrence) was hampered by fear that, if that information got out into their community, the girls would be less eligible for marriage.

Contemporary Canadian cultural views differ from traditional Somali culture on many topics, and these differences periodically caused friction in the greater community and also within the family when the children tried to embrace the norms of their new culture. For example, a member of the Somali community stated that one of the girls



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would be cursed if she pursued her friendship with non-Muslim classmates at school. Their subservient view of women was challenged on the first trip using public transit, where one of the girls felt obliged to give her seat to a healthy young Somali man, and one of the male committee members explained to her that in Canada women did not need to give up their seats to men. The children were not allowed to participate in sex education classes at school, as talk of sex is considered a private matter. The opinion of their clan and of the local Somali community greatly influenced the family's decisions in all areas, including health care practices, education choices, financial practices, socialization and leisure pursuits.

In addition to their cultural differences, many of their coping strategies that had enabled the family to survive in Africa, such as packing up and fleeing when conflict arose, made their settlement in Canada more difficult. They needed to learn strategies other than fleeing to resolve conflicts that arose for them in the apartment complex or at schools. In their previous environment of scarcity they had learned to immediately consume any food or goods they acquired, therefore skills such as budgeting and planning for the future were luxuries they had never experienced, and needed to learn.

### Ideally suited for refugee work

A "client-centred" approach, intuitive to most occupational therapists, proved an indispensable tool for our work with the family. Focusing on and respecting what the family members identified as their needs, priorities and goals was essential to

our meaningful involvement with them. Seeking to understand and recognize their culture, and acknowledging their religious holidays such as the two observances of Eid<sup>1</sup> helped build rapport and trust; it also provided an unprecedented opportunity for us to develop a better understanding of Muslim and Somali culture.

Occupational therapists, by virtue of our education and experience, are ideally suited to take an active role in the sponsorship, settlement and support of refugees who have suffered physical and psychological trauma. This unique arena, where culture and cultural adjustment impacts all aspects of occupational performance, provides a complex and challenging opportunity to utilize a client-centred occupational therapy approach where the therapist grows and learns along with the client. I am hopeful that occupational therapists will seek involvement and employment in this area in the future with pertinent government and non-governmental agencies. There is a need for a more coordinated response to refugee support, where occupational therapists could bring their holistic view, case management skills and experience working in multidisciplinary teams to help bring the various agencies involved in refugee sponsorship and support together. In this way, our profession could work to integrate services within a region and streamline processes for sponsors and refugees alike — to boldly go where few occupational therapists have gone before — and, in the process, help build healthy, independent and self-reliant Canadians.

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<sup>1</sup>These are two Moslem holy days of Eid; one celebrates the end of Ramadan and the other commemorates the completion of the Hajj pilgrimage.

# Culture, reflection and client-centred practice: Putting the pieces together

Kaitlynn Dewhirst and Ashley Whittaker

As new occupational therapy graduates from Queen's University, we are very excited about leaving the academic setting and entering the practice setting. As we reflect back on the most influential lessons we learned during our time completing our MScOTs, our international community development placement springs to the forefront. This article describes our experience of studying in Bolivia and our insights into the importance of reflective practice, culture and client-centred practice for occupational therapists working both within Canada and internationally.

For two months in the summer of 2011, we embarked on an inspiring and resilience-testing journey to Bolivia. Studying with the Ivar Mendez International Foundation (IMIF), we were afforded an opportunity to see how the principles of community development that we had learned in school were put into action. The IMIF is a non-profit charity based in La Paz, Bolivia founded by Dr. Ivar Mendez, a Bolivian-Canadian who, during a personal trip to the country, observed the effects malnutrition had on children living in the rural Bolivian Andes. The Foundation aims to remove barriers that may hold Bolivian children back from reaching their full potential, and to provide those children with a stable platform upon which to learn, grow and develop. The Foundation focuses on facilitating proper nutrition, shelter, health, and education for children and women in the Bolivian Andes, specifically in Muneca Province. The IMIF believes these essential elements are core determinants for achieving full life potential. Their focus is on assisting the children to be agents of change within and for their communities (Ivar Mendez International Foundation, 2011).

Most of our placement took place in the very rural Muneca Province in the northwestern area of the country, close to the Bolivia-Peru boarder. We spent a few weeks based at the IMIF's regional office in La Paz and the majority of our time traveling to 10 different rural communities: Huanco, Yanahuaya, Charaj, Aucupata, Puslliani, Cosnipata, Rosario, Chairani, Quiabaya and Colquencha. The travel in itself was an eye-opening experience, as, for the most part, we traveled either by bus or by foot. Our journey to the first rural

community was via a 12-hour bus ride, winding our way up steep shale mountainous roads. A few of the communities we visited were accessible by vehicle, but to access the others we had to hike for up to two hours each way. At times the hikes were dangerous as we navigated around overgrown and mucky mountain paths, rock slides and, occasionally, charging bulls. It was during these times in the rural countryside that we gained greater insight regarding how the core occupational therapy principles of reflective practice, culture and client-centredness intertwine and influence our occupational therapy practice.

## Developing skills of self-reflection

Reflection is the "active and intentional process of examining past experiences, theories, beliefs and assumptions held by clinicians with the aim of improving and shaping future alternatives" (Park-Taylor et al, 2009, p. 90). Reflective practice develops an occupational therapist's ability to engage in client-centred, collaborative and culturally sensitive practices that can address occupational challenges (Townsend & Polatajko, 2007). Engaging in the reflective practice process can expose assumptions and can result in the identification and creation of a new possibility (Beam, O'Brien, & Neal, 2010). Throughout



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our academic schooling, we developed this skill of reflective practice; however, it was through our placement experiences where we were truly able to apply it. The depth of our ability to reflect was enriched during our time in Bolivia as we were exposed to a new client population.

Our experience of reflective practice during our previous fieldwork experiences in Canada set the foundation for us to further develop our skills while in South America. We were students in a novel setting — with an unfamiliar language, new food, and new culture in every sense of the word — and the necessity to self-reflect became heightened. We felt that to understand the new culture and community we were entering we needed to understand our own biases that influenced the lens through which we viewed the communities. Interestingly, we found our reflection the most enlightening when we were exposed to difficult situations. For example, while scaling the mountainous Andes to get to our first community of Puslliani, a grueling two hour hike uphill, we encountered many children walking along side us. After some questioning of our Bolivian team we became aware that these children take this long hike every day to receive their education. We were being put in one of our most challenging situations of the trip, only to realize that the local children must do this everyday, twice a day, to receive an education. The seemingly simple act of taking a walk with a child became a window into the values of their home and community. It was not easy to scale the dangerous mountainside, but for those children the discomfort of the walk was overshadowed by the meaning and importance of education. Through such reflection we were able to identify other possibilities that may have been limited by our own assumptions and biases. In a community such as Puslliani, where agriculture is the representation of daily life, we had assumed that education took a backseat to productivity. It was vital when working with a culture to which we were not accustomed — a new culture in all respects: language, customs, rituals, socio-economic status, education, priorities and values — to put our assumptions aside and explore other frames of reference. When walking into a community where most of the families were subsistence farmers with little to no formal education, we needed to be open to all the factors that may be influencing that community. By stripping away our expectations we were able to see the possibilities available within these communities.

As our understanding of the language and culture of each remote rural community developed, so too did our ability to understand our clients' perspectives. We began to understand what was important to their communities and then were able to approach our interactions with a greater appreciation of their values and beliefs. If we had not spent the time understanding our own biases and assumptions, we would not have been able to be open to the perspectives of the communities we were working with. Our self-reflection

increased our awareness of the cultural values which, in turn, allowed us to provide client-centred care.

### **Understanding our clients' perspectives**

Our initial ignorance of the nature of the rural and impoverished communities we were working with forced us to become immersed in their holistic Bolivian culture. Our ignorance of our clients' language, culture (it was the first time either of us had been to a South American country), and environment (our first time visiting an extremely isolated and rural areas) became our biggest asset. Our ignorance made us curious; it allowed us to get beyond bureaucracy; it allowed us to get at the heart of our clients' goals.

During our time in Bolivia we were exposed to peoples of many different cultures, from the indigenous Quechua and Aymara peoples to the Spanish colonial descendants, all of whom were living in extremely rural and isolated communities. The communities themselves were vast and unique, ranging from mountainous geography to subtropical landscape; from subsistence farmers to middle class mining families. This experience allowed us to meet many different people with varying occupational profiles and occupational challenges. And the underlying message we bring back from working with all of these diverse peoples and communities is that client-centred practice is an important principle that can help guide and influence the outcome of the client-therapist interaction, be it with an individual, group or community.

Looking back over each community we visited, we learned that each approach we took to engage with each school had to be unique to their specific environment. For example, in some communities we met with children climbing on us before we were able to even get off the bus. But in one school we noticed that the children appeared frightened and nervous meeting two foreign people. Before we went further, we had to create an environment of trust and respect, so we asked ourselves: what do all children love to do? Play, of course! As a team, we took a divide and conquer approach to play. Respecting that regardless of culture there are inherent personality traits of children all over the world, Kaitlynn took on the group of curious but cautious kids for a game of Frisbee, while Ashley took the significantly shy children for sit-down songs and games equivalent to Ring around the Rosie. Play became the equalizer, helping us overcome cultural and linguistic barriers. Approaching each community with an appreciation for their individual needs was an important lesson of the importance of client-centred practice.

### **Bringing knowledge to Canadian practice**

From our experiences in a developing country with an organization that demonstrates the principles of community development, we now appreciate the importance of understanding what client-centred practice really means.

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*"We felt that to understand the new culture and community we were entering; we needed to understand our own biases that influenced the lens through which we viewed the communities."*

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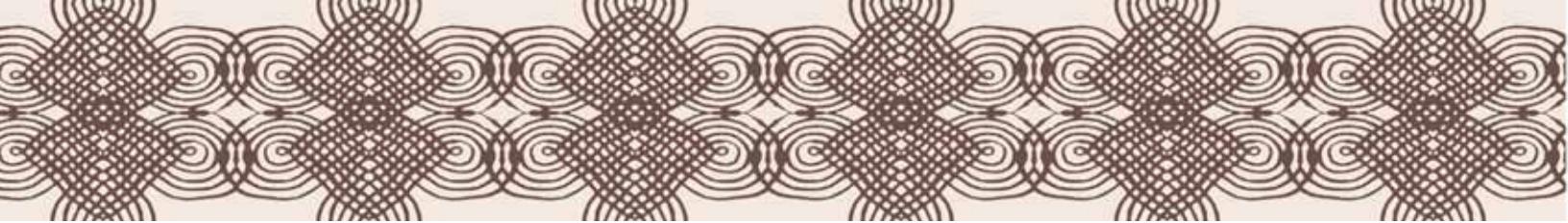
Client-centred practice means investing the time to understand the factors that influence a client's perspective and applying that knowledge to better serve your client. It also means leaving your own assumptions and biases at the door, and being open to the possibilities that the synergy a client-therapist relationship can produce. With the knowledge to apply the lessons we learned in Bolivia to our future clinical setting, we both have a true appreciation for the power that community development principles hold for inspiring change. We quickly became aware while in South America that to provide occupational therapy is not to bestow a modality upon our clients but rather to empower our clients through a collaborative process to become agents of change themselves. These same principles can be applied within Canada to any setting in which occupational therapists practice. By appreciating that the client is creative, resourceful and whole, the therapist can engage in a collaborative dialogue to improve the client's occupational profile, regardless of race, ethnicity, setting or culture in the larger sense of the word.

The two months we spent in Bolivia will forever shape our future practice as occupational therapists. We are proud to say

that our ignorant curiosity has followed us to Canada and we are now eager to use it in whatever clinical setting and context we may practice; whether that is school health, long-term care homes, or direct one-on-one treatments. It has inspired us to believe in the human potential and that our greatest resource lies in the abilities of our own clients. It is our role to appreciate the cultural context, while empowering the client to believe in themselves and their potential.

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# The male occupational therapist: Demographics, issues and recommendations

Alexandra Biriukova, Kenneth So and Donna Barker

Since its origin in the 1900s, occupational therapy has been a female-dominated profession. To date, males comprise only 8% of practicing occupational therapists in Canada (Canadian Institute for Health Information, 2010). Although this number has been slowly increasing in the past 15 years, researchers report that 74% of practicing male occupational therapists expect to leave the profession within 10 years (Brown, 1995). The following gender-related issues have been found to contribute to attrition of male occupational therapists from the profession (Parish, Carr, Suwinski, & Rees, 1990; Readman, 1992):

- Hesitancy to allow males to carry out certain treatment techniques with female clients (e.g., dressing assessment/treatment);
- Use of male practitioners to perform manual labour tasks (e.g., lifting or restraining clients); and
- Lack of appropriate departmental facilities (e.g., male change rooms).

This research is, however, outdated and incomprehensive and, as a result, we decided to embark on a research project to update current challenges of male occupational therapists in the workplace. Alexandra's interest was academic as she wanted to address the gap identified in the existing research and master the art of completing a comprehensive research project. Donna's interest was practical; she wanted to find out more about appropriate training of male occupational therapy students for fieldwork placements and their future careers. Ken's interest was more personal due to his lived experience as a practicing occupational therapist for over 25 years. In his own words:

"I have experienced many situations where my gender has dictated my role, with expectations from others to be mechanically minded, computer and technologically savvy, able to do heavy lifting and transferring, and to handle potentially aggressive clients. Fortunately for me, I did have interest and ability in these areas but such assumptions about male's interests and abilities have the potential to limit scope of practice, decrease job satisfaction and question one's place in the profession. I have experienced the refusals of female clients to participate in ADL (assessment of daily living) assessments, but I have also had clients request my involvement in their care. I was interested to see whether the experiences of male occupational therapists throughout Ontario were similar to mine."

## Male therapists in Ontario

As a result of these interests, we designed a study to collect data on the demographics of male occupational therapists in Ontario, current gender-related challenges encountered, expected attrition rates and recommendations to enhance the working experience of male occupational therapists. We gathered our data through a survey that was built on an extensive review of the existing literature and included questions about participant demographics, areas of practice, gender-related challenges encountered in practice, and future career plans.

A total of 37 male occupational therapists participated in the study. The majority of participants were 21 to 40 years of age (72.9%), held bachelor's (40.5%) or master's (40.5%) degrees in occupational therapy, practiced outside of Toronto, mostly in southern Ontario (70.2%), and were members of the Canadian Association of Occupational Therapists and/or the Ontario

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Society of Occupational Therapists during the 2007-2008 membership years. A total of 86.5 % were currently working as clinicians, practicing in the community (74.3%), private sector (60%), and rehabilitation services (57.1%) settings. Most participants worked with adult (94.6%) and older adult (81.1%) populations.

Results showed that more than 50% of participants had experienced the following issues at least occasionally, which they attributed to gender: being asked to transfer a heavy client (62.2%), being asked to control an aggressive client (64.9%), being asked to fix equipment (56.8%), and being excluded in social situations with female colleagues (60.6%). The majority of participants reported never experiencing the following issues: lack of appropriate departmental facilities (81.1%), hesitancy of employer to allow the participant to perform either a paediatric assessment (88.2%) or a psychosocial assessment/treatment (70.6%), or to allow the participant to provide sexual or feminine hygiene education sessions (90.0% and 90.9% respectively).

Study participants made the following comments about other gender-related issues they have experienced: "dress code... ok for women to wear shorts in summer but men are discouraged" and "when it came time to taking time off due to illness or burnout, I never felt that management was sympathetic to this issue". One other participant also reported being asked "to go to certain clients' homes due to female therapists being scared of being attacked."

When asked about their future plans, respondents reported that in five years they wanted to: continue working in the same clinical area (71.0%), to practice in different clinical area (35.5%), to go into occupational therapy-related teaching (25.8%), or to commence occupational therapy-related (25.8%) or non-occupational therapy related (22.6%) further education. For a time frame of 10 years these numbers were: 50.0%, 36.7%, 30.0%, 16.7%, and 23.3%, in that order. In addition, 16.7 % and 26.7% of all respondents reported that they would leave the profession altogether in the next 5 and 10 years respectively. Participants made several recommendations about improving the working experience and retention of male occupational therapists (see side panel for details).

### Some encouraging changes

After analysis, the authors determined that in this current survey, more participants held master's degrees, worked in the community and private sectors and worked with more diverse populations, as compared to previous research (Brown, 1995). Higher numbers of male occupational therapists working in community and private settings correspond to the recent proposed reform in the delivery of primary health care in Canada with the move to a community-based, home-based, and private care (Ministry of Health and Long-Term Care, 2009). It was encouraging that the number of participants expecting to leave the profession in 10 years was only 26.7%, a decrease from 74%, as reported in 1995 (Brown, 1995). Some private and community work settings can offer more autonomous and higher paid jobs for occupational therapists, which may affect the lower number of participants expecting to leave the profession as these are two of several factors that

were recognized to be very important for male occupational therapists (as discussed in Brown, 1995).

### Gender still an issue

Despite the differences discussed above, current findings did support previous research (Parish, Carr, Suwinski, & Rees, 1990; Readman, 1992) that participants reported experiencing some similar gender-related practice issues. Other factors such as practice setting, culture, skills, age and physical build of the therapist could also be associated with these issues. Further research is required to understand relationships among and between these factors.

### Recommendations from participants for improvement of occupational therapy as a career for males:

- Improve male occupational therapy networking to allow male occupational therapists to discuss issues together
- Employ "strategic education and recruitment" geared towards attracting and retaining men to the profession"
- Include "more diversity training for both genders in the curriculum" with "less gender bias in educational texts and materials"
- Employ "gender diverse occupational therapy faculty"
- "Profile more male occupational therapists in various publications and at career days in schools"
- Increase awareness "about issues male occupational therapists face in comparison to female therapists"
- Pair male occupational therapy students "with fellow males therapists during placement experiences"
- Make occupational therapy education more male-oriented by including more information about business
- Increase levels of responsibility for occupational therapists

We hope that the information from this study will be used to inform professional and government organizations that seek to advance the profession and increase numbers of occupational therapists through recruitment and retention strategies, and also used by clinical employers, educators, and university programs to enhance performance and satisfaction of male occupational therapy practitioners and students in the clinical environment. However, we also hope that this information will cause us individually and collectively as a profession to consider whether we are inviting and encouraging diversity in our profession. We need to reflect on our own words and actions and ensure that we are not making assumptions about our colleagues that restrict or dictate their practice. This study reminds us that each occupational therapist brings his/her personal touch to the art

and science of occupational therapy and we should celebrate and encourage areas of diversity such as gender that will move us forward as a profession and ultimately positively impact our clients and our society. As Ken reflected:

"I have been able to see the positive impact of males in occupational therapy and in health care in general. The opportunity to explore function in a holistic manner, work with clients to achieve meaningful personal goals and a balanced lifestyle, and the flexibility to be creative, innovative and expand the scope of occupational therapy practice keeps me interested in this great profession and excited to be an occupational therapist even after all these years!"

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# Mentorship to facilitate exploration of cultural values

Leah Dix and Sue Baptiste

Mentoring and culture can be challenging concepts to define and as such, create diverse images for each of us. In this article we discuss how engaging in mentorship can enable occupational therapists to develop increased awareness of how culture is influenced by and influences their professional practice. We look at the benefits of mentorship – both for mentors and mentees – in the context of the first mentorship module offered through the Occupational Therapy Examination and Practice Preparation (OTepp) project. The OTepp project helps internationally educated occupational therapists (IEOTs) in their transition to Canadian occupational therapy practice. Successful transition requires IEOTs to understand how cultural beliefs shape their practice in Canada.

## Culture

Culture includes more than simply ethnicity and diverse, overt characteristics (Fitzgerald, 2004; Polatajko et al., 2007). It is far more complex, influencing and being shaped by all of our professional and personal interactions (Hammell, 2009; Iwama, 1999). Culture is dynamic, continually changing, as people's views and beliefs are altered and refined. We hold cultural beliefs that impact our choices and occupations (Bonder, 2001) and that define our profession (Hammell, 2009; Iwama, 2007). Fitzgerald (2004) defines culture as "the learned, shared, patterned ways of perceiving and adapting to the world around us (environment) that is characteristic of a population or society" (p. 494). Consistent with this definition, student occupational therapists learn the cultural values and behaviours necessary for practice as an occupational therapist. The profession itself becomes a culture, with unique characteristics and beliefs. For example, occupational therapists provide client-centred services; this represents a cultural value adopted by the members of the profession in Canada. These prevailing cultural beliefs that define our

profession are and should be continually reconstructed (Iwama, 1999) over time as new knowledge is acquired.

Canadian occupational therapy graduates can struggle to find a professional identity and require a period of socialization to the profession (Tryssenaar, 1999). Tryssenaar indicates this challenge is heightened when ideals and values (thus cultural beliefs) are challenged in the workplace. IEOTs may face additional challenges in the Canadian workplace when they have been educated in countries with different educational philosophies and health care systems. For example, if an IEOT has previously practiced in a hierarchical health care system, it can be difficult to assert one's self as an autonomous health care provider in Canada. Occupational therapy practice in a hierarchical society requires following the orders of more esteemed health care professionals. This contrasts with expectations in Canada of occupational therapists to advocate assertively for the best interests of the client even if this goes against the recommendations of other team members. Hierarchical societies also favour delegation over collaboration, but occupational therapy in Canada favours collaboration. This may pose challenges for some IEOTs in interprofessional practice environments.

Professional socialization involves an acculturation into the occupational therapy profession as practitioners acquire skills congruent with the professional culture (Hayden, 1995). Some IEOTs seeking to work in Canada need to enhance their prior knowledge of occupational therapy by developing skills specific to the Canadian health care system. For example, many countries do not involve occupational therapists in providing services to clients who have experienced motor vehicle accidents. Different cultural beliefs in other parts of the world about dying, and the role of the family in that process, can result in role and skill confusion for occupational therapists working in palliative care in Canada.

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## Mentoring

Mentoring is an important process whereby occupational therapists – both as mentors and mentees – can better understand their professional cultures as well as those of their clients. Mentorship is based on a more experienced individual providing guidance, knowledge and support to a colleague with less experience (Baptiste, 2001). Mentoring allows an individual to do more than just reflect on his or her learning; reflection allows for processing learning thus validating experiences and integrating them into subsequent opportunities (Zachary, 2000). While one might argue that reflection can be undertaken individually, increased awareness is more likely to result from one being prompted by another to consider alternative meanings and actions (Moon, 2004). What is also unique about the mentoring experience is the reciprocal learning and benefits that occur, not just for the mentee but also for the mentor (Baptiste, 2001). Engaging in reflection with a mentor allows both the mentor and mentee to consider their own cultural values and practices in comparison to others. By learning from one another, each of the participants can engage in skill development and learn more about themselves and others' professional practice.

The process of working with a mentor of choice proved helpful to IEOTs participating in a mentorship experience with Canadian occupational therapists during the first offering of a mentorship module within the OTepp project. The mentors who participated were recruited via an email blast sent by the Canadian Association of Occupational Therapists (CAOT). The response exceeded expectations and not all interested mentors could participate. All of the mentors participated online and, as a result, represented different parts of Canada in addition to varied practice areas and settings. The mentees who participated in the module were educated in different countries. The majority were residing in Ontario and British Columbia, although one participated online prior to arrival in Canada. The module was offered concurrently face to face and online.

The mentor and mentee groups completed reflective exercises independently prior to meeting with one another. This allowed each to better understand and articulate their beliefs and values. Thus, both the mentor and mentee were required to examine how their cultural views could shape the mentoring experience and ultimately their practice of occupational therapy. The occupational therapists in the mentoring dyads worked in partnership around individualized goals specific to the needs of the mentees. The mentees were able to determine with their mentors how and why cultural differences existed within specific practice areas or within aspects of their transition to Canadian occupational therapy practice. Through discussion with their mentors, the mentees had the opportunity to learn more about the culture of the profession as practiced in Canada and, in some instances, the cultural uniqueness of specific areas of occupational therapy practice. The mentor dyads explored goals as varied as understanding the interview process used to hire occupational therapists in Canada to understanding the nuances of a specific hospital setting and the types of assessments used within that program.

As a result of their mentorship experience, the IEOTs indicated they were better able to understand and articulate

the nuances and unique differences between practice in the country in which they previously worked and Canada. The mentors also reported they were able to enhance their own practice by reflecting on it consciously with the IEOTs. For example, when questioned by the IEOT about the appropriateness of a specific assessment tool, one mentor reflected on and recognized the merit of its use in her specific occupational therapy practice setting.

Finally, the majority of the Canadian occupational therapists who participated as mentors expressed their willingness to return in that role. This is a testament to the overall value of the experience for them as well as for the mentees.

## Conclusion

Preliminary evidence from the OTepp project indicates that mentoring has helped IEOTs to better understand how their cultural beliefs shape their practice of occupational therapy in Canada. While clearly helpful to IEOTs, all occupational therapists can benefit from reflecting on their personal and professional beliefs and the values of the profession since both individual and professional cultural beliefs influence client interactions and the individual practice of occupational therapy.

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# Dalhousie's School of Occupational Therapy takes affirmative action for equity and culture

Lauren De Souza, Yingbo Guo and Olivia Hanson

Occupations of self-care, leisure and productivity are culturally defined, individually valued and occur in diverse contexts. The subjective nature of occupation means that providing client-centred care often begins with recognizing our own biases and evaluating the impact of these on the client's individual experiences. At Dalhousie University's School of Occupational Therapy, students have recently explored the cultural contexts of occupation and barriers to awareness to reflect upon how these biases affect our provision of care. We have done this through various activities organized by the student branch of the Affirmative Action and Equity (AA&E) Committee.

The AA&E Committee is responsible for identifying challenges to equity at the School and for recommending strategies to ensure that appropriate policies and practices are integrated in the occupational science and occupational therapy programs. As well, the committee is responsible for providing guidance on and identifying ways to address social inequalities within the school and in the everyday interactions among students, staff, faculty and community members.

The student branch of the committee was reinvigorated with the class of 2011 when we began working on changing the social landscape of the school towards becoming more equitable. As in therapy environments, visible social, economic and religious symbols as well as invisible stigma in a school environment can hinder or facilitate an individual's comfort and willingness to collaborate in learning. Being self-reflexive is an important way to create an open and safe environment in a school or therapeutic setting. The committee encouraged students to be self-reflexive to evaluate their own backgrounds while also providing students with the opportunity to share and learn from one another. Through discussion the committee identified key biases and created activities to create awareness and develop an inclusive environment.

## Identifying biases and blind spots within

Early in our program, we realized that there were biases and "blind spots" amongst our own community that might make some students feel less comfortable; certain comments challenged a sense of belonging and "right to belong". The student activities of the AA&E Committee therefore focused on three main themes through the first year:

1. Diversity is not always obvious. Diversity can arise from subtle differences in family life and from different social experiences.
2. "Disabilities" can be hidden. Our peers can be experiencing medical, social, and cultural disabilities that are invisible yet surrounded in negative stigma.
3. Client-centred care that incorporates cultural awareness begins with self-reflection.

We addressed the first theme – that diversity is not always obvious – by hosting a potluck with the theme "Foods you grew up eating." Through this, students explored various cultural foods and realized that those from similar racial, socioeconomic as well as geographic backgrounds often have diverse foods to share due to differences in family backgrounds.

To deal with the theme of hidden disabilities, we created a board titled "If You Only Knew..." inspired by Frank Warren's *Post Secret* books and presentations. Students, staff and faculty were asked to reflect and write down anonymous secrets that they wanted to share regarding experiences around anything from mental health-ism, racism, sexism, and many other "isms". These were posted to bring awareness of the diverse experiences that shape individual lives. To bring closure to and discuss the topics on the board, a faculty member eloquently summarized and grouped the types of secrets to lead an enriching discussion around concepts on the board. Discussions were initiated on categories of "mental illness", "low socioeconomic status", "aboriginal status", and



“family tragedies”, and how these concepts may arise in practice.

To address the third theme of how client-centred practice begins with self-reflection, we organized one of our largest projects. This project was a “diversity in occupation” tour at Nocturne, which is an annual all-night art show in Halifax. Our aim was to reach out to the general public to challenge their assumptions about who participates in what occupations, and to discuss the diversity in occupations. Through challenging their assumptions, we wished to promote self-reflection, both for our students who participated, as well as the public. We did this by highlighting the various art exhibits that showcased individual or group occupations in a variety of art forms. For instance, one exhibit shed light on emotions felt by those involved in the Halifax explosion. After the exhibit, the students leading the tour group asked participants how they thought the occupations of the survivors had changed or been affected after this terrible tragedy. We also asked thought-provoking questions to help participants think about the links between occupation and culture. For example, we asked them to think about what life would have been like if the survivors had a disability, or were a member of a minority group in Halifax, or were subject to discrimination?

These activities, along with many other fun and exciting projects completed by the AA&E Committee throughout the past two years, have allowed students to gain a better understanding of how social structures that disadvantage some and privilege others play out in occupational therapy practice. Through this process, students have learned that cultural issues are not limited to issues around race, ethnicity or sexual orientation, and that they are real issues that we as future occupational therapists will face in the working world. We have understood that our future peers, clients, colleagues and co-workers will come from different backgrounds, will have diverse health issues, and will indeed be faced with multiple

social influences and issues, similar to the ones brought to the forefront within the school. We have seen that it is crucial that occupational therapists gain cultural humility when faced with such issues and should be aware of and able to learn the skills necessary to meet the needs of others.

### Looking ahead: Diversity and plurality

This year, the student branch of the AA&E Committee has more interesting and stimulating activities planned. In 2012, we will be using an interactive approach to the school’s discussion board to highlight the impact of social influences on individuals’ occupational choices. Some of their proposed ideas are to post pictures from the media to provoke questions and bring to light social influences. The committee also plans to promote ways to apply our knowledge of social influences such as sexuality, race or ethnicity to better therapeutic practice. This is important as the diversity and plurality of the nation is ever increasing as immigration rates rise (CBC, 2008).

It is our hope that by encouraging students to become more aware of aspects of culture, equity and diversity, future occupational therapists will have a better understanding of how occupations are culturally defined and subjectively valued. We hope that future therapists not only provide culturally-safe care through self-reflexive practice, but also gain skills in enabling occupations for diverse clients and communities.

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# Cultural competence in mental health: Looking through the lenses of mental illness

Shirley Ramos

As a clinician practicing in adult mental health, I have come to recognize that it can be challenging for occupational therapists to fully appreciate and understand other people's hardships and life stories, especially when these stories involve recovering from a mental illness. However, looking through the lenses of mental illness or 'walking in our clients' shoes' is, in my opinion, essential in providing a culturally-competent recovery-oriented practice approach with clients diagnosed with mental illness. In this paper I share my perspectives on cultural competence in mental health and the culture of mental illness, which extends beyond the traditional connotation of culture and ethnicity, and I look at how clinicians may develop cultural competence while working with individuals with mental illness.

## Cultural and social contexts are key

Gary (2005) indicates that cultural and social contexts are large pieces to the puzzle of recovery in mental health. Whalley Hammel (2009) defines culture in an occupational therapy context as a "multifaceted concept" made up of "the knowledge, beliefs, attitudes, morals, norms, and customs that people acquire through membership in a particular group or society" (p. 7). Occupational therapists use a recovery-oriented and client-centred practice (CCP) approach when providing clinical care to their clients (Law, Baptiste, & Mills, 1995; Casey, 2011). Both approaches consist of similar core values, which include partnership, client autonomy and responsibility, contextual congruence, accessibility, and respect for diversity (Law, Baptiste, & Mills, 1995). From my perspective and experience, mainstream society places significant value on independence, higher education, employment and the material goods one possesses. Several of these determinants often define who we are as individuals and may contribute to our socio-cultural classifications. However, for clients with mental illness, engagement in activities such as education, employment, housing and leisure may be limited. Contributing factors include, but are not limited to, stigma that is attached to having a mental illness, limited family supports, inadequate funds, and decreased opportunities in employment or education (Corrigan, 2002). People with a mental illness may interpret the world through different lenses than those of individuals without mental illness. It is important to note that "lenses" is plural: there is not one universal mental health lens.

Furthermore, one can assume that lifestyle, value systems,

life experiences and choices may be vastly different for an individual with a mental illness than for a clinician. Clinicians may need to challenge their thinking and assumptions to provide quality health care for individuals with different life choices.

## Case scenario: The story of Marjorie

Marjorie, a 40-year old woman who was diagnosed with a chronic mental illness when she was 24, is referred to occupational therapy services to assess her current functional abilities and to optimize her occupational performance. Marjorie has limited contact with family, has not been employed for 15 years and does not have adequate funds, her housing situation is unstable, and it is a struggle for her to manage basic day-to-day essentials due to inadequate monies. Over the last year, she has lost 20 pounds and has left her house only a handful of times. She has not seen her friends or family in six months.

Now imagine you are Marjorie and are working with an occupational therapist. This therapist likely has factors in his or her life not present in your world. This fact alone makes you reluctant to share information since the therapist probably doesn't have a clue what life is like in your shoes. The therapist will need to spend time building rapport and obtaining a snapshot of your true environment through several community visits over a period of time. Your therapist will also need to address systemic barriers such as limited funds to afford proper nutrition or access for transportation needs and poor coping skills which hinder your engagement in meaningful occupations.

A therapist who does all of the above – that is, a therapist who integrates the practice of prioritizing and accepting Marjorie's personal values, choices and beliefs as the core foundations on which recovery goals are based upon while putting their own cultural perceptions aside in order to provide quality care – is practicing with cultural competence (Munoz, 2007).

## Finding common ground

While it is not necessary for us to experience similar life experiences as our clients to convey empathy or deliver good health care, it is critical to develop a foundational therapeutic alliance with our clients, specifically in mental health. This

therapeutic alliance and process is a building block for practicing with cultural competence and is a prerequisite for establishing intervention goals and plans with the client. The process of developing client-driven goals based on a relationship of trust helps frame a client-centred approach; this is integral to the recovery process. Corring and Cook (1999) state in their study that clinicians in mental health need to recognize and respect that their clients are valuable human beings with rich life experiences. This means viewing and accepting our clients as experts in their own lives and having unique experiences. It also means viewing mental illness as a cultural experience as there are different ways of being in and viewing the world. While this is true in any clinical setting, this is especially true in mental health because of the nature of psychosocial issues related to psychiatric conditions. Individuals with mental health issues may struggle with trust, have paranoia of others, struggle with self-esteem issues, and have fears of rejection or being vulnerable. As a clinician in mental health, I build culturally competent therapeutic alliances by:

- *Speaking in plain everyday language and avoiding the jargon associated with the culture of biomedicine.*

I do not use terminology that the client could only understand by using a dictionary or the Diagnostic and Statistical Manual of Mental Disorders (DSM) IV. Since most of my family does not practice in health care, I often reflect by asking myself, "Would my family understand this if I were relaying this information to them?" Hopefully, the answer is "yes".

- *Integrating therapeutic use of self in all my interactions by finding and appropriately sharing a commonality between the client and me, based on something the client has shared.*

For example, I may share with a client that when I am stressed, I have a tendency to drink more coffee than I typically do, especially if that is one of the client's coping mechanisms. However, it is important for me to follow up on how I have challenged myself in these situations to change my pattern of behaviour because, as a clinician, I want to model adaptive coping skills. It is amazing how many clients with mental health issues have expressed their perceptions that therapists either do not have stress in their life or that therapists deal perfectly with life stressors. Therapeutic use of self is one way of debunking this myth!

- *Validating clients' emotions.*

I try to use statements such as, "It must be frustrating or even scary when you don't understand what is happening to you." It is easier to de-escalate a situation by acknowledging a client's feelings. And it is always important to keep perspective as a clinician, to not take things personally but to frame what a client may say in relation to their mental illness and how they are viewing and experiencing the world.

- *Incorporating meaningful occupations as a way to assess*

*occupational performance issues and components and to promote a non-threatening environment.*

For example, I may ask a client to prepare coffee and/or tea for both of us to sit and enjoy.

## Competence in the culture of mental health

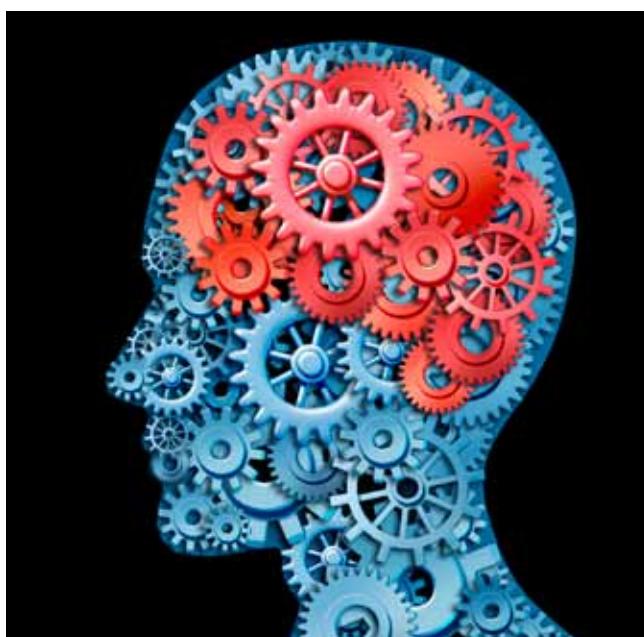
In the last few years, I have tried to incorporate cultural competence in my practice in various ways. These have included:

- *Visiting some of the homeless shelters and group homes where clients may be sent to when exploring stable housing is their longer-term goal.*  
I do this to learn how people cohabit in shared living environments.
- *Touring the resources that I refer clients to. It's important to learn the practical implications of using these resources.*

For example, I want to learn if parking is accessible or how bus routes are available within that vicinity, and who else accesses these support systems. I also want to understand the group dynamics between staff and participants, and to obtain a clear picture of the physical layout of the environment and how programs are carried out.

- *Reflecting on how life would be impacted if I was living on a limited income similar to a client who is on social assistance and/or disability income.*

All necessities, such as groceries/meals, transportation costs, and hygiene items would have to tally up to no more than \$300 for four weeks. It's no wonder that leisure activities and perhaps basic necessities are sacrificed, especially when our clients can barely make ends meet. Instead of focusing on wellness concepts such as getting involved in physical activity or joining an arts club, our clients are battling with how they will manage eating three meals a day for the next month or how will they will get to



their appointments.

- *Imagining what it would be like to have an illness if I didn't accept the illness I'd been diagnosed with.*

In imagining this, I can explore questions such as: How frustrating would it be if my world consisted of feeling isolated or rejected by others? How difficult would it be to take my medications knowing I'd have to take them for the rest of my life, and knowing that I would have to deal with long term side effects such as weight gain, decrease in libido and increase in appetite which can impact my engagement in occupations?

- *Visiting my clients' communities.*

Recommendations and strategies are relevant only when clients' actual environments are taken into account. What better way to learn about the culture in which clients live than to immerse yourself in their communities?

- *Attending conferences that are organized in collaboration with mental health organizations and individuals with mental illness.*

It is gratifying to network and learn from others who are trying to learn strategies to improve, enhance, and maximize occupational performance for individuals with mental illness.

## Conclusion

While there have been improvements in our health care system in addressing mental health issues and acknowledging

the prevalence of mental illness, stigma in mental health continues to be a significant barrier for individuals with mental illness and for families coping with these issues. One way to address this stigma is to view the experience of mental illness as we would view 'culture' and to try to view the world as a client with mental illness may view the world. Reflecting on our clients' challenges, immersing ourselves in the types of environments they use, and understanding their choices and values, even if they are vastly different than ours, are crucial to practicing with cultural competence.

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## About the author

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# Client-therapist ethnic concordance: Helpful or harmful?

Shaminder Dhillon and Rajni Dhiman

Over time, diversity within the Canadian population including the profession of occupational therapy has resulted in more inter- and intra-cultural therapeutic relationships, which has led to the need to examine ethnic/race concordance. Meghani and others (2009) identify that patient-provider race/ethnic concordance occurs when a patient and provider are of the same race/ethnic group. They discuss how this matching has been studied in an attempt to understand health disparities among minority groups in the United States. There is inconclusive evidence about whether this matching leads to improved outcomes (Meghani et al.). These types of studies are often conducted with physicians and some allied health providers; however we have not found similar studies in occupational therapy.

Through our personal communication with employers in Canada, there is a growing expectation that health care providers, including occupational therapists, reflect the ethnic diversity of their client population. When this diversity occurs, client-therapist ethnic concordance is perceived by funders and employers as the optimal approach to providing clients with the best services. The purpose of this paper is to discuss our experiences of client-therapist ethnic concordance from the perspectives of two first-generation 'South Asian'-Canadian occupational therapists. In our clinical experience/practice context the term 'South Asian' is inclusive of people who originate from Pakistan, India, Sri Lanka and Bangladesh. Given the complex history of this region, there are many similarities among South Asians, but there is also tremendous diversity. For example, Punjabi is spoken in parts of Pakistan and India, however Islam is the predominant religion in Pakistan and Hinduism in India. The examples and experiences we present in this paper are from our own practices in working with clients who originate from South Asia. Our stories are generalizations and not stereotypes, shared for illustrative purposes regarding the experience of client-therapist ethnic concordance. We do

not intend to promote racial stereotypes or to represent all South Asian people. It has been our experience that while there are benefits to client-therapist concordance, there are also challenges that need to be examined.

## Benefits

We suggest that there are benefits of client-therapist ethnic concordance as experienced in our practices. Barriers to communication can be reduced when the therapist speaks the client's first language. Some words in English cannot be translated or lose meaning when translated into another language, thereby requiring more in-depth explanation. The scope of occupational therapy practice can be challenging to explain in the best of circumstances, thus speaking the same language fluently has a significant impact when considering issues such as informed consent.

Occupations have culturally constructed meanings (CAOT, 2002). Among South Asians, some occupations are completed in specific ways for particular reasons and have unique traditions and customs that are understood implicitly by other South Asians. We have found that we can provide efficient services that are relevant to South Asian clients' lives when we understand those culturally constructed meanings. For instance, having implicit knowledge of how six yards of fabric can be tied into a turban has facilitated occupational analyses and problem-solving when working with clients who have physical and/or cognitive impairments. In response, clients have reported feeling understood.

The implicit understanding of a cultural group can assist in preventing misunderstandings and ensuring client safety. For example, when South Asian clients talk about already having a "bath stool" in their bathtubs at home, we know that this may not be a proper bath stool, but rather a small one-step stool on which the client must squat. We are aware that some South Asians traditionally use these one-step stools for bathing.

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Understanding this occupation from a South Asian perspective has safety implications for clients with limitations, such as clients who receive hip replacement surgeries.

## Challenges

We have also experienced that challenges in client-therapist ethnic concordance can occur as a result of two cultures with opposing norms and expectations coming together. In other words, there can be a culture clash between self-identifying as both a South Asian and an occupational therapist. For instance, in many South Asian languages specific names are given for direct family members. Family friends of one's parents' generation are typically given the generic names of "auntie" and "uncle". People of the same generation who are older are referred to as "sister" and "brother". In Canada, an older client is called by a title and last name such as "Mr. Singh"; however, by way of respecting an elder member of the same ethnic group, a South Asian occupational therapist may refer to the client as "uncle". Although understood by the therapist and client, this reference could result in confusion for colleagues and other clients who may inquire about whether there is indeed a family connection between the occupational therapist and client. Unfortunately, the use of relationships as titles suggests a less professional interaction even if this was not the intent.

Further boundary issues have arisen when we have been faced with personal questions as part of common South Asian cultural exchanges, such as: "Which village are you from? Are you married with children? What is your father's name?" For some South Asians, these questions are considered typical and appropriate, particularly if younger women are asked by older people as South Asian culture has traditionally been hierarchical. South Asian therapists may feel pressured to provide answers which could then result in unsolicited "advice giving" from the client about personal matters. Such interactions can leave the therapist feeling vulnerable as the focus of the interaction has shifted to the therapist. This is a slippery slope where engaging with the client can lead to increasing difficulty in maintaining a professional relationship.

South Asian culture often emphasizes hospitality towards visitors. Consequently, over the years clients have offered home-cooked treats in appreciation of our work with them. While having a "chai-tea" with a client may be a common cultural practice, it can also invite an increased focus on social discussion that could compromise the therapeutic relationship. At times, clients have expected their hospitality to be reciprocated by the occupational therapist in the form of requests either specific to their occupational therapy plan or regarding additional support in non-occupational therapy related matters. Clients do not perceive this as problematic because personal and professional relationships can be less concrete in South Asian culture. During these times, we have found ourselves again staring down the slippery slope of personal-professional boundaries.

Some culture clashes occur from the perspective of our philosophy of practice. Traditionally in South Asian culture, extended families live together and as older adults age they may expect that their adult children (sons and their wives

in particular) will take care of them in the form of assisting with daily activities. This change in roles and responsibilities between generations is part of life coming full circle. We have experienced challenges in engaging some older adult South Asian clients in occupation as they feel their family should be doing this "work". These expectations are inconsistent with our understanding of the importance of occupation for one's health and well-being.

Compounding these challenges is the perception that client-therapist ethnic concordance is the optimal approach to providing client services. This has led to us being assigned a predominantly South Asian caseload by colleagues and referral sources. As a result, the challenges mentioned previously are amplified and our job satisfaction has been affected. While we embrace our ethnicity, we also celebrate the diversity in Canada and welcome the opportunity to work with different clients.

## Future considerations

Over the years in our practice, we have reflected on client-therapist ethnic concordance. South Asian culture is part of our identity and brings a number of strengths to our practice irrespective of our clients' ethnicities. To practice authentically requires embracing this truth and reconciling it with our truth as practicing occupational therapists in Canada. The crux of the matter is that when our ethnic and professional cultures clash, we have to align ourselves with one or the other.

There is no one approach to managing the challenges of client-therapist ethnic concordance. Rather, this is an individual journey and at times an internal battle. Therapists need to consider their client population and practice setting, their roles and responsibilities as well as their personal comfort to determine their actions. There are instances when using humor to acknowledge the culture clash has reduced some of the associated tensions. There have also been instances when we have had to be direct about our professional boundaries and the requirements of being a regulated professional. These have been difficult conversations, particularly since we were not raised to speak to other South Asians in this manner. In response, some clients have been very understanding, while others have not.

Within the occupational therapy community, therapists who are ethnically and linguistically similar to clients are recognized as having strengths; however there is a need to be mindful about potentially limiting these therapists' opportunities to work with diverse client populations by assuming there are only positive outcomes from client-therapist ethnic concordance. All occupational therapists are skilled at enabling meaningful occupation with clients of diverse cultural backgrounds. Client-therapist ethnic concordance is but one consideration among many in providing quality services.

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## Update from the COTF

### The importance of funding from COTF –

**Rebecca Gewurtz, PhD, OT Reg. (Ont.), OT(C)**  
*Deciding to pursue graduate training as an occupational therapist involves a leap of faith. There are many personal and professional sacrifices involved, but the rewards can be incredible. I always wanted to pursue research; therefore, returning to school to complete a master's degree in rehabilitation science seemed like the right move. My research on how individuals come to understand their potential for work was well grounded in my experience as an occupational therapist in community mental health practice. The financial support I received from COTF and its donors was extremely helpful in providing me with income as I took time away from my clinical work to pursue this research. The support I received was not only of benefit to me financially. When I decided to embark on my PhD, I was determined to pursue the issue of employment and participation from a systems perspective and decided to consider how social policies are constructed and implemented and the impact they can have on services. As I struggled to frame the rationale for my research from an occupational therapy perspective, the support from COTF gave me a sense of legitimacy and support from our profession. It provided confirmation that the work I was doing was of relevance and importance to occupational therapy practice. I would like to thank COTF for supporting and advancing research in occupational therapy and challenging occupational therapy researchers to position our work in terms that can continue to advance our profession.*

Thanks to the support of donors, Rebecca was able to complete her graduate studies. Her testimonial is an example of how your donation dollars are used to help occupational therapists, just like you. Please continue to give so that more occupational therapists, like Rebecca, can continue in their studies and research. Thank you!

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Thanks to departing Board member Shawn Hoyland who was greatly appreciated by the Board for his work during his time with COTF.

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