Cultural Tensions in Occupational Therapy Practice: Considerations From a Japanese Vantage Point

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• area study
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Culture not only assigns a name to occupation through its language, but it also shapes the form it takes and the meaning with which it is imbued. When an individual chooses an occupation, psychological and physical concerns as well as cultural practices, values, and beliefs come into play. Although occupational therapists are trained to be culturally competent, their grasp of the importance of cultural considerations can be enhanced through detailed accounts of the way in which such concerns affect clinical practice. In this paper, I describe in detail my observations of how differences between American and Japanese culture have created tensions in occupational therapy practice in Japan. Further, largely through a case presentation, I illustrate the necessity for incorporating in-depth cultural considerations as a central part of the occupational therapy process. I argue that the study of culture and the production of culture-specific occupational therapy theories will contribute to best practice. I conclude by demonstrating that universal as well as culture-specific theories are needed to nurture occupational therapy.


Occupations are culturally shaped and named (Larson, Wood, & Clark, 2003). When individuals choose an occupation, their choices are affected not only by their physical or psychological status, but also by culture, which is historically constructed and ever changing. The necessity for cultural sensitivity has been advocated for more than a decade in the Western occupational therapy literature (Evans, 1992; Klavins, 1972; Levine, 1984; Mattingly & Beer, 1993; Whiteford & Wilcock, 2000). Additionally, several studies have demonstrated the ways in which people from minority populations, such as immigrants or indigenous groups, differ in their health values, role expectations, family structures, and attitudes toward life (Blanche, 1996; Kinebanian & Stomph, 1992; Spadone, 1992). McGruder (2003) makes a strong case that therapist empathy is contingent upon understanding the client’s cultural background. Recently, adopting a postmodern perspective in which the existence of multiple truths is accepted, Weinblatt and Avrech-Bar (2001) argue that clinicians must be open and flexible in their encounters with clients from diverse cultural backgrounds, as client needs are to a great extent culturally constructed. This idea is reinforced in the University of Southern California well elderly study (Clark et al., 1997) in which rigorous, systematic procedures were undertaken to render the intervention culturally sensitive.

In keeping with this concern, several occupational therapy scholars have pointed out the way in which cultural bias is inadvertently embedded in occupational therapy. In fact, words given centrality in occupational therapy practice such as “occupation” and “independence” have been shown to be saturated with specific cultural meanings that are not universally applicable (Hocking & Whiteford,
In this paper, I illustrate the necessity for considering in an in-depth way cultural concerns as part of the occupational therapy process, highlighting the differences between Japanese and American culture. I approach this topic by recounting my observations of how cultural tensions have affected occupational therapy in Japan. I first describe the ways in which American occupational therapy theory and practice may be at odds with Japanese culture. Next, I illustrate how this mismatch often manifests itself in clinical settings in Japan. I then briefly review the history of the infusion of American occupational therapy theory and practice approaches throughout Japan. I propose that there is a need for the development of culture-specific occupational therapy theories that are likely to lead to more culturally sensitive practice. However, I also discuss the impact of globalization on local cultures and outline several dimensions that could be useful to consider in developing both global and culture-specific theories. In the last section, I raise issues that may be of particular relevance to understanding Japanese people as occupational beings, which, if taken into account, may enhance effectiveness of occupational therapy in Japan. Finally, I argue, in accord with Clark et al. (2000), that occupational therapists need to generate both universal and culture-specific theories of occupation and occupational therapy practice.

My initial perspective on occupational therapy and occupation was formed through the curriculum to which I was exposed in Japan. The school I attended was established in 1963, the first in the country, and had been in existence for 20 years at the time of my enrollment. In the 3-year curriculum, I studied the basic sciences, basic medicine, clinical medicine, and occupational therapy. More than half of the credits for coursework were in medical science, including rehabilitation medicine, orthopedics, and neurology. These subjects were typically taught by physicians. Occupational therapy courses, per se, constituted fewer units, but I found the content to be both challenging and very satisfying, particularly when it addressed the knowledge and techniques (e.g., making splints and adaptive devices) that equip therapists to foster independence in their patients. The theory courses I took emphasized biomedical, neurodevelopmental, and rehabilitation approaches and were not unlike those that are typically included in American curricula. Other content, to which I may have been exposed at some point, I did not retain in my memory. I cannot recall as part of my educational experience, consideration of the philosophical underpinnings of occupational therapy, coverage of the history, background, and foundations of the profession, presentation of a clear sense of how occupational therapy differs from other medical professions, or exposure to the ways in which occupations are imbued with meaning.

Upon graduation, I was subsequently employed in physical disability practice at three facilities. Patients were referred to occupational therapy based on a physician prescription that included a diagnosis as well as a simple description of functional status. Upon receiving a referral, I would evaluate the patients, primarily using formalized testing, concentrating on the detection of problems that were interfering with their capacity to be independent. The analysis, which was typically in the areas of activities of daily living (ADL), work or leisure, involved identifying the components that contribute to performance, such as sensorimotor, neuromuscular, or cognitive substrates. I would then set goals that focused on returning patients to their homes or work place or both. To the extent that I took a history or assessed the social context of patients, I did so only to provide supplementary information for addressing the patients’ functional independence. Therapy sessions were devoted to the improvement of impaired components or reacquisition of functional abilities through repetition of particular skills. Frequently, crafts such as Origami, Japanese paper crafts, or even simpler tasks such as moving pegs, were employed to achieve physical or cognitive improvement. The meaning with which the patients imbued these occupations was only a tangential consideration and was preempted by the process of treatment planning just described, which focused on regaining functional ability. As a consequence of my experiences of working as a practitioner, I began to question my initial perspective on occupational therapy.

Shiro represents one person who seemed to disconfirm the adequacy of the way in which I was prepared as an occupational therapist. Shiro was approximately 80 years old and had had a cerebral vascular accident that left him with right hemiplegia and aphasia. Upon discharge from occupational therapy, he had reacquired the ability to perform most ADL, except long-distance walking and verbal expression. He had hoped to return to his home, and I had anticipated that this would be achieved since he now possessed a sufficient level of skill to take care of himself independently.
Before the accident, Shiro had been living with his eldest son, who had inherited his business, his daughter-in-law, who also helped in the family business, and his wife, who had been suffering from dementia for a few years. Throughout his life and up until the time of his stroke, Shiro had worked in the family business and this vocation had been his primary source of life satisfaction. He was held in high regard by his neighbors and had served as president of a business association. Contrary to my expectations, however, Shiro ended up consigned to a nursing home. His son and his daughter-in-law had decided not to take him back into their home. They both worked in the family business and were already caring for Shiro’s wife who had dementia. In short, Shiro’s relatives ultimately made the decision regarding his future living situation, based on their view that the nursing home was better equipped to deal with his limitations. At first Shiro was upset, but eventually he complied and adjusted. Shiro’s heroic efforts to attain a degree of independence as well as the therapeutic program I had designed for him now seemed fruitless. Acquiring functional skills was not sufficient for securing the future he desired. In the end, the decision was made by others regardless of the effort he had put forth in therapy.

Repeatedly, I discovered that the future life circumstances of my patients, such as whether or not they returned to home or work, were not simply a result of the degree of independence attained through functional training. Rather, the futures the patients would secure seemed to be contingent upon a confluence of complex and dynamic elements, such as the interplay of the patient’s functional level, their past histories, and the perspectives of others in their circles of attachment. I concluded that independence in functional skills (which I then thought represented the full spectrum of occupations) was less important for the attainment of future goals than one’s history, past experience with meaningful activities, and the attitudes, life situations, and experiences of others with whom one interacted. The approaches I had been formally educated to use seemed to constitute a mismatch in Japanese culture, in which so much decision making is appropriated to the social, familial, and occupational groups to which one belongs and with which one identifies.

The Education of Japanese Occupational Therapists: Importing Western Ideas

From the time of its establishment, Japanese occupational therapy has been influenced by American occupational therapy. In the 1950s, shortly after World War II, several Japanese physicians were dispatched to institutions in America and Europe in order to study health care systems and rehabilitation medicine (Suzuki, 1986). In America, physical medicine had strengthened its authority over physical therapy and occupational therapy by acquiring control of military rehabilitation (Gritzer & Arluke, 1985). American occupational therapy “moved to ally itself more closely with medical professions” (Gritzer & Arluke, 1985, p. 122), although some leaders in the profession during this period were critical of this trend because they feared that the holistic nature of the profession would be diluted (Reilly, 1962; Schwartz, 2003; Yerxa, 1967). Meanwhile, American occupational therapists developed numerous treatment protocols for specific illnesses or disabilities, such as hemiplegia, spinal cord injury, and amputations, using approaches that reflected the perspectives of medical science, such as the neurophysiological and biomechanical models (Brunnstrom, 1961; Carroll, 1964a, 1964b; Newsom, Keenan, Maddy, & Aguilar, 1969). These approaches to both rehabilitation medicine and occupational therapy were implemented in practice settings throughout Japan by the physicians who had visited America and were in leadership positions in Japan.

The medical model continued to be emphasized with the establishment of occupational therapy schools in Japan. Several American, as well as a handful of Japanese occupational therapists, who had been educated in America in the 1950s and 1960s, were hired as faculty in Japan’s newly established schools (Sato, 1995; Yatani, 1990). Consequently, as the survey of Yoshikawa, Tokue, Kobayashi, and Yamakatsu (1995) revealed, the particular emphases of occupational therapy that were popular in the United States in the 1950s and 1960s, such as Brunnstrom’s neurodevelopmental theory (Brunnstrom, 1961), were infused into Japanese occupational therapy education and practice.

Although the decades of the 1970s through the 1990s have been periods of shifting paradigms incorporating both medical and social models (Clark & Larson, 1993; Kielhofner & Burke, 1977) and a knowledge explosion in American occupational therapy, Japanese educational programs and practice did not keep pace with the innovations. As a result, although certain schools of occupational therapy have embraced more current Western theories and approaches, in general, occupational therapy in Japan is still significantly influenced by the earlier adopted medical model (Sato, 1995).

Unfortunately, as illustrated in the early governmental criteria for the establishment of new occupational therapy schools in Japan (Yatani, 1990), Japanese occupational therapy curricula did not emphasize a historical perspective that would have introduced students to the holistic roots of the profession. Graduates of these programs were largely...
unaware of the philosophical underpinnings of the profession and struggled to fully grasp its purpose and orientation. It is telling that at the annual Japanese occupational therapy conferences that were convened throughout the 1980s, a recurrent conference theme was “searching the core of occupational therapy” (Nihon syayo ryohoshi kyokai, 1991). Within the United States, reductionism had not always characterized the profession. Founders of occupational therapy had embraced a philosophical tradition that was counter to reductionism (Schwartz, 2003), but Japanese occupational therapists, as already stated, were not adequately exposed to these earlier perspectives.

In addition to the emphasis on reductionistic theories, the values of American occupational therapy were also incorporated into Japanese occupational therapy education. As described by Kielhofner and Burke (1977), American occupational therapists aimed to “make the disabled individual as independent as possible through utilization of his remaining abilities to care for himself, live as normally as possible in society and carry on an occupation that makes him economically independent” (p. 683). Occupational therapists were seen as specialists “in analysis of adaptive equipment, progressive resistive exercises, functional bracing, activities of daily living, development of work tolerance, and prevocational training” (Kielhofner & Burke, p. 683). The perspective reflected in these statements is grounded in Western values that celebrate independence and individualism and, one might argue, was enigmatic when it was infused into Japanese curricula.

In summary, Japanese occupational therapy practice and education have been shaped by medical model prototypes that were widespread in America in the 1950s and 1960s. Curricula were designed in accord with the Western valuing of individualism and independence, values that are not widely endorsed or even understood in Japanese culture. When I began my occupational therapy education in Japan in the late 1970s, curricula and practice were still largely reproductions of Western models. Not surprisingly, in the clinical settings it appeared that many Japanese occupational therapists seemed to be confused and frustrated by the ineffectiveness of the approaches in which they had been educated.

The Necessity for Studying Occupation From Diverse Cultural Perspectives

Occupational scientists use the term “occupational being” to refer to a particular way of viewing a person that places emphasis on his or her historical and current engagement in the world of activity (Zemke & Clark, 1996, p. vii). Thus when we regard the human as an occupational being, we focus on what sorts of occupations the person has engaged in in the past, what he or she currently does, and what he or she hopes to spend time doing in the future. One also inevitably explores how these occupations have, are, or will likely affect the health of the individual (Wilcock, 1998). Human lives are constantly occupied by participation in activities in time and space. That is, occupations, to a great extent, fill the moments of human existence. For example, one’s day may be filled with occupations such as getting out of bed, taking a shower, eating breakfast, going to school, returning home, watching TV, checking e-mail, and going to bed. When we focus on what a person does each day or even over the course of a lifetime, we are regarding him or her as an occupational being (Zemke & Clark).

While some occupations engaged in by humans are automatic, habitual, or routinized, nevertheless a large number require conscious deliberation (Clark et al., 1991). For example, in Shiro’s case, he sometimes agreed to walk in the garden of the hospital, which was one of the treatment goals of his occupational therapy session, but at other times he refused. His inconsistent choices seemed to be made based on his mood, fatigue level, and his health condition at the time. Also, as an elderly patient in a hospital in Japan he was expected to be obedient and adhere to schedules imposed on him by medical personnel. These expectations may have challenged his prior image of himself as a respected elder in his community in control of his daily activities.

As another example, consider the student who is grappling with a writing assignment. She may make the decision to remain at her computer and try to come up with an idea for her paper, or she may decide to go to the library to search for references that might be inspiring. However, should the student feel mentally exhausted and incapable of processing intellectual material, she may opt to take a break and procrastinate by going to a movie for a change of pace. In any of these scenarios, the choice will be based on a confluence of factors, including her feelings, moods, ability to impose self-discipline, physical condition, degree of compulsiveness, etc. But she must also consider the deadline for the paper, the professor’s expectations, and the strictness of the university’s policy on assignment deadlines. How these factors interact and are processed will result in her ultimate choice and will be based on the individual, the situational context, and the sociocultural order. In other words, they will be improvisational in nature rather than routinized (Lave, 1988).

While many choices of occupational engagement are positively sanctioned in the sociocultural order, others may be discouraged or prohibited. To use the same example, had the young woman chosen to go to a bar to imbibe alcohol to release her tension, instead of any of the three options...
described above, her choice may have been frowned upon, or even been illegal, in some cultures. In this instance, her occupational choice may be judged as maladaptive, and she could experience extremely negative consequences such as societal shunning or other forms of punishment. Encoded in the sociocultural order are notions of acceptable and unacceptable occupations that are often linked to race, status, class, gender, and age (Bourdieu, 1977; Kondo, 1990; Wilcock, 1998; Zemke & Clark, 1996). Although certain aspects of occupation appear to be universal, for example, the sense of joy one experiences while engaged in an appropriately challenging activity (Csikszentmihalyi, 1991), others seem to be highly contingent on culture, such as social meaning or particular styles of expression. In understanding the therapeutic value of an occupation for a patient, it would seem that one would need to understand his or her cultural background. It is therefore necessary for knowledge to be produced that not only addresses the universal aspects of occupation, but also the locally situated expression of it in diverse cultures (Clark et al., 2000).

A challenge for occupational therapists and occupational scientists in the next millennium will be to disentangle the complex weaves in which occupations express themselves in the multitude of cultures that compose global civilization. Shiro’s occupational choices, his refusal or willingness to “walk around the garden of the hospital” or his ultimate compliance with his family’s decision that he should live in a nursing home, should be considered not only from Shiro’s standpoint, but also in relation to the institutions, society, and the culture to which he belonged (Bourdieu, 1977; Rabinow, 1984). An assumption of occupational therapy and occupational science is that persons are nurtured, molded, shaped, and sometimes limited by the occupations in which they engage (Larson et al., 2003). Research focused on localized expressions of occupations and their meaning in diverse cultures has the potential for translation into more effective occupational therapy intervention. For example, a study of the impact of dining “tataami” style on physical and psychological health could lead to innovations in treatment for patients in Japan. This style of dining, which is relatively unique to Japan, involves sitting on a mat on the floor around a short rectangular table. While this dining style seems to be fading out in Japan as more and more people adopt Western lifestyles, Japanese people still sit on the floor during many daily practices and rituals. If, for example, it was found that elders retained greater joint flexibility and back strength if they regularly dined tatami style, those beginning to suffer from joint limitations and back pain might be encouraged to resist Western style dining as a daily routine, reserving it only for special occasions.

The Impact of the Global Community on Localized Cultures

Given the prevailing trend toward globalization, it will be insufficient to emphasize the description of occupation in localized cultures without considering the impact of globalization. Appadurai (1996) presents five dimensions of global cultural flows: ethnoscapes, finanscapes, technoscapes, mediascapes, and ideoscapes. These dimensions may serve as a useful conceptual tool as we build more refined knowledge on how occupations and occupational patterns in cultures are affected by the interface of localized cultures and the emerging global community.

Appadurai (1996) defines ethnoscapes as the landscape of the persons and groups moving in the world. By landscapes he means the territory, society, and culture in which persons and groups live. Modernity has made it possible for people to live in several places over the course of a lifetime. Even among those who remain in their places of birth, the movement of others into one’s community, such as neighbors, teachers, or occupational therapists, creates the possibility of in depth exposure to individuals from other cultures. Therefore, one needs to consider the influences that different ethnoscapes may have on a Japanese individual as one attempts to gain a complete sense of him or her as an occupational being.

In the postindustrial world, the financial condition of a specific area affects the economy of the whole world. Every day, global finance, or what Appadurai (1996) labels finanscapes, exerts some influence on individual occupational choices. For example, when the Japanese currency is strong, its citizens can travel to other countries more easily. When the Japanese economy collapsed several years ago, those who had in the past struggled to sustain themselves economically experienced an even greater economic burden when the government curtailed welfare and cut back on employment for people with disabilities. These repercussions, which followed a trend existing in the global economy, illustrate the dramatic effect that finanscapes can have on the lives of occupational beings.

Similarly, technology has also drastically affected the ability of individuals to engage in occupations. In certain instances, what Appadurai (1996) refers to as technoscapes may expand occupational choice. The inventions of the electric wheelchair and the speech synthesizer has made it possible for the eminent physicist Stephen W. Hawking (1996), a Nobel prize winner, who has amyotrophic lateral sclerosis, to travel throughout the world to give lectures.
The use of the computer with its access to the Internet may be one of the most important ADL for people with disabilities to master. Not only does it facilitate communication, but it also allows access to information and a world beyond one’s home without the need for physical mobility. Clearly, technology has dramatically affected how people spend their time as they increasingly become anchored to their computers as such occupations as walking to the post office, writing letters longhand, or attending meetings in a shared physical space become less common.

Today, the mediascape is not only remodeling people’s imagination, but it seems to have its most pronounced impact on the daily execution of ordinary activity. Media such as radio, TV, and movies have a profound influence on the way in which humans develop as occupational beings, instantaneously exposing persons from traditional cultures to occupations and options with which they would have otherwise been unfamiliar. A Japanese person with a disability who watches a documentary about an American with a disability who asserts his or her right to equality may no longer be content with the dependent role to which he or she may have been consigned in Japan. Exposure to the media influences identities and expands one’s ability to imagine new possibilities through the large and complex repertoire of images and narratives (Appadurai, 1996). But it may also create discontent with one’s life as the gap widens between an imaginary world and the actuality of one’s existence. Mediascapes suggest that to fully understand the occupational being, we must gain a sense of a person’s vision of his or her possible selves as shaped by media exposure (Appadurai; Giddens, 1991).

Ideoscapes, according to Appadurai (1996), are “concatenations of images, but they are often directly political, and frequently have to do with the ideologies of states and the counter ideologies of movements explicitly oriented to capturing state power or a piece of it” (p. 36). Japanese people who grew up before World War II would seem to have a starkly different view of the world than those who were born in the postwar years. Even within a given cohort, differences in ideology pertaining to freedom, responsibilities, and rights may exist between those who spent their formative years in other countries and those who have stayed in Japan. In order to understand a person, it is important to consider ideoscapes and the kinds of political situations or ideological conditions in which he or she has been situated, for how long, and how he or she has dealt with such exposure.

In summary, these five dimensions may be useful for understanding humans as occupational beings in a world in which local culture is being affected by globalization. Appadurai (1996) argues that the five dimensions of global culture are constantly in a state of change and that they dynamically interact with one another. At the level of the individual, tension may exist between localized cultural beliefs and practices and global ideas, images, and trends such that decision making about how to spend one’s time each day is rendered increasingly complex. Thus, to fully understand a person as an occupational being we must grasp the traditional aspects of the local culture in which he or she is situated as well as take into consideration the impact globalization has had on his or her consciousness and daily activities. It would seem that the best occupationalf therapy practice must grapple with the impact on patients of both the tension and fusion between local cultures and the global community.

A Preliminary Application of a Cultural Approach to the Study of Occupation in Japan

Occupational therapists in Japan typically do not take cultural issues into account in their interactions with clients, at least not in a deliberate or reflexive sense. As most clients and therapists share a Japanese family lineage, it is assumed they also share common cultural values. Moreover, the professional preparation of occupational therapists ingrains them with the idea that what they should pay attention to during the treatment process is functional ability, which tends to be presented as if it were free of cultural bias. However, in practice, the same therapists often experience frustration with the Western emphasis on functional ability and the acquisition of independence, which seems removed from the lived experience of their patients. As an example, a therapist might devote many treatment hours to rehabilitation, assisting a patient in learning to propel a wheelchair. However, while engaged in the practice, the therapist may feel conflicted, suspecting that the patient is likely to never actually use this skill when he or she returns home, since most Japanese dwellings are usually too small to freely accommodate a wheelchair. Besides the access limitations of the physical environment, many Japanese people feel uncomfortable using a wheelchair inside the house, since “wheels” conjure up the image of a vehicle used outside. The Japanese clearly distinguish inside and outside, as in the custom of “taking off one’s shoes at the entrance.” Nevertheless, most Japanese therapists have refrained from overtly rejecting this Western treatment approach, as they seem to be hesitant to modify the approaches in which they were formally trained.

Today Japan is facing serious problems related to the health of its citizens, including a rapidly aging society, declining birthrates, destabilization of the nuclear family,
escalating expenditures in the national budget, and a financial crisis in the welfare system (Kokuritu shakai hosho/jinko mondai kenkyu sho, 2001, 2002; Niki, 1998; Yonemoto, 1997). To the extent that emergent occupational therapy practice is tailored to be responsive to local cultural beliefs and practices and the impact of globalization, it will have a greater potential to become not only more relevant, but also more effective and socially valued. The following aspects of Japanese culture that might be taken into account in designing a more culturally sensitive practice. As these concepts differ significantly from those that characterize Western culture, they can be interpreted as a foil that renders the inherent Western cultural bias in occupational therapy more vivid.

Values of Dependence or Interdependence

Japanese society does not emphasize the concept of independence in the way in which mainstream American culture does. As a graduate student in the United States from 1993 to 1995, I was amazed by the degree to which elderly research participants strove to maintain their independence in a study I was conducting on assistive technology (Kondo, 1997). These participants, four women and one man, were living independently, although they had disabilities and needed assistance with certain activities, such as going shopping, cleaning, cooking, or going to medical appointments. Not only did they repeatedly express their desire to live as long as possible on their own, but they also claimed it was their right, and that society had a responsibility to provide the services required for them to remain independent. I also observed numerous people with developmental disabilities living in group homes and receiving a variety of support services. Only rarely does one observe people in Japan with disabilities living independently. In America, the values of independence and autonomy tend not only to be insisted upon by elderly people, but are accepted by society; these values depart from the values of Japanese culture, as illustrated in the case of Shiro. More typically in Japan, dependence or interdependence prevails (Anetzberger, Korbin, & Tomita, 1996; Markus & Kitayama, 1991; Nakane, 1978). Consequently, decision making and occupational choice involve multiple players who have a stake in the outcome and are negotiated in relation to a complex web of entanglements.

Taking One’s Proper Station: The Structure of Society

One of the most prominent features of Japanese society is its vertical structure or hierarchy. People perceive themselves as a part of a cluster and are expected to place themselves in the station that is appropriate to their status, credential, and background (Benedict, 1946; Kondo, 1990; Nakane, 1978). This hierarchical order is not static, however, and changes do occur with shifting contexts of power. The factors that affect place include not only age, gender, status, and class, but also time, space, settings, and atmosphere. People who fail to situate themselves in their appropriate station are likely to experience severe social disapproval. If Japanese people with disabilities are to be fully involved in society, the hierarchical arrangement of the Japanese social structure is important to consider. Each survivor of catastrophic illness or disability is likely to be situated in several hierarchical social structures.

Shiro occupied the position of retired father-in-law in his family; he occupied the position of previous president in his factory; he had been the former president of a business association in his town. Although his social position before his illness was relatively high in relation to the Japanese hierarchy, catastrophic illness had consigned him to a much lower position and it seemed he consequently viewed himself as a fragile elderly person unable to communicate with his family, employees, or members of the business association with which he had been connected. While one might argue that the Western concept of role change should be sufficient for understanding this shift, I would maintain that it fails to take into account Japanese hierarchical social order with sufficient sensitivity and precision. As illustrated by Iwama (2003) and others (Kobayashi, 1996; Yoshikawa, Miyamae, Tsuru, Ishibashi, & Kondo, 2000), the emphasis of the Western concept of roles is on the social positions that can be achieved or attained by the individual’s mind and will, whereas the emphasis of the Japanese concept of role is on the social stations that are granted and bestowed by the groups. It is true that Japanese society is changing and that the ideas of hierarchy for the older generation and younger generations differ dramatically; the structures of hierarchy are no longer as rigid and concrete as they were in the past. However, the concept of hierarchy has become more multifarious. In order to provide the potentially most influential occupational therapy program, the nettle of entangled stations having to do with “place” has to be taken into account. It would seem that occupational therapists in Japan would need to place considerable emphasis on family (Mattingly & Lawlor, 2003), environment (Stewart et al., 2003), and place (Rowles, 2003) with somewhat less emphasis on the individual than is typically the focus of Western occupational therapy.

Dynamic Location of Power

Closely related to the concept of hierarchy in Japanese culture is the notion of power. In Japan, while power is often related to hierarchy, in other instances it may be dissociated from it. Kondo (1990) provides a good example of how
power can operate outside of the hierarchical structure. She describes the relationship between women workers in a confectionery company and shacho, the president, as an example of the dissociation of power and hierarchy. One day shacho offered leftover cakes to the part-time, low-status women workers at one fourth the usual price. Shacho expected that all of the women would buy the cakes because he occupied a higher position and had offered to do them a favor. However, none of the women workers bought any of the leftover cakes. By doing so, without a formal protest, these women had insisted on their dignity and had refused to accede to shacho’s definition of his offer as a favor to them (p. 206). Kondo notes that their refusal was especially effective because it enacted disapproval in a way that would not entail the ultimate risk of dismissal. Although these women were fully aware that they were marginalized in the hierarchical structure of the company, they seized the opportunity to assert themselves in an informal social situation.

Iwao (1993) also describes the power women may exert and possess, despite their inferior status in the typical social hierarchies in Japan. She describes the contexts in which women may be free to explore their individuality in ways not permitted to men, in, for example, the area of managing the household budget. Further, she asserts that many of the Japanese women she studied considered themselves to have rights equal to their husbands’ within the confines of their home and family. Within the home, women felt highly valued because they were responsible for the overall management of the family.

In thinking about power in Japanese society, it is therefore an oversimplification, even a misrepresentation, to assume it is always tied to hierarchical status. Rather, the location of power shifts dynamically depending on the context. It is necessary to have this insight to understand the location of power in analyzing the future possibilities of Japanese patients. In Shiro’s case, it appeared that his daughter-in-law possessed the power to ultimately determine the future to which he would be consigned. This was because, in concert with Japanese culture, she prevailed in matters pertaining to the management of family and household. In retrospect, I believe she should have been included in all decisions regarding Shiro’s rehabilitation program early on and that the demands on her time and patterns of occupation should have been initially assessed with care to ascertain the likelihood of her willingness to assume a caretaker role. Currently, Japanese society is undergoing increasingly complex reorganization within the context of globalization. Further research is needed to document the relationship between power, occupational choices, and intergenerational tensions.

**Working Hard and Enduring Hardship As a Japanese Virtue**

Working hard, “ishokenmei-ganbaru,” and enduring hardship “gaman-suru,” which Kondo (1990) called “disciplined selves” (p. 76), and Benedict (1946) considered “self-disciplinary” (p. 228), may be important values for understanding Japanese people as occupational beings. The attitudes of working hard and enduring hardship have been, and still are, appreciated more than working efficiently or working with pleasure. This is truer for Japanese people who were educated before World War II, which means before the impact of Americanization. Lebra (1984), who studied women growing up under traditional Japanese customs, stated that hardship was central to the Japanese conception of virtue. She describes a woman who depicted herself as a victim of the traditional structure, and who then turned around to appreciate her hardship as a good lesson, feeling rewarded for having persevered through her wretched marriage instead of following her impulse to escape (p. 297).

Shiro sometimes refused walking in the garden of the hospital, which was specified as a part of his therapy sessions. I assume that he might have imagined walking in the garden as an easy and pleasurable task rather than one requiring hard work. Consequently, he might not have found this occupation satisfying. Shiro’s compliance with his family’s decision might also be perceived from the standpoint of hardship. In conceding to go to a nursing home he may have felt he was doing the noble thing by suppressing his desire and facing hardship rather than disturbing the peace and order of the family. Although efficiency and pleasure are more valued these days, working hard and enduring hardship are still appreciated and continue to influence the Japanese occupational choice process. In the Western world, pursuing one’s interests or experiencing pleasure have traditionally been thought of as important aspects of occupational therapy. However, in Japan it may make some sense to think of the ways in which occupation offers opportunities for hard work and enduring hardship.

**Obligation, Responsibility, and Situatedness**

The last aspect of Japanese culture that I will discuss that might be included in theory development on occupation in Japan is the notion of a “ginu,” obligation, and “sekinin,” responsibility. These are significant components of the Japanese moral code, and therefore, central to the occupational choice process. Ginu and sekinin are two sides of a coin, and are heavily connected to a sense of “shoga-nai,” the feeling of situatedness, acceptance of one’s condition, or res-
ignation to one’s fate. As an example, I will recount an interview I conducted with a friend who shared responsibility with his mother for taking care of his father. His father had dementia and my friend was designated as responsible for making family decisions. When I asked why he was willing to also assume responsibility for his father’s care, he said, “Because I’m his son, it is nothing more than that. It is ‘gimu’ for the oldest son.” My friend is situated as an eldest son, and he acts according to the relationship in which he is situated. The sense of situatedness is not simply felt in relationships among blood relatives; it also occurs in social relationships, such as that between an employer and an employee or a professor and a student. In the situated position, people choose what they do, with feelings of gimu and sekinin. Consequently, in an occupational therapy setting in Japan, a therapist needs to appraise the sense of situatedness, or the situated position of the patient among others, including his or her family, neighbors, and even medical staff, as well as feelings of gimu and sekinin associated with those relationships.

Conclusion

In this paper I have argued that occupational therapists need to study culture and take it strongly into account as part of therapeutic process. The basis for this argument rests on the assumption that occupation is shaped by and structured with culture (Clark et al., 2000). In developing such knowledge and applying it in therapy, the impact of globalization on localized cultures must also be addressed. The development of occupational therapy theories that are sensitive to particular cultures is apt to lead to more culturally sensitive practice. To make my argument clear I have analyzed aspects of Japanese culture, highlighting the differences between it and American culture. In the last section, I sketched my thoughts on how Japanese people and Americans differ as occupational beings and on what aspects of Japanese culture might be emphasized in occupational therapy practice. It would seem that best practice in any localized culture must take the universal as well as culture specific aspects of occupation into account. Fortunately, considerable strides are currently being made to create more culturally sensitive occupational therapy theory and practice. Research in this area is growing and should continue to be promoted. The number of annual international symposia are increasing and, as the papers presented are published and disseminated, sensitivity to these issues will grow. Finally, the fact that occupational therapy curricula are now including more content on diversity and cultural sensitivity bodes well for the future.

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