A Dialogue on Occupational Therapy, Culture, and Families

Maureen H. Fitzgerald

This paper, based on a broad body of relevant data, presents a dialogue that explores and integrates two important concepts: family and culture. An understanding of these concepts is important for enhancing occupational therapy practice, in particular a practice that claims to be client-centered and holistic. The dialogue focuses particularly on issues students involved in the Intercultural Interaction Project, The University of Sydney, Australia, in 2002 identified as important. These include: a lack of understanding of the concept of culture, the confounding of culture and ethnicity, considering culture as an issue only in families from "other" cultural backgrounds, assumptions about the nature of families and therapists' points of reference for making these assumptions, differences in client or family and therapist expectations, and how these expectations affect what happens in therapy and participants' level of satisfaction with the outcomes of the interactions involved. The information suggests that there is a need for a better understanding of how culture influences ideas about families and how to work with them.


Whether we live in individualistic or collectivist cultures, families are important—no matter how they are defined. They provide one of the key contexts and reference points for our socialization; they help us develop our identities and mold our behaviors in relation to others. It is within families that we learn how to be in the world—how to understand and interact with the world and the people around us. Families provide the context for learning the beliefs, values, attitudes, and customs that guide much of our lives. We learn how to be occupational beings in and through families—or by reference to ideas about families when they are absent from our lives. Although there are other influences on our lives, for most people families continue to be important throughout their lives, whether or not they are physically or emotionally accessible. Families can be a source of both support and frustration and problems. They are a cultural universal and a cultural icon.

As families are central features of all societies and, thus, all people’s lives, occupational therapists must interact with families and take them and their influences into consideration as they engage in the occupation of therapist. Families are, in fact, part of the everyday discourse of therapists as people and as therapists.

Much attention has been directed towards “the” family and families in the literature directed towards health and social service professionals; this issue of the American Journal of Occupational Therapy contributes to that literature. Increasingly this literature is explicitly dealing with culture and the family, but whether or not culture is explicitly addressed, culture always underpins what is said about families and how to work with (or around) them. As shall be demonstrated in this dialogue, discourse on families is cultural discourse. It is grounded in cultural ideas and ideals about families.
Given that there are volumes of work on families, including work that addresses cultural issues, my challenge was to decide what to address in one short article. To help me do this I turned to the students enrolled in a subject (the term subject is equivalent to a course in other countries, such as the United States) I teach on culture and communication in occupational therapy practice, which is part of the Intercultural Interaction Project at The University of Sydney (see below). At the time I approached them in 2002, the students were involved in analyzing data from interviews they had just completed with health professionals, clients, and community members. In their analyses, as in other analyses of similar data from the Intercultural Interaction Project (e.g., Fitzgerald, Beltran, Pennock, Williamson, & Mullavey-O’Byrne, 1997; Fitzgerald, Mullavey-O’Byrne, & Clemson, 1997), family was a clearly identifiable and dominant theme even though family was not the initial focus of their study.

The students were enthusiastic about the idea of an article on culture and families: it was an issue in their interviews and it was and had been an issue for them in their fieldwork experiences. In the subject, the students identify issues that they do not feel are yet well addressed in the occupational therapy literature or their education. In our discussions, the students highlighted the issues they thought should be included in this article. They suggested topics such as culture as ethnicity, assumptions about culture as only an issue in families from “other” cultural backgrounds, assumptions about the nature of families and most therapists’ points of reference for making these assumptions, differences in client–family and therapist expectations regarding families and how these expectations affect what happens in therapy, and therapists’ and clients’ levels of satisfaction with and evaluations of the outcomes of therapy and the interactions involved. These themes, the students’ suggestions and preliminary data analyses, as well as analyses from other aspects of the Intercultural Interaction Project and other related projects guided the development of this paper. Thus, throughout the article I use the inclusive “our” (data, work, etc.) to emphasize that many people have participated in the work that provides the foundation for this paper, although, in the end, I hold full responsibility for what has been presented here.

This paper is data driven, but it is not a report of a discrete research project. It draws on data I have collected, often in collaboration with students and colleagues, over many years using a variety of methods: extensive literature reviews; ethnographic style interviews, in particular interviews using a critical incident methodology (see below); and observations and participant observation in a variety of cultural contexts and countries. These data have been collected primarily in relation to two large, long-term, “umbrella” projects: the Intercultural Interaction Project and the Culture and Disability Project, both of which have specific research and educational objectives. Both projects involve student collaborators, including students enrolled in an elective unit of study on culture and communication in professional practice and research students at the honors, master’s, and PhD levels. The students use the research process as a form of inquiry learning and their data become part of the relevant project’s database. In the elective unit of study, each year the students identify a topic of particular interest to them based on their fieldwork experiences and design a project that can be incorporated within the umbrella project on intercultural interactions in health care (for more detailed descriptions of the project and the elective unit see, for example, Fitzgerald, 2000; Fitzgerald, Beltran, et al., 1997; Fitzgerald, Mullavey-O’Byrne, & Clemson, 1997, 2001). Research students select and develop their own subprojects under supervision. These projects involve a range of relevant topics and include work in several countries. Although each of these projects has a defined methodology, they can all be described as drawing upon the critical incident approach as described by Fitzgerald (see below).

Critical Incident Approach

The critical incident approach, as it is used in our work, is based on an adaptation of the concept as developed by Brislin (Brislin, Cusner, Cherrie, & Yong, 1986; Brislin & Yoshida, 1994). Elsewhere critical incidents have been defined as distinct occurrences or events which involve two or more people; they are neither inherently negative nor positive, they are merely distinct occurrences or events which require some attention, action, or explanation; they are situations for which there is a need to attach meaning (Fitzgerald, Beltran et al., 1997; Fitzgerald, Mullavey-O’Byrne et al., 1997; Fitzgerald & Mullavey-O’Byrne, 1995; Fitzgerald & Paterson, 1995). Critical incidents are “social dramas” (Turner, 1974) and can be viewed as “units of aharmonic or disharmonic process” (Turner, 1974, p. 37). Like Turner for social dramas, Sue and Sue (1990, p. 245) suggest critical incidents represent an area of conflict of cultures, values, standards, or goals, but they do not necessarily arise out of conflict situations. In our work, the conflict, if this is the appropriate term, is more often associated with “disconfirmed expectancies” (Brislin et al., 1986; Fitzgerald, Mullavey-O’Byrne et al., 1997; Mullavey-O’Byrne, 1994): The event or social drama did not “play out” in quite the way the respondent or narrator anticipated. It may have had a result viewed as negative; one that may have evoked a disquieting state of emotional arousal (e.g., frustration,
anxiety, a sense of having lost control). However, just as often, the result was viewed as positive—there was a better than expected result. In both cases there is a need for explanation, a need to attach meaning. Often it seems people tell a particular story as a way to better understand an event in their lives. (Fitzgerald, 2000, p. 190)

Critical incidents are used in three ways in data collection. First, we engage respondents in ethnographic style interviews (Spradley, 1979) during which we ask people to tell us about situations in which culture is an issue. Respondents choose the incident or incidents they want to relate and the interviewer explores the incident with the person to obtain additional information and when possible their ideas about the event (their interpretations). In the second approach, we use critical incidents related in other interviews as a stimulus for discussion. Respondents are asked to talk about the incident by discussing what they think is going on in this situation. We use a number of methods in the analysis of these data. In the first approach one of the key methods is to explore the interview data, including the incident narratives, for core themes. Thematic analysis is also used in the second approach, but as the same incident is presented to a number of respondents we also engage in a comparative analysis across respondents and respondent groups included in that particular phase. For example, the respondents may come from a range of cultural groups, they may include both health professionals and clients or community members; they may represent people from one or more professional groups or students from a range of health professions.

There is, however, a third way in which critical incidents are used in data collection. When we use observations, participant observation, or an ethnographic approach to data collection, we are inherently focusing on critical incidents. This is the nature of ethnography: to derive an understanding of, give meaning to, interpret naturally occurring human events. In doing so we draw on many forms of data to make sense of what we see and experience (Fitzgerald, 1997; Fitzgerald, Paterson, & Azzopardi, 1997), even if we do not explicitly talk about this as a critical incident approach.

Family

In our analyses of critical incidents (and other data), family emerges as an important theme. This raises the question as to why this theme emerges in projects designed to elicit cultural themes. As already noted, family is a universal institution in all cultures and human societies (Bonder, Martin, & Miracle, 2002; Ravetz, 1998). And, yet, as Keesing and Strathern (1998, p. 233) note, “Much ink has been used up, in anthropology and comparative sociology, trying to define ‘the family.’” Thus, there should be little wonder that occupational therapists and other health professionals find the concept of family seemingly simple (everybody has one) yet difficult to understand and deal with in their day-to-day interactions.

One standard definition of family is that it is “a social and economic unit consisting minimally of one or more parents and their children” (Ember & Ember, 1988, p. 329). This simple definition belies the complexities of family configurations and reconfigurations that emerge over time in relation to things like marriage, births, deaths, divorces, migration, etc. In addition, particular situations or contexts (e.g., social events like life-stage events [weddings, baptisms, or naming ceremonies], illness-related situations, etc.) also shape the definition of a family. Although for most societies some ideal family configuration has been identified (and these are often the descriptions we find in texts on families), there is, in any society, a great deal of diversity. This is especially true in multicultural societies where there are large migrant populations (and this needs to include internal migration, not just immigration) covering several generations (that is pretty much all modern societies). In such societies this diversity increases considerably. In addition, throughout the world people often identify people without blood or genealogical ties as family in both the long-term and for special situations (e.g., godparents).

For example, in an aspect of the Intercultural Interaction Project that focused on religion and spirituality, respondents in the “Christian” group identified the “Church family” within their discussions of family and social support. They did so because they saw this “family” as providing much of what they would expect from family members otherwise defined. Members of this family engaged in occupations associated with family and, as a result, acquired rights and responsibilities associated with membership in a family. Like many others, I have been “adopted” into several families as “fictive” kin, families where I have no direct blood (genetic) or genealogical ties. This includes the families of special friends (where the children call me Auntie and treat me like or just assume I am a parent’s sister) and the family I lived with during my fieldwork in Samoa. This has resulted in my acquiring rights—and responsibilities—within these families and the communities in which they reside.

The reasons for this diversity in the concept of family are vast. Some are responses to social changes that occur over time in response to environmental, social, political, and economic imperatives. Families consciously and unconsciously respond to these changes. For example, in many Western societies, there is what I have called a “crisis” in the definition of the family that reflects current social and
cultural concerns. Can a family be made up of two people of the same gender, whether or not children are involved? Do such “families” have the same rights and responsibilities (legal, social, cultural) as families otherwise defined?

Thus, despite much public rhetoric about “the” family and family values, it remains unclear just what these terms mean. If definitions of family can include anything from a parent and child to an extended family covering several generations on both the maternal and paternal side and fictive kin, and such familial configurations can occur in any culture or society and change over time, how can we possibly approach working with families with narrow frames of reference? What should the frame or frames of reference for an adequately flexible but useful understanding of family be?

**Perspectives on the Family Used by Health Professionals**

Lacking a framework from which to understand families, health professionals, like occupational therapists, use primarily two perspectives or “Gold Standards” to identify and evaluate families—both are cultural. The first perspective is experiential and based on their own families and representations of families in the social domain, including popular media. The second perspective is based on expert knowledge and models as represented in professional texts and legal and policy documents. Such documents in and of themselves reflect society’s collective standards—the society’s culture. In the first case therapists, like other members of the community, judge their own families and others based on standards they have incorporated as part of their socialization process. They are often not aware that they are doing so because people are generally not explicitly aware of these cultural standards; they are accepted as “normal.” As with other aspects of culture, people unconsciously incorporate cultural standards and rarely reflect upon them or where they come from. The standards presented in the second perspective are rooted in health professionals’ educational experiences. These explicit educational experiences are rarely critically judged, but instead are regarded as the received expert knowledge. The ability and tendency to critically evaluate such information is learned and part of a developmental and maturation process (e.g., Edwards, 1999; Kitchener & King, 1990; Whiteford, 1998); the idea that nonexperts can and should critically analyze the word of experts is also cultural. Thus the many texts and policy documents that describe families, which are generally based on social and cultural ideals, are rarely questioned. Even when people recognize that families are incredibly diverse, they still tend to judge them in terms of these ideals. “Good” families meet or come close to meeting the ideal or are viewed as those that could meet the ideal with the proper types of intervention (e.g., parenting classes, family therapy, etc.). Other families are judged as “bad,” “dysfunctional,” a “problem,” incompetent, or a “barrier” to therapeutic goals because they do not come close to the therapists’ or health professionals’ ideals (for discussions of a related phenomenon: the “good patient or bad patient,” see, for example, Duxbury, 2000; Lau, 1988; Lupton, 1994; Stein, 1990).

**Practice-Related Theme: Family Encouraging Independence Versus Dependence**

A common story in our database revolves around family doing for the client rather than supporting or encouraging independence in activities of daily living (an explicit occupational therapy value [e.g., Russell, Fitzgerald, Williamson, Manor, & Whybrow, 2002; Whiteford & Wilcock, 2000; Whybrow, 1998]). An example is the family that feeds a client or helps with dressing or bathing when in the therapists’ opinion the client could do these things independently. In fact, in many ways these families often reinforce ideals about family by being the exact opposite, by offering an oppositional contrast. At the very least they present a situation for which there is a need to attach meaning. The goal with such families is to bring them closer to a cultural ideal, or at least the health professional’s, therapist’s, or organization’s ideal. In this case the ideal is helping to foster independence, not dependence.

An excellent example of this attempt to bring families closer to a cultural ideal is presented in the book, *The Spirit Catches You and You Fall Down: A Hmong Child, Her American Doctors, and The Collision of Two Cultures* (Fadiman, 1997) (see also the discussion in Taylor, 2003). In this narrative the parents and family of Lia Lee, a child diagnosed by her doctors as having epilepsy, are judged as inadequate. After attempts to educate and modify the parents’ behavior “fail” by American standards, Lia is removed from her family until they begin to meet the health and social service professionals’ ideals and expectations. What is important about this story, and many like it in our databases, is that the health professionals are similarly judged by Lia’s family as inadequate in many ways, but the parents do not have the same kind of power to sanction the behavior of the professionals. Lia’s family behaves in ways they see as exemplifying their ideals about familial rights and responsibilities, but there is a mismatch with the ideals of the professionals with whom they interact over the course of Lia’s life. In the end no one was satisfied with the interactions that took place, nor the outcomes of those interactions.

One major area that can result in this sense of dissonance is the role the family does or does not play in therapy. In many ways our data are consistent with the seven-level hierarchy of family–therapist involvement presented
by Brown, Humphry, and Taylor (1997) and the factors they described as helping to determine what kind of family involvement will occur. The seven levels are: (1) no family involvement, (2) family as informant, (3) family as therapist’s assistant, (4) family as co-client, (5) family as consultant, (6) family as team collaborator, and (7) family as director of services. In our interviews with therapists, families are sometimes seen as a support and sometimes as a barrier to services and the accomplishment of therapeutic goals. In our data, families are described as playing all the roles outlined in this hierarchy, although the last one (director of services) is the least common. Which role the family assumes depends on several factors: the organization and ethos of the service in which the therapist works, assumptions about what the family’s role should be in therapy based on both professional assumptions about families in therapy and cultural assumptions about families from some cultural groups (families from collectivist cultures are expected to play a more significant role than families considered more individualistic), therapists’ comfort in working with families from particular cultural groups (culture general and culture specific competency), and therapists’ beliefs about their role and their rights and responsibilities. Language differences also play a role. When there is a common language (generally English) or interpreters are available (and they generally are not readily available), then families may play a more significant role, although this is not always the case. When the “language issue” is addressed and the family still does not perform in ways that meets the therapist’s expectations, we encounter disconfirmed expectancies (discussed next) and, frequently, therapists indicate a level of dissatisfaction with the situation.

**Practice-Related Theme: Disconfirmed Expectancies**

Disconfirmed expectancies, unrealized expectations, in this case based on conceptualizations of family organization and occupational roles, is a common theme emerging from our data analyses. Because everyone involved in therapists—client–family interactions enter these interactions with cultural ideals in mind (ideals about families, ideals about the occupations, roles and functions of health professionals and family members), it is not surprising that families are commonly a focus of the critical incidents and cultural discussions in our interviews. This focus is illustrated in the results of a study involving families and nursing home placements, which was based on community responses to a critical incident representing a type of incident commonly reported by therapists (Fitzgerald, Mullavey-O’Byrne, & Clemson, 2001). Results suggested that the people in professional interactions have preexisting expectations about how the situation will unfold. When the situation plays out in unexpected ways, the people involved need to find ways to explain these “disconfirmed expectancies.” For example, in another study associated with mental health the professionals struggled to understand why the family of a client from a cultural background identified as “family oriented” did not become involved in therapy (Fitzgerald, Beltran, et al., 1997).

Family organization and culturally constituted occupations and occupational roles are important considerations, but a focus on “the family” is insufficient and often results in inadequate or unsatisfying explanations. One reason this theme of family is so common is that people focus on the family and aspects of the family but too often ignore other cultural issues that may be of equal or greater importance in a particular situation. Families are not only a cultural context; they are situated in and must function in cultural contexts. This means other things can be important, such as differences in social organization, fundamental differences in explanatory models (Kleinman, 1980; Kleinman, Eisenberg, & Good, 1978) of the illness or disability, cultural beliefs about the cause of the situation and what should be done about it, attitudes toward certain kinds of conditions that are associated with socially disvalued states, behaviors, and other attributes (Armstrong & Fitzgerald, 1996; Dyck, 1998; Helman, 1994; Ingestad & Whyte, 1995), and beliefs and cultural expectations about how clients or families—and health professionals—should behave. Families cannot be treated as something separate from these other influences and, at the same time, beliefs about health, illness, healing, and therapy must be considered within the contexts of families and other social groups.

Not only do health professionals have expectations of the family that may or may not be valid, but in recent years our data have shown that therapists and community members in multicultural Australia expect health professionals to be aware of and to take culture and cultural differences into consideration. When they do not, the client or family’s expectations are not met (disconfirmed expectancies). In other words, cultural expectations in this society have changed and reflect the emphasis on multiculturalism and cultural competency in all aspects of contemporary Australian society, including health and social service systems (for explorations of the concept of cultural competency see for example: Bonder, Martin, & Miracle, 2002; Fitzgerald, 2000; Fitzgerald, Mullavey-O’Byrne, Clemson, & Williamson, 1996; Lustig & Koester, 1996; Pope-Davis, Eliason, & Ottavi, 1994; Wells & Black, 2000; Whiteford, 2000).

At the same time, our data suggest that some expectations have not changed dramatically among segments of the population, including people who provide health and social
services. In places like Australia, some people still expect that clients and families must adapt to the prevailing society, that they must learn English and conform to the expectations of dominant cultural groups. In the views of some individuals, if people do not adapt they may be viewed as culturally incompetent and potentially unworthy of certain services. This viewpoint is similar to findings presented by Jenkins and colleagues (Jenkins, 1998) in relation to people with intellectual disabilities and their carers.

When there are disconfirmed expectancies about families, health professionals initiate the process of meaning making in order to reconcile expectations with experiences (see also, for example, Hasselkus, 2002). The critical incidents reported in our interviews are often situations in which the person is still in the process of meaning making. Particularly when we encourage them to do so, health professionals who have developed interpretations of the situation present those interpretations. If they have not already developed an interpretation, they will attempt to do so in the context of the interview. Thus, even when in the opinion of the respondent a situation resulted in a reasonably satisfying outcome, the explanations for or interpretations of the outcome are sometimes not as satisfying as they could be. Perhaps this is why, as suggested earlier, respondents choose (intentionally or unintentionally) the critical incidents they do; they are using the interview context to continue to work through the event. The interview and participant observation data collection activities provide a culturally appropriate context to engage in critical reflection, frequently in the guise of “teaching” the student interviewer or observer.

Families As Cultural Units in Occupational Therapy

Given the above, we can begin to grasp why understanding the concept of family in a cultural sense could seem simple, but can actually be quite difficult. Perhaps people like Sparling (1991) provide a useful and client- or family-centered approach by recommending that each family be treated as a cultural unit. Such a perspective is explicitly and implicitly highlighted in a number of works by occupational therapists who have taken a particular interest in families and the interactions or relationships between therapists and families (Baum, 1991; Brown et al., 1997; Hasselkus, 1988, 1991, 1992, 1994; Humphry, González, & Taylor, 1993; Humphry & Geissinger, 1993; Larson, 1998; and Ravetz, 1998). In these works and others on families, culture (in relation to therapists and families) is clearly a factor although it is not always specifically articulated as such. More explicit examples exist in the occupational therapy literature, including Humphry’s (1995) work on families who live in poverty, where she looks at value orientations. Other works that address culture and family include, for example: Dyck (1989, 1991, 1992, 1998), Fitzgerald, Mullavey-O’Byrne, & Clemson (1997, 2001), Fitzgerald, Mullavey-O’Byrne, Clemson, & Williamson (1996), Krefting and Krefting (1990), Levine (1987), Mattingly and Beer (1993), Paul (1995), and Ravetz (1998). For an overview of the occupational therapy and culture literature see Fitzgerald, Mullavey-O’Byrne et al. (1997).

Confounding of Culture and Ethnicity

As I was writing this paper a representative of a government agency approached me to speak on culture at a conference. I was approached because someone who had attended one of the workshops I conduct said I presented a very different way to think about culture in their work, that I identified culture as different from ethnicity and that people were now thinking about culture in terms of all their clients, not just those identified as “ethnic” or “ethnically different.” Several authors, including Bonder et al. (2002), Fitzgerald, Williamson, and Mullavey-O’Byrne (1998), Fitzgerald and Mullavey-O’Byrne (1996), and Press (1997) have noted the problem of confounding culture and ethnicity by health professionals, including occupational therapists. By confounding I mean the assumption that these terms are synonyms.

As discussed in the citations above, culture is a notoriously slippery concept to define. With due respect to those who have written extensively on this concept and with greater finesse than I, for simplicity’s sake I will use the following as a working definition: culture is the learned, shared, patterned ways of perceiving and adapting to the world around us (our environment) that is characteristic of a population or society. This definition captures some of the core ideas that most anthropologists would agree on: culture is learned and shared (it is social and transmitted from one generation to another; it is not idiosyncratic), it is patterned (aspects are repeated or reflected in other aspects of society), it belongs to societies or populations, it is ever changing, individuals carry and transmit culture, and they do so imperfectly. Perhaps more importantly, culture is an abstract and complex concept, a shared symbol we created that came into common use only after the Enlightenment (Ray, 2001) so we could talk about humans and try to understand them as social beings. In other words, all humans are cultural beings; it is what makes us human.

Here I will use the term ethnicity, another contentious term, to refer to a sense of shared identity that can be based on many things, only one of which is shared culture (Bonder et al., 2002; Fitzgerald, Mullavey-O’Byrne, Clemson, & Williamson, 1996; Fitzgerald, Williamson, & Mullavey-O’Byrne, 1998; Fitzgerald & Mullavey-O’Byrne,
Thus, to suggest that all people who identify themselves as Chinese (and you can substitute any other ethnic label) are culturally the same is to deny the incredible cultural diversity within these ethnic groups. For example, Hong Kong Chinese are culturally different from Chinese from other countries, even though there are things, like a shared history, place of origin, or language that they can use to tie themselves together. Particularly in the last 2 years, students in the culture and communication subject have identified the confounding of culture and ethnicity as a critical issue because it means that people cannot address cultural issues when they cannot identify them, particularly when culture is not universally viewed as an important issue for all clients or families. However, it was only at the end of the semester and after analyzing data that the students have been able to identify this confounding of culture and ethnicity as a cultural issue and label it as a practice problem (for a similar response in other contexts see, for example, Dyck and Forwell, 1997, and Whiteford, 1995, 1998, 2000). This finding may be, to some degree, a product of the name of the Project—the Intercultural Interaction Project—and information on the consent form, but the students suggest that it cannot be fully explained by these factors only. Indeed, data from other contexts support their conclusion, pointing to the value of the interviews themselves for raising their awareness of this confounding.

Despite attempts to get respondents to see culture as more than ethnicity and an issue for all participants in any interaction, respondents still use ethnicity to identify the people (the cultural beings) they include in their discussions—the families they discuss are identified as being from a different ethnic group and are, therefore, assumed to be culturally different; and, the problems or issues involved in the interaction occur because the other people in the interaction are from another culture. Included in such accounts are often broad generalized statements about “people from that culture.”

Perhaps more interesting is that with a notable few exceptions, clients, families, and community members have even more difficulty in identifying cultural issues in their interactions with health professionals unless prompted with a critical incident. In fact, this is one of the reasons we now regularly include a critical incident in our interviews with these respondents. Once introduced to a critical incident, even one where culture and ethnicity is ambiguous, people can more easily identify and discuss how culture (as culture, not ethnicity) might influence the interaction, again more often in terms of age and gender, and sometimes educational differences, but other cultural issues do come out.

Thus, therapists are likely to only consider cultural issues in families they see as culturally different, those from other ethnicities. In our interviews with therapists in multicultural Australia we regularly encounter therapists who say that culture is not really an issue for them because they do not work with people from other cultures, that their client population is not culturally diverse (i.e., it is homogeneous or not different from themselves), even when the demographic data for the community indicate considerable cultural diversity. In this way they are blinded to the cultural influences on the behavior of the families with whom they work because they focus on ethnicity. They are blind to the cultural assumptions they (and the families they work with) bring into their interactions and their evaluations of the people and events involved. Therapists expect clients to conform to their ideals about families and when they do not, the families are viewed as in need of intervention. Therapists may judge the families with whom they work in terms of dichotomies, good families or bad, helpful or not helpful, supportive or not, and this can influence not only the kinds of services the family is offered, but how they are offered. Culture is a factor in all professional interactions and all these interactions are influenced by one or more cultures (Fitzgerald, 1992).

Conclusion

To ignore culture with any client or family is to ignore core factors that influence health and illness behavior and the kinds of interactions that occur in all contexts, including therapy contexts. But this understanding must go beyond recognizing that families are a cultural institution and the rights and responsibilities culturally influenced. Familial interactions and the roles played by family members are influenced by many factors influenced by culture, including perceptions of health, illness, disability, normality, expectations about the role, and the rights and responsibilities of all the people involved. In any interaction, health professionals and clients or families bring to the interaction cultural knowledge and expectations. When the cultural expectations are not met then one or more of those involved will leave the interaction less than satisfied—and this will affect the outcome not only of the interaction but the therapy. If therapists are to address the needs of the clients or families with whom they work, they must keep culture in mind with all clients or families—not just those they identify as being ethically or culturally different. All therapists, especially those working directly with families, need to acquire a better understanding of the concept of culture and its influence on them, their clients, and all aspects of daily and professional life. These therapists may benefit from engaging in
reflection about where they learn not only about their clients, but themselves as cultural beings. In addition, reflection may be useful to help therapists better identify the cultural influences on their own personal and professional behavior, roles, values, and attitudes, plus those of their clients. This reflective practice has to move beyond the superficial and enter the domain of deep reflection. This experience can be very frightening and challenging to our concepts of self. However, to do less is to not engage in client-centered or holistic health care. Moreover, to do less may be culturally or professionally incompetent (Fitzgerald, 2002).

Let me close with a final note, one I generally use to close my talks on culture and intercultural interactions: Culture—explanation or excuse? I have argued here and elsewhere (and will continue to argue) that culture is always an issue and always needs to be taken into consideration, but other social, psychological, physical, and contextual factors are also involved in our interactions with clients or families. Culture is always part of the explanation, but we must be cautious about using it as an excuse that blinds us to other important issues that need to be addressed. To lay all the “blame” on culture for an unsuccessful interaction or therapeutic outcome because we did not use a holistic approach is to use culture as an excuse. We can avoid this problem by developing a better understanding of the concept of culture, as culture—not ethnicity, and the role of culture in all of our lives. We are all cultural beings.

Acknowledgments

I would like to thank Colleen Mullavey-O’Byrne, codirector of the Intercultural Interaction Project, the more than 200 student collaborators, particularly those who participated in 2002, and the many others who have contributed to our work in so many ways. Although these people raised the points addressed in this paper, I reserve full responsibility for their presentation. The Intercultural Interaction Project has been supported, in part, with funding from the following: National Health & Medical Research Council, Public Health Research and Development Grant; University of Sydney Research Grant (URG); University of Sydney, Faculty of Health Sciences Cumberland Grant (CRG); School of Occupational Therapy Internal Grants; and the Transcultural Mental Health Centre, Sydney.

References


