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Introduction and Terminology

Culture is all pervading in our lives—especially when we view culture as more than ethnicity or race. However, when we are embedded within and surrounded by others of our own culture, our cultural identity is often experienced in a less conscious way. For some people, until they encounter cultural difference or dissonance, their own culture may barely come into consciousness. Raising consciousness about the role of culture in health psychology and health and human services work is a critical step in providing care and service that is not only competent, but culturally safe for all.

In this chapter, we introduce the main ideas of this book—cultural safety as a preferred way of working as professionals, the need to decolonize our professional practice, and the importance of using informed terminology when working in a range of cultural contexts.

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Chapter Objectives

After completing this chapter, you should be able to:

- define cultural safety in relation to health psychology and health and human services
- identify appropriate terminology and rationales for their use
- examine the relevance of colonization to your own practice or professional aspiration
- identify strategies to decolonize your practice

Overview

In this book, *A Cultural Safety Approach to Health Psychology,* we apply the concept of cultural safety to the field of health psychology and professional work in the health and human services in the U.S. 'Cultural' differences are most often thought about as those more overt differences related to race or ethnicity—language, foods, modes of dress, rituals, and behaviors. However, cultural safety as both a philosophy and model of practice, looks at culture as also including differences in terms of age, sexualities, genders, religion, migration status, abilities, or socioeconomic background. Where professionals and their clients differ in these areas, evidence shows this can be a major factor in contributing to health disparities.

Many books continue to buy into narrow 'biomedical' and 'biopsychosocial' frameworks that perpetuate individualistic, capitalistic, and medicalized viewpoints. In this book, we explore cultural safety as both a philosophy and way of working within a social model of health as an alternative approach to understanding health and illness. Furthermore, as health and illness can be directly and indirectly linked to our and other countries' colonizing pasts, we apply a decolonizing framework to professional practice.

So, we are barely into the first chapter and we have already talked about culture as a major determinant of health—culture in its broadest sense—and the impact of our colonial past on health and social care.

Educating health and human service professionals is an incredibly important, as well as daunting, task in a current climate that is often ambivalent at the least and hostile at the worst. In some sectors, the teaching of cultural diversity, difference, or acknowledgment of the impact of cultural dissonance has been seen as 'dangerous' ideas by those who seek to deny that there is any problem with the way healthcare and human services are provided. After all, we treat everyone the same, don't we? Even if that could be accepted as true, equal treatment, as we will hope to show, does not always translate to equal outcomes. Treating everyone the same, can in fact, aggravate existing disparities, by assuming everyone exists on a level playing field (Fig. 1.1).

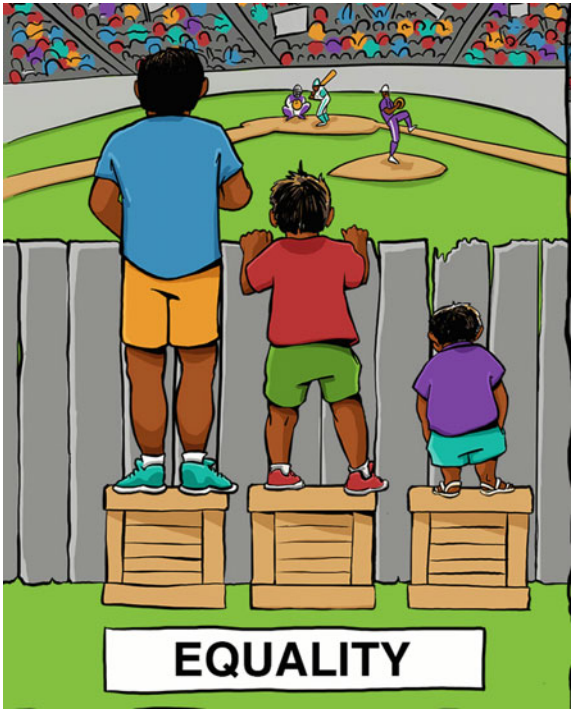

Fig. 1.1 Equal treatment does not provide equal outcomes (*Image Credit* #the4thbox Equality/Equity/Liberationimage collaboration between Center for Story-based Strategy & Interactive Institute for Social Change)

This above picture shows that while treating everyone the same seems appropriate, failing to take into account individual differences (in this case, physical differences, rather than cultural), can prove ineffective in providing appropriate support. What if the difference in accessing care or services was economic background, race or ethnicity, sexuality, religion, or gender? It would be easy to see this as discriminatory and yet it sounds reasonable in theory, to treat everyone 'equally.'

There is a myriad of examples that could be cited, of cultural differences negatively affecting the health and well-being of individuals and groups. Research has long shown that differences in cultural background between clients and professionals can lead to poorer outcomes, shorter consultations, lower quality information exchange, and more (Bailey et al., 2017; Ben et al., 2017; Tello, 2017).

Reading

A recent article identified physician–patient racial differences as implicated in higher deaths of newborn Black babies.

Greenwood, B. N., Hardeman, R. R., Huang, L., & Sojourner, A. (2020). Physician–patient racial concordance and disparities in birthing mortality for newborns. *Proceedings of the National Academy of Sciences, 117*(35), 21194–21200, https://doi.org/10.1073/pnas.1913405117.

This is not suggesting any conscious or deliberate act on the part of physicians to provide poorer standards of care. What it does demonstrate are the very real cultural biases that can influence how care is provided, such as a lack of adequate history taking, assumptions, stereotyping, discrimination, and 'othering' (i.e., the tendency to view the other as exotic and usually lesser), that can occur without even being aware of it. Sometimes, of course, differences in how care is provided may well occur with awareness, which is why racism and discrimination awareness are also necessary features of cultural safety.

Much of the literature on disparities and cultural differences, as above, has focused on culture as it relates to race or ethnicity only. To date, the emphases in healthcare and human services and policy

settings have largely expected vulnerable and marginalized people—usually those perceived to be 'the other'—to change themselves in order to change their outcomes. Less attention has been given to the changes that members of the majority or dominant groups and systems could and should make to provide more effective, or safe, care, and environments.

Here it's important to say that language and terminology will be mentioned a lot—because language matters. The words we choose are usually through a specific cultural lens and are often laden or contested. In health care, the system in and of itself, as well as the providers within that system, are 'dominant', or hold power, over those in their care in terms of access to particular knowledge or resources. But we do not mean dominant in any value sense or in the sense of any inherent quality. When we use the word 'minority', we do not mean 'less than' in any judgment of value, but in the sense of being 'outnumbered' or unequal in power relationships or access to particular resources or knowledges within a specific situation.

A recent quote from Janel Cubbage emphasizes the importance of reflecting on what specific language actually means: 'We are not minorities, we have been minoritized. We are not underrepresented. We have been systematically excluded. Language matters' (15 November, 2020, Twitter @janel cubbage).

So, in healthcare and human services, whatever the difference between professionals and clients, rather than expecting clients to 'fit in', cultural safety asks those in the 'dominant' role to examine their professional practice to accommodate client needs, where possible. There will be times where such changes are not possible, but cultural safety is about *how* things are done, as much as *what* is done. If you cannot provide a female staff member for someone who would prefer this, for example, the way this is navigated moving forward will determine the cultural safety of the encounter. Sometimes even a brief acknowledgment that you would like to be able to offer the choice, but staffing or situations at the time prevent this, is enough for someone to feel 'safer'.

Poor health and conditions in the U.S. are the result of a multiplicity of circumstances, histories, attitudes, and beliefs and therefore need to be thought about within this multiplicity of contexts. No one wants to get diabetes, for example. Biomedical explanations can only go so far in

understanding and addressing such a health issue. Diet and sedentary lifestyles may explain part of the cause, but what explains the inequitable access to fresh and affordable foods? Eating healthy is not simply a matter of 'choice'. How are we to understand and intervene for more active lifestyles when not all neighborhoods are safe?

If we, as a nation, could figure out how to improve health, well-being, and living conditions for those among us who are most at need, who are most vulnerable and marginalized in terms of health, and for everyone who seeks care, what might be the implications for health and U.S. society as a whole? At an individual level, if we learned how to deliver services so that outcomes mattered, this could improve health for everyone. Organizationally, if we learned how to structure our systems so that no one was left behind, that everyone benefitted, we would have an organizational structure coveted by all. And if our policies were such that everyone mattered, in real ways, and that policies did not present barriers but facilitated culturally safe care, again, *everyone* would benefit. This would mean providing care and services that are not delivered *regardless* of cultural differences, but *regardful of* and able to accommodate differences. Apart from all the mutual benefit, health is a universal human right and whenever there is disparity within our nation, we are all diminished. We can and must do better.

Cultural Safety: Some Key Concepts

Cultural safety, as both a philosophy and a model for practice, was developed by Māori (the Indigenous people of New Zealand) midwives in New Zealand. It is the preferred model for educating health professionals in New Zealand, Australia, and Canada but has been slower to catch on in the U.S. or to be applied in the social and human services or psychology domains. We hope that by the end of this book, we will have demonstrated the strong relevance this concept has for the U.S. and how an Indigenous-derived approach can be transformative for all.

Cultural safety is defined by the New Zealand Nursing Council of New Zealand (2011, p. 4) as:

> The effective nursing practice of a person or family from another culture, and is determined by that person or family. Culture includes, but is not restricted to, age or generation; gender; sexual orientation; occupation and socioeconomic status; ethnic origin or migrant experience; religious or spiritual belief; and disability.
>
> The nurse delivering the nursing service will have undertaken a process of reflection on his or her own cultural identity and will recognize the impact that his or her personal culture has on his or her professional practice. Unsafe cultural practice comprises any action, which diminishes, demeans or disempowers the cultural identity and well-being of an individual.

Look at the key terms in the above definition: effective care; determined by the (recipient of care); cultural difference broadly defined; reflection on practice; and the professional recognizing the impact of their own culture on their professional practice. The onus for any adaptation in the care relationship is firmly on the professional—a way of mitigating potential power imbalances for the client or patient.

Cultural competence, the model more commonly used in the U.S., has been defined as the knowledge, awareness, and skills aimed at providing services that promotes and advances cultural diversity and recognizes the uniqueness of self and others in communities (American Psychological Association, 2017). Simply, cultural safety is distinguished from cultural competence in that culturally safe practice is determined by the recipient of care and this is made explicit, while in cultural competence it is not made explicit—though one might assume that 'knowledge, awareness and skills' are assessed by supervisors or others in charge. Both cultural safety and cultural competence require self-reflection, but cultural competence emphasizes the knowledge base of the professional. This knowledge base often relates to specific cultural practices that can be perceived as fixed and able to be categorized, whereby, cultural safety focuses more on the diversity both within and between 'cultural' groups and the dynamics of cultural interactions. We explore these differences more in later chapters.

Cultural safety is also one approach that recognizes that health and well-being today is linked to our colonizing histories and asks health professionals to 'decolonize' their practice. There may be some readers

who are unclear about how history influences health care and human services today. However, understanding that colonization is a process of asserting power and dominance, then we can begin to understand that power relationships in health care and human services require attention. A decolonizing approach is woven throughout the book, offering ways that professionals might examine their own practice and work to ensure more equitable power relationships with clients.

The U.S. was brought into existence through the dispossession of land from the Indigenous inhabitants and then built and exploited using people who were stolen from their homelands. These remarks are not said to elicit guilt or anger—they are a matter of historical fact and part of the 'history-taking' that any good health or human service professional should conduct to inform their practice. The impact of colonization on health and well-being is critical to our understanding and provision of care and services today. But as the question arose earlier, shouldn't our services and care be the same, no matter who we are working with? The U.S., as a multicultural society, should include everyone, right? Why focus on particular groups?

Scenario

During a conversation at a family gathering, the conversation turned to health care. A father stated that he didn't believe his taxes or payment for health insurance should go toward paying for people who didn't have their own health insurance or for things such as women's health which did not directly benefit him. He had always taken responsibility for his own health, worked hard, and looked after himself and his family.

- How would you respond to these comments? Do they align with your own view closely, somewhat or not at all? Give a rationale for your answer. (Please note, a rationale is a reasoned case, **not** an opinion.)
- What worldview is reflected in this approach to health?
- A few months later, the father ended up unemployed due to a business closure that meant the loss of his health insurance. Not long after, his wife was diagnosed with breast cancer.
- Do these developments change any of your responses above?

> "We are only as strong as the most vulnerable person in our community, so now more than ever it is imperative for us to decolonize from individualism and reconnect with ways of community care" (Begay, 2020). What is important to acknowledge is that any one of us can be made 'vulnerable' by circumstances often beyond our control.

How We Talk About This Topic: Terminology and Definitions

To begin this and any conversation regarding culture, we need to find out what words to use to describe groups and people before we explore other topics. Establishing the correct terminology to use is like making an introduction and telling someone your name—specifically how you want to be addressed, which itself may depend on the cultural context in which it is used. Already, we are using the term 'client' to describe those receiving services or care. We could have also used terms such as 'patient' or 'service user' or many other terms (see McLaughlin, 2009). These terms come in and out of fashion and can be preferred or opposed depending on location, the group you are working with, and many other variables. While 'client' isn't a perfect term because of the inherent power implication in its use, in the absence of more appropriate term, it is the term we have chosen to use. As with other terms and labels, seek to understand the preferred terms with your clients and workplace.

We will be discussing a range of identities including gender, race, ethnicity, sexualities, abilities, religions, age, and socioeconomic status. The range of cultures and identities discussed in this book are inherently diverse and anything but static. Therefore, we need to set some parameters for the use of terminology from this point.

Acronyms and abbreviations are sometimes used for brevity and identification, such as LGBTQIAP+ and many variations of this abbreviation. However, there is quite a bit of discussion and debate about the use of abbreviations (also called initialism) because they have the potential to

exclude some or assume all individuals and groups are happy to be identified together under such labels. Here, these letters can stand for Lesbian, Gay, Bisexual, Transgender or Transsexual or Trans* as an inclusive term, Queer, or GenderQueer, or Questioning, Intersex, Asexual or Ally, and Pansexual. A ' + ' at the end is a way to include anyone else who doesn't fit into any of the other categories. There is not universal acceptance even within groups for whom these terms apply. Overall, these initials or this abbreviation are about sexualities and gender identities. Keep in mind that sexuality is different from gender identity, but these are often categorized together. A more recently suggested acronym is SAGA, for sexuality and gender acceptance. Acronyms can also be used in medical or government writings (such as AI/AN for American Indian/Alaska Native) and may partly result from publishing requirements to shorten any phrases frequently used so as to reduce costs. While some people and groups may be perfectly fine with various abbreviations or acronyms, others may not. Abbreviations and acronyms can be offensive to some people. Think about the impact of reducing to an acronym or abbreviation or a plus sign something that is an important description of your identity.

These examples highlight the need to always check with people what their preferred identifiers or descriptors are as an inherent part of a cultural safety approach. Use of various abbreviations, acronyms, or other descriptors can change depending on the person, their age, the geographic region you are in, or many other factors such as academic conventions versus common use. The need to check current and local usage is a key message of this book, as shown in each chapter section called "Making It Local."

Scenario

A new client has come to the mental health clinic. The receptionist asks them their name and the person responds: 'Amy'. When Amy provides the receptionist with their health insurance card, the receptionist says, 'This card says 'David' and David is a male name; what is your name?' Amy responds that the card has her legal name, but she prefers to be called Amy and her pronouns are she/her. The receptionist says, 'So are

you a male or a female'? And proceeds to refer to Amy in all future correspondence as 'he' and 'him'.

- How might the receptionist have handled this engagement more sensitively?
- What assumptions has the receptionist made about gender identities and legal names?
- How might this interaction impact on Amy's healthcare seeking in the future?

When the receptionist has realized that Amy is transgender, she says to Amy, "Oh I don't care about any of that, 'to each his own'; everyone can live their own life the way they want!".

- Does this statement make the situation more or less acceptable?
- What might the impact be on Amy to always have to explain her identity?

Simply starting a conversation about this topic may seem fraught with difficulty. Some might think that the potential to offend is overwhelming and there is too much 'political correctness'. Readers might therefore opt to avoid discussions relating to cultures and identities. But why do we emphasize the importance of trying to use correct terminology? Is it 'political correctness' and what does that actually mean? Could it be that when something is deemed an example of 'political correctness' it is more likely to be a resistance to acknowledging that some language, attitudes, and behaviors marginalize and demean others? It is easy to make mistakes especially in interactions with people for whom you have little experience or knowledge but, as we will discuss more in future chapters, learning through reflective practice means acknowledging any mistakes and re-orienting your approach. Indeed, it may well be that by the time this book is being read, some of our own language, terminology, and definitions may well be outdated or unacceptable.

Race and Ethnicity

Race and ethnicity are terms that are often used interchangeably, but there are important differences between the concepts that warrant discussion. Race is a concept that usually assumes biological or genetic differences between groups of people. It is often determined by differences in skin color and facial or other physical characteristics. This way of thinking was prominent in the early nineteenth century with scientists such as Samuel George Morton from Philadelphia, who believed that there were multiple racial creations. He studied this theory by exploring skull differences of people from all around the world, ultimately determining that Europeans had the highest brain capacity (and therefore intelligence), and Africans and Aboriginal Australians had the smallest. It is not a surprising result that a European researcher found Europeans to be superior. We talk about this kind of bias more in the Research chapter. This work was later used to 'justify' enslaving certain people and other racist treatment. This obsession with collecting skulls for 'scientific' research caused considerable distress and continues to cause distress to those whose family member's remains were removed without regard for the impact of such acts.

Reading
See this article about decolonizing museums:

Hunt, T. (2019, June 29). Should museums return their colonial artefacts? *The Guardian*. https://www.theguardian.com/culture/2019/jun/29/should-museums-return-their-colonial-artefacts.

Morton's research, and that of others similar to his, is now considered to be 'scientific racism' because of how racism was legitimized through 'scientific' methods. When defined in this way, it is a highly problematic concept because presumed biological or genetic differences between large groups of people do not exist (Goldberg, 1990). The often-cited information here is that there are genetically more differences *within* groups of people than there are *between* them. This means that there are no

definitive genes or clusters of genes or biological markers that determine whether someone is White or Black, for example. However, the use of 'race' as a term to categorize people is perpetuated by, for example, the use of these categories in almost all documentation in the U.S. (such as on census forms or medical documents), which has incredible power internationally in influencing ideas.

Considering 'race' as a biological or genetic reality does not have a basis in science and has led to many problems. Sociologists, psychologists, anthropologists, and other social scientists conceptualize 'race' as a *social construction*, with political, social, and economic meanings with a long history. Even if we know that race is not a biological reality, race, as a social construction, has consequences, which are certainly real. However, it can be difficult to know how the term '*race*' is being used—is it being used to infer only biological differences, or is it being used within the broader, socially constructed, concept? In the U.S., according to the Office of Management and Budget (OMB), the concept of 'race' is used when referring to White, Black or African American, Asian, Native Hawaiian or Other Pacific Islander and American Indian or Alaska Native, but 'ethnicity' is the term used when referring to people who identify as Hispanic or Latino (OMB, 1997). People who identify as Hispanic or Latino can be Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture. For the 2020 U.S. Census, people could identify their 'origin' as Hispanic, Spanish or Latino and could 'be of any race' (Marks & Jones, 2020).

Resources

For more details on language use relating to the terms Hispanic, Latino, and more, see this History article: Simon, Y. (2020). Latino, Hispanic, Latinx, Chicano: The history behind the terms. History.com https://www.history.com/news/hispanic-latino-latinx-chicano-background.

With a warning that some people may find the content distressing, watch the YouTube clip 'The Morton Collection of Human Skulls: Full interview at Penn' at: https://www.youtube.com/watch?v=mMVzPCOut1w.

In the U.S. Census, people are also asked to indicate their place of birth, their citizenship, and year of entry (U.S. Census Bureau, n.d.). Race and ethnicity in the U.S. Census are based on self-identification, although the American Indian or Alaska Native question asks respondents to indicate their 'enrolled or principal tribe(s)'. *Ethnicity* in common usage is defined as an identity that is based on shared cultural values or practices.

Think about what it would be like for you as an individual to be referred to by an imposed label. We will repeatedly remind readers to find out what is preferred locally from credible sources—ask people of the relevant group for the accepted terminology for any given region, age group, or person—rather than make assumptions. Look at the various terminology that might be used to describe Native Americans, American Indians, or the Indigenous Peoples of the U.S. Throughout the U.S. there will be differences in what terms are accepted and even what terms might be offensive to some. We have used the term 'Indigenous' at times throughout the book for readability and brevity with no disrespect intended or we have used the terminology employed in the sources we are citing, such as the U.S. Census Bureau, which uses 'American Indian and Alaska Native' in most publications. Where we refer to specific populations we have tried to ensure that the accepted identifiers have been used.

Before the colonization of the U.S., the terminologies 'Native American' or 'American Indian' did not exist as a form of self-identification for the peoples who lived in this country. These labels or identifiers were imposed by the colonizing groups. Even today, many people identify by their tribal group, but some do use these other terms. It is important to be aware that there may be multiple spellings for different language groupings, tribes, and community names.

Look at the label 'American' for example. Americans are quite a diverse group, with around 330 million people in the U.S. alone, clearly all 'Americans' are not the same. But then what about Central Americans or South Americans? Are they, too, 'Americans'? Do all 'Americans' have flags flying on their front porches and are they all largely unaware about the rest of the world and only able to speak English? Using these examples, you might see how terminology can be problematic.

In this book we have ensured the capitalization of 'Indigenous' when referring specifically to Indigenous Peoples of the U.S. According to the conventions of the American Psychological Association, we also capitalize all racial or ethnic descriptors, such as Black or White or Asian or Hispanic. Descriptors such as African American or Asian American are generally only used when referring to sources that have used those descriptors such as the U.S. Census Bureau. Not all Black people who live in the U.S. are 'from' Africa or were born in or consider themselves 'American'. While some might see using the term 'Black' as being offensive, for many, it has been adopted as a signifier of a culture and identity. The term 'African American' is generally used to indicate the history of African origin for people who embrace the 'American' identity, but again, these labels and their use can be complicated, and one should not make assumptions about their use.

Overall, people vary in their preferences for different descriptors, and, as we will learn with culturally safe practice, it is always important to ask people what their preferences are. This is not just a matter of being pedantic or politically correct but rather it is a matter of showing the same respect you would expect for yourself. As with the other terminology we discussed, it is important to understand that at least for some people, it can be highly offensive, and even considered racist, when these terms are not capitalized. Would you write your own name or nationality with small case? Probably not, but the writer, professor, and feminist, bell hooks, intentionally does not capitalize her name as a way to subvert common conventions. To capitalize her name would be disrespectful. As professionals, it is our responsibility to be aware of these possibilities and to do our best to not 'diminish, disempower, or demean' someone's cultural identity, which includes the terminology we use to describe people.

Reading
For a helpful insight into the use and misuse of the acronym POC, for People of Color, see Copes, C. (2021). Can y 'all please learn how to

use "POC"? on Medium.com. https://medium.com/an-injustice/can-y-all-please-learn-how-to-use-poc-f9931a31bcbc.

As may be already apparent, there is a diversity of terminology and respectful ways of talking with and about groups of people. Many organizations have style guides regarding terminology, and you are encouraged to seek these out at the local level.

Critical Thinking

- What is your response to the issue of terminology? Do you think it really matters or is this merely political correctness? Why do you think some requests for change are labeled as political correctness? Who benefits when something is labeled as political correctness?
- Think of an example where you have been referred to by a label imposed by someone else. How did you feel about it?
- What cultural groups are in your region—remember culture is more than ethnicity? How do they identify themselves?
- It is essential that every effort be made to find out and use the *locally* and *culturally* appropriate terminology in your discussions. How might you find out this information? Where would you look? Who would you ask?

Informal Terminology

Many people frequently use informal terms to refer to themselves and others in daily life. Usage of these terms can vary regionally and between groups of people, and what is affectionate or acceptable in some areas or by some people could be offensive in others. Perhaps the most contentious racial slur in the U.S. is the 'N' word. Though it can be heard in music, movies, comedy, and between individuals, it is one of the most-taboo words to be used today. Indeed, even in this book, we write the 'N' word without actually writing it, because, to do so, might well be seen by many as racist (McWhorter, 2019).

The use of certain terms can be an act of reclamation of power—a way of taking the intended offense and hurt away. This is not an invitation to use such terminology. It is not our place to give such permission. You may have heard certain groups using what are usually considered derogatory names within their own peer group and it would be easy to believe this was inviting the same kind of informality, only to find the recipients have taken offense.

How will you know what names are appropriate to use? Ask! Ask the person how they want to be addressed and do the same in return. Don't assume because you have heard others using a nickname or other informal term to refer to someone, that it is OK for you to do the same. We asked above, and ask again, can you think of a time when you have been addressed in a way that was offensive to you? For some young people, being called 'son', 'boy', or 'young lady' for example, could feel demeaning.

Activity

- For this activity, you will need to form a small group, perhaps with others studying this book or maybe with your family or other people you live with. Each member of the group should explain to their group one way in which they identify themselves and why. This could be their identity linked to their gender, their profession, home state or city, marital status, or all of these. Before you get started, your group should establish some rules. They might include, for example, respecting others and their choice not to identify personal information about themselves. Individual anonymity should be maintained both inside and outside the group.
- An alternative to verbally introducing yourselves, ask everyone to depict their identity/identities in a drawing. Art can be a wonderful activity that pushes people outside of their 'cultural norm' or comfort zone.
- How did people identify themselves? Reflect on the reasons people gave as to why their identity was important. Some of the common self-applied labels include marital status, parenting roles, religion, interests, employment background, and ethnic heritage or racial identity. Did

anyone identify themselves by their cultural, racial, or ethnic background? For example, if someone identified themselves as 'half Irish', 'half Black', 'one quarter Filipino' or 'Colombian', ask how they might feel if the government used that classification to restrict their travel, places of residence, rights, etc. Think about how a term such as 'half-blood' can be offensive and may cause harm when the origin and intent are not understood. Similarly, are there terms that have been assumed to be offensive that are embraced? Who decides what terms are acceptable or not?

- If you cannot do the activity in a group, recall the last time you were in a social situation with people you were not familiar with. How did people introduce themselves? What was the context of the social situation, and did that influence how people introduced themselves? For example, if you are at a work get-together, people introduce themselves through their job title ('I'm the manager'), but if you are in a family situation, people may introduce themselves through family connections ('I'm Stella's husband').

Scenario

A mother with two adolescent children has come to the emergency department with one of the children having possibly broken their arm skateboarding. The mother completes the forms and has ticked the box 'Black'. The nurse looked at the form and begins entering the data into the system. Based on the mother's appearance, the nurse suggests that perhaps she has made a mistake on the form—that she has wrongly ticked 'Black'.

Critical Thinking

- What assumptions has the nurse made about identity?
- What impact might this have on this family's experience of health care?
- How might this impact on this mother's experience of the system?
- How likely is she to feel welcome there and come back again?
- What message do the children get about their identities?

Through critical reflection (discussed more in Chapter 13), health and human service professionals and students can develop readily transferable

skills to the care of any individual or group. You will likely work with people who have experienced a variety of influences on their health and well-being, such as loss, trauma, resilience, survival, grief, pride, capacity, health, and illness. Challenging your own assumptions, stereotypes, and possible biases is an important principle of culturally safe practice.

Making It Local

- What relevance does learning about culture and cultural safety have for your own professional practice or intended practice? Write down your expectations now so that you will have them to review when you reach the end of this book.
- What do you know about the local population groups and people in your region or specific location? Please ensure you investigate your assertion thoroughly.

Colonization–Relevance for Health and Human Services Practice

We have mentioned colonization as relevant to health and human services practice, but how many agree with this idea? Colonization or colonialism is a construct that sounds as if it belongs in the history books, rather than a book for health and human services professionals. However, colonization is not a relic of the past and post-colonialism does not imply something that is over. It can also simply mean 'the period since'. Colonizing practices continue today. Colonization is about dominance and asserting power over and exploiting one's own privilege. It's about accepting systematic and institutionalized biases that disadvantage some and benefit others. The healthcare and human services industries in the U.S. are certainly dominated by the biomedical or Western construct of medicine and health care. As a wealthy, powerful country, the U.S.

healthcare system focuses largely on treatments and pharmacotherapeutics with environmental and social determinants of health remaining under-resourced and undervalued.

Look at the lack of readiness faced by the healthcare system in dealing with the COVID-19 pandemic and the value placed on a vaccine rather than low-cost strategies like social distancing, stringent handwashing, and masks in public. Indeed, with so much money going toward vaccinations and other mitigation strategies, would that money be better spent on health promotion and prevention of illnesses or pre-existing conditions? With the knowledge that people with 'pre-existing conditions' are most at risk, shouldn't we focus on reducing the causes of 'pre-existing conditions' such as improved housing, reduced pollution, increased access to healthy foods, safer living environments, and better working conditions? Of course, once a pandemic has struck, the priorities shift to deal with the immediate risks, leading to a vicious cycle of action in some areas and inaction in others. However, decisions about our health should not be either/or, as we will discuss in the chapter on Models of Health. Health care in this time, perhaps more overtly than in other times, has been politicized and, in a sense, colonized, exposing and aggravating existing disparities even further.

Colonization as an historic event, however, can also be directly implicated in health outcomes of various populations today. Most of the groups affected by colonial pasts are the Indigenous, Black and Hispanic peoples, who, as a result of history, were dispossessed, dispersed from their homelands, and decimated through conflict, disease, or other causes. There is considerable evidence that the detrimental effects of colonization have influenced health outcomes through successive generations, in areas such as mental health and chronic diseases, maternal and child health, substance misuse, and more. One example of how colonization has affected health today is the radical change from an Indigenous diet to a Western diet, which has contributed to whole families being susceptible to diabetes, heart and kidney disease.

Without an understanding of our colonizing pasts, including policies and practices that have led to a mistrust and fear of some health and other services, cultural safety will be less attainable. Colonizing practices are fairly universal—dominate, assert power over, force people to

comply, divide and conquer, suppress cultures and languages, restrict and remove freedoms, and control information and knowledge. Colonization doesn't have to involve armies engaged in conflict. Think about the language still used in health care when someone chooses to leave the hospital without completing treatment—they are noted as 'absconding', 'discharged against medical advice', or 'non-compliant'. These labels perpetuate or maintain colonization of our professional practices by implying the person is guilty of some wrongdoing rather than acting with agency and making different choices.

Decolonizing Practice

What then does it mean to decolonize healthcare and human services practice? From a cultural safety standpoint, it means making sure that we do not assert power over or dominate those of a different cultural background to ourselves. Ultimately, as professionals providing services, we automatically are in a position of power over those in our care. Clients come to us because they believe we can help or that we have something they need. But how can we reduce this power differential and be more mindful of how it might impact our services and outcomes? As a start, we examine our own biases and stereotyped ideas and assumptions, and we engage in dialogue with the clients to provide care that they will deem culturally safe. So many interactions in health and human services can be made culturally safe by adherence to these few simple principles. As cultural safety is an ongoing aspiration, there is opportunity for reflection and improvement in the ways of working.

Scenario
A young boy in the pediatric department asked for a toy from the toy box using his first language, Spanish. The large male nurse loudly stated that he would not give the boy any toys while he was speaking 'a foreign language'. 'No, when you stop talking in that language and ask me properly in English, then I'll give it to you'.

- What lessons did the child learn about the world in this one small exchange?
- What underlying message does the young boy get about his own language and identity?
- What did he learn about power?
- What colonizing strategy is evident in the nurse's response?
- How might this scene be made more culturally safe for all participants?
- Who is in the best position to change practice?

Conclusion

In this chapter, we discussed relevant terminology and asked the reader to investigate locally appropriate terminologies. We also sought to examine the relevance of identities to individual practice. We discussed rationales for studying the impacts of colonization on health and outlined some strategies for decolonizing practice.

Some key cultural safety principles have already emerged:

- Simply ask how someone wants to be addressed; respect how they choose to identify without questioning, assuming, or stereotyping.
- Consider the influence of history and decolonize practice by not continuing to impose and disempower individuals or make assumptions.
- Reflect on your use of language and terminology. Identify the origins of terminology and acceptability in the local context.
- Think about who has power when different terminology is used or when it is assumed, and who makes the assumptions.

These principles are applicable to working with anyone of a different cultural background to yourself. One assumption that is probably safe to make is that, as a professional providing services, everyone you are

working with is different to you. Culture can be generational, social, religious, or any difference that exists between you and the client or recipient of care. The following chapters will present an argument for the use of cultural safety as an underlying philosophical approach to health and human services.

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