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Doubly reflexive ethnography: contributions to the construction of occupational therapy from an intercultural perspective.

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SUMMARY:
In the field of occupational therapy, as a result of the processes of globalization, there is a growing interest in aspects relating to culture and its relationship to health and well-being. The development of occupational therapy in multicultural contexts proposes to go beyond the terminological questions to deepen and refine new guidelines related to the construction and consolidation of knowledge. Thus, this paper raises a critical analysis of the main assumptions of occupational therapy, referring to the nature of the occupation and the link between occupation, health and well-being, as well as the praxis derived from them. The professional culture of occupational therapy is analyzed through doubly reflexive ethnography, a heuristic three-dimensional model consisting of syntactic, pragmatic and semantic dimensions. This study of the occupational therapy aims to raise the development of the discipline that may be conscious and responsible for the relations of power that are implicit and explicit in the theory and practice of occupational therapy. The co-reflexion with the different actors involved is determinant in the development of an intercultural perspective of occupational therapy that may be therapeutically effective. The concept of etnoccupation may be proposed as alternative to the ethnocentric concept of occupation, proposing a vision of the occupation on economic, social and political aspects which aims at social transformation.

KEY WORDS:
Professional Culture, Occupational Therapy, Ethnography, Interculturality, Etnoccupation

Introduction

This paper presents a critical analysis –conducted after ethnographic reflection of occupational therapy's main assumptions[1], within multicultural contexts. In particular we will analyse postulates referring to the nature of occupation and its ties to health and well-being, as well as to practices derived from them.

Our study is based on two major pillars: firstly, the revision of specialized literature on occupational therapy; secondly, ethnographic material collected in Ecuador, Honduras, Morocco, Tanzania and Burkina Faso –obtained with the use of an anthropological model founded on occupational therapy.

Our main focus is to question occupational therapy's conceptual foundation, based on our collection of ethnographic material. Thus we raise questions on how to build knowledge in the field of occupational therapy so that its postulates unfold according to an intercultural perspective. This analysis poses an opportunity to build knowledge in the field of occupational therapy based on the implicit and explicit relations of power involved in theoretical development and therapeutic intervention.

The referred approach does not employ "cultural" aspects to disguise certain conflicts and social inequalities (Wallerstein, 2007), while strengthening particular relations of power reflected on structural violence. This paper transcends mere terminological assessments, to outline and delve into new guidelines associated with the construction and consolidation of knowledge and its repercussions on occupational therapists' professional practice within multicultural contexts.

Socio-historical analysis of the origin and evolution of occupational therapy shows that notions of culture are at the core of the discipline's original postulates (Moruno, 2002). Among occupational therapy's early influences we find different social and political movements[2] centred on the consequences of industrialization and the intense migratory flow that, during the 20th century's first decades, led to the progressive emergence of a multicultural, multiethnic and multilingual society in the United States. These influences, which arose at the same time as occupational therapy,

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1. Occupational therapy is defined as the therapeutic use of everyday activities (occupations) with individuals or groups, in order to attain participation regarding different roles and situations in the household, at school, in the workplace, community and other environments, as a way of promoting health and well-being, while preventing restrictions on occupational performance. (American Occupational Therapy Association, 2008: 78).

2. Prominent amongst these are "Societies of Arts and Crafts", the "Settlement Movement" and "Settlement Houses" (Moruno, 2002 and 2003).

defend the therapeutic value of occupation as the nexus between patients and their community's cultural references. Thus, an individual's occupation is considered to be a form of strengthening social ties; a means of increasing professional obligations' personal significance, while learning a craft and obtaining a source of income (Moruno, 2003). From this point of view, occupational duties promote the immigrant population's cultural adjustment and assimilation to the host society. This relationship does not only affect the origins of occupational therapy. Currently, the definition of occupation –a unique and distinctive concept within the discipline– is attached to culture[3].

To this we must add the globalization process, prominent throughout the last decades, which has favoured a growing interest in cultural aspects and their relation to health (Palacios & Rico, 2011; Flores, 2011; Zango, 2010; Mariano, 2007; Iwama, 2006; Meñaca, 2006; Bonder, Martin, & Miracle, 2004;Comelles, 2003).

Occupational therapy is inscribed within the social healthcare field, a sector questioned by people belonging to different cultural backgrounds, requesting substantive changes. In this sense, literature on occupational therapy referring to culture is focused mainly on aspects associated with sensitivity, culture competence of professionals involved (Iwama, 2004; 2006) and the analysis of interventions carried out in the West with cultural minority groups (Awaad, 2003); disregarding elements which may transcend these approaches. However, to adequately establish a debate on cultural pluralism it is essential to clearly distinguish between two planes concerning cultural diversity and its general conception within society (Giménez, 2003). According to Giménez (1997; 2000; 2003), cultural pluralism is seen as a particular conception of cultural diversity, and a specific proposal on the legislative and institutional form of praxis based on equality and the difference principle.

It is paradoxical for institutions within social healthcare systems to ignore cultural aspects (Comelles, 2003), setting culture aside while paying attention only to forms of knowledge and practices based on scientific and technical models, privileged by modern states and capitalist societies

3. Numerous definitions of occupation refer to culture. To cite some examples: "Chunks of culturally and personally meaningful activity in which humans engage that are named in the lexicon of the culture" (Clark, 1991). Units of activity which are classified and named by the culture according to the purposes they serve in enabling people to meet environmental challenges successfully (.) Some essential characteristics of occupation are that it is self-initiated, goal directed (even if the goal is fun or pleasure), experiential as well as behavioural, socially valued or recognized, constituted of adaptive skills or repertoires, organized, essential to the quality of life experienced, and possesses the capacity to influence health" (Yerxa, 1993).

(Palacios & Rico, 2011: 2). As to this, Menéndez (2000: 177 – 178) holds that there is no coherence between the description and confirmation of cultural factors present in therapeutic interaction as well as intervention in accordance with these factors carried out for the purpose of modifying a situation which is perceived as negative. According to the aforementioned author, the healthcare system, disregarding the ample proliferation of medical anthropological research studies on health/illness/healthcare processes, attaches importance to cultural factors but considers them secondary in practical interventions.

We believe that the development of occupational therapy in a global world, and within the globalization of inequality regarding relations of power, urges occupational therapists to understand culture, considering it essential to their interventions. This approach is fundamental to consolidate the discipline, as well as to carry out an in-depth study on facts emerging from interventions in multicultural contexts and which, at times, we disguise or justify as cultural facts in the context of a view severed between "otherness" and our own conventional reality.

We should not forget that occupational therapy's debate over culture is underlain by a larger discussion on the existence of absolute truths, applicable to any human experience. According to Ibáñez (2001), not to question *Absolute truth* is a consequence of some *will to Power* that is resolved only through the use of violence –more or less subtle– against those who refuse to accept *Truth* and therefore are not considered "normal," needing some form of therapy. From this point of view, authors such as Spivak (2008), try to decentralize certain approaches considered universal.

In order to achieve this, it is necessary to develop new forms of knowledge which imply feedback; a rejuvenation and decolonization of knowledge and its construction. In this regard, it is necessary to diversify universal and academic knowledge, associating it to local, subaltern and alternative forms of wisdom which, jointly, will help build up new and well thread diversified canons, with a global interest (Dietz, 2011: 6). Thus, we raise questions on occupational therapy's common beliefs, not concerning their degree of truth, but in terms of practical consequences (Ibáñez, 2001: 62).

We believe this article's anthropological perspective may notably contribute to generate a new knowledge which shall serve as a conceptual basis for occupational therapy.

As part of our goals, firstly we will reveal occupational therapy's theoretical principles, focusing on types of occupations and their relationship with health and well-being. Secondly, and considering firsthand eth-

nographic materials –collected in Ecuador, Honduras, Morocco, Burkina Faso and Tanzania between 2002 and 2011–, we will critically and self-critically question the concepts which serve as basis for occupational therapy's professional culture (Awaad, 2003; Hammell, 2009a). In order to do so, we will consider ethnography's double reflexivity[4], with the aim of establishing an inter-subjective and dialectical relationship. According to this methodological approach we raise a "reflexive ethnography which includes a view towards the syntax of power structures, contributing to accompany the main actors in their mobility itineraries and discursive vindication, but also through their existential interactions and practical transformations, which position them among cultures, types of knowledge and forms of power" (Dietz, 2011:19).

Ultimately, without omitting structural dimensions referring to the uneven distribution of power, we raise questions in order to build decolonizing and decolonized forms of occupational therapy. This we do to procure result improvement and to increase therapeutic efficiency, while ensuring people's access and right to health –specially those coming from uncommon socio-cultural contexts (Flores, 2011: 2). Occupation could thus become a source of social change and transformation.

Occupational therapy's theoretical foundations

Occupational therapy, understood as professional culture[5], shares a particular knowledge (concepts, meanings and premises), as well as beliefs, rules, perspectives and values regarding the use of occupation as therapy (Hammell, 2009a). The discipline's professional culture is transmitted through an enculturation process within the field of education

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4. According to Dietz (2011), doubly reflexive ethnography transcends postmodern ethnographical approaches as well as anthropologies of liberation, and focuses on a continuous and reciprocal process of criticism and self-criticism between the subject-researcher and the author-subject of study.

5. These are ideas, knowledge, concepts, beliefs, attitudes, morals, norms and customs which therapists acquire to become members of their professional group (Hammell 2009a). Occupational therapy is learned within a given professional realm. It moulds and determines behaviours in therapeutic interventions, providing value to people's occupations and situations, and is constantly changing and evolving (Awaad, 2003). In this sense, contributions made by Mariano (2007: 306) on what he calls the biomedical culture of culture are interesting. Biomedical theory approaches culture based on stereotypes, exotic or traditional elements, with a special emphasis on religious aspects, from a static, unhistorical perspective not permeable to social change, of a purely ethnocentric character. Therefore, cultural elements are not considered as a source of trouble in the realm of biomedicine, but something which traverses the discipline's practice and identity, establishing another explanatory variable for the disagreements present in intercultural healthcare.

that provides a particular disposition concerning its use. The proliferation of terminological confusion within occupational therapy, however, has influenced the construction of its practitioners' identity and competence (Kielhofner, 2006), moulding their professional culture. This fact involves an added difficulty when examining the discipline's conceptual basis, for, according to Palacios and Rico (2011), the terminological development and lack of consensus within the healthcare sector hinder the ability to generate reflections, proposals or discussions on health and its cultural dimensions in a global world.

Accepting these circumstances, and with the aim of establishing a new starting point to generate reflections, proposals or discussions regarding the therapeutic process from an intercultural perspective, we suggest an analysis of the basic theoretical principles established by Hammell (2009a). According to this author, these refer mainly to the nature of the occupation and the association of the latter with health and well-being.

First of all, let's check the ideas and concepts associated with the type of occupation.

There are numerous authors who raise theoretical arguments regarding the kind of occupation. Obviously, a systematic review of these is not currently possible. For this reason, we have chosen references which, we believe, synthesize, in a clear and simple way, basic ideas on the nature of the occupation.

Wilcock (2006) argues that our occupation is the foundation on which to build what he calls "doing, being, belonging and becoming". This author considers people's occupation as vital for their survival and well-being. Through *doing*, we satisfy survival and health prerequisites (basic subsistence needs, self-care and security); *being* is the result of the maintenance of health due to a balance between personal abilities –which provide meaning, purpose and satisfaction– and therefore determines people's *sense of belonging* to the community. Finally, *becoming* refers to the realization of potential to enable personal, community and social development.

Hammell (2009a) and Turner, Foster and Johnson (2003) –among many others– point out a traditional definition of occupation on different levels: occupational areas, its ability to meet individuals' needs and aspirations within their environment, as a form of controlling life and circumstance, as personally meaningful and in its relation to independence while contributing to personal identity.

Let's check these assumptions more thoroughly.

In the first place, and associated with occupational area classification, different authors have different opinions. According to Hammell

(2009b), occupations can be classified in three different areas: self-care, productivity and leisure. However, the American Occupational Therapy Association (2008: 8) offers another listing: Activities of Daily Living (ADLs), Instrumental Activities of Daily Living (IADLs), activities related to rest and sleep, as well as to education, labour, playing, leisure/free time and social participation. Associated with the classifying of occupational areas we find the concept of *occupational balance*. Although this concept has been referred to as an optimal proportion in regard to activity performance within occupational areas, Hagedorn suggested –according to Hammell (2004: 303)– a definition which was not related to performance in a context of productivity, leisure and self-care, but to harmony between the usefulness and meaning of occupations in individual lives. This conceptualization regarding balance helps explore the election, purpose, meaning and self esteem experienced and expressed through everyday occupations; occupational balance being an indispensable requisite to maintain health and well-being.

Secondly, it is assumed that people carry out occupations according to their wishes, needs or due to feeling obliged to act in coherence with their social roles, culture, environment, experience and ability. Accordingly, occupations are adjustable and serve the purpose of controlling life or, otherwise, the environment, offering appropriate responses to demands arising from people's circumstances according to each individual's social role. In this sense, Kielhofner's (2006) approach holds that each person's role serves to channel behaviour and therefore the occupations to be performed. According to this author, human beings would position themselves above and in control of their environments, just as the Judaeo-Christian tradition assumes (Hammell, 2009a: 9). Thus, it is understood that the person's conviction may decide on occupational preferences, as well as on when, where, how and with who these activities take place. Along these lines, some authors consider that people perform their occupations as autonomous agents, taking into account personal motivation and the ability to dominate, control and behave efficiently (Hammell, 2009a: 9). Thirdly, according to Reed (2005), *meaningful occupation* is that which is considered important, secure and bearing purpose. This approach believes that the most meaningful occupations acquired after a traumatic event are chosen in order to achieve a purpose or goal; occupations that are also related to self esteem while being performed under complete control (Hammell, 2004: 299). Accordingly, meaningful occupations are those that bear a particular meaning for each person involved. That is why universally meaningful occupations cannot exist (Turner, Foster, & Johnson, 2003: 26).

Fourthly, *independence* is considered the ultimate goal of occupational therapy. The discipline, therefore, focuses on the individual[6] (Hammell, 2009b), promoting an ideology based on this premise, which values the individual as a moral, independent and autonomous subject while ignoring or denying a comprehensive view of society. According to Dumont (1987), the modern individual is a socially emancipated subject, free in relation to the established order, living within a scenario of equality and freedom. Thus, individualism ignores the social relations in which each individual is immersed.

Finally, it is understood that an occupation contributes to provide meaning in people's lives (Hammell, 2004) and, thus, it is related to identity. In this case, identity is conceived as the way in which individuals interpret social interaction based on cultural factors (Unruh, 2004).

After analyzing fundamental concepts and ideas related to the nature of occupation, we will examine assumptions on the associations between occupation, health and well-being. Before we move on, it is relevant to point out that these ties have been modified through the years based on theoretical developments in relation to health and disability –in the realm of health sciences–, which serve as the foundation for occupational therapy's theoretical construction and practice –in different contexts in which it functions. According to Chapparo and Ranka (2005), health has been conceptualized along three theoretical perspectives: as an absence of pathology, disease and disability, as an ability and form of personal adjustment, and as the result of equity and social opportunity.

To consider *health as an absence of pathology, disease and disability* –an idea which is representative of the biomedical model– implies a conception which sees in health an ideal state to be attained, necessary for everyday life. According to this perspective, the intervention's main goal is to re-establish the organism's integrity (recovering the ideal state), or else heal the body, providing health professionals with an essential role in therapeutic processes. Within this perspective, any dysfunction or dis-

6. In line with Louis Dumont's, the concept of individual as well as the notion of individualism is based on the analysis of ideologies; idea-value systems which provide varying meanings to human coexistence (Stolcke, 2001: 8). Thus, civilizations differ due to the specific way in which individuals are conceived in relation to society. Dumont's analysis (1987) regarding Western individualism, whose goal is to understand different conceptions regarding the individual as an inexorable concept to modern Western ideology, is realized in contrast to the Indian caste system. According to Stolcke, Dumont uses the term "sociological apperception" to refer to the fact that concepts such as person and individual are socio-cultural constructions and, therefore, not applicable to other territories in which references to the individual are subordinate and residual, although not absent (Stolcke, 2001: 17 – 18).

turbance related to occupational performance is a consequence of health disorders, damage or abnormal development concerning the mechanisms involved in such performance (nervous system, muscle-skeleton, psychic, etc). Consequently, an individual's potential to appropriately carry out duties may be restored through activities which improve flawed aptitudes within such inner systems[7] (Moruno, 2002; Kielhofner, 2006). In this way, problems related to occupational performance[8] are expressed as medical diagnoses ignoring people's occupational needs. These approaches –still very influential in the realm of occupational therapy– have favoured the unfolding of a methodology for therapeutic evaluation and intervention, enabling the structuring of discreet and quantifiable goals in order to measure an intervention's results[9]. This conceptualization of health, however, presents a limited theoretical view on human occupational existence, situating occupational therapy's intervention in an institutional context, linked exclusively to biomedical approaches.

A change in the concept of *health as ability and personal adjustment* emerges through the influence of humanist theories (by authors such as C. Rogers, A. Maslow and F. Pearl, among others) and other investigations[10] opposing the aforementioned simplistic approach.

These changes raise a conception of human beings as biological, psychological, social, cultural and spiritual units in constant interaction with their environment. Health is conceived as a personal goal which may coexist with pathology, disease or disability. Along these lines, healthcare models are focused on the person's needs, thus, emphasizing the patient's ability to face changes affecting his or her personal skills and life circumstances.

Within this approach to health, occupational therapy recovers the occupation as one of the discipline's main concepts and develops theoretical methodologies which attempt to explain problems within occupational performance based on the dynamic relationship between person, environment and occupation. Thus, interventions involving occupational

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7. If not, equipments shall be adjusted, as well as tasks or environments, to compensate for these system's irrecoverable limitations.

8. Occupational performance is the carrying out of an activity or occupation which has been chosen as a result of the interaction between individual, context and the activity performed (American Occupational Therapy Association, 2008: 43).

9. Kielhofner (2006) points out that these facts helped the discipline attain scientific and social validity.

10. For example, works conducted by Jean Piaget, Bruner, Noam Chomsky, Newell and Simon, which, from different perspectives, serve to start cognitive psychology. As well as works by Kuhn, Lévi-Strauss and Foucault, generating a trend of thought critical with mechanistic perspectives in epistemology of health and social sciences.

therapy take place, not only in institutions, but in different community contexts. However, this perspective still doesn't question social causes and structural conditions fostering disease or disability.

Our last approach includes thoughts by disabled people in relation to social and structural causes of disease and disability, discussing *health and disability as a result of inequity and social opportunity;* associating disease and disability with social aspects. The social model of disability, central to this perspective, states that people with deficiencies are disabled as a consequence of structural disadvantages which are maintained in a society created by and for healthy and non-disabled people (Oliver, 1998). This view deals with a concept of health based on human rights, so that its interventions are focused on social changes which foster equal opportunity for everyone. Based on this health concept, the term *well-being* gains a prominent role in reference to a subjective evaluation of health, related to aspects or variables such as self esteem, happiness, energy and development of satisfactory relationships (Turner, Foster & Johnson, 2003: 27). Accordingly, occupational well-being is based on the meaning and satisfaction that a person confers to his or her occupational life, in association with behaviour and opportunity to perform meaningful occupations (Doble & Santha, 2008).

This perspective regarding health and ability has been crucial to new theoretical developments which have produced substantial changes in occupational therapy's praxis, revolving around the concept of *occupational justice* (Wilcock & Townsend, 2000). This term identifies and emphasizes the fact that people are not able to carry out satisfying and meaningful occupations which provide them with personal, familial and/or community balance, due to them being restricted, not accessible or their performance considered to be alienating (Wilcock & Townsend, 2009). In this same line of thought, Pollard, Sakellariou and Kronenberg (2008) demand a greater awareness on the political nature of occupational therapy, justifying the need to acquire political competence[11] with the aim of tying occupation to community participation and citizenship.

Currently, the latter three perspectives on health and disability coexist, to a greater or lesser degree depending on multiple factors, such as different professional performances carried out by occupational therapists, moulding each intervention's approach as well as the results to be attained.

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11. Political competence refers to the development of attitudes, skills and critical knowledge to manage conflict-cooperation situations through strategic planning, decision making, networking and political debate (Pollard, N., Sakellariou, D.,Kronenberg, F., 2008).

Ethnographic lens and critical analysis of theoretical principles and intervention in occupational therapy

Viewing things from the outside –what Lévi-Strauss called the privilege of "disorientation" (dépaysement)–, encourages a comprehensive interpretation (Stolcke, 2001: 13) in which comparative analysis between distant and complex socio-ideological realities is essential to shed light on the foundations of occupational therapy. In this way, our analytical approach emerges as a consequence of different agreements and contentions encountered in different fieldwork experiences in which we have participated as occupational therapists and researchers following anthropological guidelines.

The confrontation between occupational therapy –its main theoretical foundations centred on the ties between occupation, health and well-being– and cultures within different fieldwork scenarios is the starting point for a critical analysis that questions and develops the discipline from an intercultural perspective, relevant to each context in which it unfolds.

To start off, it is important to underline how the way in which knowledge is built has implications on people's perception of a given phenomenon: how they behave, how they interact with others and in what way power is distributed in their relationships. Likewise, the construction of knowledge on occupation has an influence on occupational therapy's services (Rudman & Dennhardt, 2008). We, therefore, deem appropriate to point out aspects of our training –common to a relevant portion of therapists– that have decisively influenced the aforementioned approaches. The fact of having studied at universities mainly managed by medicine and psychology teachers, shows how occupational therapy's knowledge is directly attached to and influenced by the Hegemonic Medical Model (HMM)[12] and, thus, a simplistic view of health, focused on dysfunction. During our academic training, occupational therapy –in its theoretical and practical dimensions– is mainly based on the concept of health as the absence of pathology, disease and disability; timidly dealing with facets such as ability and personal adjustment, while ignoring any concept of health as the product of equity and social opportunity.

While training to become occupational therapists, following the

12. The Hegemonic Medical Model (HMM) emerges when experimental science's biological paradigms are merged with Hippocratic-Galenic (empirical-naturalist) medicine with the goal of offering an etiological explanation of disease, during the late 19th century in France, England, Germany and, later, in the United States. HMM is: biology-centred, individualistic, unhistorical, asocial, commercial and asymmetrical (Menéndez, 1985).

dominant Standard Medical System's (SMS) approach, we were scarcely told about cultural factors[13] present in the mindset and practices of social groups in relation to health/disease/care. Our training as therapists disregarded how these elements intervene in the equation, showing a lack of therapeutic efficacy in varied contexts (Menéndez, 2000).

In order to carry out our analysis we have opted for double ethnographical reflexivity as the best instrument within social science's range of methods and techniques; a procedure which transcends experimental anthropology's interpretation –the simplistic approach placing emphasis on the author-anthropologist's reflexivity, as well as on that of the academic public– and anthropology of liberation –whose sole objective is to create self-aware social actors to start social movements (Dietz, 2011: 13).

Ethnographical double reflexivity is based on the assumption of asymmetrical and dialectical social relations existing between the subject-objects involved in research, advocating critical and self-critical analysis which transcends the duality between researcher and the object of study. In this regard (we once again insist), a critical analysis of occupational therapy's basic concepts advocates new ways of building knowledge and promotes an intercultural perspective to deal with the discipline. This form of ethnographical praxis favours the emergence of inner-theorizing, which thrives on feedback and discussion between activists and scholars, generating a continual and reciprocal critical and self-critical process between both sides. Consequently, ethnographic relations themselves become political praxis (Dietz, 2011: 15).

According to Dietz (2011: 17-18), the use of reflexive ethnographic methodology in intercultural situations requires a three level analysis: semantic (focused on the actor, it studies identity discourses collected through ethnographic interviews from an *emic* perspective analyzed according to his/her ethnical strategies), pragmatic (centring on the modes of interaction, it studies praxis through participant observation from an *etic* perspective analyzed according to their inner-culture and inter-culture view) and syntactic (focused on institutions, it studies social struc-

13. As to Menéndez (2000: 177-178), the Standard Medical System (SMS) is reluctant to consider cultural factors in its intervention assessing: the inefficacy of working directly with cultural factors, the lack of cultural competence among medical professionals and technicians, the risk of modifying highly complex cultural structures, the long term effects of anthropological techniques applied without assuring the problem's eradication, the variability of social collectives in regard to their daily behaviours and, finally, it doesn't consider cultural determinants or makes targeted use of them according to the characteristics and functions of biomedicine, arguing that the latter was built, to a great extent, on the science/culture opposition.

tures through intercultural forum/workshops from an epistemic framing perspective –within an *emic/etic* view– analyzed according to the organizational/institutional entity.)

The analytical approach to occupational therapy's conceptual basis, focused on the nature of the occupation, as well as its association with occupation, health and well-being, is carried out by analyzing institutional discourses, practices and structures related to the discipline. In order to do so, we will refer to ethnographic material collected firsthand by I. Zango in different fieldwork experiences from 2004 to 2011[14].

Accordingly, we are now going to give a firsthand account of our fieldwork experiences.

14. The stay in Honduras and Morocco was carried out thanks to the "Jóvenes cooperantes" (youth workers) grant provided by the Fundación para el desarrollo de Castilla-La Mancha in 2004 and 2006 respectively. In 2007, thanks to the support of the I Program of internships and final projects in Development Cooperation, and under the tutelage of Dr. Pedro Moruno, an ethnographic study was carried out, through participant observation and in-depth interviews, to analyze HIV positive women's occupational performance in Houndé (Burkina Faso). Participants in this study were selected through a purposive sampling, according to the project's selection criteria. In 2008, under the supervision of Dr. Sara Ulla, an investigation was done regarding the impact (stigma) on occupational performance suffered by HIV positive individuals in Iringa (Tanzania,) who volunteered to participate in the study and belonged to the African Medical and Research Foundation (AMREF). The methods used in this study were semi-structured ethnographic interviews and a self-made likert scale translated to Swahili by a Tanzanian occupational therapist. From 2008 to 2010 took place the assessment and start-up of the first occupational therapy centre for the promotion of mental health in Houndé (Burkina Faso), coordinated through a team which was part of ONGD Médicos Mundi Castilla-La Mancha (an NGO). The method used in the assessment and start-up processes was Participatory Action Research (PAR), based on participant observation, in-depth interviews, as well as constant encounters with different actors involved in the process. In 2011 training was carried out regarding the importance of games in child development for members of Instituto de la Niñez y la Familia de Ecuador, in the region of Bolívar (INFA-Bolívar), as well as for educational and family promoters in different children's centres due to a cooperation agreement between INFA-Bolívar and the Evergem's city council (Ghent, Belgium). Before training, interviews were carried out with children's relatives and technicians about the conceptualization and relevance of games, as well as different encounters with INFA management staff on a regional and state level. Also, previous to the training courses, and during these, participant observation was carried out, accompanying technicians in their supervision and counselling tasks, around different centres in several assistance areas of INFA-Bolívar. The anthropological approach of these different experiences has been supervised by Dr. Juan Antonio Flores.

Semantic dimension analysis:

"Excuse me, lady. Do you think your occupational therapy makes sense here?"

In 2004, thanks to a grant provided by the "Jóvenes cooperantes" (youth workers) program –funded by the Junta de Castilla-La Mancha (Spain) –, a stay was organized in collaboration with a Spanish NGO (that dealt with the nursing sector) carrying out projects with the Honduran nursing association. This took place the same year I finished my studies, which were notably influenced by the medical field. The agreeable and disagreeable personal and professional experiences I had during that stay were essential to my professional development and had great influence later on in my career as an occupational therapist working in other contexts.

Considering my professional profile, during my stay in Honduras I was assigned to carry out workshops as well as to provide basic training in occupational therapy for the nursing staff. These workshops took place in some of the region's most renowned hospitals, and lasted about three or four days. During some of these, doubts were raised regarding theoretical aspects I had presented –due to having limited practical examples to match those–, which had to do with my lack of professional experience in the field of occupational therapy and my incidental contact with therapists during my training years. To this we should add difficulties that ensued from the proverbial first fieldwork change of location. While explaining the nature of the occupation and its association with health and well-being –during basic training in the Comayagüa health Centre–, one of the nurses in the audience shyly raised her hand. Not understanding my explanation, she required me to clarify her doubts asking the following question: "Excuse me, lady. Do you think your occupational therapy makes sense here?" I felt somewhat insulted and disparaged; despite her politeness, her reference to occupational therapy as an alien subject seemed to discredit my profession and consequently my role in the cooperation program.

While I was trying to justify the importance of my newly acquired job –as well as my presence in the international cooperation program for the improvement of a professional field different from my own– I became very aware of the difficulty in explaining and understanding, without controversy or confusion, the nature of my job. This disagreement with a nurse, who –unintentionally– questioned occupational therapy's main principles, modified the course of my teaching during my stay in Honduras. From then on, I deemed it essential to carry out –prior to

training– semi-structured interviews in order to find out what Honduran professionals thought of occupational therapy's main assumptions. The information obtained provided us with some ideas on how they viewed the discipline. In all my interviews with the nursing staff it became clear that an occupation was not to be considered therapeutic according to most Hondurans. In Honduras only a minority of people are able to have an occupation which: fulfils personal needs and desires; is freely chosen; is associated with the person according to individual roles and skills while exerting control over his or her environment.

In order to approach the context of Honduras' disabled –with the use of practical examples in my training lessons–, I visited different centres and associations for disabled people. There, I interviewed individuals who attended our courses –among which were professionals, relatives and volunteers–, to find occupational aspects related to purpose, meaning, election, control and self esteem (Hammell, 2004: 299-300). The nurse's question regarding the appropriateness and meaning of occupational therapy in Honduras was present throughout these visits.

Most of these people's narratives referred to the impossibility of choosing meaningful occupations. Some emphasized the fact that after the traumatic event the chances to choose meaningful occupations where more restricted (even) than before. A disabled teenager explained, with resignation, how her condition obliged her to carry out occupations based on her situation; rehabilitation sessions where she repeated the same movement for hours. These were non-meaningful activities, but she really had no choice. This circumstance, common among disabled people in other settings, emphasized the sharp role change associated with her sudden disability. She indicated how this new situation had led her to mendacity in order to make a living and pay for rehabilitation costs.

Most of the people argued that any chance of carrying out meaningful activities would be possible only if all basic needs had been previously met. So we see how these situations condition occupational performance.

At that time I finally came to grips with the nurse's question disputing occupation's therapeutic efficiency in Honduras, as well as her emphasis on the fact that my explanations were foreign to her, as part of a particular outlook: *my occupational therapy*. This experience guided my future lines of research and points of interest, which focused mainly on the performance of occupational therapy from an intercultural perspective.

Hence, we believe the abovementioned theoretical principles –regarding the nature of the occupation– to be questionable, considering the discussed structural aspects. In this regard, the view that occupation

is tied to the person's needs, aspirations and environment doesn't take into account people who are bound to perform occupations only to obtain their means of subsistence. Lack of choice when searching for meaningful occupations was one of the recurring themes in the ethnographic narratives we obtained in Iringa (Tanzania) –a study on stigma related to occupational performance of HIV positive people. This statement is clearly discernible in the following narrative: *"If as you say I were able to choose, choose my everyday occupation, and was blessed…do you think that as tired as I am due to my illness, yes my disease, you know… I would work the land? Do you really think so?"* (Interview with DH, July 2008)

Thus, Wilcock's approach (2006) on the nature of the occupation, "doing, being, belonging and becoming" is not to be considered valid in contexts in which it is more relevant to belong than to do. As an example we transcribe an extract from an interview conducted in a centre for the disabled in Ometepeque (Honduras):

> *"To me the most important thing is being able to return to my community, you understand, ah…and for people to remember me for something I did right. I don't want people to look at me wrong because I can't work or get dressed by myself."* (Interview with MS, August 2004)

According to occupational therapy's principles, occupations are conditioned by variables such as gender, social class, religion, education, purchasing power, age, culture, geographical location and sexual orientation, among others (Hammell, 2009a). Even though these variables are taken into account in most occupational models, they are frequently set aside as secondary phenomena against those referring to election, meaningfulness and control over the occupation; in particular or especially aspects associated with social class, gender, religion and geographical location. Thus, in the assessment for a project near Nador (Morocco) to set up a cooperative for the production of argan oil –activity traditionally performed by women–, we did interviews with women to discern which occupations they considered to be most meaningful. Among these were economic management and product commercialisation. However, both occupations are directly conditioned by aspects such as gender. Hence, the impact of gender on occupations should be deemed essential, within their personal and cultural universe. Nevertheless, this variable is considered, in some cases, as less relevant than the election, meaning and control over the occupation.

Besides, occupations are conditioned by variables such as geographical location making this factor more relevant than election, meaning and control over the occupation. An example of this is the limited access to certain occupations such as children's free play in community gardens and parks –within children's centres– in the mountain areas of Bolívar. These centres' resources and possibilities are clearly influenced by their geographic location, which not only has to do with climate and its impact on performance, but also the development of community services available in urban areas or less remote locations. Thus, children's centres in the Bolívar region, which are more remote due to distance and a rugged terrain, had no access to community gardens or recreation areas for children, unlike other less remote centres near urban areas and under milder weather conditions.

Likewise, an occupation can be associated with boredom, humiliation and frustration. Consequently we cannot consider the occupation to have solely positive aspects (Hammell, 2009a; 9). The performance of certain occupations related to social class and gender may also be associated with disease and/or health risks. As an example of this we provide the results obtained in a study on HIV positive women's occupational performance in Burkina Faso (Zango & Ulla, 2009). These indicate that some of these women had been confined to carry out occupations associated with specific gender and social conditions –among other variables–, which endangered their health until they eventually contracted the disease. Take, for example, the case of a 36 year old woman who, after becoming a widow, moved to a gold-bearing region to work in a small restaurant. Due to precarious working conditions and her need to provide her children with the basic means of subsistence she was forced into prostitution. During the first months of her stay she contracted HIV, as confirmed by medical test results. In her narrative we find aspects related to structural violence, as well as feelings of guilt and frustration (Zango & Ulla, 2009: 105).

> *"they told me I could earn a lot of money in no time, and I had just become a widow so I thought it was an opportunity to support my children, but I never thought that god was going to punish me like this, and I know I was partly responsible. I should have never gone to that place (the gold-bearing location.)"* (Interview with O.O. September, 2007)

Pragmatic dimension analysis:

"They will explain what I need better than me"

Centring on therapeutic relationships, our goal is to question the theoretical principles which support occupational therapy's praxis. Usually it refers to the individual's intervention, apart from the assumption that occupation should be meaningful and purposeful for the person involved.

One of the most clarifying examples I was able to confirm regarding the contradiction between theoretical foundations and occupational praxis took place during the assessment process for the first occupational mental health centre in Houndé (Burkina Faso). For this purpose, several encounters were organized between actors involved (Diertz, 2011: 16) in which several types participated: mentally ill people, occupational therapy representatives, NGO staff members, experts and local specialists in the health-illness field (Zango, 2009).

With the intention of locating occupational needs in potential therapy practitioners, a meeting was called with mentally disturbed peopled, whose monitoring was being done by the Mental Health Unit in the Health District of Houndé. This meeting –the initiative of a male nurse with the backing of some of the region's traditional doctors[15]– took place in a room commonly used for meetings. Each person summoned was accompanied by an average of two to three relatives or relevant members of his/her community of origin. There, questions were asked on which aspects of their daily life were more affected by mental illness and what their needs were in this respect. Facing such questions, their response was silence. Finally, I asked one of the attendees about his personal occupational needs, which he answered by giving the floor to some of his companions, arguing that these would better explain his own needs.

Due to his answer, which indicated the importance of some of his companions, the meeting unfolded focusing on locating occupational needs while considering other people's opinion rather than exclusively questioning mentally ill patients.

This example shows how occupational therapy's professional culture, which focuses on the individual and therefore praises occupations which are meaningful to the person, is not relevant in Burkina Faso. We could then say that in such a context the individual doesn't decide on how or when, where and with whom occupations are to be carried

15. Traditional medicine is more accessible than the official paradigm, both geographically and culturally, providing greater coherence to the explanatory models held by the population on disease, illness and sickness, while offering a supernatural healing form which is disregarded by official medicine (Rumbero, 2007: 219).

out; considering the collective good at the expense of personal goals. Ultimately, the foundations and pillars of occupational therapy which refer to the individual –associated with independence and autonomy– and others which allude to a meaningful occupation –relative to the relevance and purpose of a given task for a particular person– are questionable in Burkina Faso (Zango, 2010).

Hence, the purpose of an intervention in this context, and in other similar scenarios, should not focus on attaining the person's independence or autonomy as to performance in given occupational areas. The performance of certain activities entails tasks which, in accordance with this setting's cultural norms, should be carried out by community members according to their age, gender and ethnicity, as well as their social and economic situation. We may exemplify our statement by pointing out activities such as bathing or having a shower –classified within Activities of daily living (ADLs) by the American Occupational Therapy Association (2008).

Such an activity does not have the same name in Burkina Faso, for its designation belongs to the device in which it is performed: the bath tub or shower tray. In this context, a tub or shower is not available to most of the population. The commonly used concept, referred to the activity in question, is to wash oneself. This device is usually outside the house and is a small enclosure used to conceal one's nudity while washing the body with water contained in a bucket. Additionally, to perform such an activity implies tasks that are performed by several actors.

In relation to this, an example which illustrates de disagreement in the practical interaction between occupational therapy's professional culture and Burkina Faso's own culture is what happened during an interview with an elderly lady –in her home– who had filled out an application to attend Houndé's occupational therapy centre. Among the different questions we asked to assess her occupational performance, she was questioned about her independence when washing herself. She was told the tasks to be carried out independently –obtaining and using supplies, lathering, rinsing and drying body parts, maintaining certain posture while in the bath and moving from the and to the bathing area (American Occupational Therapy Association, 2008).

The woman's answer, knowing she would have to do each of these activities on her own, was negative. Repeated home visits, however, as well as participant observation aimed at understanding her occupational dynamics, showed that the woman, though able to perform these activities, didn't wash alone and used some of her relatives' assistance. Participant observation revealed how certain tasks were to be performed by different

actors. Washing oneself implied fetching water from the well and bringing it back home –which, in this case, was done by the family's children, on foot or by bike–, heating the water in a bonfire –which was done by the youngest women– and putting the bucket with its utensils behind the adobe wall where the action of washing was to be carried out –which is commonly done by the person herself, the children or some spouse.

Thus, the woman repeated time and again that she didn't wash herself independently, for she couldn't do several parts of the process, which were entrusted to different family members according to age and gender. Similarly, if instead of an elderly woman we had interviewed a married man, he would have answered the same way. Therefore, occupational therapy's interventions in Burkina Faso should not focus on personal independence and meaningful occupations.

Besides, regarding these interventions, it is important to note that the occupation's division into different occupational areas –self-care, productivity and leisure– is questionable and requires research on how the person's identity is conditioned by these differentiated areas. In relation to this, fieldwork in Nador (north Morocco) revealed that occupations may not be classified universally in standard occupational areas. These are closely attached to people's daily lives, traversed by their culture. We believe standard divisions are the result of a particular professional culture, related to certain theoretical approaches mirroring a very specific social and cultural reality.

In this regard, the five daily prayers carried out by Muslim believers are essential to occupational performance, serving as the foundation on which everyday occupations are conducted. Whence, it is fundamental to consider this in occupational therapy's interventions, making therapeutic activities revolve around these five daily prayers. In this context, people find religious practices[16] essential, having an influence on the remaining occupational areas. Thus, to approach and consider this and other related aspects can be decisive in occupational therapy's praxis. In contexts such as Morocco or other Muslim regions, occupations should respectfully revolve around the religious schedule, adjusting to appropriate time spans for the performance of each occupation. That is why in the initial assessment for the argan oil production project –taking place during Ramadan–, when women saw the suggested schedule for their daily activities to be carried out in the cooperative, one of them exclaimed: "if I have no time for prayer what do I want to work for…Allah won't provide anything for me and my family" (F.M. November, 2006)

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16. Religious practices are classified according to the *American Occupational Therapy Association* (2008) within the area of Activities of daily living (ADLs).

In the same vein, the separation between leisure and work is the product of a specific cultural approach which cannot be deemed universal. In this setting, leisure belongs to certain social classes, a fact which is not translatable into other idioms, not having an appropriate word in our own language for this reality. Due to this, occupational balance's influence on health and well-being cannot be understood unless we consider each concept's distinctive features within occupational therapists' professional culture (Hammell, 2004).

As to classification within occupational areas, a woman participating in our program on HIV stigmatization –related to occupational performance– in Iringa (south of Tanzania) argued that the self-care, productivity and leisure division was not possible for, often, one of those activities could be seen both as leisure and work. According to the informant, washing clothes in a near river served as an example. This activity –which according to the therapist's professional culture fits the self-care category– and the time it provided, was used by women for other purposes too –for example while walking from the community to the river–, as to discuss the week's anecdotes, their fears and worries. This was considered to be a motivating, pleasurable and relaxing task, closer to leisure –such as it is conceived in occupational therapy's view. According to one of these women, going to the river is understood as follows: "[…] when the day comes, I'm happy after the whole week busy doing things, in a hurry, ah…normally it's Monday afternoons, after doing the housework, around 02:00 pm. Then I'm at ease, the time I have to talk with my neighbours and laugh. Sometimes one of us talks about her problems and we tell her ours, sometimes we laugh at our husbands. We go slowly and wash leisurely. It's our moment, a women's task…I hardly wash and I really don't notice any type of effort. It's our moment, do you understand?" (Interview with M.G. August 2008)

To import occupational therapy's taxonomies and de-contextualized evaluations without previously questioning them could encourage evaluations or the incorporation of occupational areas that don't exist as such, neither in the context or the collective imagination of those communities undergoing therapeutic interventions. We are referring to leisure activities within certain contexts –viewed from an occupational performance perspective–, where basic needs such as food, housing, hygiene and safety –among others– are not met. As well, the aforementioned questioning is essential not to assign social participation initiatives to communities in which even the most basic needs –such as washing one's clothes– are done collectively and wouldn't be approached in any other way. It is important to emphasize that certain cultural worldviews, which value social

relations based on interdependence, reciprocity, shared obligations and a sense of belonging, associate these situations with the person's well-being (Whiteford & Wilcock, 2000; Hammell, 2009a).

This explains the fact that in cultural contexts that don't value individualism and independence –but praise interdependence–, dependency situations do not require therapeutic intervention. Hence, in contexts where a sense of belonging and community identity prevails –versus individualism– it is important to perform interventions focused on collective occupations also called co-occupations (American Occupational Therapy Association, 2008:68).

However, having the community determine the intervention's goals according to common interest, while discarding individual goals or interests, could raise controversy within occupational therapy's intervention program (Watson, 2004). We should be aware of these situations in societies that prioritize the community rather than the individual. Thus in meetings organized with relatives of children, some of which attended children's centres in the Bolívar region –especially those living in remote mountainous areas–, wanted to place the intervention's emphasis on these centres. Not on games –which they considered irrelevant– but on aspects important to the community, such as taking care of animals, looking after younger siblings and carrying out household chores, disregarding their three year old children's interests and needs.

In the same way, after listening to disabled people's relatives in different Honduran associations, we saw how some of them asked the institutions responsible to focus the interventions on people who would be able to work again and contribute to the family economy; although professionals emphasized the contradictions that this approach would entail. "I can't pay everything related to his disability, I don't really know what's best, you are the doctors, but my son could be begging in the streets…for alms if…and you people reject it…but in that way I would be able to at least pay for his medication."

For this reason we should analyze each therapeutic situation specifically and particularly, considering intra-cultural and inter-cultural aspects. Occupation as a therapeutic method should be conceptualized according to the quality each person associates with it and not to standard forms of classification. This is due to the fact that these categories belong to a minority's outlook, which is clearly related to Western cultural values, a framework within which most of occupational therapy's theoretical construction takes place (Hammell, 2009a: 109).

Syntactic dimension analysis:

"My little girl, they are mountain wawas, that's why they don't play."

Regarding analysis, we must examine the institutions in which identity discourses and intervention practices take place, as well as contradictions being raised from comparative analysis between *emic* and *etic* ethnographic information (Dietz, 2011:17).

During occupational therapy's intervention in children's centres belonging to the National Child and Family Institute (INFA-Bolívar) –with the aim of promoting children's games in those centres–, different inconsistencies were revealed between needs assessed by the institution's technical staff, actual circumstances and the INFA's national guidelines.

The institution's professionals demanded better training for instructors, most of them local women with no special training in children's education –training related to the use of games and its benefits for child development. However, these same professionals, who supervised and monitored the centres, disregarded game processes mainly focused on aspects prescribed by national guidelines: children's attendance, control over materials, safety and hygiene during preparation.

Therefore, reports on intervention efficiency within the institution were related to aspects focused on these centres' infrastructures, based on quantity rather than quality information, while discarding the impact practical activities have on child development. For two months and a halve I joined several professionals in their visits to the sectoral areas into which Bolívar's children's centres were divided, which helped me detect contradictions revealed through comparative analysis of *emic* versus *etic* ethnographical information.

Forum/workshops were performed both with INFA-Bolívar's technical personnel and instructors in children's centres within several of the province's cantons. These forum/workshops were very helpful in order to compare *emic* and *etic* perspectives –a method termed epistemic framing by Werner and Schoepfle in 1987–, analyzing contradictions between theory and praxis (Dietz, 2011: 17) in some of the area's institutional/organizing entities. In this sense, part of those forum/workshops, regarding games and child development, didn't discuss differences between Bolívar's cantons. Instead there was a common view on the importance of games, notwithstanding palpable differences between the region's seven cantons. While returning to Guaranda by car through Bolívar's rough mountain terrain I conversed with the man responsible for instructors'

behaviour in those forum/workshops; a man indifferent to game development in children's centres, unlike other professionals working in those same institutions. This technical advisor –who was not a native of the sierra–, as if stating the obvious, said that children around the area didn't play because they were *wawas de sierra* (mountain children). He argued that the lack of meaningfulness attached to games was due to instructors' disregard. These, according to the indigenous worldview, believed that children's role was to look after their younger siblings and take care of the family's animals. Games, therefore, were no priority.

The complete disregard for local differences within the region served to perpetuated structural violence visible through identity discourses improving children's life conditions throughout the province– and interaction practices, without bearing in mind, at least in practice, each area's dominant worldview.

In Honduras, as well as in other places, there are great differences between healthcare services provided in several of the country's regions; thus showing inequality in the distribution of power. As one of the nurses at San Pedro Sula hospital (Honduras) argued: "[…] one already knows since birth…he will live more or less time…when a teenage gang (mara) member gets to the hospital, he brings with him all his family history, all the violence he has been subject to…and I always ask myself if his life could have been different…but they're almost dead when they get here… it's very difficult…" (Interview with L.S. November 2004)

Thus, structural violence is considered indirect violence, consequence of the social order. An order of things which creates huge differences between actual and potential human self-realization (Galtung, 1969), restricting occupations. Likewise, structural violence, which in Galtung's words is "as natural as the air around us" (1975), is linked to inequality and, above all, to power distribution.

Structural violence is present in institutions where occupational therapy is being performed, fostering controversy between the intervention's ultimate goals –to promote and recover people's occupational health– and the way in which the institution coerces and enforces these goals. For example, in the first months after opening the mental health occupational centre in Houndé (Burkina Faso), the Health District's Chief Medical Officer –responsible for management and medical staff supervision– decided that anyone making use of occupational therapy shouldn't be able to leave the program. He reasoned that, in order to adopt what he called "preventive measures", the community wasn't prepared to face violent situations originated by mentally disturbed people; which would propagate cases of mental illness throughout the community. This had a

grave impact on the centre's patients during this time and therefore on the intervention's goals, as well as demonstrating medical staff's ignorance regarding mental health issues.

We would also like to outline elements in the syntactic dimension analysis, such as contradictions raised while assessing the above mentioned project in Nador (Morocco). Though this project's main gobjective was to empower and train women, during the process several of their avowed needs were disregarded, such as those derived from economic management, product distribution and the cooperative's appropriation; which were channelled towards the community's relevant male figures.

Analysis of institutions in which occupational therapy takes place, taking the *emic* versus *etic* perspectives into account, is essential to assess inequalities, dominance and power distribution imbalances between actors and their context's identity policies (Dietz, 2011: 17).

Conclusion:

Towards a decolonizing and decolonized occupational therapy

The application of occupational therapy in a decolonizing way –which doesn't impose its criteria, while subduing other cultural worldviews– and decolonized form –being able to build a narrative and praxis with its own identity, not subservient to development in the medical field– implies the recognition and assimilation of other cultural worldviews, as well as analyzing theoretical principles and practices (Dietz, 2011) so that an intercultural perspective takes shape within occupational therapy. According to Giménez, interculturality in occupational therapy involves an intervention in favour of human development, pluralist and inclusive democracy, and new forms of citizenship considering the framing of "cultural aspects" jointly with socioeconomic and civic-political facets (2000; 2003).

Intercultural health –within this decolonizing and decolonized approach– is defined as a proposal to establish harmonious and humanely interactions between the biomedical and traditional health systems people use to deal with disease (Martínez & Larrea, 2010: 83). In regard to the concept of interculturality, Fenández (2008) points out that the term refers to the establishment of relationships among equals under a balanced use of power, where participants show proper disposition and mood towards active learning and mutual respect.

However, in the attempt to establish forms of occupational therapy from an intercultural perspective, it is necessary to explicitly recognize and analyze dialectical and imbalanced relations active on different levels such as: therapist and patient; the institution where the therapy is taking place and occupational therapy's professional culture; occupational therapy's Western hegemonic knowledge construction and other counter-hegemonic forms of knowledge; and, lastly, between *etic* and *emic* approaches (Dietz, 2011). Abuse of power in therapeutic interventions is at times disguised behind condescending attitudes towards disabled people, disregarding their occupational needs and wishes while enforcing occupational therapy's professional criteria (Galheigo, 2006: 89). In this vein, Allué's (2003) reflections on demands for equality notwithstanding differences among *DisAbled* people are very valuable. *This author* places special emphasis on exposing temporarily able people's attitudes, including socio-medical staff members under close scrutiny, in regard to *DisAbled* people, focusing on social interactions between them.

Also, to understand the relationship between occupation, health and well-being, we must address these concepts through a many-sided approach, bearing cultural factors in mind (Menéndez, 2000), as well as the diverse interpretations regarding the cause and nature of "malady" (Seppilli, 2000). What is more, cultural factors are not only present in group representations and practices regarding the health/illness/care process, but also in diagnosis and treatment carried out by health professionals and their respective professional cultures. In fact, the intervention's therapeutic action usually focuses on instruments, processes and manageable, efficient, swift and comprehensible situations, in terms of relation and efficacy for individuals and groups involved in the process; disregarding the latter's tendency towards exclusion and submission of socio-cultural, economic and social aspects (Menéndez, 2000: 183).

The establishment of a decolonizing and decolonized occupational therapy is thus coherent with an equitable and socially participative approach (Chapparo & Ranka, 2005) which transcends the biomedical model while considering structural aspects of health.

We believe that occupational therapy's basic theoretical principles related to occupation's nature and its relationship with health and well-being are culturally specific, questionable and scarcely bearing empirical basis, due to a lack of investigations on this central issue (Hammell, 2009a). It should be noted that most of occupational therapy's source documents have been the product of a minority's concerns –members of a culture which represents 17% of the world's population–, located mainly in urban areas within Western English-speaking countries, in na-

tions dominated by Christian morals, liberal ideology, biomedical tradition, individualism and capitalist economy.

Most of this discipline's source documents, influenced by a very specific view on occupation, perpetuate theoretical imperialism and reinforce hindrances towards knowledge accessibility. To attain this, control over knowledge development is urged validating only aspects which comply with hegemonic values while discarding practical and theoretical approaches that do not belong to occupational therapy's dominant culture. In short, this is a profoundly ethnocentric discipline which requires the assimilation of intercultural anthropological values as well as elements in medical anthropology, in order to perform efficient therapeutic interventions in a variety of contexts. According to Giménez (2003), and in line with the interculturalist perspective, this is a very interesting method with great potential for the design and establishment of community construction projects, as well as initiatives for the promotion of social cohesion and democratic coexistence.

We believe that intercultural occupational therapy goes far beyond fostering and favouring individuals' –with different cultural backgrounds– participation in meaningful occupations. Thus, our approach transcends a development of aspects related to the therapist's cultural competence and sensitivity (Bonder, Martin, & Miracle, 2004; Odawara, 2005; Muñoz, 2007). This entails an analysis and treatment of power relations and structural health determinants, as well as a multidimensional examination of identity and diversity which connects and integrates elements such as equality, difference and diversity[17].

Consequently, the development of occupational therapy from an intercultural perspective requires new forms of building knowledge on occupation. A more diversified and multidimensional discipline which takes local knowledge into account, as well as subaltern "ethno-sciences" and alternative forms of understanding (Dietz, 2011). This diverse understanding, comprehensively assembled, will foster new ways of building knowledge considering different views in an intertwined form and taking into account local and global views on occupation. In order to attain this,

17. According to Dietz (2011: 20-21), approaches centring on inequality discuss vertical analysis of socioeconomic and generic stratification, creating compensatory and assimilative responses (in correspondence with the syntactic dimension). Approaches focused on difference put forward a horizontal analysis of ethnic, cultural, gender, age and generation differences, as well as diversity regarding sexual orientation and/or disabilities suggesting these minorities' empowerment (in line with the semantic dimension). Finally, this diversity approach is based on the plural, multi-located character that every individual and community deals with through intercultural analysis (in line with the pragmatic dimension).

it is fundamental to favour and foster "dialogue among knowledges", as Sousa Santos suggests (2007), necessary to perform transformative interventions involving inter-cultural, inter-linguistic and inter-actor dimensions. Thus, this convergence of diverse forms of knowledge will favour a questioning of occupational therapy's theoretical and practical stance, highlighting the discipline's ethnocentrism.

The intercultural approach we suggest is not exclusively conceived to work with ethnic minorities or migrant population, as has been commonly the case in occupational therapy's literature. This approach holds that "we all have culture", thus interculturality is analyzed from a more critical and plural perspective (Meñaca, 2006: 107). In this regard, and according to Ibáñez (2001: 62), it is necessary to question oneself about occupational therapy's beliefs. Not in terms of their amount of truth, but in relation to their practical consequences and therapeutic efficiency, which would also contribute, as Flores argues (2011: 5), to a critical approach of health-related interculturality. Interculturality, therefore, encourages constant questioning through critical analysis and self-analysis of the context in which the intervention is being performed.

Accordingly, we critically analyze occupational therapy's professional culture[18]. Through doubly reflexive ethnography's three-dimensional analysis the analytical horizon is favoured and widened, emphasizing elements within narratives, practices and institutions where occupational therapy is taking place. It is therefore necessary and urgent to ask oneself about occupational therapy's current beliefs, not only in terms of truth but of practical consequences (Dias Barros, Garcez Ghirardi, & Esquerdo Lopes, 2006; Iwama, 2008).

In this sense, intercultural occupational therapy is approached as a technical necessity advocating result improvement, access and the right to health of people who are socio-culturally diverse (Flores, 2011: 1). This author considers that to question the efficiency of occupational therapy's interventions prioritizes the need to assess the discipline's concepts, protocols and evaluation scales. Likewise, occupational therapy's intercultural approach urges the construction of frameworks in favour of pragmatic relativism. Nevertheless, both in the relativist and absolutist plan, force and violence are present. From a methodological point of view, relativism encourages a sense of responsibility as well as ethic and political commitment because it is obliged to constantly feed the activ-

18. Occupational therapy's professional culture alludes to knowledge, beliefs, concepts, perspectives, ideas, norms, assumptions and values acquired by therapists in the training process and influences their own view on occupation and forms of intervention through it (Hammell, 2009a: 8).

ity which enlivens its values. Besides, the absolutist perspective defends a form of inertia, considering truth and values to be out there anyway, which will be present no matter what anyone does or doesn't do (Ibáñez, 2001: 61).

Hence, a decolonizing and decolonized occupational therapy, from an intercultural perspective, requires a relativist approach assessing why and to what degree subjects of interest are considered relative. These thoughts are necessary to promote the evolution of basic concepts and professional praxis, while acknowledging power dynamics in the ethical and political realm –not exclusively in the field of epistemology.

Following these principles, we suggest the concept of *ethno-occupation* as alternative to the ethnocentric idea of occupation. We are referring to *ethno-occupation* based on a relativist interpretation of occupation which is, therefore, committed to ethical and political responsibility, and encourages constant questioning considering actual experience. We propose *ethno-occupation* as a view of occupation traversed by economic, social and political aspects, whose goal is to transform social reality. This transformation entails constant conceptual analysis, demanding professional praxis to consider particulars regarding the analyzed context, as well as the organizational structure in which the intervention is taking place. According to these principles, and taking diverse experiences into account, *ethno-occupation* is raised as a perspective which approaches and tries to conceive occupational therapy as a whole, understanding each person's own occupational experience as immersed in cultural particulars proper to the context in which each person acts and grows. Thus, *ethno-occupation* suggests that each person's occupational experience is different depending on context and even considers diversities within a given setting due to cultural, economic, social and political reasons. This approach emphasizes occupational experience considering particulars while rejecting a universal intervention approach to be applied in contexts as diverse as Tegucigalpa, Houndé, Iringa, Nador, Quito and Murcia; cultural, economic, social and political aspects are decisive and are present in each individual's occupational experience no matter where the person is.

However, in spite of these changes adopted in accordance with intercultural values, there are still many professionals, also in the biomedical sector, who are reluctant to adopt these views which would destabilize already attained areas of expertise.

Finally, considering this article's entire explanation, we consider the adoption of an intercultural approach in the realm of theoretical and practical occupational therapy as a challenge. Hence the multiple contra-

dictions and reservations to be faced, as well as the opportunity to promote our discipline's development without disregarding elements such as inequality, difference and diversity affecting people who may be using occupational therapy. This entails the consolidation of a more flexible and comfortable attitude regarding the questioning of occupational therapy's theoretical development, fostering a fluent and critical identity, meaningful in each and every context in which it is applied. Nevertheless, these are some of the questions we would like to raise: are occupational therapists willing to adopt an intercultural perspective theoretically as well as in their everyday praxis, knowing its implications? How is language to be used? How can we promote critical analysis of theoretical fundamentals among students and professionals? Which forms of synergy are attainable between medical anthropology and intercultural anthropology for the development of occupational therapy?

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