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Abstract

Nurses teach, work, and conduct research in an increasingly hostile sociopolitical climate where health inequities persist among marginalized communities. Current approaches to cultural competency do not adequately equip nurses to address these complex factors and risk perpetuating stereotypes and discrimination. A theory-driven emancipatory approach to cultural competency will instead lead to lasting change and uphold the core nursing value of commitment to social justice. This article explicates key tenets of critical race, postcolonial feminist, and intersectionality theories and then applies them, using an emancipatory approach to cultural competency that can reshape nursing education, research, and practice.

Keywords

critical race theory; cultural competency; emancipatory nursing; intersectionality theory; postcolonial feminist theory; social justice

CURRENT approaches to cultural competency do not adequately equip nurses to address the complex factors that shape inequality and marginalization within society.[1] Nurses work with diverse and marginalized communities every day and are often at the front lines of health care and prevention efforts; yet, pragmatic approaches to address the growing health needs of these populations within the current political climate remain dismal. Nursing needs a more comprehensive approach for ensuring culturally competent practices. An emancipatory approach with a goal to create social and political changes offers a unique perspective to the existing discourse of cultural competence. In this article, we offer an emancipatory critique of the *Guidelines for Implementing Culturally Competent Care*, published by the American Academy of Nursing and the Transcultural Nursing Society.[2] We utilize postcolonial feminist theory, intersectionality theory, and critical race theory to inform an emancipatory perspective to cultural competency that shifts current discourse to one that critiques structures and processes of power instead of accepting them as status quo.

Statements of Significance

What is known or assumed to be true about this topic:

- We know that the nursing profession defines cultural competence as the necessary attitudes, knowledge, and skills to care for and reduce health disparities among diverse populations. We also know that social justice and quality of care are values that guide nursing practice.
- We know that marginalized populations such as racial/ethnic and sexual/gender minority populations continue to experience discrimination, implicit bias, and structural barriers that perpetuate health disparities.

What this article adds:

- This article offers an emancipatory approach to cultural competency, guided by concepts from postcolonial feminism, intersectionality, and critical race theories.
- This article applies a theory-guided emancipatory approach to several of the profession's *Guidelines for Implementing Culturally Competent Care*, published by the American Academy of Nursing and the Transcultural Nursing Society. An emancipatory approach to cultural competency is when nurses acknowledge diversity without assuming essentialized

nature of culture; develop skills to analyze processes of power; and introduce concepts of structural racism and interventions to combat implicit bias into nursing education, research, and practice.

CURRENT CLIMATE AND BACKGROUND

In recent years, discriminatory and prejudicial opinions within the United States have become more overt, from top political figures using inflammatory language in speeches to public protests and violence against groups of people based on race, identity, religion, and more. These outward expressions of long-held ideologies are quickly circulated on a massive scale through social and traditional media with implications for the health and wellness of those who are targeted. A rise in incivility and the ways in which this may impact health and well-being is a critical issue for nurses today.[3]

In the United States, implicit bias within the health care system leads to disparities in health. A systematic review conducted in 2015 found persistent levels of unconscious racial bias among health care providers similar to that of the general population, where health care providers consistently demonstrated a more positive attitude toward white Americans and more negative attitudes toward people of color.[4] Such covert attitudes continue to impact health care decision making and assessment. In one noteworthy example, a study conducted by Goyal et al[5] in 2015 on appendicitis pain among children presenting to the emergency department showed that regardless of race or ethnicity, children reported similar levels of pain overall, yet black children were less likely to receive any pain medication for moderate pain and less likely to receive opiates for severe pain.

More overt discrimination also occurs when health care providers are unaware of the specific needs of a population that is often overlooked or misunderstood, such as the transgender community. More than one-third of transgender people reported discrimination in health care settings, including experiences of harassment or refusal of care.[6] In a 2015 study conducted in the San Francisco Bay area, more than 80% of nurses reported receiving no education in relation to transgender populations.[7] Nurses also reported a high level of discomfort, misinformation, and lack of understanding about the diversity among transgender people and their health care needs.[8] Uncertainty about the health care needs of transgender patients can then manifest as interpersonal stigma and overt discrimination in the health care encounter.[9]

Outside of troubling discriminatory encounters with health care providers, additional literature shows the overwhelming negative health effects of discrimination and victimization at work, home, or school. For example, experiences of racial discrimination have been associated with elevated blood pressure[10] and low birth weight among African Americans.[11] Experiences of cumulative victimization and bullying among lesbian, gay, bisexual, and transgender youth have been associated with depression and posttraumatic stress disorder.[12] Transgender women of color in the United States experience disproportionately high rates of interpersonal violence[13] and murder,[14] and transgender youth who have been rejected by their families of origin are at greater risk for HIV infection.[15]

The American Association of Colleges of Nursing defines cultural competence as the necessary attitudes, knowledge, and skills to care for diverse populations,[16] precisely those populations discussed earlier who face ongoing discrimination. Many nurses do provide excellent and culturally competent care, with a caring/social justice ethics that underpins our practice both at the community level and as advocates for health equity.[16] Yet, the persistent poor health outcomes, particularly for populations discussed earlier, coupled with the current political climate, compel us to continue to engage in self-reflection and analysis of how to better our approach. Cultural competence is considered essential for patient-centered care that respects differences and eliminates health disparities among various marginalized groups.[16] Therefore, cultural competence is the ideal arena for

addressing the ongoing processes of discrimination, bias, and incivility that continue to deeply impact society and health care outcomes.

CRITIQUES OF NURSING'S CURRENT CULTURAL COMPETENCY APPROACH

The American Association of Colleges of Nursing recommends integration of comprehensive cultural competence content into the curricula of baccalaureate-level nursing education in the United States.[17] Culturally competent nurses can provide evidence-based care to diverse populations, advocate for social justice, and seek to eliminate health disparities. In addition to these official recommendations, the *Guidelines for Implementing Culturally Competent Care* were subsequently developed by a collaborative task force from the American Academy of Nursing and the Transcultural Nursing Society, with endorsement from the International Council of Nurses.[2] The *Guidelines* provide a 10-step approach on how nurses can implement culturally competent care in education, research, policy, and clinical practice. Both documents emphasize that nursing's approach to cultural competency should be grounded in ideals of social justice, the moral obligation to protect the dignity of all people, and a goal of increasing access to quality health care for the most vulnerable.[2,17] Overall, these documents suggest, if this approach is followed, nurses will be able to deliver care that is safe and high quality, thus reducing health disparities and achieving social justice.

Although most agree with the ideals of social justice and reducing health care disparities as expressed in these guidelines, critics have questioned whether nursing's current approach to cultural competency is truly effective. These critiques suggest that our current focus is flawed and misguided,[18] undertheorized,[1] and lacking in structural competence.[19] Structural competence is the idea that disease, behavior, and prejudicial attitudes are often downstream consequences of a number of upstream influences such as ideologies, policies, and sociostructural processes that create the status quo.[20] Drevdahl[19] presented an in-depth theoretical explanation of structural competence, suggesting ways that nursing shift toward a deeper understanding of theories that guide specific structural interventions to more comprehensively address health disparities.

In addition to this important work of developing structural competency in nursing, we propose that an emancipatory approach is warranted. An emancipatory approach to cultural competency fosters the development of nursing education, science, and clinical practice that typifies a deep understanding of the dynamics of power and dominant ideologies that shape internal, interpersonal, and societal relations. The current frameworks commonly used in nursing science do not adequately equip nurses to respond and work toward social justice because they do not necessarily or deliberatively take into account how power operates, implicitly and explicitly, to shape marginalization. As Meleis and Im state, “Cultural knowledge is important, but knowledge about how populations are marginalized is vital.”[21(p97)] In order for nurses to enact the principle of social justice, nurses need to actively examine marginalization at the micro and macro levels and to determine how to effectively disrupt it.

AN EMANCIPATORY APPROACH TO CULTURAL COMPETENCE

In this article, we utilize the definition of “emancipatory approach” as one that enhances understanding about how power works to limit opportunities, create marginalization, and perpetuate inequities.[22] Without the explicit naming of the processes of power that shape collective experiences, the current approach to cultural competency runs the risk of perpetuating stereotypes and maintaining status quo of implicit bias, prejudice, and discrimination.[1] An emancipatory approach is one that facilitates praxis,[23] by first, encouraging educators, researchers, and clinicians to develop awareness that an injustice exists and thereafter, through the process of reflexivity, they deeply examine the processes of power that create injustice and engage in action that would lead to transformation in support of a social justice agenda.

Critical theories, such as postcolonial theory, intersectionality theory, and critical race theory, seek to challenge social inequities by moving beyond what is on the surface to analyze the roots of injustice.[22] Emancipation from oppression and social transformation occurs when one critiques dominant ideologies and the hegemonic values and practices informing such ideologies.[24] Specifically, the historical processes and structures of oppression and marginalization are examined to seek liberation from injustice and create social change. Therefore, an emancipatory approach to cultural competency in nursing will be well informed from an understanding and operationalization of critical theory.

Theory can provide language and concepts to help facilitate an understanding about how power limits opportunities and creates marginalization.[21] Postcolonial feminist, intersectionality, and critical race theories are increasingly applied across nursing and public health disciplines to address health inequities among marginalized populations. In applying the tenets of these critical theories, nursing practices can shift to an emancipatory approach that allows for the transfer of power to those on the margins as well as empower the profession to contribute to lasting change.

THEORETICAL OVERVIEW

The following 3 theories all follow critical theoretical thought. Rooted in the ideas of emancipation, each critiques the processes of oppression from slightly different perspectives, offering a comprehensive set of approaches that can inform how nurses can understand cultural competency. A brief overview of the historical foundation and main ideas for each theory is explained here, with a summary of the main tenets illustrated in the Figure.

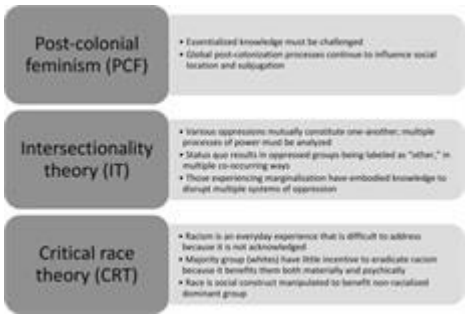

Figure.: Overview of main theoretical tenets.

Postcolonial feminist theory

Postcolonial feminism is a merging of postcolonial and feminist theories to acknowledge the political, economic, and social environments that oppress women.[25] Postcolonial feminism arose as a critique of feminisms that often depicted women in low-income nations as victims of patriarchal societies and culture, who are in a state of development, lacking knowledge or capacity.[26] In addition, postcolonial feminisms “unmask” the historical and global colonization and postcolonial processes and policies that continue to influence the social locations, livelihoods, and the oppressive realities of women today.[25]

Postcolonial feminist theory has 2 main tenets. The first is to challenge essentialized knowledge generated from a singular standpoint, emphasizing how a singular, mainstream standpoint (read Western; Eurocentric) promotes structurally dominant agendas at the expense of those on the margins.[25,27,28] Postcolonial feminisms thus seek to interrupt any discourse that is ahistorical, essentializing, and culturalist.[25] Second, postcolonial feminist theory emphasizes how, because of colonization, culture is created through non-neutral processes between the colonizer and colonized, which includes both domination and acts of resistance.[25] Culture is therefore a dynamic and negotiated process, influenced by power dynamics and historical processes of colonization.[25]

Intersectionality theory

Intersectionality theory is historically grounded in the strategies and insights of various women of color resistance movements from the 19th and 20th centuries, including abolitionist Sojourner Truth and the black feminist lesbian organization Combahee River Collective.[29] By the late 20th century, Crenshaw[30] coined the term "intersectionality" and further developed intellectual thinking on the complexity of oppression, emphasizing a shift toward thinking critically about how oppression exists both between and within categories of race, gender, and class. Around the same time, Collins[31] wrote about the interlocking matrix of domination that results from systems of racism, sexism, and classism. Intersectionality theory has been more recently developed for use within health inequity research, primarily in public health and nursing scholarship.[32–35]

The 3 main tenets of intersectionality theory include the following: First, an emphasis on how various oppressions mutually constitute one another to sustain a complex matrix of power.[33] Intersectionality theory is not about how an individual is "caught" at the intersection of multiple oppressed identities; rather, it emphasizes an analysis of the ways structures and dominant ideologies (such as colonialism, racism, heteropatriarchy, and capitalism) work together to create the matrix.[36] Intersectionality theory challenges traditional biomedical or behavioral paradigms and, instead, suggests analyzing processes of power and centering people's experiences navigating the intersections of oppression.[37] Second, intersectionality theory explains that the status quo of inequity is sustained because the complex matrix of power privileges those in the mainstream while "othering" those on the margins.[36,37] The status quo comprises a combination of norms about the dominant race, ethnicity, gender and gender identity/expression, sexual orientation, class, country of origin, age, ability, etc. Norms and standards, that is, status quo of society, result in oppressed groups being marginalized in multiple co-occurring ways. Third, intersectionality theory emphasizes that people experiencing co-occurring marginalization are navigating multiple experiences of oppression; therefore, looking at only one aspect of their social location may not reveal the simultaneous processes.[36] Those on the margins have embodied knowledge about how multiple systems work together to limit opportunities. Centering the experiences of marginalized communities highlights their specific experiences of disrupting, resisting, and dismantling oppression.[33]

Critical race theory

Critical race theory has its philosophical foundations in critical legal scholarship and radical feminism and was developed throughout the 1970s and 1980s as activists and legal scholars saw how the advances of the civil rights era were rapidly reversing.[38] Speaking to this concern, in his speech, "Racism Is Here to Stay, Now What?" lawyer and civil rights activist Derrick Bell asserted that there is an unavoidable truth in US society where there is a belief and determination for white dominance.[39] Critical race theory was later adapted from jurisprudence scholarship to public health through Ford and Arihenbuwa's Public Health Critical Race (PHCR) praxis.[40] PHCR praxis provides detailed steps for approaching health disparities research in a manner that allows for the uncovering and disrupting of the processes of systemic racism.

Critical race theory has several main tenets. First, is the concept of ordinariness: racism is an everyday experience for people of color in the United States that is not acknowledged and therefore difficult to address or eliminate.[38] The lack of acknowledgment of this reality manifests as colorblindness—the dominant idea that an individual (white) person "does not see race" and therefore "is not racist" because he or she does not display racism in his or her overt actions.[41] However, racism is not necessarily always made manifest as a personal, overt prejudice. Critical race theory therefore suggests that because racism is defined so narrowly, whites have little to no language to discuss racism as a systematic and widespread ideology. The second tenet is the concept of "interest convergence" that racism results in accumulation of material and psychological power for whites.[39] In other words, society's rules and attitudes have not changed because the majority group has little incentive or interest in working toward changing racism, because it benefits them both economically and psychologically.

The third tenet of critical race theory is that race is a social construct, with no basis in genetics, which leads to the categorization and stratification of groups of people as subject to those in power. The categories and definitions about race lack any one "truth" about what race is and are regularly shifted and manipulated to the benefit of the nonracialized dominant group.[38]

EMANCIPATORY APPROACH TO CULTURAL COMPETENCY

To demonstrate how nurses could take an emancipatory approach to cultural competency, informed by the theories of postcolonial feminism, intersectionality theory, and critical race theory, we offer suggestions about how one can apply the main tenets outlined earlier to the first 3 guidelines from the *Guidelines for Implementing Culturally Competent Nursing Care*.[2] Only 3 of the guidelines were reviewed here in order to maintain focus; it is beyond the scope of this article to analyze all of the guidelines. However, we encourage nurses across educational, clinical, and research settings to further explore how postcolonial feminism, intersectionality, and critical race theories can broaden our understanding of all of the guidelines to expand our emancipatory approach to cultural competency.

The first guideline, *Knowledge of Cultures*,[2] suggests that nurses need to understand the various values, traditions, and practices of diverse populations and cultures through education and study of various cultures. While well intentioned, this is an essentializing approach to culture. An essentializing approach is when one has an underlying assumption that culture is a stagnant collection of traditions or practices that apply to all people within a specific cultural group. Assuming inherent aspects about someone, based on his or her group affiliation, can lead to stereotyping and can thus perpetuate marginalization.[1,19] An emancipatory approach would instead acknowledge and respect diversity in values, traditions, and practices but not assume every person belonging to a specific group automatically has the exact same life experiences as the rest of the group with which he or she is being identified. Values, traditions, and practices may vary, and respecting diversity also means the consideration of a wide variety of experiences. For example, an emancipatory approach explores not only values, traditions, and practices but also how various groups may experience processes of neocolonization and globalization that shape opportunities and impact health. Nurses need to both be open to and accepting of a range of values and practices across and within people groups, as well as understanding how structures have created and reinforce inequalities.

The second guideline is *Education and Training in Culturally Competent Care*,[2] which emphasizes that nurses should be required to provide "culturally congruent care" and conduct a cultural health assessment. An emancipatory approach would also consider how an individual's social location may be marginalized because of race, ethnicity, religion, sexuality, gender identity, or country of origin. The intersectionality theory tenet of analyzing multiple processes of power would assess how an individual or community is socially located and influenced by dominant ideologies. Importantly, this assessment also requires nurses to learn about how to take a closer look at the power dynamics within hospital and other clinical settings. A lack of education about how to analyze power within our own practice settings also tends to impact nurses' ability to advocate for our patients.[42] For instance, when a young woman of transgender experience who is also refugee from Guatemala and experienced human trafficking presents for care, it is crucial to maintain not only an understanding of this individual's language and culture but also the ways in which she is experiencing oppression at the intersections of her multiple, marginalized identities. Nurses must make this assessment within an institution that is layered with power and dominance,[42] whereby when trying to advocate for this patient, the nurse's voice may be silenced.

The third guideline is *Critical Reflection*,[2] which emphasizes that nurses should engage in reflection about their own culture and beliefs to understand how their values may be in conflict with others and maintain a respectful approach. Kincheloe suggests that critical thinking, when informed by critical theory, is when people reflect on

the discursive practices and power relations present within society, in order to disengage from them.[43(p24)] An emancipatory approach to critical reflection informed by critical race theory, thus would address the idea of people belonging to the majority racial group who have no incentive to eradicate racism and no language with which to discuss it. A lack of acknowledgement about racism and the language to discuss it leads to gaps in our ability to engage with critical reflection. This is of crucial importance in the United States, where people of color are underrepresented in the US nursing workforce, with a gap that has been widening over time.[44] With the majority of US nurses being white, it is imperative to have conversations about structural racism and provide nurses with the language necessary to address implicit biases and internalized ideologies about white supremacy. Nursing scholars Hall and Fields[45] have called for such conversations in nursing to raise awareness and create spaces for open and honest dialogue about subtle racism that stems from structural inequalities and daily slights. An ongoing analysis of one's own power, privilege, beliefs, and social location is also necessary for emancipatory critical reflection. Through such reflection, nurses can become more conscious of their biases and power, as well as mindful of the impact of these on their nursing practice and ultimately, on the health outcomes of the recipients of their care. In addition, evidence-based interventions that help reduce implicit bias in nursing would address some of the most persistent root causes of US health disparities. Psychologist Patricia Devine and colleagues[46] have developed a prejudice habit-breaking intervention that has been proven to reduce unconscious racial bias over the long term (at least 12 weeks). Nurses can implement these types of interventions in practice in an effort to eliminate the bias that leads to poor health outcomes for individuals from various marginalized communities, including sexual and gender minorities.

Exemplars in nursing education, practice, and research

Power and privilege impact nurses in multiple ways at the micro and macro levels within academia, research, and clinical settings. There are no simple solutions to the complex, varied issues encountered in these multiple settings; however, this is precisely why these theories are applicable as they offer an approach to thinking about how power is operationalized at multiple levels in a complex manner at both the institutional and societal levels. One possible limitation of distilling broad theoretical ideas, as we have done here, is the potential for losing sight of the complexity and inherent value of each theory, thus making them difficult to apply. However, nurses are utilizing these theories effectively across multiple arenas to disrupt bias in health care. Exemplars of ways that nurses are already enacting an emancipatory approach to enacting cultural competence are highlighted as follows:

In nursing education, faculty have begun to utilize the tenets of critical race theory to address whiteness in nursing education by raising consciousness through an emancipatory education project, bringing awareness about how racism operates as a systemic process of inequality at every level, profiting white people at the expense of people of color.[47] A study informed by critical race theory also explored retention of African American nursing faculty through narrative inquiry, concluding that in the face of ongoing racial discrimination, more open discourse and intentional action could facilitate recruitment and retention of African American faculty.[48]

In clinical practice, we see collaborative intersectional community-based projects such as those involving public health nurses working in HIV and transgender health.[49] In one such initiative, nurses formed a partnership across various agencies and with community members to create an environment of care that was accessible and attentive to the multiple complex health care needs of transgender people at risk for homelessness, violence, HIV infection, substance use, and mental health issues.[49] Incorporating the lived experiences of individuals at the intersection of multiple marginalized identities enhanced the success of the project by increasing the depth of understanding within the nuanced realities experienced at the individual, community, and institutional levels.

Finally, nursing research has addressed globalization, intersectionality, privilege, microaggressions, and implicit bias to more comprehensively address the root causes of health disparities.[50] Although midrange theories often inform nursing research,[51] broader critical theories, such as postcolonial feminist theory, have also been used successfully, with insightful findings that can inform social justice praxis. For example, use of postcolonial feminist theory highlighted power dynamics and challenged notions about nonwhite women in low-, middle-, and high-income nations being in a state of development and lacking knowledge or capacity.[52,53] Findings from these studies offer suggestions for critical reflection on our own social location and our implicit biases as professional nurses.[25] Research endeavors with an emancipatory perspective address how structural forces shape the lives of people located in the marginalized communities we work with, stretching beyond the perspectives offered from midrange theories.

CONCLUSION

Societal ills such as racism and discrimination that contribute to marginalization and resultant health inequities must be named and examined before they can be contested and disrupted. The nursing profession has an opportunity to achieve a social justice agenda through an emancipatory approach when we intentionally address the historically dominant ideologies and sociostructural processes that have shaped health inequities for centuries and continue to exacerbate inequalities today. As outlined here, an emancipatory approach to our current cultural competency guidelines, as informed by postcolonial feminist, intersectionality, and critical race theories, provides tangible ways that nurses can use to transform education, clinical, and research practices. This emancipatory approach should not end with cultural competency, however. Emancipatory nursing is "nursing that embraces and nurtures social justice goals and outcomes, where practice becomes praxis."[23(p2)] Understanding and applying these theories can also inform an emancipatory approach by allowing for an examination of a wide variety of nursing organizations and professional standards. In so doing, the nursing profession, as already uniquely poised, can remain situated at the forefront of improving care for vulnerable populations and creating lasting change.

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