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Moving Beyond the "Exotic"
Applying Postcolonial Theory in Health Research

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Postcolonialism offers nursing scholarship a framework for understanding culture and identity as fluid and complex, historically situated, and discursively constructed. This article describes one version of implementing postcolonial theory, using examples from a research project conducted with urban American Indians on the topic of diabetes. I demonstrate the influence and value of postcolonialism throughout the research process. A postcolonial approach can help nursing researchers and practitioners avoid reproducing injustices and stereotypes, illuminate the complexities of life at the intersections, and contribute to the construction of a more socially just world. **Key words:** *culture*, *diabetes*, *methodology*, *postcolonialism*, *social justice*, *urban American Indian*

UNDERSTANDING our patients' cultures is often celebrated as a cornerstone of competent and ethical work with ethnically diverse populations. As healthcare professionals, we recognize the moral importance of understanding factors that intersect with health beliefs and practices of the patients we see. However, there are considerable theoretical and methodological challenges to researching cultures and their influence. Recent nursing scholarship has moved away from essentializing notions of culture and identity toward understanding these as more fluid and complex, historically situated, and discursively constructed. This approach is often identified as postcolonialism. Within healthcare, postcolonialism problematizes conventional assumptions around health and meaning and provides a set of strategies for researchers to explore the continuing effects of historical conditions of colonialism on present-day health. Postcolonialism, as an approach to methodology, engages a commitment to both scientific and social justice concerns. What this means for research practice, however, is not entirely clear.

This article builds upon and extends the existing literature on the methodological implementation of postcolonial theory. I will briefly provide an overview of the limitations of commonly applied concepts of culture and introduce the alternate of postcolonialism as a theory and an approach to research. Then, I will articulate one version of a methodological framework that specifically draws attention to social structures, issues of justice, and the presence of history. I will illustrate this framework, using examples from a research project I conducted with urban American Indians on the topic of diabetes, in which postcolonial theory was used explicitly in each phase of the research process. Finally, I will

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discuss the implications of using postcolonial theory for the further development of nursing research and practice.

BACKGROUND: PROBLEMATIZING THE CONCEPT OF "CULTURE" AND INTRODUCING POSTCOLONIALISM

A client-centered approach that focuses on the cultural milieu of patients is considered necessary for providing comprehensive nursing care.[1,2] The proliferation of terms (eg, cultural diversity, cultural sensitivity, cultural competency, and cultural proficiency) reflects nurses' growing interest in improving their cultural understandings of various ethnic groups. Although it is beneficial to understand the interplay between culture and health, there is a debate within nursing about the nature of culture and how exactly to research and describe it. This debate brings to the surface epistemological tensions between cultural constructions as essentialist representations and a historically contextualized multiplicity of negotiated performances.[3]

For instance, culture is sometimes conceptualized as a "blueprint" for human behavior.[4] Viewed in this manner, culture becomes something that is preexisting, discovered among a group of people, and can be written about in an allegedly neutral way. These writings often rely on nationalist vocabularies (eg, East Indian, Chinese), which refer to "nations" that have been created through Western imperialism[5] and that reflect divisive processes of racialization and binaries of colonialist projects.[6,7]

Descriptions of culture are always partial, provisional in nature, and based on the location from which they are viewed.[5] In most healthcare literature, white-dominant culture is positioned as the unspoken and centered norm.[8] Representations of "cultural competence" seldom include a discussion on whiteness. According to Allen, "...when the standpoint from which [culture] is created is inadequately articulated, the result is likely to participate in various forms of colonialist appropriations."[5(p230)]

Cultural representations tend to be presented as static generalizations. Although these are often intended to be beneficial (eg, when used strategically by groups for political unity), they are also dangerous when perpetuated as fundamental characteristics that serve to romanticize or pathologize certain groups (eg, the stereotypes of American Indians as "noble warriors" or "alcoholics"). It is difficult to maneuver outside of these stereotypes. They limit the narratives that are available to people and construct group members' subjectivities on the basis of colonialist assumptions.[9,10] These fixed, hegemonic representations serve the dual purpose of marking off some individuals while centering whites. Even in some of the health research that is intended to reduce or dissolve "differences" cross-culturally, researchers tend to present simple commonalities, implicating "culture" as the primary explanation for group behavior. In this manner, culture also becomes associated with constructions of "race," where "race" (one's physical appearance) becomes a marker for certain behaviors.[11]

For example, in literature examining indigenous illness meanings of diabetes, American Indians are often presented as having different interpretations of diabetes (ie, different from the biomedical interpretations that arise from white culture). These counternarratives become linked with cultural identity or "race," instead of history, politics, economics, or social positioning.[8] The emphasis on the gap between indigenous models and the (often implicit) "standard" of the biomedical model leads to American Indians being exoticized in a fashion similar to Said's Orientalism.[12] Often, this research is taken to mean that there are unusual, intrinsic properties associated with being "American Indian," while the norms against which these differences are judged are never made explicit.

Depicting culture as an unchanging (and uncontested) reality that primarily accounts for group behavior leaves little space for

individual variations, fluid identities, or hybrid formations. It also erases history and its continuing relevance in the presence of everyday circumstances. Historical conditions of colonialism extend beyond the forced invasion and settlement of land to include the subjugation and exploitation of people. Through discursive practices that have legitimized past injustices and ongoing legacies of oppression, social power imbalances and infrastructures have been constructed that persist today. Although made to appear inevitable and natural, these social structures are the result of historical interactions.[13] Societal structures determine control of economic means of production, access to education, distribution of capital and income, and differences in health status and care.[14]

The role that history and structural inequalities play in producing health disparities is often ignored. As McGrath notes, culture "deflects attention from social factors influencing opportunity and privilege, such as race, class, and gender, or from important institutional forces, such as political and economic structures."[15(p19)] Essentially, "culture" becomes a shorthand, a euphemism that eradicates history and the continuing mechanisms of colonial injustice.

Theorizing the concept of culture in ways that take into account history, politics, and economics makes visible the ethical dimensions of cultural representations, the relationship between science and history, and the politics between the researcher and the researched. These issues become increasingly critical when we study members of a group who have been exploited. Postcolonialism offers strategies to contextualize health disparities beyond the notion of culture.

Postcolonialism is a term that signifies a diverse range of historically situated theoretical orientations, representations, values, and activities. Informed by other critical perspectives (eg, postmodernism, poststructuralism, feminism, linguistics, and Marxism), there is no singular definition of postcolonialism.[16] Postcolonialism may be articulated in various ways to reexamine, challenge, and resist ideologies and structures of power stemming from Western hegemony. Shared in common among postcolonial approaches are a commitment to explicating history (as a set of ongoing practices) and the effects of that history. This includes an analysis of everyday encounters to determine how continuing matrices of race, class, and gender intersect to oppress certain groups of people.

Scholars working with postcolonial theory reframe knowledge within an analysis of systems of exclusion and the politics of science.[17,18] This analysis includes languages and acts of opposition to how indigenous people have been represented and marginalized as a result of Western imagery.[19] This resistance becomes a movement against colonialist essentialisms and a space for indigenous reconstruction and agency.[20,21]

Within the nursing literature, postcolonialism is articulated in various ways and often in conjunction with other theoretical frameworks. Kirkham and Anderson explore the theoretical and epistemological foundations of postcolonialism and summarize a research methodology on the basis of this tradition.[8] Other articles trace theoretical and methodological issues around cultural safety, a concept developed by Maori nurse leaders and rooted in postcolonialism, which is used to examine the dynamics of healthcare practices.[11,22] In addition, several articles pair postcolonialism with feminism to examine the explanatory power of this combination as a theory and methodology for nursing scholarship[23–26] and policy research[27] or to re-vision data and examine the exclusionary effects of healthcare systems.[25,26] Although most of these scholars relate postcolonial theory to their specific research projects, only a few outline the *application* of this framework. Operationalizing theory—translating how postcolonialism influences each stage of the research process—largely remains a "black box."

In the remainder of this article, I will describe how I applied postcolonial theory in a research project, examining the broader structural contexts that intersect with

diabetes and its management. Every step of the research design was considered a moment of ethical choice. As an interpretive framework, postcolonialism shaped participant inclusion criteria, recruitment strategies, the generation of questions, the analysis of data, the construction of results, and the dissemination of research findings.

THE RESEARCH PROCESS

The goal of this exploratory, critical ethnography[28] was to describe how historical, sociocultural, political, and economic factors shaped the way urban American Indian participants in Seattle, Wash, interpreted their lives and represented diabetes. Diabetes was used as a terrain to illustrate how participants located themselves in a history of struggle, as well as the contemporary environments in which they currently live. Methods from critical ethnography were used, because they were consistent with the goal of this project. They could also be allied with postcolonialism to explore ideologies and relationships of power.

Research preparation

As a result of exploitations by researchers and a turbulent history with whites, American Indians often associate research with damaging colonialist practices.[21] Jacobson[29] and Weaver[30] recommend methods of building trust to address challenges of conducting research in American Indian communities. These recommendations include investing time in, collaborating with, and giving back to communities. Postcolonialism is an effort committed to understanding research injustices and working to ameliorate them. To respect the issues at stake for American Indians and to acknowledge my role as a participant in this historicized domain of research, there were several ways in which I tried to avoid replicating the abuses of past researchers.

Prior to project initiation, I had already worked with American Indians for more than 10 years. I worked as a volunteer nurse on the Navajo Indian reservation in 1994 and 1996, and traveled back and forth many times in the intervening years, establishing friendships and research partnerships. In addition, my work and personal interests over the 5 years preceding study initiation brought me in acquaintance with many urban American Indians in the Seattle area. I established a variety of affiliations through participation in community events sponsored by American Indian groups at the University of Washington and local American Indian organizations. I also volunteered as a healthcare provider at the Seattle Indian Health Board (an urban Indian health clinic). Through these activities, I became familiar with key community members who were heavily involved and recognized within the urban Indian community. I met with several of these individuals to consult with them about the project topic and design.

Furthermore, I read extensi vely in the historical literature written by American Indians. These readings, such as those by Deloria,[31] Mihesuah,[32] and Ross,[33] provided alternative versions of history, which contested those framed through colonial fields of representation, justifying civilizing missions on "barbaric" groups of people. I came to the field well informed of the destructive practices that many tribes had to endure in the name of "Manifest Destiny," including military slaughters, forced migrations, religious persecution, boarding schools, and the displacement of thousands of American Indian children into non-Native homes. I also learned about the forced urbanization of American Indians sanctioned by federal policies developed to assimilate them into white society, eliminate and "unrecognize" reservations, and abrogate governmental funding and social service support.

Relationships with reservation-based American Indians in the Southwest, urban American Indians in the Northwest, and a comprehensive review of historical literature provided me with valuable insights into potential issues for contemporary American Indians. This information was useful and important for producing the idea for the study,

constructing its design, and interpreting its results. Furthermore, demonstrating a commitment to American Indian communities and an understanding of their history established my credibility with project participants.

Research foundations

I conceptualized this project with 4 central assumptions, all informed by postcolonial theory. The first was that I did not consider American Indians as a biological race, but as a diverse group of people who share similar sociopolitical histories of genocide, apartheid, and ongoing racism and colonialism. There is considerable heterogeneity among the estimated 662 tribes in the United States with respect to size, location, cultural practices, history, and language.[34] However, members of these tribes frequently participate in representative practices as "American Indians" to signify opposition to Western society.

Second, although I used the term "Indian," I understand that "Indian" is not a neutral term that is applied to indigenous peoples of the United States. On the contrary, it is a term used by the US government, replete with Western-derived stereotypical connotations (eg, savage-like, uncivilized). Although I recognize that the term "Indian" itself is a contested signifier, there was not a neutral way for me to collectively represent people who identified themselves as "American Indian" that did not reproduce this point.

Third, I recognized "diabetes" as a social construction. It signifies a specific set of biological signs, symptoms, and courses of treatment, as dictated by the Western medical belief system and culture of healthcare. Members of the biomedical community implicitly accept this account of diabetes as a normalized "truth." Distinguishing diabetes as a social construction makes the culture of biomedicine no more relevant than the culture of American Indians. Although I recognized "diabetes" as a term to mark off certain differences, it served as a terrain to generate conversations with participants regarding colonialism and how American Indians understand their interactions with dominant society.

Lastly, the goal of this project was not for me to speak imperialistically from another's perspective, but to conduct a form of inquiry that recognized the mutually fortifying relationship between biomedicine and imperialism, and problematized the epistemic authority of Western scientists. Questions about who can speak for whom involve politics of power.[18] There was an apparent contradiction in my attempt—as someone partially located within dominant society through my level of education and class status—to write about my work with American Indians in a manner that did not exploit their narratives or replicate unequal power relations.[17] My intent in this project was to center American Indian narratives as valuable sites of knowledge.

Participant inclusion criteria and recruitment

Identification of who is or is not "really Indian" is a disputed issue, and so my inclusion criteria were chosen deliberately. I based participant inclusion criteria on self-identification as American Indian rather than tribal enrollment numbers or other methods to verify "authentic" status. My view was that tribal enrollment numbers and the need to authenticate one's identity as American Indian are distinct products of colonization and encounters with whites. Tribes have continued these measures in response to the current need to politically define themselves. Although these ongoing practices that signify being American Indian are meant to unify people and are often used by tribes to mark themselves off from dominant society, they can also be contested sites for individuals who self-identify as American Indian, but who are not recognized as being "Indian" enough by their tribes. These individuals are left in the double bind of being marginalized by both Native and white societies.

Although several key urban American Indian community members offered to be intermediaries in recruitment, I chose other methods to mitigate the effects of influence that these individuals potentially had within their communities. I relied instead on informal communications with urban American Indians I had met at local events and on the resulting snowball sampling, when participants recommended this project to other urban American Indians and distributed flyers with my contact information. I identified myself as Asian American on this flyer, recognizing the exploitive history of research conducted on Native people, the assumption that researchers are commonly white, and the level of distrust American Indians often have for whites.

These recruitment methods were highly effective. Participants indicated 3 primary reasons that they enrolled in this study. First, they were interested in the topic of diabetes and wanted to speak with someone interested in their perspective. Second, they felt that they could trust me, because their friends had already gone through the process and informed them of what to expect. Third, was my self-identification as Asian American on the recruitment flyers. Several participants indicated that they would not have met with me if I had been white.

I chose not to recruit from hospital or clinic settings in order to reduce coercive effects or potential concerns of patients that their healthcare services would be altered. I also wanted to meet with individuals who might not have been disciplined by the biomedical model of diabetes, even though I recognized that most participants might have used some form of the Western healthcare system.

My intent in project enrollment was to sample as broadly as possible. I sought individuals who were diverse, in terms of their demographics and other factors (eg, the number of years that the participant lived with diabetes or the length of time that the participant resided in an urban area). My goal was to allow for a wide range of narratives and theoretical variations to be shared. For this reason, I also interviewed 2 individuals who did not have diabetes to determine whether or not there were vast differences in how they represented diabetes or their lives as urban American Indians.

Data collection

In congruence with critical ethnographic techniques, interviewing and participant observation were used in this project. All 20 participants (11 women and 9 men) completed one open-ended, face-to-face interview. I initially planned to use a semistructured interview technique created in collaboration with urban American Indians. However, I soon realized that the guide focused predominantly on the Western concept of diabetes. It failed to address historical and present-day contexts specific to this population. In recognition of the colonizing histories of urban American Indians, I believed that it was imperative to explore the implications of these consequences in a manner that turned the process more toward them. Therefore, I conducted interviews that were loosely structured. I began with open-ended questions, such as "tell me about your diabetes" or "tell me a little bit about your background," and focused on specific lines of conversation as they were offered by each participant.

Although the term "diabetes" was used in recruitment, I clarified with participants at the beginning of the interview whether or not there was a word or phrase that he or she used to refer more commonly to his or her illness, in recognition that the Western term "diabetes" was a signifier with specific connotations. Although a few participants referenced "sugar sickness" as a phrase they had heard in their childhood, all other participants used the language of "diabetes." In one particular instance, when I asked a participant if there was another term that he used to describe his illness, he looked at me askance and asked for clarification. When I rephrased the question, probing for an alternative term, he stated in a matter-of-fact voice, "We call it diabetes." The irony of this exchange was that

while I assumed he might use a "traditional" phrase, he was perplexed because he knew only of the biomedical term.

Interviewing was a fluid process that evolved with each participant. How questions were asked was often as important as the questions themselves. Eliciting answers to interview questions is an issue of access that extends far beyond permission to conduct a study or the enrollment of participants. It entails styles of social interaction requiring cultural knowledge, appropriate conduct, and an approach of respect on the part of the investigator, as well as the establishment of trust through negotiations with the participant.[35] In this study, interviewing involved carefully listening to narratives and providing the space for participants to use their own distinctive ways of talking to emphasize significant issues in their lives.

Following each interview, I asked participants for their interpretations of the interview process. Several participants commented that they were very comfortable with our social interaction. When I reflect on this comment, I believe that this interactional competence with participants was likely due to my lengthy involvement with diverse American Indian populations. For example, a friend who once visited the Navajo Nation with me commented that I used different patterns of language and behavior when interacting with Navajos. Since these are not conscious changes, the nuances are difficult to describe. However, they may have affected how I spoke or listened to project participants. Part of qualitative research is intuitive, where what you cannot articulate often makes the difference.

Participant observation was the secondary method used in the project. Participant observation entails systematic attention to practices of everyday life[36] and involvement in the life world of the project participants. These participant observations were conducted in 3 different ways. The first was through prolonged engagement with members of the urban American Indian community at powwows, meetings, and other community events during the 5 years prior to project initiation. As a volunteer nurse practitioner at the Seattle Indian Health Board, I had the opportunity to work with urban American Indians who came to the clinic for healthcare. Working with these patients and other healthcare providers provided insights into the dynamics of healthcare encounters at a center designed specifically to provide care to the urban American Indian community and a deep background into how individuals seen at this clinic talked about and managed their diabetes.

Participant observation also took place during interviews with participants. I paid careful attention to the environment of the interview (ie, where the interview took place and the general surroundings), the interactions that occurred during the interview, and other significant details, such as nonverbal cues or intonations that participants used to communicate. This information was very helpful in contextualizing the interview and provided important interpretive clues that would have otherwise been lost through transcriptions alone.

Lastly, I spent a day with 3 of the interviewed participants, learning what each did on a daily basis. I rode the bus or walked with participants as we visited the places they frequented, including local shelters, food banks, public shower houses, parks, and craft stores. I socialized with their friends, learned about participants' childhoods, viewed pictures of family members, prepared meals, examined artwork, and learned how to bead. All of these interactions gave me a glimpse into each participant's life and situated the meaning and relevance of interview data.

Participant observation is a standard ethnographic technique, but it was especially useful for a postcolonial approach. It facilitated a greater understanding of the contexts of participants' everyday lives as American Indians having diabetes and residing among dominant society. Participant observation also provided numerous opportunities to examine the interactions of class and ethnicity and explore the performative construction of their multiple identities as they moved through multiple worlds.

Data analyses

Postcolonialism focuses on issues of power and provides the framework to address health problems relating to race, class, and gender, negotiated within larger sociohistorical and cultural contexts.[8,26] Field notes and interview transcripts were analyzed to explore the intersection of diabetes with the mediating historical, social, economic, and political forces that situate life for urban American Indians. The following statement from a participant explicates this intersection:

> According to everyone else, it's actually our fault. We have bad health, because we are Native American—that's what they say. And maybe it's our DNA, but maybe it's, you know, just basic bitterness toward society that is causing all of this disease. I don't know what it is. But there's a lot of stress for Native Americans. We don't have the same opportunities that they do. I mean, I know some Natives who have good jobs and all, but it'll never be the equivalent of what whites have—and that's how whites like it, so why should it change? And I believe, me personally, that all of that stress is causing our bodies to be sick. We feel bitter, we are treated poorly, and there is constant, day-to-day stress. It is difficult for us to exist in this society. We can't be who we are, and if we are, we are made to feel embarrassed.

This participant articulated how American Indians who have diabetes are positioned as "flawed" and marginalized in a variety of ways through ongoing colonialist practices. Using postcolonialism as a framework, I analyzed this as a statement reflecting a multiplicity of ideas, ambivalence, and resistance. This participant historicized diabetes, locating it as a collective problem versus an individual disease. He also took up the biomedical model, attributing diabetes to genetics, but then transitioned into ambivalence and resistance by providing psychological and historical explanations that revolved around identity politics.

Reflexivity

Crucial to a postcolonial and critical ethnographic methodology is the notion of reflexivity. Research is an interactive and political process whereby the researcher, as a participant, constructs accounts through selective observation and theoretical interpretations that pervade the entire process.[37] The location of the researcher, the interpretive lens through which he or she operates, and the power inequalities between the researcher and the participant need to be analyzed with respect to how knowledge production and data representation are constructed.[38–40]

A researcher's biography, history, and sociocultural position shape the questions that are researched, how data are gathered and analyzed, social relations while in the field, and interpretive representations made after leaving the field.[40,41] Understanding the importance of locating myself as a participant throughout the project led me to question assumptions about myself that I routinely make and to examine some of the multiple subjectivities that I employ. At once, I can be identified as a nurse scientist, middle-class, Asian American, educated, or a woman in my thirties—and any combination of these. How project participants socially interpreted these subjectivities greatly affected how narratives were coproduced.

At times, it seemed clear that participants viewed me as an outsider. As a nurse, I was someone who could answer their questions about diabetes or the medications they took. A few participants even brought their medications to the interview, expecting that, as a nurse, I would want to review them as if in a clinic setting.

At other times, I was also distinctly perceived as an insider by the color of my skin and racialized identity as an Asian American. Feminist researchers[42,43] have explored how women of color often adjust their speech when speaking with white women, in effort to convey their story and be understood. Participants' language with me often indicated instead that I was seen as someone who understood or had experienced similar types of interactions with white society. For example, in one interview, I spoke with a woman about how she used to attend a clinic in an affluent area outside of Seattle for her healthcare. When I asked her why she no longer visited that particular clinic, she replied, "Well, *you*

know, I just didn't like the doctors I saw there . . . you know what I mean." In the context of this conversation, I thought I did know what she meant. When I asked her to clarify, she responded with surprise, "Oh, come on, you know what I mean . . . they're all white over there, and you know how they treat us . . . like they're better than us. I mean, *you know*, right?" Her questioning of *me* was both disconcerting and enlightening, as my identity had also become a part of the interview, and not just hers. Traditional social science offers the myth of the neutral observer and the off-camera, unseen interviewer. This woman, and many of my other interview participants, reminded me instead that they could see me, even though the reader cannot, and that they supposed me to live, at least at times, in the same worlds that they did. This supposition was indeed warranted and continues to remind me of the importance of both the participant's and the researcher's identities in the research process.

Even though participants' behaviors at times identified me as an insider, I was conscious of the power inequalities between us and tried to reduce this differential in various small ways. These included emphasizing the voluntary nature of this project, making interviews more of a dialogue, and conducting debriefing sessions after each interview. In addition, I recognized the need to present interpretations in a manner that did not reify "cookbook" versions of culture and neocolonialist assumptions about American Indians.

Presentation of results

Participants' narratives represented contested sites to hegemonic constructions of American Indians and exemplified the need for social change. In an effort to avoid reproducing colonialist portrayals of American Indians, I had to be attentive to how I created representations that could illuminate complexities, as well as facilitate the movement toward social justice. I tried to avoid essentialisms and instead highlight intricacies, and presented large portions of participants' narratives to demonstrate how I constructed my findings.

In their narratives, for example, participants predominantly used 2 discursive accounts of diabetes. One drew upon the biomedical discourse, locating diabetes as a physiologic disease. Assuming personal culpability for their disease, diabetes was attributed to poor diet or insufficient exercise. However, participants also talked about diabetes within a social context, using it to illustrate both historical and present-day interactions with white society. In addition to discussions of the historical colonization of food supplies, participants gave numerous examples of being treated as "second-class citizens" in today's society and spoke of their lack of opportunity. These narratives suggest that, for these participants, diabetes is inseparable from the racialized history between American Indians and whites and the multiple forms of oppression that inform their daily lives.

Participants presented these 2 accounts of diabetes simultaneously. Instead of emphasizing one representation, I juxtaposed the 2 narratives to demonstrate how participants both take up biomedical models of diabetes, through diet and exercise admonitions, and resist them by representing it as the continuing "wear and tear" of hierarchical relationships. Furthermore, I problematized commonalities among diabetes narratives by presenting outlying accounts. In addition to locating diabetes physiologically and sociohistorically, a few participants positioned diabetes as the result of a loss of spirituality or personal misbehavior.

In other findings, participants also talked about having to *perform* in a plurality of ways as urban American Indians. Some described it as a matter of being both "American" and "American Indian"; other participants described it as having the ability to "walk both worlds." However, it was evident that these performances of identity were more than the ability to deploy 2 distinct representations of oneself at different times or in different situations. Although participants frequently discussed their identities in fixed, binary ways

that reflect colonialist language, their performances around identity demonstrated a mixture and fragmentation of these 2 constructions. Using narratives that underscored identity as a site of struggle was vital to demonstrating the multiple and hybrid positions of urban American Indians.

It is clear that what I provided was only 1 possible interpretation of how participants positioned themselves at that particular moment. Using postcolonialism, one of my goals in presenting project results was to complicate simplistic versions of culture and identity, represent numerous intricacies, and leave space for individual differences. Another was to express how historical and sociopolitical relations affect people's lives and health.

Dissemination of findings

According to Kirkham and Anderson, a "feature of a postcolonial research method is its open commitment to critiquing the status quo and building a more just society."[8(p13)] Social justice requires that we take seriously the broader influences on health and acknowledge that the elimination of health disparities will require more than calls for lifestyle changes or cultural competence, but instead radical restructuring of economic and political systems. Praxis-oriented nurse scholars draw on postcolonialism to explicate the multilayered contexts of social inequalities, raise critical consciousness, advocate for social changes that will lead to improved health, and alter current healthcare practices.[8]

Dissemination of research results to multiple audiences and political activism are 2 methods of working toward social transformation. One of the tensions illuminated by postcolonialism is the conventional model of research dispersion, in which results are disseminated solely to other researchers for the primary purpose of enriching professional scholarship. Since postcolonialism calls for a change in societal structures and attitudes, researchers using this approach need to disseminate their findings more broadly (eg, to project participants and people who work with urban American Indians), so that individuals with whom the research was conducted and the communities from which they come can benefit. In addition to traditional methods of research dissemination, including oral presentations at national conferences and future publications targeted toward other researchers and practitioners, I have provided findings from this project to a healthcare clinic in Seattle designed specifically to provide care for urban American Indians, as well as to 3 of my participants who were interested in taking these findings to their social organizations.

In addition, researchers who use postcolonialism and work with underrepresented individuals need to make a commitment to remain engaged with them. My commitment to urban American Indians does not stop with this research project. I plan to develop a long-term research agenda with urban American Indian communities and engage in political activism to challenge the unequal distribution of power and resources, reshape how health inequalities for American Indians are constructed, and develop policies that enhance social justice.

IMPLICATIONS OF USING POSTCOLONIAL THEORY FOR NURSING RESEARCH AND PRACTICE

In this article, I have provided one version of implementing a postcolonial framework. My intent was to demonstrate the influence and value of postcolonial theory at each stage of the research process. A postcolonial approach to methodology brings to the surface and addresses the ethical problems of cultural representations, the politics of research, and the hegemony of Western practices. Postcolonialism opens up space for us to see the process of gazing, versus only the "object" of the gaze.

In regards to the notion of "culture," the use of postcolonialism moves nursing research away from ahistorical and depoliticized models, and toward a more contexualized

understanding. Postcolonialism gives nurses ways to see questions of cultural identity as more complicated, contested, and fluid than previous models would suggest. It also reminds us that Western biomedicine is itself a cultural production, although this is difficult to see when the tools of cultural research are products of the same culture.

Postcolonialism links the debates about "culture" to those about health inequalities and moves us beyond individualistic models of health and illness. By emphasizing historical, sociocultural, political, and economic contexts as locations for health inequalities and identifying them as relevant as physiologic processes to the reproduction of those inequalities, nurses can use postcolonialism to reframe them as reflections of racial, class, and gendered discriminations. In this manner, postcolonialism has the potential to shift knowledge and attitudes and can help nurses more fully contribute to social justice, for example, in the realm of urban American Indian health.

Finally, nurses can use postcolonialism in research and clinical practice, not as a set of concrete standards, but as a means to uncover and contest the exclusionary effects of mainstream practices that affect the health and care of their patients. This includes examining how nurses themselves participate in reproducing hegemonic structures and working to redefine current relations of power and privilege. Understanding the role that historical forces and broader social structures play in health influences the types of questions nurses ask and encourages them to improve their quality of care by extending beyond individual encounters and toward social activism. Nurses can take action in the political and economic realms to work against ongoing failures of justice.[44]

CONCLUSION

Domination and resistance mark societal relationships for urban American Indians and for many other people in the world today. Unequal distributions of power and resources contribute to health meanings and inequalities. Within urban American Indian communities, there are active conversations of how to understand daily life and health in historical terms of colonialism. Postcolonialism—as an approach to methodology as well as a theoretical framework—can help nursing researchers and practitioners avoid the reproduction of injustices and stereotypes, illuminate the complexities of life at the intersections, and contribute to the construction of a more just (and interesting) world.

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