

Creating Cultural Empathy and Challenging Attitudes through Indigenous Narratives:

Facilitation guide for Narratives



SUPPORT FOR THE CREATING CULTURAL EMPATHY AND CHALLENGING ATTITUDES THROUGH INDIGENOUS NARRATIVES PROJECT HAS BEEN PROVIDED BY THE AUSTRALIAN GOVERNMENT OFFICE FOR TEACHING AND LEARNING

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Purpose of this guide

This facilitation guide has been developed with advice from the Team member and Indigenous Reference Group Members from the collaborating universities and Health Consumers' Council.

It is by no means a definitive "how to do" manual. We consider it to be a guide to explain how the narratives were collected and edited and to provide ideas for discussion points that could be used in a classroom.

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Creating Cultural Empathy and Challenging Attitudes through Indigenous Narratives Project

Project summary:

The project has two primary aims:

- to positively influence the health and wellbeing of Australian Indigenous people by improving the education of health professionals;
- to engage students with authentic stories of Indigenous people's experience of healthcare, both positive and negative, which enhance the development of deep and lasting empathy.

Project values:

- Integrity of goals, purpose and process through respectful engagement with Indigenous people, story provider empowerment and safety, and Indigenous governance of the research process.
- Collaborative development of insightful and high quality learning materials by innovative health educators using the multimedia Indigenous stories.

Project outcomes:

- Improved capacity of health graduates to work effectively with Indigenous people;
- Improved capacity of higher education teachers to design and implement courses and resources;
- Application of narrative pedagogies to positively influence values, beliefs and actions;
- Creation of a national library of multi-media narratives of Indigenous experiences.

For more information on the rationale for this project please see Literature Review below.

Story collection methodology

The Project Team and Indigenous Reference Group members determined the methodology for this project. It was imperative the methodology be culturally appropriate and respectful of Indigenous participants.

Ethics approval was obtained from the Edith Cowan Human Ethics Committee and the Western Australian Aboriginal Health Ethics Committee.

Story collectors:

Male and female, Indigenous and non-Indigenous story collectors were recruited from metropolitan and rural areas. Seven story collectors received training in the use of yarning as a data collection tool, a methodology developed by Associate Professor Dawn Bessarab (Bessarab & Ng'andu, 2010). The two-day training was provided by three members of the Indigenous Reference Group; Associate Professor Dawn Bessarab, Associate Professor Clive Walley and Ms Laura Elkin.

Story providers:

Story providers were recruited through the Indigenous Reference Group. Eighteen story providers were recruited, the majority of whom lived in rural and remote areas of the Murchison. All interviews from story providers were developed into stories.

Story collectors made contact with the story provider and arranged for a meeting at a location identified by the story provider. A two step consent processes was used. The first to obtain consent for recording the interview, on video or digitally recorded for transcription to text. The second to obtain informed consent for the final stories derived from their interviews.

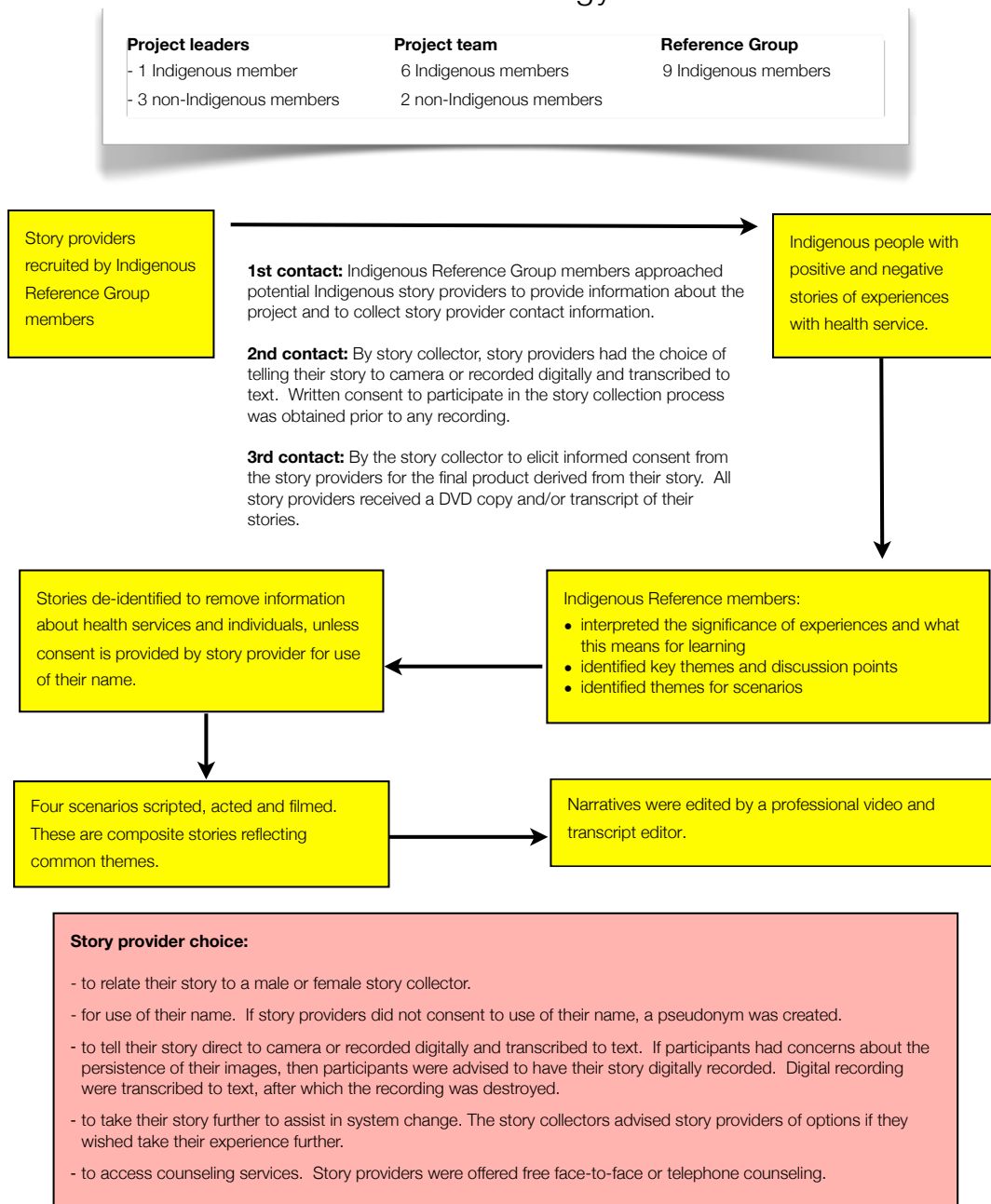
Story editing:

Transcripts of the interviews with story providers were provided to the Indigenous Reference Group who identified the themes from each of the interview transcripts, interpreted how the stories could be used in learning and determined three key themes to be developed into scenarios.

A professional video and transcript editor edited the final stories.

The diagram below illustrates the methodology used for this project.

Methodology



How to use the narratives

These narratives were collected to facilitate student discussion and highlight communication styles, stereotypes and cultural issues.

The evidence recommends that these kinds of resources be integrated throughout the health curricula for example, within as teaching resources in diverse topics such as cardiovascular disease, diabetes, infection, communication, palliative care and mental health, rather than within stand-alone “cultural diversity” units (Paul, Carr & Milroy, 2006; Dogna, Reitmanova, Carter-Pokras, 2009).

The aim is to use these narratives to encourage people to recognise their unconscious biases in a non-threatening environment (Burgess, van Ryn, Dovidio & Saha, 2007) that avoids collective guilt while stimulating dissonance, the psychological discomfort from incompatibility between behaviours and beliefs.

Not all narratives will be appropriate for all health disciplines.

We have included some general discussion points below that were identified by the Team members and Indigenous Reference Group. Not all of the discussion points will be relevant to each story.

Key discussion points

- What is important to this Indigenous person?
- What are their values and beliefs?
- How are these values and beliefs similar or different from your own?
- What examples of good or poor care were illustrated in this narrative?

- What are the facilitators or barriers to developing trust with Indigenous people?
How can you develop trust with Indigenous people in your care?
- How can you show respect to Indigenous people in your care?
- Indigenous people (as most people) understand disease and medical terms when they are explained using simple language and diagrams. How could you better explain health issues to patients?
- How can health professionals improve their communication with Indigenous Australians?
- If the story were related to members of this person's family and community, how might this influence their views about health services and their health seeking behavior?

- In a busy hospital or health service, is there anyone else you could spend time with an Indigenous patient?
- In an ideal situation how should the health care team have dealt with the situation described in this narrative?
- What changes could be made in a health service to better accommodate Indigenous people?

- All health professionals and services have a responsibility to uphold a Duty of Care to patients. Was a Duty to Care provided to the Indigenous person in this story?
- Every patient has rights, see Australian Charter of Healthcare Rights below. How were patients' rights supported or challenged in this story?

AUSTRALIAN CHARTER OF HEALTHCARE RIGHTS

The Australian Charter of Healthcare Rights describes the rights of patients and other people using the Australian health system. These rights are essential to make sure that, wherever and whenever care is provided, it is of high quality and is safe.

The Charter recognises that people receiving care and people providing care all have important parts to play in achieving healthcare rights. The Charter allows patients, consumers, families, carers and services providing health care to share an understanding of the rights of people receiving health care. This helps everyone to work together towards a safe and high quality health system. A genuine partnership between patients, consumers and providers is important so that everyone achieves the best possible outcomes.

Guiding Principles

These three principles describe how this Charter applies in the Australian health system.

1 Everyone has the right to be able to access health care and this right is essential for the Charter to be meaningful.

2 The Australian Government commits to international agreements about human rights which recognise everyone's right to have the highest possible standard of physical and mental health.

3 Australia is a society made up of people with different cultures and ways of life, and the Charter acknowledges and respects these differences.



For further information please visit www.safetyandquality.gov.au

AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTHCARE

What can I expect from the Australian health system?

MY RIGHTS

WHAT THIS MEANS

Access

I have a right to health care.

I can access services to address my healthcare needs.

Safety

I have a right to receive safe and high quality care.

I receive safe and high quality health services, provided with professional care, skill and competence.

Respect

I have a right to be shown respect, dignity and consideration.

The care provided shows respect to me and my culture, beliefs, values and personal characteristics.

Communication

I have a right to be informed about services, treatment, options and costs in a clear and open way.

I receive open, timely and appropriate communication about my health care in a way I can understand.

Participation

I have a right to be included in decisions and choices about my care.

I may join in making decisions and choices about my care and about health service planning.

Privacy

I have a right to privacy and confidentiality of my personal information.

My personal privacy is maintained and proper handling of my personal health and other information is assured.

Comment

I have a right to comment on my care and to have my concerns addressed.

I can comment on or complain about my care and have my concerns dealt with properly and promptly.

Indigenous health statistics of relevance to narratives

In 2009, the Indigenous population was estimated at 550,000 people, constituting 2.5% of the total Australian population. Of all Indigenous Australians, 6% identified as being of Torres Strait Islander origin and 4% as being of both Aboriginal and Torres Strait Islander. The majority (76%) of Indigenous Australians live in major cities and non-remote regional areas (AIHW, 2011).

Age distribution

The Indigenous population is much younger than the non-Indigenous population. In 2006, the median age was 20 years for Indigenous people and 37 years for the non-Indigenous population (ABS 2007). This is largely due to higher fertility rates and to deaths occurring at younger ages in the Indigenous population.

Aboriginal and Torres Strait Islander women give birth at a younger age (mean age 25 years) compared to non-Indigenous women (mean age 30 years) (Boyle, et al., 2008). Approximately 70% of Aboriginal and Torres Strait Islander women give birth before the age of 30 years compared to only 46% of non-Indigenous mothers (Thomson, et al., 2010).

Health disparities

Aboriginal and Torres Strait Islander people have significantly higher morbidity than the general Australian population with their burden of disease occurring at younger ages and at higher proportions (Australian Health Ministers' Advisory Council, 2011).

Despite composing only 2.4% of the population in 2003, they were estimated to carry 3.6% of Australia's disease burden (Australian Health Ministers' Advisory Council, 2011). Rates of hypertension, respiratory ailments, stroke, diabetes, cancer, renal failure, suicide and drug dependence all occur at higher levels (Australian Health Ministers' Advisory Council, 2011).

Overall, Indigenous Australians experience lower levels of access to health services than the general population, attributed to factors such as proximity, availability and cultural appropriateness of health services, transport availability, health insurance and health services affordability and proficiency in English (AIHW, 2011).

Cardiovascular disease

Cardiovascular disease is a serious health problem for Aboriginal and Torres Strait Islander people. Although the self-reported prevalence of cardiovascular disease is only slightly higher for Indigenous Australians than for other Australians, their rate of hospitalisation for cardiovascular disease is higher than for other Australians. In 2007–08, coronary heart disease (heart attack and angina) was the most common type of cardiovascular disease responsible for Indigenous hospitalisations, with the rate being 3 times that of non-Indigenous Australians. Over the period 2003–2007, Indigenous Australians were 3 times as likely as non-Indigenous Australians to die from cardiovascular disease (AIHW, 2010).

Diabetes

Type 1 diabetes is rare in the Indigenous population, but there is a very high prevalence of Type 2 diabetes. Indigenous people tend to develop Type 2 diabetes earlier than other Australians and die from it at younger ages. In 2007–08, hospitalisation rates for any diagnosis of diabetes were almost 9 times as high for Aboriginal and Torres Strait Islander

people as for other Australians. For the period 2003–2007, Indigenous Australians were 7 times as likely as non-Indigenous Australians to have diabetes recorded on their death certificate (AIHW, 2010).

Alcohol

Overall, Indigenous Australians are considerably less likely to drink alcohol than non-Indigenous Australians. However, among those who drink, a higher proportion of Indigenous Australians drink at risky or high-risk levels (AIHW, 2010).

Injury

Injury (including poisoning) is the third leading cause of death and the main cause of hospitalisation (excluding dialysis for kidney disease) of Indigenous Australians.

Literature review

Project rationale

Australian Indigenous health outcomes are amongst the worst in the developed world; this impacts seriously on Indigenous individuals, families and communities and the wider Australian society. Australian Indigenous people bear a two-and-a-half times greater burden of disease than non-Indigenous Australians (Cooperative Research Centre for Aboriginal Health 2008).

Racism has been identified as a significant cause of the socio-economic and health disadvantage of Aboriginal Australians (Eckerman et al, 2006; Henry, Houston & Mooney, 2004; Larson, Gillies, Howard & Coffin, 2007; Paradies, Harris and Anderson, 2008). Paradies' systematic review of 138 studies found strong associations between self-reported racism and negative mental health outcomes and health-related behaviours (2006).

Racism is ubiquitous in Western Australia, with 52% of urban residents and 69% of regional residents revealing prejudice against Aboriginal Australians (Pederson, Griffiths, Contos, Bishop & Walker, 2000). This suggests that the actions of potentially more than half of all health workers will be influenced by racist beliefs.

Larson, Gillies, Howard & Coffin's research (2007) on the impact of racism on Aboriginal Australians in a rural Western Australian town concludes that:

"...improved health care and other initiatives may not eliminate health inequalities in the absence of fundamental changes in how non-Aboriginal people behave towards Aboriginal people" (pg 322).

To improve the cultural safety of health services and increase Indigenous levels of access and satisfaction, we must change the way health professionals behave (Toussaint, 1999, 2003). However, this is a complex challenge.

The literature on cultural safety is littered with alternative definitions - cross-cultural care, cultural awareness, cultural competency, cultural sensitivity, cultural security - terms which create an aura of complexity and are often difficult to translate into practice (Park et al, 2005; Gibbs, 2005; Johnstone & Kanitsaki, 2007; 2008). Several projects exist which are designed to facilitate the development of cultural competence skills or programs that focus on improving cross-cultural communication skills.

However these programs are likely to have limited effects on the unconscious cognitive processes that result in stereotype activation and application (Burgess, van Ryn, Dovidio & Saha, 2007). In the US, Reimann and colleagues (2004) found that knowledge of cultural factors per se and simple exposure to other cultural groups, do not directly facilitate culturally competent care.

Research on reducing racial bias offers a number of successful approaches for teaching and learning, including:

- Providing evidence of racial disparities in the quality of health care (Burgess, van Ryn, Dovidio & Saha, 2007);

- Using techniques that lead people to recognise their unconscious biases in a non-threatening environment (Burgess, van Ryn, Dovidio & Saha, 2007) that avoids collective guilt and stimulates dissonance; the psychological discomfort from incompatibility between behaviours and beliefs (Pederson, Walker & Wise, 2005), and;
- Increased perspective taking and empathy (Batson et al, 1997; Finlay & Stephen, 2000; Burgess, van Ryn, Dovidio & Saha, 2007; Pederson, Walker, Rapley & Wise, 2003; Pederson, Walker & Wise, 2005).

The narrative approach which is the focus of this project incorporates all these strategies.

Empathy

Social categorisation involves the perception of a person in terms of his/her group membership rather than with respect to their individual, unique characteristics. People favour ingroup members in evaluation, attributions, material resources and helping. This ingroup bias is considered to be a normal, functional psychological process (Dovidio, Gaertner, Saguy, 2009).

Prejudice is related to social categorisation and decategorisation approaches include emphasising the individual qualities of others and personalised interactions (Dovidio, ten Vergert, Stewart, Gaertner, et al, 2005). Personalisation induces empathy (Batson & Ahmad, 2009).

“Prejudice dehumanises people by denying them individuality” (Lancellotti, 2008).

Empathy is appreciating or imagining another’s emotions (Stepien, Baernstein, 2006). Empathy involves a cognitive element (taking the perspective of another) and an emotional element, unlike sympathy which has only an emotional element. Taking the perspective of another leads to affective reactions (empathy) that causes dissonance, which motivates people to modify their attitudes.

Batson et al, 1997, describe the process of empathy; taking the perspective of the individual leads to feelings of empathy for that person, empathetic feelings increases the importance of their welfare and the concern for an individual’s welfare generalises to the stigmatised group.

Cultural empathy is defined as “feeling, understanding, and caring about what someone from another culture feels, understands and cares about” (Rasoal, Eklund, Hansen, 2011). Cultural empathy requires “the mental capacity to deal with ambiguity and unfamiliarity” (Cui and Van Den Berg, 1991) and even overcome cultural gaffs (Dogra, Giordano, France, 2007).

In a study done by Eklund, Andersson-Straberg & Hansen in 2009 there was a positive association between empathy for a character in a story and research participants’ previous similar experiences. Similar experiences appear to be an important factor for feeling empathy for another. Similarities then, have priority over differences as to understand differences we must relate to something that is similar.

The resources the project has develop seeks to enhance cultural empathy by providing students with the opportunity to understand Aboriginal Australians “from the outside in”

(Ridley & Lingle, 1996), to experience the story provider's feelings and values and imagine the world from their unique individual perspective using the student's own subjective experience as a reference for empathy (Eklund et al, 2009).

Self reflection

Health providers hold stereotypes and biases, the application of which often occurs outside their conscious awareness (Burgess, van Ryn, Dovidio, Saha, 2007) yet can be devastating to health recipients. Research in the area of cultural diversity training suggest a reflective approach is necessary as competent care is strongly predicted by the recognition of cultural factors and awareness of personal biases. Johnstone & Kanitsaki (2008) assert that recognising racist attitudes and behaviours is vital to developing strategies for providing culturally competent care.

To facilitate this self-reflection educators use narratives and case studies as triggers to prompt discussion and questions. The stories enable learners to experience a new reality and encourages reflection of their own assumptions, values and issues of social justice (Kumagai, Lypson, 2009). Significant learning and growth through cognitive dissonance occurs when a persuasive new perspective confronts existing beliefs and values.

Attitude change through narrative

The power of narrative to change beliefs has never been doubted and for this reason censorship has been in place for centuries (Green & Brock, 2000). Interest in the use of narrative in persuasion and to overcome resistance is a growing area of research in psychology and health promotion. Education entertainment (the use of stories to promote specific behaviours) storytelling and testimonials are increasingly used by health authorities throughout the world to disseminate anti-drug or healthy promoting behaviour messages (Hinyard & Kreuter, 2007).

Dal Cin, Zanna and Fong (2004) argue that narratives are a particularly useful strategy in challenging strong attitudes that are resistant to change using rhetorical persuasion strategies. The authors suggest the mechanisms that make narratives especially suited to overcoming resistance are that narratives reduce the amount and effectiveness of counter-arguing and increase identification with characters in the story. The concept of using scenarios from these stories is informed by the literature on ethnodrama (Rolfe, Mienczakowski & Morgan 1995; Mienczakowski 1996; Gray et al. 2000; Shapiro & Hunt 2003; Kontos & Nagile 2006; Dow et al 2007) and clinical and scenario-based simulation in health education (Carroll & Messenger 2008; Kneebone 2005).

Narrative approaches can be successful in changing attitudes, but have not been widely exploited in Indigenous health, often due to a lack of understanding of the pedagogy and a lack of appropriate resources.

The narrative pedagogy, adopted in this project incorporates and builds on case study and problem-based learning methodologies. It encourages reflective, interpretive learning as outlined by Reimann et al. (2004) and influences cultural attitudes by challenging self-evident assumptions (McAllister et al, 2009).

Narrative presented in written and audio form, film and theatre is 'the next best thing' to learning from genuine human experience. It gives students a vivid experience of the patient, their thoughts and feelings, values and beliefs in context rather than a narrow focus on clinical and technical knowledge (Swenson & Sims, 2000; Evans & Severtsen, 2001; McAllister, 2000). The melding of cognition and effect creates the capacity for developing ethical knowledge, an understanding of caring and culture and promotes empathy and understanding (Davidhizar & Lonser, 2003; Brown, Kirkpatrick, Mangum & Avery, 2008).

We recognise, and want to promote an intrinsic link between the value placed on experiential learning and traditional-story-telling in Indigenous cultures and the value of experiential learning in a student-centered approach to teaching (Estes 2004).

"Stories are everywhere. We hear them, we read them we write them, we tell them. We use them to motivate others, to convey information and to share experiences. We tell stories to connect to new people and make sense of the world around us. As we tell stories we create opportunities to express views, reveal emotions and present aspects of our personal and professional lives. Our ability to communicate not just our own experiences but experience of others enables us to transcend personal frameworks and take on wider perspectives. This attribute together with its international, transhistorical and transcultural usage make story telling a powerful teaching and learning tool." (McDrury & Alterio, 2003).

When storytelling is formalised in meaningful ways, it can capture everyday examples of practice and turns them into an opportunity to learn - encouraging reflection, a deeper understanding of a topic and stimulating critical thinking skills. The technique can accommodate diverse cultural, emotional and experiential incidents, and may be used in many different contexts eg formal/informal; one-on-one/group setting.

In addition, research on teaching strategies giving greater emphasis to narrative and experiential approaches may be more supportive of a cultural safe learning environment for Indigenous students (Norman 2004; Vaughan 2005). Scenario and narrative based resources learning activities fit comfortably within these parameters.

This approach, profiles a shame-neutral learning environment (where neither Indigenous nor non-Indigenous students are shamed) in which students can *learn to learn* from Indigenous people. A further effect of these learning experiences will be performative, in that the educator comes to role-model a genuine alliance with Indigenous people. These learning activities will help non-Indigenous students (and teachers) to develop an empathic stance where they are also prepared to learn from their future interactions with Indigenous people.

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