

Graduate Research Papers in Rural Health

Edited by
QUYNH LÊ



UNIVERSITY OF TASMANIA

RURAL HEALTH

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Quynh Lê

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Acknowledgement

The publication of *Graduate Research Papers in Rural Health* owes the assistance of many people. Graduate research students are the first to be thanked and congratulated for their contribution to this book. Their enthusiasm, dedication and collaborative spirit have been a source of inspiration to many of us. Our thanks should also be extended to the supervisors who have given their valuable research advice and supervision to our students, particularly those who contributed their supervision reflection papers in this book.

Associate Professor Lisa Bourke and Assistant Professor Susan Korol are our special colleagues outside the University of Tasmania who have played an important part in our graduate research networking. Their contribution to this publication is indicative of our collaborative work in a wider context.

We would like to express our profound gratitude to Associate Professor Sue Kilpatrick, Professor Judith Walker and Professor Carey Denholm for their solid support and encouragement. Last but not least, our thanks must go to Cecilia Chiu for her editorial assistance.

Dr Quynh Lê

Rural Health Graduate Research Coordinator

Foreword

Carey Denholm

Graduate Research, University of Tasmania, Australia

I am very pleased to provide some introductory comments to *Graduate Research Papers in Rural Health*. I am aware that this UTAS publication has been under consideration for some time and I know that it will have a significant and lasting impact both within the rural health research training landscape and in assisting to shape and encourage research activity within the field.

As Dean, I have had the pleasure of witnessing a remarkable growth in the number of rural health candidates, the breadth of research activity and the interdisciplinary nature of the research, the growing number of publications in significant journals and, the dissemination of the research at national and international conferences.

The first UTAS candidate in Rural Health enrolled in 1998, the first MMedSc candidate graduated in 2005 and the first PhD candidate graduated in 2004. Within a nine year period, there are now a total of 30 candidates (6 full time and 24 part time) enrolled in Rural Health. Such rapid growth has also required positive collaborative relationships with staff in areas such as Education, Nursing and Midwifery, Medicine and Psychology. Thus, Rural Health has done much at UTAS to promote interdisciplinary activities and the staff and

candidates are to be applauded for stimulating this momentum within the UTAS community.

The *Graduate Research Papers in Rural Health* is a product of the successful seminar series conducted in Hobart and Launceston over the past several years and in reading the contributions I know you will also be “caught” by the energy, passion, colour, commitment and ownership of candidates to their work, the crucial relationship that has been established between candidates and their supervisory teams, the emerging balance between quantitative and qualitative methods and, the drive to be at the forefront of leadership within the field. These seminars have been characterised by curiosity, rigor, collegiality and a positive spirit, all of which contributes to the development of a stimulating and supportive intellectual and emotional climate.

All candidates experience a time of profound existential aloneness during their candidature when the realisation is made that it is they alone who have to write their thesis in their own way. Research candidature is about being a “trailblazer”. However, publications such as this serve to minimise the impact of isolation, provide a series of pathways particularly for the commencing candidate and provide a source of encouragement for those candidates who are in mid-candidature and who maybe wondering if they will ever finish.

For those candidates who may be in search of a little more inspiration, I know you also will be inspired after reading these contributions. For those candidates in need of encouragement, I

hope you are able to rediscover the passion for your research endeavours. For those of you who have perhaps felt a little isolated, I know this work will assist to give you a new sense of belonging to a family of fellow researchers who have zeal and passion for their work.

My congratulations to the editor and to all the contributors.

Professor Carey Denholm,
Dean of Graduate Research, University of Tasmania

October 2007

Contributors

Lisa Bourke is an Associate Professor in the School of Rural Health, University of Melbourne. Lisa graduated with a Masters in Sociology from Utah State University and a PhD in Rural Sociology from The Pennsylvania State University in the United States. Lisa has over 15 years' experience as a social researcher in rural communities in the United States and Australia, conducting a range of research projects at the national, state and local levels. She also has more than 10 years' experience as a postgraduate supervisor and teacher of social research methods. She has a particular interest in developing the field of rural health and improving the health and wellbeing of rural Australians. Her main research interests include rural health, wellbeing in rural communities, rural young people, Aboriginal health and community participation in health.

Rosemary Cane has been a Junior Research Fellow (Oral Health) at the University Department of Rural Health Tasmania since 2003 and is located in Launceston. This position represented a significant milestone for research in rural oral health at the University of Tasmania. Since graduating as a dentist from the University of Sydney, Rosemary has had a long career in private and public dental practice and dental undergraduate clinical education. During 2003-2006, Rosemary conducted research as part of the strategic

development research project in oral health funded by the National Health and Medical Research Council. This primary health care workforce project investigated access to equitable oral health care for disadvantaged adults living in rural communities. She was also part of the Partners in Health Oral Health Workforce Education Project, which established the dental undergraduate clinical placement program in Tasmania. Since 2005, Rosemary has carried out three scholarly evaluations of the annual clinical placement programs and published case studies that represent the importance of the integration of oral health and general health in the rural setting. She has been engaged in conference presentations and has published a number of papers in refereed journals promoting improved access to dental care for disadvantaged populations.

Carey Denholm is Professor and Dean of Graduate Research at the University of Tasmania. In his role as Dean, Carey has overall responsibility for graduate research supervision and training, and regularly conducts workshops and seminars for candidates and supervisors.

Alexandra Fitzpatrick is a PhD candidate in the Department of Rural Health at the University of Tasmania. Her research on child neglect is being carried out as part of the Partners in Health Research Program, which is a collaborative partnership between the University of Tasmania's Faculty of Health Science and the Department of Health and Human Services.

Sue Kilpatrick is Associate Professor and Director of the University Department of Rural Health, University of Tasmania. Her research interests are rural health systems, community participation in health, social capital, rural leadership and vocational education and training in regional Australia. She has published extensively in these areas besides working as a consultant and researcher with rural communities at the local level. She is particularly interested in researching the processes through which rural communities can develop effective partnerships with local health services to help their regions prosper, and to build community capacity. Sue is a member of the Tasmanian Early Years Foundation Board, and a board member of Family Based Care (North), which provides community care to the aged and people with disabilities.

Chona Hannah is a PhD candidate at the Department of Rural Health, University of Tasmania. Her thesis is on the health and wellbeing of intermarried Filipino women in rural Tasmania. She completed an MEd at the University of Tasmania with a focus on acculturation. She has worked as a college teacher and child care worker.

Andrew Harris is a registered psychologist, working part time between the University Department of Rural Health in Launceston as a Lecturer, and the Child Development Unit in Burnie as an assessment psychologist. He is also a Master student at the University Department of Rural Health, Tasmania. His interest in working with African men developed when he was Coordinator of the Phoenix

Centre, the torture trauma service for refugees in Hobart. Previously Andrew has worked as a school psychologist, child protection officer and civil and environmental engineer. He lives in Launceston to be close to his children.

Ha Hoang is a Master of Medical Science candidate at the University Department of Rural Health, Tasmania. Her thesis is on the views and attitudes held by migrants in rural areas towards maternity care. Ha undertook her undergraduate study in Vietnam and postgraduate study at Griffith University, Australia. She has an intercultural background with work and research experiences in Vietnam and Australia. Her research interests include maternity care, multicultural health and research methodology.

Clarissa Hughes commenced work as a Research Fellow with the University Department of Rural Health in early 2002. She has a background in Sociology and is passionate about conducting theoretically informed social research and evaluation that makes a difference to people's lives. Clarissa has developed and presented research workshops for graduate students and health care professionals throughout Tasmania. She has also delivered sessions on evaluation design and planning at various meetings and conferences including the GP/Hospital Integration Project workshop and the Tasmanian Rural Mental Health Workers Network Meeting. She is experienced in report writing, has published in peer reviewed journals and has presented at numerous national and international conferences including the National Social Norms Conference in Boston

in mid-2007. She undertakes collaborative work with the Department of Health and Human Services and the Tasmanian Institute of Law Enforcement Studies and is very proud to be supervising three very capable PhD students.

Susan Korol is Assistant Professor of Psychology at Cape Breton University, Canada. She teaches clinical psychology, abnormal psychology and health psychology. Her doctoral work at the University of Canterbury in New Zealand explored the socio-cultural determinants of dissociative identity disorder. This early work kindled her passion for investigating the social and cultural factors associated with a broad range of mental illness. She is also currently exploring practical community based, holistic interventions to mitigate culture-bound psychopathology. Sue's other interests include identity formation, psychopathology in the postmodern era and cross cultural insights into mental health.

Quynh Lê is a Lecturer in Rural Health and the Graduate Research Coordinator at the University Department of Rural Health, Tasmania. Her current research interests include social determinants of health through multilevel analysis and spatial analysis, population health, health informatics and intercultural health.

Peter Mulholland has been involved with ambulance service since 1986 following a six year career in general nursing. Initially trained and employed by Metropolitan Ambulance Service Melbourne for six years, he then moved to South Gippsland, and was stationed at Wonthaggi branch station for three years. After moving to Tasmania,

he was trained to the level of Intensive Care Paramedic, and has been working in Launceston since. He is currently employed with the Tasmanian Ambulance Service in the role of Clinical Support Officer. He is a Master student at the University Department of Rural Health, Tasmania.

Kate Squibb is a diagnostic radiographer. She has an interest in image interpretation and disclosure of diagnosis which initially evolved from her work in obstetric ultrasound and was rekindled by her current position as a sole radiographer in a rural hospital. Kate is a PhD candidate at the University Department of Rural Health, Tasmania.

Judith Walker is Professor of Rural Health and Chief Executive of the University of Tasmania's Rural Clinical School. As Deputy Dean, she has overall responsibility for the Faculty of Health Science's academic rural health portfolio. Her background and achievements exemplify the interdisciplinary and multiprofessional nature of academic rural health and her track record strengths are reflected in the innovative nature of her work as a rural medical educator, health systems researcher and consultant. She is the lead chief investigator on a 3 year Australian Research Council Linkage grant investigating the mechanisms behind age related network shrinkage and social disengagement in order to design service models to assist older rural people to stay engaged socially. Judi is a member of the University of Tasmania's Board of Graduate Research.

Introduction

Quynh Lê

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Australia

Graduate research is an important aspect and a vital force of university based research. Experienced academic researchers and research students work collaboratively to enrich the research discourse, to maintain a continuing flow of research within a university and to enhance the impact of research nationally and internationally.

The *Graduate Research Papers in Rural Health* is a manifestation of the contribution to research in rural health by graduate research students at the University of Tasmania. Most significantly it indicates their dedication to research inquiry and commitment to graduate research.

The *Graduate Research Papers in Rural Health* features research papers at different stages of research inquiry and this reflects truly the dynamic process of research engagement of a research candidate, which includes various aspects of an active inquiring mind such as brainstorming, searching and re-searching, reflecting, questioning, challenging, and so forth. This research process is not confined to the university context but moves beyond it to ensure that research is constantly and actively engaged with a changing world.

On this basis, apart from the papers contributed by our graduate research students and research supervisors, the *Graduate Research Papers in Rural Health* also includes several papers of colleagues from other institutions who play an important role in our international research networking.

Rural health is not a new concept. It has been dealt with in various aspects of population health. However, public attention on health issues in rural and remote Australia in terms of health policy, resource distribution, skills shortage, health services and health stereotype has highlighted a strong need for a rural health workforce and rural health research. With the rapid growth and collaboration of research in related fields such as social epidemiology, e-health, biomedical research and multicultural health, rural health research has established itself as a research discourse and has made a valuable and timely contribution to the sustained improvement in the health of rural communities.

The *Graduate Research Papers in Rural Health* includes research papers in progress: some are at the early stage of research inquiry and others are at the final stage in which researchers reflect on and evaluate their research journey. The papers deal with a variety of topics and use different research approaches in response to the increasing challenge of the complex nature of rural health research. All the papers published in this book share a common interest in rural health and graduate research. However, each paper has different features in terms of graduate research enhancement, health issues,

research impact, methodology, and each reflects its own research pathway. The contributed papers reflect a collaborative research discourse including graduate research candidates, academic staff and supervisors, and networked health researchers.

Graduate research: Part of a growing and vibrant tradition of rural health research in Australia

Sue Kilpatrick

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The foundation for a vibrant rural health research culture in Australia was strengthened when the national University Departments of Rural Health (UDRH) program was established in 1997 by the Australian Government's Department of Health and Ageing. While the major aim of this program is to facilitate university education for a rural health workforce, its objectives include undertaking research into rural and remote health issues. In 2001, the national Rural Clinical Schools (RCS) program was launched to provide clinical training opportunities for medical students in rural and regional Australia and to extend clinical research capacity in and about rural communities.

In 2003, the University of Tasmania's Faculty of Health Science created an academic rural health portfolio to provide a focus for rural health education and research through its RCS (North West

region) and UDRH (state wide) activities. This is an encouraging effective integration of academic rural health initiatives with school based teaching, learning and research core business. A particular strength has developed in the area of rural health graduate research.

The collaborative, multidisciplinary characteristic of academic rural health reflects the nature of health professional practice in rural and remote areas. There is a strong drive for interdisciplinary practice due to limited numbers of practitioners in any one location, professional isolation, workforce shortages and long distances from tertiary facilities. This collaborative, interdisciplinary and isolated practice raises particular sets of questions to be answered through research. The contribution of a number of rurally based health practitioners to the growing body of knowledge about rural health issues, education and service models, and rural clinical practice is underpinned by a sense of inquisitiveness and a thirst for understanding, inspired by their own experiences.

Academic rural health in Tasmania has a culture of research development among rural health practitioners. They have benefited from the pathway provided by the Primary Health Care Research, Evaluation and Development program (PHCRED), another Department of Health and Ageing funded initiative, the Research Capacity Building Initiative of which is situated jointly in the UDRH and the Menzies Research Institute. PHCRED supports primary health care practitioners to become researchers through a series of skills based workshops, mentoring and funding for dedicated research time at

various levels from beginning Researcher Development Program positions through to Fellowships. This pathway allows rural health practitioners to get a taste for the world of research and develop the skills and confidence that encourage many participants to go on to enrol in graduate research.

Dissemination of the results of research is an essential part of the research to practice and policy cycle that moves from questions through to answers and implementation, and often generates further questions. Australian rural health research dissemination is supported by the international electronic journal *Rural and Remote Health*, published by the Australian Rural Health Education Network (ARHEN) and the Federation of Rural Australian Medical Educators (FRAME), the national bodies for the University Departments of Rural Health and Rural Clinical Schools. The journal's aim is to provide an easily accessible, peer-reviewed, international evidence-base to inform improvement in health service delivery and health status in rural communities. The journal is an important part of disseminating rural and remote health research findings from around the world, as is the *Australian Journal of Rural Health*. Conferences are another excellent venue for sharing research findings. The annual General Practice and Primary Health Care Research Conference and the biannual National Rural Health Conference are opportunities to relay research findings to practitioners, policy makers and fellow researchers. Many of rural health graduate researchers supported by ARHEN and FRAME have presented at these conferences and published in *Rural and Remote Health* and the *Australian Journal of Rural Health*.

The collection of research papers in this book illustrates the multidisciplinary nature of rural health research in Australia. Academic rural health in Tasmania, through the UDRH and the RCS, is supporting the graduate researchers featured in this volume who are enrolled in PhD and Master of Medical Science by research degrees. These people reflect the profile of professionals working in rural health. They are paramedics, doctors, nurses, dentists, physiotherapists, pharmacists, radiographers, social workers, psychologists and educators. The profile of rural health graduate research in Tasmania has grown from a very small number of students and supervisors in the late 1990s to around 30 graduate researchers and 15 registered supervisors in 2007. The work they have and are generating will contribute to the evidence-base for rural health policy and practice.

There are many traditional academics in health disciplines, especially in metropolitan based institutions who are being influenced by these emerging research directions in rural health. The Australian Government's national rural academic network of health education and research, through the establishment of multidisciplinary rural clinical schools and university departments of rural health, is helping to raise the status of rural health practice and, in turn, is changing academic, professional and consumer perceptions of rural health. Graduate research is an important part of this growing and vibrant tradition of rural health research in Australia.

A supervisor's perspective of postgraduate study in rural health

Lisa Bourke

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Abstract

Rural health research is not yet well respected in academia, in part due to the nature of the discipline, its history and the impacts of rurality on research. This paper argues that if rural health research is to progress, all postgraduate students in rural health need to understand five important issues. These are: (1) that rural health is multidisciplinary; (2) that the rural health context is not well understood or theorised; (3) that rural relationships impact rural health research; (4) that there is a lack of evidence in rural health; and (5) that rural health research tends to lack methodological rigour. The paper calls for all rural health postgraduate students to not only acknowledge these issues in their research, but to contribute to the discipline by addressing these shortcomings. Some suggestions for doing this are proposed.

Keywords: rural health, postgraduate study, rural health research, rurality

Rural health research, not health research in rural!

Rural health is an interesting discipline. As an academic discipline, it was established by a committed few who sought an arena for discussing practice issues and who identified the problems of providing health services to a scattered and small population by a few under-resourced health professionals. The field expanded when rural health was placed on the political agenda as key issues could no longer be ignored, including that rural Australians had poorer health status and less access to health services and the rural health workforce was overworked and understaffed (AIHW, 2005; Dixon & Welch, 2000; Humphreys, 1999; Humphreys, Mathews-Cowey & Weinand, 1997; Humphreys & Weinand, 1991; Wakerman & Humphreys, 2002; Wilkinson & Blue, 2002). Since then, rural health has gained a profile and many argue it should become a discipline. However its rise out of need, inequality and political agendas has meant that the development of knowledge has also been driven by political agendas and focused on a few key problems, namely those of access, workforce and disadvantage. Together, these have contributed to “rural” being the victim, the poor cousin to the cosmopolitan and well-resourced “urban”. The latter we know is a myth, which questions the former. What do we know about rural health and is the rural disadvantaged perspective the one we should be pushing? As scholars of rural health, these are issues we must consider: what are the key issues facing rural health, what is the nature of the discipline and how does one undertake study in rural health.

It is due to the nature of the discipline of rural health, along with the setting in which rural health scholars undertake their research, that has implications for being a postgraduate student in rural health. For these reasons, I think there are five key issues that a student and researcher of rural health must acknowledge, namely that (1) rural health is multidisciplinary; (2) the rural health context is not well understood; (3) rural relationships; (4) lack of evidence in rural health; and (5) rural health research lacks methodological rigour. Failure to acknowledge these issues means that rural health research is undertaken like any other research and its context has gone unnoticed. Rural health research then becomes health research in a rural location rather than rural health research. In this paper, I would like to discuss these five issues and reflect on how rural health postgraduate students can develop the field of rural health. Before I do this, I provide a brief comment about the nature of postgraduate students and a biographical note about myself.

Rural health postgraduate students: Rural health tends to attract a particular kind of postgraduate student. Unlike urban campuses who seek out the top honours students for the PhD scholarships and place students in large research teams, University Departments of Rural Health have postgraduate students of a different profile. Most are rural health practitioners, who, through their hard work and conscientious and reflective nature, identify a particular practice issue that they feel warrants analysis. Most are mature age, employed (many full time), have not studied in many years and do not currently work in a research or academic environment. On the other hand,

most are passionate, enthusiastic and committed, so they add study to an already hectic workload and lifestyle. Most students that I work with are committed to change and improving rural health. It is these factors that make rural health postgraduate students exciting colleagues. But unlike the cohort of full time, young, PhD students in Melbourne and Sydney, who share references, have coffee together daily and continually discuss research methods, rural health postgraduates work in relative isolation, some among peers who comment "*why are you doing that?*" One can easily argue that the rural postgraduate student confronts barriers but I also suggest that their studies are real – they are confronted daily with practice dilemmas for which there is no evidence and are regularly challenged by research sceptics to whom they have to defend their research.

Who am I to make these comments? I am an academic in rural health, passionate about improving the lives of the residents of rural Australia. I come from the field of Rural Sociology. During my 11 year career as an academic, I have supervised a range of postgraduate students, including six honours students, 13 Masters students and three PhD students. They were not all success stories; the honours students all finished but five of the Masters students are in progress and four of the postgraduates withdrew, two for lifestyle reasons and two because, in my observation, they "just got sick of it". I have also taught postgraduate research methods for 10 years and talked to and observed over 80 postgraduate students in some part of their program. While others have done more, I feel I have something to offer!

In this paper, I discuss five issues that I think postgraduate students need to not only understand but also contribute to their development and/or resolution. At the very least, acknowledgement of these issues will assist postgraduate students to better understand the context in which they undertake their studies. At the outset, I acknowledge that many, including rural health scholars, would not agree with me, so I raise these issues, not as facts but as issues warranting debate, critique and discussion. If I provoke such discussion, then I have contributed in a small way to developing the discipline of rural health.

Key issues in rural health research

1. Rural health is multidisciplinary; yet this is rarely recognised. We need to embrace this and become interdisciplinary where rural researchers respect equally a randomised control trial and a discourse analysis. The reason this is not the case is because most rural health academics were not trained in rural health but in a specific health discipline. Health disciplines not only draw on different research methods but on different paradigms of research. For example, medicine, epidemiology and physiotherapy draw on a positivist paradigm (see Guba & Lincoln, 1994) whereby scientific theories, principles and protocols are key. These researchers are drawn to randomised control trials, hypothesis testing, statistical analysis and large, random samples. Other fields, such as nursing and social work, have critiqued positivism as inappropriate for studying people, arguing that researchers cannot be objective and all

research is value-laden. These researchers turn to feminist, constructivist, action research and emancipatory frameworks for studying their topics, which have theoretical drivers and are open to non-objective processes of analysis (see Crotty, 1998; Guba & Lincoln, 1994). The scientific critics argue that these latter research frameworks are subjective and label such research as “soft” and descriptive. In turn, the feminists and constructivists respond that all researchers are subjective (from the decisions to conduct research and the topic selected) and that they are more honest about their subjectivity. Many agree that there is no one paradigm appropriate for all research; we want all new drugs tested via randomised control trials but these are not appropriate in community health. Regardless of your perspective, I think it important that postgraduate students work with supervisors who value the paradigm that the student is working from. Students and supervisors can have different backgrounds, come from different disciplines and work with different methods, but embracing the same paradigm of research for a project is important to learning. Rural health is one of the few fields that work across different research paradigms, so identifying the position of the student's research is important.

2. The rural context is not well understood. The rural health literature is full of health dilemmas, problems, practice issues, policy recommendations and crises. However, there is much less to explain the rural context. I recommend to my students that they seek out discussions of rural from other fields because rural health does not have a well theorised understanding of rurality. There is a tendency

to define rural ecologically and move on rather than discussing the complex nature of rural. Rural health needs to be developed theoretically so that we understand the context of practice, of service delivery and of change. And such theorisation needs to focus on the positives and negatives, the strengths and weaknesses, of rural health. The continued focus on rural disadvantage, the tyranny of distance and under-resourced services limit our understanding and make rural health an unattractive field to those not already converted. Many of us love rural health, are committed to rural practice and see not only huge challenges but significant benefits to our working context. These include the relationships we have with patients/clients, the ability to implement change, the diversity of practice, the ability to reach most of the local community, and our own autonomy. However these have not been well articulated in the rural health literature. Postgraduate students can contribute to understanding the rural health context.

3. Rural relationships: In rural health research we often have existing relationships with the people involved in our research. The nature of rural life is that we know, or know of, many of the people that we come into contact with (Bourke, Sheridan, Russell, Jones, DeWitt et al., 2004). We often have pre-existing relationships with them and so professional and personal relationships become blurred (Hays, 2002; Scopelliti, Judd, Grigg, Hodgins, Fraser et al., 2004). Furthermore, most postgraduate students want to research an area of interest that often involves their own practice. That is, their research may involve researching people they know and work with. Thus they are likely to know participants and may have relationships,

professional and/or personal, with participants prior to the research. This raises significant ethical issues, but students should not be deterred. This is a part of rural research and, with care, such research can be undertaken. Educating examiners, ethics committees and other researchers about rural relationships is part of the rural health research process.

4. There is a lack of evidence in rural health. In the past, rural health has often adopted general health evidence and applied it to rural health research and practice without question. There is increasing awareness that urban health practice and research strategies are not necessarily the most appropriate for rural health settings. Many now believe that models of health services in rural settings are often more appropriate when developed for the specific rural context, and that best practice in urban health is not necessarily “best” for rural health. For example, rural health services will never be like tertiary hospitals and so evidence relevant for tertiary hospitals may not be appropriate for rural hospitals. Given this, there is a need to develop a body of evidence in rural health. We need to know the appropriate and successful ways of improving the health of rural Australians. While this does not apply to one-to-one clinical practice, the provision of health services, models of health service delivery, and programs in community health all need to be developed for the rural context rather than imported from urban models. That is, the diagnosis of diabetes will be the same but treatment options, access to information, consumer support and a range of other factors will differ. Rural health has developed

innovative and resourceful models and services, but evidence for these that tests their effectiveness in the rural setting is lacking. Postgraduate students in rural health are contributing to developing a body of evidence in rural health.

5. Rural health research needs more methodological rigour.

Students usually jump into their postgraduate studies enthusiastically. They usually begin with a large research topic that is first narrowed and then eagerly work their way through relevant literature. Keen to begin their research, they often quickly develop a simple research design. If rural research is to progress and be respected, research designs need to be carefully and critically planned, thought out and developed over time. Postgraduate students need to understand research methods and be able to justify their choices and applications of these methods. I am not suggesting that rural research needs to become more methodologically complex or sophisticated, but that a greater understanding of and critical thought about research methods would benefit the field. For example, a key issue in rural health research is sampling. Rural health research is continually criticised for small samples, case study approaches and for being non-generalisable (and therefore insignificant). Rural health will always have small samples because the nature of rural is a smaller population. Again, our expectations of sampling in rural research cannot be the same as in urban research because rurality makes it different. What becomes important is that we maximise our sample size and we are particularly careful in our selection. Further, many confuse a small sample with a population; sometimes it is possible for

us to research the entire population because our numbers are smaller and more accessible. This is not a weakness but a strength of rural research. Turning potential weaknesses, such as small samples, into strengths, such as including the entire population, is possible. Thus, more thought and rigour into research methods will improve rural health research.

Suggestions for studying rural health

In summary, rural health research is not the same as urban health research and should not try to be. For postgraduate students, it is a matter of making your study rural while not apologising for it and not “going soft” either. Maintaining rigour while applying your research design to a rural context is possible and it is imperative that you understand how and why you have done this. Therefore, I suggest:

1. Think about how your project and research contributes to a body of rural health evidence. Try to make your project a contribution, that is something new in the rural health literature. You can do this by applying concepts from other disciplines to the rural context.
2. Make your research quality. Ensure methods are sound and the whole study is well thought out. If you are starting, do not be in a rush to jump in but think about your research topic and design carefully and critically. You have to be able to defend it, so make sure it is thorough at the outset.

3. Read and think about the rural context. Think about how it has shaped your research, in terms of your awareness of issues, interaction with people and need to problem solve. Be critical in your reading of the rural context, and strip away the myths and assumptions from discussions of rural. Acknowledge the relationships that you have with clients and other health professionals, and identify how these are both strengths and weaknesses.
4. Think about the duality of the social world and the complexity of rural health. If there were simple solutions, they would have been developed and implemented by now. Rural health and rural life is complex, so explore these complexities, think about how issues are both positive and negative, advantageous and disadvantageous. Georg Simmel wrote that everything has a dual purpose and meaning; nothing is entirely positive and negative but everything is both (Levine, 1971).

As with all postgraduate students, I also suggest that you:

- Identify your strengths and weaknesses (in terms of research) at the outset, and have your supervisor as well as yourself focus on improving your weaknesses. Strengths take care of themselves.
- Write referenced summaries of everything you read, so you can easily integrate these into your thesis when you need to.

- Learn how to use your university library and how to reference. Take the time to learn these skills early on as they will save time in the long run.
- Keep writing.
- Make concentrated time in a good environment for studying. Your own computer with internet access is extremely helpful.
- Learn to write well. It is a great skill to have but takes time to learn.
- Develop your research aim/question/hypothesis carefully. The key to all research is the research question/aim, so take the time to develop this with thought, but once you have developed it, stick to it regardless of how interesting other tangents might be.
- Have regular meetings with your supervisor, by telephone if necessary.
- Keep going. "Time out" from your studies usually leads to wanting more "time out", and while life gets in the way sometimes, keep going when you can.
- Do not let yourself burn out. Move to a new section if at a standstill.

- Integrate ideas from other disciplines into your approach to your topic.
- Read methods textbooks so that you are informed of the methods that you use. Also, select a method rather than assuming you will use one you like (the research question should drive methodological choices).
- Take time to read about and learn techniques of data analysis, be it statistics, thematic analysis or whatever, and remember, computer software packages (e.g., SPSS or NVivo) do not do the analysis for you.
- Be aware that a thesis is an academic piece examined by academics and so it needs to address academic criteria (but do not stifle your imagination).
- Identify the strengths and weaknesses of your project early on, so you are aware of them and not disheartened at the end.
- Do not use research as your soapbox. If you have an opinion, write a letter to the editor, but if you have a question/problem where you are open to new ideas and solutions, research is a good vehicle.
- Finally, talk about your project and laugh about it with others!

I tell my students that “if you could sail through your postgraduate degree, if it wasn’t challenging or demanding, then it wouldn’t be an

achievement". Make your degree an achievement by pushing yourself in terms of time, intellectual pursuit and commitment. It will not happen overnight, but by keeping at it, reading broadly, thinking critically and building on your ideas, your thoughts will develop so that you do make an academic contribution. And always let your passion for rural health and your practice be a part of this process. Rural health needs more quality researchers and more rural evidence, so you have much to contribute. *I wish you well!*

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Evaluating an innovative dental clinical placement program: Opportunities to enhance learning

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Abstract

Limited access to public dental care in Australia is evident in long waiting lists for comprehensive care, absence of recall, and an increased likelihood of more extractions and fewer preventive services occurring. Public dental services in Tasmania are constrained by a number of factors including isolation from dental schools and the public hospital system, and the lowest national ratio of dentists to population (25.3 dentists per 100 000 population), which is almost half the Australian average (46.9 per 100 000). In response to the oral health workforce shortage and lack of local workforce education, the Partners in Health (Department of Health and Human Services, Oral Health Services Tasmania), in conjunction with the University of Adelaide launched the Bachelor of Dental Surgery (BDS) Undergraduate Clinical Placement Program in September 2005.

The Department of Rural Health, University of Tasmania has evaluated three annual dental undergraduate clinical programs held in Tasmania (2005-2007), which apply a qualitative methodology for key informant interviews and questionnaires and an extensive literature review of international and local clinical placement programs. Areas for review included the clinical learning process (experiential learning) as part of the broad educational and service objectives of the program.

The clinical placements are viewed as being a *very attractive option for final year students* by all respondents mostly due to the opportunity to increase students' clinical competence and confidence. From the students' perspective, identified educational strengths of the program include the "real world" aspects of the program, educational input and approach of clinical supervisors ("prompting") and engagement with local clinical services staff. Increasing the support available to local clinical supervisors, such as increasing the professional development opportunities with clinical academic staff and extending the role of clinical supervisor as mentors are likely to be among future benefits of the program.

Keywords: student clinical placements, experiential learning, clinical skills acquisition

Introduction

The introduction of dental undergraduate clinical placements programs has been a significant milestone for the dental workforce in the predominantly rural state of Tasmania (Cane & Kilpatrick, 2005, 2006, 2007a), where access to public dental care is characterised by long waiting lists for comprehensive care, absence of patient recall, high level of extractions and fewer preventive services (Brennan, Spencer, & Slade, 1996; Spencer, 2004; Stewart, Brennan, & Carter, 1998). As the only Australian state without a dental school, fewer than 2% of the recent dentist graduate population from the five Australian dental schools were attracted to work in Tasmania in 2003 (Partners in Health, 2003). The state's rurally distributed population (472,795 (ABS, June 2002), low income per capita and the absence of a dental school indicated that ground breaking strategies were needed to address the state's ability to recruit more dentists and improve access to services (Partners in Health, 2003). In 2003, with 38% of the population dependent on a government pension or benefit being eligible for public dental services (Trewin, 2004), the public sector dentist workforce had fallen to 13 (full time equivalent).

As an outcome of the Partners in Health (PiH) collaboration formed between the Department of Health and Human Services (DHHS) and the Faculty of Health Science of the University of Tasmania (UTAS), the Tasmanian dental undergraduate clinical placement program was introduced in September 2005 (Partners in Health, 2003). Dental

undergraduate clinical placement programs may refer to outreach programs, community based programs or extramural placements, which are part of the dental curriculum occurring outside the traditional dental school environment. There have been three voluntary, six week programs held in Tasmania, with the service and educational objectives of the program being uniquely determined by an agreement between the School of Dentistry, University of Adelaide and the Tasmanian state government.

Evaluation method

The Department of Rural Health, University of Tasmania (UDRH) has evaluated three annual programs, with ethical approval being given by the Social Sciences Human Research Ethics Committee, University of Tasmania. Qualitative methods guided collection and analysis of perspectives, with the application of “grounded theory” (Meadows, Verdi, & Benjamin, 2003; Pope & May, 1995; Strauss & Corbin, 1994) as a basis for developing explanatory frameworks (Strauss & Corbin, 1994). Inquiry included closed and open ended items seeking the views, expectations and perspectives of the different interest groups: students (pre and post placement), clinical supervisors (pre and post placement), staff (post placement), patients (post placement) and stakeholders (post placement); and the extent to which success was achieved in their terms. The data has been analysed using a standard procedure for coding and data management under separate themes representing the most salient issues. Interpretations of the data are supported by detailed reference to the data upon

which those interpretations are based so that the reader is in a position to agree or disagree with the interpretation (Cane & Kilpatrick, 2007b, 2007c).

An extensive review of articles listed in the medical database *Pubmed* was conducted to identify studies related to the service and educational objectives of the clinical placement program. The search was conducted using the keywords underpinning the objectives: “enhanced learning opportunities”, “enhanced professional experience”, “improved access to (dental) services”, “opportunities for the delivery of workforce education”, and “career opportunities” relevant to dentistry. As an integral part of the overall findings, this article outlines the research findings related to enhancing learning opportunities during an undergraduate extramural clinical placement.

Overview of Tasmanian BDS clinical placement program

The focus of the clinical placement is to provide students with a broad range of clinical experiences within a working environment. This gives students the opportunity to take responsibility for patient care, self reflect on their decisions and receive constructive feedback within an appropriately supervised environment. For the Tasmanian dental undergraduate clinical placement program, a small number of students, selected from those expressing an interest from the School of Dentistry, University of Adelaide, provide a range of supervised comprehensive and episodic dental care as part of mainstream services at two locations, Northern Dental Centre (NDC), Launceston

and the Southern Dental Centre (SDC), Hobart. The majority of clinical time is spent diagnosing, treatment planning and providing comprehensive dental care for patients who are from the waiting list for public dental services. Students also provide services for patients presenting for episodic care, which are most likely to involve planned, simple and minor surgical extractions. Students contribute to the dental care of a number of paediatric and special needs patients requiring treatment under general anaesthesia in sessions at the Royal Hobart Hospital and Launceston General Hospital, with supervision being provided by public sector dentists. Teleconferencing facilities at the two clinical sites are used for weekly tutorials presented by local dental specialists (oral surgeons and a periodontist). Comprehensive care patients are not screened, although some screening for patients requiring planned surgical procedures may occur. Students are given the opportunity to work with dental assistants on a one to one basis for all clinical sessions. Local dental practitioners (public and private sector) provide clinical supervision and attend a local training session provided by the dental school. The clinical supervisors do not undertake clinical work during rostered sessions, which takes full advantage of the opportunity for educational input, such as discussions on diagnosis and treatment planning and patient management. This process also enhances the acquisition of clinical skills through student self-reflection, self-assessment, professional guidance and support. Clinical supervisor student assessments are obtained at the completion of the program. The state government has fully funded all three programs, including

students' accommodation, travel and allowances as well as funding nine undergraduate scholarships for either one or two years duration.

The students perceived that the educational experience was “better than expectations” due to the opportunity to provide dental care for a broad range of patients, with the support of efficient and accommodating dental assistants. While on placement in Tasmania, student productivity was similar, that is, the students treated a similar number of patients during a similar number of visits and they completed a similar number of items of treatment. In comparison, student productivity was more varied for the period of the year (first semester) at dental school. From the technical and administrative perspective, the clinical placement program provides an enhanced opportunity for each student to acquire knowledge and skills related to a similar range of clinical experiences in the “real world” setting. A comparison of individual student operator profiles per items of treatment recorded during the clinical placement program also indicates that students' clinical experiences were very similar, with an appropriate mix of services. (Figure 1)

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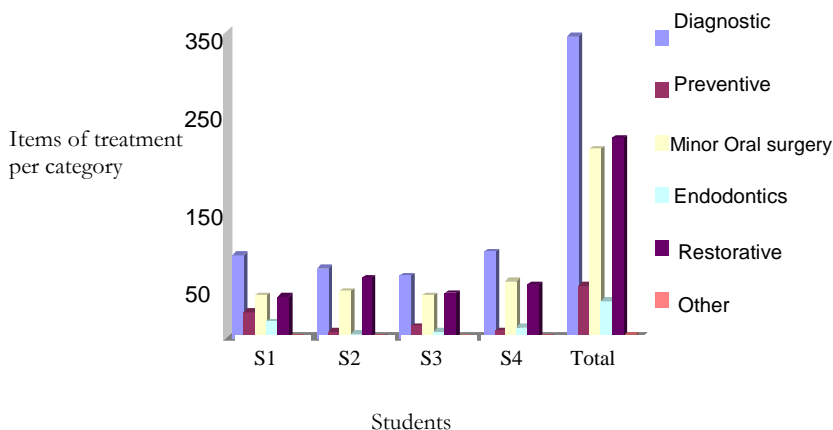


Fig 1: Comparative individual student operator profile (items of treatment) during placement (Tasmania, 2005)

Source : Student operator profile EXACT information systems, Oral Health Services Tasmania 2005

The students also perceived that the timing of the program (six weeks at the end of their undergraduate studies) was an appropriate period to consolidate their skills, gain confidence and be away from their home state. The quality of the supervisor relationship was identified to be a significant influence on the overall positive learning experience. The clinical supervisors perceived that the educational experience was “better than expectations” due to the sound administrative planning of the program, the broad range of clinical experiences, and the high level of patient management skills demonstrated by the students.

Discussion

Over the last decade, dental education has been challenged to develop curricula that address the emerging science, technology and disease patterns associated with an aging and diverse population (ADEA Commission on Change and Innovation in Dental Education, 2006). Internationally, a series of curricula changes have included clinical placements as a means to “redirect dental education to emphasise community health; encourage experimentation with new methods and less expensive forms of dental education; emphasise active learning, critical thinking, and community involvement; and stimulate the development and use of community based providers in the training of dental students” (DeCastro, Matheson, Panagakos, Stewart, & Feldman, 2003). This has been matched by a growing demand by dental students for clinical experiences in “real world settings” (Ayers CS, 2003) and for the increased use of community based health centres by dental schools for intrastate, interstate and, in a few cases, international placements and student exchange. In Australia, several dental schools have introduced curricula changes that encompass extended student clinical placements as an integral part of the curriculum. The School of Dentistry, University of Queensland places students for the final year at public dental clinics throughout Queensland (“1-3-1” model) (Seymour & Walsh, 2001; Walsh & Seymour, 2001). During the final year of the new curriculum at the School of Dentistry, University of Western Australia, students undertake a “pre-graduation internship” that includes an optional placement in a rural, remote or Indigenous communities. In the latter

case, the placement program is part of a comprehensive strategy to address the current shortage of rural dental practitioners in the long term (Bazen, Kruger, Dyson, & Tennant, 2007; Steele, Pacza, & Tennant, 2000).

A common objective of outreach programs is to provide experiences that lead to the development of “a generalist more aware of and more confident and capable of requirements and the needs of society” (Weaver et al., 1997). In the United Kingdom, the *Options for Change* document proposed that in future education for the whole dental team should focus on “developing the skills needed in practice with an increased use of primary care outreach schemes throughout undergraduate training” (Department of Health, 2000). In a study to evaluate a local community based family dentistry program at the University Dental Hospital of Manchester, Blinkhorn (2002) found that most students considered extramural training developed their productivity, clinical skills, confidence and patient management skills (Blinkhorn, 2002). Educational objectives are met by providing appropriate experience of integrated restorative care, developing a holistic approach to patient care, co-ordinated treatment plans, and confidence in diagnosis and treatment planning (Blinkhorn, 2002). The authors identified the acquisition of skills occurred mostly in time management, treatment planning, integrated patient care, and the treatment of dental emergencies (Elkind, Blinkhorn, Blinkhorn, & Duxbury, 2005). Another study associated with this same pilot program described the patients treated by undergraduates and noted that not screening the patients provided the students with the

“opportunity to experience life in practice, deal with emergencies and formulate full treatment plans taking into account all the patients’ dental health needs” (Elkind et al., 2005).

From an educational perspective, extra mural placements offer an ideal opportunity to engage in experiential learning, that is, the integration of knowledge, skills derived through experience, practice and reflection as a personal construction in which the individual imposes meaning by making connections (Maudsley & Strivens, 2000; Woronuk, Pinchbeck, & Walter, 2004). This theory underpins the educational success of extra mural placements through a positive impact on self confidence, motivation, skill development, student role socialisation, clinical competence and clinical decision making (Cane & Kilpatrick, 2007b, 2007c; Kilminster, 2000; Maudsley & Strivens, 2000; Woronuk, Pinchbeck, & Walter, 2004).

The quality of the relationship between the supervisor and the student is probably the most important factor of effective supervision. Giving students responsibility for patient care, opportunities to review patients, direction and constructive feedback that are interpretive, respectful, focussed and practical are notable features of effective supervision (Kilminster, 2000; Manogue, Brown, & Foster, 2001). Irby identified four key factors that distinguish the “excellent” clinical teacher from other instructors as being “a positive role model of a competent and compassionate health care provider, provides effective supervision and mentoring for learners, employs a varied and dynamic approach to teaching, and is a supportive person” (Irby,

1995). Communicating clear expectations of students' behaviour and performance, providing practical and helpful "just in time" teaching (commonly known as "prompting"), engaging in discussions on rationales and techniques are other approaches that have been found to be most effective (Henzi, Davis, Jasinevicius, & Hendricson, 2006). These strategies include regular feedback on performance, personal reflection, and absence of lecture based instruction. The students on placement in Tasmania reported that these features were characteristic of the clinical supervision during the placemen program.

Clinical supervisors were largely dependent on the available time that the dentist could be away from his busy private practice or the public sector dentists' number of rostered working sessions. Mills et al conducted an extensive review of the literature clarifying the different levels of involvement that established practitioners could take in student learning by defining the concepts of "mentoring", "clinical supervision" and "preceptoring" for Australian rural nurses (Mills, Francis, & Bonner, 2005). The authors noted that the evolving nature of mentoring relationships are broad and "encompass improved clinical practice, career progression scholarly endeavour and personal achievement" and often take place in the participants' own time (Mills, Francis, & Bonner, 2005). Clinical supervisory relationships and mentoring rely on the development of a strong sense of mutual exchange and accountability over time. Preceptoring is a method of preparing students for practice "using clinical staff who are not academic staff to provide clinical supervision and instruction to new practitioners or undergraduates" within the

workplace and involves an “experienced clinician who teaches, instructs, supervises and serves as a role model” as part of a formalised student program (Usher, Nolan, Reser, Owens, & Tollefson, 1999). Mills et al contended that positive preceptorship experiences “can shape future career decisions and are vitally important for succession planning” (Mills, Francis, & Bonner, 2005).

Conclusion

Overall, the Tasmanian dental undergraduate clinical placement program is seen to be a very positive learning experience by all respondents. Internationally, there is evidence that clinical placements play an integral role in enhancing students' clinical competence and confidence and will play an increasing role in dental curricula. Locally, evidence is emerging to suggest that the roles of experienced local practitioners as clinical supervisors, as well as the range of experiences in patient care and provision of support by dental assistants, are likely to be important factors in the success of the program. A number of issues require further investigation, including the extension of supervisory roles into mentoring roles for new graduates, with the provision of appropriate training and administrative support, and increasing the opportunities for local clinical supervisors to interact with dental academic staff. In this way, local practitioners are given the opportunity to enhance life long learning opportunities while engaged in active practice and maximise the rewards for their commitment, especially when the clinical placement takes place in the rural setting.

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The “chronic” neglect of neglect: A brief literature review

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Abstract

This paper presents a brief review of research findings dealing with the issue of child neglect, which is being carried out as part of a PhD project to examine how neglect in the 0–4 age group is conceptualised and responded to in child protection and community health practice in rural and regional Tasmania. The overview therefore confines itself to the main issues that are relevant to the aims of this particular study within the context of the “neglect of neglect”.

Keywords: child neglect, infant neglect, child maltreatment, child protection

Introduction

At the very earliest years, perhaps less than one children know whether or not they have hope and opportunity. (Lindsey, 1994, p 302)

The development and future life chances of children are the result of a complex set of interacting factors operating at the level of the individual, the family and the community (Belsky, 1993; Jack, 2000). If the development of young children is to proceed effectively, there are certain identifiable basic needs, both physical and psychological, that must be met; failure to do so is what essentially constitutes neglect (Garbarino & Collins, 1999; English, Thompson, Graham, & Briggs, 2005). How these needs are defined is partially dependent on the particular society and culture, but there is a general recognition of the fact that children require minimum community standards of care (Garbarino & Collins, 1999). Unfortunately, research indicates that the needs of some children are not being met, directly or indirectly, by parents and caregivers, child protection and welfare systems, or community health services (See, e.g., Gillingham, 2006; McSherry, 2007; Parton, 1995; Spencer & Baldwin, 2005).

Child neglect is the most prevalent and rapidly growing form of child maltreatment in the Western world. Statistical data from the United States indicates that it is the form of child maltreatment most frequently reported and substantiated and the most frequently associated with child placement (Connell-Carrick & Scannapieco, 2006; Dubowitz, Pitts et al., 2005; English et al., 2005; Stowman & Donohue, 2005; Watson, 2005). The available data from the Australian Institute of Health and Welfare (AIHW) for 2005–06 reveal that neglect and the inter-related maltreatment category of emotional abuse were the most common types of substantiated maltreatment across the different jurisdictions and that neglect was

the most commonly notified and substantiated form of maltreatment in Tasmania (AIHW, 2007; Jacob & Fanning, 2006).¹ Notifications of neglect in Tasmania during 2005-06 made up 39.2% of all notifications, followed by emotional abuse at 31.7%, physical abuse, 18.4%, and sexual abuse at 10.7% (Jacob & Fanning, 2006, p 35). Infants and young children less than four years of age are shown to have the highest substantiation rates throughout Australia, ranging from 35.9 per 1,000 children in Queensland to 6.3 per 1,000 in Western Australia (AIHW, 2007).²

It is a matter of concern, therefore, when research evidence clearly shows that “contrary to popular belief, the child victims of neglect emerge as the most severely negatively affected” of the victims of maltreatment (Gaudin, 1999, p 89). Research also confirms that it is infants and young children under four years of age who are the most vulnerable and who suffer the most devastating consequences – such as retarded growth, neurological and cognitive deficits, poor motor and language development, non-organic failure to thrive, behavioural problems, and physical injuries – with reports of child fatality due to neglect in the United States ranging from 32% to 48% of all reported child deaths (Scannapieco & Connell-Carrick, 2002, p 602). While data is not available for all Australian jurisdictions, of 75

¹ Notifications to child protection systems throughout Australia have more than doubled in recent years, from 107,134 in 1999–2000 to 266,745 in 2005–06 (AIHW, 2007), thereby placing enormous strains on child protection services throughout the country (see Liddell, Donegan, Goddard & Tucci, 2006).

² Such large differences in substantiation rates among jurisdictions provide some indication of the wide-ranging effects resulting from differences in child protection policies, practices, systems and legislation.

child deaths over a three year period in New South Wales that were attributed to abuse or neglect, 40 children died as a result of child abuse, 31 children died due to neglect, and four children died in circumstances suspected to involve abuse or neglect; the highest number of deaths was among 1-4 year olds (35) and infants under 1 year (16) (Lawrence & Irvine, 2004).

A major problem for protective and welfare services is that child neglect, especially in association with substance misuse, is more chronic and intractable to intervention than other forms of child maltreatment (Wilson & Horner, 2005, p 472). Chronic or persistent neglect, including neglect within health and protective systems, causes many different forms of harm in its own right as well as allowing other harmful forms of maltreatment to occur (Tanner & Turney, 2003). The inter-relatedness of neglect with other types of abuse – such as emotional or psychological abuse, and failure to protect from the effects of family violence (see Kaufman Kantor & Little, 2003) – highlights the importance of recognising the pervasiveness of this form of maltreatment as well as its chronicity (Wilson & Horner, 2005, p 472).

The “neglect of neglect”

The “neglect of neglect” was coined by Wolock and Horowitz (1984) more than 20 years ago. It continues to be used to the extent that it is at risk of becoming a cliché but as Dubowitz (1999) says, like many clichés, its use continues to be amply justified (p vii). The “absurd

paradox” is that despite consistent evidence showing more profound developmental and other effects and higher incidence rates than other types of abuse, it remains the most understudied and least understood form of maltreatment (McSherry, 2007, p 607). Child neglect continues to suffer from inattention in research, policy, and human service and health practice, while physical and sexual abuse continue to evoke a much greater response from the public and professionals alike (Garbarino & Collins, 1999; Dubowitz, 1999; Lawrence & Irvine, 2004).

Nigel Parton (1995) believes the issue of neglect “exemplifies many of the central tensions in child protection policy and practice more generally”, which in turn underlies “what many see as a major failure of child protection policy and practice over the last 20 years; in other words, the ‘neglect of neglect’” (Parton 1995, p 67). In a similar vein, Wilson and Horner (2005) see neglect as “the metaphorical elephant in the living room in modern child welfare systems”, and the neglect of neglect as “a stubborn refusal to come to grips with the centrality of neglect in child protection” (p 471). They observe that the amount of attention devoted to the different types of child maltreatment appears to be in inverse relation to its frequency in both scholarship and practice (p 471).

“Neglect of neglect” in research. The lack of attention in research is confirmed by a review of the trends in child maltreatment literature over a 22 year period by Behl, Conyngham and May (2003) – articles examining physical and sexual abuse “comprised the vast

majority of the child maltreatment literature”, while neglect and emotional abuse “comprised a small minority”; articles examining child neglect or child emotional abuse remained consistently low over the time period; those examining child physical abuse decreased, and those examining child sexual abuse increased (p 223). Neglect receives much less definitional attention, as well as attention generally, than other types of maltreatment (Connell-Carrick, 2003; Dubowitz, 1999; Dubowitz, Pitts et al., 2005; Dunn et al., 2002; English, Thompson, Graham & Briggs, 2005; Runyan et al., 2005; Tomasin, 1995; Watson, 2005; Zuravin, 1999). Although infants and toddlers are more likely to be victims of neglect than any other maltreatment type and comprise those at highest risk of mortality due to maltreatment, overall, this age group has received little attention in the literature (Scannapieco & Connell-Carrick, 2005, p 1308-09).

An extensive literature search conducted by the author in 2006 found that there was very little, if any, Australian research that focused specifically on child neglect, apart from a few government and institutional reports and papers.³ The child neglect research base relies heavily on the United States – although there is an increasing body of work emanating from the United Kingdom (Tanner & Turney, 2003; Watson, 2005) – which is problematic for Australian researchers and policy makers, given the socio-cultural differences (including legislative and definitional differences referred to below) that exist between the countries.

³ Including a literature review of child neglect by Watson (DoCS, 2005); Lawrence & Irvine's (2004) “Defining Fatal Neglect” (AIFS); and Tomison's (1995) “Spotlight on Neglect” (AIFS).

“Neglect of neglect” in policy and practice. Child protection and social workers are caught between a rock and a hard place when it comes to striking a balance between excessive intervention and protecting children from harm (Parton, 1995; Parton, Thorpe, & Wattam, 1997; Platt, 2006). Nonetheless, the events leading to the serious harm or death of children often involve a series of failures or missed opportunities to intervene, which can also be viewed as a chain of neglect on the part of individuals, the organisations associated with them, and the community at large. Enquiries into the deaths of children in the United Kingdom⁴ and in Australia – for example, the Victorian Child Death Review Committee’s (2006) *Child Death Group Analysis: Effective Responses to Chronic Neglect* – have found that professionals and agencies failed to act or intervene to protect children who had been brought to their attention more than once.

It has been suggested that neglect is neglected in practice because it is poorly understood in theory (Stone, 1998), and the difficulty child protection and social workers have with its identification and assessment is due to the complexity of its nature (e.g., Horwath, 2006; Jones & Gupta, 1998; Minty & Pattinson, 1994; Stone, 1998). Studies have found that social workers are either “overwhelmed” by the enormous and impervious problems presented by neglectful families or “underwhelmed” to the point where practitioners “normalise” neglect (Horwath, 2005a, p 100; Platt, 2006). Workload

⁴ See, for example, Victoria Climbié (Lord Laming, 2003, in Platt, 2006) and ‘Paul’ (The Bridge Childcare Consultancy Service, 1995, in Jones & Gupta, 1998).

pressures, resources and local systems have all been shown to have an influence on how the assessment task is interpreted in practice (Horwath, 2005a; Horwath, 2006). Moreover, there is little agreement among professionals regarding thresholds for referral or baseline standards of care, or even what constitutes a neglectful environment (Horwath & Saunders, 2005).

Like social workers, nurse practitioners find understanding and assessing neglect to be fraught with problems, characterised by lack of agreement and operational inconsistency, and ambiguities in its definition – all making identification and decision making difficult (Adams, 2005; Truman, 2004). Research has shown that the roles of community maternal and child health nurses and emergency nurses in relation to child protection responsibilities are still in the process of evolving, but there is a clear need for training in the assessment of neglect (Crisp, 2004; O'Neill, Hall & Miller, 2002). Medical practitioners in general under-identify and under-report cases of child maltreatment, but general practitioners take an even more cautious attitude about reporting than paediatricians do (Flaherty & Sege, 2005, p 352).⁵ The most common themes in studies about their reluctance to report neglect and abuse were: lack of feedback and communication from child protection investigators, general mistrust of child protection services due to negative previous experience, and the “insensitivity” of the authorities (Flaherty & Sege, 2005; Schweitzer, Buckley, Harnett & Loxton, 2006).

⁵ In Tasmania in 2004-05, for instance, medical practitioners were responsible for only 0.4% of notifications of suspected child maltreatment; hospital/health workers, 3.4%; and social workers, 5.3% (Jacob & Fanning, 2006, p 42).

Key research into child protection in the United Kingdom revealed that the vast majority of neglect cases are filtered out of the system at an early stage, without service or protection or family support, despite the children having the highest number of poverty indicators and as many indicators of vulnerability as those referred for physical or sexual abuse (Parton, 1995, p 85–6). Studies in the United States also found that neglect is given lower priority than physical or sexual abuse in many child protection agencies, even though the risk of recurrence may be particularly high – a policy which was supported by the local agency – and that investigations of physical and sexual abuse were required to be made within much shorter periods of time than reports of neglect (24 hours vs. 5 days) (DePanfilis & Zuravin, 1999, p 236). Initial assessment of concerns about neglect and emotional abuse tend to be “low key and to concentrate on risks rather than on the needs of the children” (Wilding & Thoburn, 1997, p 343). Allegations of neglect are also the least likely to be substantiated and the least likely to receive continued social work involvement (Parton, 1995, p 83; Wilding & Thoburn, 1997). All in all, child neglect has a much higher re-notification rate than other forms of maltreatment,⁶ is given low priority within the child protection system, and is a substantially neglected form of maltreatment in child protection policy and practice generally (see e.g., Connell-Carrick, 2003; Connell-Carrick & Scannapieco, 2006; DePanfilis & Zuravin 1999; Forrester, 2007; Wilson & Horner, 2005).

⁶ Jacob and Fanning (2006) express their concern about the high re-notification rate in Tasmania, which has increased from 58.3% in 2003–04 to 74.2% in 2005–06 (p 34).

Key issues for research

Conceptualisation and definition of neglect. While neglect may be seen as being central to the field of child maltreatment – its incidence, aetiology, effects and treatment – difficulties in defining what constitutes neglect have contributed to the lack of high quality research and the lack of agreement about how best to treat it and measure it (Garbarino & Collins, 1999). Statutory and legal definitions are vague and differ widely, nationally and internationally; clinical definitions vary from agency to agency and among professionals; research definitions are neither standard nor universal – inevitably, this affects reporting systems, intervention and treatment programs, research and policy planning (Zuravin, 1999). Arriving at a standardised operational definition of neglect in the United States has been impeded by definitional debates concerned with numerous issues such as whether or not definitions should be:

- broad and general or narrow and precise;
- based on instances of actual harm or potential harm;
- inclusive of incidents of emotional harm (also referred to as psychological harm);
- encompassing of all acts that jeopardise the development of children;

- focused on harm to the child, or parental behaviour, or a combination of the two;
- concerned with parental intent. (Zuravin, 1999, p 25)

There are two major issues in the continuing debate occurring in the United States. The first concerns what specifically lies within the scope of neglect – whether neglect should include potential harm or only actual harm (Zuravin, 2001; Dubowitz, Pitts et al., 2005). The difficulty is that the nature of neglect is such that it is often not possible to classify it in terms of either “risk” or “harm”, as the “harm” to a child as a result of omission of care in neglect is often neither imminent nor observable (English et al., 2005). The second major issue in the conceptual debate is whether child neglect should be viewed in terms of the child’s basic needs not being met or be deemed to occur on the basis of parental omissions of care (Dubowitz, Pitts et al., 2005, p 494). This also raises the central question of what the basic requirements of children in this age group are (see, e.g., English et al., 2005; Dubowitz, Newton et al., 2005). The needs-based approach can be seen as an attempt to address the fundamental problem of attending to neglected children’s needs, which are not taken into account within a risk assessment approach to child protection (Jack, 1997, 2000; Parton, 1998).

The debate is still at a very early stage in Australia, but the following have been described as central elements of the concept of child neglect:

- Acts of omission or commission (parental intent) – distinctions made between acts of omission and commission are quite tenuous, as children may suffer serious neglect as a result of both “deliberate actions” and “extraordinary inattentiveness” on the part of parents (e.g., failure to seek medical care and refusal to accept medical care have the same outcome).
- Standards of care – it is central to defining neglect: what constitutes “adequate care” necessarily varies with age or developmental level. The question is what constitutes acceptable and unacceptable standards of care between the obvious extremes.
- Severity of consequences – the level of severity of consequences is difficult to quantify and the type of harm (e.g., physical, psychological, developmental) varies among definitions.
- Actual or potential harm – debate around the focus on risk of harm, or actual harm, or both (with “risk” being poorly defined and difficult to assess).
- Chronic neglect versus the single episode – there is an important distinction to be made between a persistent failure to meet a child’s needs and a single episode of neglect.
- Individual versus community focus – the majority of definitions focus on the child and the individual parent and the failure of parental (maternal) care. An ecological approach draws

attention away from individual pathology as a cause of neglect, towards the role of the community and structural causes such as social disadvantage, poverty and social isolation. (Lawrence & Irvine, 2004, p 8–9; see also Jack, 1997, 2004)

Assessment of “risk” and discriminatory practice. Although risk assessment has become central to child protection practice with children and families, and has been promoted as the most reliable way to prevent maltreatment, recent research has suggested that “children are being left in situations, leading to further maltreatment, by the very agencies responsible for their protection” and that risk assessment “is implicated in any problems that children’s protective services face” (Gillingham, 2006, p 86–87). The widespread adherence to a discourse of “risk” in child protection practice, policy and research has been brought into question, particularly in Australia and the United Kingdom (Firkins, 2003; Gladstone, Boydell & McKeever, 2006; Goddard et al., 1999; Hayes, 2006; Parton, 1998). The problem is, just as definitions of what constitutes “child abuse and neglect” differ, so do definitions of what constitutes “risk” of abuse and neglect (Bromfield & Higgins, 2003). In addition, concepts such as “risk of harm” and “actual harm”, like the different maltreatment categories, are used interchangeably in practice (Gillingham, 2006). Critics argue that there are dangers and shortcomings in an approach to child protection that is based on a medical/disease model of abuse and heavily focused on individual pathology (Broadhurst, 2003; Goddard et al., 1999; Jack, 1997; Masterson & Owen, 2006; McConnell & Llewellyn, 2005; Murphy &

McDonald, 2004; Parton, 1998). They claim that such approaches focus on the assessment and management of risk when they should be aimed at meeting the needs of children or responding to child maltreatment (Goddard et al., 1999; Jack, 1997, 2000; Parton, 1998).

It has been repeatedly shown that the construction of maternal identity is “integral to risk assessment” and involves moral judgements about what mothers should or should not do – “images of mothering are found repeatedly in the files and where these images are breached, children receive surveillance” (Parton, Thorpe & Wattam, 1997, p 214–15; Horwath, 2006). The “feminising of neglect”, the “idealisation of motherhood” and “mother blaming” in child protection practice have numerous implications for both practice and research (Allan, 2006; McConnell & Llewellyn, 2005; Turney, 2000), as does the absence of fathers from the child protection discourse (Daniel & Taylor, 1999; Taylor & Daniel, 2000). Studies have also found that in cases of maternal mental illness, and intellectual disability, workers attribute parenting difficulties to parental pathology or incompetence; and poverty, isolation and other deprivations are increasingly being perceived as risk factors rather than explanatory factors (e.g., Gladstone, Boydell & McKeever, 2006; Jack, 2000; Masterson & Owen, 2006; McConnell & Llewellyn, 2005, 2000; Tanner, 2000).

Rural issues. There is even less research on either neglect or child protection in rural areas in Australia, but there is evidence to suggest

that there are unique problems facing social work and health practitioners in small rural and regional communities – such as remoteness and isolation, lack of theoretical knowledge and understanding of neglect and evidence based practice, power relations, and community, family and personal relationships. Given that the main factors associated with child maltreatment are poverty and social and geographical isolation, the investigation of neglect in rural areas is highly justified. One study in Victoria found that rural social workers have the lowest level of knowledge and application of evidence based practice (Murphy & McDonald, 2004), which has important consequences for an issue as complex and difficult to identify and assess as neglect. Problems of power, status and marginalisation of social workers in multidisciplinary health care teams and in child care proceedings in rural communities have also been found (Murphy & McDonald, 2004; Dickens, 2006, respectively). This has important implications for communication and collaboration issues which have been shown in other (non-rural) research to be a critically important area of concern in child protection (see, e.g., Firkins, 2003).

Horwath's (2006) study of child neglect in rural areas of the Republic of Ireland revealed that being more visible and having personal knowledge of children and families influences referral practices, with social workers expressing particular concern about how referring families to child protection would be perceived in the community (p 13 of 19). A review of the case files in the same study suggested that perceptions of neglect varied from worker to worker but also

according to location; workers assessed neglect in different ways in the different “community care” areas (Horwath, 2005b, p 79). The study highlights that “it is not just the nature of the concern that influences referral practice but a range of other factors that are not related to the needs of children” (Horwath, 2006, p 1 of 19), which lends support to other findings that assessment practice is as much a moral and ethical activity as a technical-rational one (see, e.g., Gregory, 2005; Parton, 1998; Parton, Thorpe & Wattam, 1997).

Conclusion

This review substantiates allegations of the “chronic” neglect of neglect in research, policy and practice. On the other hand, the review provides evidence that some progress is being made. The main barrier to continued progress is the complex nature of this issue. Child neglect is a multidisciplinary problem; its inherent complexity highlights the need for a multidisciplinary response to it. Critics are now beginning to recognise the connections between poverty, hopelessness, child maltreatment and child welfare structures. Changing and improving child protection legislation, practices and social policies is the only way of providing hope for a better life for families under stress (see Wilson & Horner, 2006).

Child protection services are the first and foremost statutory bodies: practice is closely tied to the relevant legislation in each jurisdiction; that is, to the objects, powers, principles and definitions outlined in the different Acts. Child neglect, particularly in infancy and early

childhood, is also a medical, welfare and social issue which needs thorough assessment and a rapid response. It is of fundamental importance, therefore, to provide legislators and lawyers, together with medical practitioners, nurses, social workers and child protection workers with better understandings of this complex issue if we are to develop definitions, responses and interventions which attend to the unmet needs of young children – as opposed to the current forensic approach which focuses on the parent as “perpetrator”.

Examining the nature of neglect in relation to infants and very young children would provide a unique opportunity to explore the concept of neglect in terms of the child’s developmental needs and would be a logical next step towards the prevention of chronic neglect and its devastating long term effects. A better understanding of what constitutes neglect in this age group, its wide ranging effects and the factors that are associated with it must be achieved if we are to see an improvement in definitions of and responses to the needs of these children and their families.

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Health and wellbeing of intermarried Filipino women

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Abstract

Racial intermarriage can be viewed both as a global trend of human interaction and existence and a social phenomenon which has many stories to tell. Migration to a new country is a challenge to many migrants, particularly for those whose culture is very different from that of the target country. It is a journey which requires emotional intelligence of the migrant to handle possible culture shocks. Although there is abundant information about intermarriage between Filipino women and Australian men, particularly in the press and e-communication, little research has been undertaken to examine the acculturation of intermarried Filipino women into the Australian socio-cultural discourse. This paper highlights some issues about the wellbeing and health of intermarried Filipino women such as intermarriage context, culture shock, expectation and the importance of social networking.

Keywords: health and wellbeing, intermarriage, acculturation, ethnicity, migrant

Introduction

As the world is metaphorically viewed as a global village, people of different cultural and racial backgrounds have the opportunities to share their world views and experiences across national boundaries. Due to the multicultural and multiracial nature of Australia, intermarriage between people of different cultural and racial backgrounds has become a common social phenomenon.

Different from some Asian countries such as Japan, Vietnam, Korea and China, Australia is the land of migrants in the sense that many Australians have a migrant background: they or their parents or grandparents were born overseas. There is a tendency that some migrants prefer to marry someone from the same ethnic background. Another social phenomenon is the intermarriage between Australians and their spouses from a different country. The intermarriage of Filipino women and Australian men has become a common social phenomenon in Australia.

Intermarriage and the subsequent migration of Filipino women from the Philippines require great efforts of the migrant to acculturate into the Australian society in general and into the rural areas of Tasmania in particular. There are successful cases and there are also culture shocks and various problems facing Filipino wives in adapting and coping with personal, social and cultural problems.

Intermarriage

Racial intermarriage has been a growing social phenomenon in the world. Basically it refers to marriage of two people of different races. There are different contexts of racial intermarriage. In one context, it can be seen as a very rare phenomenon whereas in another context, it is seen as a common phenomenon. There are three main contexts of intermarriage on the basis of ethnicity and nationality.

Context 1: intermarriage of the same nationality but different racial background.

In a multiracial society such as the United States, Australia, and Canada which are “young” nations, the intermarriage of people of different racial backgrounds is a common phenomenon. In Australia, due to the fact that many Australians were born overseas, racial intermarriage among white Australians or among Asian background population have been a contributing factor to the cultural and racial melting pot of Australia.

Context 2: intermarriage of different ethnicity and nationality.

For the past two decades, Australia has witnessed the phenomenon of intermarriage of different ethnicity and nationality. It is normally the case that white Australian men marry Asian women but not the other way round. The intermarriage between Australian men and Filipino

women is more widespread than the one between Australian men and women of other Asian countries.

Context 3: intermarriage of the same ethnicity.

Older parents tend to hold the traditional view that they prefer their children marry people of the same ethnicity. This view is popular in big cities where there are strong ethnic communities such as Cabramatta and Bankstown in Sydney and Footscray in Melbourne. There are also many cases of Vietnamese and Indian Australians going back to their original home countries to marry spouses of the same ethnicity and sponsoring them to migrate to Australia.

According to Cooke (1980), although marriages between Filipinas and foreign men have taken place for a long time, these have generally been contracted in the context of traditional colonial and economic ties. Cross cultural marriages in the Philippines, therefore, have commonly been contracted between Filipino citizens on the one hand and American or Spanish nationals or members of overseas Chinese groups on the other. This practice persists but, in the last decade, there has been an increase in the number of brides who were not leaving for countries that are linked traditionally to the Philippines such as the United States. A noticeable trend has developed wherein marriages are contracted between Filipinas and nationals from a number of European countries, as well as from Japan, New Zealand and Australia.

Mowatt & Wall (1992) points out some problems that relate to different expectations of the marriage due to cultural values, including attitudes to the family and extended family. The Filipino wife, for example, may expect to provide some financial support for needy family members; expect her parents, if they are in Australia, to live with her; expect to socialise with the family and friends; and expect to speak her community language. Other differences relate to the care of the children, religious practice, financial management and food. The unfamiliarity with the Australian lifestyle, compounded possibly by isolation in the suburbs, lack of employment, the husband's opposition to his wife working, non-recognition of qualifications, lack of appropriate child care and settlement issues experienced by some. New settlers would not have sufficient knowledge of the Australian legal system, specifically in relation to divorce, maintenance, access to and custody of children, plus police intervention in cases of domestic violence which the migrant wives might confront later.

Many Filipino women engage in interracial marriage. In 1989 alone, over 700,000 Filipinas were married or became fiancées to Australians, Germans, Taiwanese and British. In Australia, a total of 20,000 Filipino women are married to Australian men, some 90% of whom came through the system of serial sponsorship. In 1995-96 hundreds of Filipino women were married in a mass ceremony to the members of a religious organisation called the "Moonies", the majority of whom are South Korean men; and in the United States,

some 50,000 Filipinas married through the mail order (sic) practice (National Commission on the Role of Filipino, 2004).

The surge in interracial marriage between Filipino women and Australian men builds the desire of men in Australia to look for partners in the Philippines (Cunneen, C. & Stubbs, J., 1996).

Acculturation and potential problems

There are some similarities and differences between Filipino and mainstream Australian cultures in terms of politics, religion, language, and traditional views and beliefs. The acculturation process of intermarried Filipino women in Australia to a large extent is influenced by the gap between the two cultures.

There are also factors which could affect the wellbeing of Filipino women who migrated to Australia on an intermarriage basis. These include:

- English language competence,
- educational background,
- familiarity with mainstream Australian culture,
- social networking, and
- area/location of residence.

English language competence

Halliday's theory of language provides a very comprehensive view of language which is more pragmatic than other theorists such as Chomsky and Skinner (Halliday, 1994). According to Halliday (1994), people know what language is because they know what language can do for them in real life. Thus one can argue that the limit of our language is the limit of our world. This statement indicates that when Filipino women come to Australia, they can be at a disadvantaged position if their knowledge of English is very limited. Their limited English can confine them to a narrow domain of interaction, mainly with their Australian spouses and their families. As language is fundamental to communication and interpersonal relationship, Filipino women with little English could be placed in a socially isolated cell and this could lead to over dependence on their husbands. These Filipino women are used to a social environment in the Philippines where they live and share their feelings and thoughts daily through verbal interaction. Now in the Australian context, the lack of social interaction can be detrimental to their wellbeing and health.

Educational background

Education is seen by many Asian people as a magic key to the social and intellectual world. Education enhances cognitive ability and broadens one's world view. In many cases, Filipino wives are more educated than their Australian husbands. The gap between the educational backgrounds of Filipino wives and their Australian

husbands can be detrimental to their relationship and understanding. For example, Filipino wives may prefer academically orientated activities such as visiting a library or a museum, whereas their husbands may prefer social activities such as attending a wood-chopping carnival or drinking at a local pub with their mates. The opposite situation also happens in terms of educational gaps between Australian men and their Filipino wives.

Filipino women with high educational backgrounds, for examples university graduates, may accept their domestic role as devoted housewives in the initial stage of their intermarriage. However it is not uncommon for some Filipino women to aim at jobs which suit their educational qualifications. Some may extend their education by undertaking advanced courses at TAFE colleges and universities. There are positive situations in which the Australian husbands provide full mental and financial supports to their Filipino wives to strengthen their academic achievement. However, there are also cases in which conflicts occur between husbands and wives and the conflicts could lead to depression and mental suffering due to lack of understanding and communication.

Familiarity with mainstream Australian culture

The Filipino culture has been strongly influenced by Western cultures, mainly Spanish and American. Historically Spain and the United States occupied the Philippines for a substantial period of time. This is clearly indicated in music, religion, government, food, and sport. However there is a traditional Filipino culture which is still very deeply

rooted in the hearts and minds of Filipino people such as strong family solidarity, close community with its collective spirit, world views and spiritual belief (Burma, 1951; Cornell & Hartmann, 1998).

It is possible that conflict arises when Filipino women live in a mainstream Australian cultural environment. They tend to expect their children devote more time and financial assistance to them when they get older. Their children, particularly those who have little contact with Filipino communities, may be brought up and educated with values and world views quite different from their mothers. Such discrepancy can lead to unhealthy relationships between Filipino wives, their husbands and children, which affect particularly the emotional life of Filipino women.

Social networking

Social networking plays an important role in the life of intermarried Filipino women in Australia. As stated, Filipino women are strongly family orientated in the sense that family members support one another mentally, emotionally and financially regardless of age, gender and social status. Thus while Filipino women are living with their children and husbands in Australia, they still maintain a strong family tie with their families in the Philippines. It is not unusual for them to send money back to their families to support them such as providing health care for their parents and siblings and supporting their nieces and nephews to further their education.

There are social organisations which have been established to promote social networking for Filipino women and their families. These organisations tend to be very active in big cities. For those living in remote and rural Australia, social networking with other Filipino women is very limited.

The loss of close family ties or disruption in social support has been identified as a common stressor encountered when migrating to a new country (Bollini & Siem, 1995). The level of social support a migrant receives influences the way they adapt to their new country (Barankin, Konstantareas, & DeBosset, 1989). It is important to have an appropriate level of support from family or friends as they are a “source of pleasure and companionship and can buffer stress” (Adams & Blieszner, 1995). Thus, migrants who are able to maintain some level of social support with friends and family or can build new friendships will be able to adapt better and experience less stress compared to those who cannot (Jehobo, 2001).

Nevertheless, there are Filipino women who are “mahiyain” in nature, which means shy. They prefer not to socialise with other people aside from family members and close friends. This also puts their situation in danger especially when they live in a new cultural environment. For example, some intermarried Filipino women stay within a violent relationship and because of their so-called cultural values “hiya”, they are ashamed of letting people know about what is happening to them and they are also afraid of more possible violence (Abano, 2006).

Area or location of residence

For those Filipino women who had lived in big towns and cities in the Philippines before they migrated to Australia, the cultural transition has been a difficult one. The situation becomes more pessimistic when they have to live with their new husbands in remote and rural Australia. Migrants tend to group together in suburbs such as Footscray in Melbourne and Bankstown in Sydney. In these suburbs, they are living in “a home away from home”. They can have access to public and private services using their native languages. Filipino women find it hard to acculturate into a rural community with little or no support for their acculturation. Further problems occur if the rural people are not familiar with “foreigners” living in their community and may have negative views and attitudes towards them. In this case, Filipino women can be subject to prejudice and discrimination.

Culture shocks

Migrants meet some challenges in the new environment and one of these is culture shock. The term, culture shock, was introduced for the first time in 1958 to describe the anxiety produced when a person moves to a completely new environment (Guanipa, 1998). This term expresses the lack of direction, the feeling of not knowing what to do or how to do things in a new environment, and not knowing what is appropriate or inappropriate. The feeling of culture shock generally sets in after the first few weeks of coming to a new place (Guanipa, 1998).

Guanipa (1998) further describes culture shock as the physical and emotional discomfort one suffers when coming to live in another country or a place different from one's place of origin. Often, the way that we lived before is not accepted or considered as normal in the new place. Everything is different, for example, not speaking the language, not knowing how to use the banking machines, not knowing how to use the telephone and so forth.

The description of culture shock here best describes what intermarried Filipino women may face in their first few months living in rural Tasmania.

According to Walker & Le (1999), the acculturation process normally consists of the following stages, cognitively and affectively:

- *Conflict*: This is a shock stage as a new culture is rejected as a whole, due to negative attitudes towards the new culture.
- *Confusion*: This is the time when negative attitudes toward the new culture are challenged by other people or events, or when the new culture becomes a part of that person's life.
- *Exploration*: Accidentally or intentionally, a few "things" about the new culture are discovered.
- *Familiarisation*: Learning more about the new culture in order to function well in it.

- *Acceptance:* The new culture has been accepted. The crisis has disappeared.

Health issues

Wellbeing has four dimensions which are important for migrants:

- The physical state centres on one's health and sense of wellness, satisfying physical needs through a healthy lifestyle.
- The material state centres on essential needs such as shelter, food and financial resources.
- The mental state centres on the need to learn, grow, achieve, to be recognised and accepted.
- The spiritual state centres on a person's religious/philosophical needs and may provide powerful support for values, morals, strength of character, and endurance in difficult and dangerous circumstances (Department of the Army, 2007).

If all these dimensions work together, there is a sense of wellbeing and people are more equipped to deal with various problems and stresses in life.

Health is very vital for the intermarried Filipino women because health is vital to their existence, especially in a country like Australia where everyone is health conscious. Health for them is the primary source of happiness; the main reason is that being sick makes them

feel lonely and particularly homesick of family members in their homeland. In the Philippines if someone is sick in the family, he/she is being served and looked after by their parents or siblings. They are well looked after by their devoted family members. Filipino women find it hard to be sick in their new home especially if they are coming from the rural parts of the Philippines where they rely on herbal medicines. When they get sick they are looking for the herbs that they used to drink even though there are lots of tablets or medicines available in the chemists here in Australia.

Before intermarried Filipino women come to Australia, they apply at the Australian Embassy for a spouse visa and once granted the visa, they are given some information about living in Australia, particularly about health services. They tend to have a high expectation of the health services, due to the information received from others who came to Australia earlier.

For the intermarried Filipino women, health and wellbeing is something that is mutually inclusive, which means if a person is healthy he/she is free from all the stress and hassles physically, emotionally, mentally and spiritually. Wellbeing in the Filipino eyes is a satisfaction about everything in life. According to Richard Eckersley (2004), wellbeing is more than about living “the good life”; it is about having meaning in life, about fulfilling our potential and feeling that our lives are worthwhile. For intermarried Filipino women, to attain a good health and wellbeing is hard in the first few years because they have to cope with the new environment, new cultural values, new

food, new family, new set up and so forth. When the women move to Australia, their families expect that they are physically, mentally and emotionally looked after by their spouses and the public health services.

Changes in the type of medical care after migration may also affect health (Jehobo, 2001). Migrants tend to bring with them several types of medical systems and medical services have accompanied migration from immigrants from all around the world. One example is Chinese herbal medicine. Immigrants from countries that do not culturally and traditionally practice biomedicine (the most dominant medical system in Australia) may be faced with problems choosing an appropriate medical service and the decision to use mainstream medical services may affect their health. Some may decide to remain with the service that they relied on in their original country. For example, it was reported by Jehobo (2001) that many Vietnamese immigrants often rely on Vietnamese therapies to treat physical illnesses due to their lack of faith in biomedicine.

Although there may be changes in health, the changes do not necessarily have negative effects. For instance, an individual may have migrated from a place of poverty to a country where there is better sanitation, easier access to medical advice and nutritious food. Thus, one can expect that the general health would improve in these situations. It has also been argued that a migrant's health would be better than a native (or non-migrant) (Jehobo, 2001).

Conclusion

Migration to a new country is a challenge to many, particularly for those whose culture is very different from that of the target country. It is a journey which requires emotional intelligence of the migrant to handle possible culture shocks. For intermarried Filipino women, life in a new country can bring both joy and misery depending on the support that they receive during their acculturation process. Living in remote and rural Australia is a big adventure to many intermarried Filipino women. It can be a paradise for those who are enthusiastically keen to take the challenge. It is also an exile for those whose expectation and dream have never been achieved.

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Development of culturally appropriate counselling for African men in Tasmania: Background and progress to date

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Abstract

This study seeks to identify culturally appropriate counselling methods for African men who have arrived in Tasmania as refugees. Acknowledged obstacles to service delivery include the impact of cultural transition, the effects of having endured torture, war and deprivation, and the lack of commonality between African and western help-seeking and help-giving assumptions. This paper provides a broad background to the problem under investigation, outlines some of the methodological issues addressed, and presents some extracts from the pilot phase.

Keywords: counselling, cross culture, migrants, refugees, health services

Introduction

This study has its origins in my long-standing interest in the conceptualisation of counselling as an existential interaction, coupled with a desire to engage in phenomenological research as a natural partner to existentialist practice. I have worked with a range of client groups, including complex cases where formulaic outcome-oriented counselling models struggle to account for either the extensive and sophisticated attempts by some clients to effectively address the issues, or for the sense of helplessness and powerlessness on the part of the therapist. The notion of existential encounter allows for meaning-making and collaborative partnership between the client and therapist, including their respective human limitations and frailties, as well as chance events.

When I was confronted by the challenge of responding to the needs of clients of the Phoenix Centre⁷, most of whom were refugees of African origin, I felt that it would be particularly helpful to focus on the universal aspects of the human condition offered by an existential model. There were essentially two major challenges, in addition to the pragmatic problem of language translation: one was that many within the client group had suffered treatment that was so horrific that it defied imagination, let alone understanding. This had a number of apparent effects, including the difficulty that oftentimes, a genuine

⁷ The Phoenix Centre is the Tasmanian service funded by the Australian Commonwealth Government to provide counselling support for refugee survivors of torture and trauma

empathic response was beyond the emotional range of most counsellors, which interfered with their attempts to assist.

The second challenge was that these extreme experiences, and the clients' attempts to deal with them, were contextualised within cultural norms that were in many respects strange to western eyes. Despite the efforts that therapists made to familiarise themselves with clients' cultural backgrounds, and clients' ongoing attempts to negotiate their identities within the western systems that now informed their lives, this lack of shared experience resulted in many misunderstandings and confusions. Given that, faced with extreme challenges, most people rely on culturally familiar coping mechanisms, the gap between therapist and client was even greater for the most affected clients. It was therefore unsurprising that western therapeutic models, originating as they do from western cultural norms, might be expected at times to prove inadequate. I was suspicious of a frequently cited claim by many counsellors in the field that "Africans do not understand the concept of counselling", which I felt was more likely a reflection of the inadequacy of western methods rather than a conceptual deficit on the part of Africans. It seemed to me that this was a circumstance which would test the most inclusive of western approaches, and that applying the principles of existential encounter (which seek to emphasise that which is common to all humans) and phenomenological research (which emphasise the therapist's and/or client's lived experience) might prove fruitful. I found that Eastmond (2000) has summarised my observations well (p 67):

The afflictions and suffering of many refugees call for our human engagement as well as for interdisciplinary enquiry. Such an inquiry also needs to be critical and reflexive.

A third dilemma became more evident as the study progressed, and is again well described by Eastmond (2000), p 68:

...this is a question of capturing patterns of social relations, cultural meanings, and identities in the process of their disruption and transformation.

One of the processes of transformation that I witnessed was the development of western style counselling expertise by many of my participants through their exposure to formal training in social work, psychology and welfare studies. When this subject came up in one interview in the pilot phase, my participant contrasted the African style of counselling with the western style:

(Now) I am trying to help like a baby walking. If I can leave and it walks properly, then let it go its way. If there is trouble I hold the hand until they are walking. I used to work the African way; but it meant that they wouldn't be independent by themselves; they come back tomorrow and tomorrow. (P5)

This shift was accompanied by a recognition of the different social and legal issues that a western counsellor faces:

Because it is important not to work the African way: because of the way things work here. You will be in trouble if you keep advising them; they

*will say “X told me to act so” and the trouble will come back to you.
(P5)*

Also, I found myself hearing the familiar western practices recontextualised and integrated practically and linguistically in novel and attractive ways:

For example with their children: you must consult with the people and point out consequences. Now what do you think; how are you going to deal with this? What have you done so far; what is the outcome; how is he going to do it, the what what what? How do you feel or think about that? But this way makes them very responsible for their problems. I am more relaxed now. (P5)

These examples show the powerful constraints restricting the development of clearly defined methods of culturally appropriate counselling. They emphasise the need for a responsive, reflective approach to the research, allowing for the recognition that answers would not necessarily be definitive.

Existentialism and phenomenology

Buber (e.g., Buber, 1958) provides an early description of the existential encounter: a thorough-going acceptance of each individual by the other, with each being open to all of the contradictions of the other. This idealised relationship was famously developed as the basis for client-centred counselling by Rogers (e.g., 1951). However, in order to appreciate the capacity of the concept of existential

encounter to generate new approaches to counselling, it is instructive to recognise, as Buber acknowledges (Buber, 1965) that its origins are found in the struggles by 19th and 20th century philosophers to overcome the challenges implicit in the works on epistemology and morality by Immanuel Kant (Abbott, 1909). These challenges were pivotal in the development of western society. For example, Kant identifies that any claim of objective knowledge of the world by human consciousness is open to challenge (human consciousness cannot know itself, and therefore cannot be precise about the limits of its knowledge), and that there are profound limits to what can be contained within any notion of universally applicable morality (moral decisions presuppose subjective choice, and therefore free will is guided by reason, not edicts). Despite the technological advances made possible by the implementation of the scientific method initiated by Descartes' famous assertion "I think therefore I am", Kant's analysis of the limitations of the notion of objective certainty led many philosophers to seek alternative ways of understanding the nature of existence.

Within this context, the early existentialist philosophers such as Soren Kierkegaard and Friedrich Nietzsche took up the challenges to absolutist ideas, undermining the legitimacy of conventional ideas of morality and human meaning by systematically showing their dependence on the notion of an objective certainty that could never be verified. In postmodern terms, they "unpacked" the meaning of Kant's assertions in relation to beliefs represented within their contemporary society. Both authors, in different ways, propose

radical positions whereby human beings were ultimately responsible for every decision. They claim that the anxiety associated with the recognition of this degree of responsibility is the true source of the power of conventional morality: humans are for the most part not moral, rather they are seeking in established norms, ways of avoiding the terrifying truth of the experience of the human condition (Kierkegaard & Kierkegaard, 1954; Nietzsche, 1994). These and subsequent writers, such as Heidegger, Camus, Sartre, and Kafka, explored aspects of human experience which became accessible when a priori assumptions were suspended. Their conclusions and explorations differ in degree and style, but emphasise the complex struggle involved in authentic expression of free will, and share the quality of being deeply disturbing.

Meanwhile, mainstream western psychology developed modes of practice grounded primarily in the hypothesis-testing “scientific method” which had enabled the unprecedented advances in natural science and technology. Perhaps in recognition of the limitations to objective certainty posed by Kant, this methodology relies on a probabilistic evidence based approach, which depends on repeatable experimental outcomes based on tightly constrained hypotheses. However, this method has limitations. In relation to psychological research, a subject’s self reports of inner experiences such as thoughts, memories, and feelings cannot be objectively confirmed. Furthermore, these methods, especially when they rely on the objective expert status of the practitioner or researcher, struggle to account for the exercise of human free will by the subject, and for

individual differences. Thus the 20th century trend is an emphasis on observable, measurable behaviour (rather than intra- and inter-psychic events) as the basis of experimental psychology, and the phenomenon that individual differences are often uncritically relegated to the status of “confounding variables” in textbooks on experimental research (e.g., Gravetter & Wallnau, 1992, p. 12). Noting this, Giorgi (1970) emphasises the need for description and exploration, and calls for a broader conceptualisation of scientific psychology.

This irony, that the preferred methods for investigation require that perhaps the central features of human psychology identified by Kant, have become a nuisance factor, obscures what may be an even more serious problem. Psychology is inherently self-referential: the scientist/observer, regardless of the precautions one takes into account for this problem, is confined by the limits of one’s own mind. Important behaviours and phenomena will therefore inevitably remain unnoticed by the scientist/observer, and through normal psychological processes, will be dismissed, denied or diminished where they conflict with the observer’s expectations of possible or meaningful behaviour. One plausible analysis would hold that this pursuit for certainty can be construed to be in itself an expression of our intrinsic existential anxiety. In this analysis, a defining feature of human existence, namely existential anxiety, provides both the motivation and the method to ensure that no meaningful study of it occurs!

In his novel *When Nietzsche Wept*, Yalom (1993) explored this feature of the challenge presented by existential philosophical thought to medical/psychological thought and practice, by fictionalising an intensely recalcitrant Nietzsche seeking assistance for his migraine headaches and other physical ailments from Joseph Breur (regarded as the young Sigmund Freud's most influential teacher). Nietzsche proves to be a difficult, if instructive, patient. The imagined interaction between Breur and Nietzsche is a device to illustrate the tension between the claim to superior objective status by modern medical practice (and by extension, scientific psychology), and the insistence on radical subjective responsibility posited by Nietzsche's existential morality. In a neat twist in the novel, Breur's crisis of meaning provides the impetus for the conversations between Breur and Freud that gave rise to psychoanalysis.

At the time of this story's setting, the late 19th century, Husserl (1982) proposes an approach which could better account for the diversity and complexity of being human. He sets out methods by which an investigator might account for these limitations, moving away from the idea of objective certainty to an emphasis on exploration of both the subject's and investigator's experiences. This approach, known as phenomenology, revolves around the paradoxical position that the closest approximation to objective knowledge or universality will be by the elaboration and conscientious exploration of the individual human experience as mediated through the senses and the cognitive structures. Husserl identifies the critical nature of the immediacy of our experience of our own lives, and notes that this has primacy: our

experiences as scientists, or students, or mothers, have as a precondition that we live our lives. It is the lived experience, or “life-world”, that Husserl targets for examination in phenomenology (Giorgi, 1970, p134). The practice of phenomenology thereby makes a claim to being able to obtain reliable, subjective information on the human condition.

Husserl considers that it is a reasonable proposition that humans generally will identify with the matter-of-fact notion that they have an experience of the world, and that other humans also have an experience of this common world, but it will differ in some way that is not completely accessible to “the other”. The convergence of experience allows the development of the claim of objectivity. Following this argument, and applying it to the practice of counselling, Yalom (1980) identifies four categories of problematic human experience which he holds to be universal: Death, Isolation, Meaninglessness, and Freedom. Existential counselling focuses on these four areas: if a problem cannot be categorised in such a way, then it is assumed to be culture-bound, or idiosyncratic.

In terms of cross cultural research and practice, existential and phenomenological thought offer ways to explore the limits of one's world view and seek points of connection with those from the “other” culture, to identify areas for development. Qualitative methods have become recognised as offering significant advantages in developing an understanding of complex phenomena, especially where such an understanding demands that the engagement with the material occurs

from a less conventional world view. Ponterotto (2002) argues that qualitative methods are ideal for exploring the complex interactions of cultural difference and therapy.

One hoped-for outcome of this research will be to enable exploration of the limitations of the existential/phenomenological approach as defined by western thinking, in forming an appreciation of the life-world as it is experienced by someone from a culturally different background. For example, existential thought is strongly tied to particular forms of meaning making (for example, intellectual analysis by individuals) which may not enable proper appreciation of some forms of African meaning making, as represented in dance, song, collectivistic traditions, and spirit based beliefs.

Preliminary investigation

With this background of understanding, in 2005 I began informally interviewing African staff to test out the areas of universal experience that might offer points of connection between western cultural norms of counselling, and the experience of African clients. Drawing on my previous experience of existential interaction, I selected themes in these encounters which seemed related to Yalom's four existential problematics, and enquired after them. I sought to obtain an understanding of some of the overt norms of African cultural experience as part of this process, but I was more interested in the personal experience of the interviewees, and how their knowledge was obtained or developed. This was also an aspect of the

counselling work I was doing with clients, although in client work the orientation was necessarily toward identifying opportunities which were relevant to the client's immediate situation, rather than providing material for my understanding.

It did not take profound intellectual activity to observe many of the most profound limitations in our service delivery. We lacked appropriate language ability, most State and Commonwealth agencies and NGOs in Tasmania lacked even basic skills in the use of interpreters, there were incidents of overt racism, and more subtle expressions of attitudes of racial superiority, there were hardly ever clear descriptions to clients about the processes they were engaged in, and unnecessarily oppressive legalistic and financial systems dominated the lives of many clients. A key consideration was that even for Africans who obtained employment within the service agencies, daily indicators of their implied inferior status impeded the effective deployment and development of their skills. For most entrants, even after several years working in Australia, our culture continues to throw up surprises which are challenging and upsetting.

The cultural moral deficit inherent in the fact that we take it for granted that one needs to be very cautious in buying a used car, is brought home by the bewilderment expressed by Africans who, on discovering the problems with their car, go back to the vendor to seek redress, only to have their rights summarily dismissed with no opportunity for this to be followed up. Other day-to-day examples of the failure of decent conduct could be overwhelming. It was

therefore difficult to find African people who had sufficient status and security, and who were sufficiently respected for their abilities, that they had confidence to engage in conversation with the assumption of existential equality. For my part, as well as feeling challenged by this evidence of the shortfalls of my culture, the stories of survival of extreme adversity which had by this time become part of the daily mix of conversation, continued to challenge my conception of the meaning of survival.

I recall one particularly compelling illustration of the gap between my “life-world” and those of my clients. A staff member reported to me that they had been sent an email by a recent arrival, which had been forwarded perhaps 20 times to all the relevant members of the community. I was told that it contained photographs that the client wanted us to see, out of respect for the interest we had shown in their experience. I was advised that the photographs were both of the same man: the first, smiling at the camera in the company of our client. The second photograph depicted an object on a table, clearly dead, and recognisably the same man. What was particularly disturbing was that the body had been reconstructed from its parts by the perpetrators of the torture. I understood that this had been specifically done in order that it be recognisable to the family, and serve as a reminder both of the torture, and of the degree of power that the perpetrators held over the community.

I was told all of this before I saw the email, or the photographs. After debriefing the staff member, I now found myself in an

extraordinary position: in addition to the involuntary exposure to horrors which occurred daily, and to the stresses of running the service, I felt an obligation to contend with a visual depiction of everything that we were making a claim to deal with. How could I pretend to empathise with people who suffered from these issues, if I would not even face the evidence? I knew also that to do this properly would take some time, a proper examination of the photographs and an emotional engagement with the issues. How do I prioritise this? Eventually, I chose a day when I already felt deeply affected by various issues, and set the afternoon aside.

Around this time I was fortunate to sit down for a chat with Edward Benjamin Ade, at that time one of the African staff working in settlement in Queensland. To my great surprise, he described himself as “an African counsellor” (as distinct from a Sudanese community worker), and very willingly outlined a description of this practice which I found moving and compelling. I immediately sensed that I had not only been given insight into African counselling practice, but at the same time been shown ways in which this practice, and the assumptions which are brought to the counselling setting, could lead to the development of approaches which would complement the mainstream western counselling traditions. Edward also had first hand, life-long experience of oppression and war, and has endured imprisonment, torture, flight, and life in the refugee camps, and enabled me to gain better access to the emotional impact of these events. I wrote down my memory of the conversation, and after a series of fortunate events, I found the opportunity to develop my

learning to that point in the context of this research project. I was particularly fortunate, (bizarrely so, given the state of cross cultural expertise prevalent in Tasmania), to encounter Dr Peg LeVine, who not only has extensive experience both in cross cultural counselling, trauma, and qualitative research methods, but was able to immediately support me in an application to commence a Masters program.

Key considerations were:

- How do I take necessary care to ensure that subjects are not abused in the process of gathering data?
- How do I test the generalisability of my learning to date across national groups and levels of knowledge of counselling?
- How do I manage the shortcoming that my understanding is based on a very limited sample?
- How do I account for my lack of first hand experience of African culture? This issue was well captured in a saying that was offered in the pilot phase focus group: “It is like you are trying to climb a tree from the top!”
- How do I give appropriate credit to the people who have provided me with this understanding, given that they are so readily subjugated to secondary roles?

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- How do I reconcile these issues with the more structured considerations and concerns embedded in the formal university ethics clearance process? For example, it was important to me that my informants had some claim to the honour of the outcome of the research, but our cultural preferences of confidentiality and privacy mitigated against this.
- How do I account for the strong gender roles inherent in African culture; for example the effect of my own gender?
- How do I manage the dual role of researcher and practitioner, and the impact of my status as manager of the service?

Many of these problems have been resolved as the process developed. For example, through my active involvement in assisting various members of the African communities to overcome some difficulties and achieve more secure positions, I have established a reputation of honourable conduct and helpfulness. More importantly, and completely unintentionally, by responding in an interested and participatory way to invitations to social gatherings, and by disclosing my hopes to research the African ways, I have shown respect to the communities. By virtue of the fact that I shaped the Phoenix Centre service according to the feedback of clients and the outcomes of my initial enquiries, I showed the potential benefits of contributing, and apparently enabled more people to be assisted more effectively. One important aspect of this was in recruiting Edward to provide counselling in his African languages, and supporting his claims to legitimacy through formal training in western

counselling methods, so that he at least could be acknowledged as an important contributor to this research. I have left the position of manager/practitioner at Phoenix, so I no longer have a dual role difficulty. I met a number of African practitioners at a conference in Berlin, who have offered to comment on my research findings to enhance reliability.

Other issues have been addressed through the project design. I restricted the study to men, to avoid the complexities of contradicting gender mores. Separate focus groups were to be composed of members of each of three nationalities to seek to identify themes at both the etic and emic levels. I began by seeking advice from a range of African staff engaged in the sector whose status was established as key informants subject to formal consent requirements. These subjects provided advice on how to conduct focus groups both to prevent harm and to maximise benefit, as well as contributing directly to my understanding of African counselling methods through their expertise. It is hoped that more reliability will be achieved by developing a questionnaire and distributing it among the African communities. I recruited a female African professional who has contributed data as a way of controlling for gender bias.

Qualitative methodology

Problems associated with working with culturally diverse populations who have suffered from extreme events have received scholarly attention in western literature since the 1950s, particularly with

respect to Polish refugees from World War II (e.g., Krupinski, 1967; Zubrzycki, 1956). Early writers on the need to adapt to the needs of particular cultural groups include Calia (1966), who highlighted the impact of the class differential between most therapists and many of their clients, and the unsuitability of conventional counselling techniques which assume access to resources, for clients in poverty. He advocated group and family techniques as possible areas for development, and, although tending to label the client as “culturally deprived” he acknowledged the potential benefits of many aspects of non-middle class culture, and the need for the counsellor to recognise and engage them. Broader ideas of the intersection of culture and therapy became prevalent in the 1980s, when the techniques of anthropology and ethnology became more frequently accessed by the social sciences in research and practice. For example, Kleinman (1980) outlines a methodology whereby a practitioner can engage with a client’s personal and cultural beliefs and assumptions in order to inform the negotiation of the treatment approach. From the late 1980s there has been a burgeoning of research studies utilising a range of methods, into the issues facing refugees and others of diverse cultural backgrounds who have suffered from extreme events (Ahearn, 2000). There has been a parallel development in the literature on the provision of therapy to clients from culturally diverse backgrounds, (D. W. Sue, Arrendondo, & McDavis, 1992; S. Sue & Zane, 1987) including specific attention to trauma (Danieli, 1998; Minas, 1994). The more recent formal codification of cultural competencies (American Counseling Association, 1995; American Mental Health Counselors Association,

2000; American Psychological Association, 2002) is evidence of the stage of maturity of the thinking about the particular skill-sets required for working with culturally different clients. Initial work has also been done on formulating appropriate interventions for approaching issues of trauma (e.g., Fernando, 2004).

Two of the themes that are evident in the literature on cross cultural counselling are the need for individual therapists to actively adapt their interventions for the client groups that they encounter (D. W. Sue, Arrendondo, & McDavis, 1992), and the notion that, as all counselling involves a requirement for the practitioner to attend to the nuances of the encounter with the client (Pederson, 1991), all counselling is to some extent cross cultural. In relation to research, there is a need for further development of appropriate qualitative methods for researching culturally diverse populations (Ahearn, 2000). Taking this logic further, referring both to the practice of therapy and research, Goh (2005) argues that specific training in cultural competency is an essential part of the skill development of a therapist. He states (p 76): *"There is almost verbatim consensus, in every definition of ethical practice by professional mental health associations, that culturally competent practice equals ethical practice. It is therefore incumbent that mental health researchers who study expertise in counselling reflect this basic assumption."*

The local socio-political context for increasing numbers of African refugees settling in Tasmania provided the trigger to examine this question more thoroughly. On the whole, the Tasmanian mental

health system is unprepared for the challenges of providing culturally appropriate services. The cultural mix in Tasmania is more homogeneous than mainland Australia: in 2001, approximately 10 % of Tasmanians were born overseas compared with 22 % of Australians as a whole (Australian Bureau of Statistics, 2001). This relative homogeneity and the associated degree of ignorance of other cultural groups is perhaps exaggerated by the effect of the more extreme decimation that was perpetrated on the Tasmanian aboriginal population when compared with the mainland states. For well over a hundred years the myth of the extermination of the Tasmanian aboriginal population was readily maintained both in the minds of the general populace and in the formal policies and population estimates of the State Government. The recognised population of people of Aboriginal descent in Tasmania was approximately 80 in 1835 (Rowley, 1970, p. 51), comprised the remnants of the group that had been resettled on Flinders Island. The number reported in the 1961 Census was 38: at that time the Tasmanian Government statistics recorded no Aboriginal people (Rowley, 1970, p367). The extent of this misrepresentation can be inferred from the current estimated resident Aboriginal and Torres Strait Island population in Tasmania of 15,773 (Australian Bureau of Statistics, 2001). The Tasmanian Government has since acted strongly to counter some of the effects of this marginalisation, by offering a formal apology, accelerating the return of tribal lands to aboriginal people, and passing the Stolen Generations of Aboriginal Children Act 2006 which includes provision for some compensation (Australian Human Rights and Equal Opportunity Commission, 2006).

Even allowing for these features of Tasmanian society, considering the increased emphasis in the literature on the necessity for development of cultural competency, the extent of the deficit within the mental health sector is hard to comprehend. The Tasmanian Mental Health Service Strategic Plan (2005-2010) (Mental Health Services, 2006) contains no reference to the requirement to implement strategies to improve performance in relation to ensuring equity of access and appropriate treatment for people from culturally diverse backgrounds, despite this being a clear recommendation from the Burdekin Report (Burdekin, 1993) and, more recently, part of the National Action Plan (Council of Australian Governments, 2006). Perhaps this is a measure of the degree of ignorance of the existence of people from culturally diverse backgrounds in the client population. This explanation fits with the lack of provision for data collection on ethnic background and preferred language, and the limited use of interpreter services (26 occasions of service in 2004-05) within the Mental Health Service (personal communication to the author by Associate Professor Des Graham, Manager of the Mental Health Service, 2006).

The extreme nature of the deficit within the mainstream services, combined with the associated need for awareness raising, training and education of the professional and general community, means that a substantial burden is placed on specialist services such as the Phoenix Centre, with no State funding to compensate. This lack of provision for development of cultural competence in counselling, recognised in many areas as a necessary component of ethical

practice, highlights the need for formally constituted research to be conducted in this area in Tasmania. The continued intake of refugees of African origin to Tasmania, and the well documented need for a wide range of assistance over a considerable period of time for African refugees (e.g., Collopy, 2007), including effective mental health care, suggest this population as a crucial one for such research.

In addition to offering better approaches for working with the Africans, I felt that a formal investigation of the knowledge embodied by this group may also offer new ways for counsellors to think about their practice with more mainstream client groups.

The main objective of this study is therefore to obtain information from encounters with the client group that can be used to develop better approaches to counselling. A robust methodology was devised in order that findings could be held to have reliability.

Study methodology: Considering issues of gender

One of the most immediately evident features of African culture, and a feature of tribal societies more generally, is that gender roles are strongly defined. In particular, issues that confront the culture as a whole are for the most part, deemed to be primarily the province of men. Perhaps as a result, the most assertive African individuals in relation to the issues that confront the African communities arriving in Tasmania, and the majority of those working in the field, are men. Many of these individuals expressed immediate enthusiasm in the

study when it was suggested, showing that there should be little difficulty in recruiting sufficient subjects.

Furthermore, the relations between men and women are more highly culturally prescribed than those between same sex individuals. The complexities that would be confronted by a male researcher exploring sensitive issues might become unmanageable if women were included in the study, assuming that female candidates could be identified. The issues of bias associated with approaching only the males are considered to be less significant than the risk of bias associated with making claims about data that could be confounded by little-understood gender relations. On both pragmatic and culturally sensitive grounds then, the study is restricted to exploring the responses of African men. However, in order to strengthen the study in relation to this identified potential source of bias, a female African counsellor was recruited to provide data.

Study methodology: Considering national differences

Of course, Africa is culturally diverse, comprised many countries each populated by a range of tribal groups, urban and rural communities, and migrants from all over the world. To generalise about the nature of African culture is in itself a form of cultural naivety. However, the term “African” was frequently used in a general sense by most of my informants and the interviewees in the pilot phase (for example, Edward’s unsolicited statement “I am an African counsellor”) so it seemed legitimate to begin with this term and seek to tease out

generalities as well as specific issues associated with particular groups. Members of different national groups could be recruited and issues explored across and within these groups. On the basis of the proportions of refugees, the nationalities selected for the study were Sudan, Sierre Leone, and Ethiopia. This differentiation is in itself a simplification; for example Sudan contains approximately 600 different ethnic groups with over 400 distinct languages spoken (Collopy, 2007). However, there is sufficient commonality of language and experience that focus groups can be readily formed where all members share at least one language. In the event, all Sudanese interviewed during the pilot phase were from Southern Sudan and shared a tribal language, and all spoke good English. No claim is made that the participants represent Sudan as a whole; however they do offer a differentiated group which can be contrasted with the participants from the other two nationalities.

Study methodology: Cultural quandary and pilot study

The very proposition of research on a minority culture through a university based study immediately asserts the dominant culture in ways which cannot be completely accounted for. Many participants were engaged in or working toward university study themselves, with the time and resources required for respondents to pursue such qualifications representing considerable sacrifices, adding to the delay in their attaining secure positions in life; and compounding their vulnerability to misfortune or ill-health. Those who did hold qualifications and expertise invariably had encountered resistance to

those qualifications being accepted in Australia, highlighting their diminished status. I wanted to find methods that could account for my privileged position, both to ensure better reliability of the research, and to avoid compromising the security of participants.

Fortunately, a natural entry point to such methods was provided by the Africans who had obtained employment in the refugee support sector. These staff quickly moved into collegiate relationships with Australian staff where this was welcomed, and readily accepted the role of cultural consultant. For them, the step to engage as a formal participant in a study was therefore quite small. A pilot phase was devised which enabled me to gain a better understanding of the issues which might confound data collection, and therefore to find ways to address them. It comprised interviews with five staff, which I recorded with hand-written notes to minimise the impact if audio or video recording were a concern for participants. All African staff were familiar with processes such as meeting documentation, case work and other records, so such a method was part of our normal day to day collegiate experience.

Our collegiate status also meant that I had the opportunity to recruit those staff who had shown themselves to be assertive in their views, which was also demonstrated in their feedback on interview summaries. These factors (shared appreciation of context and ability to assert their views) are identified as critical components of the use of participant agreement as a form of validation (Ashworth, 1993). The interviews also allowed the development of trust with those

particular participants, which enabled further interviews to be conducted with more confidence. The final interviewee became enthusiastic about the prospect of arranging a group of older Africans to discuss the role of elders, and took up the initiative to arrange a group, including the role of ensuring that they were aware that the group would be video-recorded. This gave me an opportunity to experiment with a group session as part of the pilot study, as well as to obtain valuable early group data. Due to a delay of ensuring informed consent for the video, and also due to background noise making transcription difficult, this session was partly recorded on video supplemented with handwritten notes.

The pilot phase has functioned as a navigational tool for me to develop confidence in the integrity of subsequent stages of research; particularly issues that might need attention in the conduct of group sessions with African men who had not necessarily chosen work roles in the sector. This included clarification of interviewees' opinions on the likely response by prospective group participants, to issues such as informed consent and recording, as well as to the study generally. This generated discussion around means by which I could account for obstacles, or capitalise on strengths. This enabled me to have more confidence in both the integrity of the research, and the security of participants.

A second theme that I explored in the pilot phase was interviewees' direct knowledge and experience of methods of counselling that were effective with Africans. This elicited a range of accounts of aspects of

counselling at a level of clarity and suggested a degree of expertise that surprised me: I found myself speculating as to whether I would have such a clear and compelling response, if someone asked me about methods of counselling that were effective with western clients.

An interesting feature of the development of the methodology has been that, through the working out of issues of formal ethics requirements and study expectations, a range of opportunities to orient myself to the issues of cultural difference have arisen. Although not all of them were subsequently the subject of discussion in the formal study, my ability to respond to the implications of the differences exposed have allowed me to engage in different, and I believe for the purposes of the study more effective, ways of being. This necessarily required periods of reflection and adjustment. In some cases aspects of my approach to my own life have changed. It certainly meant that I have benefited from the part time nature of the research, as deadlines have not pushed me as quickly into premature conclusions.

For example, the notions of confidentiality and informed consent for a study carry with it the assumption that an individual has the right and expectation of participating individually and without wide consultation. There are a number of limitations to this when exploring issues with people who have collectivistic, rather than individualistic, identities. I found myself at times put in the position of imposing a practice of privacy, in the sense that we mean it in western culture, on people who simply assume that their families, and sometimes their

wider communities, would be involved in any serious discussion. This did not seem in keeping with ethical practice – a very neat paradox!

In one delightful situation, I was explaining the purpose of the study and the commitment to privacy and confidentiality, to a prospective participant. We had to cut short our conversation as a death had occurred recently in the community, and I was invited to attend the associated gathering. There were perhaps 50 people present, all fitting neatly into two rooms in a house, and I felt honoured to be so warmly welcomed by so many people who did not know me. During the period when people were speaking about their loss, my host turned to me and said quietly “would you like to take this chance to explain to us all what you are wanting me to do? We are all together!” It was clear that, to some degree, virtually all the people in this gathering would be contributing to the study, whoever among them actually spoke with me.

The individualistic/collectivistic tension has been the subject of considerable discussion in the literature on cross cultural research. In reflecting on a series of studies relating to Afghan refugees in the United States, Omidian (2000) notes that:

Almost every interview, even when I was able to conduct my own in Dari or German, had family members who would come into the discussion and put their opinion, correct a statement that the principal interviewee had made or take over if the interviewee had to leave the room for a moment...After initially struggling against this routine, I gave in to what I realised was a cultural style based on family collectivity. Afghans do

not see themselves as individuals, but as part of a family. It would be rare for them to invite someone into their home and exclude others in the family from joining in. (p51)

This was one of many methodological tensions that I encountered in the pilot phase of the study. The western emphasis on privacy and individual choice embedded in university based study has become increasingly clearly a cultural preference, rather than intrinsically important to human beings. Witnessing the benefits of alternative ways of being has caused me to question these preferences and to explore the alternatives personally. I have been moved by the generosity, thoughtfulness and sheer hospitality of many of my participants and their families and communities. Oddly, my own family has seemed to me to become warmer, more relaxed, and more tolerant of each other. I recently shared my one-bedroom flat with my two ageing parents for a week, and we all seemed to find plenty of space. Are the African ways rubbing off on me? I hope so!

Results

At the time of writing, the pilot phase has been completed, and analysis of the interviews is underway. From the analysis to date, preparation for the group sessions is likely to include the following:

- Ensure good preparation including multiple mechanisms for reminder. Thorough explanations of the purpose of the study in groups, with individuals, and with key stakeholders will be

important. Mixing with the community prior to the event will be helpful. Arranging the food to be done by the women would be a key; the women will then talk about the event, as well as the men. Make a list of all possible pathways for reminder: the intention is not so much to get broad participation as it is to ensure that it is being discussed, and participants will therefore remember to attend. A secondary advantage of this would be that the issues will be under discussion prior to the meeting so the men will be primed.

- Be prepared to be repetitive in explanations leading up to the event. Prepare a speech or series of short speeches as a way of reiterating the purpose of the study, in line with the suggestions of participants. Acknowledge reasons for people having reservations (e.g., video, confidentiality, lack of noticeable benefit to participants in previous studies). Ensure that at least some of the general issues identified by the interviewees are referred to, and make it clear that discussion of those issues is not the purpose of the study. However allow some time for a Question & Answer session on these issues so that participants gain something tangible from the event.

A number of coherent descriptions of aspects of counselling have emerged from the initial interviews. These descriptions will require further research to ensure their reliability, but three extracts from the interviews are provided below to offer a sense of the richness of the likely findings.

I was doing an interpreter job once; the client said to me "What did she say she is a counsellor? What do they mean? I'm not mad! - I don't have a mental problem." I say as the interpreter she means I listen to you and see how about I can help you. Because if I have problem I need to speak with someone; if I don't speak with someone the problem might increase and bring something bad for me. (P5)

For example in working with couples, you have to ask the complete history of each man and woman separately. Next thing, after getting the complete scenario, ask if they would now like to come together. Get them to tell their stories with each other present. If one is talking the other is to be quiet – "don't interrupt your turn will come".

Ask them if they would like to bring someone with them. Ask for each party to give advice – objective is to keep couple together. Always then visit the family as a blessing; your presence is a reminder of their decision or the healing; like the Minister who married them visits to remind of the vows. (P4)

One of the reasons for the authority of the elders and for the respect paid to older people in traditional societies, is that they are the representatives of the Ancestors. People believe that if they break a taboo, or if they don't show respect to the Ancestors properly, they will come into harm. So in order to know whether they are respecting the Ancestors, they ask the older people. Also, older people have gone through much more, and perhaps they have gone through a similar problem, in which case they can suggest a solution to a problem that they found has worked before. (P3)

Although analysis of the data is in early stages, and there is more data to be obtained, I feel confident in being able to assert that such statements would be unlikely to be made by people who “don’t understand the concept of counselling”!

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How does culture play the role in pregnancy, birth and after birth? A cross cultural study of human reproduction

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Abstract

Today Australia has become a multicultural society with people having migrated from around 200 countries. Migration to Australia has involved primarily young nuclear families intending to settle permanently in Australia. Consequently, young immigrant women often experience their first childbirth in Australia. Asian migrant women have brought with them a wealth of cultural beliefs and practices about childbirth, many of which are in contrast to western medical and cultural understanding. Conversely, Australian health care professionals often lack knowledge about the migrants' beliefs and practices. Such cultural differences may result in conflict between patients and health care providers. Therefore, it presents a great challenge for policy makers and health care professionals to provide culturally sensitive and appropriate health services for communities with such diverse language and cultural backgrounds. This paper

presents a literature review on intercultural research on human reproduction.

Keywords: intercultural research, Asian migrants, cultural beliefs and practices, culture

Introduction

Australia is one of the most ethnically diverse societies in the world. Based on the 2001 census, people from around 200 countries have migrated to Australia; around 23% of Australia's population were born overseas, while an additional 20% of the population were born in Australia but had at least one parent born overseas; and more than 200 languages are spoken in Australia. This creates a great challenge for policy makers and health care professionals to provide culturally sensitive and appropriate health services for a community with such diverse language and cultural backgrounds.

Due to the selection criteria, migrants to Australia have predominantly involved young people intending to settle permanently, resulting in migrants often having their first child in Australia. Asian migrant women have brought with them a wealth of cultural beliefs and practices about childbirth, many of which are in contrast to western medical and cultural understanding of reproduction. Such cultural differences may result in conflict between patients and health care providers. Thus, there is a pressing need to understand the cultural beliefs and practices surrounding child birth of the minority community and their cultural requirements.

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This paper presents a literature review on intercultural research of human reproduction. First, it examines the culture and its relationship with health and reproductive health. Then it investigates cultural beliefs and practices in intercultural research. It continues to focus on migrant women's childbirth experience in their new country and the barriers to care. Finally, it provides a review of research on migrants in Australia.

Culture and the relationship with health and reproductive health

Culture refers to the way of living, distinctive knowledge, habits, ideas, language shared by a group of people (Linder-Pelz, 1987). A group of people can range from a few members of a family to millions of people in a nation. Culture provides its members with a world view, an ideology, acceptable behaviours and a common set of beliefs. Culture ultimately affects every aspect of daily life: how people live, how they think, how they behave and how they view and interpret the world around them. Culture is not genetically inherited. People acquire it during childhood when they absorb the basic values and norms in the society they live. It is a combined process of socialisation and enculturation.

The cultural values and norms that people learn differ from one society to another. Therefore, people of different cultural backgrounds hold different perceptions and views of illness, medical treatments and pain. As Helman (1994) states, the values and

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customs associated with ill health are part of the wider culture. People's beliefs about health and about the factors causing illness and methods of treatment are very much influenced by culture. In one culture, people see illness as a result of some combination of bad luck, external factors and individual behaviour, whereas in other cultures the causes may be explained in terms of bad behaviour, spiritual affliction or emotional stress. Culture also plays an important role in the way people make decisions about their treatment. People from one culture may choose to take herbal medicine instead of western medicine because they have been brought up to believe in the tradition of herbal medicine in their culture. Helman (1994) comments that cultural background has an important influence on many aspects of people's lives including attitudes to illness and pain, and these may have important implications for health and health care.

As discussed above, health and health care are greatly influenced by culture. Reproductive health, therefore, has a strong connection with culture. In consequence, notions of human reproduction, care of the expectant mother and the unborn child, methods of giving birth and post-natal care vary considerably according to cultural beliefs and traditional practices. The beliefs and practices of childbearing, child birth and childrearing in different cultures differ though the common aim is to maintain the wellbeing and safety of the mother and child.

Childbirth is a universal and biological event. The physical process of childbirth is similar for everyone, but not the experience of giving birth. The birth experience takes place in a cultural context and is

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shaped by the views and practices of that culture (Cheung, 2002; Jordan, 1978; Priya, 1992; Rice, 2000). For example, in Vietnamese culture, a pregnant woman must avoid seeing or hearing horror scenes or bad language as it is believed that the baby hears and sees just the same as the mother does (Tran, 1994). Most Cambodian pregnant women drink herbal brew made from a plant because according to their beliefs, it will speed up the birthing process (Douglas, 1994). In Thai culture, the placenta is important for the newborn's future health. Therefore, Thai people traditionally place the placenta and the cord in a bamboo water pie and either bury it by a tree or tie it to the branches. The placenta contains the baby's soul. If the baby subsequently becomes ill, one can ask the spirits to contact the soul in the placenta and ask the baby's soul to come back (Priya, 1992).

These examples indicate that cultural beliefs and practices have strong influence on childbirth experience of women from different cultures. Rice (1994) states:

Every society provides a system of knowledge and behaviours for coping with life crisis of childbearing. This system includes sets of beliefs and practices concerning pregnancy, parturition and the puerperium; the social organisation of birth; and the mobilisation of emotional and social support. In different cultures, pregnancy, parturition and the puerperium are each and therefore experienced differently.

Rice (1994, p 1)

Cultural beliefs and practices in intercultural research

There are three approaches found in the literature. First, researchers have investigated the cultural beliefs and practices around childbirth within one country. Second, they have examined birthing practices across different countries. Third, researchers have focused on a particular group of ethnic minority women living in their adopted country. The first two approaches are addressed in this section.

Cultural beliefs and practices around childbirth within a single country have attracted a lot of interest from researchers (Egwuatu, 1986; Kaewsarn, Moyle, & Creedy, 2003; Kit, Janet, & Jegasothy, 1997; Liamputtong, 2004; Maimbolwa, Yamba, Diwan, & Ransjo-Arvidson, 2003; Liamputtong, 2005). Kaewsarn et al. (2003) conducted a survey on traditional postpartum practices of 500 Thai women in Thailand and found that the most popular practices after childbirth of Thai women are sexual abstinence and restricted activity, taking hot drinks and hot baths, food restriction, practices to maintain body heat such as “lying by fire”. Liamputtong et al (2005) provides detailed descriptions of traditional childbirth beliefs and practices related to dietary, behavioural precautions and preparation for an easy birth among Thai women in Thailand. For instance, during pregnancy, Thai women believe that they should not have certain kinds of food for example papaya salad or pickled food as it is believed that they may have a negative effect on the health and wellbeing of a foetus. Women are also warned against the consumption of spicy food as the baby may be born hairless. In

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addition, it is believed that the consumption of coffee and tea will make the child unintelligent.

The above studies focused on the role culture plays in pregnancy, birth and after birth in a particular country. Their findings provide some insights for health professionals and assist them to better understand women from different cultures. However, this work was undertaken with women in the familiar environment of their homeland. What happens to the women who are no longer in their cultural environment and who have settled in a new land? Do they still observe and follow their original cultural beliefs and practices? These questions result in the third approach in the literature which will be examined later in this paper.

The publication of Hart et al (1965) *Southeast Asian birth customs: three studies in human reproduction* can be considered as an early form of cross cultural study in human reproduction in which three studies in human reproduction are presented in one book with the purpose of comparing cultural similarities and differences of beliefs and practices associated with pregnancy and birth among three cultures in Southeast Asia. Their contribution should be viewed as pragmatically significant since they presented a collection of customs associated with birth across different cultures, given in the context that knowledge in this area was not always available in English and rarely found in publications. Culture exists in every society and affects all aspects of life including health and health care. People from different places have different culture and different point of views towards health and health care. What makes sense and is

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normal and acceptable to people in one culture may be shocking and unacceptable to people in another. However, every culture makes sense to the people within it (Schott & Henley, 1996) and they are all equal and should be respected (Branch, 2003).

A significant contribution to research in cross cultural study is the work of Jordan (1978). She focused on how she perceives the childbirth systems in Yucatan, Holland, Sweden and the United States as an anthropologist and investigated the range of the biosocial production of childbirth practices across different systems. Jordan describes the childbirth event in four different cultural settings as “a medical procedure” in the United States, “a stressful but normal part of family life” in Yucatan, “a natural process” in Holland and “an intensely personal, fulfilling achievement” in Sweden. She broke new ground by her contribution of cross cultural comparison to the development of maternity policies which could accommodate cultural values. Jordan (1978) recognises the importance of the cross cultural comparison in childbirth as:

Cross cultural comparison can be expected to provide information for a better understanding of the process of childbirth, an understanding that is not available from the inside point of view of any particular system. To the extent that comparison is made within a biosocial framework, we should expect to get two sorts of results: one regards biology, that is to say the physiological – medical aspects of birth. The second should tell us about the ways in which childbirth is socially organised and culturally produced. Both types of results should provide guidance for strategy

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considerations regarding the unavoidable change of contemporary ways of doing birth.

Jordan (1978, p 4)

Chu (1993) conducted one of the most comprehensive studies on cross cultural childbirth in Taiwan and Australia. She points out that reproductive beliefs and behaviours are shaped by cultural, social and individual factors. She shows that there are many cultural differences in diet and behaviour between Chinese and Australian women during the postpartum period. She argues that different beliefs and behaviours in postpartum care result in varied health outcomes of the new mothers. For example, her study found that postnatal depression was reported by a significant number of Australian women who received less support during the month after childbirth and had social pressure to recover their strength and figure. In contrast, postnatal depression was rarely found among Chinese women who received family and social support and plenty of rest during confinement. Her work is valuable as it raised the awareness of health care providers of the traditional explanatory models of illness in Chinese culture that would help improve the services they provide to Chinese clients in Australia.

More recent cross cultural study takes a different approach – “childbirth as a system operating within a specific cultural context” (Shi, 1999). As stated earlier in the first approach in human reproductive research, questions are raised whether the women who no longer live in their familiar culture and environment still observe

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and practice their original cultural beliefs. This new wave of the literature aims at answering that question.

Migrant women's childbirth experience in their new land and barriers to care

Living in a new country is never easy for migrants as they have to face new environment and new culture which are often completely different from their own. Therefore, before going further in explaining the third approach in reproductive research, it is necessary to understand migrants' birth experience in their new land and the barriers they have to face. Schott and Henley (1996) state:

For many, life outside the security of the home becomes a series of exhausting compromises and adjustments, many of them touching people's deepest feelings and undermining their confidence. The personal and social skills that worked in their own culture may no longer be effective. And it can be hard to understand those that are effective in the new culture and harder still to adopt them.

Schott and Henley (1996, p 23)

Being a new mother and migrant in a new country simultaneously makes a woman's experience more complex because for most of the immigrant women this could be the first time that they interact with the health care system. For the first time they have to deal with a system which is completely different from what they experienced in their original country.

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Current literature suggests that non-English speaking background (NESB) women experience less adequate and appropriate health service provision in their new country. Research found that Asian women were less likely to schedule a cervical pap smear while under obstetric care, less informed about reproductive health issues such as the advantages of breastfeeding and the need for breast self-examination and made less use of services such as parenting classes or postnatal exercise groups than their non-Asian counterparts in Scotland (Firdous & Bhopal, 1989). McLachlan and Waldenstrom (2005) also found that Vietnamese women used less pain relief, reported more pain, and described childbirth overall more negatively than Australian women. Small (2002) further confirmed that immigrant women were much less likely to experience care that gave them what they wanted.

In addition, studies underlined that universally, minority patients have an unequal access to health care in host countries (Durieux-Paillard & Loutan, 2005). There are some significant areas of concern with respect to NESB women in relation to access to maternity care services such as late and poor attendance at clinics. Therefore, the barriers to maternity care for those migrant women need to be explored in order to improve the services and consequently improve the wellbeing of the mother and the new born baby.

According to the Ethnic Health Unit of Queensland Health (1994), a major barrier to NESB persons receiving appropriate health care is that the health system does not adequately address the linguistic and

cultural needs of its clients. In addition, the most common barriers for migrants accessing health care found in the literature, are also language and culture (Documet & Sharma, 2004; Durieux-Paillard & Loutan, 2005; Garrett, Treichel, & Ohmans, 1998). As Barron et al (2004) recognised providing care to clients who come from different countries is a challenge for health care providers as they traverse the issues of cultural health beliefs and practices, and language and knowledge deficits. It is just as difficult for the clients as they face new cultural customs, language barriers, and unfamiliar health care systems and medical management plans.

Lack of knowledge of ethnic minority groups among health care professionals

Evidence gained from the literature about health professionals meeting the needs of patients from ethnic minority groups revealed a number of critical issues. Lack of understanding of cultural diversities (Leininger, 1978), racism and racial stereotyping (Bowler, 1993), and lack of knowledge (Chevannes, 2002) are the explanations for the failure of health professionals to meet the needs of ethnic minorities. Bowler (1993) found that midwives tended to view Asian patients as a homogeneous group, uniformly deviating from the norms of maternal and patient behavior. The stereotyping of Asian patients was organised around 4 themes: communication difficulties, lack of compliance with care and service abuse, a tendency to make a “fuss about nothing” and lack of maternal instinct. The author went on to

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find that midwives characterised women who spoke little or no English as unresponsive or unintelligent. In other cases, a lack of understanding of colloquial language led midwives to consider these patients rude.

Although health professionals rated meeting the needs of ethnic minorities as very important, the health professionals acknowledged that they lacked sufficient knowledge of the culture, health beliefs and experiences of ethnic minorities to provide quality care (Chevannes, 2002). A study of maternity care for Chinese migrants in Brisbane further confirmed that though health professionals were aware of the diversity of cultural beliefs and practices in the society, they still lacked knowledge and training for dealing with conflict situations in terms of providing culturally appropriate services (Shi, 1999).

These issues above have been evaluated from different perspectives. From a transcultural point of view, Leininger (1995) suggests that knowledge of a client's cultural beliefs, values and attitudes is an integral part of providing total health care. She states that the purpose of transcultural nursing remained to discover and establish a body of knowledge and skills focused on transcultural care, health and illness in order to assist nurses to give culturally competent and congruent care to people of diverse cultures worldwide. Schott and Henley (1996) approach the issues in a different way concerned about the danger of "cultural knowledge" becoming "cultural stereotype". They suggest that in every culture, individuals make

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sense according to their environment and their own personality. They come to a conclusion that the best means to identify individual needs is to ask and to listen to people (Schott & Henley, 1996). Rice (2000) supports Scott and Henley stating that asking and listening to the patients and showing the women genuine concern are the best way to meet the needs of the clients from different background.

Immigrants are generally underserved in health matters; health care professionals lack knowledge of the culture, health beliefs and experiences of the ethnic minorities; and cultural and language barriers exist between health providers and migrants. These facts pinpoint a need to bridge the gaps in order to provide culturally sensitive and appropriate care for migrants. The third approach in human reproductive research focuses on bridging gaps between them.

Maternity care for migrants in the host country

Due to the reasons stated above, researchers explored childbirth experiences of some minority ethnic groups living in western countries (Bodo & Gibson, 1999; Cheung, 1997; Chu, 2005; Liamputtong & Naksook, 2003; McLachlan & Waldenstrom, 2005; Roberts, 2002). Cheung (2002) contributed to the literature by her study in the United Kingdom to analyse the cultural and social differences in childbearing experiences of Chinese and Scottish women. Interestingly, her study does not support the transcultural nursing models which tend to search for something homogeneous within each culture and fail to capture the changes and variations within a culture and cultures over time in

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response to new situations and pressures. These models encouraged stereotyped and inaccurate information about other groups. Her study suggests that a culture that is in contact with other cultures undergoes a continual process of change. She highlights:

In practice, the health care providers should be aware of the substantial differences in the notion of health, social and cultural expectations between Scottish and Chinese women. This may be reflected in their choice of medication, food, bodily cleansing and contacts, and mobility. For example, Scottish women would choose to use folic acid, vitamins and iron tablets in pregnancy and analgesia for pain control in labour. In contrast, most Chinese women would avoid doing so, when they could.

Cheung (2002, p 290)

The findings of Yeo, Feters & Maeda (2000) further raised health professionals' awareness of potential conflicts between two cultures in providing maternity care for Japanese women in the United States. Some Japanese women seemed to be almost offended by being encouraged to take prenatal vitamins. Those women regularly resisted doctors' order to comply as Japanese people believe in and prefer nutritionally balanced meals instead of taking vitamin supplements. This study concluded that it was still difficult for caregivers to provide culturally competent care for Japanese childbearing couples in the United States even if the program has strongly invested in health professionals and support staff who were fluent in Japanese and knowledgeable about Japanese culture.

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Conflicts still occurred because of the language barrier and cultural differences.

Within the literature reviewed on migrant birthing practices, all research found that traditional beliefs and practices are very different in the migrants' home lands. Therefore, such cultural differences could contribute to misunderstandings between health care providers and patients and could affect the quality and efficacy of the health care provided. The refusal of the Asian mothers to breastfeed after delivery reflected a cultural norm of waiting for the milk to come in, but midwives interpreted it as a lack of normal maternal instinct (Bowler, 1993). Thus, these cross cultural studies raised the awareness of cultural differences for health care professionals and assisted them in providing the best and most effective health care possible.

A key contribution of cross cultural studies in childbirth is that they offer useful insights into the analysis of different beliefs and practices associated with the pregnancy, childbirth and childrearing of minority women in the host country, and suggestions in providing sensitive and culturally appropriate care. Research in this area has a common aim of helping health care providers and the health system bridge the gap between themselves and immigrant women by better understanding the women's cultural beliefs and practices and overcome language difficulties.

Research focus on migrant women in Australia

As noted earlier, Australia has one of the most ethnically diverse societies in the world with speakers of over 200 languages. Undoubtedly, Australia is a multiracial and multicultural society. This presents a great challenge for policy makers and service providers to provide culturally sensitive and appropriate health services for the community with such diverse language and cultural backgrounds.

My forty days: Childbearing experiences of non-English speaking background women (Rice, 1993) fills an important gap in the multicultural literature in highlighting the different cultural practices in childbirth. Women in their stories were often confused and torn between conflicting practices taught to them by their mothers and those advised by the hospital staff. Rice's work raises the awareness of various concerns about prenatal care, diet, communications, physical activities after birth, the importance of providing information and the need for choice. She then suggests some solutions which addressed cultural and linguistic issues to improve birthing services for non-English speaking background women in Australia.

Chu (2005) not only describes the postnatal cultural practices of Chinese migrants in Brisbane but also identifies their postnatal health needs and proposed a set of strategies to address them. In her work with Hmong women in Melbourne, Rice (2000) found that the Hmong community still follows some traditional childbearing practices despite living in a western country such as Australia. This is important since it

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means that health care providers will continue to come across the many traditional beliefs and practices of the Hmong when working with the community. She suggests that an appreciation of Hmong cultural beliefs and knowledge of their expectations and social circumstances is essential for sensitive and culturally appropriate birthing care.

Asian mothers, Australian birth: The Asian experience in an English speaking country (Rice, 1994) is another significant multicultural literature. The book was written by a group of authors who highlighted the critical importance of good communication in birthing services in a multicultural society. Other societies' cultural beliefs, attitudes and practices associated with pregnancy, childbirth and childbearing need to be understood, respected and accommodated. Importantly, they found that with genuine care and understanding, the new mother and health care professional can comprehend the reasons for each other's view. The experience of motherhood for the new mother in a new land should not be complicated by misunderstanding and confusion.

Within the broader field of public health research, the qualitative method has been widely used to investigate cultural beliefs, individual experiences and expectation in health care. Most studies of migrant women giving birth in a new country have explored these women's views and experiences by qualitative methods (Cheung, 1997; Chu, 2005; Ito, 2002; Rice, 2000; Rice & Naksook, 1998; Yeo, Feters, & Maeda, 2000; Yeo, Feters, & Maeda, 2000).

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Researchers employed the common techniques in qualitative method including in-depth face-to-face and telephone interviews, field visits to selected community organisations and focus group discussions.

Conclusion

Pregnancy and childbirth are the most significant events in a woman's life. It is a period of achievement, happiness and fulfilment, but also a time of dependence and vulnerability. The birth experience takes place in a cultural context and is shaped by the views and practices of that culture. Research in human reproduction is found within a particular country, across different cultures and specific social context (minority women in their new country). Research in this area enriches our knowledge and understanding of different cultural beliefs and practices around childbirth. More importantly, it offers policy makers and health professionals useful insights into the analysis of different beliefs and practices associated with pregnancy, childbirth and childrearing of minority women in the host country and gives suggestions on providing sensitive and culturally appropriate care. The aim of research in this area is to assist health care providers and the health system to bridge the gap between themselves and immigrant women by better understanding their traditional beliefs and practices and improving communication between them.

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Reflections upon the PhD experience

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When I was invited to contribute to this volume I was pleased to have been given the opportunity, but a little unsure about what to write. The suggested theme of “reflections on supervision” did not seem to narrow the scope very much! However, once I began writing I realised that I did have a lot to reflect on. In particular, I have had many conversations with people who have imparted wisdom and insight, and whose words have stayed with me.

I commenced as a supervisor of Research Higher Degree students in 2002, shortly after being appointed as a Research Fellow at the University Department of Rural Health (UDRH). Despite the enthusiastic encouragement and support of my colleague and mentor (and later co-supervisor!), Professor Judi Walker, I remained unsure of my ability to supervise students so soon after having occupied the student role myself. It was with some hesitation that I completed the paperwork to become a registered supervisor – but since that day I have never looked back.

My own PhD supervisor, Professor Malcolm Waters, once commented to me that an important part of being a supervisor is assisting the

candidate to “find their style”. At the time, I was not really sure what he meant. Like many other early-stage candidates, I was far from convinced that I even HAD my own learning style or writing style, so the chances of me finding them seemed remote! Now, as a supervisor, I have greater insight into this wise comment. It is not up to the supervisor to impose their own preferences, but to facilitate the discovery and utilisation of the candidate’s own style in an effort to achieve academic excellence.

I am also reminded of a conversation with Dr Rosalind Bull in which she spoke about the “imposter syndrome” that is common amongst graduate students. During my own candidature, I recall thinking that I was not a normal, “real” PhD student – I had completed my Honours degree part time, was married, had children (one when I started and three by the time I submitted my thesis!), had not studied at another university, and worked mostly from home. I did my best to integrate into the wider student group but essentially my life circumstances meant that it suited me to only be on campus when I was running tutorials, attending seminars or using the library.

The feeling that I was not a “real” PhD student dogged me for some time. Despite being far from clear about what defined a “real PhD student”, I managed to convince myself that I was not one of them. Nonetheless I worked hard, developed extraordinary time-management skills and the ability to concentrate in spite of long-term sleep deprivation, took opportunities to publish in journals and

present at seminars and, over time, wrote what is apparently a very good thesis.

When I look back I realise that I made things unnecessarily difficult by comparing myself to a mythical being – the “real PhD student”. I now see that “real PhD students” study full time and part time, they have uninterrupted career trajectories and career breaks, they have extensive work experience and little work-experience, and they have studied at many settings and also at the one institution. Accordingly, I try to reassure my students that they are all “real PhD students” also, regardless of their age, background or other factors.

I believe that one of the great strengths of UDRH is that so many of its graduate students have established professional careers prior to commencing their research - and continue to work in their profession during their candidature. This is one way in which UDRH can help to ensure that these candidates conduct research that is relevant to practitioners and policy makers as well as to those in academia. I am very proud of my long association with the University of Tasmania and am very keen for it to continue for some time, as I play my part in helping to encourage, support and supervise the “next generation” of academics and researchers.

The fragmented self: Mental illness and the postmodern identity crisis

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Abstract

In an era of change in the Western world, social and personal identity is besieged by the crumbling social institutions of family, community and church. Where individuals formerly anchored their identities and values, now they find change and instability. In the void left by the dissolved social structure, mass media now markets identities where it once marketed goods. From the perspective of soaring rates of mental illness, the erosion of social institutions precludes the development of strong identity which functions as a protective factors against mental illness. The individualism accompanying postmodernism also weakens social connection. The legacy of postmodernism is individuals who lack strong identity and meaningful social connection. In the presence of trauma, they are ill equipped to stave off mental illness.

Keywords: identity, postmodernism, mental illness

Over the last few decades, the postmodern West has seen an epidemic rise in culture-bound psychopathology. Rates of depression have increased dramatically since the 1950s (Seligman, 1990;

Hagnell, Lanke, Rorsman & Oesjesjoe, 1982). Diagnoses of borderline personality have also been rising in Western culture (Millon & Davis, 1995; Paris, 2001), and the incidence of dissociative disorders has risen exponentially in the last few decades (Braun, 1986; Ross, 1989). Incidence of consumptive disorders (i.e.: alcoholism, eating disorders, sex addictions and compulsive shopping) have also skyrocketed (Schumaker, 2001). The soaring rates of psychopathology in Western society are closely connected with a social and cultural climate that is hinged on change and disconnection. Alienation, stress and a lack of meaning in life are all factors that have been associated with the development of psychological illness in postmodern times (Schumaker, 2001).

Perhaps counter intuitively, modern culture's individualistic climate and emphasis on identity development in fact hamper it. With all the choice afforded to us in postmodern society, individuals bear the responsibility for creating their personal reality and forging a unique life path. And as young Westerners may be afforded every opportunity for self-reflection and exploration, lack of common beliefs and value structure certainly stands in the way of solid identity formation.

The role of the community and culture

It is important to note that individualism alone is not necessarily responsible for the postmodern epidemic of mental illness. But coupled with the lack of a cultural superstructure of values and

institutions, as is the case now with the West's current state of cultural flux, inhabitants of postmodernity are frequently adrift.

A look at identity development cross culturally shows that irrespective of the collective or individualistic nature of society, strong identity formation may be a factor of traditional values and social institutions. For example, Barth (1997) studied the concepts of self in two distinctly different non-Western cultures: the Baktaman of New Guinea and Bhuddist Monks and laity in Bhutan. What he found was extreme examples of collectivity and individualism in how these peoples conceptualised their identities. The Baktaman, for example, had limited terminology for expressing views about their selfhood or that of others. Their social structure and supporting rituals were strongly aimed at reinforcing the notion of collectivity. The Bhutanese, however, expressed strong individualisation, almost to the exclusion of social contact, favouring the pursuit of their individual paths to spiritual enlightenment.

Although these two cultures appear poles apart, one sociocentric, the other egocentric, from the perspective of identity formation, they bear great similarity. Individuals in both groups are born into very well defined social roles, which guide their behaviour and help to strengthen identity within the parameters of the community and culture. The ritualistic component of both the Baktaman and Bhutanese cultures provides a significant additional anchor for their social identities. For example, the path of the young Baktaman males from childhood to their mid-thirties is punctuated by secret sacred ritual,

divinely sanctioning the passage from one developmental milestone to the next. Similarly, much of the Bhutanese identity is constructed by a set ritualised path toward spiritual enlightenment. Connection with fellow Buddhist monks and lay people is not emphasised; however the relationship between the monk or lay person and his religious or secular teacher are of paramount significance.

When compared to postmodern Western identity, the stable social structures upon which the self is built in these Tibetan and Indonesian cultures is much more reliant on social norms and ritual. Increasingly, the role of ritual, common social norms and values is eroded in the West, and the concept of filling a role within a social is becoming foreign to many postmoderns. Kenneth Gergen (1991) argues that the rapid technological advances linking people with each other globally has widened our social spheres to such an extent that we are disconnected and *identity-less* through saturation of social connection. And furthermore, the globally saturated self functioning across different societies and value systems may have little cultural foundation and limited support from social institutions with which one identifies. (Not only is this saturated self lacking contact with important social institutions, but those traditionally stable institutions are themselves in a state of flux.)

While Gergen speaks of the “saturated self”, Phillip Cushman (1995) argues that the West’s consumer-driven, materialistic culture is a result of societies of “empty selves” in search of identity. Cushman argues

that it is the West's identity crisis that fuels the consumerism and materialism so characteristic of Western culture.

The result of the postmodern disconnection is that the inhabitant of postmodern culture lacks the conviction of belief that hails from social identity and the profound social connections integral to emotional well-being.

Pluralism, the offspring of globalisation, creates an existence for the modern which pulls one in opposite directions. And the various roles he is invited to play undermines the formation of an enduring identity. Gergen claims that "under postmodern conditions, persons exist in a state of continuous construction and reconstruction; it is a world where anything goes that can be negotiated. Each reality of self gives way to reflexive questioning, irony, and ultimately the playful probing of yet another reality. The centre fails to hold." (p.7)

Schumaker (2001) contends that it is the postmoderns' fragile sense of self that produces their lack of emotional resilience and, ultimately, explains our current epidemic of mental illness.

Why is strong identity important?

From the context of the development of mental illness, the formation of strong identity provides resilience against trauma.

In his extensive research with children, Alan Sroufe (1983) has found that children who display strong identity are more resilient to stress.

This resilience contributes considerably to their awareness of their place in society and their formation of strong social bonds.

In the postmodern era during which many of society's social structures are losing authority (Fornäs & Bolin, 1995, Featherstone, 1995), strong identity provides an important front line defense. Erikson's (1968) view of identity formation provides some clues to the nature of the resilience. He argues that identity is the end result of a period of identification, and can be considered the solidification of one's sense of being. This indicates the progression toward independent self-hood, as opposed to identification and the reliance on others for response cues. So, in the presence of trauma, those benefiting from strong identity may look inward for validation of self worth and confirmation of values relating to what is befalling them. Those who have hindered identity formation will seek their comfort and protection from around them. In the case of those suffering from mental illness, such protection is often not to be found (Blizard, 1997; Putnam, 1997; Kluft, 1993; Neisser, 1997).

Now more than ever in the West, strong identity is particularly valuable in staving off mental illness. It is conceivable that in cultures that have maintained strong social institutions (i.e. family, community, and religion), these institutions may provide a measure of protection in the face of adversity for those who have failed to develop strong identity. Where meaningful social institutions are on the decline, the onus is progressively on the individual to provide skills to cope with whatever trauma life deals up.

Cross cultural research has pointed to a conspicuous absence of psychopathology in some cultures where social institutions are rigid and family and community remain the focus of everyday life (e.g., Schieffelin, 1985; Hollan, 1988). In the 21st century Westernised world, however, places which may have provided strength and protection have themselves crumbled. In this environment, those without strong identity are greatly vulnerable to mental illness in the face of trauma.

The effects of pluralisation on identity

The requirement of individuals in modern society to operate in a fragmented world makes it all the more important that they come from a secure base to ensure the development of a strong sense of identity (Berger et al., 1973). Pluralisation, they state, has become part of the process of primary socialisation. The outward, as opposed to internally focused, early socialisation, highlights the critical value of secure early attachment in the development of identity. The plurality of modern societies has increased individuals' vulnerability in identity formation. This vulnerability relates to the "fragmentation" that occurs in communities, and of the self because of the lack of integration of individual roles. The ever-changing objects of identification in postmodern society (in the absence of former roles and role models) has created an insecure and ever-changing ideal identity to which members of society may aspire. This fluidity results from the lack of static cultural values and enduring roles for the purposes of identification. Both of these areas of fragmentation may interfere

with identity formation. The dissolution of community undermines the stability of place for children with developing identities. The elimination of stable roles (and role models) greatly reduces the benefit of “community”. The largely integrated societies of pre-modern times offered an inherent safety net for children to develop a sense of place in communities if the family environment fell short.

The danger of postmodernism and the fragmented self to identity formation is ultimately about the lack of social structure and society’s burgeoning individualism. Modern societies, by virtue of consumerism and the abandonment of old institutions, have become individualistic, in which the focus of the individual is to look after oneself. Moghaddam (1997) describes individualistic ideology as an ethos emphasising self-help, personal responsibility and, above all, getting ahead on one’s own, in other words, “making it” as an individual. The American rags to riches dream is characteristic of moderns’ choice of individualistic freedom over community.

Where individualism is critical in the development of Dissociative Identity Disorder (DID) is in the corresponding decline in the strength and significance of social connections. Henry (1965) documents the effects of consumerism on the health of society. He states that modern society has likely created and traversed all of the paths to insanity, much more so than pre-modern societies. Our society is as adept in psychopathology as technology, he states, a telling reality since psychosis can be considered the consequence of cultural malaise. On a personal level, the cultural illness is transmitted through the parents

to the children, and the fluidity of cultural values means none but a non-modern outsider may recognise the folly.

Mental health in the urban and rural environment

Research into the social and mental health of urban and rural communities reveals some very telling information about the protective nature of the rural context. The term rural, as it is used here, requires definition. Given the context of this discussion on the consequences of postmodern culture on identity formation, rural can be described as a traditional environment where there is physical location tied to generations of history. While the geography is essential in this context, it is not all encompassing. The term rural, in fact, implies a physical, social and cultural connectedness, often expressed through shared values, rituals, meaning and understanding. Common religious and or spiritual beliefs are normally a factor of rural communities.

Giddens (1991) states that a necessary component to developing identity is the establishment of trust and reliability. This, he argues, begins with the primary relationship and helps to establish a continuity between the memory of past events and present that can be safely lived through the predictability of the future. The development of identity relies on an understanding of the self in relation to the “other”. In the primary relationship, the role of the “other” is assumed by the caregiver. Not surprisingly, other figures in the individual’s life do not provide the same degree of security and

predictability because there has been no continuity. Traditional rural environments, by virtue of the commonality of belief structure, shared experience and sources of meaning, provide an opportunity to generalise the conception of the trusted and predictable “other” across the broader community. Giddens argues that in an urban modern environment, the development of “self-identity” is fiercely challenged. Rather than commonality of belief and expression, here we find pluralism of beliefs, value structures, religion, behaviours and sources of meaning. Clearly, in this environment, there can be no generalisability of the secure and predictable other, and this, Giddens asserts, impinges on the development of a sense of self and self-identity. From this perspective, the ever-changing, fluid postmodern urban environment presents many problems in the development of personal and community identity.

Leighton (1976) describes the very clear connection between traditional rural environments and identity and mental health. He compares the social and psychological health between divergent communities of the same ethnicity (two Navaho and two Inuit) with starkly different results. Inhabitants of the intact, traditional groups were presented as “exceedingly well put together communities”. He describes them as resourceful, self-contained, effective human social systems whose members maintained their pride despite intense physical adversity. Although some trappings of modern western culture appeared in these traditional communities, they were nonetheless, virtually unaffected in terms of their social connectedness, resilience and group identity. In fact, Leighton remarks on the

surprising similarities between the dispositions of the traditional Inuit with the traditional Navaho peoples in marked contrast to their displaced counterparts. The communities that had been largely influenced by postmoderns and the postmodern way of life were described by Leighton as lacking a whole and coherent culture, where many of their residents eschewed traditional values in favour of membership on the “septic fringes” of modern society. The loss of their cultural connection had translated to a wide-scale sense of aimlessness, lack of meaning, loss of belonging and, consequently, loss of identity.

The characteristics of urban modern life, including social disconnection, alienation, individualism and pluralism, increase the challenges to identity formation through the lack of connection to place, to “the other”, to shared meanings, beliefs and values that are evident in traditional societies. The modern is characterised as chameleon-like adoption of a succession of different identities in an attempt to find place, predictability and shared meaning. In the absence of traditional community values, this, of course, will not be possible.

Conclusion

The critical message in the above discussion of the nature of identity is to highlight its profoundly important social component, and the effects of the erosion of postmodern community on identity development. Postmodern societies have had a profound impact on identity formation. Pluralisation, individualisation and secularisation are the

consequences of the postmodern age. Their consequences are poor community connection, isolation and a life devoid of faith. The weakening of the pillars of community and church means that the identity roles to which young members of the community looked toward in the past are gone. In their place, they have found transient pop-cultural icons (Fornäs & Bolin, 1995). The manner in which this trend has endangered identity formation is that cultural values are perpetually and arbitrarily changing, and postmodern identification is blowing in the wind. As infatuation is to love, superficial identification that is whimsical and groundless has replaced strong identity formation and a solid place in society.

Practically speaking, a secure place in community, in itself, provides a buffer to trauma and stress. With it comes social identity, connectedness and support. Without a confirmed place in society, and suffering from hindered identity development, many postmoderns are simply ill-equipped to handle trauma and adversity. Their vulnerability in this regard provides the foothold for psychopathology.

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Pathways to graduate research

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Abstract

Graduate research should not be viewed narrowly as an academic course. It is also an important aspect of university research. Australian universities tend to share a common pathway to graduate research, which consists of a range of research-orientated courses from undergraduate to postgraduate levels. It has been pointed out that there should be alternative ways to acculturate students into an academic research discourse. Apart from the common pathway to graduate research, it is important to have an alternative for undergraduate and postgraduate coursework students to progress to research. It is constructive to promote research awareness, research skills, and research networking for students currently studying in undergraduate courses. The initial stage of a graduate research life can be a mixture of excitement, inspiration and worry. Graduate research students need an educational environment in which they are encouraged to develop their research profiles and research networking to enhance their research progress, interpersonal interaction, and future employment.

Keywords: graduate research, academic research, research courses, research and higher degrees

Introduction

I could not help drawing an analogy between a graduate research student and a lively, active and youthful rivulet. If all these rivulets join together, what a dynamic and powerful river they would form! This imagination brings to me images of a mighty river which gives vigour and vitality to the land and makes it more fertile. Similarly, our students are a source of strength and inspiration which could easily create a dynamic river of academic research discourse. The challenge for staff as well as students is how to fully appreciate and cultivate this unique phenomenon, and turn imagination and hope into reality.

Graduate research is not a separate entity. It is a fundamental component of the context of university research. It maintains the vitality of a university in its quest for more knowledge and research impacts at various levels within and outside a university. This chapter examines aspects of graduate research such as rationale, pathway, and graduate research enhancement.

Why graduate research?

Why graduate research? This question is in the minds of many undergraduate high achievers who are facing a choice: taking a job or going on to a higher degree with a focus on research. There are

many reasons for undertaking graduate research courses. Individuals make decisions on the grounds which reflect their academic strengths, personal interest and cultural traditions. The reasons for undertaking a graduate research course can be summarised as:

- *A career in academia:* A graduate research qualification is necessary.
- *Job requirement:* A common requirement in the selection criteria for a lectureship is PhD qualification or substantial progress toward a PhD.
- *Intellectual challenge:* The continued challenge and enjoyment of independent research are for many rewards in themselves.
- *Employment:* Graduates from graduate research programmes are highly employable, particularly in research-orientated enterprises.
- *“Why not!”:* It first appears to be not a proper rationale. However it reflects a situation in which students decide to make an academic choice not on the basis of “lack of knowledge” or “confusion”, but perhaps due to intellectual curiosity and risk-taking.

Common pathways to graduate research

It appears that most Australian universities share a common pathway from undergraduate courses to research courses. There are some slight differences in terms of length, entry requirement, coursework and research component and assessment. Basically the pathways to graduate research can be illustrated as follows:

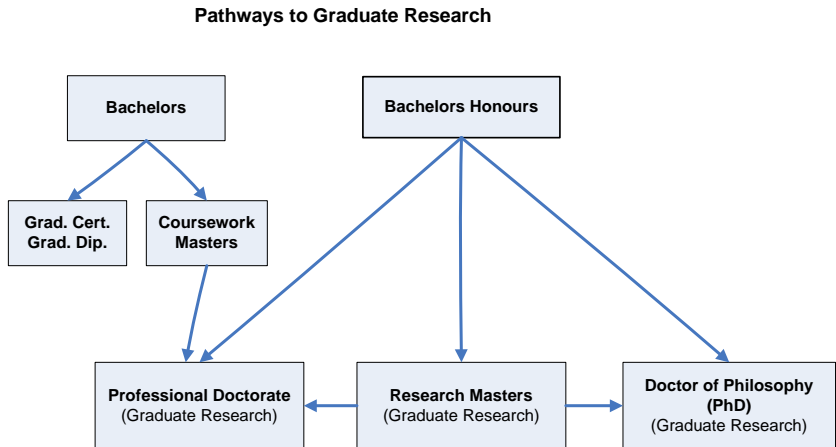


Figure 1: Common pathways to graduate research

At the undergraduate level, the focus is on coursework. The introduction of the honours year provides excellent undergraduate students with an opportunity to proceed to a research higher degree course. Basically there are pass-degree courses and honours courses. Students with outstanding academic results are invited to undertake honours courses. At the postgraduate level, there are several

categories of courses: research only, coursework only and courses with a mixture of research and coursework. This is referred to as “structural pathway”. Masters preliminary course is a kind of “bridging program” which suits those who are not quite ready for direct entry into the research masters course and need to improve their research ability.

There are two interesting issues here. First, the traditional pathway does not favour students who may not have outstanding academic results at the undergraduate or postgraduate levels but who have great interest in research and may wish to switch to a research pathway



later. Second, there is a difference between undertaking a research degree course and participating in a research discourse. The traditional structural research pathway, if not flexible enough, can create a rigid division between research and learning, while in reality these two aspects are not mutually exclusive.

There are several aspects of research enhancement in a university context. In terms of research pathways for prospective students, the traditional pathway model is still a dominant one, starting from the bachelors degree honours level to the doctorate level. Those who are not eligible for this pathway have to make a “detour” (e.g., Masters Coursework) to enter the research pathway at a later stage or will be turned away from the research discourse altogether.

In a few universities, there is also an alternative structural pathway with a research emphasis for outstanding students starting in the first year of their undergraduate courses. The Bachelor of Philosophy (Honours) is an initiative which attempts to incorporate research into the bachelor course from the beginning. It is a research focused degree first introduced in the Faculty of Science for intellectually ambitious students who want to study at the highest level. Each student receives intensive individual attention from an academic supervisor who acts as a research mentor. Gradually, other faculties have also introduced the Bachelor of Philosophy (Honours) into their undergraduate programs.

The Bachelor of Philosophy (PhB) degree is flexible in its structure, with a student's program being determined each year in collaboration with the program convener. One quarter of studies in the first three years consists of individually tailored advance studies courses, specifically designed to provide students with a strong base in research (The Australian National University, 2007).

The Bachelor of Philosophy degree is an alternative to the traditional pathway to capture the research interest and research enhancement of young gifted students at the doorstep of the research pathway. It can be seen as a research nurturing strategy which identifies students early in their academic program and acculturates them into the research discourse. Otherwise they will have to wait for three or four years for their research candidature. The Bachelor of Philosophy (BPhil) at the Australian National University is a unique course in

Australia. The BPhil's earliest form is graduate degree at the Oxford University. Other universities have introduced this model in their undergraduate course such as the University of Newcastle upon Tyne, Miami University, University of Pittsburgh, Northwestern University, and University of Birmingham.

Early research enhancement

In Australian universities, students tend to take a long pathway to reach the level of academic research, that is, from undergraduate, postgraduate either by coursework or coursework with some research, Masters Honours to research thesis. During undergraduate education, students are introduced to basic knowledge of a certain discipline and receive training for their chosen future profession. They enter postgraduate education for the purpose of professional and vocational qualification and enhancement and postgraduate programmes are mainly teaching based courses. Students have little access to research training or experience until they undertake Research Masters or PhD.

Apart from the common pathway to graduate research, it is important to have an alternative to acculturate undergraduate and postgraduate coursework students into a research discourse. It is constructive to promote research awareness, research skills, and research networking for students currently in undergraduate courses (Gates, Teller, Bernat, Delgado, & Della-Piana, 1998). This is a way to accommodate students with excellent academic results achieved in

the previous years, particularly those who will not take the Honours course. However, those without outstanding results should be given opportunities to participate in research-orientated activities if they show great interest and potential.

The following strategies and activities can be incorporated into a research acculturation program for those who have not been included in the traditional graduate research pathway model. The acculturation program may not be an academic unit in itself but it should offer a research induction experience. Here are some suggestions:

- Students are introduced to research methodology in undergraduate courses.
- Students are regularly informed of new research issues, particularly in education.
- Each student will be paired with a staff member or a graduate research student (current or past) who acts as a research mentor.
- Students are invited to attend research seminars.
- Students can incorporate their research knowledge and interests into their current assignments or projects (subject to their lecturers' approval).

- Students are encouraged (and helped with editing) to publish their papers in journals and to participate in local and international seminars/conferences (if financially viable).
- At the end of each academic year, participating students receive a letter commending their participation.

As some students could be discouraged by any extra programs and academic experiences which put more pressure and workload on their current undergraduate or postgraduate program, it is important to assure them that the program is flexible to accommodate their interests and changing situations.

Students should be guided to develop a research-orientated portfolio which may include the following items:

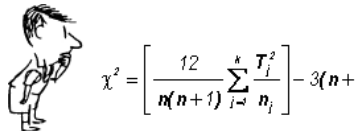
- Developing a research pathway in close consultation with a mentor;
- Developing a yearly portfolio which should include items such as: interesting/useful research articles, notes, questionnaire samples;
- Writing reflective notes or journals on research ideas and issues;
- Writing a list of references;
- Collecting interesting/useful materials;

- Attending regular research seminars specifically organised for this program;
- Communicating regularly, face-to-face or by email, with others in the department/faculty;
- Writing notes on various research seminars and conferences of interest.

“I doubt, therefore I think, and therefore I am”

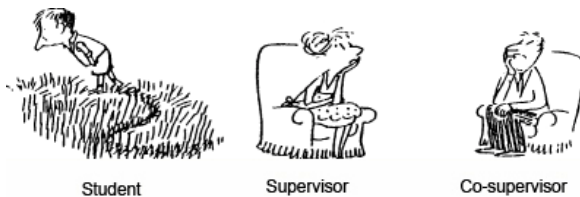
The Latin expression “I doubt, therefore I think, and therefore I am” highlights the nature of research. I borrow Descartes’ (1637) statement in his book *Discourse on Method* “Je pense, donc Je suis” (I think therefore I am) to describe a common phenomenon of graduate research as all research starts with doubt and questioning as the basis of Western philosophy with an emphasis on rationalism. The following graphics can be used to illustrate the initial stage of some graduate research students in many universities.

At the beginning, research matters can be very confusing and complicated, intellectually, emotionally and interpersonally!



Source: Adapted from *My PhD Study Life* (Sempé, Bugeaud, Mignotte, & Normandin, 2006)

You spend hours and hours searching without finding anything.



Source: Adapted from *My PhD Study Life* (Sempé, Bugeaud, Mignotte, & Normandin, 2006)

Not everyone knows exactly what they will do for their research. While some students feel confident right at the beginning of their research journey, there are a few who find the first year a traumatic experience. Here is the frustrating voice of a graduate research student in a university.

It is a truth universally acknowledged that a PhD student in their first year will spend most of that year sitting in a library wondering what on earth they should be doing. They will then spend the next two or more

years wishing they had put that year to better use. Unfortunately nobody ever warns you about this. In fact the Wasted First Year is just one of many PhD hazards that nobody ever warns you about - followed by loneliness, poverty, and tutors who think that it is their responsibility to ensure that you suffer as much as they did.

(Zuram, 2005)

The following diagram shows the first step in graduate research from an exploratory study (Head, 2007) on how students majoring in humanities and social sciences use the Internet and library resources for research.

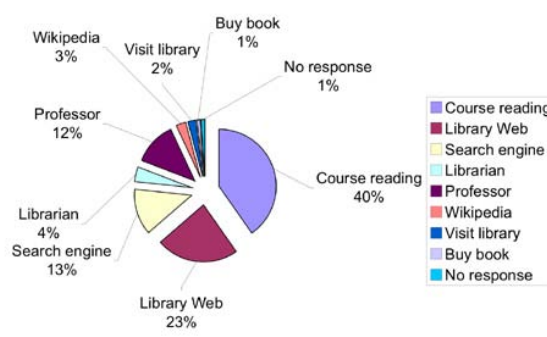


Figure 2: The first step in the student research process.

Source: *Beyond Google: How do students conduct academic research?* (Head, 2007).

It is interesting to note the emergence of the Web as a tool for literature search.

Emotional intelligence!

It is not uncommon to hear comments from some graduate research students such as:

- I do not use quantitative methodology in my research because I am not good at statistics.
- I have to follow the advice of my supervisors as I do not want to offend them and they are the ones who know best!
- I am worried as my thesis has only 221 pages while others have much more. Is mine good enough?
- I feel scared and want to give up if I hear that someone has done a similar research topic at another university. What is the point of doing something which has been done by others?

The remarks given above illustrate the confusion as well as fascination in conducting graduate research. These remarks open up many issues relating to common practice, standard, expectation, and judgement. One cannot give a simple “yes” or “no” to those remarks. However it is important that they are raised so that critical discussion can be generated. Research should be seen as a meaning making process, not just in terms of intellectual development but also emotional intelligence.

Developing a personal research profile

When students embark on a graduate research course, the main thing in their minds is to complete the thesis as soon as possible so that they can “go on with life” after years of research and thesis writing. In the current research context, students are encouraged to develop their research profile during their candidature.

Apart from focusing on writing and completing a research thesis which is the ultimate goal of all graduate research candidates, they should be encouraged to develop their research profile so that it enhances their research pathway or career opportunities before and after graduation. This includes conference presentations, session chairing, being a member of a conference organisation team, publications in a journal, book or conference proceedings, and so forth.

Traditionally graduate research students attend conferences to learn from experienced researchers and they tend to play a passive role. Nowadays in small research seminars as well as major conferences, we notice the prominent presence of graduate research students playing an active role in organising, presenting research papers, and conducting research-orientated activities. There are also conferences organised specifically by and for graduate research students.

Some major research conferences provide pre-conference or post-conference workshops for students or conducted by students, singly or jointly with their supervisors. To encourage their participation, students

are given special conference registration rates or granted conference travel awards.

An issue which may be confusing and uncomfortable to students is about joint authorship with their lecturers. When a student works in a team on a “team based” research project, joint authorship is not an issue. The names of the team members should be the joint authors’ names. The reason is that everyone in the team works closely together. However, conducting a PhD is a different matter. Students are the main agents responsible for the management of the research. Supervisors are academic mentors. Thus, joint authorship is not just an interpersonal matter between graduate research students and their supervisors. It can reveal problems and issues about social relationship, control power in the decision making process and unethical discursive practices which need to be critically examined. Students are often in a vulnerable position to negotiate this matter. My personal view is that students should acknowledge their supervisors in a statement, but not as joint authors unless the supervisors write half of the papers.

Enhancing research networking

Traditionally, the only experts that students work closely with are their supervisors. There are cases in which the students spend the whole candidature with their supervisors and there are no interactions with others in relation to their research. It is possible that students can complete their research in this way. However, this can result in

intellectual isolation, which can be unhealthy intellectually, socially and emotionally.

It is important that students are active members of various research discourses. They should be encouraged to engage in networking with other research students, colleagues and experts locally, nationally and internationally. Isolation and lack of interaction can make your academic life unproductive. In a research context, the limit of our interaction is the limit of our research world. Thus, networking is important for expanding our research horizon in terms of professional relationship and knowledge enhancement.

Graduate research and early career researchers

The recent emergence of the Research Quality Framework (RQF) in tertiary education in Australia has created a need for a revision of or a fresh look at the way research is promoted, assessed and valued. The RQF is an initiative developed by the Australian Government's Department of Education, Science and Training (DEST) with the main aim to assess the quality and impact of publicly funded research at Australian universities and other research-orientated institutions.

Though the focus of the Research Quality Framework is on funding of research for Australian institutions, mainly universities, there are implications for graduate research. As stated at the beginning of this chapter, universities take graduate research seriously as it is an important contribution to the research discourse of a university in

terms of research productivity, enhancement of research environment, cultural diversity, internalisation of research and finance. The long term gain for universities is the connection between graduate research and early career research.

Metaphorically, it is important to nurture young plants for maintaining the foundation and continuation of research in an institution. Both universities and the Australian Research Council recognise the potential contribution of budding researchers. They want to foster the careers of Australia's bright and promising researchers. According to the Australian Research Council (2007) an early career researcher is one who is currently within their first five years of academic or other research related employment allowing an interrupted or stable research development following completion of their postgraduate training, mainly PhD. Universities develop their own plans and strategies to ensure that graduate research students and early career researchers have opportunities to grow and later on become the mainstream of their research discourse.

Mentoring in research

Mentoring from the Greek word means enduring guidance between those who knows and cares and those who need help and care for personal growth and development. Mentoring tends to happen in various discourses such as family, company, school and university. In a community unit such as family and village, mentoring occurs naturally. An experienced fisherman teaches his children how to swim and catch

fish. Parents coach their children how to cultivate their garden or rice field. Mentors act as a guide, a source of information, a sounding board and offer support and encouragement. This is natural mentoring. It is both a socialisation process and mentoring co-existence. However, in a university research discourse, natural mentoring is not enough. There should be a systematic approach to research mentoring for early career researchers as well as graduate research students.

Universities do take research mentoring seriously. However, their techniques, strategies and resources vary a great deal among these institutions. In some universities, the emphasis is on the research discourse of each academic unit such as department, school, division, faculty and inter-faculty collaboration. Research mentoring is about research capacity building, individually and collectively, and it is an important aspect of research discourse enhancement, particularly in a competitive research environment.

Conclusion

Embarking on a graduate research pathway is an intellectual and emotional journey which can bring excitement, inspiration as well as confusion and possibly pain. It would be unrealistic to expect a rosy experience for all graduate research students. The role of the graduate research program is to provide a creative, research-friendly and challenging environment so that graduate research

students not only think creatively and constructively but also feel positive about their research journey.

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Comparing rural and urban paramedical practice: A case study approach

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Abstract

Asking the question how the differences in rural paramedical practice and urban paramedical practice can inform rural paramedical curriculum, is a Masters project titled “Rural paramedics: Bridging the gap between education, training and practice”. The decision to use a case study approach is discussed. Multiple cases from sites in Tasmania and Victoria are used as a means to increase generalisation of results, and mixed methodology is utilised with the introduction of quantitative data. Purposeful selection of units of analysis for cases has been designed around ensuring correct terminology for “paramedics”, and defining what will be rural and what will be urban. An important feature of selection is the use of proposed models of paramedical practice in order to provide a unique approach to comparison of rural and urban paramedical practice.

Keywords: rural paramedics, education, training, practice

Introduction

Should paramedics working in a rural area expect to be doing anything different to their urban counterparts? Isn't it all just a case of attending emergency call outs? An ambulance is an ambulance after all. Case studies provide a useful strategy for supporting the proposal that a specific rural curriculum will enable extended scope of practice for rural paramedics.

The small body of research which has been conducted in Australia regarding the work of rural paramedics suggests a model of practice involving not only emergency response but extended scope of practice, primary health care and rural community engagement (O'Meara, 2003a, 2003d; O'Meara, Burley, & Kelly, 2002; O'Meara & Strasser, 2002; O'Meara et al., 2006; O'Meara, 2002; O'Meara, Kendall, & Kendall, 2004; Raven et al., 2007; Raven, Tippet, Ferguson, & Smith, 2006). Despite this, there remains a paucity of literature comparing the work of rural paramedics with that of urban paramedics. Of this, much is concerned with ability to practice certain skills such as intubation (Brown, Copeland, Gough, Garrison, & Dunn, 1996; Burton, 2003; Jemmett, Kendal, Fourre, & Burton, 2003), inexperience with paediatrics (Stevens & Alexander, 2005), or even higher ambulance crash rates amongst rural paramedics (Chng, Collins, & Eaddy, 2001). In addition, several reports from the UK and USA reveal a mismatch between curriculum and practice (Cooper, 2005; Hauswald, Raynovich, & Brainard, 2005; Kilner, 2004; Lendrum, Wilson, & Cooke, 2000).

Although Australia is witness to the recent innovative establishment of a graduate certificate in rural and remote paramedical practice at James Cook University in Queensland (James Cook University, Accessed 21st August 2007), questions must be raised. How do we know that rural paramedical practice is really all that different to urban paramedical practice? Why do we need a rural paramedic curriculum? How can the differences inform rural paramedic curriculum?

These questions form the basis of a current Masters study conducted through the University Department of Rural Health, Tasmania. Titled “Rural paramedics: Bridging the gap between education, training and practice”, this study adopts a case study approach.

This current paper discusses the decision to use case study methodology and various issues in study design including varying classifications used when investigating paramedical practice, and the concept of what is rural and what is urban within the chosen case sites at Victoria and Tasmania.

Paramedical practice within Australia also has variation across rural areas and this is managed with reference to various rural paramedical models. It is with consideration of these models of practice that the case study design has been developed.

Selection of a case study methodology

Examination of the small amount of literature that compares rural paramedical practice and urban paramedical practice reveals a common theme amongst methodology in that quantitative techniques are a preferred option (Brown et al., 1996; Burton, 2003; Chng et al., 2001; Jemmett et al., 2003; Stevens & Alexander, 2005). Some qualitative paramedical research is evident in Australia (O'Meara, 2003a, 2003c; O'Meara et al., 2002; O'Meara et al., 2006; O'Meara, 2002; O'Meara et al., 2004) and a report to the Australian Council of Ambulance Authorities (CAA) regarding rural paramedical practice makes use of case study methodology (O'Meara et al., 2006). Although recent research is building a concept of rural paramedical practice within Australia, what is missing is a comparison of rural paramedical practice with that in an urban environment.

Recognising a gap, this particular Masters study asks the questions: How do we know that rural paramedical practice is really all that different to urban paramedical practice? Why do we need a rural paramedic curriculum? How can the differences between rural and urban paramedical practice inform rural paramedic curriculum? Yin (2003) suggests that this type of how and why questioning, with no requirement for experimental control and a focus on contemporary events, is well suited to a case study approach (Yin, 2003).

The questions posed are used to formulate various propositions. What is known from the literature is that there is a growth in the support of extended scope of practice for paramedics in rural areas (Ambulance Service of New South Wales, 2006; American College of Emergency Physicians, 1997; Doy & Turner, 2004; Garza, 1994a, 1994b; O'Meara, 2003c; O'Meara et al., 2002; O'Meara et al., 2006; O'Meara, 2002; O'Meara et al., 2004; Raven et al., 2007; Raven et al., 2006; Shoup, 1995). Because of this, a simple theory, that a specific curriculum designed for rural paramedics will enable an extended scope of practice, develops. A rival theory can also be proposed such as extended scope of practice of rural paramedics naturally occurs due to individual people appointed and thus no specific rural curriculum is required.

It is this theory development, prior to data collection, that is central to the use of case study methodology (Yin, 2003) and sets aside the methodology from methods such as “grounded theory” (Creswell, 1998; Glaser & Strauss, 1967), ethnography (Creswell, 1998; Hansen, 2006), or phenomenology (Creswell, 1998; Hansen, 2006), which typically avoid determination of a theoretical proposition prior to any investigation (Yin, 2003).

Elaboration of theory is developed within the case study and the approach lends itself to examination of multiple cases thereby further strengthening the theoretical standpoint by application of replication logic within and across cases (Huberman & Miles, 2002; Yin, 2003). This allows for generalisation of results beyond the immediate project,

a characteristic one would have to approach with trepidation if adopting a study of a single subject such as with a biographical approach.

Coming from this stronger theoretical foundation, other methodologies may then later emerge to further develop the concepts revealed. The political implications of differences in urban and rural paramedical practice will be well suited to a feminist perspective, and new approaches to curriculum can be developed using participatory action research.

But what of the quantitative methodology common amongst paramedic research? This is not lost in the case study approach, and indeed a mixed methods approach using quantitative data such as types of cases dispatched to paramedic crews serves to enhance other evidence gained. This triangulation of data in a case study approach allows for increased rigor of the research (Creswell, 1998; Hansen, 2006; Yin, 2003).

An issue of terminology and purposeful selection

Strength of design is not only in the ability to use triangulation of data, it must be taken back to a “grass roots” level and here important factors relating to terminology used for both “paramedics” and what is rural and what is urban become paramount.

Within Australia, the terms “paramedic” and “ambulance officer” are interchangeable depending on which state or territory is being

examined. Adding to the confusion, the terms “paramedic”, “advanced life support paramedic” and “mobile intensive care paramedic” are also interchangeable. An examination of current websites for various Australian ambulance services will show the same qualifications respectively referred to as: Victoria – “qualified ambulance paramedic” and “mobile intensive care paramedic” (Rural Ambulance Victoria, accessed 15th August 2007); Tasmania – “ambulance officer” and “paramedic” (DHHS Tasmania, accessed 15th August 2007); New South Wales – “ambulance officer” and “paramedic” (Ambulance Service of New South Wales, accessed August 2007) ; Queensland – “paramedic” and “intensive care paramedic” (Queensland Ambulance Service, accessed 15th August 2007); West Australia – “ambulance officer” and “paramedic” (St. John Ambulance West Australia, accessed 15th August 2007), and South Australia – “paramedic” and “intensive care paramedic” (South Australian Ambulance Service, accessed 15th August 2007). In a comparative case study approach examining the work of “paramedics”, it is important that purposeful selection of cases is carried out in order that “paramedics” are compared with “paramedics”.

In a similar fashion, the concept of what is rural and what is urban must also be clearly stated. Of common use in Australia are the Accessibility / Remoteness Index for Australia (ARIA) and the seven point Rural, Remote and Metropolitan Area classification (RRMA). The ARIA definition categorises communities from those which are highly accessible and have relatively unrestricted accessibility to a wide

range of goods and services and social interactions, to very remote, with very little availability of goods, services, and social interactions (Department of Health and Aged Care, 1999). RRMA is population-oriented and has the largest non metropolitan population (RRMA 3) of between 25,000 – 99,999 people (Department of Primary Industries and Department of Human Services and Health, 1994). The ARIA definition is useful in that it categorises what is rural and what is remote.

Also in use is ARIA+ methodology which serves as a basis for Australian Standard Geographical Classification (ASGC). The ASGC uses a different island weighting factor for Tasmania, and is also based on distances to five categories of service centres rather than the four as with ARIA (Australian Institute of Health and Welfare, 2004). When conducting a comparative study of rural and urban paramedics in Tasmania and Victoria, given the specific weighting for Tasmania, it would seem desirable to select ARIA+ or ASGC. A conundrum however develops in that the capital city Hobart becomes classified as Inner Regional (IR) whereas cities such as Melbourne or Geelong in Victoria are classified as Major Cities (MC) (Australian Institute of Health and Welfare, 2004). On the other hand, RRMA classification of Hobart and Melbourne has both as capital cities.

The researcher, however, when selecting rural sites for study, needs to be aware that RRMA uses straight line measurements from urban centres to determine rurality or remoteness. In reality, some areas

may be more isolated than indicated due to actual travel time or road conditions (Australian Institute of Health and Welfare, 2004).

Returning to the RRMA classification of Hobart and Melbourne as capital cities, it is obvious that Hobart, with a population of just over 200,000 (Australian Bureau of Statistics, accessed 17th August 2007) and access to only one major public hospital is very different to Melbourne with a population of over 3.5 million (Australian Bureau of Statistics, accessed 17th August 2007). Paramedics in central Melbourne alone have access to several public hospitals. Purposeful selection is again important and in order to conduct this study using Tasmania and Victoria, the cities of Hobart in Tasmania and Geelong in Victoria are selected, although the RRMA classification of Hobart as a capital city (M1) differs to that of Geelong, an “other” metropolitan centre (M2) (Australian Institute of Health and Welfare, 2004). Both cities are very similar in size, have similar hospital situations, and have paramedics with similar crewing arrangements and qualification.

Case design – the use of paramedic models

The “grass roots” approach to the case study design is to ensure that what is being examined in respect to rural and urban paramedics is consistent within cases. Purposeful selection of cases is important in regard to terminology for paramedics themselves, and the concept of what is rural and what is urban. There is however one further and very important consideration with paramedic practice in that several

models of rural ambulance practice are proposed within the literature, and these models are useful in examining paramedics from several locations.

The ability to investigate paramedical practice across several locations is necessary in order to maintain a degree of external validity. In other words, in line with Yin (2003), the use of cases across states allows for analytical generalisation of information with evidence compared both within and across cases, providing a replication of data in support of the proposed theory.

This Masters project uses case sites in Tasmania and Victoria and this eventuates due to a close alliance when initial paramedic courses were established, and the current decision of the Tasmanian Ambulance Service to adopt Clinical Practice Guidelines based on those of Rural Ambulance Victoria (Rural Ambulance Victoria, accessed 15th August 2007). Despite this close alliance, rural cases in particular are difficult to select for comparison because the rural paramedic workplace varies between locations. Within both states, a paramedic in a rural area may work as a solo practitioner, being backed up by or backing up volunteer units, work full time with a volunteer crew, or work full time with another paramedic.

A solution is offered in a body of work presented regarding models of ambulance practice, and in particular rural ambulance practice (Adams, Wright, & Cooke, 2005; Cooper et al., 2004; Everden, Eardley, Lorgelly, & How, 2003; Neely et al., 1997; O'Meara, 2003a; O'Meara et al., 2002; O'Meara et al., 2006; O'Meara,

2002; O'Meara et al., 2004; Raven et al., 2007; Raven et al., 2006). Selection of rural cases for this project is determined by their fit with particular models of rural practice. Two of these models are the paramedic practitioner working in a community/volunteer model (O'Meara, 2003b; O'Meara et al., 2002; O'Meara, 2002), and the RESP model (rural community engagement, emergency response, scope of practice extension, primary health care) (O'Meara et al., 2006).

With volunteer services a mainstay of many rural communities, O'Meara (2003) proposes a community/volunteer model as having a place within rural Australia. This community controlled and operated ambulance service aims to meet the pre-hospital expectations of a local community, sometimes with the support of a paramedic (O'Meara, 2003b). This community interaction by paramedics is one aspect of what has been termed the practitioner model, and O'Meara (2002) suggests the practitioner model also has an increased depth of treatment and clinical decision making, offering an extended scope of practice.

Further to the practitioner model is the recently proposed RESP model, developed using a case study approach across four Australian states, and proposing four core paramedic activities:

- Rural community engagement;
- Emergency response;
- Scope of practice extension;
- Primary health care (O'Meara et al., 2006).

These two models of practice, community/volunteer practitioner and RESP, are represented in Figure 1 as the rural cases for investigation.

Also represented in Figure 1 are the urban cases of Victorian urban paramedic and Tasmanian urban paramedic, and an important feature of the design to note is that each case is constructed using units for analysis. Ensuring the same paramedic terminology within each unit, that each matches rural classification and each meets criteria of models of practice, allows for purposeful selection of these units. In the rural cases, this allows for several units of analysis to be used and each embedded in their respective model of rural paramedical practice.

Because some rural areas may only have one paramedic to interview, as in the RESP model, the use of several units of analysis allows input from various sources. Yin (2003) suggests one of the pitfalls of case study data collection is the possibility of confusion between data collection and the unit of analysis. This is not a study of individual paramedics. The use of structured or semi structured interviews with several paramedics, combined with documents, archival records, observations, and quantitative data such as the types of cases dispatched to rural and urban ambulance crews, allows triangulation of data and increased rigor of the research (Creswell, 1998; Hansen, 2006; Yin, 2003).

The combined evidence gathered from these units of analysis builds strong urban and rural cases. The case study approach aims to seek similar results or literal replication (Yin, 2003) of data across urban

cases, as it does with rural cases. In support of the premise that rural paramedical practice and urban paramedical practice are different will be the contrasting results between urban and rural cases, or theoretical replication (Yin, 2003). From this standpoint, a picture of rural paramedical and urban paramedical practice can be presented for further analysis in regard to the issue of curriculum.

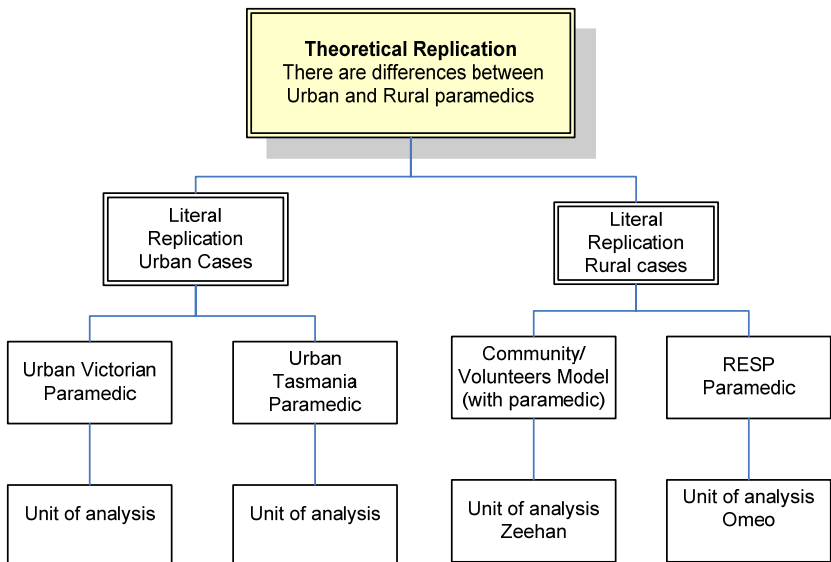


Figure 1: Case Study Structure

Conclusion

Case study methodology provides a useful strategy for comparing rural paramedic practice to urban paramedical practice, and as such is adopted for a Masters study through the University of Tasmania's Department of Rural Health. In light of recent advances toward an extended scope of practice for rural paramedics, this study asks the questions: How do we know that rural paramedical practice is really all that different to urban paramedical practice? Why do we need a rural paramedic curriculum? How can the differences inform rural paramedic curriculum?

It is this how and why questioning that suits the case study methodology. The research is seeking ways in which rural paramedic curriculum can be informed and as such puts forward a proposition that there are differences between rural and urban paramedical practice and a specific curriculum designed for rural paramedics will enable an extended scope of practice. Development of rural and urban cases and subsequent comparison will determine the differences and provide replication of the proposed theory.

An advantage of a case study approach when dealing with a topic such as paramedical practice and curriculum is that several cases can be examined across different locations and data verified by the use of literal replication. In this way there is a wider generalisation of results. This is a study of rural and urban paramedical practice, not a study of individual paramedics, and data from various sources

including interviews, observation, archival records are used. The case study approach will also make use of mixed methodology in the gathering of quantitative statistics. This triangulation of data will serve to increase the overall robustness of results.

The initial case design must be taken back to basics though, and within Australia there exist various definitions for the terminology “paramedics”. In addition, there is difficulty in determining what is rural and what is urban, despite the existence of several rural and remote classification tools. Each of these terms has to be clearly defined in the particular study and cases purposefully selected according to the definitions.

This purposeful selection has one further dimension important in the consideration of paramedical practice. That is different models of rural paramedical practice are proposed in literature. In this case study approach, the presence of rural models allows for rural cases to be designed according to criteria pertaining to these models. Units of analysis for each case are therefore selected using several aspects, such as definition of rurality, definition of paramedic, and alignment with a particular model of practice.

There is of course a possibility that literal replication between rural cases and urban cases may not occur. Victorian urban paramedics may present differing information to Tasmanian urban paramedics, or RESP rural paramedics may not compare to volunteer/community paramedics. In this event, the case study approach allows for elaboration of a new theory. For example, perhaps the difference

lies between states or models and not urban or rural paramedical practices.

Support for and development of any theory or propositions begins with the case study design. This paper stops short of describing data analysis involved, but we can see how selection of units of analysis according to the criteria set down by terminology, definitions of rurality, rural and urban models of paramedical practice, and triangulation of information from different sources means that the researcher can be confident that cases developed are an accurate representation of paramedical practice.

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Rural radiography, not so much black and white as shades of grey

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Abstract

Australian radiology operates according to a two tiered hierarchical framework that has existed for over 80 years. This model comprises radiologists and radiographers, with radiologists as medical professionals responsible for radiographic interpretation and radiographers responsible for radiograph production. As a consequence of this hierarchy, radiographers do not report on radiographs despite the fact that once they have performed a radiographic examination, they potentially hold in their hands a definitive diagnosis. Education has been put forward as the reason for the evolution of this model as early radiographers often lacked or had limited formal training. This is no longer the case, and the literature reveals that radiographers today possess a high level of competency at radiographic interpretation. In the rural setting, without a radiologist readily accessible to report the radiographs, radiographers tend to come under some pressure to provide a

diagnosis on radiographs which has been suggested as involving the bioethical principles of beneficence and non-maleficence. It has also been identified in the literature that radiographers are not confident in what information they may disclose to patients and it further suggests that this raises the bioethical issues of veracity and autonomy. The bioethical rule of confidentiality is also revealed as an issue for many rural health care workers that may well include radiographers. The result is that rural radiographers are operating within an interpretative and bioethical paradigm for which they may be under-prepared.

Keywords: rural radiography, bioethics, radiographic interpretation

History of radiography

The 19th century saw several notable scientific discoveries that had significant impact within the field of medicine. These discoveries in the closing years of the 1800s included the discovery of X-rays. Professor Wilhelm Conrad Roentgen is credited with the discovery of X-rays on 8 November 1895 (1996). Roentgen, although a physicist by training, was immediately aware that his discovery had medical implications (Larkin, 1978). Although the first reports of Roentgen's discovery appeared in the London press on the 7 January 1896 (Hamersley, 1980, p. 41), news did not reach the Australian press until the 31 January 1896 (Hamersley, 1980, p. 42). From 1896, when "X-rays mania" (Goodman, 1993) gripped the world, the terms radiologist and radiographer were used interchangeably until 1925 (Price,

2001). Hamersley (1980) reveals the identity problem that this presented for the medically qualified skiagraphist when their professional colleagues tended to treat them as picture takers when lay practitioners of radiology were precisely that, picture takers. This ambiguity came to an end in 1925 (Price, 2001) in the United Kingdom with medical practitioners claiming the term radiologist and along with it the rights to radiograph interpretation; radiographers were relegated to the role of producing radiographs. Australian radiology operates according to this same hierarchical model that has also been in place since the 1920s (Smith & Baird, 2007, p. 629). Ryan, Sutton and Baigent (1996) mention that disharmony existed between radiographers and radiologists in the early years of radiology in Australia with the essence being educational, with radiologists being medical practitioners whereas some of the early radiographers began their careers as electricians or even hospital trolley boys. Indeed the first X-ray in Australia may well have been produced by Reverend James Slattery, a science master at St Stanislaus College in New South Wales, but an exact date is not documented (Hamersley, 1980). Radiography education in Australia is now university based and indeed “[r]adiography education in Australia is of a high standard” (Smith & Baird, 2007, p. 630) and according to Price et al radiography is coming “...full circle with the re-emergence of radiography reporting” (Price, 2001, p. 105).

Radiographic interpretation

It would seem that radiographers are well placed to provide radiographic interpretation when Hall, Kleeman and Egan (1999) in their series of studies into the accuracy of Medical Imaging Technologists (MITs) at Alice Springs Hospital, in determining normal compared to abnormal radiographs, showed an overall accuracy of 91.2 percent against the “gold standard” of the radiologists report. In reporting the limitations of their study, the authors mention that they assumed that the “gold standard” for the radiologists represented 100 percent, and if allowance is made for some inaccuracy by radiologists, then the results would reflect a higher standard. Brealey et al (2005) report that in their review of radiographers’ accuracy in reporting plain radiographs, there is “...no evidence of difference in reporting accuracy between selectively trained radiographers and radiologists of varying seniority” (Brealey et al., 2005, p. 239). Interestingly Smith (2006) says at the time of writing his article that Australian radiographers have no legal diagnostic duty to their patients, and no obligation to provide or liability for non disclosure of their opinion with regard to examination findings. It is of particular interest to note that despite this apparent lack of diagnostic duty, Smith (1995) suggests that there is anecdotal evidence that a sole radiographer in a country hospital, which has infrequent attendance by a radiologist, may be called upon up to several times a day to assist local doctors with interpreting radiographs and that this may alter the patients’ treatment. Cook, Oliver and Ramsay also report that “[i]t remains unclear as to the extent to which radiographers,

particularly in rural and remote centres have been anecdotally providing informal verbal reporting” (Cook, Oliver, & Ramsay, 2004, p. 61). These findings are supported by Hall et al with their assertion that MIT’s working in “remote locations have informally offered opinions for many years” (Hall, Kleeman, & Egan, 1999, p. 11).

Red dot system

One initiative that goes some way to addressing and formalising this issue of radiograph interpretation by radiographers is the red dot system. This system allows a radiographer to notify a referring clinician of an abnormality on a radiograph prior to a radiologist issuing a formal report. The practical application of the red dot system involves a radiographer examining the radiographs and on identification of an abnormality placing a red dot on the image to alert the medical practitioner of an abnormality. Smith reports that in 1995 the red dot system had existed in the UK “...for over a decade” (Smith, 1995, p. 86), but in 2006 it is reported as being only used sporadically in Australia (Smith, 2006, p. 4). Smith believes that “[t]here appears to be no reason why some radiographers could not reach the academic standard needed to provide descriptive reports on a defined range of radiographic examination types” (Smith & Baird, 2007, p. 631) and further suggests that transferring some reporting from radiologists to radiographers would maintain or even improve patient care. This idea contributes to maximising the efficiency of the available health workforce and reducing the maldistribution of the existing workforce through realigning existing

workforce roles. As such this idea is in line with the findings of the Productivity Commission's (2005) report.

Expanded scope of practice

This concept of realignment which incorporates cross skilling and broader scope of practice falls within an expanded scope of practice. Expanded scope of practice (ESP) is currently receiving much attention both within Australia and overseas. This term has crept into the lexicon of many health care professional bodies and consequently into the associated literature. ESP, as the name suggests, is an expansion from the traditional model of practice for a particular health care profession. ESP would seem to encompass health care professionals assuming multiple roles (Akroyd, 1990), or acquiring skills that will enable them to perform tasks originally outside of their traditional scope of practice (Verrier, 1991), or simply extending the scope of practice so that health care professionals utilise a skill that they already possess (O'Connor, 2005). Clearly, employment of the red dot system and radiographic interpretation are examples of ESP for radiographers. Wakerman and Lenthall (2002) describe remote health practice as multidisciplinary and where practitioners in extended roles often work without sufficient preparation. Therefore, by definition many rural practitioners are already employing ESP, and according to the Productivity Commission (2005), one of the many positive aspects of health care in rural and remote Australia is that they are "incubators" for the development and testing of models

of ESP and that these innovations potentially will provide the base for system wide change.

Friends as patients

It seems we should move with some caution with regards to ESP in the rural environment if ,as suggested, “[t]he new multiskilled approach to the way work is done alters job tasks, roles, and relationships...” (Akroyd, 1990, p. 163), because relationships are a recurring theme in the literature detailing the rural experiences of general practitioners, nurses and some allied health professionals. Specifically, a friend as a patient was considered an issue by several authors. Ozolins, Greenwood and Beilby (2004) in a study of women General Practitioners in rural South Australia revealed that these doctors were aware of the blurring of the boundaries between patients and friends. Fuller, Edwards, Procter and Moss (2002) and Glover (2001) add fuel to this concept with their findings of the ambiguity that exists at the boundary between rural professional practice and social relationships. The impact of this point becomes clearer when you consider the following finding by Dwyer (1996). In this study which set out to identify the stress producing factors reported by registered nurses in an Australian rural hospital’s emergency room, it was found that more experienced nurses ranked nursing a family member or close friend higher than less experienced nurses. From this finding, Dwyer concluded that the more experienced group, being older, would be expected to have established more extensive family and social networks than the younger, less experienced, and more

geographically mobile group. Fuller et al (2002) support this claim as they also believe that over a 2 year period it would be very difficult for a health care professional not to become a friend or at least social acquaintance to many of the residents of a small town. Ethical dilemmas may arise as a consequence of these pervasive issues of familiarity and interwoven relationships within rural communities (Cook, Hoas, & Joyner, 2000; Cook, Hoas, & Joyner, 2001; Glover, 2001; Roberts, Battaglia, & Epstein, 1999; Turner, Marquis, & Burman, 1996; Warner et al., 2005). An ethical dilemma is a situation that involves questions of morality (Mundy, 1999), or conflicts between personal values and professional responsibility (Turner, Marquis, & Burman, 1996). This idea is supported by Glover(2001) who reveals that confidentiality is an ethical issue due to multiple relationships, and that as an issue it is both prevalent and problematic. Turner et al (1996) found that one concept central to contributing to ethical dilemmas was a conflict between commitment to personal values and professional responsibility. Lynn (1999) believes that radiographers face making decisions everyday with regard to their professional skills in patient care, and the morality and legality of their relationships with their patients, doctors and work colleagues. She further suggests that the basis for these decisions is dependant upon each radiographer's awareness of the law and their personal and professional ethics. If Lynn's proposition holds true for rural radiographers, then perhaps it is a logical progression to conclude that if you complicate the relationships, then you complicate the decision making.

Bioethics

Rurality then creates specific issues that necessitate exploration, particularly those issues with a bioethical context such as friends as patients. According to Lynn (1999), the eight principles of biomedical ethics are autonomy, non maleficence, beneficence, justice, paternalism, fidelity, veracity and confidentiality. Five of these principles are revealed in the literature as relevant to rural radiography, namely autonomy, non maleficence, beneficence, veracity and confidentiality. This is of concern when in a small pilot study of Australian radiographers, Lewis (2002) found that some of the radiographers who were interviewed had difficulty with the comprehension of some ethical concepts and terminology. This idea is supported by Cook, Hoas, Joyner (2001) and Turner, Marquis & Burman (1996) as they have identified that rural nurses were sometimes unaware of what constituted an ethical issue. Lewis (2002) also introduces the topic of radiographers not being confident in their knowledge of what information they may disclose to their patients. Reading this in light of McBrien's (2005) acknowledgment that rural radiographers are often called upon to interpret radiographs raises questions, particularly if disclosure is considered to be aligned with autonomy and veracity (Lewis, 2002).

According to Smith (2006), there are also bioethical principles applicable to the use of the red dot system, namely beneficence and non-maleficence, beneficence by drawing the medical practitioner's attention to an abnormality on the radiographs and non-maleficence

by avoiding the inappropriate discharge of a patient requiring further care. Smith further suggests that “the misleading interpretation of radiographs by radiographers becomes unethical” (Smith, 2006). Therefore there is obviously a bioethical component to radiographers becoming involved in radiographic interpretation. Another of the basic tenets of biomedical ethics, confidentiality, is mentioned by several authors as an issue for rural health care providers (Cook, Hoas, & Joyner, 2000; Glover, 2001; Simon & Williams, 1999; Turner, Marquis, & Burman, 1996). Confidentiality “...prevents redisclosure of information that was originally disclosed in a confidential relationship” (Beauchamp & Childress, 2001, p. 304). Maintaining patient confidentiality requires conscientious effort (Dalton et al., 2002; Glover, 2001; Wakerman & Lenthall, 2002). This may be difficult in a rural community because Simon and Williams (1999) believe that confidentiality problems are often inherent and inescapable in small communities, but it is important that the health care professionals meet their professional obligation to ensure that a breach of patient’s right to confidentiality does not occur even though information regarding the patient may become common knowledge (Glover, 2001).

Lack of preparation for rural practice

Rural radiographers are regularly dealing with bioethical situations which may be foreign to the urban setting. Further to this, rural radiographer’s experiences differ from those of their fellow rural health care workers because of the type of bioethical issues that

confront radiographers, which essentially arises because they have a diagnostic ability, and it would seem that they operate without clear directives as to how this ability is to be employed. According to Larkin (1978) , Wakerman and Lenthall (2002) and Blue (2002), this is of concern when practitioners are often insufficiently prepared for rural and remote practice. Von Bertouch (McBrien, 2005) further supports this concept as he recognised that there is a daunting learning curve associated with rural and remote radiography. O'Regan (1991) believes that working in the bush, as he calls it, requires jumping in the deep end and either sinking or swimming. Therefore the literature sourced reveals that there are indeed differences between rural and urban radiography. O'Regan provides evidence that rural radiography operates in its own peculiar environment, with "[r]ural radiography suffers from the common ailments induced by the resources needed to overcome the peculiar problems posed by remoteness and isolation" (O'Regan, 1991, p. 18). It is significant then to note that, "[i]nterestingly radiographers in rural areas are barely distinguishable from their counterparts in urban areas, generally exhibiting similar professional skills and habits" (Petros, 1999, p. 73). To overcome the differences in the required skill set, the Productivity Commission suggests that there exists a need to "equip practitioners with the additional or different skills required to deliver services in rural and remote areas" (Productivity Commission, 2005, p. 213).

Conclusion

With significant evidence to show that radiographers are adept at radiograph interpretation, initiatives are afoot to bring radiographers to the fore in radiographic reporting. This initiative may be complicated in the rural environment because the reality is that there are bioethical issues surrounding rural radiography. From the search of the literature, it would seem the answer to the question of what are the ethical experiences of rural radiographers is unclear. Perhaps the extrapolation of the themes identified from the literature pertaining to other medical professions is accurate and so it is reflected by the experiences of comparable health care professionals. If this is the case, then the literature review has unravelled the complexities of rural radiography, an understanding of which may not be addressed well during university training and clinical placement which is based on the historical two tiered model. We need an understanding of what it is to be a rural radiographer so that we can adequately prepare radiographers for rural practice and also to provide them with appropriate support once they are integrated into the rural environment. In order to understand ethics, Tschudin suggests,

Ethics makes sense when we engage with it. It is hearing other people's stories – their values, beliefs, reasons and reasoning, whys and wherefores – that we engage with these things ourselves. Stories are therefore essential elements to learning about ethics and learning to be ethical beings. (Tschudin, 2003, p. 62)

Consequently the next step in this journey to understanding bioethics and rural radiography will be to engage with rural radiographers and have them reveal their experiences of bioethics in the rural environment. This will be an investigation into non-normative descriptive ethics because the objective will be to establish what "...is the case, not what ethically ought to be the case" (Beauchamp & Childress, 2001, p. 2).

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