



InterHealth

Intercultural Competences
for Healthcare Professionals

Curriculum for Intercultural Competences of Healthcare Professionals



*"For a world where we are socially equal,
humanly different and totally free"*

Rosa Luxemburg

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This publication reflects the views only of the author, and the Commission cannot be held responsible for any use which may be made of the information contained therein.



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Erasmus+ project, Strategic Partnerships for vocational education and training

INTRODUCTION

InterHealth – Intercultural Competences for Healthcare Professionals – is a strategic partnerships project for vocational education and training which is part of the Erasmus+ programme funded with support from the European Commission. The project will last from October 2016 until December 2018.

InterHealth aims to increase the intercultural competences of healthcare professionals in Europe, through non-formal training. The main objective is to train them with the intercultural competences required to provide a superior quality of medical and healthcare services. The tailored training developed within the project was designed to cover the needs of final beneficiaries, namely culturally diverse populations such as migrants, refugees and other ethnic minorities.

To do so, partners from Austria, France, Greece and Spain developed a Curriculum keeping in mind that non-formal educational methods could be combined with formal education for healthcare professionals and could improve quality of care provided within the healthcare system in European countries.

Therefore, partners conducted a state of the art / training needs analysis notably interviewing health professionals and final beneficiaries. The overall state of the art¹ included context analysis, needs and recommendations.

The above-mentioned state of the art enabled partners to have, at national and European levels, an overview of healthcare professionals' needs and intercultural competences. In other words, issues health professionals deal with in their daily practice as well as intercultural education offer (formal and non-formal education) and challenges they meet to develop intercultural competences.

Based on the state of the art, partner developed InterHealth Curriculum on the following four themes:

- Interreligious competences,
- Intercultural communication and counselling,
- Self-awareness for professional health-carer,
- Management in healthcare settings.

InterHealth Curriculum is available and freely unloadable from the project website: <http://www.interhealth.eu/en/curriculum/>.

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¹ <http://www.interhealth.eu/en/forschungsarbeit/>

Module 1 :

Rationality and Reason

Module 1 : Interculturality and religions

This module will stay focus on the importance of the cultural and religious impact faced by the health professional during their daily work with migrants patients. This module is dealing with the relation to the body, to the death and to the expression and management of pain.

The health professionals will be led to realize the impact of their own cultural and religious identity when they work with patients. They will learn to implement strategies that overcome those cultural and religious differences.

KNOWLEDGE		SKILLS		COMPETENCES	
at the end of the unit the learners will be able to					
<ul style="list-style-type: none">• To perceive the social, cultural and religious manifestations of pain to be able to better understand• To be aware of the diverse cultures and how they can affect the relation to the body• To distinguish within the different practices related to the death, what is important or not, the morals to be respected and what can be avoided or managed without generating disturbances.		<ul style="list-style-type: none">• To understand societal, cultural and religious identities in the health environment.• To use self assessment tools to improve self-awareness and relationship skills		<ul style="list-style-type: none">• To raise awareness and to work on one’s own beliefs and prejudices• To know how to assess the importance of the relations between the treatment offered and the cultural and religious identity• To be able to think about one’s professional practices• To set up winning strategies• To be aware of what can be an obstacle with one’s relation to the others• To be open-minded• To develop intercultural communication skills to improve one’s interactions with migrant patients• To be able to practice self-assessment• To develop skills as empathy, active listening and respect	
EQF LEVEL			ECVET CREDIT		
5			1		
LEARNING HOURS					
Total = 24		Contact = 6		Hands-on = 4	
				Self-study = 6	
				Assessment = 8	
This unit will be delivered through:					
<input checked="" type="checkbox"/> Discussion		<input type="checkbox"/> Presentations			
<input type="checkbox"/> Field work		<input type="checkbox"/> Working groups			
<input type="checkbox"/> Hands on		<input checked="" type="checkbox"/> Self-assessment/personal research			
The unit will be assessed through:					
<input type="checkbox"/> On-going assessment		<input type="checkbox"/> Presentation		<input checked="" type="checkbox"/> Self-assessment	
<input type="checkbox"/> Oral examination		<input type="checkbox"/> Project		<input checked="" type="checkbox"/> Written exercise	
<input type="checkbox"/> Portfolio		<input checked="" type="checkbox"/> Reflective diary		<input type="checkbox"/> Written assignments	
<input type="checkbox"/> Practical		<input type="checkbox"/> Report		<input checked="" type="checkbox"/> Written test	
		<input type="checkbox"/> Workshop			

Training modules 1

Duration of unit: 8h of training / one activity per day

1.1. Common topic

Title <i>The title should be one of the modules defined on the table below (i.e. intercultural./interreligious competences)</i>	Interculturality and religions
Abstract/Aim <i>(max 150 words - 10 lines)</i>	<p>The combined effects of major political and technological changes, and particularly dense migratory flows... lead to think about the importance of intercultural and interreligious issues today.</p> <p>All social sectors are concerned and obviously health professionals are directly involved by these issues especially when they have to deal with emergency.</p> <p>The existence of this “other” who has another culture or/and religion, who speaks another language, makes us wonder what is the role of each one and what kind of communication means (form or terms) we are supposed to use. This leads us to considerate strategies to manage and to adjust to different situations whether they deal with the expression and management of pain, the relation to the body or the relation to death.</p>
Key words <i>Max 5 keywords</i>	Body identity; pain assessment; representations, cultural differences; beliefs;
Learning objectives <i>1 per sub-module, in bullet points</i>	<ul style="list-style-type: none"> - To acknowledge and to work on beliefs and prejudices - To assess the importance of the relation between treatments and cultural & religious identity - To think about our own practical work experience - To introduce win-win strategies
Tips <i>(transversal) (no more than 6 for do and don't depending on the sub-topics)</i>	
References/further reading <i>available in English or other languages (specify)</i>	<ul style="list-style-type: none"> - Association DSM-IV. Manuel diagnostique et statistique des troubles mentaux, Masson, Paris, 1996. (American Psychiatric Association DSM-IV “Diagnostic and Statistical Manual of Mental Disorders”.) - Augé M. et Herzlich C., Le sens du mal. Anthropologie, histoire, sociologie de la maladie, Archives

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- **Boltanski L.**, Les usages sociaux du corps, Annales, Économie, Sociétés, Civilisation, Vol 6, 1971, pp2015-233 ("Social uses of the body")

- **Bourdieu P.** Les trois états du capital culturel, in Actes de la recherche en Sciences Sociales. Vol 30, pp. 3-6. 1979. ("The three states of cultural capital in Act of social science research")

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- **Côté D.** : Penser la douleur à la rencontre du culturel et du biologique : repères anthropologique, Altérités, vol 6, N° 2, 2019, 26-47. ("Thinking of pain when culture and biology meet : anthropological landmarks")

- **Dominicé Dao M.**, Douleur et culture, quelles spécificités et comment les explorer, 5^e Rencontre francophone Suisse et France, voisine de la douleur chez l'enfant. 2012 ("Pain and culture, what specificities and how to explore them, 5th Francophone meeting Switzerland and France, neighbouring pain in children")

- **Eberhard C.**, Droits de l'homme et dialogue interculturel, 2011, Paris, Editions Connaissances et savoirs, p. 587. ("Human rights and intercultural dialogue")

- **Faure J.**, Pour une prise en charge globale des patients migrants originaire d'Afrique, Carnet de santé, 2008. ("For a holistic care of migrant patients from Africa")

- **Grandsard C.**, in Metzger C. et Coll., soins infirmiers et douleurs. Paris, Masson, 2000, pp 115-119. ("Nursing and pain")

- **Guille-Escuret G.**, Les rendez-vous de la mort et de la culture, in L'Homme, N°215-216, édition de l'EHESS, 2015 ("Meetings between death and culture")

- **Lorin F. Dr.**, Douleur médecine et judaïsme, www.psychiatriemed.com. ("Pain medicine and Judaism")

- **Lalleman. L.**, Les représentations culturelles de la douleur au Bénin ont-elles un rôle dans son ressenti, dans son expression, dans son soulagement ? Quelques outils pour une meilleure compréhension des représentations de la maladie dans un pays d'Afrique de l'ouest? Médecine humaine et pathologie. 2014. ("Do cultural representations

of pain in Benin have a role in people's feelings, in its expression, in its relief? Some tools for a better understanding of the representations of disease in West Africa?")

- **Le Breton D.**, *Anthropologie de la douleur*, Paris, Métailié, 1995. ("Anthropology of pain")

- **Le Breton D.** *Anthropologie du corps et de la modernité*, PUF, 2008. ("Anthropology of body and modernity")

- **Miner H.M.**, *Body Ritual among the Nacirema*, The American Anthropologist, Vol 58, 1956.

- **Nathan T.**, *L'influence qui guérit*, Odile Jacob, Paris, 1994. ("The influence which heals")

- **Ndiaye L.**, *Mort et altérité: Approche socio-anthropologique d'un phénomène indicible*, Éthiopiennes, N° 74, 1^{er} sem 2005. ("Death and otherness: A socio-anthropological approach to an unspeakable phenomenon")

- **Pelletier B.**, *Pratiques interculturelles en milieu hospitalier*, in *Gestion des risques interculturels.com*, 2012 ("Intercultural practices in hospitals")

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- **Turner B.S.**, *The Body & Society*, Exploration in social theory, 3rd Edition, Sage, 2008.

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- **Zborowski M.**, *People in pain*, Jossey-Bass, San Francisco, 1969.

1.2. Expression and management of pain

Theoretical and contents 2-3 pages	Expression and management of pain <p>Many anthropologists and sociologists highlighted the social nature of illness. Marc Augé – French anthropologist – notes that illness is “the most individual and social thing” because the criteria to identify it are social: “thinking about one's illness already refers to others”. These different perceptions of suffering and illness, of their causes and their symptoms will define the treatment that health professionals will provide.</p> <p>Even though pain phenomenon seems to be universal, its expression it is not. All these factors contribute to the way we experience and express pain: our gender, age, culture, religion, the social status of the person(s) who face the expression of that pain....</p> <p>All of these factors are exacerbated when we do not share the same language.</p> <p>Pain is therefore an intimate phenomenon which is also combined with social, cultural and relational factors that are the fruit of an education.</p> <p>A) <u>From religion to pain</u></p> <p><u>For a materialistic western society</u>, pain is often perceived as a scandal, something to be eliminated at any cost, never mind its cause and consequences. Its intensity will be assessed accordingly.</p> <p>Religion influences how pain is felt, how it is perceived and how it is treated.</p> <p><u>For Christians</u>: usually there is no any resignation to pain. It is accepted as part of life and every way to reduce or eliminate it is welcome. It should be stated that this interpretation of pain is a recent phenomenon. Indeed, in the 17th Century, suffering was seen as purifying from sins.</p> <p><u>For Islam</u>: God taught men to forgive and to hope in order to heal from moral pain, but also to take care of oneself in order to heal from physical pain. According to the Prophet, God created a remedy for all diseases. That is why, during the rites, the worshippers' health status is taken into account: no Ramadan if they are ill, no prayer gestures if they cause physical pain...</p> <p><u>For Judaism</u>: To make it short, Judaism is not a religion of mortification or asceticism. People are allowed to complain and to do everything possible to get rid of the pain.</p> <p>To make an exhaustive list of all existing religions and to give tips on how to act with regards to pain is an impossible bet.</p>
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Indeed, what is important to understand is not the doctrine itself rather than the representation we make of it and the way it is integrated to our culture and history.

B) From culture to pain

The influence of cultural affiliation on management of migrant patient pain is therefore very important.

Indeed, if pain is common to all living beings, its expression can be very different from one person to another and especially from one culture to another.

Examples:

- The Baribas (Benin)

This tribe is famous for the absence of reaction to any painful stimulus whatever the intensity (childbirth, serious injuries ...). For these people, pain demonstration is a sign of cowardice and arouses shame. According to one of their motto *"To choose between death and shame, death is far more the best option"*.

- Expression of pain amongst African or Asian patients

For these patients, pain is like burning from top to toes, like having worms in the head or ants teeming under the skin. But, according to the very serious psychiatric manual DSM-IV, these symptoms expressed by a Western patient would evoke delirious state.

- The influence of belonging on painful experience and its expression

Comparing several patients attending the same hospital in the United States, the anthropologist M. Zborowski observed different behaviours in relation to pain according patients' cultural backgrounds: "Jewish" patients and patients from Italy do not hesitate to express their pain and to look for their relatives, while Americans of old strain and Irish concealed their suffering for as long as possible.

Health member staff, when dealing with suffering patient, looks for the pain causes. Beyond the physiological origin of the pain, the patient tries to understand its meaning by answering the following questions: why does it happen to ME? Why now? Obviously for some cultures: Where does my pain come from? Who has sent it to me?

This questioning can be the first steps of possible misunderstandings between health professionals and patients. According to the psychologist Nathan T., those misunderstandings can create a true traumatism inflicted by the formers on the latters.

To decrease misunderstandings, different solutions can be introduced such as creating partnerships between hospitals and migrant associations (as it is already existing in Belgium, France, Switzerland, the United States ...)

This partnership is based on:

- community support (visit to the patient's bedside at the hospital, at home; meals-on-wheels service...)

	<ul style="list-style-type: none"> - cultural mediation (to ease communication between patient and caregiver) - ethnomedicine consultation: a transcultural care - mutual training: sharing of knowledge between members of the association and health member staff. <p>Conclusion</p> <p>When we deal with pain within an intercultural / religious approach, what is important for health professional is to understand social and cultural structure of pain rather than to have an exhaustive knowledge on the subject.</p> <p>Indeed, the focus should be on the suffering person's intimacy in order to understand how he/she integrates physiological data through his/her (cultural, religious, life ...) history to appropriate his/her pain and to give it an acceptable meaning.</p>
<p>Activities</p> <p>1 activity max 4 pages</p> <ul style="list-style-type: none"> - Title - Objectives - Keywords (max 5) - Contents (please always cite the source and add the references in the module spaces dedicated to the references) - Material (the material can be also multimedia, like pictures, videos, drawings, material to be printed by the learners...) 	Title: Identity
	Objective:
	- To be aware of one's obstacles in relationship with others
	<p>Keywords: self-awareness</p> <p>Contents:</p> <p>The person you are today has built up through your life path:</p> <ul style="list-style-type: none"> - The country in which you were born - The culture in which you were raised, the one you built up - The religion (or the absence of religion) in which you were raised, the one you have chosen - Your personal, professional history ... <p>To what extent do these components consciously or unconsciously influence how you will apprehend the other's pain?</p> <p>√ Think about who you are today.</p> <p>√ How does it impact your relationship with others?</p> <p>√ What are your limits (what you cannot stand)?</p> <p>√ What can you accept?</p> <p>√ What do you refuse?</p> <p>On the basis of this reflection, answer the following question: <i>In my working life, it happened that what I am, what I think, has had a negative impact on the way I understand the other's pain.</i></p> <ul style="list-style-type: none"> - If you answer yes, try to see what stopped you. Think about which strategies you could have used to avoid it. - If you answer no: note the strategies and skills that you have used. <p>Are they repeatable, transferable?</p>
<p>Case studies</p> <p>1 or 2 (no more than 1 page in form of a storytelling)</p>	<p>Title: The parable of the elephant: an illustration of different views in the world</p> <p>Objectives:</p> <ul style="list-style-type: none"> - To extend one's point of view - To enrich one's view of the world <p>Keywords: perception</p> <p>Content: Parable of an Islamic poet</p>

An elephant had been brought by Hindus in a dark place. In order to see it, several people entered, one by one, in the darkness. Since they could not see with their eyes, everyone touched it in the dark with the palm of their hand. In the case of the first person, whose hand landed on the trunk, said "This being is like a thick snake". For another one whose hand reached its ear, it seemed like a kind of fan. As for another person, whose hand was upon its leg, said, the elephant is a pillar like a tree-trunk. The one who placed his hand upon its side said, "elephant is a wall". Another who felt its tail, described it as a rope. The last felt its tusk, stating the elephant is that which is hard, smooth and like a spear. Also, whenever someone heard a description of the elephant, he understood it from the part that had been touched. According to the part felt, the affirmations differed and a man called it Dal when another one called it Alif. If each of them had held a candle, differences would have disappeared from their words.

Brainstorming question

In your activity, it may have happened that your colleagues or yourself have only seen "a part of the elephant".

- ✓ Think about strategies that you have adopted?
- ✓ What was your behaviour at that time?
- ✓ Which skills have you used?
- ✓ Were they relevant?
- ✓ Could you do better today?

Summary of key points

Culture is present at any time during pain management protocol and it influences:

- ✓ **The tolerated level before visiting health professional**
- ✓ **The kind of complaint expressed and its relevance**
- ✓ **The expression of complaint**
- ✓ **The understanding of the disease causes**
- ✓ **The perception of the severity and of the prognosis**
- ✓ **Attitudes and expectations from caregivers**
- ✓ **Beliefs about required treatments**

Consequences if cultural and linguistic differences are not taken into account:

- ✓ **Misunderstandings**
- ✓ **Negative judgments, stereotypes, discrimination**
- ✓ **Inadequate therapeutic cooperation**
- ✓ **Non-optimal quality of care**
- ✓ **Patients' dissatisfaction**
- ✓ **Frustrations of health professionals**

Self-evaluation questions*Multiple choice questions with more than one correct answer. (min. 5)***Question 1: Title of question**

Content of question	What are the components of pain?
Answer 1	Socio-economic components
Answer 2	Affective-emotional components
Answer 3	Behavioural components
Answer 4	Cognitive components
Correct answer(s)	1,2,3,4

Question 2: Title of question

Content of question	What are the consequences of pain ?
Answer 1	Psychological : depression, anxiety
Answer 2	Social : withdrawal, isolation
Answer 3	Spiritual
Answer 4	Physical
Answer 5	Somatic: lack of appetite, weight loss
Correct answer(s)	1,2,3,4,5

Question 3: Title of question

Content of question	Which factors influence pain?
Answer 1	Social values
Answer 2	The history of each one
Answer 3	Living conditions
Answer 4	Individual and collective history
Answer 5	Family interactions
Correct answer(s)	1,2,3,4,5

Question 4: Title of question,

Content of question	What is the most important in health professionals' behaviour?
Answer 1	Empathy and availability
Answer 2	Do not have any prejudice
Answer 3	Understanding/being respectful
Answer 4	To create a climate of confidence
Answer 5	To know one's limits/distress
Correct answer(s)	1,2,3,4,5

Glossary (if requested)*Most important terms, specific for the sub-module.*

Ethnomedecine	Medicine with regards to ethnicity
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1.3. Relation to the body

Theoretical contents 2-3 pages	and Relation to the body To take care of migrant patients who may have different background or religious beliefs can be a challenge for health professionals. Practices and beliefs can have an important influence on patient's care: <ul style="list-style-type: none">- either on patient's point of view about the treatment quality he/she receives (listening, respect ...)- or on decisions to be taken by himself/herself or his/her family regarding that treatment. Health professionals will be open-minded and comprehensive about some peculiar migrant patients' needs and reality. All existing works, whether anthropological, psychiatric or psychological... prove how the body is built by cultural, religious and geographical contexts. The body is therefore a changing and symbolic reality. Beyond the physics factors common to everyone (head, arms, legs, etc.), each human being considers his/her body according to his/ her education, life experience ... Some basic factors such as gender (male/female), in any societies, are related to specific behaviours with one's body (or certain part of the body). <ul style="list-style-type: none">- For example, it is acceptable in our Western societies to see a shirtless man at the beach. The same outfit for a woman usually results to moral judgments. In individualistic societies, where each one is separated from the other and relatively autonomous in his/her initiatives and values, the body is perceived as something which can be isolated from a person to whom it gives a face. On the other hand, in traditional and communal societies, the body does not exist as an element of individuation. These disparities of approaches will result in massive differences between how people establish if something is acceptable or not either physical contact, kind of treatment to use. Cultural and religious differences are sometimes difficult to take into account in care because of diverse ways of living and of considering care. Some migrant communities could be suspicious about provided treatments and about staff members who provide them: <ul style="list-style-type: none">- sustained contact may not be appreciated or even prohibited;
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- staff dress code can be considerate as inadequate;
- relation to intimacy;
- causes of diseases (e.g. for Asian community, disease can be the consequence of bad behaviour);
- provided treatment by a person of the opposite sex;
- hierarchical position of the person in charge of care/treatment;
- female health professional's authority for migrants who do not consider women as equal as men;
- different perception about the body (an African mother may consider that her child's overweight is synonym of good health)
- different perception about physical disability ...

These cultural and religious differences may sometimes create difficult relationships.

We forget as well that we consider these differences because of our own culture and that therefore we judge their behaviour.

Hence, it is necessary to understand where misunderstandings come from in order to adapt attitude when:

- the way we see the cycle of life (childbirth, ageing, diseases ...) is not compatible with the way some migrants may perceive it;
- we do not consider the fact that people from different background are seeing things differently when we establish a treatment plan, when we implement it or during the follow-up;
- we proposed them what can be considerate unusual treatments (for people from a different background) without explanation;
- the proposed treatment is scary for them according to their culture;
- we disregard the decision-making hierarchy that migrants may have within their family or within their cultural community.

Conclusion

The practical answer is not about knowing in detail the important variety of cultures and religions in their relation to the body but to be aware of the existence of these varieties and of how they can affect health practices.

Knowing does not mean understanding and will not prevent misunderstandings.

Indeed, it is necessary for health professionals to be as sensitive to patient's cultural heritage as their own inheritance, and to be

	<p>aware of what happen when these different heritages are in presence.</p> <p>It is therefore important:</p> <ul style="list-style-type: none"> - to develop a mentality open to difference, - to focus on communication to build up good relationship, - to increase empathy, listening and negotiation skills.
Activities 1 activity max 4 pages <ul style="list-style-type: none"> - Title - Objectives - Keywords (max 5) - Contents (please always cite the source and add the references in the module spaces dedicated to the references) - Material (the material can be also multimedia, like pictures, videos, drawings, material to be printed by the learners...) 	<p>Title: Personal analysis</p> <p>Objectives:</p> <ul style="list-style-type: none"> - To manage interaction with migrants - To develop intercultural communication skills - <p>Keywords: Observation – thought – implementation</p> <p>Contents:</p> <p>Describe a specific situation in which you have faced cultural differences in relation to the body. Then read the grid of analysis and analyse your situation.</p> <p>1- Describe the situation?</p> <hr/> <hr/> <hr/> <p>2- Grid of analysis of hard situation?</p> <ul style="list-style-type: none"> - <u>What was my objective during the conversation?</u> Explain which was the impact you wanted to have on the other; Ex: <i>I wanted him/her to undress in order to do a check up</i> - <u>What were my feelings toward the patient?</u> Most of the time nonverbal situation reveals our feelings and emotions. The patient can understand them and change his/her behaviour. Ex : <i>I was impatient because I did not have much time.</i> - <u>When did I realize that our communication was starting to be hard?</u> Answers to that question are different according to context. The situation could have been difficult before. Or it can become harder while talking. Indeed, it may appear that health professional and patient were not on the same tracks so they could not fully understand each other. Ex: <i>When he/she told me that..., when his/her face went down..., when he/she stepped back...</i>

- How can I explain what happened?

Answering that question doesn't mean that we must blame the others. Because even if we consider rightly the situation, condemning the other does not help us to better manage conflictual relationships within the intercultural framework.

Ex: When he first refused, I tried harder to make him/her understand my point of view.

- What could I have done differently?

It is rare to find only one way to say things. We should avoid saying that we cannot do anything else, otherwise we stopped the opportunity to move ahead.

Ex: I could have tried to understand why he/she was hesitating.

- What do I learn from that situation?

The fact that we analyse an inconvenient situation allow us to understand efficiently why we act that way in an inconvenient situation.

Ex: When someone disagrees with me, I become nervous and I argue even more to defend my point of view.

- What can I do to take into account this learning in my future intercultural interactions?

Improving our competences in intercultural interactions by adding new behaviours and new ways to act in everyday's life.

Ex: Next time a patient will refuse my treatment, I will focus on him/her to understand his/her point of you as much as I can.

3- Analyze the situation using the grid above

What was my objective during the conversation?

What were my feelings toward the patient?

	When did I realise that our communication was starting to be hard?
	How can I explain what happened?
	What could I have done differently?
	What do I learn from that situation?
	What can I do to take into account this learning in my future intercultural interactions?
Case studies 1 or 2 (no more than 1 page in form of a storytelling)	Body Rituals <u>Unusual body behaviours, Text by Horace Miner anthropologist</u> Material : <p>“The Nacirema have an almost pathological horror of and fascination with the mouth, the condition of which is believed to have a supernatural influence on all social relationships. Were it not for the rituals of the mouth, they believe that their teeth would fall out, their gums bleed, their jaws shrink, their friends desert them, and their lovers reject them. They also believe that a strong relationship exists between oral and moral characteristics. For example, there is a ritual ablution of the mouth for children which is supposed to improve their moral fiber. The daily body ritual performed by everyone includes a mouth-rite. Despite the fact that these people are so punctilious about care of the mouth, this rite involves a practice which strikes the uninitiated stranger as revolting. It was reported to me that the ritual consists of inserting a small bundle of hog hairs into the mouth, along with certain magical powders, and then moving the bundle in a highly formalized series of gestures.</p>

In addition to the private mouth-rite, the people seek out a holy-mouth-man once or twice a year. These practitioners have an impressive set of paraphernalia, consisting of a variety of augers, awls, probes, and prods...”

Questions :

- Try to find out the geographical location of this ethnic group.
- What communication difficulties could you face with that kind of ethnic group?
- Can you see differences between their hygiene standards and yours?
- What kind of eating habits could have this ethnic group ?

Answers :

- The word “Nacirema” is the anagram of American. Horace Miner studied oral behaviours of 20th century Americans under an anthropological view. It shows that our behaviours may seem crazy even through our own eyes. What’s happening when we look at different cultures with our own values ?

Summary of key points

Questions : Which factors can interfere with the management of the migrant patient?

- Linguistic limits?
- Eating habits?
- Differences between hygiene standards?
- Mistrust of health professional?
- What is forbidden and what are the religious or traditional obligations?
- Ignorance and fear about treatments?
- Domination of the husband, of the in-laws?
- The wiped-out women role in this society?
- Beliefs regarding diseases and their origins?
- Belief in traditional care? ...

Answers :

- Listening, being sensitive to patient’s life, culture, values
- To understand signs showing what the patient wants to say (they can be verbal or nonverbal)
- To know how to manage one’s emotions in order to avoid misunderstandings, conflicts
- To have an appropriate behaviour in terms of: gestures, looks, posture, clothing, facial expressions
- To listen and assess oneself in order to change, to adapt our behaviours toward patient’s situation and expectations.
- To acknowledge the patient’s autonomy and respect that he/she should receive

- To show some related to their culture and religion

Self-evaluation questions

Multiple choice questions with more than one correct answer. (min. 5)

Question 1: Title of question

Content of question	Which factors can interfere with the check-up of a migrant patient?
Answer 1	Language
Answer 2	The community culture
Answer 3	Religious prohibitions
Answer 4	The person's social value
Answer 5	The person's place within his/her family
Correct answer(s)	1 ; 2 ; 3 ; 4 ; 5

Question 2: Title of question

Content of question	What can be the limits of the patient's body check-up?
Answer 1	Prudishness
Answer 2	Mistrust
Answer 3	Fear
Answer 4	The fact that they sometimes have to undress
Correct answer(s)	1 ; 2 ; 3 ; 4

Question 3: Title of question

Content of question	What are the attitudes and gestures that could help with a migrant patient check-up?
Answer 1	Dialogue
Answer 2	Listening
Answer 3	Intervention of a mediator
Answer 4	Spotting signs of verbal and non-verbal communication
Answer 5	Understanding
Correct answer(s)	....

Question 4: Title of question

Content of question	What is the most important in migrant's patient care?
Answer 1	Observation
Answer 2	Respect
Answer 3	Confidence
Answer 4	Understanding
Answer 5	Listening and dialogue
Correct answer(s)	1 ; 2 ; 3 ; 4 ; 5

1.4. Relation to death

Theoretical and contents

2-3 pages

Relation to death

Death is a reality people don't like to face.

In most cultures, Men fear death, and many of them want to believe that there is an after. Depending on the period of time, different countries or religions, this "after" has various names: "Elysium" in Greek mythology, "Heaven or Hell" for Christians and Muslims, or the reincarnation of souls according to Hinduism.

For most cultures, the importance of funeral rites is to remind us the inevitability of death and the need to have a social regulation system to make it acceptable for the living.

However, nowadays, there is a dichotomy between two systems of thought.

The first, coming from *individualist societies*, presents death as an embarrassing, increasingly technical and medicalized phenomenon. This system puts the deceased's relatives at distance, leads to funerary rites simplification or retraction and to a society that, according to Patrick Baudry, gets rid of "death, the dying and the dead".

The second is coming from *communal and traditional societies*. This system includes and celebrates death, gives it a much more explicit place and assigns to the dead a central role in the building of the living society.

Some examples:

COUNTRY/REGIONS	RITUALS
Mexico	Celebration of the dead (Día de los Muertos): offerings, picnics on graves.
Madagascar/ Indonesia	The ceremony of turning corpses: every 5 years (or every two years in Indonesia), the living dig up their dead, wrap them in new shrouds and walk through the cemetery with them before burying them again.
In the Great Lakes region (Africa)...	The dead are considered as enemies, so they are not buried together but each of them is buried next to his hut.

This dichotomy is not only observable through behaviours towards the dead and featuring of death, but on "death" verbalization, which can lead to misunderstandings.

ex: In African culture, people are not afraid of facing death. Therefore using precautionary measures as periphrasis instead of the word "dead" can sometimes be considered as a lack of precaution for Africans hence there is a considerable number of problems comparing to workers with European culture (Louis-Vincent Thomas quoted by Lamine Ndiaye, Death and alterity).

This dichotomy can also be found in the status of death within different societies. In one hand, there is a radical division between both statuses (life and death), on the other hand, there is a kind of continuity and permeability between these two states.

This division will then lead to diverse ways of getting people ready for their death, to organize the moment of their agony and finally to organize the after-death rituals.

The integration of those disparities can be a real problem in hierarchical environment such as in Western hospitals. Health professionals too often struggle with keeping on hospital or organizations rules and respecting the different rituals practices around death.

Several conditions are likely to smooth out these difficulties and avoid misunderstandings:

- using intercultural mediation by involving a person who knows both cultures;
- dialogue and communication with patients and their families, whenever possible;
- intervention of an interpreter to help health professionals to understand the people involved.

The idea behind is to identify in migrant's practices what is fundamental and what is not, which principles should be respected and which practices can be avoided or arranged without shocking.

Conclusion:

The way health professionals interact with migrants in death situation cannot be based on an exhaustive knowledge of all cultures and religions and their relation to death.

Respecting, listening and communicating are the keys to peaceful interactions between people from different cultures and religions.

Activities

1 activity max 4 pages

- Title
- Objectives
- Keywords (max 5)
- Contents

(please always cite the source and add the references in the module spaces dedicated to the references)

- Material (the material can be also multimedia, like pictures, videos, drawings, material to be printed by the learners...)

Title: Self-assessment on intercultural competences

Objectives:

- To assess one's competences
- To receive some feedbacks on one's competences
- To fix objectives for improvement

Keywords: self-assessment – intercultural competences

Contents:

Activity 1: Self-assessment

For each of the following statements, using the proposed scale, fill in the questionnaire below (1 if the statement does not fit you ..., 7 if the statement fits you). You will then fill in your answers in the first column of the 3rd document below (column "me").

Document 1

Not much	1	2	3	4	5	6	7	A lot	
I try to understand ideas and points of view which are different from mine									
I listen carefully and rigorously									
I am aware of the consequences of my behaviour on others									
When someone argues against my opinions, I am able to discuss peacefully									
I take the initiative to clear up misunderstandings when they occur									
I respect people I am talking to, in any situation									
I put forward specialized information									
I present my point of view without provoking hostility									
I care about others' concerns									
I make the effort to express myself in ways that people can understand									
I am neither arrogant nor scornful									
I try to know what the person I am talking to thinks or feels									
I say what I think in an acceptable way									
I distinguish what is essential and what is not									
I don't have any bias									
Within a group, I foster everyone to express themselves									
I am attentive to my interlocutor's body language									
I rephrase my interlocutor's words to make sure that I have understood									

Activity 2: Look for feedbacks

In this activity, the aim is to have an external point of view: document 2 will be filled in by someone from your professional environment or even by your relatives. However, keep in mind that the way you communicate may be different in private context. It is recommended that one questionnaire should be filled in by person you are facing difficulties to communicate with. If possible, the questionnaire should be completed anonymously in order to obtain forthright answers.

Document 2:

Not much	1	2	3	4	5	6	7	A lot
Tries to understand ideas and points of view which are different from his/hers								
Listens carefully and rigorously								
Is aware of the consequences of his/her behaviour on others								
When someone argues against his/her opinions, he/she is able to discuss peacefully								
Takes the initiative to clear up misunderstandings when they occur								
Respects people he/she is talking to, in any situation								
Puts forward specialized information								
Presents his/her point of view without provoking hostility								
Cares about others' concerns								
Makes the effort to express him-/herself in ways that people can understand								
He/she is neither arrogant nor scornful								
Tries to know what the person he/she is talking to thinks or feels								
Says what he/she thinks in an acceptable way								
Distinguishes what is essential and what is not								
Doesn't have any bias								
Within a group, fosters everyone to express themselves								
Is attentive to his/her interlocutor's body language								
Rephrases his/her interlocutor's words to make sure that he/she has understood								

For each statement, you will fill in the column called "Other" with the average obtained scores.

You will then report the difference between the two columns "Me" and "Other" in the 3rd column:

Example : **Me (5) minus Other (7) = difference -2**

Document 3

Statements	Me	Other	GAP
To understand ideas and points of view when different from his/hers			
To listen carefully and rigorously			
To be aware of the consequences of his/her behaviour on others			
To accept to be contested			
To clear up misunderstandings when they occur			
To respect people he/she is talking to, in any situation			

To put forward specialized information			
To present his/her point of view without provoking hostility			
To care about others' concerns			
To make sure he/she is well understood			
Not being arrogant nor scornful			
To be attentive about what the person he/she is talking to thinks or feels			
To say what he/she thinks in an acceptable way			
To distinguish what is essential and what is not			
Not having bias			
To foster everyone to express themselves			
To be attentive to body language			
To rephrase one's words to make sure he/she is understood			

In document 4 below, write down in the left-hand column the 4 statements with the highest differences. In the right-hand column, comment the differences.

If differences between your self-assessment and the other's assessment is short, that means you well know the impact of your behaviour when you interact with someone. On the other hand, if there are significant differences, reconsider a bit more your personal analysis and observation about your behaviours when you interact with someone. Do it especially when the differences are positive because it means that you overestimate your abilities on that point.

Document 4

STATEMENTS	COMMENTS
-example: having no bias	Example: <u>Circumstances</u> under which bias can be demonstrated. <u>Strategies</u> to be more open-minded
-	-
-	-
-	-

Activity 3

Starting from the information you have now, try to answer the following questions to rephrase your learning objectives.

What are your strengths in the field of interactions? Your strengths are with the highest score (between 5 and 7) and with the shortest difference (less than 2).

Which competences should you acquire or develop?

Given the two previous answers, fix an objective of development.

Phrase the means you are going to use to reach you objective.

Activity 4 : Feedback on learning outcomes

Approximately 3 months after this self-assessment, do again the previous activities and answer the following questions.

Back on behaviours identified in Activity 3.

Did the implemented strategies help you to improve your interactions with migrants?

Do you still need to improve interactions with migrants?

If so, which means are you going to implement to strengthen what you have learnt?

Summary of key points

- To understand that mourning, death and everything around it does not have the same meaning from one culture to another
- Empathy, listening and respect are the keys to successful interactions with migrants.

Self-evaluation questions

Multiple choice questions with more than one correct answer. (min. 5)

Question 1: Title of question

Content of question	Factors which interfere with death for migrant patients and their relatives?
Answer 1	Beliefs and religion
Answer 2	Cultural affiliation
Answer 3	Apparent physical integrity
Answer 4	Respect of rituals
Answer 5	Personal view of dignity
Correct answer(s)	1 ; 2 ; 3 ; 4 ; 5

Question 2: Title of question

Content of question	Regarding death, how to accommodate the migrant patient and their relatives' requests with internal rules of the host country and the organization?
Answer 1	Intervention of mediator who knows both cultures
Answer 2	To listen
Answer 3	To respect
Answer 4	To explain
Correct answer(s)	1 ; 2 ; 3 ; 4

Question 3: Title of question

Content of question	Regarding death, how to avoid misunderstandings with migrant patients and their relatives?
Answer 1	Dialogue
Answer 2	Listening and respect
Answer 3	Cultural mediation
Answer 4	To be aware of one's own obstacles
Correct answer(s)	1 ; 2 ; 3 ; 4

Module 2 : Intercultural communication and counseling



Module: Intercultural communication and counselling

The workplace of health professionals is a multicultural environment which demands special skills for the communication between health professionals and hospitalized persons/patients/healthy population/health services users. This module focuses on the development of communication and counselling skills of the health professionals. They should be adequately qualified in order to be able to communicate, understand and care for persons with a different cultural background. That means they need to develop an intercultural adequacy.

KNOWLEDGE

SKILLS

COMPETENCES

At the end of the unit the learners will be able to

<ul style="list-style-type: none"> Defining verbal and nonverbal communication and understand the difference between them Know the principles of verbal and nonverbal communication Define empathy in intercultural care and be able to use it in everyday practice Outline essential skills required for active listening that is needed within the healthcare professional-patient relationship. Understand aspects of culture and manifestations in everyday-life and behavior 	<ul style="list-style-type: none"> Assess, the level of verbal communication of the interlocutor as well its understanding of your language Observe carefully and ask open questions in order to understand the way that the interlocutor communicates Assure there is an agreement between verbal and non-verbal messages Use empathy in everyday practice Monitor progress in active-listening use. Increase awareness about own cultural prejudices and how they affect everyday judgments 	<ul style="list-style-type: none"> Focus on the person and his/her cultural characteristics Approach the interlocutor with respect Assure the privacy of the conversation Increase self-awareness and self-reflection about own communicational skills and listening level Self-reflection own cultural origin and influence on everyday life and work Combine the self-awareness level with counseling skills and apply in healthcare practice
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EOF LEVEL

6

ECVET LEVEL

?

LEARNING HOURS

Total:	Contact:	Hands-on:	Self-study:	Assessment:
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This unit will be delivered through

<input checked="" type="checkbox"/> Discussion	<input checked="" type="checkbox"/> Presentations
<input type="checkbox"/> Fieldwork	<input checked="" type="checkbox"/> Working groups
<input checked="" type="checkbox"/> Hands-on	<input type="checkbox"/> Other (please specify)

The unit will be assessed through

<input checked="" type="checkbox"/> On going assessment	<input type="checkbox"/> Presentation	<input checked="" type="checkbox"/> Self-assessment	<input type="checkbox"/> Written exercise
<input checked="" type="checkbox"/> Oral examination	<input type="checkbox"/> Project	<input checked="" type="checkbox"/> Skills demonstrations	<input type="checkbox"/> Written assignments
<input type="checkbox"/> Portfolio	<input type="checkbox"/> Reflective diary	<input type="checkbox"/> Structured feedback	<input type="checkbox"/> Written test
<input checked="" type="checkbox"/> Practical	<input checked="" type="checkbox"/> Report	<input type="checkbox"/> meetings/discussions	<input type="checkbox"/> Other (please specify)
	<input checked="" type="checkbox"/> Workshop		

Training modules template

Duration of unit: 1 training day (8h – to be confirmed)

1.1. Common topic

Title <i>The title should be one of the modules defined on the table below (i.e. Intercultural./interreligious competences)</i>	Intercultural communication and counselling
Abstract/Aim <i>(max 150 words - 10 lines)</i>	<p>The workplace of health professionals is a multicultural environment which demands special skills for the communication between health professionals and hospitalized persons/patients/healthy population/health services users. Health professionals should be adequately qualified in order to be able to communicate, understand and care for persons with a different cultural background. That means they need to develop an intercultural adequacy.</p> <p>Indeed, attitudes and behaviors such as ethnocentricity and stereotypes constitute very important obstacles between communication and familiarization with another culture. Ethnocentricity refers to the sense of superiority of an ethnic group against another. Stereotypes refer to the belief that the cultural characteristics of a person define that person. Quite often ethnocentricity and stereotypes contribute to the development of prejudice against other cultural groups thus negative attitudes towards persons with a different cultural background because of their cultural identity.</p> <p>Health professionals should receive an adequate intercultural education so as avoid ethnocentricity and stereotypes and develop special communication and counselling skills such as skills on verbal and non-verbal communication, empathetic communication and active listening. This module focuses on the development of communication and counselling skills through lectures as well as experiential learning techniques such as reports, case studies, activities, self-study and self-assessment.</p>
Key words	verbal communication, nonverbal communication, empathy, empathetic communication, active listening, counselling
Learning objectives	<ul style="list-style-type: none">Defining verbal and nonverbal communication and understand the difference between them

	<ul style="list-style-type: none"> • Know the principles of verbal and nonverbal communication and develop the relative skills • Define empathy in intercultural care and be able to use it in everyday practice
Tips	<ul style="list-style-type: none"> • Focus on the person and then on its cultural characteristics • Assess, first, the level of verbal communication of your interlocutor as well his understanding of your language because you may need a mediator or a familiar person to translate • Approach your interlocutor with respect • Observe carefully and ask open questions in order to understand the way that your interlocutor communicates • Assure there is an agreement between your verbal and non-verbal messages • Don't raise the tone of your voice so that your interlocutor understands you • Try to find a quite environment and plenty of time for your communication with the person with different cultural background • Take a seat on the same level with your interlocutor • Assure the privacy of your conversation
References/further reading <i>available in English or other languages (specify)</i>	<ul style="list-style-type: none"> • Abu-Ras, W. M. (2007) Cultural beliefs and service utilization by battered Arab immigrant women. <i>Violence Against Women</i>, 13, 1002–1028. • Boyle, F. M., Robinson, E., Heinrich, P., Dunn, S. M. (2009). Cancer: communicating in the team game. <i>Patient Education and Counseling</i>, 74, 295–301. • Back, A. L., Curtis, J. R. (2002). Communicating bad news. <i>West J Med</i>, 176, 177–80. • Cabana, M. D., Jee, S. H. (2004). Does continuity of care improve patient outcomes? <i>J Fam Pract</i>, 53, 974–80. • Calloway-Thomas, C. (2010) <i>Empathy in the global world: An intercultural perspective</i>. Los Angeles: Sage. • Davies, J. (2003). <i>A manual of Mental Health Care in General Practice</i>. Canberra: Department of Commonwealth Health and Ageing. • D'Ardenne, P. & Mahtani, A. (1999). <i>Transcultural Counselling in Action</i>. USA: SAGE. • Dziopa, F. & Ahern, K. (2009). What Makes a Quality Therapeutic Relationship in Psychiatric/Mental Health Nursing: A Review of the Research Literature, <i>The Internet Journal of Advanced Nursing Practice</i>, 10 (11), 65-69.

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1.2. Verbal communication

<p>Theoretical contents 2-3 pages</p>	<p>and Verbal communication</p> <p>Though communication constitutes an element of culture, however it varies by culture. Despite the various similarities in the communication contexts, verbal intercultural communication is influenced by cultural dynamics (perceptions, core values, and views) and seems to vary through time as culture is not a static concept (Wilby et al, 2017).</p> <p>Definition of Verbal communication</p> <p>Verbal communication is simply defined as sharing information by using speech. However, accurate and efficient intercultural verbal communication involves a wide range of linguistic skills, human skills, listening skills, personality traits, non-verbal communication, psychological adjustment and combination of all the above which should be considered within the frame of cultural</p>
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awareness since participants have not the same experiences or understanding of a topic (Harmsen et al, 2005).

Definition of Intercultural verbal communication

Intercultural verbal communication may be extremely difficult if the communicator and the receiver share few mutual and recognizable symbols or if the message received may not match the message sent. Familiarity with words is helpful but words themselves may carry meanings that are not always understood or their context is difficult to be interpreted correctly.

As a consequence, miscommunication is possible to emerge on surface since the cultural context holds different meanings for the words used than the source intended. Strikingly, being more “patient-oriented,” is a key-element to narrow the gap between cultures (Newell, et al, 2015).

It is also noteworthy that words have two types of meanings: denotative which is the meaning often found in the dictionary and connotative which is found in the community of users and is not universal. Therefore, to avoid misunderstandings or avoid complexity is essential to literally mean what one is saying or to simplify concepts of verbal communication.

Characteristics of effective verbal communication

For all the above reasons, verbal communication should include certain characteristics. Firstly, it should be clear and consistent, state needs and feelings and separate fact from opinion. Secondly, verbal and nonverbal messages should be congruent while enunciation and tone of the voice need to be in concordance with words. Thirdly, verbal communication should incorporate clarity of speech, politeness, calmness and constant focus on the topic under discussion.

Formal or informal ways of verbal communication

Formal or informal ways of verbal communication are essential to be considered when interacting with culturally diverse population. Individuals belonging to a particular culture communicate with little need for the listener to interpret the message or they communicate in such a way that requires a high degree of listeners’ understanding of context, tone etc. Moreover, hierarchy has an impact on verbal communication as in some cultures an individual might be much more critical of ideas or in some others may hesitate to say what really means. Accordingly, verbal communication should be at the receiver’s

level of readiness and understanding, given their age, development or experience (Meina Liu, 2016).

Communication skills and steps for effective verbal communication

Verbal communication as an instrumental behavior includes technically based skills that are used in problem solving such as giving directions, giving information, asking clarification, asking questions, counselling, etc (Verlinde et al, 2012).

More in detail, verbal communication may be presented as a circle-procedure having a start and an end. Basic communication skills include the following: a) effective speaking and conversational skills, b) questioning skills and techniques and c) reflecting.

When opening a verbal communication the use of encouraging words and positive reinforcement are significant to meet initial expectations of each part. Equally important are encouragement to participate in discussion, pave the way for the development of discussion, show openness and reduce shyness or nervousness.

Questioning is an essential skill to obtain the appropriate information and show interest to the person that needs to obtain the message. Moreover, as the process is in progress, prerequisites for verbal communication are the active listening, remaining concentrated on the main direction of the speaker's message and avoiding distractions. Messages should be checked for ensuring that are received as they were intended by the method of reflecting.

Reflecting is a process of feeding back information already given by the speaker and a simple way to check whether the message has been clearly understood. Reflecting : a) encourages participants to continue talking, b) shows the speaker that the listener perceives the intended meaning of the words or at least is trying to understand the messages and c) allows the speaker to 'hear' his own thoughts and messages. The two main domains of reflecting are: a) mirroring that involves repeating precisely what the speaker said and b) paraphrasing that involves the use of other words to describe what the speaker said. Significantly more paraphrasing shows the attempt to understand what the speaker said.

Summarizing the main points of the message or asking questions to assess comprehension allows both parties to review and agree to the already exchanged communication between them. Therefore, summarizing is an effective way to minimize

	<p>misunderstandings (Smith, et al., 2011) At the close of interaction, verbal communication should be encouraging and permitting of future arrangements (Neuliep, 2017).</p> <p>Finally, a "patient-centered communication" requires readiness to listen to patients and includes elements of 'genuineness, warmth and empathy' (Wilby et al, 2017 & Ha et al, 2010).</p> <p>Effective verbal communication increases willingness to talk with others or come into contact, thus reducing stereotyping, prejudice, and bias (Wang et al., 2014 & James, 2017) and creates a therapeutic relationship which in turn enhances satisfaction (Verlinde et al, 2012).</p>
Activities 1 activity max 4 pages - Title - Objectives - Keywords (max 5) - Contents (please always cite the source and add the references in the module spaces dedicated to the references) Material (the material can be also multimedia, like pictures, videos, drawings, material to be printed by the learners...)	Activity of verbal communication: Create TV ad
	Objectives To understand the importance of effective verbal communication
	Keywords Verbal communication, effective communication
	Contents: FROM Practice Guideline College of Nurses of Ontario Practice Guideline: Culturally Sensitive Care (2009) Available at http://www.cno.org/globalassets/docs/prac/41040_culturallysens.pdf Accessed 3 /7/2017 NOTE: This exercise does not require cameras or multimedia recording. If available this can be used, but the purpose of the exercise is to focus on the idea of why empathy is important rather than technical production skills. Students are put into groups of four to six. Their task is to devise a “television” commercial of up to 1 minute’s duration. The purpose of the ad is to promote the value of effective verbal communication in healthcare to their audience. Students are responsible for writing and acting out the ad for presentation to the rest of the group.
Case studies 1 or 2 (no more than 1 page in form of a storytelling)	CASE STUDY 1 Arab immigrant women are reluctant to seek or accept external intervention after partner abuse, as it is indicated by the low rate of domestic violence reports to the police. Women's attitude and their behavior in seeking for help is influenced by cultural and religious beliefs. Unfortunately, many Arab women choose not to break an abusive marriage or to avoid seeking for help for various reasons such

as being socially unacceptable, revealing family privacy, having low or not at all financial support and custody of their children and several other reasons. Both Arab immigrant women and Arab women living in Middle Eastern countries share the same attitudes, beliefs and thoughts by rejecting revealing the abuse or the intervention by authorities. (Abu-Ras, 2007 & Shalhoub-Kevorkian, 2000).

REPORT

It was nearly midnight when an Arab immigrant woman admitted to the Emergency Department of a public hospital accompanied with a friend of hers. The woman reported severe headache and claimed to have fallen from stairs at home. During physical examination, there were observed spread bruises on her left arm and her back as well as restraints or grip markings. She looked terrified and was hardly speaking. In medical history she also reported chronic headaches and stomach pain.

The injury mechanism as was reported by her could not explain the signs on her body. Possibly, the woman had been a victim of domestic violence. Despite the obvious signs, she tried to hide the abuse possibly due to fear or shame about the abuse.

Initially, verbal communication with health professionals was limited as the woman denied to speak or give any further details. Additionally, the woman refused any contact with language interpreters. Though she was not speaking Greek fluently, she managed to answer questions about her status of health and described her mood as consistently sad and discouraged.

Nurses tried :

- to create a safe, tranquil and welcoming environment promoting shared respect
- to ask questions in a respectful way trying to avoid any discomfort
- to admit her in a separate medical ward (however available for not too long) so as to feel more relaxed or avoid any curious patients
- to communicate not in a loud voice but showing apprehension of her words, sitting opposite to her but on the same level
- to reassure her that their communication was confidential.

As she was suspected with possible intracranial injury, she underwent cranial computed tomography which demonstrated no neurological signs or symptoms. Before hospital discharge, nurses provided elaborate information using simple, non-medical terms about the therapeutic regimen.

Finally, nurses felt obliged to ensure that the woman fully understood the status of her health by repeating the most important points of their discussion and providing time to express her feelings or other misunderstandings.

Furthermore, nurses declared their willingness to provide psychological help in case she wished to reveal her problems.

The Arab immigrant woman though was not very talkative at

first, she gradually felt more safe to ask information for health care services dealing with this sensitive issue in culturally appropriate care.

Case study 2

A nurse is asked to teach a 60-year-old woman of Chinese descent how to perform self-continuous ambulatory peritoneal dialysis. The woman has no family, speaks only Mandarin and lives in a Chinese housing environment. The visiting nurse identifies the language barrier and creates a care plan with the goal of promoting communication. The client identifies her next-door neighbour as an interpreter she would be comfortable with. The nurse asks the neighbour if she is willing to help in this role. The neighbour agrees, and the nurse reviews with the neighbour the need to maintain client confidentiality. A written list of visit dates and times is given to the neighbour, who agrees to be available for scheduled nursing visits. The care plan indicates that the nurse will knock at the neighbour's door at the start of each visit, the neighbour will accompany the nurse to the client's apartment, and the nurse will use the interpreter to promote communication throughout the visit.

Discussion

The care planning demonstrates a thoughtful process, responsive to the client's needs. There is evidence of the nurse consulting with the client and supporting the client's choice of an interpreter. The nurse stresses confidentiality and respects the neighbour's schedule by providing a list of planned visits.

http://www.cno.org/globalassets/docs/prac/41040_culturallysens.pdf

Summary of key points

- Verbal intercultural communication is influenced by cultural dynamics (perceptions, core values, and views) and is not a static concept.
- Verbal communication constitutes an integral part with other dimensions such as personality, non-verbal communication, listening psychological adjustment, etc.
- Being more “patient-oriented,” is a key-element to narrow the gap between cultures.
- Verbal communication should be clear, consistent, state needs and feelings and separate fact from opinion.
- Verbal and nonverbal messages should be congruent
- Enunciation, stress and tone of the voice should be in concordance with the words while intercultural verbal communication demands clarity of speech, politeness, calmness and focus on the topic under discussion.
- Verbal communication should be in line with the receiver's level of readiness and understanding, given their age, development or experience.
- The procedure of communication consists of the following elements: effective speaking, conversational skills, giving speech, questioning skills and techniques, and reflecting.

Self-evaluation questions

Multiple choice questions with more than one correct answer. (min. 5)

Question 1: Understanding verbal communication

Content of question	Verbal communication demands :
Answer 1	Linguistic skills
Answer 2	Human skills and psychological adjustment
Answer 3	Listening skills
Answer 4	Non-verbal communication
Answer 5	All the above
Correct answer(s)	5
Question 2: Characteristics of verbal communication	
Content of question	Which of the following characteristics are needed for an effective verbal communication?
Answer 1	Clear and consistency
Answer 2	State needs and feelings
Answer 3	Clarity of speech & politeness
Answer 4	Calmness & short duration
Answer 5	Focus on the topic under discussion
Correct answer(s)	1 & 2 & 3 & 5
Question 3: Summarizing	
Content of question	The main advantage of summarizing is :
Answer 1	Offering back to the speaker the initial meaning of what was said
Answer 2	Signifying interest in what other people have to say
Answer 3	Understanding all verbal communication by the listener
Answer 4	Review of both parties and agreement to the already exchanged communication
Answer 5	1 & 4
Correct answer(s)	5
Question 4: Communication skills for verbal communication	
Content of question	What are skills in verbal communication?
Answer 1	Effective speaking & conversational skills
Answer 2	Questioning skills & techniques
Answer 3	Reflecting
Answer 4	Focus mostly on visual messages
Answer 5	All the above
Correct answer(s)	1 & 2 & 3
Question 5: Reflecting	
Content of question	Reflecting is defined as
Answer 1	Memories and impressions of learner of other languages
Answer 2	Attitudes based on experiences with family and/or friends of another culture
Answer 3	Learning experiences.
Answer 4	Beliefs and assumptions about messages
Answer 5	None of the above
Correct answer(s)	5

Glossary *Most important terms, specific for the sub-module.*

Verbal communication	Verbal communication is simply defined as sharing information by using speech
Reflecting.	Reflecting is a process of feeding back information already given by the speaker and a simple way to check whether the message has been clearly understood.
Mirroring.	Mirroring is a domain of reflecting that involves repeating precisely what the speaker said <i>finition...</i>

1.3. <Non-verbal communication>

**Theoretical
and contents**
2-3 pages

Non- verbal communication

Non-verbal communication is the communication through means other than language. For example, silence, personal space, eye contact, touch, and other. It also includes the concept of cultural space, which gives us our identity thus is very important for health care providers to address the cultural differences of the nonverbal communication in order to avoid misunderstandings. It is usually stated that non-verbal communication expresses the real meaning of the message compared to verbal communication (Taylor et al, 1997), it conveys messages about the persons' emotions, it indicates its social status but it also gives messages of deception if someone is lying (Martin & Nakayama, 2014).

Principles of Non-verbal Communication

Nonverbal Communication conveys important interpersonal and emotional messages. It is stated that 65-90 % of our meaning is derived from nonverbal signals (Guerrero et al, 2006).

1. Nonverbal Communication is more involuntary than Verbal. Non-verbal communication always shows our underlying thoughts or feelings.
2. Nonverbal Communication is more ambiguous. Most of nonverbal signals can be related to multiple meanings. Few nonverbal signals have universal meaning.
3. Nonverbal Communication Is more credible than verbal communication because it is innateness.

<https://2012books.lardbucket.org/pdfs/a-primer-on-communication-studies.pdf>

Functions of Nonverbal Communication

1. Nonverbal communication transfers meaning by reinforcing, substituting for, or contradicting verbal communication. For example, gestures can help health care professional to ask the patient to open his/her mouth.
2. Nonverbal Communication Influences Others. Verbal and nonverbal communication very often contradicts each other.
3. Nonverbal Communication Regulates Conversational Flow.
4. Nonverbal Communication Affects Relationships. Our nonverbal messages influence our relationships in positive and negative ways.
5. Nonverbal Communication expresses who we are. Our identity is communicated through the way we dress, stand, tone of our voice, etc.

<https://2012books.lardbucket.org/pdfs/a-primer-on-communication-studies.pdf>

How do culture influence nonverbal communication patterns?

Basic emotions such as happiness, sadness, disgust, fear, anger, surprise, are communicated using nonverbal communication in many cultures by the same

way. The stimulus which causes this nonverbal behavior varies from one culture to other. For example, smiling is an international nonverbal behavior but what is it causing smile varies between different cultures (Martin & Nakayama, 2014).

Types of nonverbal communication

Touch. Touching has a different meaning for each person and its experience is a result of cultural characteristics. In general, it is regarded as a nonverbal way to communicate love, safety, affection, sympathy and also anger and aggressiveness! (Taylor et al, 1997).

Types of touch which must be avoided:

- Avoid touching people you do not know unless you are introduced to them or you are offering assistance.
- Avoid hurtful touches and apologize if they occur, even if they happen accidentally.
- Avoid surprising another person with your touch.
- Avoid interrupting physical contact such as hugging someone while they are talking to someone else.
- Avoid moving people out of the way with only touch—pair your touch with a verbal message like “excuse me.”
- Avoid overly aggressive touch, especially when disguised as playful touch (e.g., horseplay taken too far).
- Avoid combining touch with negative criticism; a hand on the shoulder during a critical statement can increase a person’s defensiveness and seem aggressive.

<https://2012books.lardbucket.org/pdfs/a-primer-on-communication-studies.pdf>

Sounds (paralinguistics)

Vocal behaviors during communication include important messages. Tone of voice, volume, rate, speed and also crying, moan, αναστεναγμός and difficulty in breathing could be explained in a different way. For example, someone crying because he/she is happy or sad, difficulty in breathing indicates pain, fear or surprise! (Taylor et al, 1997).

Silence

Silence could mean understanding, embarrassment or anger!

Eye contact

Eye contact is considered a dimension of personal space as it arranges the personal space. Direct eye contact decreases the distance between two people. Beliefs about eye contact vary between different cultures (Martin & Nakayama, 2014). Eye contact in the West and American culture means paying attention and respect. In Kenya and China it shows rudeness and disrespect. In Arabic countries, hijab is a kind for the women’s body protection from the men’s eyes. Undress the hijab someone could see the real identity (Martin & Nakayama, 2014).

Facial expressions

Facial expressions can express many emotions (disgust, happiness, fear). Health care professionals must pay attention on patients' facial expressions and on their own facial expressions when caring for people. Chinese people don't use this kind of expressions.

Gestures

Gestures (arm and hands movements) are used very often when two people speak a different language. Some gestures are perceived in the same way by different cultures while some other gestures have a different meaning in each culture. For example, tapping the foot usually means anger and stress.

Moreover, the "thumbs up" gesture means "one" in mainland Europe, but it also means "up yours" in Greece (when thrust forward) and is recognized as a signal for hitchhiking or "good," "good job / way to go," or "OK" in many other cultures. <https://2012books.lardbucket.org/pdfs/a-primer-on-communication-studies.pdf>

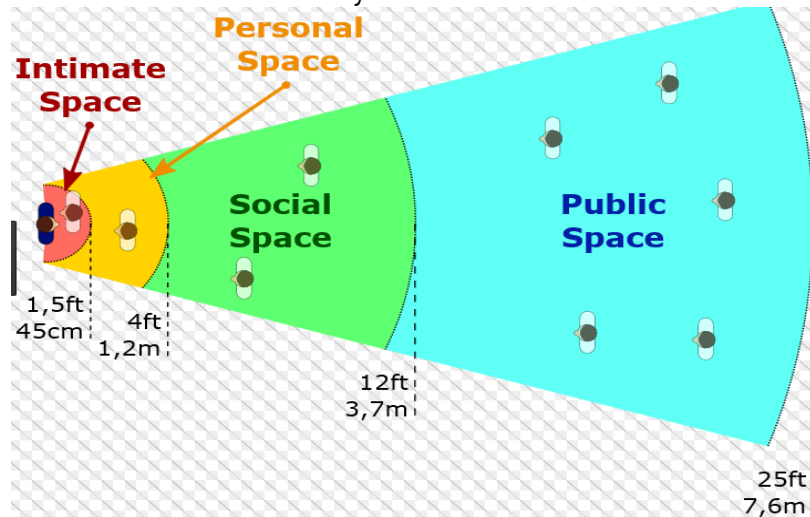
Personal space

Personal space is a balloon around us which marks the safe distance between ourselves and the others (picture 1). The space around us is divided in zones/spaces, each of them has a different rank of privacy. 30 cm from our body is regarded as the *Intimacy space* and only the closest friends, family, and romantic/intimate partners are allowed in it. Personal space, (30 cm to 150 cm from our body) is reserved for friends, close acquaintances, and significant others. Its violation produces feelings of discomfort and upsetting. Social space (1,5 m to 3,5 m from our body) is reserved people unknown each other and it is in the context of a professional or casual interaction. In Public zone, (3,5 m to 7,5 m from our body) the communication is formal and we are often not obligated or expected to acknowledge or interact with people who enter our public zone (<https://2012books.lardbucket.org/pdfs/a-primer-on-communication-studies.pdf>).

If the patient goes back during our communication it means that the intimate zone was violated. If the patient goes near to health care professional it means that he/she needs proximity. For health care professionals, the personal zone is regarded as the optimal zone during the communication with the patients (Taylor et al, 1997).

Some cultural groups are defined as contact cultures and some other as non-contact cultures. Contact cultures are people from countries such as Mediterranean countries, northern Africa, Eastern Europe, Indonesia, Latin America, South America. In these cultures, people are standing closer during communication, and frequently use direct eye contact, touch and speak loudly. Noncontact cultures are people from China, Thailand, Japan, Philippines, Korea, Germany, Norway, Finland, Sweden, Norway (Martin & Nakayama 2014). In this

cultures people stay away from the other person during communication, maintain less touch and eye contact.



Picture 1. Personal space.

https://commons.wikimedia.org/wiki/File:Personal_Spaces_in_Proxemics.svg

Activities

1 activity max

4 pages

- Title

- Objectives

- Keywords

Title: Activities for non- verbal communication

Objectives: Understand your own culture and analyze your own body language

Keywords: body language, non-verbal communication

Contents: FROM Practice Guideline

College of Nurses of Ontario Practice Guideline: Culturally Sensitive Care (2009)

Available at http://www.cno.org/globalassets/docs/prac/41040_culturallysens.pdf

Accessed 3 /7/2017

<p>(max 5)</p> <p>- Contents (please always cite the source and add the references in the module spaces dedicated to the references)</p> <p>- Material (the material can be also multimedia, like pictures, videos, drawings, material to be printed by the learners...)</p>	<p>These suggestions have been developed to assist health professionals in understanding their individual cultures. Carefully consider the question before writing your answer. As well, consider how someone from another culture might respond to the same question.</p> <p>■ Think about a time when you were with a group of people from another country, or even another part of Canada. What were the similarities and differences in culture?</p> <p>■ What would you describe as your culture?</p> <p>How would you rank the following in order of importance: ethnicity, family, work, the future, diet and religion? Do you believe that your clients have the same priorities?</p>	<p>Consider the list of areas where cultural variations in beliefs and values frequently occur. (See Acquiring Cultural Knowledge above). Can you immediately determine your preferences? What about the preferences of a friend or current client? Would the choices you make in your role as a health professional be different from those for yourself or someone you care about?</p> <p>■ Do you believe it is appropriate to discuss health issues with a client's family and friends? Why? What about discussing health issues such as menstruation, pregnancy and sexually transmitted disease with members of the opposite sex?</p> <p>■ What does your body language say about you? How might a client from another culture interpret your posture, eye contact and the tone of your voice? Could your body language be communicating something different from your words?</p> <p>■ As an individual, how do you value personal independence, family, freedom, meaningful work, spirituality, etc.? How does this have an impact on your relationships with clients?</p> <p>Continually reflecting on your reactions to your and your clients' cultures will assist you in providing culturally acceptable care.</p>
<p>Case studies</p> <p>1 or 2 (no more than 1 page in form of a storytelling)</p>	<p>Case study 1: A patient, who doesn't speak your language, is hospitalized after a surgery in the hospital where you work. The communication is very difficult and a colleague of yours states that his pain is 10 in the 10th point scale of pain. When you visit him to his room you find him squatting, speaking to the phone and laughing.</p> <p>What about his verbal and non-verbal messages?</p> <p>What is happening in your opinion?</p>	

	<p>What do you think should be the body language if pain is 10? What are you going to do to manage the situation?</p> <p>Case study 2 A woman from a different culture is hospitalized in the unit where you work after a collapse incident. She is alone without her family. The healthcare providers are very curious about this woman. She seems to know and understand the language because she answers to the questions and she respond well when someone asks her to do something. However, she sits quietly in her bed, she doesn't look around, and she doesn't communicate with anyone in her room. In the afternoon, she has visitors of different ages. She looks happy and communicates with them. The woman and the visitors sit on the floor in a quiet corner the lounge of the unit. They eat food which they have brought from home, they speak their own language and have fun together.</p> <p>Which are the possible explanations of the woman's behavior? Which are the possible explanations of the visitors' behavior? Which is the possible behavior of healthcare providers in this reunion? http://rcnhca.org.uk/top-page-001/communication-methods/non-verbal-communication-2/</p>
<p>Summary of key points</p>	<ul style="list-style-type: none"> • Non-verbal communication is the communication through means other than language, for example, silence, personal space, eye contact, touch, and other. • Nonverbal Communication conveys important interpersonal and emotional messages. It is stated that 65-90 % of our meaning is derived from nonverbal signals. • It is very important for health care providers to address the cultural differences of the nonverbal communication in order to avoid misunderstandings. • Nonverbal communication transfers meaning by reinforcing, substituting for, or contradicting verbal communication. • Personal space is a balloon around us which marks the safe distance between ourselves and the others. For health care professionals, the personal zone is regarded as the optimal zone during the communication with the patients. • Some cultural groups are defined as contact cultures (Mediterranean countries, northern Africa, Eastern Europe, Indonesia, Latin America and South America). • Some other cultural groups are defined as non-contact cultures (China, Thailand, Japan, Philippines, Korea, Germany, Norway, Finland, Sweden, and Norway).

Summary of key points

- Non-verbal communication is the communication through means other than language, for example, silence, personal space, eye contact, touch, and other.
- Nonverbal Communication conveys important interpersonal and emotional messages. It is stated that 65-90 % of our meaning is derived from nonverbal signals.
- It is very important for health care providers to address the cultural differences of the nonverbal communication in order to avoid misunderstandings.
- Nonverbal communication transfers meaning by reinforcing, substituting for, or contradicting verbal communication.
- Personal space is a balloon around us which marks the safe distance between ourselves and the others. For health care professionals, the personal zone is regarded as the optimal zone during the communication with the patients.
- Some cultural groups are defined as contact cultures (Mediterranean countries, northern Africa, Eastern Europe, Indonesia, Latin America and South America).
- Some other cultural groups are defined as non-contact cultures (China, Thailand, Japan, Philippines, Korea, Germany, Norway, Finland, Sweden, and Norway).

Self-evaluation questions

Multiple choice questions with more than one correct answer. (min. 5)

Question 1: Title of question: Non-verbal signals

Content of question	A health professional informs a patient from a different cultural background about his condition. During their conversation the health care professional presents a non-verbal communication pattern. Which is the right answer concerning the non-verbal communication pattern? What kind of messages, the health care professional passes in the answer 1 and the answer 2?
Answer 1	The health professional is standing on the door, one foot in and one foot out of the patient's room, is keeping some medicines in his hands and is speaking at the same time with his colleagues who are walking in the hall.
Answer 2	The health professional is sitting near the patient to the same level, having eye contact, the door is closed, the environment is quiet and he seems to be there only for the patient.
Correct answer(s)	2

Question 2: Title of question: Communication and personal space

Content of question	A Chinese woman wants to ask you about her medicines. She is standing about 3.5 meters (social zone) away from you and she is speaking quietly. You can't hear her question. What are you doing?
Answer 1	Tell her to speak loudly and repeat the question.
Answer 2	Move next to her about 0.5 meter away and tell her to repeat her question.
Answer 3	Move close to her, hold her and tell her to repeat her question.

Answer 4	....
Answer 5	....
Correct answer(s)	1. The Chinese culture is defined as a non-contact culture which means that people stay away from the other person during communication; maintain less touch and eye contact.
Question 3: Title of question: Be flexible!	
Content of question	A woman from an Arabic country visits the health center where you are working. You should give her an intramuscular injection. The woman refuses the injection. Your gender is male. What are you doing?
Answer 1	You don't give the injection and the woman leaves the health center.
Answer 2	You insist more to give the injection in order to relieve her from her pain.
Answer 3	You ask your female colleague to make the injection when she finishes her work.
Correct answer(s)	3.
Question 4: Title of question Arabic culture	
Content of question	In Arabic countries, hijab is
Answer 1	A topical delicacy
Answer 2	A kind of protection for the women's body from the men's eyes
Answer 3	A period of fastening
Answer 4	Engagement between a young girl and an older man
Correct answer(s)	2
Question 5: Title of question Communication and space	
Content of question	Social space is reserved for people unknown to each other and it is in the context of a professional or casual interaction The social space refers to:
Answer 1	30 cm from our body
Answer 2	(1,5 m to 3,5 m from our body)
Answer 3	30 cm to 150 cm from our body
Answer 4	3,5 m to 7,5 m from our body)
Correct answer(s)	2
Glossary	
<i>Most important terms, specific for the sub-module.</i>	
Non-verbal communication	Non-verbal communication is the communication through means other than language.
Personal space	Personal space is a balloon around us which marks the safe distance between ourselves and the others. The space around us are divided in zones/spaces, each of them has different rank of privacy.

1.3 <Empathetic communication>

Theoretical contents 2-3 pages	and Empathetic communication <p>Health /helping professions combine the evidence of scientific knowledge with the skill of caring for another human being. The art of caring involves actions and attitudes of virtue including compassion, respect, and empathy (Lovan & Wilson, 2012).</p> <p>A classic explanation of empathy is the ability to perceive the internal frame of reference of another with accuracy, while maintaining a sense of self (Rogers, 1957 p.95).</p> <p>Health professionals must have knowledge about evidence based practice, as well as to be competent in human relations. They interact with people who are in their weakest moments in an intimate manner; therefore it is necessary that health professionals are equipped with the skill of empathy. The ability to express empathy fosters a sense of trust which thereby deepens the level of communication with patients (Nunes, et al, 2011).</p> <p>According to the definition of empathy within the framework of the Person-Centered Approach, empathy is the ability to deeper understand other's frame of reference and involves being able to put oneself in the other's position.</p> <p>When a health professional is empathetic, he or she begins to see past a patient's behavior and understands the patient's inner experience at that time. Empathy enables the professional to truly comprehend what the patient is going through because empathy involves the intellectual and emotional comprehension of another person (Smith & Parker, 2015). More importantly empathy is not only the ability to perceive the meaning and feelings of another but also to communicate those feelings to the other person (Stein-Parbury, 2013). The internal experience of understanding of another person's perspective is only part of what is meant by empathy. To be empathetic, a person must not only understand, but express understanding to the other and validate that understanding.</p> <p>Thus empathy is the ability of a person to understand what another is experiencing from the receiver's perspective and the ability to communicate that understanding to the receiver. The reciprocal nature of the helper-patient relationship is grounded in the idea that patients have their own interpretation of their situation and thus the helpers must validate inferences made before drawing conclusions.</p> <p>Empathy involves the helper's intellectual and emotional comprehension of another. The helper who employs empathy is able</p>
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to gather the perspective of the patient's experience from a caring and unbiased standpoint, communicate that interpretation to the patient for validation and then act on behalf of the patient's needs at that time (Smith & Parker, 2015).

Cultural empathy means awareness and understanding of the values, beliefs and views of people from a different culture to one's own. Empathy towards people of same culture has been characterized as more effortless, while the greater the difference in cultural background, the more efforts required for empathy (Hoffman, 2000; Howe, 2013).

A multidimensional definition of empathy has been given by Calloway-Thomas (2010), an intercultural communication specialist who stated that "empathy is the ability imaginatively to enter into and participate in the world of the cultural other cognitively, affectively, and behaviorally" (p. 8).

According to Kiosses et al (2016) empathy is sometimes described as a cognitive attribute featuring understanding of experiences of others, sometimes as an emotional state of the mind featuring sharing of feelings, and at other times as a concept involving both cognition and emotion.

According to Everhart et al (2016) along with elements of self-awareness, handling relationships, managing feelings, and motivation, empathy forms one part of Emotional Intelligence.

Empathy contains two distinct components: a cognitive component and an emotional component. Perspective-taking which is Empathy's cognitive component is important to the process of developing empathy to understand how other people may be affected by a situation, as well as understanding that there may be other perspectives to a situation, while Compassion which is Empathy's emotional component means that an individual often feels compassion for another and becomes motivated to understand that person in a new way.

Taken together, these two components create empathy and empathic ability. In

addition, empathy's two components—this compassion and the ability to understand how a person may be affected by their situation—is often what leads individuals to want to help others and to act to help them (Everhart et al, 2016).

Everhart et al (2016) raise the point that we must reconceive empathy as a skill, rather than as a personality trait or virtue, empathy should be viewed as a learnable skill, an ability or set of abilities that can be

developed, taught, practiced, and cultivated. One way it can be learned is through experiencing caring relationships held between nurse and patient (Metcalf & Putnam, 2013).

However, the use of experiential learning styles has been demonstrated to be more effective than other learning styles in knowledge gain and behavior change of nurse expressed empathy with undergraduate nursing students (Brunero et al, 2010). Williams et al (2015) demonstrated the effectiveness of an experiential approach to learning through case study, role play and reflection with 293 nursing students in Australia in improving self-reported empathy levels.

Evidence suggests that the role of health professionals' education must be examined for how educators may promote empathy development in students and that several strategies exist to improve nurse's ability to use empathy (Ward et al, 2012). Examples of such strategies include use of standardized patients for role playing, provision of pseudo hospitalization experience simulation, exposure to empathetic role models, and by giving students the opportunity to listen attentively to patients' narratives of their illness (Ward et al, 2012).

Medical and other health care professional schools have included educational interventions to maintain and enhance empathy in undergraduate students (Kiosses et al, 2016).

Empathy and clinical outcomes

There is a relationship between empathy and positive clinical outcomes as it is shown that clinical outcomes become better with an increase in empathy of the health professionals (Hojat, Gonnella, & Maxwell, 2009). The use of empathy is further documented as a vehicle for health professionals to engage patients (Brunero et al, 2010). There is also evidence that shows that patients experience less distress with nurses who express empathy (Leloirain, Brédart, Dolbeault, & Sultan, 2012). Also, empathy has been linked to improved teamwork and integrated patient care (Hojat, Bianco, Mann, Massello, & Calabrese, 2015). Patients who perceive empathy from their providers are more likely to engage and comply with treatment (Hojat et al, 2010).

Another study found that nurse expression of empathy, when present, resulted in a 33% reduction in restraints or seclusion (Yang et al., 2014). Effective empathic communication that is based on the patients' perception of the experience should lead to better patient outcomes overall thereby reducing cost on the healthcare system. Policy makers grappling with health care quality and cost issues recognize shared

	<p>decision making and patient engagement to be important mechanisms to improve care and reduce costs (Bernabeo & Holmboe, 2013).</p> <p>Nowadays, however a decline in health professionals' levels of empathy has been noted. Rationale to explain empathy decline is speculated to be that of several contributing factors such as lack of time to engage in empathetic communication, lack of support or negative attitudes from clinical faculty and healthcare personnel, and competing priorities within the healthcare setting (Ward et al, 2012).</p> <p>The reason for which clinical empathy has been introduced to health care curricula is related to empathy's expected positive attributes, including dutifulness, prosaic behavior, moral reasoning, reduced malpractice litigation, improved history taking and physical examination, patient satisfaction, physician satisfaction, improved therapeutic relationships, and overall improved clinical outcomes (Kiosses et al, 2016).</p> <p>As Papadopoulos and Pelezza (2015) point out modern societies become increasingly multicultural thus the health professions educators and managers of health care teams should be aware of the need for intercultural empathetic skills.</p>			
Activities 1 activity max 4 pages - Title - Objectives - Keywords (max 5) - Contents (please always cite the source and add the references in the module spaces dedicated to the references) - Material (the material can be also multimedia, like pictures, videos, drawings, material to be printed by the learners...)	Title: Empathy activities			
	Objectives: To ensure the group has the same understanding when they use the term 'empathy'			
	Keywords: empathy, empathetic communication			
	Contents: Monash university empathy activity <p>1. Icebreaker: Students are asked to continue this sentence on their post-it note: "Empathy is ... ". Post-it notes are collected and read aloud either individually or in themes e.g. patient's shoes or emotional distance etc. (10 mins).</p> <p>2. Empathy matching cards (see at conclusion of Appendix 3): Each card (term and definition) is randomly placed on a table. Participants must match each term with its definition. The intention is for participants to consider the nuances of the different terms and consider what this might mean for the different health care professions and holistic health care and teamwork. It also ensures the group has the same understanding when they use the term 'empathy'. (10 mins).</p> <table border="1" data-bbox="480 1809 1385 1973"> <tr> <td data-bbox="480 1809 951 1854"> Empathy matching cards </td><td data-bbox="951 1809 1385 1854"> Definitions: </td></tr> <tr> <td data-bbox="480 1854 951 1973"> Empathy Matching Cards (Source Macquarie Dictionary): </td><td data-bbox="951 1854 1385 1973"> Entering into the feeling or spirit of a person or thing; appreciative perception or </td></tr> </table>	Empathy matching cards	Definitions:	Empathy Matching Cards (Source Macquarie Dictionary):
Empathy matching cards	Definitions:			
Empathy Matching Cards (Source Macquarie Dictionary):	Entering into the feeling or spirit of a person or thing; appreciative perception or			

	<p>Terms:</p> <p>Empathy</p> <p>Sympathy</p> <p>Compassion</p> <p>Caring</p> <p>Emotion</p> <p>Rapport</p> <p>Pity</p> <p>Affinity</p>	<p>understanding.</p> <p>The fact or the power of entering into the feelings of another, especially in sorrow or trouble.</p> <p>A feeling of sorrow for the sufferings or misfortunes of another.</p> <p>Exchanges of confidences, particularly in relation to some distressing experience, which are intended to promote emotional healing.</p> <p>Any of the feelings of joy, sorrow, fear, hate, love, etc.</p> <p>Connection, especially harmonious or sympathetic relation.</p> <p>A natural liking for, or attraction to, a person or thing.</p> <p>Sympathetic or kindly sorrow excited by the suffering or misfortune of another, often leading one to give relief or aid or to show mercy.</p>
	<p>ANSWERS (Source Macquarie Dictionary)</p> <p>Empathy Entering into the feeling or spirit of a person or thing; appreciative perception or understanding.</p> <p>Sympathy The fact or the power of entering into the feelings of another, especially in sorrow or trouble; fellow feeling, compassion, or commiseration.</p> <p>Compassion A feeling of sorrow or pity for the sufferings or misfortunes of another.</p> <p>Caring Exchanges of confidences, particularly in relation to some distressing experience, which are intended to promote emotional healing.</p> <p>Emotion Any of the feelings of joy, sorrow, fear, hate, love, etc.</p> <p>Rapport Connection, especially harmonious or sympathetic relation.</p> <p>Affinity A natural liking for, or attraction to, a person or thing.</p>	

	<p>Pity Sympathetic or kindly sorrow excited by the suffering or misfortune of another, often leading one to give relief or aid or to show mercy.</p>	
<p>Case studies 1 or 2 (no more than 1 page in form of a storytelling)</p>	<p>Objectives: To increase awareness of culturally determined interpretations and explanations of other culturally-influenced behaviors</p>	
	<p>Scenario 1 The client is a woman who has developed a very good relationship with the nurse in the community health clinic. On a visit, she asks the nurse how to arrange for the excision of female genitalia for a member of her community.</p>	<p>Discussion 1 Regardless of her personal feelings about female genital excision, the nurse needs to understand the meaning of this custom for the client, which is linked to values about family purity and family honor. The nurse, however, also knows that the practice is illegal in Canada. The nurse needs to inform the client, in a non-judgmental manner, of the potential risks and harm associated with the practice and of the legal implications. By exploring the custom and providing education and support to the woman, the nurse has a better chance of preventing a practice that carries considerable risk of harm.</p>
	<p>http://www.cno.org/globalassets/docs/prac/41040_culturallysens.pdf</p>	
	<p>Scenario 2 A nurse, working as a community case manager, visited the home of a toddler with severe physical and developmental delays. She explained to the parents that with their consent she would refer the child to physiotherapy and occupational therapy program that would help the child be more independent. The parents refused, saying that it was their duty to care for their child because the child’s condition is punishment for having conceived before they were married. They were not supportive of a program to increase independence. The nurse was upset and felt the parents were not acting in the child’s best interests.</p> <p>;</p> <p>Discussion 2 The nurse did not understand the family’s initial refusal of treatment. After reflection and discussion with colleagues, she realized that her personal and professional values of independence were causing her to feel upset with the parents’ refusal. She decided to explore with the family their goals for their child. In doing this, she learned that the parents wanted their child to become stronger and have fewer infections. When the same therapies were</p>	

described as a means of meeting these goals, the parents were quite willing to participate. The program was developed to meet the goals that the family identified as important.

http://www.cno.org/globalassets/docs/prac/41040_culturallysens.pdf

Scenario 3

http://www.cno.org/globalassets/docs/prac/41040_culturallysens.pdf

Scenario 3

A client from a First Nations community requests that a sweet grass ceremony be performed in the hospital as part of the treatment. The ceremony involves chanting and burning some substances, which will result in small amounts of smoke (similar to that of burning an incense stick). The nurse's initial reaction is that something like this has never been done, and that it is against hospital policy. However, she also understands the significance of this ritual for the client. The nurse raises the issue with the unit administration and, with the support of colleagues, explores the potential impact on other clients. The nurse also reviews relevant fire policies and consults with appropriate staff in other departments. It is determined that any risk to other clients can be removed by transferring the client to a private room. This is done, and the ceremony is performed.

Discussion 3

The nurse's commitment to client-centered care prompts her to explore ways of meeting the client's needs within the limits of the hospital setting. Lack of experience and fear are two of the most common barriers to providing culturally sensitive care. Through collaboration with other colleagues, the nurse is able to address the assumption that it cannot be done and to determine ways of meeting client needs without exposing other clients to discomfort or risk. The nurse succeeds in meeting the needs of her client, not only because of her creativity, but because she takes responsibility for influencing policies and procedures in the practice setting.

Summary of key points

- Modern societies become increasingly multicultural thus the health professions educators and managers of health care teams should be aware of the need for intercultural empathetic skills.
- Health /helping professions combine the evidence of scientific knowledge with the skill of caring for another human being. The art of caring involves actions and attitudes of virtue including compassion, respect, and empathy.
- Cultural empathy means awareness and understanding of the values, beliefs and views of people from a different culture to one's own.
- The ability to express empathy fosters a sense of trust which thereby deepens the level of communication with patients

- Positive clinical outcomes that have been documented are less distress of patients with professionals who express empathy, improved teamwork and integrated patient care better patient compliance, reduction in restraints or seclusion, better patient outcomes and reducing cost on the healthcare system.
- The use of experiential learning styles such as simulation, exposure to empathetic role models and active listening of students to patients' narratives, has been demonstrated to be more effective than other learning styles in knowledge gain and behavior change of health professionals' expressed empathy.

Self-evaluation questions

Multiple choice questions with more than one correct answer. (min. 5)

Question 1: Understanding the term of empathy

Content of question	Empathy is defined as
Answer 1	A feeling of sorrow or pity for the sufferings or misfortunes of another.
Answer 2	"The ability imaginatively to enter into and participate in the world of the cultural other cognitively, affectively, and behaviorally"
Answer 3	The fact or the power of entering into the feelings of another, especially in sorrow or trouble; fellow feeling, compassion, or commiseration.
Answer 4	Sympathetic or kindly sorrow excited by the suffering or misfortune of another, often leading one to give relief or aid or to show mercy.
Answer 5	Connection, especially harmonious or sympathetic relation.
Correct answer(s)	2

Question 2: Decline in empathy

Content of question	A decline in health professionals' levels of empathy has been noted. This is due to:
Answer 1	Lack of time to engage in empathetic communication
Answer 2	Lack of support or negative attitudes from clinical faculty and healthcare personnel
Answer 3	Competing priorities within the healthcare setting
Answer 4	All the above
Answer 5	1,2
Correct answer(s)	4

Question 3: Positive attributes of empathy

Content of question	Clinical empathy has been introduced to health care curricula is related to empathy's expected positive attributes, including:
Answer 1	Improved therapeutic relationships
Answer 2	moral reasoning

Answer 3	Improved history taking and physical examination
Answer 4	Patient satisfaction
Answer 5	All the above
Correct answer(s)	5
Question 4: Empathetic education techniques	
Content of question	Examples of strategies to promote empathy development in students include:
Answer 1	Use of standardized patients for role playing
Answer 2	Provision of pseudo hospitalization experience simulation
Answer 3	Exposure to empathetic role models,
Answer 4	Giving students the opportunity to listen attentively to patients' narratives of their illness
Answer 5	All the above
Correct answer(s)	5
Question 5: Empathy components	
Content of question	Empathy contains the following components:
Answer 1	A cognitive component in order to understand how other people may be affected by a situation,
Answer 2	Compassion which is an emotional component and means that an individual often feels compassion for another
Answer 3	Rapport which is connection, especially harmonious or sympathetic relation.
Answer 4	1 and 2
Answer 5	1,2,3
Correct answer(s)	4
Glossary	
Empathy	Empathy is the ability of a person to understand what another is experiencing from the receiver's perspective and the ability to communicate that understanding to the receiver.
Cultural empathy	Cultural empathy means awareness and understanding of the values, beliefs and views of people from a different culture to one's own.
Empathetic communication	Health /helping professions combine the evidence of scientific knowledge with the skill of caring for another human being. The art of caring involves actions and attitudes of virtue including compassion, respect, and empathy
Compassion	A feeling of sorrow or pity for the sufferings or misfortunes of another.

1.4. <Active listening>

Theoretical and contents 2-3 pages	Active listening Active listening is an essential skill in general practice consultations and everyday life. It can improve outcomes for healthcare contexts, and deserves equal importance as developing clinical knowledge and procedural skills (Davies, 2003). Patients frequently experience psychological distress and require highly skilled communication. Previous researches demonstrated that higher quality of services provided in healthcare settings was highly related to communication and active listening (Dziopa & Ahern, 2009). The art of communication is the development of several skills some of which very covered in the previous subunits. Raising awareness on communication importance and active listening produces benefits for the patient and healthcare professional relationship. Effective communication is achieved through active listening (Davies, 2003). Active listening levels There are two aspects in active listening, awareness and listening. Awareness has been described as an intuitive state in which individuals are being attentive of both the external and internal received information (Feltham, & Horton, 2001). That could be, environmental input, what they see, hear, potential sounds, images, emotions as well as sense and energy. The information is always received as humans have by nature thousand receivers and processors (cells, nerves, nervous system, sense organs, and cognitive functions) (Eysenck, 2015). However, if the individual will become conscious of the received information –awareness state- is a matter of trained skills and attention. The second and major aspect of active listening is how individuals listen. Awareness seems to be a prerequisite for active listening, as the first step that provides the ground information for effecting listening. Clearly, active listening is part of a process that they individual is actively leading. During this process, three listening levels have been proposed (Whitworth et al., 2007). The first level is “internal listening” or “awareness to the self”. For example, while listening a conversation the focus is on what these words mean for the individual. An internal conversation takes place and focuses on the self. The individual is becoming conscious about feelings, thoughts and overall information. The second active listening level is “focused listening”. In contrast with the first listening level, this time, the focus is on the talker.
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	<p>Additional attention is given to the words mentioned, expressions, voice tone, pace and volume; listening of the talkers' subjective interpretations of experience. At this point, the listener acts as a mirror to what is being said by the talker and is asking for clarifications and collaborating for further discussion that is led by the talker.</p> <p>The third active listening level is "global listening". As this is the last active listening level, it combines the two previous levels. The individual receives information from every source at once. This level includes information from the senses, what is being spoken and unspoken, alterations in energy and emotions. Information received forms the response. In other words, level three includes action, inaction and interaction. Then, the individual is acting/behaving in informed choices, is observing the impact of his response and is able to adjust his behavior accordingly.</p>
<p>Activities</p> <p>1 activity max 4 pages</p> <ul style="list-style-type: none"> - Title - Objectives - Keywords (max 5) - Contents (please always cite the source and add the references in the module spaces dedicated to the references) - Material (the material can be also multimedia, like pictures, videos, drawings, material to be printed by the learners...) 	<p>Title: Become an active listener</p> <p>Objectives:</p> <ul style="list-style-type: none"> • To outline essential skills required for active listening that is needed within the healthcare professional-patient relationship. • To raise trainees' awareness about own communicational skills and listening level • Monitor trainee's progress in active-listening use <p>Keywords: active listening, awareness, communication</p> <p>Contents:</p> <p>Activity framework: This is an individual evidence-based, self-learning activity that is built in six steps. The steps should be followed in a hierarchic order, starting from the first step and completing the activity in the sixth step. The individual is asked to make the activity in a natural context, in his everyday life environment. Five different conversations should take place in five days. The activity should take place in five days in-a-row. After the fifth day the individual is asked to make a final reflection report. The conversations will provide the base for self-reflection. The individual is asked to pay attention to the four conversations changing the attentional focus each time. The conversations should involve only two members, the listener and the talker and be short (no more than 20 minutes). The individual is asked to behave naturally in each conversation, feeling comfortable and free to respond according to his will. After each conversation, the individual is asked to record his observations in the activity reflection diary freely in daily reflective reports. There are no specific questions to answer in each reflective process, as the guidelines are provided within each step of the activity. The sixth step is the writing an overall reflection report based on the previous reflective-reports.</p>

The activity involves selective attention skills, self-awareness and reflection.

- **First step:**

The first conversation takes place the first day. The individual is asked to pay attention in the conversation flow and his role and impact in response with the other member of the conversation. After the conversation takes place, the individual is asked to write down his observations in the activity reflection diary.

- **Second Step:**

Before the second conversation, the individual is asked to read the active listening skills theoretical background provided. Then, the second conversation takes place the second day. The attentional focus of this conversation reflects the first aspect of active listening which is “awareness”. The individual pays attention on environmental inputs, sounds, images, emotions as well as sense and energy during the conversation. After the conversation takes place, the individual is asked to write down his observations in the activity reflection diary. He is also asked to notice any differences in the conversation/self/impact comparing to the day 1 conversation.

- **Third step:**

Before the second conversation, the individual is asked to read the active listening skills theoretical background provided. The third conversation takes place third day. The attentional focus of this conversation reflects the first level of active listening which is “internal listening”. The individual is asked to pay attention to his feelings, thoughts and overall information (environmental, conversational, and self). After the conversation takes place, the individual is asked to write down his observations in the activity reflection diary.

- **Forth step:**

Before the second conversation, the individual is asked to read the active listening skills theoretical background provided. The forth conversation takes place the fourth day. The attentional focus of this conversation reflects the second level of active listening which is “focused listening”. The individual is asked to focus on the talker. Attention is given on information coming from the talker during the conversation, for example facial/body expressions, words, voice tone/volume, pace etc. At this point, the listener is an active observer, mirroring back the information to the talker and asking for clarifications. The discussion is mostly leaded by the talker. After the conversation takes place, the individual is asked to record his observations in the activity reflection diary.

	<ul style="list-style-type: none"> • Fifth step: Before the second conversation, the individual is asked to read the active listening skills theoretical background provided. The fifth conversation takes place the fifth day. The attentional focus of this conversation reflects the third level of active listening which is “global listening”. The individual is asked to pay attention to the overall informational input (external, internal, conversational, and environmental). According to this information, the individual is asked to form an answer and respond to the talker. He is then asked to pay attention to the impact of his response and observe the interaction with the other member of the conversation. He is also asked to make any alterations in his behavior/response according to the observed impact. After the conversation takes place, the individual is asked to record his observations in the activity reflection diary. • Sixth step: The sixth step is a self-reflective process that involves individual reading, self-reflection and meaning making. No conversation takes place in this step. The individual is asked to read the previously written daily reflective reports. He is asked to focus to potential differences in observed conversations before and after reading the theoretical material. He is further asked to reflect on the overall process and active listening impact on communication and create a final reflective report.
	<p>Material:</p> <p>The material used for the daily reflection process after the conversations made, is the “activity reflection diary”. The diary provides the space for the individual to record his observations and make self-reflection about the conversations. The observations written for the five different conversations should be written separately. The final reflection report should be also written separately. For example: Conversation 1-Day 1: Conversation 2-Day 2: Conversation 3-Day 3: Conversation 4-Day 4: Conversation 5-Day 5: Final reflection report-Day 6:</p>
<p>Case studies 1 or 2 (no more than 1 page in form of a storytelling)</p>	<p>Sam is a 35 year old woman suffering from a chronic skin disease, psoriasis. Recently, she observed new psoriasis symptoms in particular, new papules and plaques appeared in her face area. She visited a doctor in the dermatology clinic because she has been</p>

unable to manage the new symptoms. The following conversation took place during the meeting with the doctor.

Dialogue 1:

Sam: I have these new plaques on my face. This is so hard for me, everyone sees that I am sick. At least before they on my body and I was able to hide them.

Doctor: More than 10 patients came today with similar psoriasis symptoms. It is important to stay calm.

Sam: It seems weird because I have been taking my medicine right and despite that new ones appeared. It is like I have no control over it

Doctor: There is an explanation for it, psoriasis is that emotional and environmental factors have a crucial impact in disease etiology and exacerbation of symptoms. So let's start with severity evaluation.

Sam: Okay...

Dialogue 2:

Sam: I have these new plaques on my face. This is so hard for me, everyone sees that I am sick. At least before they were on my body and I was able to hide them.

Doctor: Is it important what other people may think when they are looking at you? Why do you automatically guess that they will think that you are sick and not that they are looking your blue eyes?

Sam: Yes but I am also looking at me, I am sick... It is hard for me to approach people or to open a conversation with an interesting guy...

Doctor: ok.. Let's try to look the alternatives in medical treatment.

Sam: Oh, good, so there is something that could help me out.

Dialogue 3:

Sam: I have these new plaques on my face. This is so hard for me, everyone sees that I am sick. At least before they were on my body and I was able to hide them.

Doctor: Is it important what other people may think when they are looking at you? Why do you automatically guess that they will think that you are sick and not that they are looking your blue eyes?

Sam: Yes but I am also looking at me, I am sick... It is hard for me to approach people or to open a conversation with an interesting guy...

Doctor: I can see that these new symptoms are very hard to deal with. It seems like, because they symptoms appeared on the face they are always visible reminding you that they are there. The face is the part of our body that relates with the world and other at the most.

Sam: yes, so I cannot go back to normal. I want to be myself and feel comfortable talking with people. So this is why I came here today, is there any alternative medical treatment? What can I do?

Doctor: So let's try to look the alternatives in medical treatment. Also, it might be helpful to consider psychological support as well.

Sam: yes, I think this could help me a lot.

Reflective questions:

Which is the active listening level in dialogue 1?

Which is the active listening level in dialogue 2?

Which is the active listening level in dialogue 3?

Consider the goal of the doctor-patient discussion which is assessment and intervention. Which of the three dialogues was, according to you, holistic and met the goals of the discussion?

Summary of key points

- The activity is evidence-based and self-learning
- This activity that is built in six steps.
- The steps should be followed in a hierarchic order.
- The activity takes place in naturalistic, everyday conditions.
- Five different conversations should take place in five days in-a-row.
- The conversations will provide the base for self-reflection.
- The individual is asked to pay attention to the four conversations changing the attentional focus each time.
- The conversations should involve only two members, the listener and the talker and be short (no more than 20 minutes).
- After each conversation, the individual is asked to record his observations in the activity reflection diary freely in daily reflective reports.
- The sixth step is the writing an overall reflection report based on the previous reflective-reports.
- The activity involves selective attention skills, self-awareness and reflection.
- In each conversation, there is additional focus on each active listening level
- The sixth step is a self-reflective process in which the final reflective report will be written

Self-evaluation questions

Multiple choice questions with more than one correct answer. (min. 5)

Question 1: Active listening

Active listening is –among others- an essential communication skill

Answer 1

yes

Answer 2	no
Correct answer(s)	yes
Question 2: Active listening	
How many aspects consist active listening?	
Answer 1	1
Answer 2	2
Answer 3	3
Answer 4	4
Correct answer(s)	2
Question 3: Active listening	
In how many levels is active listening divided?	
Answer 1	1
Answer 2	2
Answer 3	3
Answer 4	4
Answer 5	5
Correct answer(s)	3
Question 4: Active listening levels	
“Internal listening” and “awareness to the self” are both referring to the first active listening level	
Answer 1	Yes
Answer 2	No
Correct answer(s)	Yes
Question 5: Active listening levels	
In the “focused listening” listening level the focus is on the talker	
Answer 1	Yes
Answer 2	No
Correct answer(s)	Yes
Question 6: Active listening levels	
In “global listening”...	
Answer 1	... the two previous levels are combined
Answer 2	... there is focus on the information that comes from the senses
Answer 3	....the talker is leading
Answer 4	....the listener focuses only in environmental information
Correct answer(s)	1,2,3
Glossary (if requested)	
Environmental input	<i>This term refers to the resources/information (sounds, images, smells, energy etc.) that are being received by the sense organs</i>
Cognitive functions	<i>Cognitive functions are higher order mental processes that help us gather and process information (Eysenck, 2015)</i>

1.5 <Intercultural Counselling skills>

Theoretical and contents

2-3 pages

Intercultural Counselling skills

Patient counseling plays very important role in curative, preventive and promotional healthcare. One of the most interesting findings in healthcare counseling is provided by studies that have established an association between clinician–patient relationship, communication and patient health outcomes (Mikesell, 2013). In the healthcare literature, counseling and communication are used interchangeably even though effective communication is the mediator of counseling. Counseling is further defined as “a method that is based on principled relationship that applies active listening and discussion in order for the person to be able to manage psychological, psychosomatic issues and changes, including health conditions and chronic pain, crisis and developmental needs as well as self-identification” (Feltham & Horton, 2001, p. 2). Communication within the counseling context is found be linked with improved health outcomes (see figure 1 below).

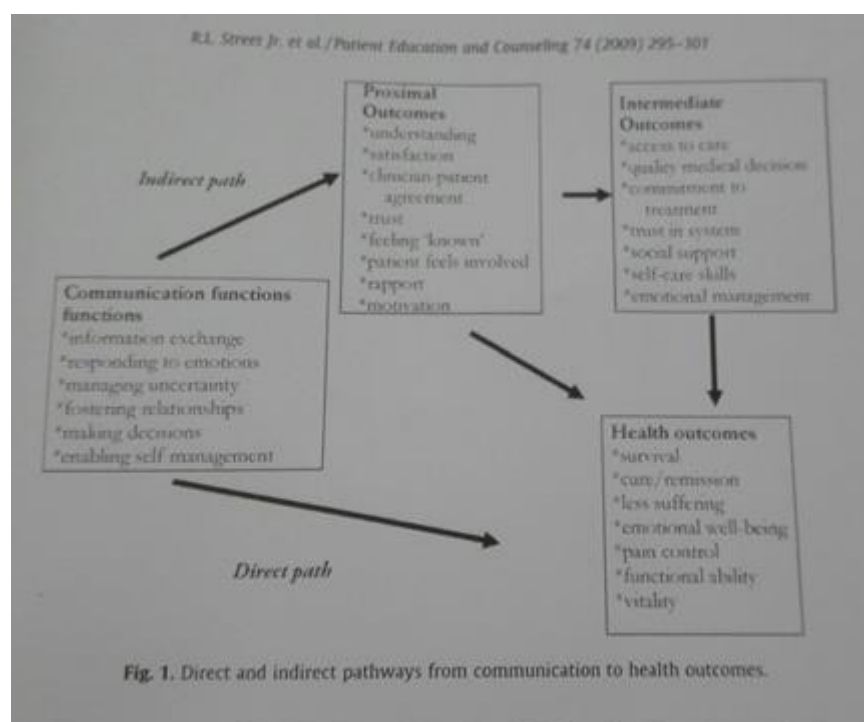


Figure 1: Street et al. (2009) proposed that communication pathways affect health outcomes

Security, confidentiality and stability are essential in counseling in the healthcare context. According to Rogers (1957) the therapeutic alliance between client and counselor is therapeutic by itself. The client is considered to be vulnerable or in distress and the counselor is responsible

to facilitate the relationship. Respect, genuine attitude and unconditional positive regard towards the client are shaping the context of this relationship (Dziopa & Ahern, 2009). The therapeutic alliance includes the interrelationships among the patient and multiple health care professionals, friends, family members, and caregivers (Fuertes, et al., 2007). Indicators of a strong therapeutic alliance include mutual trust among all parties, coordinated and continuous health care, and the patient's perception of feeling respected and cared for (Epstein & Street, 2007). These alliances are 'therapeutic' because the quality of these relationships can affect health outcomes in two respects. First, a patient's perception that he or she has good care, will not be abandoned, and is understood can promote emotional well-being (Henman et al., 2002; Thorne et al., 2006), especially when facing serious and life-threatening illness (Ogden, 1996). Patient's trust in his clinicians and the health care system can have an indirect effect through better continuity of care, patient satisfaction with decisions, and patient commitment to treatment plans (Cabana & Jee, 2004; Kim, Kim & Boren, 2008; Martin, et al., 2008; Nutting et al., 2003]. The clinician-patient alliance is enhanced when clinicians are optimally informative and show empathy with the patient's circumstances, when patients have an opportunity to express their concerns, and when the patient receives consistent messages and coordinated care from the clinical team (Epstein & Street, 2007).

The importance of communication and relationship in general healthcare practice has been further found in several studies showing that almost two-thirds of the problems managed were done so without pharmacological treatment (Moore et al., 2013). A recent literature review found that increased patient and doctor satisfaction, better adherence to treatment, improved follow up and decreased litigation are some of the benefits of a good patient-health professional relationship (Fuertes et al., 2007). Patient compliance can be predicted by a combination of patient satisfaction with the consultation process, patient understanding of information and doctor-patient communication (Boyle et al., 2009). There are also benefits for healthcare professionals (Nutting et al., 2003). A study of primary care physicians found that undertaking an intensive education program in counselling skills improved patient outcomes, personal well-being for the healthcare professionals and increased job satisfaction (Mikesell, 2013). Counselling may further enhance the patient's sense of worth, confidence, and hope, may provide meaning, motivation, and energy needed to pursue work or leisure activities, and allow the patient to enjoy greater quality of life despite the disease (Kessler et al., 2013).

General counselling skills (Feltham & Horton, 2001)

Literature divides counseling skills in general, internal and external skills. General counseling skills are considered:

- The ability to create and maintain psychological contact with the clients
- The ability to ensure a therapeutic-structured context
- The development and progress of the therapeutic relationship
- The ability to self-reflect during and after the process
- Empathetic understanding

These general skills are linked with communication skills (which were analyzed in detail in the previous sub-units). The effectiveness of counseling depends also to some internal and external skills.

- Attention
- Observations (body language/posture, appearance, facial expressions, what is being said, why is being said, how is being said)
- Active listening and awareness
- Response/facilitation skills
 - paraphrasing,
 - summarizing,
 - questioning with open-ended questions,
 - asking for clarifications/examples,
 - confrontation,
 - self-disclosure

Intercultural counseling

Counseling drives the process of understanding experiences, one could say that cultural factors are central concepts in an individuals' life that should be considered within the counseling context (Feltham & Horton, 2001). D'Ardenne and Mahtani (1999) describe culture as common history, customs and beliefs that constitute the connection within religious, racial or geographical group of people. These shared groups influence all aspects of an individuals' life such as language, perception, beliefs, behaviors and relations. The intercultural counseling approach requires from the counselors to have intercultural competencies and cultural sensitivity, to be aware of racial prejudices and cultural stereotypes and to be able to identify how they can influence their behavior towards the clients of different cultural backgrounds. In order to establish a therapeutic alliance, counselors should be aware that during a session, they bring their own historical and cultural stories.

An essential element in every therapeutic alliance is communication (Rogers, 1957). The role of the counselor is to understand what the client says, verbally and non-verbally, consciously and unconsciously. In an

intercultural relationship there is much space for misunderstandings and lack of communication. Different language, different body-language postures and different emotional expressions affects the counseling relationship (Feltham & Horton, 2001). To add, culture influences deeply the way that people seek for support and also what is considered to be problematic. Counselling or therapy models are originated from western cultures, therefore, such constructs may be unfamiliar to other cultures.

Intercultural counseling competencies (Feltham & Horton, 2001):

- Awareness of counselor's beliefs, prejudices, stereotypes and racism that affects counselling process
- Awareness of counselor's own historical/cultural backgrounds as well as knowledge for other historical/cultural backgrounds
- Knowledge about history of racism/prejudices in the societal context that affects counseling
- Ability to work with people from different cultural backgrounds
- Flexibility and readiness to re-evaluate their own beliefs and attitudes about cultural and racial issues
- Commitment to the intercultural approach to counseling

Counseling approach in the healthcare context

The medical literature also provides reassuring evidence that an effective patient-centered approach does not require more time than a biomedical-centered approach (Dziopa & Ahern, 2009). The values and principles of the patient-centered approach can be applied in the daily healthcare practice in these two steps:

1. Identify the patient's needs / concerns: Identifying the needs concerns the primary discussion with the patient, in order to understand his / her views and perceptions about his / her health and quality of life. Lack of patients' information is also identified (Fuertes et al., 2007). A further aim is to strengthen the patient's ability to manage his condition, based on his goal setting. Patient respect and confidentiality of the process is also ensured. Clinicians can help patients manage their distress in ways that directly or indirectly mediate the suffering. Providing clear and thorough explanations about health and treatment options can help patients gain a greater sense of control, be more hopeful, and manage uncertainty (Henman et al., 2002). To add, eliciting, exploring, and validating patients' emotions can reduce patient anxiety and depression (Ogden, 1996). When successful, effective identification of patient needs can increase satisfaction, facilitate participation in the consultation, increase the patient's ability to cope with illness, promote greater trust in their

	<p>clinicians, all of which could increase the patient's commitment to treatment (Moore et al., 2013).</p> <p>2. Decision-making: The patient is the key person in the decision-making regarding his care and treatment services plan. Healthcare professional act as resource providers for the patients. Additional information and training so that the individual can properly identify his needs is provided (Martin et al., 2008). Support to the patient is also provided in order to make his / her health decisions. Patients will more likely experience better health when they and clinicians reach decisions that are based on the best clinical evidence, are consistent with patient values, are mutually agreed upon, and are feasible to implement (Stewart et al., 2003).</p>
Activities 1 activity max 4 pages - Title - Objectives - Keywords (max 5) - Contents (please always cite the source and add the references in the module spaces dedicated to the references) - Material (the material can be also multimedia, like pictures, videos, drawings, material to be printed by the learners...)	Title: Cultural awareness and counselling
	Objectives: <ul style="list-style-type: none"> • To help trainees to understand aspects of culture and manifestations in everyday-life and behavior • Increase awareness about own cultural prejudices and how they affect everyday judgments • Explore own cultural origin and influence on everyday life and work • Combine the new awareness level with counseling skills and apply in healthcare
	Keywords: intercultural competencies, counselling skills, multicultural, patient-center approach
	Contents: <p>This activity is a simulation of a counselling session using the role-play method based on a patient scenario. Using the knowledge about intercultural counseling skills and general counselling skills, trainees' will be asked to provide response to the patient, in a counseling simulation context. Each session should be completed in 15 minutes and the overall duration of the activity is estimated in 60 minutes. The group should be consisted of three people. Each learner within the group will rotate through three roles:</p> <ul style="list-style-type: none"> • An observer that gives feedback to the counselor/healthcare professional. • An patient with an health-related issue. • A counselor/healthcare professional that is practicing counselling skills in order to identify the patient's needs and proceed with an inclusive decision-making process for his treatment plan. <p>Each learner within a group will practice each role in every activity. After completing the first session, members will rotate roles and</p>

repeat the role-play. Allowing each learner to perform all three roles has several advantages. Each learner gets to practice counseling skills, observe the process and be in the shoes of the patient. This process will be repeated three times so that all trainees' get to role play of the observer, patient and counselor/ healthcare professional. When rotation has been completed, trainees' are asked to fill out the session's checklist. Debriefing discussions within the triads will take place so each trainee can reflect and provide feedback about the role-play process and counselling skills practiced.

Material:

Materials needed for this activity are handouts of session checklist and a client scenario.

Session checklist

Identify the counselling skills used during this role-play:

Session checklist

Reflect on counselor's:

- ✓ Understanding patient's condition and needs
- ✓ Assessing patient's views about treatment process
- ✓ Exploring/considering client's cultural background
- ✓ Counselor's cultural prejudices/assumptions
- ✓ Provide necessary information about the condition
- ✓ Discuss alternative treatment plans and inclusive decision-making
- ✓ Was the patient approach holistically, in a patient-based approach?
- ✓ Overall attitude based on counselling values (genuinity, contact, openness, unconditional positive regard)

Reflect on patient's:

- ✓ Needs/concerns and presenting problem
- ✓ Emotional response
- ✓ Collaboration/agreement and compliance
- ✓ How was the counselor-patient relationship
- ✓ How was the patient-counselor communication
- ✓ Was the patient supported
- ✓ Was the patient offered with alternatives?

	<p>Client scenario</p> <p>Varya is a 21 years of young woman from Latvia living alone in Poland. She does not speak good Polish and had no regular job. She has just been to see the hospital because she had some unusual symptoms to her genital area. The gynecologist diagnosed Varya with HPV sexual transmitted virus. She had never heard before anything about this virus. After discussing with the doctor, she explained that she had unprotected sex with multiple partners. The gynecologist suggested that she should further wait for the biopsy results in order to assess virus severity and immediate treatment.</p>
<p>Case studies 1 or 2 (no more than 1 page in form of a storytelling)</p>	<p>Celin is a 31 year old Muslim woman from Iran living in Greece. She is the mother of 3 children and her husband, also from Iran, was living and working in Germany. Celin was not speaking Greek and could barely speak English. She has been sick lately and was taking some pills that her pharmacologist suggested. Celin was getting worse, so she visited the hospital in order to get some help. The doctor that she has been referred to, was a man. The doctor made some introductory questions, asking Celin about her background information and symptom history. Celin was refusing to be examined by doctor who was man with no presence of her husband. The doctor explained to Celin that the assessment process is a normal procedure that he has been doing for hundreds of people daily. He further explained hospital protocols and ethics code however, Celin was insisting to be assessed by a woman doctor. The doctor showed understanding and referred Celin to a female doctor colleague. The female doctor introduced herself and discussed with Celin the issue. She further proceed with Celin's case.</p> <p>Reflective questions:</p> <p>The organizational and structural impact is essential for healthcare counselling application. Intercultural counselling skills may be used for managing similar situations and helping patients to gain sense of control and support. For example, a hospital may have no woman doctor at the time, or women doctors/nurse may be busy at the moment. What if Celin's request could be satisfied?</p> <p>Given the language barrier, how would that act upon an already difficult communication with Celin-man doctor?</p>

Was the man doctor culture sensitive?
Did he identified Celin' s needs?

How would Celin feel if she was assessed by a doctor who was a man?

How do you imagine that the doctor felt with Celin's request?
What he may had thought about Muslims, or Iranian culture?

Did the doctor provided with adequate information about the processes to Celin?
What factors were barriers in Celin-doctor communication and relationship?

Summary of key points

Bullets with most important points from the content (max. ½ page)

- Simulation of a counselling session
- Role-play method and a patient scenario.
- Apply previously acquired knowledge about intercultural counseling skills and general counselling skills,
- Each session should be completed in 15 minutes
- The group should be consisted of three people (observer, patient and counselor/healthcare professional)
- Each learner within a group will practice each role in every activity.
- Filling out the session's checklist will provide the basis for debriefing discussions within the groups

Self-evaluation questions

Multiple choice questions with more than one correct answer. (min. 5)

Question 1: Counseling definition

Counseling is defined as...

Answer 1	... a method that is based on principled relationship
Answer 2	.... a method that thought active listening and discussion manages significant for the person issues
Answer 3	.... effective communication
Correct answer(s)	1,2

Question 2: Communication and relationship effects

Healthcare professional- patient communication and relationship is linked with...	
Answer 1	.... increased patient and doctor satisfaction
Answer 2	.... patient compliance
Answer 3	.... job satisfaction of the healthcare professionals
Answer 4	.... more pharmacological treatment
Answer 5	.... lower quality of life
Correct answer(s)	1,2,3
Question 3: General counseling skills	
General counseling skills are:	
Answer 1	Empathetic understanding
Answer 2	Confrontation
Answer 3	The ability to create and maintain psychological contact with the clients
Answer 4	Self-reflection
Answer 5	Paraphrasing
Correct answer(s)	1,3,4
Question 4: Intercultural counselling competencies	
Intercultural counseling competencies are:	
Answer 1	Change own beliefs and attitudes about cultural and racial issues
Answer 2	Ignorance of counselor's cultural background and history
Answer 3	Awareness of counselor's beliefs, prejudices, stereotypes and racism that affects counselling process
Answer 4	Ability to work with people from different cultural backgrounds
Correct answer(s)	1,3,4
Question 5: Title of question	
Literature suggests that patient-centered approach requires in practice more time than a biomedical-centered approach...	
Answer 1	Yes
Answer 2	No
Correct answer(s)	No

Module 3: Social and individual identity strengthen self- awareness



Module: Social and individual identity strengthen self-awareness

In this training session, participants explore the meaning of identity, constructing a personality, its history and different contexts, linking it to cultural social and religious determinants of identity, exploring the meaning of identity in socially-defined concepts of health and well-being Disease and broadening through biographical work both the view of the own and the foreign or the options to avoid barriers an misunderstandings in communicative settings.

KNOWLEDGE		SKILLS	COMPETENCES	
At the end of the unit the learners will be able to				
<ul style="list-style-type: none">• The term identity, as a background for development of individual and social identity• Historic dimension and actual concepts of Identity and development of its meaning• Meaning of nations and their overcoming in current identity concepts• Meaning of identity in postmodern society• Knowledge about cultural concepts• Concept of biographical work and its significance in dealing with representatives of foreign cultures		<ul style="list-style-type: none">• Taking part in the current discourse on a high level• To illuminate and understand everyday phenomena in professional life in the context of societal, cultural-religious identity concepts.• How to use tools concerning self-awareness of appreciation of others in other cultures• Overcome communication barriers in healthcare settings• Applying rules for biographical work in a professional context• Recognize and use informal ways of competence development• Enlarge awareness of the versatility and transferability of personal identities	<ul style="list-style-type: none">• Development of an appreciative open ambiguity-tolerant attitude• To promote self-reflection ability as a basic building block for the intercultural competence• Deal with different expectations considering different concepts of health and disease• Overcome contact fears and prejudices• Self-assurance strengthens openness and acceptance• Recognise the own boundaries in personality and to deal with it• To reflect the own biography and to use biographical knowledge in professional life	
EOF LEVEL		ECVET LEVEL		
6		1 Credit		
LEARNING HOURS				
Total:	Contact:	Hands-on:	Self-study:	Assessment:
This unit will be delivered through				
<input checked="" type="checkbox"/> Discussion		<input checked="" type="checkbox"/> Presentations		
<input type="checkbox"/> Fieldwork		<input checked="" type="checkbox"/> Working groups		
<input checked="" type="checkbox"/> Hands-on		<input type="checkbox"/> Other (please specify)		
The unit will be assessed through				
<input checked="" type="checkbox"/> On going assessment	<input checked="" type="checkbox"/> Presentation	<input checked="" type="checkbox"/> Self-assessment	<input type="checkbox"/> Written exercise	
<input type="checkbox"/> Oral examination	<input type="checkbox"/> Project	<input type="checkbox"/> Skills demonstrations	<input type="checkbox"/> Written assignments	
<input type="checkbox"/> Portfolio	<input type="checkbox"/> Reflective diary	<input checked="" type="checkbox"/> Structured feedback meetings/discussions	<input type="checkbox"/> Written test	
<input checked="" type="checkbox"/> Practical	<input type="checkbox"/> Report		<input type="checkbox"/> Other (please specify)	
	<input checked="" type="checkbox"/> Workshop			

Training modules template

Duration of unit: 1 training day (8h)

Project Ref. No: 2016-1-EL01- KA202-023538

Erasmus+ project, Strategic Partnerships for vocational education and training

1.1 Common topic

Title	Social and individual identity strengthen self-awareness
Abstract/Aim (max 150 words - 10 lines)	<p>A strong identity is necessary for a self-assured and confident manner, and therefore essential to the competence of healthcare professionals. Many migrants undergo an ordeal of debasement, uprooting and destabilising, which often leads to psychosocial problems. This course examines and defines the term <i>identity</i>, and its function as the core and anchor of individual personality, as an integral part of qualification in the context of intercultural competence. Self-reflection and the strengthening of individual identity in the context of social life lie at the core of the process of heightening self-awareness. This also means the ability to keep stable in unstable life situations, as well as making one's own identity negotiable and transferable.</p> <p>Working structure: The term <i>identity</i> and the effectiveness of identity-forming processes are dealt with in the following segments of this course, primarily through lectures and discussions, literary studies, case studies and exercises with a strong focus on self-recognition: On the current discourse on identity – An outline of the topic Working hypothesis on meaning and effectiveness – Basis for discussion Definition of terms – History and roots of semantic contexts Contexts of identity: Personal, political, sociological and philosophical definitions of identity, psychological approaches Significance of identity in</p> <ul style="list-style-type: none"> • Post-modern liberal democracies • Collectivist societies <p>Habitus and identity Negotiation of identity – Transfer and reconstruction options Identity and Biography work Identity and self-awareness – Reflection on own history of identity – part of the activities section</p>
Key words	Identity, self-knowledge, individuality versus collectivism
Learning objectives	<ol style="list-style-type: none"> 1. History of the development of identity <ul style="list-style-type: none"> - We learn how the image of identity has changed and developed through the course of history 2. New theories of identity <ul style="list-style-type: none"> - We learn which modern theories exist on understanding our identity 3. Identity through Biography work <ul style="list-style-type: none"> - Biography work helps us understand our identity

References/further reading available in English or other languages (specify)	<p>Dissertation by Bernadette Müller Kmet, university assistant at the Education Sciences Group of the Vienna University of Economic and Business since March 2013; Main focus: research into identity and biography, comparative international social research, social inequality, educational sociology, research in higher education in Sub-Saharan Africa. Key areas: qualitative and quantitative research methods; sociological data analysis, methods of scientific work, theories on identity, culture and migration, analysis of social structure.</p> <p>Kulturelle Identitäten in Zwischenräumen – Migration als Chance für Fremdverstehen und kritische Identitätsaushandlung? [<i>Cultural Identity in Transition – Migration as a chance for intercultural understanding and critical negotiation of identity?</i>] COMCAD working paper No. 52, 2008 Otto von Guericke University, Magdeburg.</p> <p>Integration und Identität in Einwanderungsgesellschaften [<i>Integration and Identity in Immigration Societies</i>]. Michael Meimeth, John Robertson, et al. 2008</p> <p>Migrationserfahrung als Ausgangspunkt von Biografie Arbeit – Ein Ansatz zum besseren Verständnis und zur Integration [<i>The Migration Experience as a Starting Point for Biography Work – An approach to better understanding and integration</i>]. Dr. Dipl. Psych Jan Kizilhan.</p> <p>Autobiographisches Gedächtnis: Mentale Repräsentation der individuellen Biografie [<i>Autobiographic Memory: Mental representation of the individual biography</i>]. Strube G. Weinert F.E. 1987</p> <p>Erlebte und erzählte Lebensgeschichten [<i>Narrated Life Stories</i>]. G. Rosenthal. 1995</p> <p>Identität und Migration [<i>Identity and Migration</i>]. Essay in the Magazine <i>Perlentaucher</i>. Francis Fukuyama. Teaches political economics at the University of Baltimore.</p> <p>Das Geschlechterverhältnis als Gegenstand von Ungleichheitsforschung [<i>Gender Relation Within Inequality Studies</i>]. Aulenbacher Brigitte 1994</p> <p>Auf dem Weg in eine andere Moderne [<i>On the Way to New Modern Times</i>]. Ulrich Beck 1986</p> <p>Sozialer Raum und Klasse [<i>Social Space and Class</i>]. Pierre Bourdieu 1985</p> <p>Relationships among Multiple Identities. Peter J. Burke 2003</p> <p>Die Gesellschaft der Individuen [<i>The Society of Individuals</i>]. Norbert Elias 1996</p> <p>Identität und Lebenszyklus [<i>Identity and Lifecycle</i>]. Erik H. Erikson 1979</p>
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Der Mensch vor der Frage nach dem Sinn [*Humans Before Their Quest for Meaning*]. Viktor E. Frankl 2001

Identität der Mensch als soziales und personales Wesen [*The Personal and Social Identity of People*]. Hans-Peter Frey and Karl Haußer.

Religion und Identität. Im Horizont des Pluralismus [*Religion and Identity. On the Horizon of Pluralism*]. Werner Gephart 1999

Kollektive Identität. Die Intellektuellen und die Nation [*Collective Identity. The Intellectuals and the Nation*]. Bernhard Giesen 1999

Wir alle spielen Theater, Die Selbstdarstellung im Alltag [*We Are All Actors – Presenting ourselves in our daily lives*]. Erving Goffman 1969

Leib, Körper und Identität [*Body and Identity*]. Robert Gugutzer 2002

Geliebte Objekte. Symbole und Instrumente der Identitätsbildung [*Beloved Objects. Symbols and Instruments of Identity*]. Habermas, Tilmann 1999

Riskante Freiheiten. Individualisierung in modernen Gesellschaften [*Risky Freedoms. Individualisation in Modern Societies*]. Ulrich Beck and Elisabeth Beck-Gernsheim 1994

Zum Identitätsdiskurs in den Sozialwissenschaften. Eine postkoloniale und quer informierte Kritik an George H. Mead, Erik H. Erikson und Erving Goffman [*On the Discourse on Identity within the Social Sciences. A post-colonial, cross-sectional critique on George H. Mead, Erik H. Erikson and Erving Goffman*]. Ingrid Jungwirth 2007

Soziale Ungleichheit und Gesundheit [*Social Inequality and Health*]. Andreas Mielck 2000

Biografie Forschung und narratives Interview [*Biography Research and Narrative Interview*]. Fritz Schütze 1983

Symbolic Interactionism. A Social Structural Version. Sheldon Stryker 1980

Quellen des Selbst. Die Entstehung der neuzeitlichen Identität [*Sources of Self. The Creation of Modern Identity*]. Charles Taylor 1996

Theorie des Subjekts. Subjektivität und Identität zwischen Moderne und Postmoderne [*Theory of the Subject. Subjectivity and identity between modern and post-modern times*]. Peter V. Zima 2000

Globalkolorit – Multikulturalismus und Populärkultur [*Global Flair – Multiculturalism and Popular Culture*]. Mark Terkessidis 1998

1.2. Historical Development of Theories of Identity

Theory and content	<p>On the current discourse – Identity in liberal democracies: A breakdown of problem areas as an introduction to the topic</p> <p>Strengthening professional identity within healthcare occupations relies on a flexible and transferable basic attitude and manner, allowing for a conscious self-perception within a system of set values. Self-awareness relies on self-knowledge. Our self-placement is based on an identity that is influenced by the collective, or, in other words, self-awareness is the manifestation in my overall bearing of the realisation that my contributions are honoured by society and my individual attitudes have a place in society's system of values. Our valuations are formed by the collective and lived out individually. The individual freedom prevalent in our post-modern society, which seems to signal unlimited individuality and to permit anything, free from any collective constraints, stems from a collective agreement that this is the way things are. At the core of liberal societies lies the conviction, that identity should not be derived from a religious or nationalistic source, but from individual freedom and the canon of liberal values. The seemingly unlimited possibilities of individual existence do not, however, find any social cohesion in the question of values, as the necessary foundation for this has been lost to the sight of society. The debate on dominant culture mirrors a process of the search for meaning within our post-modern culture, which is also initiated by immigration. The resulting confusion leads to old, previously settled questions of identity being re-examined – re-nationalisation, re-culturalisation, rediscovery of religious/Catholic identity, are all experiencing a revival and are throwing political categorisations at large, as well as the political orientation of their protagonists, into turmoil and upheaval. Left-wingers celebrate liberal Muslims, the separation of state and religion is replaced by questions of control, culturalisation instead of social categorisation. It seems that immigration is testing the boundaries of liberal democracy. If we do not know who we are and what we want, then we cannot convey the appropriate guidelines. The debate on the issue of a dominant culture brings a dilemma into focus – while one group is busy arguing about the content of the discussion, the other is denying the validity of the entire debate. If, however, society's only parameters for identity are, that there should be none, then it becomes arbitrary. Everything becomes permissible, everything has its place, everyone can find happiness how they want. The formation of identity according to conveyed values does not happen, there is not real commitment. It is therefore a challenge for modern democracies to define and describe their guidelines, what should remain immutable, where their borders lie, and, above all, what will not be tolerated. The current discourse mirrors this highly political process. Occupations which involve dealing with people are particularly affected by the resulting agreements, as any changes will directly impact their daily work – in its general parameters as well as in dealing with people from a different way of life with alternatively influenced identities.</p>
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Working hypotheses on the meaning and effectiveness of identity:

1. Identity is the particular totality which distinguishes an entity or an individual.
2. Identity allows for normative orientation, positive self-perception based on multiple affiliations and solidarity and recognition.
3. Self-worth and identity are two sides of a coin, the loss of identity or belonging brings instability and isolation, with consequences for psychosocial health.
4. Identities do not follow a static or homogenous construction.
5. If identity is seen as transformative and negotiable, then the deconstruction and reconstruction imply flexibility, innovation and creativity.
6. Individual identity always rests on an identity that is – often not explicitly – formed by society, and is subject to social changes, in particular those that have been brought about by migration in recent times.
7. Migration as a relevant phenomenon changes identities on an individual level as well as on a social level.
8. Collective social norms have strong identities – the system of valuations is stringent, oftentimes restrictive and generalises effectively.
9. Postmodern societies and liberal democracies have a poorly defined identity, and are forced by immigration to deal with questions about who we are, what we want and how we should behave toward the “others”.
10. The socio-political process of negotiation is in full swing.
11. In the current political debate, old concepts which were believed to have been outdated and overcome, are gaining new attention. Identities based on nationality, religion and culture are on the rise.
12. Identity is not static, but is constantly being negotiated, both at an individual and at a social level. Therein lies an opportunity to conceptualise new realities and develop new affiliations.
13. Identity, self-confidence and psychosocial health are each determined by the other.
14. Strength of identity (in the sense of self-reflection) is thus essential for healthcare professionals, regardless of their own biographic/identity history, in order to be able to deal with unbalanced and precarious individuals appropriately.

The term *identity* and the historic development of its meaning:

Identity is derived from the Latin word “idem”, which translates as “the same”. This translation already points to a certain unity and equality persistent over time. A general formulation of the term *identity* could be “the complete agreement of a person or thing with that, which it is, or which it is described as” (Brockhaus 1997).

As far back as antiquity, several philosophers explored questions to the unity of objects. Plato and Aristotle were the first scientists to philosophise about this.

The 16th century was the time in which the medieval world view was shaken, both by the discovery of the New World as by the new, heliocentric view of the universe. The Polish astronomer Nikolaus Copernicus (1473-1543) not only went against the teachings of the church, but also came to represent rational thinking, with his discovery that the earth moves around the sun. **René Descartes** (1596-1650) finally empowered the individual itself to rational thinking in the 17th century, with the known phrase “Cogito ergo sum”. **Enlightenment was no longer sought after in some exterior order, but rather shifted inside the individual** (Taylor 1996: 263). John Locke (1632-1704) first uses the term “personal identity” in his work on the historic development of identity, and dedicates a chapter to it entitled “Identity and Diversity”, which was referred to by renowned philosophers such as Gottfried Wilhelm Leibnitz (1646-1716), David Hume (1711-1776) and others. Following on from Descartes, Locke saw **consciousness as the central component of personal identity**, for through it one became what was called “I” or “self” (Hausner 1994: 42). Locke formulates this as follows: *“As it is consciousness that always accompanies thought, and makes every man into that which he calls his self, and whereby he distinguishes himself from all other thinking creatures, it is therefore herein alone that the identity of the person, that it to say, the staying-true to oneself, of a rational human lies.”* (Locke 1981). Leibnitz, on the other hand, holds the soul, or mind, responsible for identity. “Soul” is to be understood as a substantial unity, a life principle. Representing the Enlightenment of the 18th century, the philosopher Jean Jacques Rousseau redirected attention from reason to individual feelings and emotions. The identity of a human is revealed in their innermost feelings about their “true” self. In this sense, Taylor (1996: 635) formulates the fundamental principle underlying Kantian ethics thusly: “Be true to what you really are, namely a rationally acting being.” **Kant** propagates a view of humans being led by rationality and reason, free from any dependence on a divine being. **Humanity is left to its own devices**. At the end of the 18th century, **Romanticism** developed as a counter movement to the reason-driven Enlightenment. Following from Jean Jacques Rousseau, inner feelings and a return to our own emotional nature stood at the forefront of this cultural epoch. Our innermost emotions serve our self-awareness. **Realisation is only possible from a subjective perspective**, and all subjects are to be regarded as equal in value, and are valuable per se in their individuality. Personality traits serve to set us apart from others and allow us to express our uniqueness. The growing significance of individual personality can be observed in the increasing use of personal traits in biographies since the end of the 18th century. With this call to individuality and taking charge of our own personality and developing our own potential, identity became a problem in a way that had never been experienced before. **What had previously been preordained by society was now put under the**

responsibility of the individual (Baumeister 1986: 59ff.). The modern period and individualisation both point to the increased status of the individual, and to a decline in affiliations with traditional social groups. In the 15th, 16th and 17th centuries, Europe underwent a shift from a primarily authoritarian to an increasingly autonomous way of thinking. Before this time, generally accepted authorities (religious or political leaders) had provided the answer to life's questions, small or large.

Identity in psychology and social sciences:

Identity is a universal theme which concerns every individual, as everyone either already possesses a personal identity, or is seeking one. Within the field of psychoanalytics, Sigmund Freud's work brought the unity of the self into question. Freud's division of the person into *ego*, *super-ego* and *id*, quickly became accessible to a large audience (Langbaum 1977: 9). It was, above all, the discipline of psychoanalysis, and ego psychology in particular, that provided the decisive impulse for the discovery of the concept of identity within social sciences and in our daily lives.

The problems during and after the Second World War prompted questions on **national identity or national character**. Getting to better know and understand one's own society was seen as an important task for the social sciences. An old idea, which stated that certain characteristics could be attributed to particular groups of people, received new attention and a scientific debate about the different traits of nations ensued. The American anthropologist and ethnologist, **Margaret Mead**, carried out studies on the American national character (Mead 1942), which until the 1930s were referred to as "culture-and-personality studies". This term already indicates an **interrelationship between personal, individual and cultural identity**. The way in which a particular culture forms personal identity was examined. Margaret Meads' work are significant for the quick dissemination of the concept of identity, as she upheld a personal exchange of views with Erik H. Erikson, which led to notions of a psychoanalytical concept of identity finding their way into studies on the national character (Gleason 1983). America was and is a nation of immigrants, which supported the development of ethnic and cultural plurality. During the Second World War in particular, many immigrants faced the dilemma of going to war against their homeland, or that of their ancestors. Citizens with foreign names needed to be convinced that they were American. Erikson himself, as a German immigrant, was directly affected by the tensions between his European origins and his new American homeland. The criticism of mass society in the 1960s addressed the relationship of the individual with society. Ways of manipulating individuals were discussed. Popular buzzwords included alienation, anomie, ethnocentricity, peer pressure, group affiliation and conformity. It is hardly surprising that approaches to identity research are to be found in the psychoanalytic tradition, where the individual stands at the centre of analysis. Moreover, conflicts arising

from the discrepancy between individual needs and social expectations – in other words: from the discrepancy between personal and social identity – are often thematized by psychoanalysis. **Erik Homburger Erikson** (1902-1994) can undoubtedly be described as a classic figure of identity research, and his work continues to contribute to the field to this day. He further developed the classic perspective of **Freudian psychoanalysis**, adding to it a psychosocial and psychohistoric dimension. Thus, **identity is understood as a process, which can be localised both within the core of the individual and within the core of his common culture** (Erikson 1980).

Identity in post-modern times:

Stuart Hall talks of a sociological concept of identity which is able to overcome the dichotomy of the individual and society. **“Identity sews together or ... binds the subject to the structure.”** The resulting measure of stability between the subject and its environment cannot, according to Hall, be maintained any longer in post-modern times due to social upheaval and the increasing pluralisation of environments. The consequences for the subject are grave, according to contemporary authors: “Decentration and fragmentation of the subject” (Hall 200), “Patchwork of identities” (Keupp 1999), “patchwork existence” (Hitzer/Honer 1994), “the flexible human” (Sennett 1998), “postmodern life strategies” (Bauman 1997), “oversaturation and population” (Gergen 1996), “derailment” (Giddens 1991) etc. The balancing act that the ego identity has to perform between the inner and the outer world is becoming increasingly difficult, the range of possible identities is multiplying, and **the individual finds himself in a continuously changing interactive process of development.** It is exactly the postulated crisis of identity in (post-)modern times that adds to the significance of identity for the individual. Classic questions on identity such as “Who am I?”, “How did I come to be what I am?”, “Who do I want to be?”, “What are my goals in life?”, “What is the meaning of my life?”, “What image do others have of me?”, and other similar formulations, continue to play a central role in how we cope with life, now more than ever.

New concepts of ID – as exemplified by Weigert’s theory:

Identity is a highly important category in itself, which **has the ability to turn a biological being into a human person.** (Weigert 1986). Human identity is simultaneously social and uniquely personal. After having intensively consulted existing literature on the topic, she discerns five key points, or problem areas, concerning human identity.

(1) “The dialectic on subjective and objective identity”: Individuals in modern society construe their identity somewhere between the public and private definitions. The discrepancy often found between

these two perspectives frequently results in negative consequences, such as mental health ailments and impairments of well-being. In our modern society, the dialectic on objective and subjective identity has become a central problem for each individual seeking meaning in life. The creation of identity became a private affair, accompanied by emotions ranging from self-esteem to self-loathing. This process must provide a plausible identity for oneself as well as for others.

(2) “The sociohistorical availability of identities”: Individuals can only choose an identity which is available in the times and society in which they live. From today’s point of view, it is impossible to assume the identity of a knight, as this does not exist in the reality of our society. Erikson already points out the historic aspect of identity. If we want to find everyday examples of currently emerging new identities, we need only look to the changing role of women and the effects on the family and the labour market: A businesswoman with children, or a house-husband, do not have the possibility of falling back on socially established identities, which leads to insecurities.

(3) “The organisation of multiple identities”: The complexity, anonymity and mobility of modern societies are mirrored in the identity-structures of their members. Individuals in modern societies are coming to possess an increasing number of different identities. These identities need to be organised according to their importance for the self, but also in accordance with the expectations of others. In any case, the ability to adapt this organisational structure to a specific situation is necessary. Individuals generally have a “main identity”, which in itself contains an organisational structure for all other identities. In some situations, it can be difficult to decide which identity to activate. In an interactive situation, individuals must decide which person they want to be perceived as, and then convey the respective significance of their identities accordingly.

(4) “The continuity of identity”: The multiple identities of modern society raise the issue of the necessary continuity, which needs to be reaffirmed from situation to situation, serving to guarantee order, responsibility and mental health as a type of overarching identity. Individuals strive to maintain a degree of continuity throughout their lives, although it is much harder to construct a seamless biography in modern societies. Members of traditional societies can depend on stable, predetermined social structures, such as family, gender, peer groups and the like. Nowadays, people need to construct their own biography and find meaning and continuity in their life themselves. Nevertheless, a society in which its members do not experience any continuity at all is unthinkable. In everyday situations, individuals can uphold a certain degree of continuity by trying to combine their social roles with their personal identity. In the course of their lives, they will strive to uphold both memories of their own self and wishes about their future identity, and they do this in a way that lets their social contacts know about it as well. Another possibility to keep continuity

is through nostalgic practises, whereby only the self of the past is maintained and idolised. An example would be the retired professional athlete, who polishes his medals every day, watches videos of his past achievements and brags about them to his grandchildren.

(5) “Identity and emotions”: There is little room in (post-)modern, rational and bureaucratic societies for emotions, and yet it is necessary to integrate them into one’s own identity, as they represent an important dimension in the construction of identity. Non-integrated emotions can result in a damaged identity. Weigert et al. (1986) illustrate this with the example of soldiers returning from the war. The traumatic experiences, and the associated negative feelings cannot be assimilated, which often leads to an irrational rage that prevents them from taking up normal lives in their homeland. They are not capable of reconciling their identity with the roles and offers of meaning provided by society.

Social Identity:

This category includes concepts of identity which derive from affiliation with a certain social group (nation, religion, culture, ethnicity, political party, family, faith community, etc.). The sum of all social part-identities which an individual possesses can be described as their social identity.

The social identity of a person includes the identity of social roles (e.g. employee, mother, neighbour, patient), collective identities (e.g. European, Austrian, Styrian, GT fan, middle class person, etc.) and symbolic/material elements. A social part-identity is a social category which is characterised by rules of membership and the associated bundle of traits and expectations. Sometimes it is wrongly assumed that social categories are a part of objective social reality and are therefore viewed as immutable and normatively correct. An example of such a category is the role of men and women, which until recently was clearly defined and seen as intrinsically natural. Social categories are in fact constructed by society (Fearon 1999). Social roles are connected to specific expectations, which are generally fulfilled by the person in that role, which serves to facilitate daily interactions.

Habitus and Identity

Pierre Bourdieu emphasizes that our lifestyle is not entirely chosen freely, but is formed by our position within society and class (Bordieu 1985). Bordieu attempts a structural theory of action, in which he considers the context and the situation. He tries to connect the micro and macro levels of theory with the basic formula “Structure – Habitus – Practice”. The concept of *habitus* serves as an intermediary between the objectivist structure, which is ordained by social standing and its inherent economic and cultural living conditions, and actual practice, which finds its expression in a particular lifestyle. The habitus is defined as a system of class-specific schemes of thought, perception

and action. It is gained through specific social interactions (structured practice) and is largely only experienced subconsciously by the individual. The habitus is expressed by class-specific actions and thus simultaneously serves to reproduce the objective structures (structuring practice) (Burzan 2004). “The habitus of an individual is assimilated history in the sense that an individual does not merely gain cognition of the social structures (norms, values, power structures, interaction patterns, etc.) of the society in which he lives, but rather that these are internalised quite literally into his very flesh and blood through the course of his socialisation and other processes of experience and learning” (Gugutzer 2003). The habitus has thus become second nature to humans. A specific type of perception, action and valuation, is experienced as obvious and natural, without any awareness of its social development. A child has no difficulties adapting to actions and practices of its own group in its socialisation, and after the socialisation process these are viewed as unquestionable (Bordieu 1979). Every person is influenced by the habitus of a group. Since individuals in modern societies are affiliated with more than one group, the habitus becomes multi-layered. It expresses itself in peculiarities in thought and behaviour, though without the conscious awareness of the individual. **The social habitus is the largely unconscious portion of the social identity, which becomes apparent in a comparison of different forms of habitus.** An illustration would be a worker and a child of academics. Their different forms of habitus can express themselves through, for example, their choice of words or eating habits.

Personal Identity:

Personal identity includes phenomenon which are unique to a specific individual, albeit influenced by social processes. Individual traits that define the personal identity are, among others: personality traits, biography, genetic predispositions such as height, the colour of skin or eyes, fingerprints, certain forms of disability or illness, tone of voice, intelligence, talents, etc. This first categorization still does not allow for a definite allocation of current terms of the (post-)modern discussion on identity (search for identity, identity development, patchwork identity, identity risks, identity crisis, etc.). The reason for this lies in the fact that these phenomenon occur at both a personal and a social level and have either a connecting or separating effect on these. These processes take place in an overarching meta-category, which represents the ego identity or the self of a person in the true sense. The ego identity of a person is the image they have of themselves, the creation of which was influenced by their interaction partners. The identity provides information about the type of person we are, our expectations as well as the expectations of others. It serves as an aid to orientation and a frame of reference for conscious and unconscious decisions in relation to our behaviour and attitudes. It forms the background against which individual behaviour, both of a personal and a social nature, becomes understandable. **Identity as a**

	<p>continuous process of interaction between the individual and society, builds a bridge between the personal and societal spheres.</p> <p>Main source; Dissertation by Bernadette Müller Kmet, university assistant at the Education Sciences Group of the Vienna University of Economic and Business since March 2013; Main focus: research into identity and biography, comparative international social research, social inequality, educational sociology, research in higher education in Sub-Saharan Africa. Key areas: qualitative and quantitative research methods; sociological data analysis, methods of scientific work, theories on identity, culture and migration, analysis of social structure.</p>
<p>Activities 1 activity max 4 pages - Title - Objectives - Keywords (max 5) - Contents (please always cite the source and add the references in the module spaces dedicated to the references) - Material (the material can be also multimedia, like pictures, videos, drawings, material to be printed by the learners...)</p>	<p>Title: Appreciative interaction with others</p> <p>Objectives:</p> <ul style="list-style-type: none"> - Enabling respectful interaction with other identities - Recognising the significance of failure and rejection in the development of identity - Learning to approach other people and cultures with openness and appreciation <p>Keywords: Appreciation of ourselves, Appreciation of others, Appreciation of other cultures</p> <p>Content: We practise being appreciative and respectful of ourselves and others</p> <p>Material: Notebooks and pens, chairs</p> <p>Remarks to this lesson:</p> <p>The participants learn to better reflect on themselves. How do I interact with myself and with others? Am I interested in other people? Am I interested in other cultures? Can other cultures benefit me in some way?</p> <p>The participants should only talk about the things they wish to share. As some statements will later on be discussed in the group, it is important that the participant always clearly states what they would be happy sharing with the group, or what they have only told their partner for the exercise, but do not want the whole group to hear about.</p> <p>Instructions</p> <ol style="list-style-type: none"> 1. The trainer gives a short introductory talk (10 minutes) on theories of identity based on the intellectual input above. 2. The participants form pairs. Pairs should be formed by participants who do not already know each other well, or, ideally, at all. Given the case, participants with a migrant background should not be paired with other migrants, but should work with a participant without a migrant background. 3. The participants in each pair are asked to introduce themselves to each other. They should talk about themselves, taking care to practise self-appreciation while doing so. The partner listens actively and appreciatively. At the end, the

	<p>partner can ask some questions for clarification, in order to understand everything properly. It is difficult to talk about positive things about yourself for at least five minutes, and some participants will surely struggle. They should make the attempt nonetheless.</p> <ol style="list-style-type: none"> 4. The partner listens actively and may also take notes. Once they feel they have understood everything, they provide feedback. This feedback should be focussed on the extent to which the speaker was successful in showing self-appreciation while relating. 5. Now the roles are swapped. The listener becomes the speaker. The partner listens actively, asks questions for clarification at the end and then provides feedback about the kind of self-appreciation the speaker has shown. 6. When the exercise is finished, all participants come together as a group. 7. In the group, all participants are now introduced by their partner, with a view to their own self-appreciation. Important: Nothing should be said which the participant stated they do not want discussed in the group. 8. Finally, the participants can be asked how it went, what feelings they experienced doing the exercise. Important: participants should talk about their own feelings and not those of their partner. 9. The exercise should not take longer than two hours in total. That means 30 minutes for each client with feedback and then another 60 minutes maximum for feedback in the group.
<p>Case studies 1 or 2 (no more than 1 page in form of a storytelling)</p>	<p>Remarks to this case:</p> <p>Based on the following case, participants should discuss in small groups (4-5 participants) in which way identity was formed for the person in the story. The participants try to be appreciative of the woman and her fate, and to understand her background. The participants should discuss in which ways identity can be formed, and how they can be viewed by others. They should ask themselves the following questions:</p> <ol style="list-style-type: none"> 1. Is her identity based on her country of origin? 2. What happens if the nationality changes? 3. What happens when the nationality of the person in the story is changed involuntarily due to war and displacement? 4. Is the identity of the person based on their religion? 5. Is the identity of the person based on their habitus? 6. Is the identity of the person based on their affiliation with a majority or minority group within the population? What happens when one is the only person from a particular ethnic group? 7. Was the person able to establish new identities? Did they remain bound by old identities and if yes, what were the resulting consequences? 8. What effects does a lost identity have on the psyche of the person? 9. Did the person's family provide an identity? To what extent did the person build on individual identity in their life?

	<ol style="list-style-type: none"> 10. How strong is the influence of friendship on the development of identity? 11. Is it helpful to be able to view identity from different perspectives? Would it have helped the person in the story? 12. Which parts of the story did you feel you could identify with? 13. Is there right or wrong in the story? <p>-----</p> <p>CASE:</p> <p>A typical Austrian family story</p> <p>Austria united many different ethnic groups under one nation during the monarchy: Hungarians, Italians, Czechs, Ukrainians, Germans, just to name a few.</p> <p>Our case deals with a Ukrainian woman who was born in 1912, during the monarchy. Her nationality was therefore Austrian, yet she came from a Ukrainian home, where Ukrainian was spoken and Ukrainian traditions were upheld. When she met with her friends, she also spoke Polish, German, Yiddish and Romanian. Her family kept the Russian Orthodox faith.</p> <p>She married a German-speaking Austrian out of love. Language was not a problem since both of them spoke several, as was usual in those days. As they had to agree on a church, the wedding was held in a Roman Catholic church. A year and a half later, a child was born and given a Jewish name, after a good friend of the mother's.</p> <p>Then the Second World War broke out, and the young family had to flee on account of their Austrian nationality. The parents, sisters and brother of the woman, who had all married Ukrainians and Romanians, stayed. So the young woman was separated from all her friends and relatives. All she had now were her husband and their three children. One child died during the war, and the woman was alone with her grief, as she had neither friends nor relatives around her. There were no Ukrainians where they had moved to. There was also no Russian Orthodox church, so she started visiting the Roman Catholic church. But she was accustomed to different rites, which she maintained after a fashion throughout her life, as she never fully came to grips with the Catholic rites.</p> <p>Culturally, she was very open-minded, and closely followed all the trends of the time. This had been the case in her home, and she tried to keep the same attitude in her new homeland.</p> <p>She stayed lonely in her new world, which, although she understood the language, still remained strange in its customs and rites. Somehow, she just did not manage to adapt to her new environment, even though she came from a very ethnically diverse world. This loneliness naturally had its effect on her psyche. She became aggressive, haggard and uncooperative until old age.</p> <p>The exercise should last 50 minutes in small groups, following which all groups take turns to present their insights to the whole group. This should take an additional 50 minutes.</p> <p>Materials: Flipcharts, pinboards, media pack</p>
Activities 1 activity max 4 pages - Title - Objectives - Keywords (max 5)	Title: Europe's identity constellations Objectives: Does belonging to Europe impart identity? Keywords: Identity, constellation work, respect Material: Notebooks, pens, cards with European country names that can be hung around the neck. Sufficient open space to move around freely.

- Contents (please always cite the source and add the references in the module spaces dedicated to the references)
- Material (the material can be also multimedia, like pictures, videos, drawings, material to be printed by the learners...)

Remarks to this lesson:

We will use constellation work to get an image of Europe and its identities. It is a game in which all are allowed to participate. The countries are presented by a volunteer. Several rounds can be played. The rules are explained below, and should be adhered to by all players.

This game is meant to show how the participants imagine the different identities in Europe, how they view the various countries, what they think the advantages and disadvantages of living in these countries are. All this under the personal assumptions of the player presenting their image of Europe. The presenting players live the identity of the respective country, the pros and cons, the prejudices and also the assumed privileges that each country has to offer.

The game should take three hours, with coffee breaks recommended after sections one and two.

Theory on Constellation work:

The most well-known type of Constellation work is that of Family Constellations and Family Sculpture. The activities in this project were developed following these two methods.

Family Constellations work is intended to bring the hidden constellations of the family system to light by physical representation of family members. This process should help people to discover systemic correlations which they might not be able to readily recognize outside of Constellation work, or might not want to. It is important to understand that Constellation work is not a roleplay. Representatives physically fill in for a specific person, and are encouraged to let their thoughts and emotions dwell on the person being represented, but beyond this they should hold back completely. What is also permitted is that the seeker looks for correlations within themselves while they are being represented, since everyone lives in a family system and there are often similarities to discover.

Anyone who has a question they want to try and solve can volunteer to be the seeker. People are chosen from the group of participants to act as representatives. The seeker then places these representatives in positions relative to each other, based on their own intuitive feeling. There is also a representative for the seeker themselves, who is also placed into position by the seeker, so that they can observe their own place within the system. During the process, the seeker will be able to recognize their place within a system, and this is the effect we will draw upon in our constellations-game of Europe.

Constellations work itself also includes interviews, interpretation tests and solutions. We will not elaborate further on these aspects, however, as we will not use them in our game.

Family Sculpture, developed by Virginia Satir, expands on traditional Constellations work by also focussing on the physical posture that the seeker lets the representatives assume. We will make use of this in our game as well.

Rules of the game:

1. The participants discuss the advantages and disadvantages of the countries being presented.
2. A seeker is chosen.
3. All participants draw a card with the name of a Country.

4. The seeker determines where the countries are placed. The “countries” choose which posture they want to assume.
5. The “countries” do not speak.
6. The trainer does not interrupt, except to set an intervention.
7. The seeker ends the game by removing the name cards from the representatives, thereby dismissing them from their role.
8. Finally, the trainer should hold a round of discussion and feedback on the insights of the individual participants.

Instructions for gameplay:

1. The trainer acts as facilitator and explains the background of the activity and the rules of the game at the outset.
2. A participant volunteers to be the seeker.
3. The facilitator places cards with the names of all the countries in the European Union on the floor. (In the second round, cards could also include the names of other relevant countries, e.g. USA, Russia, Israel, Turkey, Norway, Switzerland, etc.)
4. The participants view the names and discuss the countries among themselves along the following questions:
 - Are the people in that country open towards visitors?
 - Is it a rich country?
 - How much money does the country spend on social benefits?
 - Does the country have good healthcare?
 - Do people in healthcare occupations earn a decent wage?
 - How stable is the political system in that country?
 - Would I like to go there on vacation?
 - What role does the country play within the European Union?
 - Would I like to live there?
 - What could I hope for, were I to move to that country?
 - What could my identity have in common with the country’s identity?
 - Which part of my identity could I give up, in order to adapt to a new country?
 - How will the identity of that country develop, in the context of the European Union, and the rest of the world?
5. Participants with a migrant background can add any knowledge they have of a particular country to the discussion, however they should not choose their own country of origin to represent.
6. Each participant randomly draws a card with a (European) country name. This is the country they will represent. The card is then hung around the participant’s neck, officially making them a representative of that country.
7. Now the trainer places the countries in the following order, although the countries are allowed to express their own thoughts and opinions at this point. The seeker observes.
 - Placement of countries in a line according to the size of their population, ascending from right to left.
 - Placement of countries according to the stability of their political system. (How democratic do the countries seem externally?)
 - Placement of countries in a line according to their wealth.
 - Placement of countries according to the diversity of minority groups.
 - Placement of countries according to the diversity of their migrant population.
 - Placement of countries according to their apparent tolerance toward foreign cultures.
8. Now the seeker places the countries:

- Placement of countries according to their geographic location.
- Placement of countries according to similarities in their political direction, in terms of the perceived convictions of their leaders.
- Placement of countries according to similarities in their political direction, in terms of the perceived convictions of the majority population. Are there common identities?

Summary of key points

- Identity is a category of national and individual self-awareness that is currently at the centre of a hefty debate within society.
- Identity is subject to social change, and is therefore continuously being redefined within new contexts.
- Identity is based on a mutualized self-perception of individual existence.
- In the post-modern world, the collective self-definition of identity is becoming increasingly obscure.
- Migration is a strong challenge to modern democracies in terms of their self-perception.
- Identity becomes effective and significant at both an individual and a social level.

Self-evaluation questions

Multiple choice questions with more than one correct answer. (min. 5)

Question 1: Title of question

Content of question	Have you ever contemplated the term <i>identity</i> ?
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Answer 1	yes
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Answer 2	no
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Question 2: Title of question

Content of question	Was it helpful for you personally to gain some insights into the term <i>identity</i> ?
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Answer 1	yes
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Answer 2	no
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Answer 3	don't know yet
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Question 3: Title of question

Content of question	Did you gain some insight into how identity can develop in people?
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Answer 1	yes
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Answer 2	no
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Answer 3	don't know yet
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Question 4: Title of question

Content of question	Did you have thoughts on your own identity during the exercise?
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Answer 1	yes
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Answer 2	no
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Answer 3	don't know yet
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1.2. Identity and Biography work

Theory and content

2-3 pages

Identity and Biography work:

A biography creates a connection between social and personal identities. Nowadays, life in western societies is largely led along individual lines, yet there still remains a strong institutionalised element. Basic education, for example, is prescribed by law and generally follows a rigid pattern set by the state, which is shared by all members of society. The transition into retirement is also regulated by law to an extent. It is evident that people in modern societies have more freedom of choice regarding their biography; they cannot, however, be completely free of social institutions. Institutional preconditions and limitations cannot, on the other hand, deny the individuality of a biography, because the specific combination of phases and events in one's life is unique. A biography thus contains both an individual and a societal element.

Theory on Biography work

The word *biography* is formed from two Greek words, “bios” = life, and “graph” = writing. Put together, the two words mean a description of life and life processes, or a written narrative of one's life.

The word *work* indicates that there is indeed work involved in dealing with the life description of others, in contemplating and recording it, and **utilising it for the creation of relationship processes**.

Another description of the term “biography work” clarifies this further:

“Biography work endeavours to perceive a person as a whole, i.e. as a fully-formed individual that cannot be understood without the specific life experiences that helped form it.

Biography work is the inclusion of the individual history in the present moment and possible future of that person. It is always more than the sum of objective events.” (Geriatric care examination 1998)

Approaches to Biography work

Primary biographic information mostly consists of stories and descriptions of the person or their loved ones. This is called “**hard data**”. Hard data is based on facts, although these are interpreted differently as they are observed by others.

It is different when a person tells a story, however, and lets their feelings, such as joy, grief or pride, flow into the story, and the listener can empathise with what is being related. The story thus comes to life, as it offers a view from within. These lived experiences are called “**soft data**.”

The biographic conversation

Conversation lies at the heart of Biography work. In relating and exchanging impressions and experiences based on age, gender and culture, people of all nationalities can gain a part of their identity. Knowledge of the different functions of conversation makes it easier to approach Biography work, aids in the search for suitable methods and enables an efficient utilization of the different elements, orientated to the needs of the population.

The function of biographic conversation

Processing daily experiences: Everything that a person experiences, all exterior influences, need to be translated into that person's own language. Relating something with one's own images, terms and descriptions, lets new and unknown things become known and familiar. If an experience is not related, however, then the meaning fades in time and ceases to exist.

Transforming and creating: It is an adaptation and evaluation of certain experiences, dependent on the stage of development. In time, humans learn to recognise new aspects to their experience, to evaluate them differently and to draw wisdom for other life situations from them. Relating experiences can help a person to see the situation from a new perspective and also re-evaluate them.

Overcoming exceptional circumstances: When processing exceptional and dramatic circumstances, storytelling allows for the possibility to turn the “strange” into something familiar. A story that is repeated and re-told makes integrating new realities easier, or in some cases, even possible. As with a fairy tale, one then tries to find the key to solving a problematic situation, possibly even a scary situation, in order to overcome the challenge. Connecting active storytelling with a passive imparting of old wisdoms can be a healing factor. Strange or troubling life experiences can then be viewed in a new light and integrated as an enrichment to one’s life.

Access to buried experiences. (Understanding, repairing): There are many experiences in our lives that either do not fit with the form of life, cannot be related as a story, and those that are too bad to talk about. The more often a person talks about associated events and experiences, the more often they can appear as shadow images, until they hesitantly find their way into the storyteller’s account. The meaning which people derive from these experiences also influences their behaviour in the future. Storytelling provides the source of transformation and a chance for change.

Looking back and rounding off (quest for meaning): If one is successful in observing the life-arc in its entirety, and in re-living it through storytelling, then contemplation and evaluation become possible, as do either accusation or reconciliation. Again, those pieces of the puzzle can be taken from the life story that provide a harmonic, well-rounded image. The achievements of one’s life to date are packaged into words and entrusted to another person. Life receives meaning.

Bringing the inner images of the past to life: When a conversation delves into the past, it can happen that associated feelings are brought to the surface. It is possible to experience smells that are associated with the past event being told. Images are also brought to life. The father performing his after-work ritual, the mother cooking, certain gestures, and so forth.

Re-living past emotions: Relating life stories sets off old emotions, making them accessible for renewed processing. In contrast to feelings set off by images, there are also feelings which are connected to certain actions. Many things become deposited and harden within a person, as layers of rock. Layer upon layer. The pain this causes is too great to talk about at first. Storytelling lets a person begin to cautiously approach these painful memories. The dark sides of our life can be observed more objectively. The power of storytelling (combined with realisations gained over time) brings life into these barren expanses of the soul. Events long past are brought to life again and set out on a journey through time, from the past to the present, whereby they can often take on a new appearance.

Personal emphasis and form-giving: Each storyteller chooses a particular subject and sets it in a context. From the beginning to the end. These stories are oriented around a protagonist, who is usually the storyteller. A time and a place are mentioned as elements. The moral of the story, which becomes apparent at the end, is the subjective truth which the storyteller has realised. The whole narrative follows these rules. One possible format is poetry, putting the narrative of past events into verse, intended to capture the mood, condensed and often abstract.

Accentuation of good and evil: The telling of life stories also means confronting past experiences in all their beauty (good) and terror (evil).

Through re-living past events, the storyteller is pulled into an emotional whirlpool. This can lead to the narrative being abruptly halted, as the person is overwhelmed by the past experience. If such a situation is handled sensitively and empathically, and the person receives the right guidance, then old wounds can be tended to and set upon a path of healing. The healing effect lies in the fact that the experience can be divided into good and evil, thereby assuming a more objective position. The storyteller can differentiate their own person from the experience (the ghosts of the past).

Awareness of the societal, political and cultural roots: The telling of life stories leads to a profound understanding of the connection between one's own life with societal, political and cultural flows. It shows the storyteller why particular developments were possible in no other way because the political or social state at the time simply did not permit any other alternative. People's system of valuations are conditioned by culture and the current epoch:

Access to repressed experiences: The telling of life stories can bring unresolved issues to the surface. In everyday life, dark stains in our lives are mostly suppressed. These experiences can only be partially removed, however. Hateful thoughts, loathsome acts, the worst experiences, are repressed from consciousness and become taboo subjects. These taboos spread like a poison, affecting all around, becoming unwritten laws and often even affecting entire generations. Anxiety, depression, psychosomatic changes, are often visible signs of such processes. Here, a targeted therapeutic intervention is necessary, yet a biographic conversation can also facilitate access to repressed experiences and ease the resolution of these entanglements.

Experiencing significance and valuation: The telling of life stories lets us appreciate the significance of the difficult moments in our lives. The storyteller can reassure themselves of their life, while receiving appreciation from an attentive listener. In times of illness or crisis, not only the current events are worked out, but there is also an opportunity to examine old scars and to dignify them. Much will depend on the listener's attitude, whether or not a person experiences what it means to be valued and accepted – in times of illness and suffering, or at the dusk of their lives.

Awareness of specific life situations: The telling of life stories brings the storyteller into contact with the stations of their life and affords a view of the entire landscape of their life. This can happen in different ways: Some people might relate their entire life's experiences in great detail, while others might tentatively approach first one and then another experience of their past. The arc spans from early childhood experiences to those of the previous day. The true scope of life becomes apparent and the wealth of experience comes to the surface. The question: "Who am I?" stands at the heart of this process. Imagination and memory aid the seeker in finding an answer to this question.

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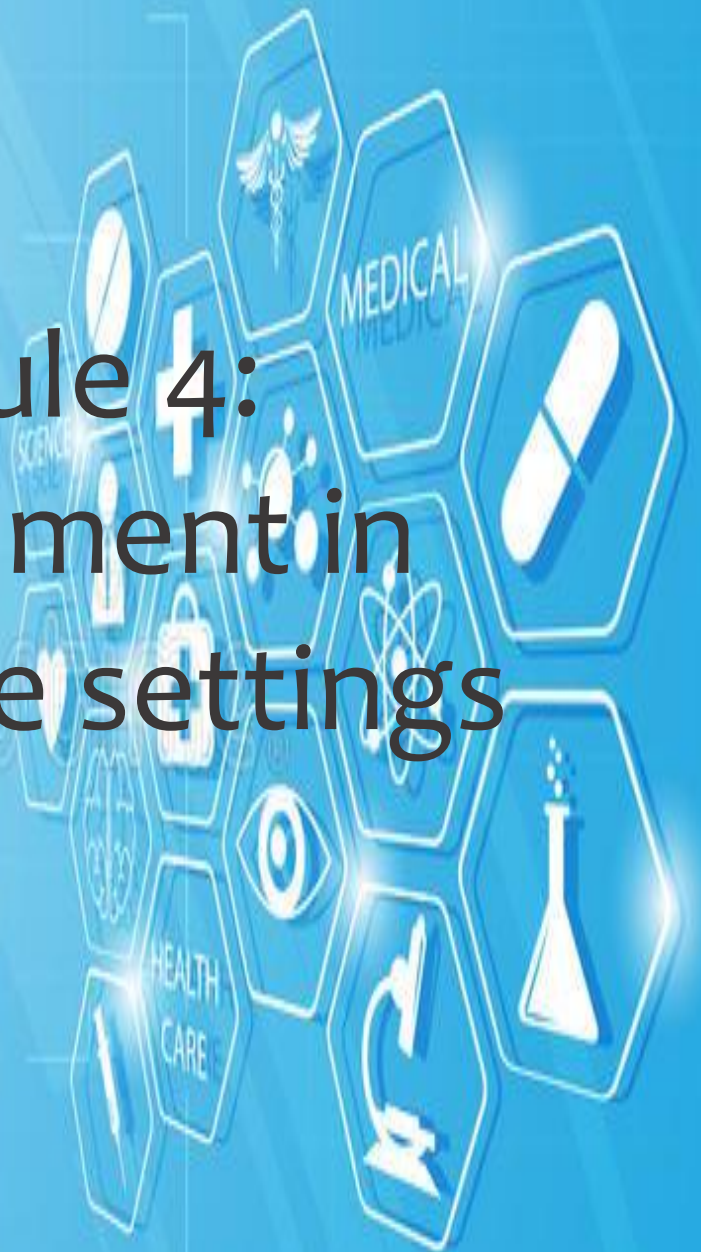
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Biography work	Title: Instrument for biography work, creating a biographic map
	Objectives: Heightening awareness of one's own identity
	Keywords: Biography work, strengthening own identity
	Contents:
	<p>Materials: We need flipchart sheets and pinboards, media pack, tables of workbench allowing participants to write and draw on the flipchart paper.</p> <p>Remarks to this lesson:</p> <p>We will let the participants create their own biographic map. Creativity and self-appreciation are hereby strengthened. This exercise may also lead to the realisation, why the biography of migrants is so important to them. It is one of the few things they still possess, and a great source of identity to them. Allow at least 40 minutes for the participants to create their biographies. Careful attention should be placed on the presentation of the individual biographies. Each participant must receive sufficient time and appreciation, so it is important that all participants applaud the presentations!</p> <p>Exercise:</p> <ol style="list-style-type: none"> 1. The trainer gives a short introductory talk on the subject, based on the theoretic input above. 2. Each participant receives a sheet of flipchart paper and large markers to write and draw. They may also use other materials if they wish. 3. The trainer asks the participants to create a biographic map of their lives. The participants are asked to graphically illustrate significant and meaningful events in their life. The simplest way to do this is to record various events along a number line. For the example of family: the birthday would be day zero, followed by birthdays of siblings, death of a relative, birth of a child, etc. 4. At the least, number lines should be created for the following subjects: <ul style="list-style-type: none"> – Family – Profession – Hobbies, leisure, friendships 5. Additional subjects: migration accounts, wither directly experienced or in the second or third generation. 6. Group presentation
<p>Summary of key points</p> <ul style="list-style-type: none"> - Biography work presents a method to make visible and document identity-giving processes at an individual level. 	

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Self-evaluation questions	
Question 1: Title of question	
Content of question	Does it require courage to talk about oneself?
Answer 1	yes
Answer 2	no
Answer 3	don't know yet
Question 2: Title of question	
Content of question	Can biography work address life issues which are difficult to express otherwise?
Answer 1	yes
Answer 2	no
Answer 3	don't know yet
Question 3: Title of question	
Content of question	Has creating a biographic map let you find out something new about yourself, or led to any other realisations?
Answer 1	yes
Answer 2	no
Answer 3	don't know yet

Module 4: Management in healthcare settings



Module: Management in Healthcare Settings

Healthcare professionals have to address new challenges in their daily basis that require the development of certain skills to deal with very diverse population with different cultural backgrounds. They need to reinforce, increase their intercultural competences and manage certain issues in the healthcare settings that impact at interpersonal, institutional and organizational level. Some of the issues are ethical dilemmas, environmental safety and the rapport with their patients.

KNOWLEDGE		SKILLS		COMPETENCES	
At the end of the unit the learners will be able to					
<ul style="list-style-type: none">• Develop skills to manage challenges that healthcare professionals face in their healthcare settings regarding ethical dilemmas, environmental safety and the rapport with their patients with a culturally diverse background.• Increase their competences concerning personal values, decision making processes and actions that professionals engage in their daily practice in the institutional and organizational context• Know principles, models and theories about management of certain intercultural issues in healthcare settings.• Know other cases and good practices in these topics.		<ul style="list-style-type: none">• Understand the motivations behind the behaviours of culturally diverse groups of people.• Build trusting relationships with patients with a culturally diverse background.• Examine the Health services Environment in the interpersonal, institutional and organizational contexts to include multiple perspectives and ways of thinking.		<ul style="list-style-type: none">• Tackle ethical dilemmas in the decision making.• Apply ethic values in the daily work.• Self-evaluate the rapport with patients with a culturally diverse background.• Apply essential standards in healthcare settings to have a safe environment. Assess the environment in the healthcare setting in terms of safety.	
EOF LEVEL		ECVET LEVEL			
6		?			
LERNING HOURS					
Total: 25		Contact: 5	Hands-on: 5	Self-study: 10	Assessment: 5
This unit will be delivered through					
<input checked="" type="checkbox"/> Discussion		<input checked="" type="checkbox"/> Presentations			
<input type="checkbox"/> Fieldwork		<input checked="" type="checkbox"/> Working groups			
<input checked="" type="checkbox"/> Hands-on		<input type="checkbox"/> Other (please specify)			
The unit will be assessed through					
<input checked="" type="checkbox"/> On going assessment		<input type="checkbox"/> Presentation	<input type="checkbox"/> Self-assessment	<input type="checkbox"/> Written exercise	
<input type="checkbox"/> Oral examination		<input type="checkbox"/> Project	<input type="checkbox"/> Skills demonstrations	<input type="checkbox"/> Written assignments	
<input type="checkbox"/> Portfolio		<input type="checkbox"/> Reflective diary	<input type="checkbox"/> Structured feedback	<input type="checkbox"/> Written test	
<input checked="" type="checkbox"/> Practical		<input type="checkbox"/> Report	meetings/discussions	<input type="checkbox"/> Other (please specify)	
		<input type="checkbox"/> Workshop			

Training modules template

Project Ref. No: 2016-1-EL01- KA202-023538

Erasmus+ project, Strategic Partnerships for vocational education and training

Duration of unit: 1 training day (8h – to be confirmed)

1.1. Common topic

Title <i>The title should be one of the modules defined on the table below (i.e. Intercultural./interreligious competences)</i>	Management in Healthcare Settings
Abstract/Aim <i>(max 150 words - 10 lines)</i>	<p>Healthcare professionals have to address new challenges in their daily basis that require the development of certain skills. The population they attend is very diverse and in many cases with culturally diverse backgrounds.</p> <p>Healthcare professionals need to reinforce, increase the intercultural competences and manage certain issues in their healthcare settings that impact at interpersonal, institutional and organizational level. Some of them are ethical dilemmas, environmental safety and the rapport with their patients.</p> <p>They often face ethical dilemmas that led them to moral distress and they have to make ethic decision to solve problems. Regarding to their work environment, it is essential to work in safe environments that guarantee the patients with a culturally diverse background and employees' safety and the organizational conditions.</p> <p>In other hand, building patient's rapport based in trust produces benefits and positive outcomes in patients' treatments and generates a positive organizational climate.</p>
Key words <i>Max 5 keywords</i>	Ethical dilemmas, safety, rapport, trust building, skills
Learning objectives <i>1 per sub-module, in bullet points</i>	<ul style="list-style-type: none">- To develop skills to manage challenges that healthcare professionals find in their healthcare settings regarding to ethical dilemmas, environmental safety and the rapport with their patients with a culturally diverse background.- To increase the competences of healthcare professionals concerning personal values, decision making process and actions those professionals take in their daily performance in their institutional and organizational context.- To know principles, models and theories about management of certain intercultural issues in healthcare settings.

	<p>- To know other cases and good practices in healthcare.</p>
<p>Tips (transversal) (no more than 6 for do and don't depending on the sub-topics)</p>	<p>A one-size-fits-all instructional strategy does not exist.</p> <ul style="list-style-type: none"> ✓ “I do have a wide variety of instructional strategies within my repertoire to deal with in everyday practice during the care of people with a different cultural background” ✓ “I don't use the information, tools and methods provided if I don't feel safe with or I don't know about”. <p>Reflection and being aware of educational needs is a great place to start understanding the motivation behind the behaviours and planning for effective change regarding the current situation in healthcare concerning the healthcare needs of culturally diverse groups of people.</p> <p>Building trusting relationships with patients with a culturally diverse background, their families and employees' safety and the organizational conditions is at the core of culturally responsive instruction. Health services -Community Connection.</p> <p>Trust is necessary for us as it increases tolerance of uncertainty in the interpersonal, institutional and organizational contexts.</p> <ul style="list-style-type: none"> ✓ “I do not deal alone with important Health services problems; I will include all actors, health care professionals and services in each country, as well as relevant health care policies, social workers, networks, organizations and external resources”. <p>Allowing multiple perspectives and ways of thinking is essential in healthcare relationships. Therefore, it is also important to examine the Health services Environment in the interpersonal, institutional and organizational contexts.</p> <ul style="list-style-type: none"> ✓ “I don't focus only in one argument and way. I try to cover and think in external factors (social, economic, familiar, religion, beliefs, etc.)”.
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1.2. Specific to sub-topic

Theoretical and contents 2-3 pages	Ethical dilemmas <p>An Ethical Dilemma is a decision making problem between two possible alternatives, neither of which is unambiguously acceptable or preferable and it's not clear which one is the right one (Banks, 2005: 1011).</p> <p>Ethical dilemmas may arise for patients and family members with a culturally diverse background, medical staff members and physicians alike covering interpersonal, intercultural, institutional and organizational context.</p> <p>Regarding to administrators, they play a significant role in establishing the programs and environments that directly affect patient care delivery within their health system, institutional and organizational context.</p> <p>They often are responsible for making financial decisions that can impact both their health care organization and the quality of care delivered and they have to work with staff to resolve complaints before legal action has to be taken. Health care administrators may work to manage relationships with many stakeholders, including external vendors who provide products and services, including brand-name medications, diagnostic equipment, and software solutions. Health administrators are also industry leaders with the education and authority to shape ethical policy in health care.</p> <p>They have to be prepared for certain situations where ethical leadership and decision making are key skills.</p> <p>An important ethical principle is maintaining the right to privacy and autonomy. Administrators should ensure that the technological systems for recording, storing, and transmitting sensitive health information adhere to all the relevant laws and regulations.</p> <p>For the part of healthcare providers, ethical dilemmas appears in certain issues such as abortion, contraception, euthanasia, professional misconduct, confidentiality truth telling, professional relationship with relatives, religion, traditional medicine and business concerns.</p> <p>There are some areas of possible ethical dilemmas:</p>
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1. *Confidentiality*: “The principle that binds the practitioner to hold in strict confidence those things learned about a patient in the course of a medical practice” (Edge, 2006).
 - Confidentiality it’s important to create a trust building environment.
 - The obligation of confidentiality prohibits the health care provider from disclosing information about the patient's case to others without permission and encourages the providers and health care systems to take precautions to ensure that only authorized access occurs.
2. *Royal Fidelity*: “Royal fidelity entails the specific loyalties associated with a particular professional designation”.
 - It is a special form of the principle of beneficence that captures the quality of the commitment which exists between the healthcare professional and the patient.
3. *Sexual Misconduct in Healthcare*: sexual practice between practitioners and patients are considered unethical.
4. *Allocation of scarce resources*. In situations of allocation of scarce resources the most ethical method is the Utilitarian Theory of Justice: resources are provided in order to provide the most good to the greatest number of people.
 - The application of this theory should guarantee the equal treatment regardless the socio-economic and legal status of patients.
5. *Patient Autonomy*: “Personal self-determination; the right of patients to participate and decide questions involving their care” (Edge, 2006).
 - Informed consents are required to inform migrant and from ethnic minorities’ patients about risks involved in a determinate intervention (for example, blood transfusion) and to empower him/she to decide if he/she will receive that intervention.
6. *Dealing with AIDS (or other risk infections) in Healthcare*.
 - It could be a conflict between the right of the professional to know information that can affects to his/her personal safety/protection and the right of the patient to the confidentiality.

Conflict of principles and ethics actions in the healthcare practice

Ethical principles (respect for autonomy, beneficence, non-maleficence and justice) sometimes conflicts with each other leading to those ethical dilemmas.

Types of conflicts:

- Conflict between two ethical principles: two principles are valid but one contradicts the other one. For example, when a patient from ethnic minorities doesn't want to continue treatment (autonomy) and the healthcare provide knows a treatment that can benefits the patient (beneficence).
- Conflict between two actions with reasons for and against: when taking actions can harm the patient but not taking actions will harm the patient as well. For example, a patient that present self-aggression because of his/her pathology and it's necessary to immobilize his/her extremities (action against the freedom of the patient but not taking it would generate more injury).
- Conflict of evidences: when therapeutics actions are carried out against the patient, by the decision of the family. For example: when patients with a terminal illness decisions are delegated to family (loss of the right to the autonomy).
- Conflict between the personal ethics and the professional role: when healthcare providers performs an activity against their moral and ethics personal principles. For example: when not being agrees with the application of euthanasia.
- Conflict between ethics and law: Same with application of euthanasia. For example: family is agreeing with the application to a patient in terminal status but it is not authorized by law.

Method for ethical problems-solving

Resolution of dilemmas demand the best of the healthcare providers' knowledge of relevant laws and ethics, his/her training and experience, his/her religious conviction and moral principles as well as his/her readiness to benefit from ethics consultation and the advice of his/her colleagues.

There are numerous regulatory mechanisms that are designed to ensure that the highest standards of ethics are met in healthcare settings (for example International Council of Nurses' ICN Code of Ethics).

This states that nurses, in addition to carrying out their main responsibilities of promoting health, mitigating suffering, and preventing illness in patients, must also display “a respect for human rights, including cultural rights, the right to life and choice, to dignity, and to be treated with respect”.

In some healthcare settings, there is an Ethics Committee.

The Ethics Committees are interdisciplinary groups responsible for the decision making in ethics conflicts covering interpersonal, intercultural, institutional and organizational context.

They take into account facts, antecedents, values in conflict, scientific concepts, technical rules, philosophical ideas (about the profession, professionals involved and the patient), laws, internal rules, organizational issues, etc.

They are formed to answer about which are the duties and obligations of healthcare workers regarding to their patients by performing their activity? How ethics values are incorporated to their performance?

Following, it is presented a model for ethical decision making, the DOER Method, which is based in the scientific method and applied by the Ethics Committee.

The DOER Method involves four stages:

1. **Delimitation of the conflict:**

- Integral valorization of the patient’s health (physic, psychic, sociocultural and spiritual), identifying causes, circumstances and facts that led to take a determinate attitude.
- Consideration of the Deontological Code/ code of conduct of the professionals to check which action must be taken in that situation.
- Confrontation of the results from the valorisation of the patient with a culturally diverse background with the attitude that the professional must take according to his/her code of conduct, delimiting in an objective way the real dimension of the conflict.

2. **Offered options:**

- Objective, truthful and complete information provided by the professional to the patient about the actions of the professional according to

	<p>his/her code and to the options that the patient has to solve his/her problem.</p> <ol style="list-style-type: none"> 3. Selection of the option. <ul style="list-style-type: none"> ○ The patient with a culturally diverse background must choose freely the desired option among the presented alternatives. 4. Conflict resolution. <ul style="list-style-type: none"> ○ Communication to the interdisciplinary team the chosen option by the patient and the position to adopt, performing under the informed consent and registering all the process. <p>Evaluation</p> <p>Finally, Ethics education should begin from the impressionable age in homes, continued in the medical schools and after graduation to ensure that doctors develop good ethical practices and acquire the ability to effectively handle ethical dilemmas. Also, education of patients with a culturally diverse background and sanction of unethical behaviour will reduce ethical dilemmas.</p>
<p>Activities</p> <p>1 activity max 4 pages</p> <ul style="list-style-type: none"> - Title - Objectives - Keywords (max 5) - Contents (please always cite the source and add the references in the module spaces dedicated to the references) - Material (the material can be also multimedia, like pictures, videos, drawings, material to be printed by the learners...) 	<p>Title: Ethical dilemma's solving</p>
	<p>Objectives:</p> <ul style="list-style-type: none"> - To analyze a real ethical dilemma - To reflect about ethic values incorporated in the daily performance of healthcare providers - To apply a model for ethical decision making
	<p>Keywords: ethical dilemma, principles, problem solving</p> <p>Contents:</p> <p>For the following activity let's imagine that you are part of the Ethics Committee in your healthcare setting.</p> <p>Please, think about an ethical dilemma that you or some of your colleagues have had (or you are currently having) and try to solve it following the stages of the DOER Method.</p> <p>This activity can also be worked in group sessions.</p> <ol style="list-style-type: none"> 1. Delimitation of the conflict: Analyze the conflict providing information about: <ul style="list-style-type: none"> - The situation of migrant and from ethnic minorities' patient's health, the level of required attention and necessary priorities. The Diagnostics. Make an integral valorization (physic, psychic, sociocultural and spiritual). - Ethical dilemma posed.

	<ul style="list-style-type: none"> - What your deontological code/code of conduct consider regarding this situation. - Migrant and from ethnic minorities patient's expectations and considerations. - Your professional considerations. - Other professionals' considerations, if applicable. - Legal, ethical, etc. reasoning's. <p>2. Options.</p> <ul style="list-style-type: none"> - Write the priorities applying the principles of ethical dilemma beneficence, justice, autonomy, confidentiality, etc. - List the options you can offer to the patient according to your code of conduct and the valorization you previously did. <p>3. Selection of the option.</p> <p>In case you don't know the election of the patients at this moment, make a supposition about it.</p> <p>4. Conflict resolution.</p> <ul style="list-style-type: none"> - Explain how you communicated or you would communicate to the rest of team the decision taken. - Explain the next steps in the process and action plan (informed consents, registration of the information, etc.) <p><u>Evaluation:</u></p> <ul style="list-style-type: none"> - Write the problems you have encountered by trying to solve this problem. - The ethical dilemma has being solved? - The objectives have been accomplished? - How do you feel about it?
<p>Case studies</p> <p><i>1 or 2 (no more than 1 page in form of a storytelling)</i></p>	<p>Material:</p> <p>Sheets and pen</p> <p>Work log</p> <p>Institutional information papers</p> <p>Minutes of agreements</p> <p>Kauri is a young man from Ghana. He worked as farmer in his country and currently works part-time trimming vegetation in some private properties.</p> <p>One day Kauri comes into the clinic for a check-up. His nurse requests a sample of urine for a toxicity test. Kauri agrees to give the urine because he has signed a contract as part of his treatment for ADHD (Attention Deficit Hyperactivity Disorder).</p>

Kauri tests positive for cannabis. He confesses that he smokes cannabis very often and drinks alcohol as well. In addition, he frequently forgets to take his medication for his seizure disorder.

The nurse feels moral distress because:

- Kauri is using illicit drugs and alcohol.
- She must maintain confidentiality.
- Kauri is not taking his seizure medications.
- He can injury himself or others.

When nurse talks to Kauri to say that what he is doing is not safe and that he can injure himself and others, Kauri's reaction is aggressive. He shouts that he can do what he wants, the use of cannabis is quite culturally accepted in his origin country (mainly among workers that develop hard professions as farmers) and he threatens the nurse about telling his business.

The moral distress that the nurse feels is due to an ethical dilemma, the patient with a culturally diverse background right to confidentiality and the nurse's responsibility to protect from harm.

Moral distress can causing suffering in the nurse and even disrupts her ability to do her work.

- ✓ Could de maintenance of confidentiality lead to the harm of Kauri or others?
- ✓ If you were this nurse, what decision would you take?
- ✓ Would you ask for some colleague's help?
- ✓ On which elements, principles or theories of ethical reasoning would you base your decision?
- ✓ How would you apply the DOER Method to solve this ethical dilemma?

Summary of key points

- An Ethical Dilemma is a decision making problem that may raises for healthcare professionals and the patient with a culturally diverse background and their families.
- There are Ethical principles (respect for autonomy, beneficence, non- maleficence and justice) sometimes conflicts with each other leading to ethical dilemmas.
- Areas of possible ethical dilemmas as confidentiality, royal fidelity, sexual misconduct, the patient with a culturally diverse background patient's autonomy, etc.
- When some of these ethic principles conflicts with each other leading to ethical dilemmas.
- The DOER Method is a model for ethical decision making, based in the scientific method that involved four stage plus final evaluation: delimitation of the conflict, offered options, selection of the options and problem resolution.

Self-evaluation questions*Multiple choice questions with more than one correct answer. (min. 5)***Question 1: Title of question**

Content of question	In an ethical dilemma, the two possible alternatives for solving the decision making problem are...
Answer 1	right
Answer 2	it's not clear which one is the right one
Answer 3	Neither is preferable but one is the right one
Correct answer(s)	2

Question 2: Title of question

Content of question	Do the principle of confidentiality permits the healthcare professional to disclose information about the patient with a culturally migrant background?
Answer 1	Yes
Answer 2	No
Answer 3	Yes with patient's permission
Correct answer(s)	3

Question 3: Title of question

Content of question	Which are the instruments used to guarantee a patient from an ethnic minority's autonomy?
Answer 1	Registration form in the healthcare setting
Answer 2	Informed consents
Answer 3	Answers 1 and 2
Correct answer(s)	2

Question 4: Title of question

Content of question	Which principles are conflicting against each other when a patient from an ethnic minority doesn't want to keep the treatment and the healthcare provider consider that the treatment can benefit the patient?
Answer 1	Autonomy and beneficence
Answer 2	Respect for autonomy and justice
Answer 3	Answer 1 and 2
Correct answer(s)	1

Question 5: Title of question

Content of question	In which stage of the MOER method is necessary to check the Deontological Code/Code of conduct of the professional?
Answer 1	Conflict resolution
Answer 2	Evaluation
Answer 3	Delimitation of the conflict situation
Correct answer(s)	3

1.3. Safe environment

Theoretical and contents 2-3 pages	<h4>Safe environment</h4> <p>Maintaining a safe environment reflects a level of compassion and vigilance of the patients with a culturally diverse background's welfare that is as important as any other aspect of competent health care.</p> <p>A safe environment in health care settings is based on several elements as patient safety, essential environmental health standards and positive practice environments for health care professionals (interpersonal, intercultural, institutional and organizational context).</p> <p>Patient safety</p> <p>Patient safety has being defined as a discipline in the health-care sector that applies safety science methods towards the goal of achieving a trustworthy system of health-care delivery. Ethnic minorities' patient and migrant patients' safety is also an attribute of health-care systems; it minimizes the incidence and impact of, and maximizes recovery from adverse events.</p> <p>Patients with a culturally diverse background are not only harmed by the misuse of technology, they can also be harmed by poor communication between different health-care providers or delays in receiving treatment. Individual healthcare providers can improve patient safety by engaging with patients and their families, checking procedures, learning from errors and communicating effectively with the health-care team. Such activities can also save costs because they minimize the harm caused to patients</p> <p>Safety culture in healthcare settings is created through:</p> <ol style="list-style-type: none">1) The actions management takes to improve both patient and worker safety;2) Worker participation in safety planning;3) The availability of appropriate protective equipment;4) The influence of group norms regarding acceptable safety practices; and5) The organization's socialization process for new personnel. <p>To improve patients with a culturally diverse background's safety is needed to understand and change organizational conditions, components, and processes of health care systems. Some recommendations are:</p> <ul style="list-style-type: none">• The establishment of a Quality, Occupational Health & Safety management system and an environmental policy.
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- Provide services which security, fitness for use and duration meet patients' expectations, in compliance with specifications, requirements, standards and applicable laws, integrating health and safety of workers and patients and protection at all levels of the organization and decisions.
- Progressively improve the quality system risk assessment
- Training, education (with certification) motivation and awareness for health providers so that they are aware of their obligations towards the patients, personal non-personal health protection and risk prevention.
- Training will also guarantee that all rules, requirements and applicable laws are known.
- Self-control to continuously improve in all areas and activities

In other hand, both patients and employees are affected by organizational climate. According to *Clarke SP*, organizational climate refers to an atmosphere, which is a moveable set of perceptions related to working and practice conditions, many of which can be directly influenced by managers and organizational leaders.

A positive organizational climate and high quality healthcare environment fosters positive outcomes at three levels: staff, patients and organizational.

According to the World Health Organization, the challenges that healthcare providers need to manage for guaranteeing quality and safety of healthcare are the following:

- Meaning and importance of patient safety.
- Understanding systems and the impact of complexity on patient care.
- Being an effective team player.
- Understanding and learning from errors.
- Understanding and managing clinical risk.
- Introduction to quality improvement methods.
- Engaging with patients and carers.
- Minimizing infection through improved infection control.
- Patient safety and invasive procedures.
- Improving medication safety.

Essential environmental health standards in health care settings (institutional context).

Positive policies are required at national, state, regional, district and health-setting levels to encourage appropriate levels of environmental health in health-care settings.

Safe environments in health care settings are characterized by some health standards.

The World Health Organization (WHO) has set essential environmental health standards of safety conditions to provide adequate health care.

Firstly, *Standards* are defined as the requirements that must be met to achieve minimum essential environmental health conditions in health-care settings. They must be clear, essential and verifiable statements.

Depending on the type of healthcare setting (large health-care setting as an hospital, small health-care setting as an health care center in a rural or urban area, emergency or isolation) settings the issues involved in environmental health will have a different dimension (in terms of for example, disease transmission risks, range of facilities and services and financial and material resources).

The standards and their indicators are the following:

1. *Water quality* (microbial quality, chemical constituents, disinfection, drinking water quality, water for cleaning, water for medical purposes, for example, water used for haemodialysis).
2. *Water quantity*: use of minimum water quantities.
3. *Water facilities and access to water* (drinking-water points, handwashing, handwashing facilities, showering facilities, laundry facilities).
4. *Excretal disposal*: Adequate, accessible and appropriate toilets are provided for patients, staff and carers (ratio of people per toilet, local technical and financial conditions, social and cultural considerations: for example, separate toilets for men and women, special children toilets, toilets should be designed and equipped to respond to cultural identities e.g. anal cleansing with water; hygiene and safety concerns, handwashing points, accessibility, leaning and maintenance).
5. *Wastewater disposal* (wastewater drainage systems, prevention of environmental contamination, rainwater and surface run-off).
6. *Health-care waste disposal* (segregation and separate storage, storage and collection, treatment and disposal, waste-disposal zone).

7. *Cleaning and laundry* (routine cleaning, intensity of cleaning routine, blood or body fluids, cleaning soiled line, transporting soiled linen, beds and bedding). Colouring code has also mentioned in literature as necessary to identify safety risks. Some healthcare settings have already adopted a National Colour Coding Scheme of Healthcare.
8. *Food storage and preparation* (food handling and preparation, separation of food and equipment, cooking and serving, storage, washing and use of water, powdered infant formula).
9. *Building design, construction and management* (ventilation, air extraction to minimize pathogens, lighting, movement between areas, cleaning, building design).
10. *Control of vector-borne disease* to protect Patients, staff and carers (minimizing disease vectors protect patients and staff from vector-borne diseases, prevent spread of vectors).
11. *Information and hygiene promotion* (training in infection control, behaviours for limiting disease transmission, adequate facilities,

Positive practice environments for health care professionals (organizational context).

There are settings that strengthen and support the workforce and, in turn, have a positive impact on patients with a culturally diverse's outcomes and organizational cost-effectiveness. These are Positive Practice Environments (PPE).

They aim to ensure the health, safety and personal wellbeing of staff, support quality patients with a culturally diverse's care and improve the motivation, productivity and performance of individuals and organizations (with appropriate resources both financial and human).

The key elements on workplaces that promote positive practices environments:

- Occupational health, safety and wellness policies that address workplace hazards, discrimination, physical and psychological violence and issues pertaining to personal security;
- Fair and manageable workloads and job demands/stress;
- An organisational climate reflective of effective management and leadership practices, good peer support, worker participation in decision making, shared values;
- Work schedules and workloads that permit healthy work-life balance;
- Equal opportunity and treatment;

- Opportunities for professional development and career advancement;
- Professional identity, autonomy and control over practice;
- Job security;
- Decent pay and benefits;
- Safe staffing levels;
- Support, supervision and mentorship;
- Open communication and transparency;
- Recognition programmes; and
- Access to adequate equipment, supplies and support staff

Promoting and maintaining positive practice environments involves a range of players (e.g. governments, employers, professional organizations, regulatory bodies, unions, education institutions, etc.) and it occurs on many levels of an organization.

For the part of health professionals and their representative organizations there are certain measures that they can carry out to develop a positive practice environment:

- Continuing to promote the role of health professionals.
- To raise awareness and defining the scope of practice so that health professional's works to their full potential for patients with a culturally diverse care.
- Lobbying for professional recognition and remuneration.
- Support research which focuses on why workers will stay, rather than why workers leave ("job embeddedness").
- Evaluating the health well-being and motivation of staff.
- Developing and disseminating a position statement on the importance of a safe work environment.
- Building capacity of health professionals and others involved in health sector management and policy-making positions.
- Strengthening health professional organisations and having access to decision-making bodies.
- Supporting research, collecting data for best practice, and disseminating the data once it is available.
- Working with management and government to ensure that the principles of PPE are fully embedded.
- Establishing alliances across different health professional groups and health sector stakeholders, e.g. patients/consumer associations/migrants associations.

	<ul style="list-style-type: none"> • Ensuring that other disciplines are involved in the development of policies for safe work environments. • Raising awareness, understanding and support of all relevant stakeholders about the positive impact healthy and supportive work environments have on the recruitment and retention of staff, ethnic minorities' patient outcomes and the health sector as a whole.
Activities 1 activity max 4 pages - Title - Objectives - Keywords (max 5) - Contents (please always cite the source and add the references in the module spaces dedicated to the references) - Material (the material can be also multimedia, like pictures, videos, drawings, material to be printed by the learners...)	Title: Safe environment assessment checklist
	Objectives: <ul style="list-style-type: none"> - To get aware about essential standards in healthcare settings to have a safe environment. - To assess the environment in your healthcare settings in terms of safety. - To reflect about your personal circumstances regarding to a positive and safe environment in your work.
	Keywords: Safety, standard, safe environment Contents: The following checklist provides a set of affirmative sentences regarding to essential environmental health standards in your health care setting (HCS). You can assess how safe is the environment in your HCS by checking those sentences which you are agree with. Maybe some standards are not applicable to your HCS. Please, also add some comments when necessary. Standards regarding to: Water quality <ul style="list-style-type: none"> ▪ Water for drinking, cooking, personal hygiene, medical activities, cleaning and laundry comes from a safe source (free from faecal contamination). ▪ The quality of the water source is monitored regularly. ▪ The water storage, distribution and use facilities in the HCS are adequately maintained to avoid contaminating the water. ▪ There are sufficient supplies and adequately trained staff to carry out treatment. ▪ The water is acceptable (smell, taste, appearance). ▪ When the water is not acceptable there is a safe alternative supply of drinking-water. Water quantity

- There is sufficient water and is available at all times for drinking, food preparation, personal hygiene, medical activities, cleaning and laundry.
- There a suitable alternative supply in case of need?
- The water supply is operated and maintained to prevent wastage?

Water facilities and access to water

- There are sufficient and clearly identified drinking-water points?
- Water-use facilities are available and in the right place in the health centre to allow convenient access to, and use of, water for drinking, food preparation, personal hygiene, medical activities, laundry and cleaning.

Excreta disposal

- There are sufficient toilets in the health-care setting in use for patients, staff and careers.
- The toilets are maintained and repaired in a timely and effective way.
- The toilets are designed to suit local culture and social conditions.
- The toilets provide privacy and security.
- The toilets are clean and without smell.
- There is an effective cleaning and maintenance routine in operation.
- There are handwashing facilities close by the toilets.
- The toilets easily accessible for all users.

Wastewater disposal

- Wastewater is disposed of rapidly and safely
- The wastewater drainage system have sufficient capacity
- Protective features (e.g. grease traps) are properly maintained.
- Cleaning and wastewater disposal activities are prevented from ending up in the open environment and contaminating rainwater and run-off.

Health-care waste disposal

- There are facilities (waste containers) in place for segregating health-care waste at the point of generation.
- The segregation facilities are used effectively.
- The waste containers are emptied, cleaned and replaced (or disposed of) frequently enough.
- There is a specific waste-disposal zone with the necessary features.

Cleaning and laundry

- Surfaces and fittings are cleaned routinely and they are visibly clean.
- The cleaning requirements of different zones of the HCS are defined.
- Are different zones of the HCS are cleaned according to their specific requirements.
- The contaminated spills are cleaned and disinfected immediately.
- There are sufficient laundry facilities at the HCS.
- Soiled linen is placed immediately in bags and then correctly washed and dried.
- Clean and soiled linen is transported and stored separately
- Mattresses and pillows are cleaned between patients and whenever soiled.
- There is appropriate equipment available for cleaning, disinfection and sterilization of medical equipment.
- Medical equipment is appropriately cleaned and then disinfected or sterilized between uses.

Food storage and preparation

- There are handwashing points in the food preparation area and at the toilets that food handlers use.
- Food storage and preparation areas are designed and built so as to be easy to keep clean.
- There are facilities and equipment provided for preventing contact between cooked and raw Foodstuffs.
- There are cooking facilities adequate for heating food
- Sufficiently.
- Food is kept at safe temperatures.
- Do facilities exist to allow the safe preparation, storage and handling of powdered infant formula.

Building design, construction and management

- The HCS is designed and built so as to provide comfortable and healthy conditions.
- The ventilation of the HCS is designed to minimize airborne disease transmission, for example, severe acute respiratory syndrome.
- The lighting system of the HCS is sufficient to ensure safe working conditions and security, and is it appropriate to local conditions.
- The HCS activities are organized to minimize the spread of contamination.

- The HCS easily accessible by people with physical handicaps and does it have sufficient space (e.g. between beds) to minimize the spread of contamination.

Control of vector-borne disease

- HCS environments protected from vector-borne disease.
- HCS buildings designed and built to exclude disease vectors.
- Insecticide is sprayed in and around the HCS.
- HCSs equipped with bed nets and window screens.
- All patients, and particularly ethnic minorities' patients with vector-borne diseases, treated or protected to prevent further transmission.
- Infectious substances are removed or covered or disposed of immediately and completely.

Information and hygiene promotion

- There is a plan for hygiene promotion and staff management.
- Staff is aware of this plan.
- Staff is adequately trained in infection control procedures.
- There is sufficient communication support available for hygiene information.
- Staff provides appropriate hygiene information to careers and ethnic minorities' patients.
- Health-care setting facilities maintained so as to be easy to use hygienically

To finalize, also assess some personal circumstances that also contribute to a positive and safe environment:

- I feel motivated in my job.
- My work schedule and workload permit me a healthy work-life balance.
- I have opportunities for professional development and career advancement.
- I have access to decision-making bodies.
- There is a Quality, Occupational Health & Safety management system (or similar).
- I'm aware about the environmental policy in my HCS.
- I have training/education of intercultural competences and I'm certified about professionals and ethnic minorities' patient safety, safe environment, risk prevention, etc.
- I have appropriate protective equipment to guarantee personal and patient safety.

	<p>Material:</p> <p>Sheets and pen Institutional information papers</p>
<p>Case studies 1 or 2 (no more than 1 page in form of a storytelling)</p>	<p>It is presented a case study of a Hospital in Baltimore that has created a Comprehensive Unit-Based Safety Program to improve patient safety.</p> <p>The program involves eight steps: (1) assess the unit's culture of safety, (2) educate staff about safety sciences such as systems thinking, (3) identify safety concerns, (4) meet regularly with a senior hospital executive who supports the removal of system barriers, (5) prioritize and implement improvements, (6) document and analyze results, (7) share success stories, and (8) reassess the unit's safety culture.</p> <p>Improvement teams were formed to identify and promote safety improvement efforts. These teams consisted of a physician, a nurse, and administrator, plus other staff who wished to join).</p> <p>It was reported in the hospital that nursing staff and residents frequently did not know the goals of ethnic minorities' patients' therapy. Then, the improvement team took the measure of drawing up a short-term patient goals form to be used as a checklist during physician-led rounds to identify tasks that need to be completed by the care team and to identify and mitigate safety risks.</p> <p>A related project aimed to reduce bloodstream infections associated with the use of central venous catheters, which were often inserted in ICU patients to provide medication, nutrition, and fluids. A multidisciplinary team decided on the following interventions:</p> <ul style="list-style-type: none"> • Require providers to receive education about evidence-based infection control practices and successfully complete a posttest as a precondition to inserting catheters. • Supply a catheter insertion cart with standardized supplies needed to meet infection control guidelines for the sterile insertion of catheters. • Follow a checklist to ensure adherence to evidence-based guidelines for safe catheter insertion. • Empower nurses to intervene if guidelines are violated. • Add an item to the daily goals sheet that prompts the ICU team to ask physicians daily during patient rounds whether catheters can be removed. <p>After the introduction of this program, there were improvements on ethnic minorities' patient safety. Some of them were that medication</p>

errors were eliminated in order to transfer patients out of the ICU; senior executives' involvement with the ICU led to structural changes, including the creation of specialized patient transport teams and the presence of pharmacists in ICUs; documented catheter-related bloodstream infections were eliminated, etc.

The work in certain units was replicated successfully to other units so an organizational culture of safety was built in the hospital.

The Comprehensive Unit-Based Safety Program is now being used as a framework for patient safety improvement throughout the Hospital.

Reflection questions:

- ✓ Do you think that the Comprehensive Unit-Based Safety Program is replicable in your healthcare setting?
- ✓ Is there an organizational culture of safety in your healthcare setting?
- ✓ Could you list some identified risks and the measures taken in your healthcare settings to improve ethnic minorities' patient safety?

Summary of key points

- A safe environment in health care settings is based on several elements as patients with a culturally diverse background safety, essential environmental health standards and positive practice environments for health care professionals (interpersonal, institutional and organizational context).
- Responsibility for safety resides in each department and individual from administration to the clinical and nonclinical staff, to housekeeping and volunteers, the shared accountability for patient safety has no boundaries engaging all the people involved and coordination in healthcare settings are essential.
- Evidence is accumulating that links work environments to behavior, attitudes, and motivations among clinicians. These behaviors and orientations can, in turn, affect quality processes and outcomes.
- It is essential to build an organizational culture of safety to create positive practice environments and guarantee both professional and patients' safety.

Self-evaluation questions

Multiple choice questions with more than one correct answer. (min. 5)

Question 1: Title of question

Content of question	The organizational climate affects to...
Answer 1	The organization
Answer 2	Patients and employees
Answer 3	Answers 1 and 2
Correct answer(s)	3

Question 2: Title of question

Content of question	Which of the following elements promote Positive Practices Environments?
Answer 1	Occupational health, job security and extra meals for professionals
Answer 2	Equal opportunity and treatment, open communication, professional autonomy
Answer 3	None is correct
Correct answer(s)	2
Question 3: Title of question	
Content of question	For what is responsible the Quality, Occupational Health and Safety management system?
Answer 1	Patients with a culturally diverse background safety
Answer 2	Administrative procedures of patient's admission
Answer 3	Patients, employees' safety and organizational conditions
Correct answer(s)	3
Question 4: Title of question	
Content of question	Can healthcare professionals contribute to develop a positive practice environment by evaluating the motivation of staff, for example?
Answer 1	Yes
Answer 2	Only in large healthcare settings
Answer 3	No
Correct answer(s)	1
Question 5: Title of question	
Content of question	Which measurable instruments would you use to assess how safe is the environment in your healthcare setting?
Answer 1	Patient's perceptions
Answer 2	Healthcare providers' expectations
Answer 3	Essential standards and indicators
Correct answer(s)	3

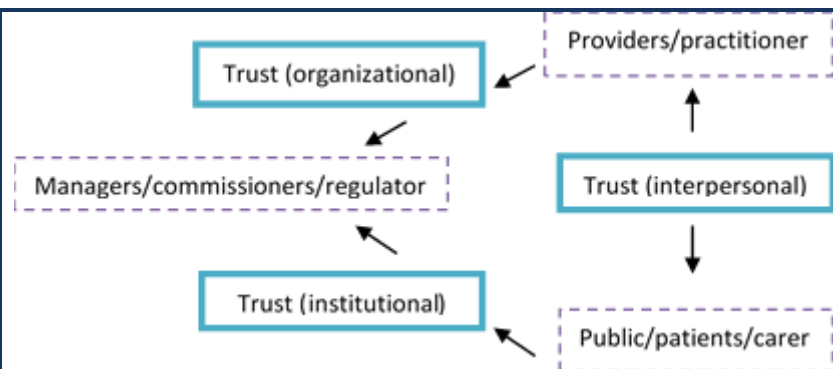
Glossary (if requested)

Most important terms, specific for the sub-module.

Standard	Standards are the requirements that must be met to achieve minimum essential environmental health conditions in health-care settings.
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1.4. Trust building

Theoretical and contents 2-3 pages	<h3>Trust building</h3> <p>The concept of trust is important in healthcare because health and healthcare in general involve an element of uncertainty and risk for the vulnerable patient who is reliant on the competence and intentions of the healthcare professional (Alaszewski, 2003). The Oxford English Dictionary defines trust as the “firm belief in the reliability, truth, or ability of someone or something”.</p> <p>Trust is not primarily dispositional or an individual attribute or psychological state, but is constructed from a set of inter-personal behaviors or from a shared identity. These behaviors are underpinned by sets of institutional rules, laws and customs. Trust has two dimensions, the cognitive dimension (grounded on rational and instrumental judgments) and an affective dimension (grounded on relationships and affective bonds generated through interaction, empathy and identification with others). Therefore, trust is necessary for us as it increases tolerance of uncertainty; trust reduces social complexity by going beyond available information and generalizing expectations of behavior in that it replaces missing information with an internally guaranteed security. In this respect it is enabling as it encourages people to take risks when the outcomes are uncertain.</p> <p>Trust has traditionally played an important part in the relationship between its three key actors: the state, healthcare practitioners, and patients with a culturally diverse background and the public. We can distinguish between trust relations at a micro level between an individual patients with a culturally diverse background and clinician, between one clinician and another or between a clinician and a manager, and those at a macro level, which include patient and public trust in clinicians and managers in general, in a particular healthcare organization, and in the National healthcare system and institution (interpersonal, institutional, intercultural and organizational context).</p>
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At the level of interpersonal trust between patients with a culturally diverse background and practitioner, it has been argued that trust is important for its potential therapeutic effects. High levels of trust have been associated with many benefits, including a perception of better care, greater acceptance to recommended treatment and adherence to that treatment, lower anxiety in relation to any treatment taken, and reportedly facilitate access to health service.

From an organizational perspective trust is believed to be important in its own right: it is intrinsically important for the provision of effective healthcare and has even been described as a collective good, like social trust or social capital (Khodyakov 2007).

In addition, trust has an important impact on workplace relations in healthcare settings by facilitating commitment to the organization, encouraging collaborative practice between clinicians and it is also associated with job satisfaction and motivation, institutional and organizational context.

Gilson (2006) suggests that a health system based on trusting relationships can contribute to generating wider social value because health systems establish the social norms that shape human behaviour. To the extent that these norms help establish a moral community whom you can trust, they may provide the basis for generalized trust.

However it has been identify possible influences on variations public trust in healthcare systems: the extent and nature of institutional guarantees (for example extent of regulation and protection of patients with a culturally diverse background rights), the quality of care provided, media images and the influences of different cultural differences in public attitudes, that is people in different countries may differ in their general orientation or predisposition to trust institutions and people; too much bureaucracy in some services, scarce resources and

inflexibility to adapt them to the needs of population; lack of resources to foster smooth communication, valorization.

A thoughtful digital marketing strategy can build trust between patients with a culturally diverse background and healthcare organizations covering interpersonal, intercultural, institutional and organizational context.

- Building trust through online ethnic minorities' patient education by promoting online health assessments, sharing case studies reflecting consumer interest, easing pre-appointment anxiety,
- Building trust through social proof by promoting events organized by health care staff (wellness fairs, car seat checks, etc.), events attended by health care staff (school festivals, sports medicine), or volunteer work performed as a group.
- Building trust with positive health outcomes Inspire trust by sharing patients' health outcomes.
- Building trust with organizational uniqueness by introducing members of the health care team (short biographies of physicians or key members, promoting the successes...)

For healthcare professionals it is important to become familiar with the characteristics of their community, especially when working in contexts with people with a culturally diverse background.

A ethnic minorities' patient's language level and reading skills may not match their intelligence, so when possible it helps to provide language assistance services, such as bilingual staff and interpreters, at all points of contact for ethnic minorities' patients.

Keeping an open mind and being sensitive to the beliefs and practices of patients will make them feel more comfortable telling the healthcare providers about their habits, lifestyle choices, beliefs, other treatments they are trying or any problems they have complying with the treatment plan. Most importantly, it is vital for the entire health care team to remember that the ethnic minorities' patient is a whole person. Our health has spiritual, psychological, and physical components.

In the context of healthcare, we can consider some essential

elements for the trust building between patients and healthcare providers.

- Competence in knowledge;
- Honesty;
- Competence in social/communication skills;
- Confidentiality and caring;
- Showing respect.

Competence in knowledge. Ethnic minorities' patients have confidence and feel secure in the advice provided when healthcare professionals are knowledgeable in their specific field of practice.

In addition, some patients, mainly migrant people, don't know about the health care system and they also need professionals that can explain and help to understand how it works.

In other hand, when mistakes happen, patients are more likely to trust healthcare professionals who honest in their approach, admit to errors, apologies and do everything in their power to rectify any mistake (by providing explanations, giving more information, ongoing support, confidentiality and continuity of care).

Honesty also refers to the healthcare professional's ability to advise patients with a culturally diverse background appropriately and believe that they are acting in their best interests at all times.

Competence in social or communication skills (For further reading and extend the knowledge go to the module *Intercultural communication and counseling*).

Effective communication skills include an awareness of non-verbal as well as verbal communication. It is important that patients with a culturally diverse background feel they are being listened to and given information in a respectful way, to avoid judgmental, condescending, or scolding statements; this will help build a trusted relationship.

As a healthcare provider, try to see things from a patient's perspective, and empathize with their emotions.

	<p>In terms of confidentiality, beside that this is a legal requirement; ethnic minorities' patients need to know that they can trust healthcare professionals to respect their privacy and dignity.</p> <p>Showing respect and caring. Every patient deserves to be treated with dignity and respect. Being compassionate, spending appropriate time with patients, demonstrating active listening, and helping to advise and resolve the patients with a culturally diverse background problems will all contribute to building a trusting, respectful relationship.</p> <p>Showing respect for patients with a culturally diverse background starts with remembering their name and medical condition. Patients also need to feel comfortable, without interruptions and secure when disrobing in an exam room or walking down the hall in a gown, for example. Modesty is an issue that lowers their trust in a healthcare professional.</p> <p>Because trust and compliance improve when you connect with your patient, patients with a culturally diverse background must feel that the healthcare provider understands their condition and has their best interests at heart. Just spending two or three minutes totally focused on your patient can reap benefits and build rapport. You begin building rapport the minute you meet a patient.</p> <p>Finally, to include ethnic minorities' patients and families in the decision making and the treatment to have an effective collaboration produces better outcomes.</p> <p>Following up on ethnic minorities' patients also builds credibility and sends the message "we care."</p> <p>It is vital to keep ethnic minorities' patients informed, explain your role, describe the treatment plan, and what will happen next. Contact the patient often and give them a sense of control by involving them in scheduling appointments.</p> <p>Encourage patients with a culturally diverse background to be change agents in their own treatment because patients are best served through a collaborative team approach in which patients are members of the team. Patients who are encouraged to talk will often reveal clues about their health.</p> <p>The rapport between healthcare professionals and patients isn't just built on the first visit. It is needed to reestablish it on an ongoing basis.</p>
Activities 1 activity max 4 pages	Title: Trust building in my healthcare context Objectives:

<ul style="list-style-type: none"> - Title - Objectives - Keywords (max 5) - Contents (please always cite the source and add the references in the module spaces dedicated to the references) - Material (the material can be also multimedia, like pictures, videos, drawings, material to be printed by the learners...) 	<ul style="list-style-type: none"> - To reflect and be aware about trust relationships in a healthcare context institutional and organizational. - To self-evaluate the rapport that healthcare providers are building with their patients with a culturally diverse background in their daily work. - To encourage healthcare providers to take actions to keep working on the trust building with their patients with a culturally diverse background in order to get better outcomes in their treatments.
	<p>Keywords: trust building, rapport, communication</p>
	<p>Contents:</p> <p>Following you will find a set of questions to evaluate the trust relationships in your healthcare institutional and organizational context and mainly the rapport you establish with your patients with a culturally diverse background.</p> <p>Please write down your answers and list the actions you can take to improve each situation.</p> <ol style="list-style-type: none"> 1. Do you consider that there is a collaborative practice between healthcare workers in your organization/place of working? Could you list some evidences? 2. What do you think that make patients with a culturally diverse background trust in your organization? Could you list some evidences? 3. Do you know the requirements and administrative procedures that your patients with a culturally diverse background patients need to accomplish for receiving healthcare? 4. Do you know institutional information about your healthcare setting? 5. Do you identify and address training needs for both yourself and your staff on a regular basis? 6. Are you familiar with the characteristics of the community you work with? Could you describe some of them? 7. Do you attend people with a culturally diverse background? What do you know about their cultures? 8. Do you prepare somehow before meeting your patients with a culturally diverse background? 9. Do exercise to relax your muscles and ease your mind's tensions prior to entering a meeting with a patient? 10. Do you use to remember the name of your ethnic minorities' patients and their medical condition? If so, do you use any strategy to do it?

11. How is your body language when you communicate with your patients? Do you make eye contact? How is your tone of voice?
12. What kind of language do you use to use with your ethnic minorities' patients, everyday words or medical jargon? Even to teach them about institutional and organizational context, laws and rules?
13. How do you react when you don't like the other person's model of the world, or agree with it?
14. What attitude do you use to adopt to respond patients with a culturally diverse background criticism or complaints?
15. Do you think you show consistency between the message and vessel that delivers it? For example, when you have to offer negative news.
16. Do you take some time to ask your patients with a culturally diverse background about their hobbies, other interests...?
17. How much time do you spend with each ethnic minorities' patient?
18. Think in a case where trust has influenced in the decision making of one of your patients.
19. Do you use to encourage your patients when their condition has improved?
20. Do you mail, call or visit our patients to follow them up?
21. How do you protect the data of your patients?
22. Do you keep doors closed when your patients with a culturally diverse background are changing, and offer gowns that cover the front and back when walking from room to room to preserve modesty of patients?
23. Do you ask for help ask or consult other specialists to advise you on how to proceed when your abilities as a caretaker are not compatible with a patient?

Material:

Sheets and pen
 Work log
 Institutional information papers
 institutional roadmaps

Case studies

1 or 2 (no more than 1 page in form of a storytelling)

Since the right to health is directly and closely linked to other factors such as trust in the health care system both internally and externally, coordination between health care providers and other actors Institutional or social requires a vision beyond the provision of the services of Medical care.

In Madrid Region, some entities working with people with fewer opportunities and people with a culturally diverse background reported a lack of coordination between social and healthcare institutions.

They decided to create a working group in order to improve this coordination and promoting trust building.

Public administration was also involved in the working group.

The priority interesting points were:

- Accessibility (geographical and economical) and quality of healthcare services: intercultural competences of healthcare professionals, equipment in good conditions, and perspective of gender.
- Coordination between healthcare professionals and social agents.
- Adoption of appropriate measures.
- Sharing of good practices.

After several group sessions, the working group presented a set of proposals, listed below, to the responsible body in Madrid Region:

- Training/capacity building for healthcare professionals, especially for professionals working with people with a culturally diverse background, homeless people, people with mental pathologies, drug-dependants, etc.
- Coordination with other counselling's and departments to improve patients and employee's safety.
- To include in the regional budget for healthcare certain products as hearing aid, glasses, dentists services to children in situation of vulnerability.
- Free psychological attention to minors.
- Support to single-parent families.
- Free access to medicines to low-income families.
- To establish a fund to address the pharmacological and other required payments for people in situation of social need.

- To promote digitalization of healthcare for prevention, patients' following up, and access to the healthcare system...
- To raise the ratio of nursering staff.
- Creation of groups of discussion to take part in the decision making process in healthcare.
- To include the perspective of gender.
- To promote rehabilitation programs and services for people with problems of drug abuse.
- To create Intercultural Mediation Programs in healthcare.

Reflection questions:

- ✓ Do you know the existence of working groups in your region to improve the coordination between social healthcare institutions?
- ✓ Have you ever participated in one of this?
- ✓ Do you think that some of these measures could be applied in your working context to build an internal trust environment?
- ✓ Would you agree to share the results of these working groups with immigrant associations to build an external trust environment?
- ✓ Would it be positive to know and disseminate results of these groups to patients with a culturally diverse background to build an external and internal trust environment?

Summary of key points

- Trust is necessary for us as it increases tolerance of uncertainty in the interpersonal, institutional and organizational contexts.
- In healthcare, trust and compliance improve when healthcare providers connect with their patients.
- There are some essential elements for the trust building:
 - Competence in knowledge;
 - Competence in social/communication skills;
 - Honesty;
 - Confidentiality and caring;
 - Showing respect.
- Building patient rapport is critical for creating positive case management outcomes.

Self-evaluation questions

Multiple choice questions with more than one correct answer. (min. 5)

Question 1: Title of question

Content of question	Which actors are involved in trust relationships in healthcare?
Answer 1	Managers, providers, patients and volunteers
Answer 2	Public, administrative staff and cleaning staff, practitioners
Answer 3	Answers 1 and 2
Correct answer(s)	3
Question 2: Title of question	
Content of question	When working with patients with a culturally diverse background...
Answer 1	Healthcare providers should refuse to work with people that doesn't speak the local language
Answer 2	It's important that healthcare professionals become familiar with the characteristics of the community where they work
Answer 3	Healthcare professionals should share the cultural perspective and beliefs of their patients
Correct answer(s)	2
Question 3: Title of question	
Content of question	Does public trust in healthcare systems in general?
Answer 1	Yes
Answer 2	There are some possible influences
Answer 3	Depend on the origin and age of the patient
Correct answer(s)	2
Question 4: Title of question	
Content of question	Which of the following elements are considered as essential for trust building between healthcare provider and patient in an intercultural context?
Answer 1	Communication skills and confidentiality
Answer 2	Working hard
Answer 3	Creative skills
Correct answer(s)	1
Question 5: Title of question	
Content of question	Which are the dimensions of trust?
Answer 1	Cognitive and affective
Answer 2	Cognitive and cultural
Answer 3	Cultural and affective
Correct answer(s)	1