

# Bulletproofing Indigenous health students and staff against racism

Maggie Grant<sup>1</sup>, Catrina Felton-Busch<sup>2</sup>, Jacinta Elston<sup>3</sup>, Vicki Saunders<sup>4</sup>, Lisa Crossland<sup>1</sup>, Shaun Solomon<sup>2</sup>, Cynthia Payne<sup>1</sup>

<sup>1</sup>School of Medicine and Dentistry, James Cook University, <sup>2</sup>Mt Isa Centre for Rural and Remote Health, James Cook University,

<sup>3</sup>School of Indigenous Australian Studies, James Cook University, <sup>4</sup>Indigenous Health Unit, Faculty of Medicine, Health and Molecular Sciences, James Cook University

## Abstract

### Objectives

The aim of this project was to describe how Indigenous health students and staff have experienced and responded to racism, in order to identify strategies that promote resilience and to explore how this knowledge can be translated into an organisational response in health service and tertiary education settings. It was thought that an exploration of *bulletproofing* might provide useful additional strategies to the main aim of reducing racism itself.

### Design and setting

This was a two-phase exploratory qualitative study involving interviews and a literature review conducted between 2004 and 2005. The twenty-six participants were Indigenous health service and academic staff and health students.

### Results

Each participant was able to recount many experiences of racism in classroom and health service settings, some of the most disturbing being that directed at patients. Participants described a small number of different racist events that were highly predictable and repeated over and over again. Staff described the long-term stresses associated with racism, including the considerable stress associated with deciding whether and how to respond and the sense of success or failure associated with how this went. A strong sense of guilt was associated with not responding or responding in a way that was self-appraised as being ineffective. Long term staff described factors that promoted their personal resilience, which included having a number of 'successes' dealing with racist events, having support of other Indigenous staff and family and working in a supportive institutional environment. There have been a range of training programs, though few directly about racism, that have useful lessons for Indigenous resilience building.

### Conclusion

Racism was reported as a major stressor and was commonly experienced by Indigenous health students and staff. Resilience training is the under-explored flip-side of current cross-cultural training and along with improved institutional responses has the potential to increase the sense of well-being of Indigenous staff and students and their participation in the health professions. Bulletproofing Indigenous health students and staff, offers benefits while racism persists.

## The context

Cross-cultural training has evolved in numerous ways to become a permanent feature of mainstream health services and health professional training. Cross-cultural competence is regarded as a mandatory graduate outcome at James Cook University (JCU)<sup>1</sup> and other universities.<sup>2</sup>

From the mid-nineteen nineties, the Faculty of Medicine, Health and Molecular Sciences at JCU embarked on building Indigenous student and staff numbers, increasing Indigenous course content and contributing in turn to building Indigenous participation in the health workforce. However, there was strong anecdotal evidence that racism persisted as a common event and a major cause of stress for Indigenous health students and staff, contributing to reduced Indigenous engagement in study and work activities. Supporting this was a large body of international evidence about stress triggered by racism and marginalisation.<sup>3 4</sup>

By 2001, JCU staff from a range of ethnic backgrounds and professions had become increasingly aware of the limitations of cross-cultural training and other strategies to reduce racism, which had hitherto been regarded as cornerstones of efforts to reduce racism in work and study places.<sup>5</sup> Some staff had observed racism directed at Indigenous nurses, perpetrated by staff who had undertaken this training. Increased course content on Indigenous issues in health science programs, for all its benefits, had the unintended consequence of exposing Indigenous staff and students to more in-class discussion about Indigenous issues, sometimes in environments in which staff were poorly equipped to manage this.

Appropriately, the primary aim of cross-cultural training is to reduce racism by working with non-Indigenous people. However, early discussions revealed a shared perception that cross-cultural training did not meet the needs of Indigenous people. Staff suspected that little effort had been made to identify the needs of Indigenous participants in cross-cultural training, framed as it was around changing the attitudes and behaviours of non-Indigenous staff.

Some members of the team had heard Aboriginal leaders Associate Professor Errol West and Dr. Puggy Hunter comment that cross-cultural training was in danger of becoming a new form of social control that gave ... *whitefellas a licence to manage us better*. Others were aware of resilience issues among Holocaust survivors through their families and wondered how this might be relevant to Indigenous health students and staff.

Cross-fertilisation of these ideas led to a shared interest in the under-explored *flip-side* of cross-cultural training aimed at meeting the needs of Indigenous students and staff. It was from this that the *Bullet-proofing Project* emerged.

The Bulletproofing Project aimed to examine the experiences of Indigenous health students and staff as targets and witnesses of racism. It aimed to identify the form this racism took and how Indigenous people responded to it, in order to identify strategies that promoted self-esteem, confidence and resilience. The final aim was to explore how effective responses to racism might be taught and incorporated into institutional training programs.

## Methods

A seven member Steering Committee was established which included JCU staff who had been involved in the germination of the Bulletproofing concept. All members had considerable experience in cross-cultural training, Indigenous health services and delivering Indigenous health subject content at

tertiary level. Five members were Indigenous. The group included staff from the Mount Isa Centre for Rural and Remote Health (MICRRH), the School of Medicine and the Indigenous Health Unit. The committee had oversight of the project, including the scoping of the project, sampling, conduct of interviews, analysis of data, review of and reporting on project findings and support and training of the principal researcher.

Two Project Officers who were Indigenous, were employed to undertake the literature review, recruit participants and conduct interviews.

The project was a two-phase study, with phase one consisting of a literature review, discussions amongst members of the Steering Committee and unstructured interviews with health professionals who were identified by the Steering Committee as key informants. These interviews were taped with the prior consent of participants. The review of literature focused on identification of responses to racism and the educational interventions that had been developed to assist individuals and groups to cope with racism and build resilience. These pilot interviews and the literature review were thematically analysed and the results used to develop an approach for the second phase.

Steering Committee discussions were not taped and later on in the study this was recognised as a missed opportunity as these discussions were candid and insightful.

Phase two consisted of audio-taped, semi-structured interviews using an interview proforma which had been piloted prior to commencement of the main body of interviews. Interviews were mostly face-to-face with a small number of telephone interviews with people residing outside north Queensland. Some interviews involved more than one participant at their request.

During both phase one and two some participants found it too painful to talk about their experiences on tape and chose to turn off the tape to discuss particular occurrences. Only audio-taped information was in the analysis. This may have resulted in an under-estimation of the seriousness of racist events and their effect, as some of the most extreme examples and people's responses to them were excluded from the analysis.

A counsellor was appointed to provide support to participants who were given a card with contact details at the completion of each interview.

## Sampling

The targeted group was Indigenous health students, academic staff and those working in both primary health care and hospital-based care across Queensland. A list of potential participants was developed by the Steering Committee members to represent different professional groups and levels of organisational seniority. In phase two, a snowballing technique was used to identify further participants.

## Participants

Forty-two Indigenous health professionals and 80 students were approached to participate in this study with an overall number of 26 (23 health professionals and 3 students) agreeing to participate. Of the 23 health professionals who contributed to our study, 12 participated in phase one and 11 in phase two. Students only participated in phase two of the study. The list of potential interviewees was drawn from Queensland, New South Wales, the Northern Territory and Victoria. The age of the participants ranged between 18 and 68 years. The Steering Committee was particularly interested in the experiences and perceptions of long-term staff members—the *stayers*.

The low response rate for students perhaps reflected the timing of the study late in the academic term and the sensitive nature of this project, with many of those invited to contribute to the study expressing concern about discussing their experiences on tape. The student participants were Aboriginal and their views do not necessarily reflect the Torres Strait Islander perspective.

## Analysis

Interview audio-tapes were transcribed and returned to participants for their approval. Transcriptions were then thematically analysed using N6 QSR software. Analysis followed a keyword approach and findings were grouped in identified themes. Triangulation and verification of the resulting themes was achieved by using the Steering Committee members as key participants in each stage of analysis.

## Results

### Experiences of racism

Participants described a wide range of experiences relating to racist events.

These experiences of racism were consistent with other work on racism including Mellor's four categories,<sup>10</sup> namely,

- verbal (individual level)
- behavioural (individual level)
- discrimination (often embedded in institutional practices)
- community/cultural (also institutional but occurs at macro rather than individual level).

Participants nominated specific incidents that fell into several of the categories proposed by Mellor.<sup>8</sup>

Racist remarks were reported as being most commonly overheard, but also made directly to participants about themselves and frequently about others. Remarks included name-calling (*boong; coon; monkey*), derogatory remarks (*dirty; stupid*), denial of identity (*but you're not like them*), joke telling, verbal intimidation and threats. Participants appraised these as being either purposefully hurtful or made through ignorance.

Commonly experienced behavioural incidents included actions such as ignoring, avoiding, staring, insulting facial expressions, back-turning, pushing-in, patronising and being treated as less senior professionally than they were. It was common for staff, patients and families to approach and direct conversation to non-Indigenous staff in the presence of more senior Indigenous staff.

Community/cultural racism included promotion of a selective view of history (Australia has a tradition of giving everyone a fair go), historical ignorance (so much money has gone into Aboriginal health), perpetration of myths (their health problems are because they all drink). Students described many experiences in class in which Indigenous issues were debated freely as if Indigenous students were not present ('they' do this or that).

### Racism as a cause of stress

The findings of the study regarding individual experiences of racism highlighted the sensations of powerlessness, frustration and cumulative trauma through the life-long experiences of individuals.

Participants described hurt and anger associated with experiencing racism, as well as the stress of having to constantly react to it.

Acute and chronic stress associated with racism was reported by all participants and in the literature.<sup>6</sup>

Participants commonly described racism-related stress as being pervasive and occurring on an almost daily basis.

Several examples of reactive stress were cited. Constant anticipation of racism prior to an event and  *sussing out* individuals with whom they interacted, was reported as being an everyday event and the result of lifelong conditioning. Responding to an event perceived as racist commonly involved having to make stressful decisions about whether to respond and how to do this, particularly when this involved patients. Reviewing an event was a common reaction and involved constantly going over the details to gauge if it was racist and to self-appraise the quality of their response to it.

All participants recalled events which they gauged they did not manage effectively. Many expressed regret, reflected with some emotion, about 'showing anger', 'saying the wrong thing' and of doing 'embarrassing and humiliating things'. Guilt associated with not responding or responding in a way that was self-judged as inadequate, was reported as a considerable stressor.

### Responding effectively to racism

Most participants reported that they had learned to respond more effectively to racism over time, despite suffering much hurt along the way. *Stayers* reported having a wide range of coping strategies and an ability to choose the right one for the job. These strategies closely align with those described by Mellor including confronting racism, protecting self and controlling responses.<sup>7</sup>

A number of participants reported gradually adopting less confrontational styles that required the perpetrator to self-examine, rather than lecturing or berating them. These responses were regarded as generally being less stressful, building more collegial support and more effective in changing the views of the perpetrator.

The importance of Indigenous and non-Indigenous collegial and family support was regarded as being critical to coping with racism by the *stayers*. Participants reported turning to supportive colleagues in ways described by Mellor, including for emotional support, to escape to a safe place, to reinterpret the event, to imagine possible responses and even discuss revenge.<sup>8</sup>

Effective institutional responses to racism and discrimination were reported as being critical to coping with racism. This included Indigenous staff feeling that they could turn to a person in authority for support. This promoted self-confidence and gave staff permission to address racism. The perception of the inadequacy of institutional responses was said to be a common reason for participants feeling that they needed to respond personally to all occasions of racism. Personal recognition that managing racism was an institutional responsibility and not that of the victim, was reported as being an important cognitive breakthrough.

Participants described the importance of a strong knowledge base and conceptual understanding of Indigenous culture and history, to build self confidence and facilitate effective responses to racist myths.

Many described how perceived successes dealing with racist events promoted optimism and self-confidence, that importantly included the confidence not to respond.

## Teaching effective responses and resilience

One of the problems associated with developing interventions for individuals experiencing racism is the assumption that there will be an outcome which can be measured. However, measuring the efficacy of an intervention is particularly difficult because of the dynamic nature of the process and the range of individual definitions of effectiveness. An additional complication encountered when developing such interventions is that an individual may use various coping strategies<sup>8</sup> and there is conflicting evidence about the effectiveness of different strategies.<sup>9</sup>

A review of literature revealed a paucity of training programs promoting effective responses to racism. However, there have been some international and Australian experience and reported successes in response and resilience training for Holocaust survivors<sup>10</sup> and among those who are the victims of bullying or rape.<sup>11</sup> While acknowledging the primacy of broader institutional and social remedies for discrimination and racism, the focus of many of these programs has been on victims' experiences and on building effective personal responses to them. They may help inform Australian Indigenous cross-cultural training.

Several models were identified that described trauma and coping processes akin to those of victims of racism. Kanel's three stage model focuses on the responses of victims of rape.<sup>12</sup> The great value of this model is that it describes opportunity for movement forward to resolution and healing and offers clues to response and resilience building opportunities.

Kanel's three levels of coping are:-

### Primary appraisal (or immediate crisis reaction)

This first level is centred on the initial reaction and draws heavily on the individual's personal belief systems (utilising cultural, religious or other alternative lifestyle practices to contextualise the experience).

Commonly the individual will remain problem-focused and will seek to alter the environment that is harmful, threatening or challenging in order to arrive at solutions. Individuals at this response level will remain emotionally focused in order to manage internal states through defensive appraisals. They will utilise their support networks and will seek to engage their caring relationships, that is the people who share the same vision and passion; who understand, are caring and compassionate. In the absence of supportive networks and caring relations, substance misuse/abuse can be an issue as the individual becomes overwhelmed and withdraws.

### Secondary appraisal (or reintegration)

At this level of the coping response, movement is made from being victims to being survivors—emerging stronger, assertive, and more aware of themselves with increased self-esteem. Respect is paramount, as are continued support networks and caring relationships. This level demonstrates the capacity of the individual to be resilient, that is, they can spring back with renewed vigour.

### Coping (or reorganisation)

In this final level of coping response, a state of equilibrium is reached where the self-messages are about not dwelling on the event, but continuing to move forward.<sup>12</sup>

## Discussion and recommendations

The Project found that racism remains a pervasive part of the lives of Indigenous health students and staff and a significant, preventable cause of stress.

Responses to racism need to be led by institutions, government and the law with the main aim being to stamp racism out. However, there is a place for helping individuals build personal resilience and respond more effectively to racism.

Over the last few years there has been a critical appraisal of the effectiveness of cross-cultural training. However, in its current form this training remains focused on non-Indigenous people and this in itself may be discriminatory. There is enough experience now to begin to design programs that focus on the needs of Indigenous students and staff.

A number of opportunities present themselves.

### Training and education

In order to articulate and develop a set of strategies that might be used in training activities, study participants were asked to suggest training strategies that would assist Indigenous health staff and students. Participants nominated self-reflection activities and problem-solving approaches, the importance of access to formal and informal networks and mentoring relationships, and being informed about race discrimination policies. An encouraging finding was that most participants reported institutions were responding more effectively to racism over time.

A small number of racist events recur over and over again and this presents an opportunity to allow people to practise their response to racism in simulated settings. *Stayers* reported using a suite of coping strategies and an ability to choose the right one for the job. Role playing and other activities may allow victims of racism to explore a range of responses, build self-confidence by practising these and to identify those that are appropriate for their own personal style.

One suggestion was to develop a set of a *Frequently Asked Questions and Comments about Indigenous Australians* that can be used in training sessions as a basis of discussion of the issues behind these questions and to give participants practice responding to these (Peachey, Louis. Phone conversation with Maggie Grant. c.2008).

Having a strong knowledge base of Indigenous history and a strong Indigenous cultural identity was considered by participants to be very empowering and critical to the development of effective coping strategies. It is important to build programs designed specifically for Indigenous people that focus on international and Australian Indigenous history and on racism

Familiarising individuals with affirming experiences about successful Indigenous people and activities from which people draw strength and empowerment, facilitates the promotion of self-confidence.

Familiarising Indigenous students and staff with institutional rules and the law regarding racism and discrimination and with the staff who are responsible for this, is also important in efforts to build a toolkit of strategies to respond to racism.

### Building support networks

The importance of Indigenous and non-Indigenous collegial and family support was regarded as being critical to coping with racism.

Activities which engage the families and significant others of Indigenous staff and students should become a regular part of the institutional calendar.

In situations in which there are small numbers of Indigenous students and staff who may be from different communities and isolated from each other, support networks may not develop easily. Institutions should facilitate the growth of networks through the development and support of Indigenous organisations.

Indigenous students and staff whose experience has mostly been that of exclusion from power networks should be linked to senior staff members to whom they can go for advice and support and who will advocate for them. In universities, support networks should include teaching staff who are sensitive to the marginalised position of Indigenous students and who manage classroom events in ways that support Indigenous students. Teaching staff need to be trained to do this.

The importance of having non-Indigenous supporters points to the benefits of building links between Indigenous students and staff with non-Indigenous allies through shared activities such as Indigenous special interest groups

## Conclusion

The experience of racism is a major stressor for Indigenous health students and staff. Bulletproofing strategies have a significant role in combating the effects of racism, while racism persists. Institutions need to further develop anti-racism strategies and in parallel, develop programs that are the Indigenous flip-side of cross-cultural training.

## Acknowledgments

- Mrs Karen West who has worked within health departments and faced the challenge of having to fight racism at work directed towards herself, her family and her community members.
- Ms Colleen Gray from *Ways Forward* who acted as counsellor for participants and staff.

The Commonwealth Department of Health and Ageing funded this Project:-

- The Office of Aboriginal and Torres Strait Islander Health provided funding for the Study Team.
- PHCRED funded the employment and qualitative research methods training of the Research Officer.

## References

- 1 James Cook University. Graduate attributes -undergraduate. [http://www.jcu.edu.au/policy/teaching/teaching/JCUDEV\\_007031.html](http://www.jcu.edu.au/policy/teaching/teaching/JCUDEV_007031.html) (accessed 24 Jan 2009).
- 2 Chapman L. Graduate attributes resource guide: integrating graduate attributes into undergraduate curricula 2004; UNE: 2-5.
- 3 Clark R, Anderson NB, Clark VR, Williams DR. Racism as a stressor for African Americans: a biopsychosocial model. *Amer Psy* 1999; 54(10): 805-816.
- 4 Harrell SP. A multidimensional conceptualisation of racism-related stress: implications for the well-being of people of color. *Am J Orthopsychiatry* 2000; 70(1):42-56.

- 5 Guerin B. Combating every day racial discrimination without assuming racists or racism. *Behaviour and social issues* 2005; 14(1): 46-9.
- 6 Utsey SO, Adams EP, Bolden M. Development and initial validation of the Africultural coping systems inventory. *J Black Psychol* 2000; 26(2): 194-215.
- 7 Mellor D. Responses to racism: a taxonomy of coping styles used by Aboriginal Australians. *Am J Orthopsychiatry* 2004; 74(1): 56-71.
- 8 Holahan CJ, Moos RH. Life stress and health: personality, coping, and family support in stress resistance. *J Pers Soc Psychol* 1985; 49: 739-47.
- 9 Carver CS, Sheier MF, Weintraub JK. Assessing coping strategies: a theoretically based approach. *J Pers Soc Psychol* 1989; 56(2): 267-83.
- 10 Appel M, Appel G. The Mark and Gail Appel program in Holocaust and antiracism education at York University. Centre for Jewish Studies The Canadian Centre for German and European Studies, NYU. 2005; 329. <http://www.yorku.ca/tfff/overview.htm> (accessed Feb 2006).
- 11 Kanel, K. *A Guide to Crisis Intervention*, 3rd ed. Pacific Grove CA; Brooks/Cole Publishing: 2002.