Ethnocultural Empathy

Measurement, psychometric properties, and differences between students in health care education programmes

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CONTENTS

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PREFACE

The studies

This thesis is based on the following papers, which will be referred to in the text as papers I, II, & III.

I Rasoal, C., Hau, S., Edvardsson-Stiwne, E., Carlbring, P., & Andersson, G. (2009). *Empathy across ethnocultural borders - validation of the Swedish version of the Scale of Ethnocultural Empathy*. Manuscript submitted for publication.

II Rasoal, C., Jungert, T., Hau, S., Edvardsson-Stiwne, E., & Andersson, G. (2009). *Ethnocultural versus basic empathy: Same or different?*. Manuscript submitted for publication.

III Rasoal, C., Jungert. T., Hau, S., Edvardsson-Stiwne, E., & Andersson, G. (2009). Ethnocultural empathy among students in health-care education. *Evaluation & the Health Profession, 3,* 300 -313.

Introduction

The topic of this thesis is how empathy is expressed when it is directed towards individuals with an ethnic background different to one's own, which in the thesis will be referred to as "ethnocultural empathy". The thesis will cover the translation and validation of a self-report scale for measuring "ethnocultural empathy", investigate whether the construct is separate from more general basic empathy, and also investigate differences in ethnocultural empathy among health care students.

Western society is becoming more ethnically and culturally diverse. Today, people live in a globalized world in which individuals from various ethnic and cultural groups come into contact with each other on a daily basis in both informal and professional contexts (Daun, 1998; Dysart-Gale, 2006; Ekblad, 2007). These individuals and groups from different cultural and ethnic settings potentially experience the world in different ways, and inter-ethnic group prejudice (Verkuyten, 2002) can be regarded as a social and political problem which in history has occasionally lead to severe conflicts (e.g. war). In Swedish society, the effects of globalization are becoming more and more evident. As a result, Swedish society is becoming more ethnically and culturally diverse (Daun, 1998; Ekblad, Janson, & Svensson, 1996; Mlekov, & Widell, 2003; Svanberg, & Runblom, 1989). For a long time, Sweden was a country with a relatively homogeneous population of Germanic origin, while today the Swedish population is more heterogeneous. According to a report from the Statistical Central Bureau in Sweden (SCB, 2005) approximately 12.4% of all Swedish citizens in 2001 were not born in Sweden. If we include citizens who have at least one parent born in another country than Sweden, the number increases to 17%. It is estimated that 15%, or every seventh Swedish citizen, will have been born in another country by 2020. If we include persons who have at least one parent born in another country, this figure will be 28%, or nearly a third of the population (SCB, 2005).

Sue and Sue (2003) stressed the necessity for everyone to acquire cultural competence in today's society, which is characterized by ethnic diversity. This competence may be described as an augmented awareness, understanding, tolerance, and acceptance of individuals from other ethnical groups. According to the Swedish Integration Board, it is not uncommon that individuals from non-Swedish ethnic

groups feel discriminated against by different public authorities such as health care, in private companies and by other institutions such as schools (Akrami, Ekehammar, & Araya, 2000; Integration Board, 2005). Even in higher education, and especially among students in health care education, there is a lack of awareness of these issues (Swedish National Agency for Higher Education, 2002). According to higher education regulations and education programmes in health care professions in Sweden, students who study in graduate programmes in Psychology, Medicine, Nursing, and Social Work should continue to develop self awareness and acquire empathic ability during their education.

The ability to empathize is of vital importance for people working in the field of education and health care where cross-cultural understanding, self awareness and acceptance of cultural differences are important aspects in professional encounters. *Ethnocultural empathy* is defined as empathy directed towards people from ethnic and cultural groups different from one's own ethnocultural group (Wang et al, 2003). Ethnocultural empathy implies a process of decentering and, hence, the acceptance of a possible relativism of one's point of view. In other words, it assumes the identification of ethnicity and that the target of empathy is viewed as different from oneself. The development of ethnocultural empathic abilities can lead to changes in attitudes toward clients who have different ethnic backgrounds. Accordingly, it is important to examine possible misinterpretations that can arise in various situations in which professionals (e.g. psychologists, social workers, nurses, doctors, lawyers, teachers, and police officers) and their clients have different ethnic and cultural backgrounds (Dysart-Gale, 2006; Ibrahim, 1991; Ivey, Ivey, & Same-Downing, 1997; Sue, & Sue, 2003). Increased empathy can reduce conflicts and increase understanding, respect, and tolerance between people with similar as well as different ethnic and cultural backgrounds in informal and professional contexts (Stephan, & Finlay, 1999).

Many researchers have asserted that empathy plays a central role in social interaction in both informal and professional contexts (Davis, 1996; Eisenberg, & Strayer 1987; Holm, 2000). One possible way to understand the relationship between professionals in health care from one ethnic group and clients with a different ethnic or cultural background is to study the relationship in terms of the presence or absence of ethnocultural empathy (Holm, & Aspegren, 1999; Howard, Mary,

Maccera, Enid, & Deborah, 1993; Rasoal, Eklund, & Hansen, 2009; Reynolds, & Scott, 2002).

The concept of empathy

Previous views on empathy

Empathy, like many other psychological concepts, seems easy to understand at first sight. A more careful inspection reveals that it is an ambiguous concept that has been defined and operationalized in many different ways. The term was first described by Lipps (1903), whose teacher was Sigmund Freud who used the term "*Einfühlungsvermögen*". The English term was derived from the work of Lipps (Preston, & de Waal, 2002). Titchner (1924) was probably the first psychologist to use the English concept of empathy to convey understanding of other human beings. Despite the lack of consensus regarding a definition of empathy, a substantial body of empirical results has been generated. The concept of empathy has been investigated in many ways in a range of fields such as developmental psychology (e.g. Eisenberg, & Strayer, 1987), social psychology (e.g. Batson et al., 2007), personality psychology (e.g. Miller, & Eisenberg, 1988), and clinical psychology (e.g. Duan, & Hill, 1996).

Recently, brain research on the mirror neuron system in the brain has attracted attention among empathy researchers, and people in general (Galles, 2001; Lamm, Batson, & Decety, 2007; Singer, & Frith, 2005). Researchers in this field have proposed that empathic ability can be described as a neural matching mechanism that is realized by a mirror neuron system in the brain which facilitates understanding of another person's mental states. Clinical and social psychologists have often used the concept of empathy in therapeutic contexts and in more theoretically oriented works on interpersonal behavior and altruism.

Empathy has been described as consisting of either cognitive/intellectual or affective/emotional components and as a combination of both components. Intellectual cognitive ability involves mental activities when acquiring and processing information for a better understanding of another person's intellectual state. Affective ability im-

plies the sharing of emotions which are manifested in subjectively experienced feelings (Colman, 2001; Holm, 2000). An overview of how empathy has been understood by researchers in their respective fields indicates that there is more disagreement than agreement about the main definition of empathy, whether it is mainly a cognitive or emotional process or whether it has multiple components (Duan & Hill, 1996). Examples of definitions and descriptions of empathy and its intellectual/cognitive aspects are as follows:

- Kohut (1971) described empathy as a cognitive phenomenon: "Empathy is a mode of cognition that is specifically attuned to perception of complex psychological configuration." (p. 300)

- Dymond (1949) defined empathy as "the imaginative transporting of oneself into the thinking, feeling, and acting of another, and so structuring the world as he does." (p. 127)

There are other researchers who define and describe empathy from a more emotional/affective point of view. The ones that seem to be most relevant for mentioned here define empathy as follows:

- Batson (1994) defined empathy as "other-oriented feelings congruent with the perceived welfare of another person." (p. 604)

- Eisenberg (2002) defined empathy as "an affective response that stems from the apprehension or comprehension of another's emotional state or condition, and that is similar to what the other person is feeling or would be expected to feel." (p. 135)

- Hoffman (1987) defined empathy as "an affective response more appropriate to another's situation than one's own." (p. 48)

There are other researchers who argue that empathy involves both intellectual/cognitive and affective/emotional components. In other words, they understand empathy as a multidimensional phenomenon (e.g. Bennett, 2001; Davis, 1996).

- Bennett (2001) defined empathy as "a mode or relating in which one person comes to know the mental content of another, both affectively and cognitively, at a particular moment in time and as a product of the relationship that exists between them." (p. 7)

- Davis (1996) defined empathy as "a set of constructs having to do with the responses of one individual to the experiences of another. These constructs specifically include the process taking place within the observer and the affective and non-affective outcomes which results from those processes." (p. 12)

- Finally, Reed (1984) pointed out the difficulties with the concept: *"It is difficult to conceptualize something that is predicated at once as a form of knowledge, a form of communication, a capacity, a process, an ego expression, a mode of data gathering, ability, an experience, a means of understanding, and a mode of perceiving."* (p. 13)

To sum up, a range of different perspectives and definitions of empathy have been expressed in the literature, and there is no consensus on its definition. Many aspects are commonly not covered in the literature, such as the role of ethnicity which is the topic of this thesis.

Research on empathy show that individuals and groups are more able, disposed and inclined to empathize with individuals and groups they have most contact with, such as family members (Ickes, 1997). In addition, this also concerns those who have the same geographical backgrounds. Members of ethnic, religious or cultural groups are more likely to empathize with in-group members than with outsiders. Meanwhile, we are less able to empathize with those who have dissimilar backgrounds in term of ethnicity and culture than one's own (Hoffman, 2000; Ickes, 1997, 2003; Levenson, & Reuf, 1992).

Interacting with people from other groups may help persons become more empathetic towards them. Regardless of awareness and acceptance of cultural differences, it is, however, likely that people favor and feel without much reflection more empathy towards those closest and most similar to themselves. Although empathy can be regarded as less morally defensive if it is directed toward specific individuals (e.g. family members), it is often associated with morality if it is expressed for others irrespectively of whom they are (Olsen, 2001). Therefore the tendency to favor individuals who are close may conflict with the morally prescribed recommendation to treat all people equally. One important factor, which has been discussed recently in empa-

thy research, is the role of culture/ethnicity (Lawrence & Luis, 2001; Wang et al., 2003). A conceptual model of how empathy can be viewed in relation to proximity is presented in Figure 1.

We empathize most weakly with them

Outgroup-ethnically and culturally

City-Country

Religion-language

Friends -neighbours

Members of the Family

We empathize most strongly with them
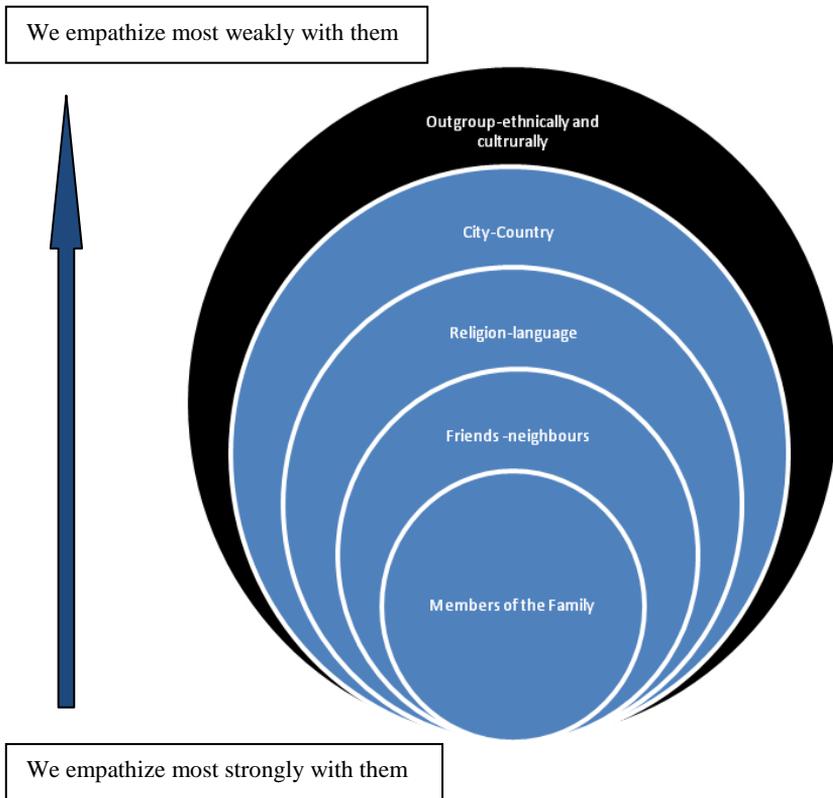
Figure 1: A conceptual model of manifestation of empathy

Empirical research shows that the ability to empathize can counteract hostile attitudes and behaviors and thus improve relations between different ethnic groups and subcultures (Litvack-Miller, Mac-Dougall, & Romney, 1997; Wang et al., 2003). Studies have demonstrated a relationship between a lack of empathy, negative attitudes and aggressive behavior (Davis, 1996). Other studies have found that a lack of empathy leads to hostility toward other ethnic groups and individuals (Stephan, & Finlay, 1999), including homosexuals (Johnson,

Brems, & Alford-Keating, 1997), and increased risk of child abuse (Letourneau, 1981) and sexual aggression (Fesbach, & Fesbach, 1969; Lisak, & Ivan, 1995; Miller, & Eisenberg, 1988). Empathy can even serve as an effective tool for reducing intolerance, conflicts, and discrimination that occur daily in a multiethnic-cultural society (Wang et al., 2003).

How the concept of empathy is defined in this thesis

A comprehensive summary of research on theories of empathy was presented by Davis (1996). He developed a model according to which much of the research on empathy can be organized. The model is called "the organized model" and is comprehensive but also complicated. Davis (1996) defined empathy as a multidimensional concept in which empathy can be seen as a process, outcome, phenomenon, intrapersonal or interpersonal phenomenon and as well as helping behavior. He has also developed an instrument that measures empathy with all its important components. This instrument is commonly used in research and is called the Interpersonal Reactivity Index (IRI).

Basic empathy in this thesis is defined as a construct with four affective and cognitive components (Davis, 1983), which is in line with his reasoning. However, basic empathy can also be used as a single construct. Studies have shown that basic empathy is predicted by age, gender (DiLalla, Hull, & Dorsey, 2004; Endresen, & Olweus, 2001; Pastor, 2004; Schieman, & Van Gundy, 2000) and education (Alligood, 2007; Spencer, 2004). Higher education, age and female gender are associated with higher levels of empathy.

On the other hand, Green (1998) argued that basic empathic ability is not universally applicable in a multi-cultural society with ethnic diversity. According to Green, empathy is about having access to another person's inner experience in the form of feelings and thoughts. At the same time, one must have a certain direct experience of the cultural context from which these feelings and thoughts originate. Hence, empathy without knowledge of the cultural background and practical experience of different ethnic groups may not be possible to the full extent. This could then affect, for example, helping behavior towards individuals and groups from ethnic backgrounds other than one's own.

This may also be the case in health care situations. As mentioned previously, it is likely that the ability to be empathic towards others increases if the other person is similar to oneself in terms of ethnicity, gender, age or other background variables (Batson, 1994; Hoffman, 2000). Also, one should not take it for granted that all cultures place equal value on learning about foreign cultures. It is even possible that some cultures, or subcultures within countries, discourage learning about other cultures than one's own. In this thesis, an effort is made to distinguish between empathy that is directed towards an unidentified target and empathy directed towards persons from different ethnic and cultural backgrounds. These people may or may not be familiar, but the main point is that the ethnocultural empathy concept attempts to isolate the role of ethnicity from the more general concept of empathy.

Definition of Culture

While empathy has been convincingly related to factors such as helping behavior and altruism, there are important factors that can affect empathic ability that have not been studied systematically. One important factor that has emerged more recently in empathy research is culture and ethnicity (Lawrence, & Luis, 2001; Wang et al., 2003). There are numerous definitions and interpretations in psychology, anthropology and allied disciplines of what can be understood by "culture" (Toomela, 2003). While the term culture first appeared in an English dictionary in the 1920s (Kroeber, 1949), the first use of the term in an anthropological work was by Tylor (1871), who defined culture as "that complex whole which include knowledge, belief, art, morals, laws, custom and any other capabilities and habits acquired by man as a member of society" (p. 1). Two rather short, but now widely used definitions were later proposed. Linton (1936) suggested that culture means "the total social heredity of mankind", (p. 78) and Herskovits (1948) proposed that "culture is the man-made part of the human environment" (p. 17). In contrast to these concise definitions, there are also several other examples of what is included in the concept of culture. One of these is by Wissler (1923), who included speech, material traits, art, knowledge, religion, society, property, government and war. Kroeber and Kluckhohn (1952) suggested that six major classes of definition of culture were to be found in the anthropological literature:

descriptive definitions, historical definitions, normative definitions, structural definitions, genetic definitions, and psychological definitions. All the definitions mentioned above allow researchers to choose the definition that best suits their purpose. Several authors have found such a practice reasonable (e.g. Toomela, 2003; Jahoda, 1995; Triandis, 1994).

In this thesis, a psychological conceptualization of culture was used, mainly because this would be able to capture a variety of psychological qualities. In this thesis, culture will be defined as learned communication in terms of verbal and non-verbal expression, and this leads to the establishment of interaction and communication in a particular group. This definition is rather broad and consists of both attitudes on an implicit level as well as explicit behavioral as a cultural phenomenon (Berry, Poortinga, Segall, & Dasen, 2006).

Definition of Ethnicity

The term ethnicity is also ambiguously and controversially discussed in the humanities and social sciences. There is also similar inconsistency in definitions of race and ethnicity (Bradby, 2003). For example, in the United States 'race' is still perceived more as a biological characteristic, whereas in the United Kingdom there is greater acceptance that it is a social construct (Dogra, & Karnik, 2004). There are two basic approaches in the definition of ethnicity, essentialist and constructivist, and their significance lies in the established criteria distinguishing one ethnic group from another (e.g. in terms of physical traits). The distinction can include language, religion, history and more; however, there is rarely if ever a single criterion for defining an ethnic group (Bradby, 2003). Brante, Heine, and Korsnes (2001) defined ethnicity as "a term to indicate differences between social groups on the basis of cultural criteria, the most important of which are the notions of a common origin and shared historical fate. It is important to note that most often it is only minorities in society that are described as ethnic groups, whereas the majority group is usually identified with the nation." (p. 74)

The constructivist approach assumes that a group's ethnic identity is determined by an individual's or group's choice, and is also the approach endorsed in the present thesis. From a biological perspective, ethnicities are exclusive in the sense that one must be born into them

and have a certain appearance (e.g. skin color) to be accepted as a member of a specific ethnic group (Bradby, 2003; Dogra, & Karnik, 2004).

In this thesis, ethnicity is viewed in accordance with both the constructivist and the biological "essentialist" perspective. The constructivist definition was used when measuring the ethnic background of those respondents, who participated in the thesis, i.e. ethnicity is determined mainly by the individuals themselves. The consequences of this definition show that the notions of culture and ethnicity are not definitive and they can change and take on different forms depending on how the individual in question relates to them. The biological (essentialist) definition was probably used by participants when they completed the questionnaire package, i.e. ethnicity is determined mainly by the imagination and categorization of what people with another ethnic and cultural background look like, for example, in terms of physical traits such as skin color.

Ethnocultural Empathy

Empathy is a well-researched topic but, as mentioned, not in relation to culture and ethnicity (Chung, & Bemak, 2002; Green, 1998; Lawrence et al., 2001). The researchers who recognize the value of cultural and ethnic components have established the relatively new empathy concept of *ethnocultural empathy* (Wang et al., 2003). This ability is also known as cultural competence, culture empathy or as trans-cultural empathy (Chung et al., 2002; Green, 1998; Lawrence et al., 2001; Wang et al., 2003).

Cultural empathy as a concept first emerged in therapeutic contexts in which white American psychologists met more and more patients with ethnic backgrounds other than their own (Dysart-Gale, 2006; Ivey, Ivey & Simek-Morgan, 1997; Lawrence, & Luis, 2001). The therapists realized that they needed to increase their knowledge and competence concerning ethnic aspects to be able to give adequate treatment to these client groups (Bohart, & Greenberg, 1997; Snyder, 1992). Even the client groups reported that they were not treated empathically by the therapists (Chung et al., 2002; Lawrence et al., 2001). This is why some clients whose ethnic backgrounds differ from their

therapists terminate therapeutic treatment when compared to clients with the same ethnic background as their therapists (Karlsson, 2005).

Ridley and Lingle (1996) were the first to use and define the concept of cultural empathy. They argued that cultural empathy goes beyond general empathy and includes understanding and acceptance of another person's cultural point of view. According to Ridley and Lingle these insights enable therapists to have more open attitudes and provide the necessary knowledge to work successfully with clients with ethnic background different from their own. They stated that cultural empathy "involves a deepening of the human empathic response to permit a sense of mutuality and understanding across the great differences in value and expectation that cross-cultural interchange often involves" (Ridley, & Lingle, 1996, p. 22). Based on the above theoretical review a number of obstacles to feeling empathy for a person from another culture can be identified:

- General lack of knowledge about cultures other than one's own.
- General lack of practical experience of being in other cultures.
- Lack of ability to perceive similarities and differences between the other's culture and one's own.
- Negative experiences of other cultures.

Ethnocultural empathy can be defined as empathy directed towards people from racial and ethnic cultural groups different from one's own ethnocultural group. Wang et al. (2003) coined the term 'ethnocultural empathy' from theories on general and cultural empathy, and operationalized the concept by developing a scale of 'ethnocultural empathy'. Wang et al. (2003) conducted three studies on the importance of cultural and ethnic aspects of empathy. According to Wang et al., ethnocultural empathy has four components:

- Empathic Feeling and Expressions (EFE) focuses on the verbal expression of ethnocultural empathic thoughts and feelings toward members of other ethnic groups. This component can also be expressed through actions (e.g. "I share the anger of those who face injustice because of their racial and ethnic backgrounds").

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- Empathic Perspective Taking (EPT) is the ability to understand how a person with a different ethnic background thinks or feels (e.g. "It is easy for me to understand what it would feel like to be a person of another racial or ethnic background other than my own").
- Acceptance of Cultural Differences (AC) is concerned with accepting why people from other ethnic groups behave as they do, for example, wearing traditional clothing, or speaking their own language (e.g. "I feel irritated when people of different racial or ethnic backgrounds speak their language around me").
- Empathic Awareness (EA) is to be conscious of how society, media and the job market treat other ethnic groups (e.g. "I am aware of institutional barriers [e.g. restricted opportunities for job promotion] that discriminate against racial or ethnic groups other than my own").

The main difference between basic and ethnocultural empathy is the target of empathy, that is, the person for whom the empathy is intended. In basic empathy, this is not specified whereas in ethnocultural empathy, it is specifically a person and groups from a different cultural and ethnic backgrounds. Ethnocultural does not alter the fact that the focus is on empathy. What the concept of ethnocultural contributes is a condition of the relationship between the empathizer and the other person (Rasoal, Eklund, & Hansen, 2009).

Research on empathy and ethnocultural empathy among health care education programmes and professions

Health care professionals often act in a standard way towards their clients and patients (Ekblad et al., 1996; Ridley, & Lingle, 1996; Squire, 1990), informed by their culture and training. This might lead to inadequate treatment, given the reality that many clients and patients have cultural and ethnic backgrounds that differ from their therapists and doctors. It can also lead to misunderstandings and unsuccessful clinical treatments in health care (Dysart-Gale, 2006; Ekblad et al.,

1996; Mercer, & Reynolds, 2002). Yet many educational programmes such as psychology, medicine, nursing, social work and teacher education largely lack courses that cover the importance of ethnicity and cultural aspects in interaction with people with ethnic backgrounds other than one's own. Many researchers think these educational programmes for health care professionals should include and integrate knowledge about clients' ethnic and cultural background as a relevant element (Chung et al., 2002; Lawrence et al., 2001).

As mentioned, cultural empathy as a concept first emerged in therapeutic contexts. The therapists realized that they needed to increase their knowledge and competence concerning ethnic aspects to be able to provide an adequate treatment for these client groups. Despite the conceptual ambiguity, it is interesting to note that empathy is among the most frequently mentioned humanistic dimensions of patient care (Linn, DiMatteo, Cope, & Robbins, 1987; Hojat, 2007), although it can sometimes go under different related names such as compassion and prosocial behavior (Gilbert, 2005).

Aims of this thesis

A major challenge facing health care professionals in Western societies in general and in Sweden is the treatment of new client groups with different cultural and ethnic backgrounds. In order to meet this challenge, research must be conducted on empathy between individuals and groups with different ethnic and cultural backgrounds in both everyday life and as well as in professional contexts such as in health care. Even if cultural aspects are sometimes implicit in research on empathy, there is a clear lack of research identifying the specific characteristics of ethnocultural empathy in comparison with more basic empathy.

The main purpose of this thesis was to translate and adapt an ethnocultural empathy scale to a Swedish context, and then measure this ability among students in health care education programmes. The studies presented in the thesis address the following research questions:

1) Following translation and adaptation of the SEE for Swedish settings, how is the Swedish version of the SEE internally structured in terms of its discriminant and convergent validity?

2) Is there a correlation between a basic empathy construct as measured by the IRI and an ethnocultural empathy construct as measured by the SEE?

3) Are gender and age predictors of IRI and SEE, and are SEE and IRI predicted by ethnic diversity in school?

4) Are there differences in the levels of SEE, including its subscales and IRI, between students in health care education i.e. the undergraduate programmes in Medicine, Psychology, Nursing, and Social Work?

5) Are there differences between early and late semester students in the programmes, and how demographical variables were associated with SEE and IRI scores?

General outline of the studies

The context of the studies

The context in which the studies have been conducted includes one 5-year Master's programmes in Medicine, one 5-year Psychology programme, and 3-year bachelor programmes in nursing and social work. Medicine and psychology are regarded as prestigious programmes with high entry criteria (in terms of grades), and 70-100 students enroll in the programmes each time. Three of the programmes have a large proportion of scheduled lectures, practical work and lessons, and are based on the principles of problem-based learning (PBL). The exception is the social work programme, which is not based on PBL. In PBL, students are divided into small tutorial groups, which constitute the basic work form in the programmes. The importance of interaction and communication to the learning process is emphasized. In PBL, group dynamics and problem-solving in the tutorial groups are stressed as important (Gallagher, 1997). Tutorials, a kind of co-operative learning method, are regarded as valuable for student motivation because together students can support individual progress. In study I, participants from study programmes in legal affairs and behavioral sciences as well as secondary school students were also included. These programmes are not based on PBL.

Measures

The general methodological approach in this thesis was to use a questionnaire package and quantitative methods. The questionnaire package used in all the studies consisted of 79 items in total.

Basic empathy

The IRI (Davis, 1996) is considered by many to be the best measure of empathy (Baron-Cohen, & Wheelwright, 2004). The Swedish version of the IRI was used because it is a robust instrument with adequate reliability and validity (Cliffordson, 2001). IRI includes 28 items and

is designed to tap four separate dimensions of basic empathy (Davis, 1996). In this thesis, the total score of the IRI was used in the analyses, but in a confirmatory factor analysis, the subscales "perspective-taking", "fantasy", "empathic concern" and "personal distress" were included. Both internal reliability (alpha coefficients for total IRI ranged from α =.70 to .78 for the subscales) and test-retest reliability (from r =.61 to .81 over a period of two months period) could be regarded as acceptable (Davis, 1983). In the present study, the alpha was α =.73.

Ethnocultural empathy

When Wang et al. (2003) developed the SEE, it was refined until it reached a satisfactory degree of internal consistency. The scale of ethnocultural empathy (Wang et al., 2003) is intended to measure intellectual and emotional expressions of empathy aimed at people and groups who have an ethnic background different from one's own. The SEE is a 31-item forced choice self-report measure that produces an overall score and four subscale scores; Factor 1: *Empathic Feeling and Expression* consists of 15 items; Factor 2: *Ethnocultural Empathy Awareness* consists of 4 items; Factor 3: *Acceptance of Cultural Differences* consists of 5 items; and Factor 4: *Empathy Perspective Taking* consists of 7 items (Wang et al., 2003). In the present thesis, the focus is on the SEE total score. Wang et al. reported an internal consistency of α =.91. Scores for the SEE are obtained by summing item scores. Higher scores indicate a higher level of ethnocultural empathy.

Participants in the empirical studies

There was a total of 788 participants in the studies. In study III, a smaller subsample was used. Data were collected between 2005 and 2008. In the first study, a sample of 337 undergraduate students was drawn from courses and programmes at Linköping University and secondary schools in Sweden (see Table 1 for a further description).

Table 1. Descriptive data for the participants in the three studies (n-788).

Variable		Frequency in % (N)
Sex	Male	29.8 (235)
	Female	70.2 (553)
Ethnicity	Swedish	92.8(721)
	Bosnian	1.4 (11)
	Finish	1.1 (9)
	Latin American	0.8 (6)
	Iranian	0.5 (4)
	Polish	0.5 (4)
	Croatian	0.5 (4)
	Other	2.4 (29)
Age	Age 15-19	13.0 (101)
	Age 20-23	45.7 (362)
	Age 24-28	25.5 (200)
	Age 29-33	6.5 (52)
	Age 34-48	9.3 (73)
Place of growth	City (e.g. Stockholm)	33.0 (261)
	Town (50,000 inhabitants or more)	18.8 (148)
	Village (less than 50,000 inhabitants)	48.1 (379)
Primary school	With mostly Swedes	74 (583)
	Mixed ethnicity	21.7 (171)
	With mostly non Swedes	4.2 (34)
Secondary school	With mostly Swedes	60.4 (467)
	Mixed ethnicity	37.1 (292)
	With mostly non Swedes	2.5 (20)

In the second study, there were 788 participants from undergraduate courses at Linköping University and secondary schools in Linköping, Sweden. In all, 553 participants were female (70%) and 235 were male (30%). Most of the respondents described themselves as ethnic Swedes.

In the third study, the participants consisted of 365 undergraduate students in four study programmes at Linköping University, Sweden. Participants studied in graduate programmes in Medicine, Psychology, Nursing and Social Work.

Participants completed a questionnaire package in large groups during lectures. In the questionnaire package, the participants were asked about their gender, age, ethnicity, size of the city where the participants grew up, the degree of ethnic diversity in their primary and secondary schools and native language. The anonymity and confidentiality of the respondents were guaranteed and participation was on a voluntary basis. They could withdraw from the study at any time. It took approximately twenty minutes to complete the questionnaire package.

Analyses

Study I consisted of two parts. In part one, the validity and reliability of a Swedish translation of the SEE (Wang et al., 2003) was investigated in a sample of 326 undergraduate students. In part two, a confirmatory factor analysis (CFA) was used to test the factor structure obtained by Wang et al. (2003), who found a four-factor solution. The LISREL program (Jöreskog & Sörbom, 2004) was used in a larger sample of 788 participants to specify the expected factor loadings in SEE.

Study II investigated the association between basic empathy, as measured by the IRI (Davis, 1983), and ethnocultural empathy, as measured by the SEE (Wang et al., 2003). The investigation was performed in a sample of 788 undergraduate students. Furthermore, the study was used to explore the question of whether a set of background variables would predict the two forms of empathy. Multiple regression analysis was conducted using SPSS 16.0 in order to find out which (predictor) dependent variable best predicts basic empathy and ethnocultural empathy. For the confirmatory factor analysis we used EQS

6.1 to test the higher order factor structure of the SEE and the IRI using the subscales of the measures.

In study III, differences in basic empathy and ethnocultural empathy were explored in a sample of 365 undergraduate students at the beginning and end of four Master's programmes in health care (Medicine, Psychology, Nursing and Social Work). Differences between students in health care professions were tested with univariate analyses of variance (ANOVA). Post hoc tests were performed with Tukey's HSD test (Honestly Significant Difference). Between-group differences (first vs. later semesters) were also tested with ANOVAs and, subsequently, Tukey's HSD tests. Data were analyzed using SPSS 16. An overview of the studies is shown in Table 2.

Table 2. Study design indicating type of study, number of respondents, data collection, and statistical analysis.

Study	Type of study	Respondents-sample	Data collection	Statistical analysis
I	Validation study	**788** undergraduate students and secondary schools in Sweden	**Years 2005- 07** Participants completed a questionnaire package in large groups	Explorative and Confirmatory factor analysis Correlations ANOVA
II	Empirical and methodological study	**788** undergraduate students and secondary schools in Sweden	**Years 2005-08** Participants completed a questionnaire package in large groups.	Regression analysis Correlations Confirmatory factor analysis
III	Empirical study	**365** undergraduate students	**Years 2007-08** Participants completed a questionnaire package in large groups.	ANOVA Pearsons-Correlations T-test

Ethical standpoints

Ethical aspects influence the whole research process, and the principles of research ethics in the humanities and social sciences consist of four major general principles and requirements: (a) information requirements, (b) consent requirements, (c) confidentiality requirements and (d) usage requirements (Swedish Research Council, 2002).

In the present thesis, the information requirement was met since in the first encounter, all the students were informed about the purpose of the study and how the research results would be used. The information included the aim of the study, how to contact the researcher, what responding to the questionnaire would involve and that all students were fully aware that their participation was on a voluntary basis. The requirement of consent was obtained orally when potential participants were invited to participate. Moreover, the students could withdraw at any time from the study if they wished. This was emphasized immediately before distribution of the questionnaire package. The anonymity and confidentiality of the respondents were guaranteed and participation was on a voluntary basis. Finally, the usage of data requirement was met in the present thesis, since it will be used only for research.

Summary of studies

Study I: Empathy across Ethnocultural Borders – validation of the Swedish version of the Scale of Ethnocultural Empathy

Purpose

The aim of the study was to translate the American version of the SEE and test the reliability and validity of a translated Swedish version. A second aim was to determine whether the factor solution of the Swedish version of SEE was compatible with the American version, and a third aim was to investigate whether the SEE is associated with social desirability and other measures of empathy, and gender differences.

The internal structure of the Swedish version of SEE and its discriminate and convergent validity with basic empathy as measured by the IRI were investigated. According to Wang et al. (2003), the SEE is the first measure used to provide support for the theoretical construct of empathy in multicultural settings. Hence, it is important to identify measures and afterwards find ways to develop the ability of ethnocultural empathy between different ethnic groups, particularly in the health care professions in order to reduce conflicts and increase the level of tolerance, openness, and respect in human relations. Adapting the SEE for Swedish cultural settings might give a valuable contribution to better understand the structure of ethnocultural empathy and thereby make it possible to measure this ability and apply it in different contexts (for example, as admission to higher education especially in the health care professions, e.g. Psychology, Medicine, Nursing, and Social Work programmes).

Method

Samples of 337 undergraduate students were drawn from courses and programs at Linköping University and secondary schools in Norrköping in Sweden. The questionnaire package was administered in person (11 missing or invalid). The final sample used in the analyses

consisted of 326 persons. Participants completed the scale in large groups of 60 students. There were 232 female (71%) and 94 male (29%) undergraduate students and secondary school pupils. Their ages ranged from 15-47 years (M = 23.4, SD = 6.4). Most of the respondents described themselves as ethnic Swedes (92%, n = 300). In the remaining groups, 2% were ethnic Finns, and less than 1% had other ethnic backgrounds. In the questionnaire package, we asked the participants about their gender, age, ethnicity, native language, size of the city where they grew up, religion, education, parents` occupation and education level, number of friends from other ethnic groups, and the degree of ethnic diversity in their primary and secondary schools.

The questionnaire package used in this study consisted of four parts: a questionnaire on demographics, the SEE, the IRI (Davis, 1996) (28 items) designed to tap four separate dimensions of basic empathy (Davis, 1996) and the impression management subscale (IMS: Paulhus, 1988) (20 items) designed to tap positive self-presentation targeted at a public audience. The latter scale was included because we suspected that some students might be worried about their responses being associated with racism and discrimination (Paulhus, 1988). All the items were listed in random order and rated on a 5-point Likert-type scale (1 = strongly disagree to 5 = strongly agree). The items were phrased both positively and negatively to offset any potential response bias. Negatively phrased items were reversed in the scoring. Participants were assured of their anonymity and were informed that they were free to withdraw from the study at any time. A time of approximately 20 minutes was needed to complete the questionnaire package.

Results and Discussion

The principal–components factor analyses with varimax rotation revealed a four–factor solution.
Factor 1: reflected *Empathic Feeling and Expression,*
Factor 2: reflected *Empathic Awareness,*
Factor 3: reflected *Acceptance of Cultural Differences,* and
Factor 4: reflected *Empathic Perspective Taking.*

Factor selection was based on the following criteria: factors with eigenvalues greater than 1.0 and items possessing factor loadings of .30 or greater were assigned to a factor. Factors were retained if they

had at least five items possessing factor loadings of .30 or higher. The first component (12 items) accounted for 25% of the total variance (eigenvalue = 7.63). The second component (7 items), the third component (5 items), and the fourth component (7 items) accounted for 8%, 7%, and 5% of the total variance, respectively (eigenvalues = 2.47, 2.01, and 1.55). CFA was used to test the factor structure obtained by Wang et al. (2003), who found a four factor solution. LISREL (Jöreskog, & Sörbom, 2004) was used to specify the expected factor loadings. Results showed that the four-factor solution was not replicated.

The Swedish factor solution revealed four distinct factors underlying the scores of the SEE. The result is not identical to that obtained in the American version. Overall, 25 out of 31 items of SEE loaded on the same factors as in the original American version, whereas 6 items loaded on different factors. The results from the exploratory factor analysis suggest that the concept of ethnocultural empathy can be measured in Sweden and that the structure of the SEE is fairly equivalent between countries and languages. In contrast, the CFA did not replicate the original findings, making the interpretation of the exploratory factor analysis difficult.

To conclude, the results show that the central tendency, distribution of scores, intercorrelations, and factor structure in the Swedish version of SEE was well-matched and largely similar to the American version, albeit not in the CFA analysis.

Study II: Ethnocultural versus basic empathy: Same or different?

Purpose

In study II, the association between basic empathy, as measured by the IRI (Davis, 1996), and ethnocultural empathy, as measured by the scale SEE (Wang et al., 2003), was investigated. A second aim was also to explore if a set of background variables predicted the two forms of empathy.

Method

There were 788 participants from undergraduate and secondary schools in Sweden. Ages ranged from 15 to 48 years ($M = 24.3$, $SD = 5.9$) (see table 1). Participants completed a questionnaire package in large groups during lectures. In the questionnaire package, the participants were asked about their gender, age, ethnicity, size of the city where the participants grew up, the degree of ethnic diversity in their primary and secondary schools and native language. The response rate was 66%. In all, 553 participants were females (70%) and 235 were males (30%). Most of the respondents described themselves as ethnic Swedes. The anonymity and confidentiality of the respondents were guaranteed and participation was on a voluntary basis. They could withdraw from the study at any time. It took approximately twenty minutes to complete the questionnaire package. The questionnaire package was administered during the autumn semester of 2007 and spring semester of 2008. Participants completed a questionnaire package in large groups in conjunction with regular lectures.

Results and Discussion

In this study, the association between basic empathy, as measured by the IRI, and ethnocultural empathy, as measured by the SEE, was investigated. Secondly, the study explored whether a set of background variables could predict the two forms of empathy. Two multiple linear

regressions were computed using the total scores on the SEE and IRI as criterion variables. Five independent variables were entered into the linear regression using the "enter" method. The model, with SEE as a dependent variable, showed that gender, place of growth and age were significantly related to higher ethnocultural empathy.

A confirmatory factor analysis was used to test whether a higher order, two-factor structure would be obtained. The first factor specified the four subscales of the SEE (Wang et al., 2003). The second factor included the four subscales of the IRI (Davis, 1983). EQS 6.1 (Bentler, 2006) programme was used to specify the expected factor loadings. Results showed that the fit of the proposed two-factor model was poor (Satorra-Bentler $\chi^2/df = 46.7$, CFI = .60, RMSEA = .24, 90% = (0.23; 0.25), SRMR = .26). This study raises questions regarding how ethnocultural empathy should be measured. In particular, in the light of the significant association between impression management and empathy, it might be that more indirect and implicit measures of empathy should be used.

Study III: Ethnocultural empathy among students in health care education

Purpose

There have been several studies indicating inequalities in health and health care between patients and clients from different ethnic and cultural backgrounds compared with the majority of the population (Albin, Hjelm, Ekberg, & Elmstahl, 2006; Essen, Hanson, Ostergren, Lindquist, & Gudmundsson, 2000; Gadd, Johansson, Sundquist, & Wandell, 2003; Robertson, Iglesias, Johansson, & Sundquist, 2003; Robertson, Malmstrom, & Johansson, 2005). While the importance of empathy is often stressed in literature on health care and in training programmes, there is relatively little empirical research on differences in empathy between different professions. As mentioned earlier, there have been many studies of students in Medicine, Psychotherapy, and Nursing with regard to basic empathy (Dyche, & Zayas, 2001; Kim, Kaplowitz, & Johnston, 2004; Ridley, & Lingle, 1996). Research on ethnocultural empathy of students in health care programmes has not been studied to any great extent.

In this study, levels of basic empathy and ethnocultural empathy among students in a number of health care education programmes (i.e. the master programmes in Medicine, Psychology, Nursing and Social Work) were measured. The IRI was used because it measures basic empathy and is a robust and frequently used instrument with high validity (Cliffordson, 2001). SEE was used because it is the only instrument that specifically targets ethnocultural empathy. In order to examine whether the levels of empathy of the students differed at the beginning and at the end of their studies, empathy was measured in the first semester and at the end of the study programs.

Method

The participants consisted of 365 undergraduate students in four study programmes at Linköping University, Sweden. Participants were enrolled in graduate programmes in Medicine (N=76), Psychology

(N=89), Nursing (N=93), and Social Work (N=107). The students were enrolled in their first and in a later semester, ranging between the sixth and ninth semesters.

The response rates for students of Psychology and Social Work were 95%, whereas the response rate for students of Medicine and Nursing were 66% for both. In all, 286 participants were female (78%) and 79 were male (22%). The proportion of female students in the programmes was 87% in Nursing, 88% in Social Work, 63% in Medicine, and 71% in Psychology. Ages ranged from eighteen to forty-four years ($M=25.2$, $SD=5.7$). For each study programmes, the average ages were as follows: 23.6 years ($SD=4.3$) for Nursing, 26.3 years ($SD=6.8$) for Social Work, 23.7 years ($SD=4.2$) for Medicine, and 27.4 years ($SD=6.2$) for Psychology. Most of the respondents described themselves as ethnic Swedes (91.8%, $n=353$).

Results and Discussion

Empathy variables were correlated with background variables and there were several small to moderate correlations between the variables ($r=.12$ to .33), where gender had the highest correlation with empathy. Gender was associated with higher empathy scores. Differences between the different study programmes were also calculated on a subscale level. While the subscales were correlated ($r=.18$ to .63), they are relatively distinct (Wang et al., 2003), hence meriting separate analyses for the subscales.

The results of this study showed that students in the first semester of the Psychology programme reported both higher general empathic skills as well as higher ethnocultural empathic skills compared to students in the other programmes. Differences between the study programmes were less marked in the later semesters. Overall, the results did not show that students in the later semester had higher empathic skills than students in the first semester. However, there were three interactions between cohort and study programmes.

Since ethnocultural diversity is becoming more prevalent in many health care settings, I believe that it is important to consider what implications ethnocultural empathy may have for health care relations. Indeed, training students in health care education in ethnocultural em-

pathy is of great importance. When preparing for future clinical work, cultural aspects should be considered.

General Discussion

The ability to empathize is generally regarded as important and positive in both professional settings and everyday life. However, definitions and descriptions of this ability are often inadequate and unreliable, and one aspect which has been neglected among empathy researchers is consideration of culture and ethnicity. Empathy without knowledge of cultural background and practical experience with different ethnic groups may not lead to satisfying and fair treatment and helping behavior, particularly in health care situations. The main purpose of this thesis was to explore empathy in relation to sociodemographic variables, and education programmes that might influence experiencing empathy for people whose ethnic and cultural background differs from one's own in the context of health care profession.

The main results indicate that the Swedish version of the SEE was well-matched and largely similar to the American version of the SEE in terms of explorative factor analysis and its discriminant and convergent validity, although not in the CFA analysis. Additionally, a significant strong correlation between basic and ethnocultural empathy was found, suggesting that the two constructs overlap substantially. The correlation between SEE and IRI was stronger in study II ($r = .65$) than in study I ($r = .29$). Since a larger sample was included in study II and additional study programmes were added (e.g., Medicine and Psychology), it is possible that restriction of range is responsible for the weaker correlation in study I. No differential predictors were found, suggesting that the two concepts of empathy are similar. Finally, students from all programmes in health care professions had fairly high scores on both basic empathy, and ethnocultural empathy scales. There were, however, some significant differences between the study programmes. Students in Psychology in particular and in Social Work to some extent distinguished themselves by having higher scores than students in the Medicine and Nursing programmes.

Theoretical discussion

The concept of empathy has been studied and explored in many approaches, and there is an enormous volume of literature on the phenomenon in a variety of scientific disciplines. There is understandable disagreement among empathy researchers about what really constitutes natural empathy, and this is not resolved in this thesis.

Empathy is a well-researched topic in different research disciplines but not in relation to culture and ethnicity (Chung, & Bemak, 2002; Green, 1998; Lawrence et al., 2001). A common denominator in empathy research is that empathic ability has almost exclusively been studied among individuals with the same ethnic and cultural background. The researchers who recognized the value of cultural and ethnic components established a new empathy concept which they named ethnocultural empathy (Wang et al., 2003), which was adopted and explored in this thesis.

As reviewed in this thesis, different conceptualizations of empathy have been proposed, and an effort was made to measure ethnocultural empathy as a separate contruct. According to the view presented in this thesis, the main difference between basic and ethnocultural empathy is the target of empathy, that is, the person at whom the empathy is directed. In basic emphathy this is not specified, whereas in ethnocultural empathy the target is specifically a person and groups from a different cultural and ethnic background. At the outset of this thesis, it was assumed that SEE would be able to capture this difference.

In the present thesis, an attempt was made to empirically differentiate between basic and ethnocultural empathy. There are several aspects that distinguish ethnocultural empathy from general definitions of empathy. The first aspect is the need to consider the other person's cultural context. The client and patient should not be understood as an individual independent of the cultural context, but rather the individual's experience is interpreted and placed in a cultural context. A second aspect that distinguishes ethnocultural empathic ability is the need to control one's own subjective perception in the form of prejudices towards and stereotyping of individuals and groups with cultural and ethnic backgrounds different from one's own. A third aspect that sets ethnocultural empathic ability apart is that aside from theoretical

knowledge, it is also dependent on practical experience of the other culture. One can encounter difficulty adopting other ethnic perspectives if one has not been in contact with individuals from other cultures, or perhaps not lived in other countries over an extended period of time, or has never been in similar situations as people from these ethnic groups. According to Wang et al. (2003), ethnocultural empathy is a meaningful construct regardless of its somewhat high correlation with basic empathy. The present thesis was not successful in differentiating the two constructs of basic empathy and ethnocultural empathy. In spite of the problems to empirically separate basic from ethnocultural empathy, it is still possible to see them as separate as the target for empathy is different. The Swedish self-report version of the SEE has an overlap with the basic empathy construct and the further testing of the construct is needed, for example, by constructing a measure that asks the same questions regarding empathy but with different targets (e.g. ethnicity, gender or age).

Discussion of the empirical studies and their limitations

In study I, the purpose was to investigate the internal structure of the Swedish version of the SEE and its discriminate and convergent validity with basic empathy as measured by the IRI. The results show that the central tendency, distribution of scores, inter-correlations, and factor structure in the Swedish version of SEE were well-matched and largely similar to the American version, albeit not in the CFA analysis. The findings from this validation study indicated that the Swedish version of the SEE is a reliable and valid measure of empathy directed towards people from racial and ethnic cultural groups different from one's own ethnocultural group. There are some limitations to this study. First, this study relied on self-report measures and while this facilitates the collection of large data sets, we are aware that self-report does not always result in actual behavior, in this case behaviors that would corroborate the concept of ethnocultural empathy (Fan et al., 2006). A second limitation of the present study might be the use of primarily undergraduate students and secondary school students in the region of the University. Obviously, these students may not be repre-

sentative of all individuals in Sweden and not even the student population in Sweden. Clark and Watson (1988) stressed the importance of examining the factor structure of psychological assessment scales in heterogeneous samples.

In study II, the purpose was to investigate the association between basic empathy as measured by the IRI and ethnocultural empathy as measured by the SEE. Secondly, whether a set of background variables predicted the two forms of empathy was also explored. Significant strong correlation between basic and ethnocultural empathy was found, suggesting that the two factors overlap substantially. No differential predictors were found, suggesting that the two forms of empathy are similar. There are two main limitations of study II. First, we had a relatively homogenous sample in a university setting, with most participants being ethnic Swedes. Second, the study relied on self-report measures that were translated from English into Swedish. It could be that measures of empathy and, in particular, ethnocultural empathy, do not generalize to other cultural settings.

In study III, the purpose was to investigate levels of basic empathy and ethnocultural empathy among students in a number of health care educations (i.e. the master programmes in Medicine, Psychology, Nursing, and Social). The results show that students from all the programmes in health care had fairly high scores on both the empathy scales. There were, however, some significant differences between the study programmes. Students in Psychology in particular and in Social Work to some extent distinguished themselves. This result is due to the expectation that these students would be highly empathic and their high interest in helping people with psychological needs. On the other hand, there were only significant differences between the cohorts in nursing. This result is probably due to a change in emphasis in the program, from biology and anatomy to behavioral sciences where the focus is on the thoughts and feelings of the patient.

This study also has several other limitations. First, as students in different cohorts were compared, I cannot conclude whether the empathic skills of the students have developed over time. In this study, it was only possible to determine whether these skills differ between the cohorts. Differences found may depend on different backgrounds and expectations of the cohorts, and the year in which the students enrolled in their programmes. Furthermore, teachers and student counselors may change in the programmes over the years, which may have an

impact on the empathic skills of the different cohorts. Holm (2000) found that students may identify themselves with teachers who are perceived to be highly empathic, and that this may increase the student's level of empathy. Research on empathy suggests that it is possible for people to learn how to improve their empathic skills (Batson et al., 1995; Decety, & Lamm, 2006). However, only students at one university were included. It should be noted that the curricula of students in Psychology, Medicine and Nursing in Linköping are based on problem-based learning, which means that they are trained to work with different people in groups.

Future studies

In this thesis, self-report measures of ethnocultural empathy were used and this raises questions regarding how ethnocultural empathy should be measured. To my knowledge, there are no studies in which more implicit and indirect measures of ethnocultural empathy have been used, although there are studies in experimental social psychology that could inform such investigations (Akrami, & Ekehammar, 2005). It would be interesting to investigate the associations between self-reported ethnocultural empathy and, if possible, indirect measures of implicit cognition and psycho-physiological measures.

Conclusions

The studies presented in this thesis show that:

- A self-report measure of ethnocultural empathy has adequate psychometric properties and the factor structure is largely similar to the original American scale. The original factor structure could not, however, be replicated using confirmatory factor analysis.

- Ethnocultural empathy is significantly associated with basic empathy, and it also shares similar predictors with basic empathy. This is in contrast to the original study by Wang et al.

(2003), who regarded the ethnocultural empathy constructs as more distinct.

- Student in different health care education programmes report different levels of ethnocultural empathy, with psychology and social work students reporting higher degrees of ethnocultural empathy than students in nursing and medicine.

Overall, the studies show that ethnocultural empathy is a measurable construct but that the self-report version has an overlap with the basic empathy. Further testing of the ethnocultural empathy construct is needed.

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