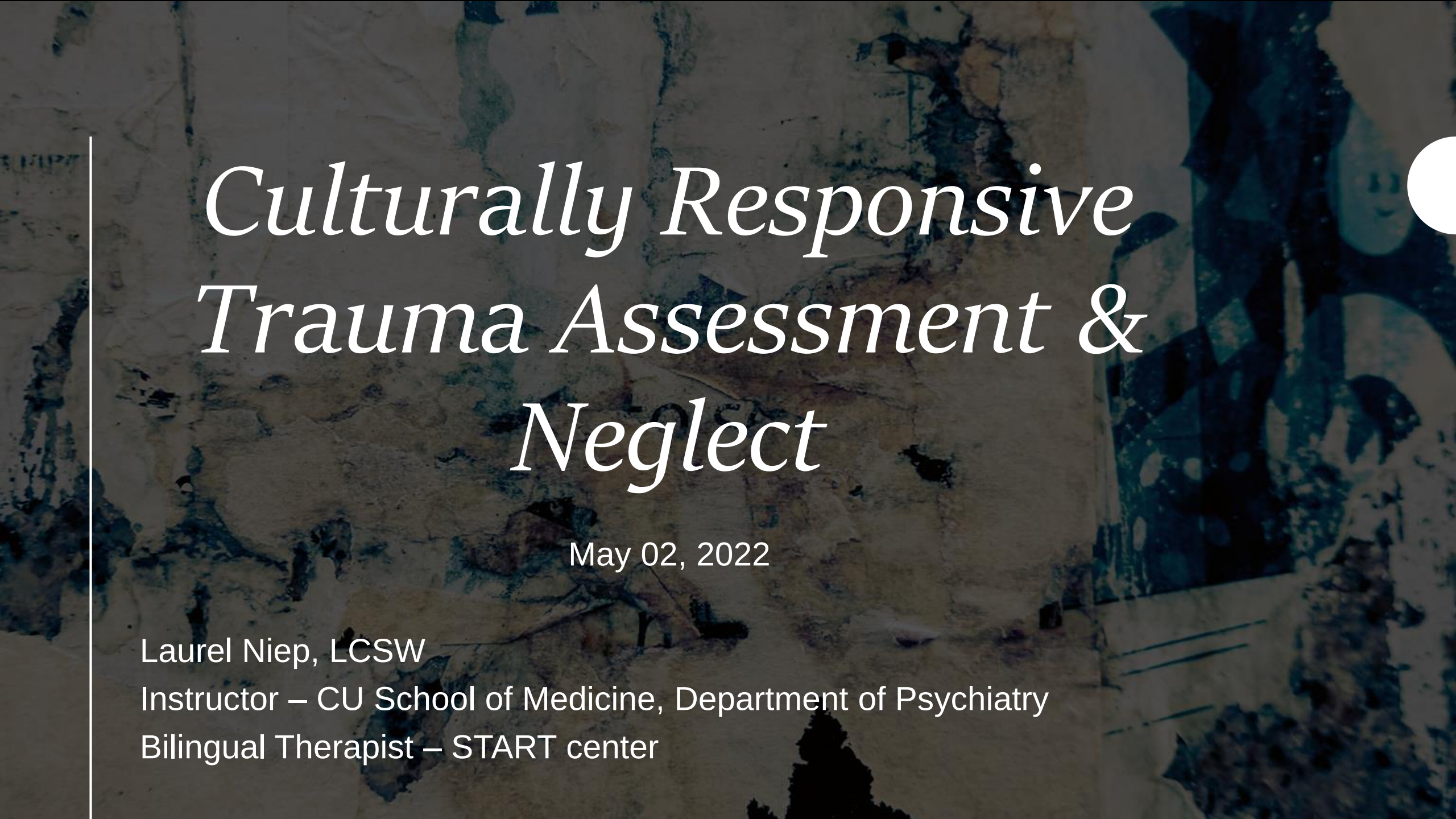

Culturally Responsive Trauma Assessment & Neglect

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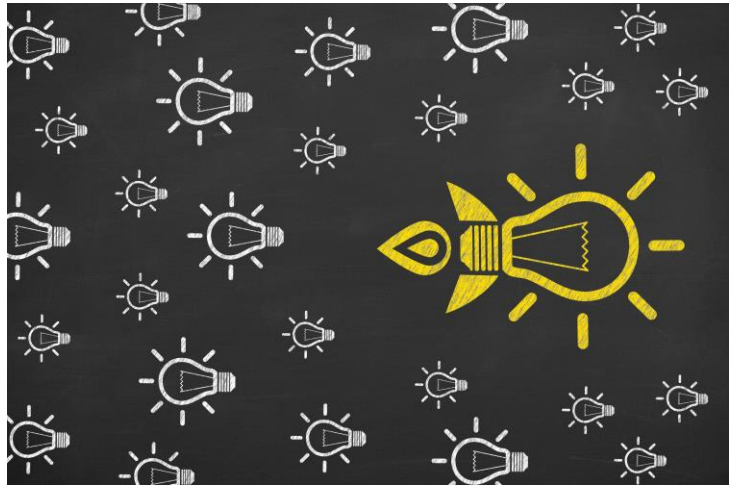
Learning Objectives

- Methods for gathering and incorporating information on the patient/family beliefs and values.
- Ability to recognize strengths that come from patient/family identity, culture, and experience.
- Strategies for naming power/oppression dynamics that inherently impact provider/patient interactions and opportunities. Methods to build rapport within these dynamics.
- Understand the intersections of neglect assessment and culturally responsive assessment.



Introductions

- Laurel Niep, LCSW: MSW – University of Denver, Graduate School of Social Work
- White
- Cis-gender
- Female

What does it mean to be culturally responsive?

- Importance of recognizing that each patient brings **ALL** of their identities and experience with them to every appointment and interaction.

  - This includes identities that are readily perceived as well as those that require disclosure.

  - This also includes past experiences – positive and negative with providers.
- This is a lifelong process with no ‘end’ achievement.
- With **intention** creating space that is welcoming and inclusive.

Components to Consider

- Institutional Oppression
- Medical Environment
- Patient Interaction
- Personal Work

Institutional Oppression

- Oppression that occurs within macro contexts – governments, schools, criminal justice system, medical system, etc
- These systems were set-up to further power, position, and control for privileged groups
- Examples: school to prison pipeline; White patients being more likely to be offered/receive pain medication than Black patients; forced sterilization; children of color (particularly Black and Indigenous children) being overrepresented in out-of-home care

Environment

- How is the space decorated?
- Do the patients see themselves represented in the space?
  - *Pamphlets / handouts?*
  - *Photos on the walls?*
  - *Staff / Providers who look like them?*
- What language are the materials in?
- Perceived discrimination results in negative impacts on mental & physical health (Pascoe & Smart Richman, 2009)

Patient Interaction - Greeting

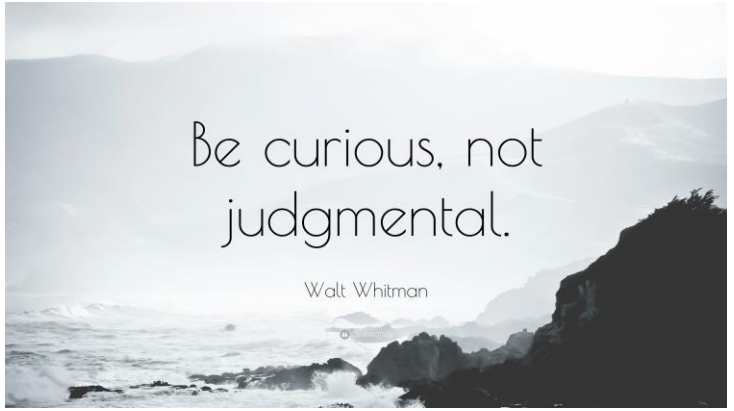
- How do you greet your patient?
- Names are IMPORTANT! If you are unsure of how to pronounce their name, ask. And ask what they would like to be called.
- During their evaluation, be aware of assumptions you might be making, and ask questions instead.
- Perceived discrimination creates reluctance to seek care (Hibbler, 2021)

Patient Interaction - Evaluation

- Does your evaluation include questions about the following:
  - *Past experiences with providers*
  - *Religious or spiritual beliefs*
  - *Culture*
  - *Family values*
  - *Traditions*
- Language of the questions (Shelton & Delgado-Romero, 2013)

Patient Interaction – Rapport

- Address differences head on
  - *Communicate in a way that is genuine for you*
  - *Acknowledge your role and goal to be helpful/supportive*
  - *“I want to acknowledge that my lived experiences may be very different than yours. My goal as a provider/doctor/etc is to provide a space where I can hear your experience and support you in accessing care for your needs.”*
- Importance of non-judgement
- Own your mistakes and missteps



Patient Interaction – Strengths

- Identify strengths in the information you're hearing
- How are the patient/family beliefs, experience, and culture assets?
- What is the patient/family sharing about their world that they view as a strength – even if it is different from your lived experience or 'expectations'?
- How can their strengths be leveraged to address their needs?

Cultural Responsiveness & Neglect

- Neglect is the most common concern reported to DHS
- Most deadly form of abuse – can impact physical, emotional, and psychological well-being
- Defined as ‘failure to provide for the development of the child in all spheres: health, education, emotional development, nutrition, shelter, and safe living conditions’ (WHO, 1999)
- Focus should be on assessing for actual or potential harm to the child

Cultural Responsiveness & Neglect

- Cultural Implications and Differences for a variety of factors
  - *Medical care*
  - *Religious practices*
  - *Discipline*
- Age of the child is a consideration
  - *12 y/o vs. 4 y/o left home alone*

Intersections in Assessment

- Impacts of poverty or lack of resources
  - *What is neglect vs. barrier to care?*
  - *Poverty itself is not abuse.*
- Impact of poverty and race
- Impact of poverty and disability
- What options are available to support the family AND protect the child?
- Awareness of your own bias and impact of dominant culture

Personal Work

- Cultural humility is a journey – there is no end
- We always have more to learn about ourselves
- Accountability partners – highly recommend
- Set personal goals for your own growth and learning – don’t rely on others to ‘teach’ you or push your learning forward
  - *Particularly important re: not asking or expecting someone who identifies with the marginalized identity teach you about your privilege in that same identity*

Why does this matter?

Institutional Oppression: the system is set-up to function this way. Acknowledging this provides opportunity for disruption.

As providers within this system, who are also human, we can (and often do) engage in discriminatory and oppressive behaviors.

Assessing neglect requires awareness of cultural implications and impacts. There are intersections of multiple marginalized identities

There is extensive research documenting the negative impacts of discrimination – even perceived discrimination, on mental and physical health.

In order to prevent additional harm and heal past experiences, we need to actively employ culturally responsive techniques with our patients.

Reflection

What do you want to be more intentional about in your patient care?

Questions?

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Resources for Growth / Learning

- Understanding White Privilege – Creating Pathways to Authentic Relationships Across Race by Frances E Kendall

- Promoting Diversity and Justice – Educating People from Privileged Groups by Diane J. Goodman

Resources

Hibbler, LeChey S., (2021) "Perceived Discrimination Within The Patient-Provider Relationship And Its Impact On Help-Seeking Behaviors". *Dissertations*. 558. https://digitalcommons.nl.edu/diss/558

Hornor, G., (2014). Child Neglect: Assessment and Intervention. *Journal of Pediatric Health Care*, 28(2), 186-192. https://doi.org/10.1016/j.pedhc.2013.10.002

Pascoe, E. A., & Smart Richman, L. (2009). Perceived discrimination and health: a meta-analytic review. *Psychological bulletin*, *135*(4), 531–554. https://doi.org/10.1037/a0016059

Shelton, K., & Delgado-Romero, E. A. (2013). Sexual orientation microaggressions: The experience of lesbian, gay, bisexual, and queer clients in psychotherapy. *Psychology of Sexual Orientation and Gender Diversity, 1*(S), 59–70. https://doi.org/10.1037/2329-0382.1.S.59

World Health Organization. (1999). Report of the consultation on child abuse prevention, 29–31 March 1999, WHO. Geneva. Geneva, Switzerland: World Health Organization.

Vignettes – Case #1: Chris

Chris, a 3-year-old multiracial Black/European American male who presents with his mother for follow up in your primary care office after an emergency room visit for a closed head injury he sustained after reportedly falling down 6 stairs from the house's back deck onto the concrete pavement. You review records from the emergency visit and note that a head CT was completed, which showed a small linear right frontal bone fracture with overlying soft tissue swelling and a small underlying subdural hemorrhage. He had no other injuries documented.

On physical exam, he is alert and very playful in the room. He has a small hematoma on his right forehead, scattered bruises on his shins, and a large abrasion and bruising on his right shoulder and forearm. While you speak with the mother, he is attempting to climb onto the stool to get to the sink and turn on the water. Mother apologizes and tells you she is exhausted because she never gets much sleep. She tells you that she did not see him fall from the deck and found him crying at the bottom of the stairs on the concrete, as she slept a little later than usual yesterday morning because she had taken her "sleeping pill" after work. She reports that her daughter had recently left to catch the bus for school that morning, so she might have left the back door open.

You review prior charting. You note that a many of child's routine visits have been canceled or rescheduled. His past medical history is significant for a speech delay and referrals for services have been made. He was also seen in your office 2 months ago for superficial burns to his chest after he reportedly spilled a bowl of soup on himself. Mother reported that she did not witness the burn that occurred after the 10 y/o sister had prepared soup in the microwave. Mother reported that she was asleep at the time and awakened to find her son screaming in the kitchen. She found him with a wet shirt and soup on spilled on the floor.

Vignettes – Case #1: Chris cont.

Additional Social History is obtained:

- The parents are divorced, and the father is uninvolved in the children's lives.
  - *The 10yo sister is a half-sibling from a prior relationship.*
  - *Mother as a diagnosis of depression. She has a therapist and she under the care of a psychiatrist. She is prescribed an antidepressant and Ativan, but she also takes Ambien as needed to help her sleep.*
- Mother works "2nd shift" at the local meat processing factory.
  - *A trusted 75 yo neighbor, who the children call "Nana" helps babysit while mother is at work, but she leaves at 7:30am to take her grandson to school.*

Vignettes – Case #1: Chris cont.

1) What are the noticeable strengths in this situation?

2) Which elements of this patient's history raise concern? What are those concerns? Why?

3) What additional history will be important to collect for your assessment?

4) How would you discuss your concerns with the parent?

Vignettes – Case #2: Tommy

Tommy is a 4-year-old Latino (Guatemalan) boy, who lives with his mother, father, and 7-year-old sister. Neither he nor his sister have been at a medical appointment for over one year. He comes to the clinic with his mother, Jane. Jane is somewhat unkempt, seems distracted, and is hard to engage. She answers your questions with single words or short sentences. She reports no concerns about Tommy's health or behavior and apologizes for not bringing him for a visit last year. She stated that last year was very busy and appointments slipped her mind. There is a record of Tommy being seen in the ED for an upper respiratory infection with fever.

Tommy is casually dressed, but appropriately dressed. Since his last visit Tommy has only gained 3 pounds and has grown an inch. He has fallen off his growth curve. Furthermore, he has bug bites all over his body and several small scars that were not noted at his 2-year exam.

Vignettes – Case #2: Tommy cont.

1) What are the noticeable strengths in this situation?

2) Which elements of this patient's history raise concern? What are those concerns? Why?

3) What additional history will be important to collect for your assessment?

4) How would you discuss your concerns with the parent?

Vignettes – Case #3: Danny

Danny is a 9-month-old multiracial (White/Latino) boy who lives with this mother, father, and two older siblings (ages 4 and 2). Mother is an overnight custodian, and father works at a home improvement store.

Mother reports that Danny cries “all the time” and dad describes Danny as “a little cry baby.” Both parents describe Danny as being difficult and “mostly annoying.” They do note that he sits up on his own, has been crawling for at least two months, but that he mostly stays in his pack and play because he hates to be touched.

Danny makes few verbalizations, absent of repetitive sounds (like “bababa” or “mamama”). The parents have Danny in his stroller and are affectionate with one another but do not interact with Danny.

Vignettes – Case #3: Danny cont.

1) What are the noticeable strengths in this situation?

2) Which elements of this patient's history raise concern? What are those concerns? Why?

3) What additional history will be important to collect for your assessment?

4) How would you discuss your concerns with the parent?