Trauma Informed Health Services Research

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Intention

Facilitate a conversation on equity, inclusion, gender bias and trauma in health services research and share ideas about interventions
Overview

• Part I.
  • Quick terminology and principles
  • The role of bias, gender informed and partner defined quality

• Part 2
  • The role of trauma: SELF, Sanctuary and embedding trauma informed best practices

• Part 3
  • Self analysis and feedback
  • ‘Do’s’
Before we begin, take two minutes and:

- Write down a less than optimal outcome you've experienced (or are concerned might experience) with your research.
- I will ask you to share with a partner this issue, through the lens of trauma, gender and partner defined quality.
- Specifically, I'll ask you to critically analyze the situation:
  - What role might there be due to bias?
  - Is this as gender informed as I hoped it might be?
  - What is/are the impact(s) of trauma in the research collaborators? The team? The organization?
- What are action steps I can take to explore/address these issues?
Optimize your team’s impact, learn more effectively and more efficiently and enhance your skills as a physicians in a diverse society.

DIVERSITY INCLUDES ALL OF US!!!
Equal versus Equitable

Here, it is assumed that everyone will benefit from the same supports. They are being treated **EQUALLY**

Here, all are given different supports to make it possible for them to have equal access to the game. They are being treated **EQUITABLY**

Here, all three can see the game without any supports or accommodations because the cause of the inequity was addressed. The **SYSTEMIC BARRIER WAS REMOVED**.

1. Equality: is giving people the same thing/s.
2. Equity: is fairness in every situation.
Office of Diversity, Equity & Inclusion

means we seek to achieve:

- Sense of Belonging
- Culture of Wellness and Resilience
- Appreciation of Individual Attributes
- Access to Opportunity
- Equitable Reward & Recognition
- Common Purpose Meaningful Work
- Respect
- Trust
- Cultural Competence

Inclusive Environment

Inclusion

Drexel University College of Medicine
Team Composition Diversity Leads to More Ideas and More Productivity
The Casualty of (laser) focus

Using eye-tracking technology, the Yale study found that in a typical classroom setting, preschool teachers were on the lookout for “challenging behaviors” from black boys 42 percent of the time, much more than they watched other children, including white boys and girls. The behavior occurred, the researchers concluded, even if no children were acting up.

Good Intentions Does not Equal Good Outcomes

Photo A.Núñez 2008
The Golden Rule Makes Assumptions
Tweaking the Golden Rule
Color Blind – Not A Useful Approach

I don't see race. I've evolved beyond that.

I just pretend everybody's white, and it's all good.
One Size Rarely Even Fits One!!!
BIAS

Conscious and Unconscious

How do you see the world?

Conscious Mind

The Unconscious

Freud compared the mind to an iceberg.

We don't see things as they are; we see them as we are.
Cognitive Bias

• Bias is a human experience
• Bias drives behavior
• Unconscious bias and medicine plays a role in being effective in your role and in leadership
• We see who we are, not who you are.
• Becoming aware of unconscious bias results in getting the outcomes you say you want
Neurocognitively Speaking, Unconscious Bias (UCB):

• Is a type of rapid cognition that finds patterns supported by small bits of information (of the rapid reflex/danger detector type)

• Refers to social stereotypes about certain groups of people that individuals form outside of their own awareness (Fiske & Taylor, 1991, Valian 1998, 1999)
HOW DO WE REASON?

Dual Processing Theory Reasoning Model

• System 2 - Analytical Reasoning - Described analytical, deliberate, rational, slow, explicit, purposeful, and generally more reliable.

• System 1- Intuitive Action - Described as intuitive, tacit, experiential, pattern recognition, a shoot-from-the-hip” approach, and a gut reaction.

• And posits that we toggle between these two

How does the world shape your good intentions?

Implicit Bias – when it’s hidden from you, by you unknowingly

[IMPLICIT APTITUDE TEST](https://implicit.harvard.edu/implicit/selectatest.html)
Sex/Gender Bias

• “Women’s bodies are valued as ornaments. Men’s bodies are valued as instruments” – G. Steinem

• Research literature finds characteristics of successful leaders are often stereotypically masculine (e.g. assertive, forceful, dominant, competitive). Whereas stereotypical female characteristics are communical (e.g. warm, compassionate, gentle).

• These descriptors find their way into letters of recommendation.

Sex Stereotypic Role Congruity or Incongruity

• I’m Nicole (not Martin) – his week as a woman

• “Ask Keith” – women owned firm creates fake co-owner and increases profits
Diversification at work –
How Might Biased Duality Play a Role in IA’s

Biased duality – privilege, can do opposites but negative doesn’t stick or impact; lesser – negative sticks
Biased Duality - Biased Duality (gender) - a group with privilege can be two different things at no jeopardy

*At the extreme, a young man can sleep with many women (be “a player”) and be a ‘good catch’ as a husband. Not true for a young woman.
*A young man can make a mistake, but that does not indelibly write him off as ineligible. This may not be as true for a woman (or other group)
Benefit of the Doubt, Risk and Optimism

• Bias, including unconscious, of good hearted people is rarely meant to be hurtful.

• We extend the benefit of the doubt on people for whom we have confidence. (e.g. think they can ‘do it’, expect them to ‘know the rules’, expect them to be predictable by our own perspectives)

• We rarely extend the benefit of the doubt of people who seem foreign, different, unpredictable – who might not follow ‘the rules’. We rarely extend benefit of the doubt if we feel that there is a risk (e.g. safety related)
Cultural Bias – Model Minority Trap

Model Minority - Individuals in the ‘Model Minority’ group are misperceived as uniformly excelling in math and sciences (therefore ‘sure bets’ regarding graduation performance).

This bias flies in the face of reality. All groups live within a bell curve of great to at-risk.

Those who ‘trip up’ are viewed as unusual for ‘their group’ (‘what a surprise!’) – which augments the burden on those individuals.

Avoid the Bias Trap by thinking where they fit in the bell curve...

“Model Minority” Myth

“I am fed-up with being stereotyped as subhuman or superhuman creature. It. Some are superachievers, most are average citizens and a few are criminals. They are only human– no more and no less”

- Phillip Chie, Asian-American Writer
Minority as Deficit

• As humans, we more easily see disadvantage more than advantage.

• To what degree do we worry about the burden of advantage?

• Often language that includes ‘taking a risk’ on candidates are used on groups with whom minority is seen as a deficit. It serves as a justification ‘it is important to bring them in so they can take care of their populations and do primary care” rather than they’d be good in their leadership role. The diversity challenge here, in our College of Opportunity, do we support diversity leaders?
Physicians’ Implicit and Explicit Attitudes About Race by MD Race, Ethnicity and Gender
Sabin, Nosek, Greenwald, Rivara,
MD Attitudes about Race

Self-Report by Gender

Implicit Report by MD Race/Ethnicity

Sabin, 2009
Implicit Attitudes about Race

By Gender

MD’s IA by Race/Ethnicity and Gender
Bias and Race/Ethnicity

• Getting a job or an AirBnB acceptance
• About health status regardless of income
• About safety while driving (and shopping and...)
• Getting promoted in academics

http://race.bitc.org.uk/all-resources/infographics/racialbiasinfographic
So some take home’s:

• Humans favor men, whites, youth, heterosexual, physically able over each group’s counterpart.

• Unconscious bias affects hiring, evaluation, leader selection and daily interactions.

• We can prevent being unaware of UCB driving our behavior – if we actively do things about it.
Three Sure Fire Triggers of Unconscious Bias

• Time Constraints
• “Shooting from the hip” proclamations
• Inability of being able to see pros and cons (even if you are heavily weighted either way)
Strategies - Bias Mitigation

• **Education:** Full training on unconscious bias

• **Think of counter-stereotypic examples:** Identify scientists of diverse backgrounds in your field *(Blair et al)*.

• **Perspective-taking:** Imagine what it is like to be a person who experiences people questioning your ability or skills because of your social identity *(Galinsky & Moskowitz)*.

• **Interrupt automatic biased thoughts:** Identify when you may be most influenced by implicit bias (e.g., evaluating performance) and create an action plan (e.g., review evaluation criteria before assessing each person’s performance in the form of IF and THEN statements) to increase mindfulness of, or mitigate the influence of, implicit bias *(Stewart & Payne)*.
Figure 1. The ecological model for ambulatory patient safety in chronic disease represents an extension

Sarkar, et al. 2009 Joint Commission on Accreditation of HealthCare Organizations, Vol 35; No. 7
Gender analysis framework – iterative; dynamic

Gender Analysis Framework

**Part 1:**
Patterns of ill health

**Part 2:**
Factors affecting who gets ill

**Part 3:**
Factors affecting responses to ill health

Environment
Bargaining Positions
Resources
Activities
Gender Norms

Households
Communities
Influence of States / markets/international relations
Available Health Services

This is the first step in designing, implementing and evaluating health policies, projects and research in a gender sensitive way. The gender analysis helps to identify:

1. who suffers from ill-health (Patterns of ill-health)
2. why particular groups suffer from ill-health (Factors affecting who suffers from ill-health)
3. how men and women’s responses to ill-health are influenced by gender (Factors affecting responses to illness)
<table>
<thead>
<tr>
<th>Why do different groups of men and women suffer from ill-health?</th>
<th>Household</th>
<th>Communities</th>
<th>Influence of States / markets international relations</th>
</tr>
</thead>
<tbody>
<tr>
<td>How does the ENVIRONMENT influence who becomes ill?</td>
<td></td>
<td>e.g. lack of health and safety legislation to protect workers</td>
<td></td>
</tr>
<tr>
<td>How do the ACTIVITIES of men and women influence their health?</td>
<td>e.g. washing clothes increases women’s exposure to schistosomiasis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>How does the BARGAINING POSITION of men and women influence their health?</td>
<td></td>
<td>e.g. male community members decide to use funds to build a meeting house, not to build a well as favoured by the women members</td>
<td></td>
</tr>
<tr>
<td>How does access to and control over RESOURCES influence the health of men and women?</td>
<td></td>
<td>e.g. women’s lack of income earning opportunities may lead them to commercial sex work as a livelihood strategy</td>
<td></td>
</tr>
<tr>
<td>How do GENDER NORMS influence health?</td>
<td>e.g. son preference may mean that daughters are fed last and receive less nutritious food</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Matrix Factors Affecting Who Gets Ill

<table>
<thead>
<tr>
<th>How are men and women's responses to ill-health influenced by gender?</th>
<th>Household</th>
<th>Communities</th>
<th>Available health services</th>
</tr>
</thead>
<tbody>
<tr>
<td>How do the <strong>ACTIVITIES</strong> of men and women influence responses to illness?</td>
<td>e.g. women are responsible for caring for sick family members</td>
<td>e.g. formal care schedules may not fit the schedules of different groups of men and women</td>
<td></td>
</tr>
<tr>
<td>How does the relative <strong>BARGAINING POSITIONS</strong> of men and women influence responses to illness?</td>
<td>e.g. a man with an STD may be able to decide to seek care without his wife’s knowledge but she would need to ask him before seeking care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>How does access to and control over <strong>RESOURCES</strong> influence how men and women respond to ill-health?</td>
<td></td>
<td>e.g. traditional healers may accept payment in kind, while cash is required for user fees at formal services</td>
<td></td>
</tr>
<tr>
<td>How do <strong>GENDER NORMS</strong> affect responses to illness?</td>
<td></td>
<td>e.g. men and women with stigmatised diseases may be treated differently</td>
<td></td>
</tr>
</tbody>
</table>

*note: Do your answers apply across different social groupings /identities (e.g. race, class, age, religion)?*

*note: Have you thought about information gaps/ bias?*
Co-Creating the Solution

• “Go in search of Your People
• Love them, learn from them
• Plan with them, serve them;
• Begin with what they have;
• Build on what they know.
• But of the best leaders,
• When their task is accomplished,
• Their work is done,
• The People all remark:
• ‘We have done it ourselves’”
PDQ Defined

• A quality improvement process.
• Goal - increase quality and accessibility of services
• Methodology greater involvement of the community in defining, implementing and monitoring.
• Focuses upon mutual responsibility for problem identification and problem solving
PDQ Optimally Deployed When:

• Action is needed (not just information).
• Change is needed and wanted from providers and community.
• All are willing to be flexible.
• Garnered key stakeholder support.
• Time sufficiently resourced to achieve goals.
Value Proposition of PDQ

• Helps eliminate social and cultural barriers to better health
• Strengthens community’s capacity to improve health
• Creates mechanism for rapid mobilization around health priorities
The role of mixed methodologies

- Why, how?
  - Process informing
- How much?
  - Impact informing
Impact of Trauma and Repetitive Trauma
Trauma, S-E-L-F, Sanctuary Approach

- Safety
- Emotion identification and regulation
- Loss
- Future

“what happened?” vs “what’s wrong with you?”

http://www.sanctuaryweb.com/

S.Bloom
Principles

• Safety
• Transparency, Authenticity, Trustworthiness
• Choice / Options
• Collaboration and Mutuality
• Empowerment
Safety and Transparency

• Safety
  - Place, space – culturally, emotionally, physically safe and aware of an individual’s discomfort or unease. Team members represent your outreach group.
• Transparency, Authenticity, Trustworthiness
  - Full disclosure in more than one communication vehicle with intentional repetition, cuing (‘what’s next’), foreshadowing (‘this might be tough to talk about’). Authentic, clear communication.
Choices and Collaboration

- Choice / Options
- Collaboration and Mutuality

- Critically designing options and choices vs singular ‘best practice’. ‘best of the worst’, at times
- Collaboration – not mine, not yours but the ‘birthed’ third combining our two. Relationship development, reinforcement and forging. Dedicated time and processes to facilitate shared decisionmaking. Mutuality derives from being in ‘others mind’ not reciprocity.
Empowerment

Strengths based from the start (vs deficit based). Validation of expertise of the lived experience and their potential and contributions. Concrete acknowledgements, awards, celebrations of successes and milestones. Building on collective successes and ongoing validation.
The Triangle and (Invisible) Role of Family

In search of a trauma informed approach... S.Bloom Sanctuary
**Key Components of TIC**

- Incorporating the approach to every aspect of the organization, creating a genuine culture change
- Staff at all levels change their behaviors, actions, and policies in keeping with a TIC approach (Jennings, 2004)
- "Involves vigilance in anticipating and avoiding institutional processes and individual practices that are likely to retraumatize individuals who already have a trauma history"
- Demonstrating greater awareness of the impact of trauma on all individuals served by the program, organization, or system, including its own workforce
- Changing the thinking from "what is wrong with this individual?" to "what happened to this individual?"
- An acceptance that trauma influences the effectiveness all human services (care coordination, medical care, criminal justice, etc.) (SAMHSA, 2015)
- Solution-based service approach
- Recognizing the pervasiveness of trauma
Trauma-Informed Care calls for a change in organizational culture, where an emphasis is placed on understanding, respecting and appropriately responding to the effects trauma at all levels.

(Bloom, 2010)

- Ensures administrative commitment to integrating a trauma-informed culture
- Provides introductory training to all staff
- Establishes an internal trauma team
- Includes providers and providees in planning and evaluation of services
- Conducts early and respectful trauma screening and assessment for all
- Addresses any potential retraumatizing policies and procedures

(Fallot & Harris, 2001)
# Retraumatization

## What Hurts?

<table>
<thead>
<tr>
<th>System (Policies, Procedures, &quot;The Way Things Are Done&quot;)</th>
<th>Relationship (Power, Control, Subversiveness)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Having to continually retell their story</td>
<td>Not being seen/heard</td>
</tr>
<tr>
<td>Being treated as a number</td>
<td>Violating trust</td>
</tr>
<tr>
<td>Procedures that required disrobing</td>
<td>Failure to ensure emotional safety</td>
</tr>
<tr>
<td>Being seen as their label (i.e. addict, schizophrenic)</td>
<td>Noncollaborative</td>
</tr>
<tr>
<td>No choice in service or treatment</td>
<td>Does things for rather than with</td>
</tr>
<tr>
<td>No opportunity to give feedback about their experience with the service delivery</td>
<td>Use of punitive treatment, coercive practices and oppressive language</td>
</tr>
</tbody>
</table>
Interventions and Activities At All Levels

• Individual – those in target audience; with need for intervention, intentions of intervention (and unintentional); with risks and benefits; considering access and overall impact

• Interpersonal & Relational – interactions (e.g. how impacts social, cultural, gender norms); individual-level barriers; impact of other people (family, friends, HCPs, community workers, research team members) and how they interact; trauma informed (TI) training on messages and support

• Organizational – impact on system and policies that result in group and individual behavior change; engagement by organizations regarding TI messages and support

• Community – TI developed community and coalition collaborations with activities, events, communication campaigns all themselves TI

• Policy – State, local, federal, tribal agencies and policies engaged to promote health behavior change
Stress for your team:
includes burnout; vicarious trauma; secondary traumatic stress; compassion stress

**Risk Factors**
- Personal trauma history
- Type of trauma story
- Length of employment
- ‘always on’ – always being empathetic
- isolation

**Protective**
- Team spirit
- Seeing change as a result of the work
- Training
- Supervision
- Balanced workload
- Stress inoculation training
- Space for self care
- Practice of gratitude and ‘shout outs’
- Workplace wellness rituals (walks, lunch)
From good to great...

• Take your situation you wrote down and consider the following, with a critical eye:
  • What role might there be due to bias?
  • Is this as gender informed as I hoped it might be?
  • What is/are the impact(s) of trauma in the research collaborators? The team? The organization?

• What are action steps I can take to explore/address these issues?

• Spend 3 minutes thinking and 2 minutes sharing with a partner
Expanded Model for *Philadelphia Ujima*

- **Community Partners and Patient Participants**
- **DUP Clinical Experts**
- **Community Health Education Experts**
- **Data and Evaluation Experts**
- **Health System Partners / Government**
- **Information Systems**
- **Community Resources**
- **Ujima Research Team**
Improving the Culture of Health - Philadelphia Ujima:

**Cultural of Health Focus**
- Making Health A Shared Value
- Fostering Cross-Sector Collaboration
- Creating Healthier, More Equitable Communities
- Strengthening Integration of Health Services and Systems
- Improved Population Health, Wellness and Equity

**Philadelphia Ujima Focus**
- Wagner Chronic Disease model & the Ujima model
- Inclusion from onset of cross sector collaborators (from needs assessment, community health assessments to outcomes)
- Engaged communities promote healthier communities
- System level and individual navigation of health complexity
- Take a loved one to work
Philadelphia Ujima™ Principles

• Good health flourishes across sectors (geographic, demographic, social)

• Attaining best health possible is valued

• Individuals & families have the means & opportunity to make healthiest life promoting choices

• Collaboration of sectors (business, government, individuals, organizations) build healthier communities & lifestyles

• No one is excluded

➤ Principle reinforced by Ujima community network and lay health ambassadors

➤ Best health, best cost, best access (or strategies to overcome barriers)

➤ Family system (and social hub) engagement an imperative

➤ Ujima model based upon cross sector collaboration

➤ All in!
If you don’t know or understand – equity is elusive...

If you can't and/or don’t engage – it remains so...
Selected Resources


Recommended 'Do's'

• Do get trained in bias mitigation and unconscious bias; do get your team trained.

• Consider getting formal trauma and gender informed training across all your spheres of influence.

• Consider giving yourself sufficient time in program development to ensure PDQ can happen and is embedded.

• Keep asking yourself 'how are WE doing?" "what can we, collectively do, to make it better?"
New Opportunity to Showcase Your Work: *Health Equity Journal*

Sign Up for Free Briefings in Health Equity!!
Thanks!
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