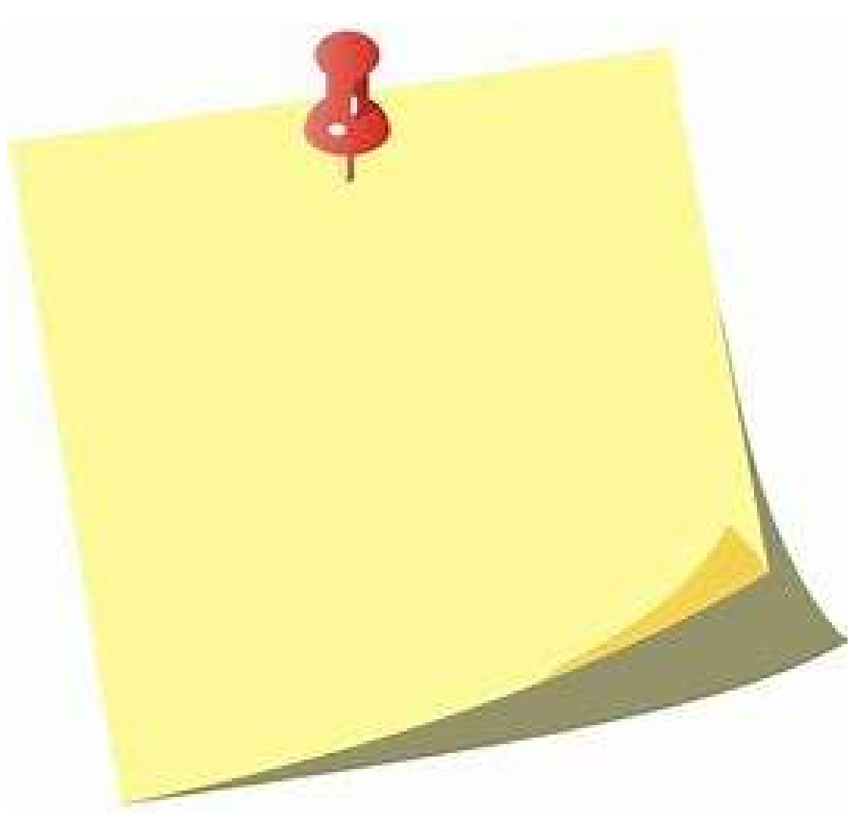
CULTURALLY INFORMED WORK: FOSTERING ENGAGEMENT AND RESILIENCE IN TREATMENT

Dr. Tyffani Monford

FLOW

- Our understandings
- Difficulty in addressing culture and definitions
- Impact of race and culture
- How shows up in our work
- Treatment and Assessment implications



NOTE: THE PROBLEM WITH BIPOC

- Assumes that the experiences of Black, Indigenous, and Other People of Color are the same
- Does not fully allow for a discussion of the unique needs and experiences within mental health systems for these communities
- Contributes to the language of "othering" of BIPOC communities while non-BIPOC people are viewed as the norm

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FIRST-PERSON LANGUAGE

Reminder to focus on the humanity of the individual—regardless of the reason they are being seen

In cases of those who are justice-involved, they are "more than the worst thing they have ever done"

OUR AGREEMENTS

- Treatment works
- Everyone deserves *good* therapy
- There should be a reasoned approach to supervision in cases of those who are justice-involved
- Connections matter-and “Community” & “Culture:” foster strong ones
- Access to things/resources that are culturally relevant can provide additional motivation

OUR UNDERSTANDING

- There is often a stigma around mental health
- For those who are justice-involved, there is often pressure to focus on punishment vs treatment
- For children/adolescents, family/community are highly influential in treatment engagement/success

YET…WHEN ADDRESSING SEXUAL HARM

- We ignore that “kid” can be different from another kid based upon their identities
- Holistic must include representation
- Family views of systems, treatment, sexual harm, and “family” can be impacted by culture
- Not checking our privileges and biases in working with COC
  - Beyond privilege and bias there is also the power we hold in their lives
- Does “evidence-based” include our clients?
- Accepting that our practices can cause harm when we do not know, accept, or implement this understanding

WHY THIS MATTERS TO ME

- I am
  - A believer that people can change
  - I advocate for *good* therapy
  - One who values this work
  - Black
  - A psychologist who believes in doing the best work
  - A person who recognizes that culture matters/informs everyone's lived experiences
  - An everyday observer of covert bias and overt racism
  - A practitioner who knows we must do this work together
  - A person who experiences Black joy

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RECOGNITION

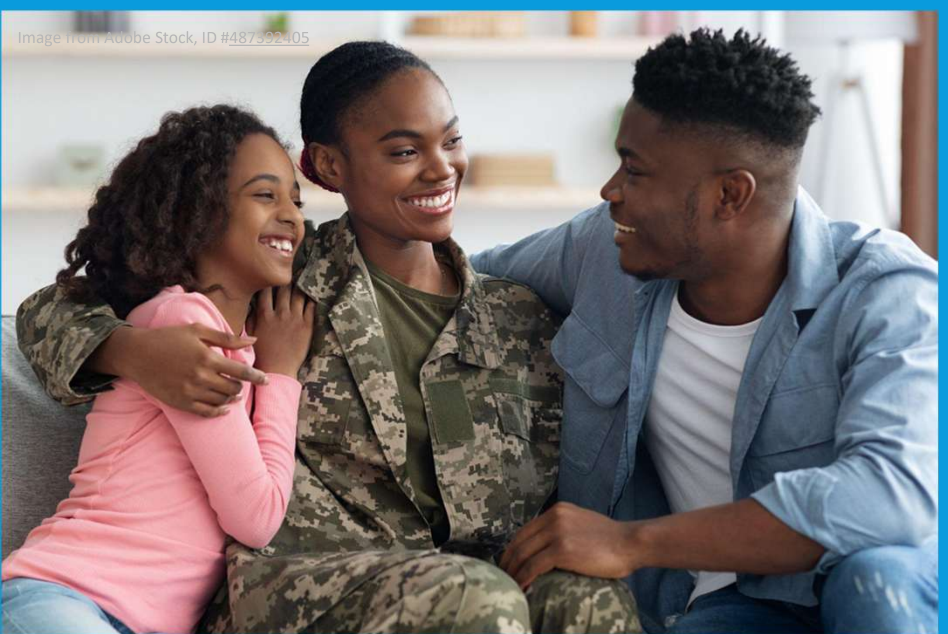
- **Children and their caregivers come to us via systems.**
- Within juvenile justice/child welfare, there is an expectation that caregivers will engage in services.
- Different communities' engagements with and beliefs about those systems are culturally informed.
- Culture is community – and oftentimes culture is encompassed in racial/ethnic identity
- The therapeutic relationship matters – and feeling as if one's culture is understood and treatment is designed with them in mind – is a part of building that alliance.

WHAT IS CULTURE?

- A group's shared set of beliefs, norms, and values (Office of the Surgeon General et al., 2001).
- Components of culture (Medium, 2020)
  - Learned
  - Shared
  - Symbolic
  - Integrated
  - Adaptive
  - Dynamic

CULTURAL FRAMEWORKS

- Racial/Ethnic culture
- Religious culture
- Name Others



CULTURE INFORMS

- What is acceptable behavior
- What is valued
- Who is valued
- Willingness and ways engage with systems
- Beliefs
- Access
- Options (living, resources, etc.)

LET'S TALK

What are some of the beliefs, values from your own culture?

RACE/CULTURE MATTERS: WHETHER WE ACKNOWLEDGE IT OR NOT

LET'S TALK

What have been the challenges in addressing culture within your systems?

YET…WE STRUGGLE TO ACKNOWLEDGE IT

- Think acknowledging it is somehow bad ("I don't see color")
- Believe that doing so means that we are not looking at the individual
- Anticipate feeling guilt, shame, and worse if we look at it
- Fear in the "you always make it about race" label
- Anticipate having to re-examine every aspect of our work if we do acknowledge it
- Anticipate strong push back from our colleagues if we talk about it
- Anticipate feeling less effective at our work if we acknowledge it

ADDRESSING RACE/ETHNICITY IN OUR WORK SHOULD NOT BE VIEWED AS POLITICAL

- We have come to understand that work we do with female clients cannot simply mirror what we do with male clients
- We are open to identifying how faith can play a role in treatment depending upon the client
- APA & American Psychiatric Association have identified the failures within its system related to the way it addressed COC as well as the ways it did not
- Yet, even doing this work without RPP is deemed political—daily we can't avoid based upon "political" conversation in either area

EQUALITY, EQUITY, & JUSTICE

- Equality-programming the same for everyone
- Equity-programming meets needs of the individual
- Justice-programming addresses and eliminates barriers to engagement needed by the adolescent

LET'S TALK

Does your organization engage in equality, equity, or justice in its work with adolescents who cause sexual harm? How do you know?

TRULY INDIVIDUALIZED TREATMENT IS EQUITY

- Not providing the same thing to everyone, but instead providing everyone what they actually need
- Culture influences their experiences, what matters, access to services, etc.
- Cultural considerations is a part of equity

CULTURAL FRAMEWORKS

- Regional Culture
- Subcultures within Culture (intersectionality)
- Racial/Ethnic Culture
- Religious Culture

LET'S TALK

What are some ways that you see cultural belonging impact service access?

How have the systems in which you operate addressed cultural issues in client needs/presentation/recommendations?

INTERSECTIONALITY

- Coined by Dr. Kimberle Crenshaw in 1989
  - (37 years ago! – This is not new!)
- Oppressive institutions/oppressions and/or privileges and their interconnectedness ---inform how we experience the world and how the world engages with us
- 1+1=3
- A major implication is not to assume that your experience is like others'.
  - "I know what you mean" may be the worst response

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IDENTITIES IMPACT

- Our mental health
- How we see mental health
- Willingness to engage in mental health services
- Access to appropriate, culturally-informed services
- How our behavior is viewed by systems/consequences
- Reasons for our behaviors

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WHEN WE ADDRESS CULTURE/RACE IN TREATMENT

We acknowledge that identities matter

We are open to treatment "looking different" based upon what we know/learn

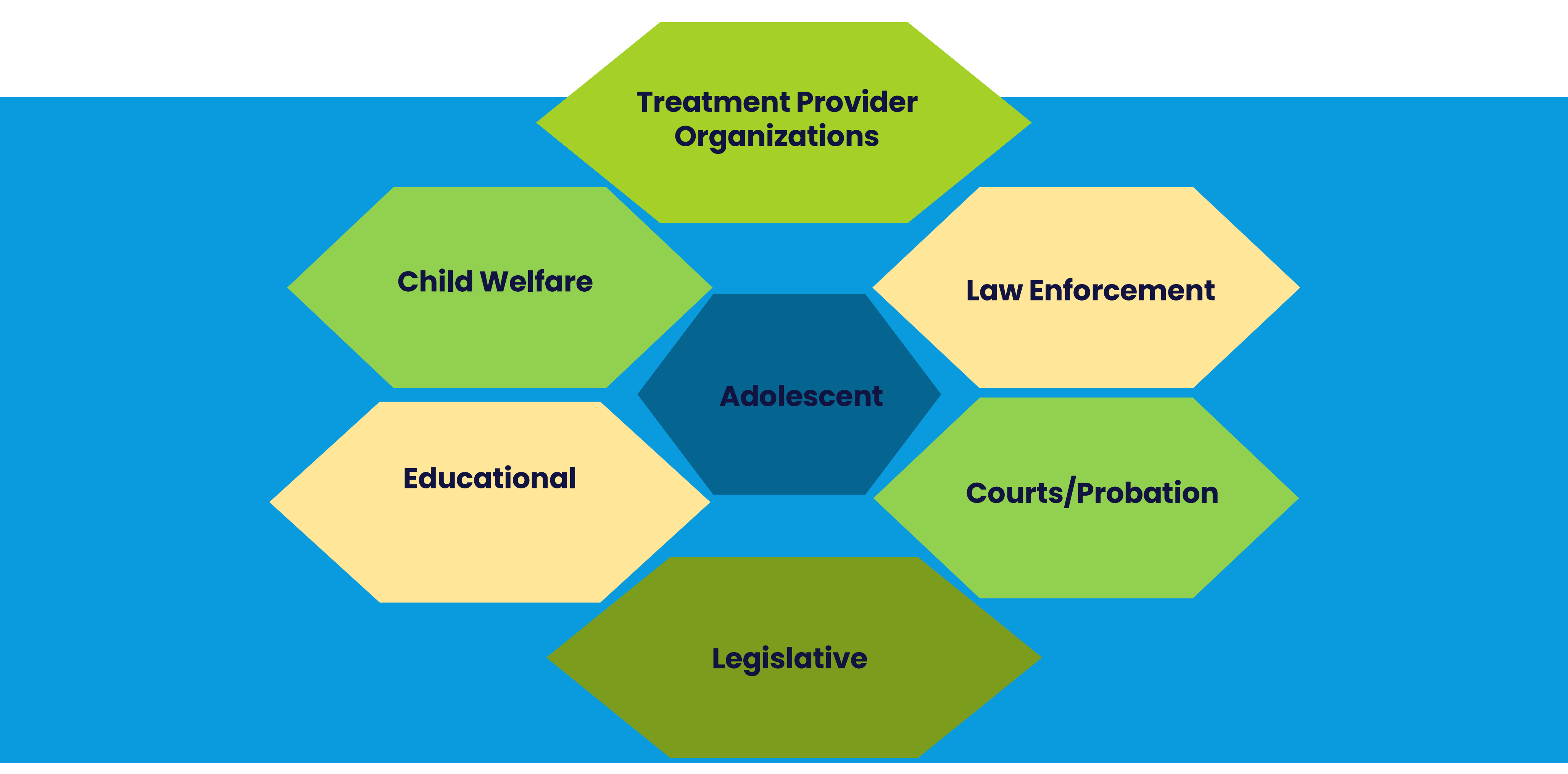
Our views can be influenced by biases

We can do harm---even unintentionally

CULTURE/RACE/PRIVILEGE SHOW UP

- In our Systems
- In how our clients present/their concerns
- In how we treat/assess/supervise

In Our Systems



Ways in which Race shows up/impacts

REGARDLESS OF HOW THEY GET TO US---RACE IMPACTS

Impacts where they are placed/seen

Annie E. Casey Foundation (2021)
Sickmund et all (2022)

CUSTODY STATUS

Black youth 16x more likely to be in custody than white counterparts

Asian/PI 4x likely

Hispanic 3x more likely.

RESIDENTIAL

Over 54% White

25% Black

15.8% Hispanic

1.8% Native

.7% Asian

PUNISHMENT VS TREATMENT

Whites viewed Black youth as committing larger proportion of crimes than they actually committed

More likely to be transferred from juvenile court to adult court for same crimes

Jurors/police perceive Back youth as older and more mature than white youth

BIPOC AWCSH were in the correctional facility for a significantly longer period of time, although no difference between these groups in severity of behavior (Burton & Meezan, 2004; Burton et al., 2011)

EVEN IMPACT ON OUR TOOLS RELATED TO POLICE CONTACT

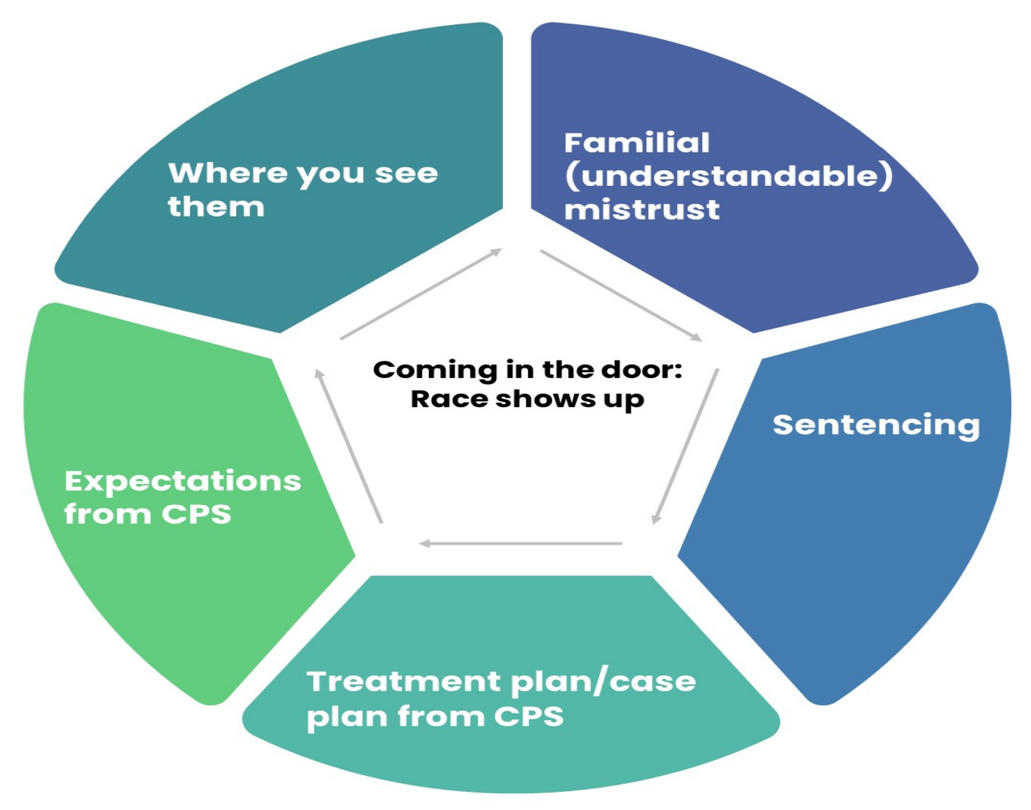
- “race-neutral” on face, target
  - Low Income
  - People of Color

TERMS USED

- Probation officers were prone to explaining Black youths’ offenses by their individual or dispositional traits but explained White youths’ offenses using external attributes, such as environmental characteristics. Thus, Black youth were seen as more dangerous, culpable, and less amenable to treatment than White youth (Bridges & Steen, 1998)

CHILD WELFARE

- Lower threshold for neglect for Black families (Ards et al., 2012)
- Over-reporting of alleged abuse/neglect for Black parents, underreport for White parents (Putnam-Hornstein et al., 2013)
- Racial disproportionality identified within Child Welfare , poorer overall outcomes (Example Black kids 14% of pop, 23% in foster care)
- Trauma associated with removal (Mitchell & Kuczynski, 2010; Sankaran et al.,2019)


Where you see them
Familial (understandable) mistrust
Coming in the door: Race shows up
Sentencing
Expectations from CPS
Treatment plan/case plan from CPS

STIGMA

Mental health related stigma is consistently identified as a deterrent to help-seeking (Fripp & Carlson, 2017)

And in COC

- “Crazy”
- “Sharing our business”
- “Faith is all we need”
- Others?

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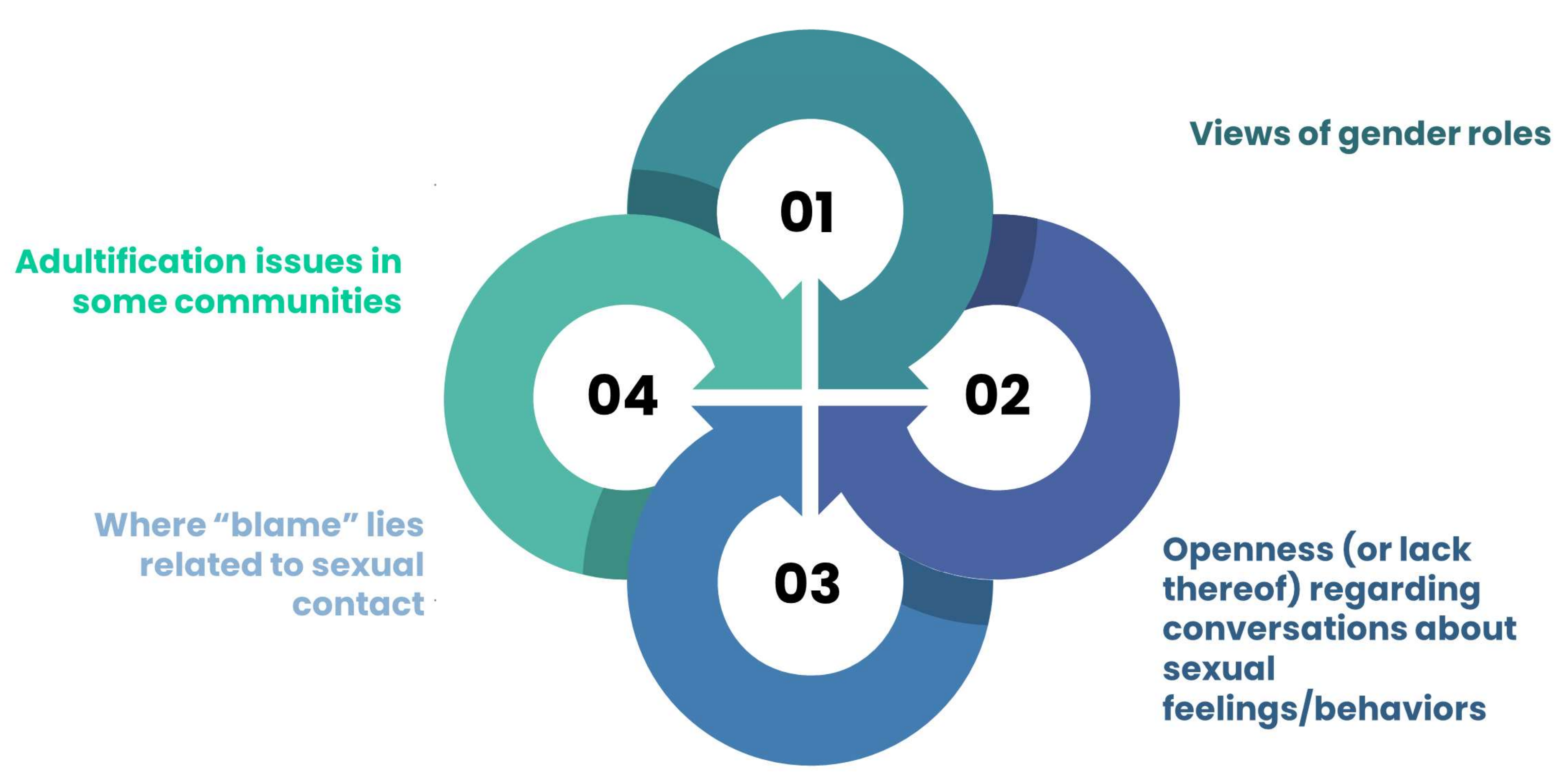
CURRENT SOCIETAL ISSUES

- Poverty
- Over-policing
- Child welfare engagement
- Immigration status—of ourselves & those we care about
- Negative stereotypes
- Return to normalizing systemic racism
- Failing to acknowledge systemic racism's impact
- Disproportionate COVID impact as the "Perfect Storm" of the oppressions

MENTAL HEALTH

- BIPOC youth are disproportionately at higher risk for poor mental health outcomes compared to their White peers (Alegría & Green, 2015).
- Persistent feelings of sadness and hopelessness have increased across all ethnic and racial groups over the past 10 years and are highest among nonwhite and non-Asian youth. American Indian and Alaska Native youth report the highest levels of poor mental health and the highest rates of suicidal ideation and attempts compared to peers in other racial and ethnic categories (Mpofu et al., 2021).
- Lack of access to culturally appropriate mental healthcare. Barriers to mental healthcare access also include negative experiences with systems of care, institutional mistrust, and lack of access to evidence-based care

Sexual Themes That May Impact



UPBRINGING

Exposure to intimacy/relationship interactions between adults and older others

Messages received from media (tv, music, social media)

“Locker room talk”, “Barber shop conversations”

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- Gender roles defined by community
- Who holds responsibility for sexual contact
- "Protecting" of community secrets and those who cause harm

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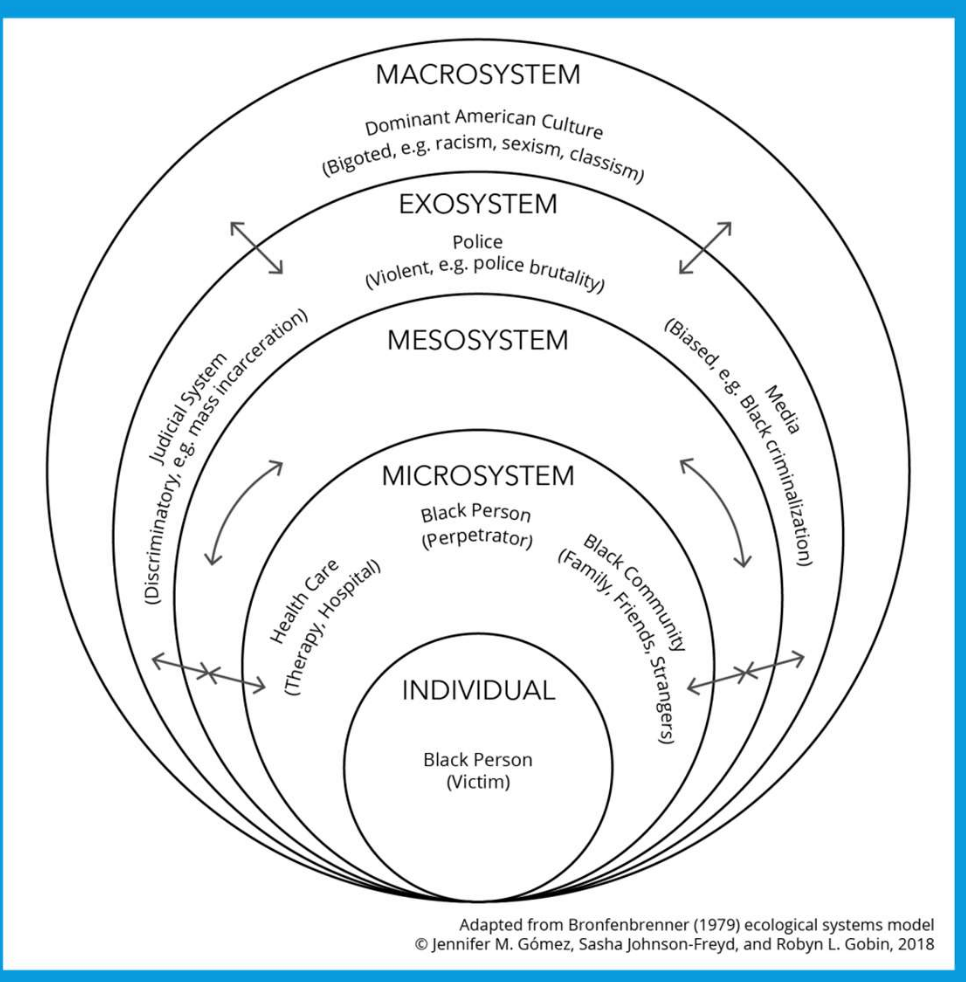
"SAVE OUR SONS, SACRIFICE OUR DAUGHTERS"

CURRENT-CULTURAL BETRAYAL TRAUMA THEORY



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WE ARE BEGINNING TO ACKNOWLEDGE THE DISSERVICE, BUT ARE WE FIXING IT?

ISSUES

- Still use assessment measures that pathologize COC
- Hiding behind “evidence-based” and “individualized”
- Those making decisions do not acknowledge biases/privileges
- Dearth of culturally humble service providers
- Normative defined from Heteronormative Eurocentric perspective (who is family, values/beliefs)
- Mis-framing familial responses

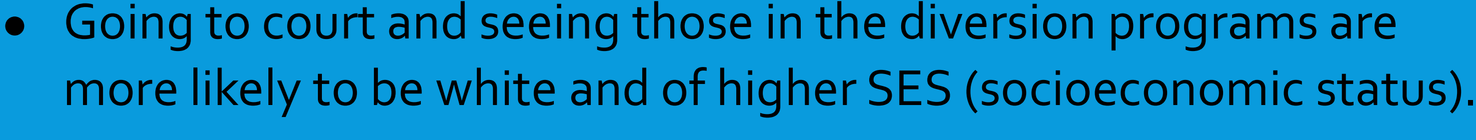
IN OUR CLIENTS & THEIR FAMILIES

AS WE TELL OUR CLIENTS (THEY SHOW UP…REGARDLESS)

- Ignoring signs does not make it not true
- Beliefs matter
- Relationships matter
- Perceptions matter

HOW DIVERSITY IMPACTS TREATMENT

- Signs
- Beliefs
- Relationships
- Others?



- Going to court and seeing those in the diversion programs are more likely to be white and of higher SES (socioeconomic status).
- Working in detention centers and seeing higher rates of incarceration for Black and Brown youth, for the same offenses as those you see who are whiter and wealthier in the community.
  - But bringing this up can result in harsh responses from colleagues and administrators.
- How our world has demonstrated this phenomena in other "crises"—
  - Opioid = rehabilitation

    versus
  - Crack-incarceration

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BELIEFS

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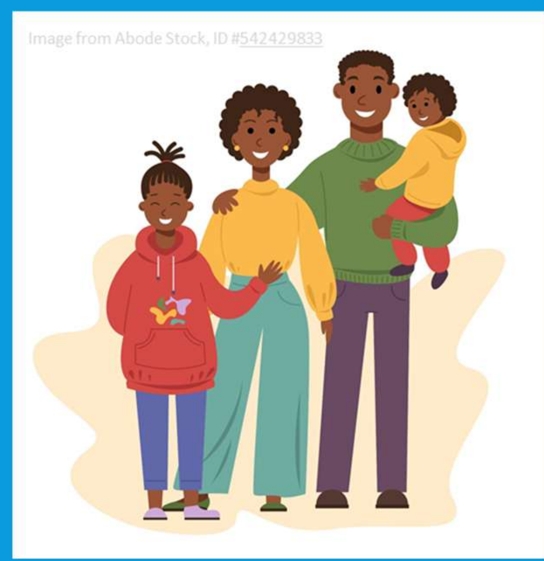
- How Communities of Color (CoC) view mental health
- How CoC view "systems"
- How CoC view disclosure
- How CoC view incarceration
- How CoC define healthy sexuality

RELATIONSHIPS

- Who is deemed family?
- Who is viewed as community?
- Where loyalties lie
- Where reconciliation and reunification will need to occur



PERCEPTIONS

- **Society viewing historically excluded groups as a "group" versus as individuals when mistakes are made**
- **Framing of CoC as "dangerous" and even younger children as "adults" who do not deserve grace, forgiveness, or trust**
- **Some communities have internalized negative beliefs about themselves**
- **Possible pathologizing of healthy sexual behavior because it is not cis-heteronormative**
- **Views on authority, compliance, disclosure**
- **Whether or not vulnerability is allowable**

IN US

KEEPS US FROM LISTENING TO BIPOC CO-WORKERS AND PATIENTS

Insist that we know "all clients and treat them as individuals"

Feel judged when challenged

View evidence-based as the only intervention requirement vs whether the sample includes BIPOC

Performative vs truly impactful services/outreach

OUR FAILURE TO SEE OUR PRIVILEGES (AND THOSE FOR CISGENDERED, HETEROSEXUAL, MIDDLE CLASS, WHITE FOLKS) CAN CAUSE HARM

- We come from a heteronormative framework
- We use resources that center heterosexuality
- The research that informs our work do not fully include BIPOC and LGBTQIA+ clients
- Our expectations for supervision and engagement (our hours of operation, the time court hearings are scheduled, fines, limited options for places to live unless you are rural or have money to move)
- Many of the treatment resources and assessments are normed on groups that do not look like them
- As we've seen throughout history, misunderstanding can smolder for centuries

WE DO NOT DO THE WORK

- “Hide behind” manuals
- What we “know” matters more than what we need to know
- Discussion of racial impact are deemed “political” vs sound clinical practice
- “Cultural competence” pursuit
- Ignore our privileges and worldview impact
- How “being the system” can impede engagement
  - We need to be clear and honest with ourselves and others how we fit into their lives

OTHER PRIVILEGE FAILURES

- By nature of our roles, our clients must "listen" to us—even if we get it wrong
- Pushing for individualization from within a research-based framework that does not include them
- Not "explaining" how our measures may be impacted by our clients' options/experiences in the world

LACK OF CULTURALLY INFORMED PROVIDERS

Insist on "evidence-based" even if limited evidence of use with COC

Not incorporating cultural healing practices

Minimize/dismiss role of client's identity intersections in mental health presentation, goals, and lived experiences

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HOW WE FRAME LACK OF ENGAGEMENT

Tom & Family

- Struggling to engage
- Parents having a hard time acknowledging what he has done
- Weary of court hearings

Michael & Family

- Resistant
- Parents are in denial
- Seem to blame the system

FAILURE TO HONOR INTERSECTIONALITY

- Ignore "Living While BIPOC"
- Dismiss historical/transgenerational trauma
- Minimize significance of system perceptions of Black children/families
- Utilize assessment and treatment resources not designed with them in mind
- Cultural competency emphasized instead of Cultural Humility
- Ignoring systemic inequities that may play a role in psychological distress

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THE “EVIDENCE” FOR “EVIDENCE-BASED WORK”

- Questioning the sample
- Biases within measures without explaining them in our own work/reports
- Culturally-informed resources
- Resources for the intersections (gender-identity, sexual orientation, race, ethnicity?)
- We are often unable to sort through conflicting evidence or place it in context
- Bias: “Our sample included a number of people from minorities; therefore our research applies to minorities”

TREATMENT IMPLICATIONS WHEN WE CONSIDER CULTURE

- Clinical assessment cognizant of cultural biases
- Family engagement
- Mistrust of you as the system
- Discussion of sexualized behavior
- Language/linguistic needs
- Representation in resources used

ASSESSMENT

Do assessment tools pathologize family dynamics or the community (e.g. over-surveilling, how child welfare involvement framed)

Do your assessment questions include your own biases/assumptions? Are you asking for clarification? Are your questions framed by negative stereotypes of the community?

Are you failing to ask questions about potentially harmful practices because you do not want to be viewed as not being culturally sensitive?

Do the collaterals include those deemed as familial to the child?

FAMILY ENGAGEMENT

- Who is being defined as family?
- How is the other child(ren) harmed defined in terms of familial or nonfamilial relationships
- How are you framing familial lack of engagement (if applicable)

SYSTEMS

- You are part of the system---how are you acknowledging this?
- Importance of not minimizing or dismissing familial view of systems (historical and present context)

EMPIRICALLY SUPPORTED TREATMENT

- How do you revise/adjust evidence-based curricula/interventions in ways that meet the needs of different communities?
  - Identify cultural values regarding family, healthy sexual behavior, boundaries, disclosure, communication and how they can inform therapy and supervision
  - Identify and use language/sayings (when appropriate and not mimicking) that the community uses as a part of treatment
  - Again, acknowledge views of systems, talking outside of community, etc. and how that impacts treatment engagement and future expectations of reporting

COMBINING EBT AND CULTURALLY RESPONSIVE PRACTICES

- Evidence-based treatments focus on the importance of implementation fidelity and efficacy of contextual aspects to mental health care
- Culturally responsive mental health treatments fit clients’ and practitioners’ cultural background, including age, cultural values, gender, language, race, and sexual orientation (Cabassa & Baumann, 2013).
  - Understand own biases
  - Aware of values/beliefs of clients

SEX

- What are the cultural norms regarding discussion of sexual behaviors?
- What are gender role and sexual messages society has about the culture of the child? How is this discussed with child and parent in developmentally-appropriate ways?
- Issues of adultification and how may minimize or over-blame Black girls with sexual behavior problems
- Differences in start of puberty within cultures and how education included in treatment

LANGUAGE

- Are resources in the languages of families served?
- Going beyond simple translation but included cultural stories/nuances within resources used

CULTURAL & INTERSECTIONALITY IMPACTS ON TREATMENT NEEDS/EQUITY

INTERSECTIONS

- John is a 15-year-old Black male who is referred for depression. He is often irritable and threatens self-harm
- How might "adding" these impact your questions, interventions, understanding of John?
  - John is a Black male
  - John is a Black gay male who has not come out to his family
  - John is a Black gay male who has not come out to his family and identifies as Missionary Baptist

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INTERSECTIONS

- Ilaria is a 16-year-old girl referred to you after being sexually assaulted
- How might "adding" these impact your questions, interventions, understanding of Ilaria?
  - Ilaria is Afro-Latinx
  - Ilaria is a trans girl
  - Ilaria parents do not speak English well

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RESOURCES/IMAGES USED SHOULD REFLECT OUR CHILDREN

REPRESENTATION MATTERS

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CULTURAL EMPHASIS: SEXUAL-HARM SPECIFIC

- Identifying other ways survivor may want justice and incorporate in consequences for the offending student
- Restorative justice practices may not be offered as an option
- Need to acknowledge concerns about disproportionate punishment
  - Acknowledgement of system unfairness while also acknowledging harm done
  - Decrease push for carceral accountability may be viewed as minimizing harm caused—how to address this?
- Restorative justice practices do "pull" on African principles/practice (Ubuntu)-Schoeman (2013) and how can incorporate in treatment
  - Seeing humanity in the victim
  - Recognizing harm to victim, self, and the community

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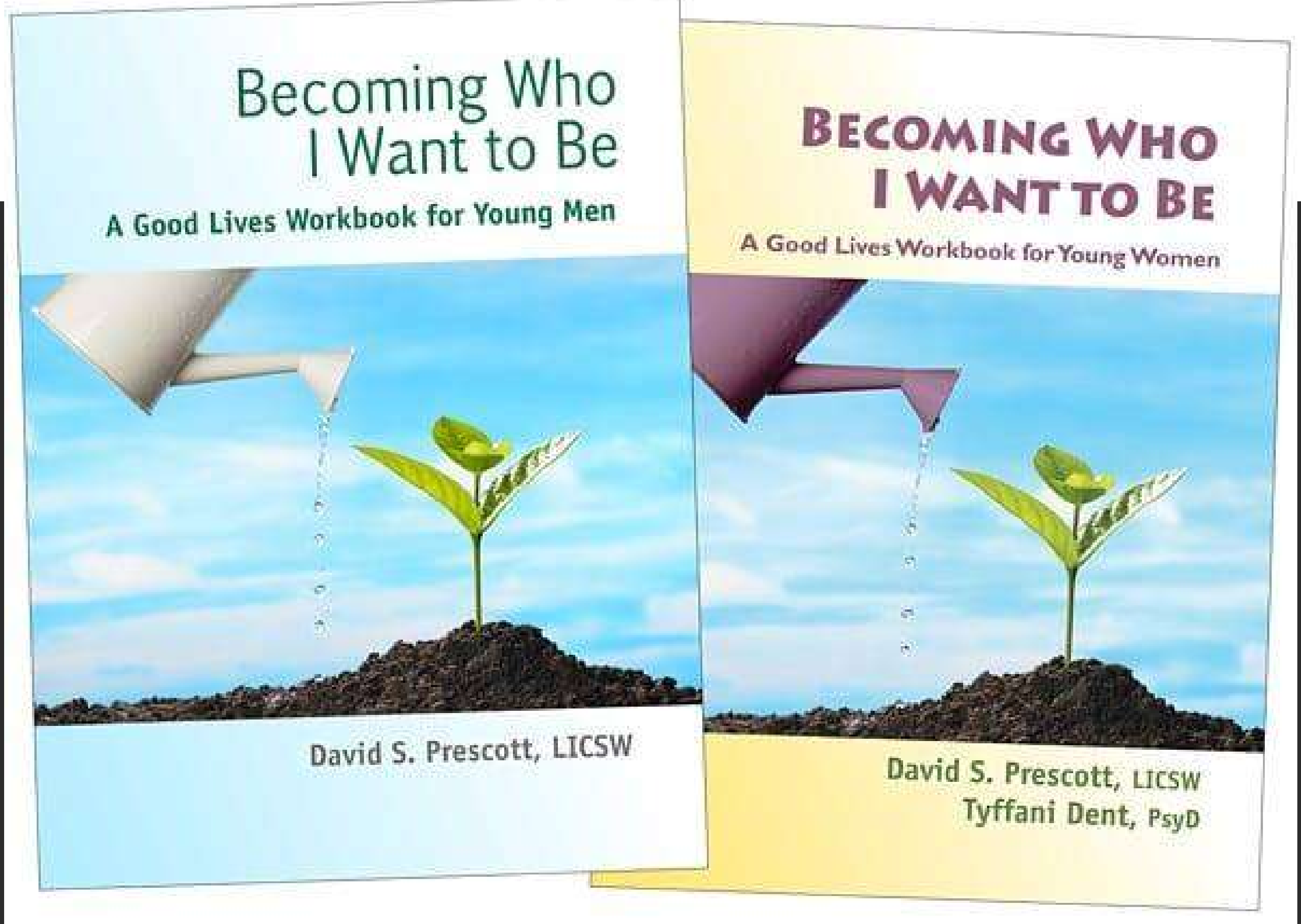

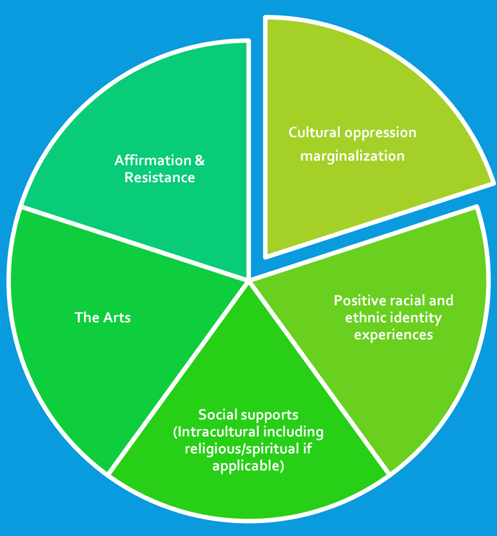

MUST INCORPORATE THEIR UNIQUE EXPERIENCES

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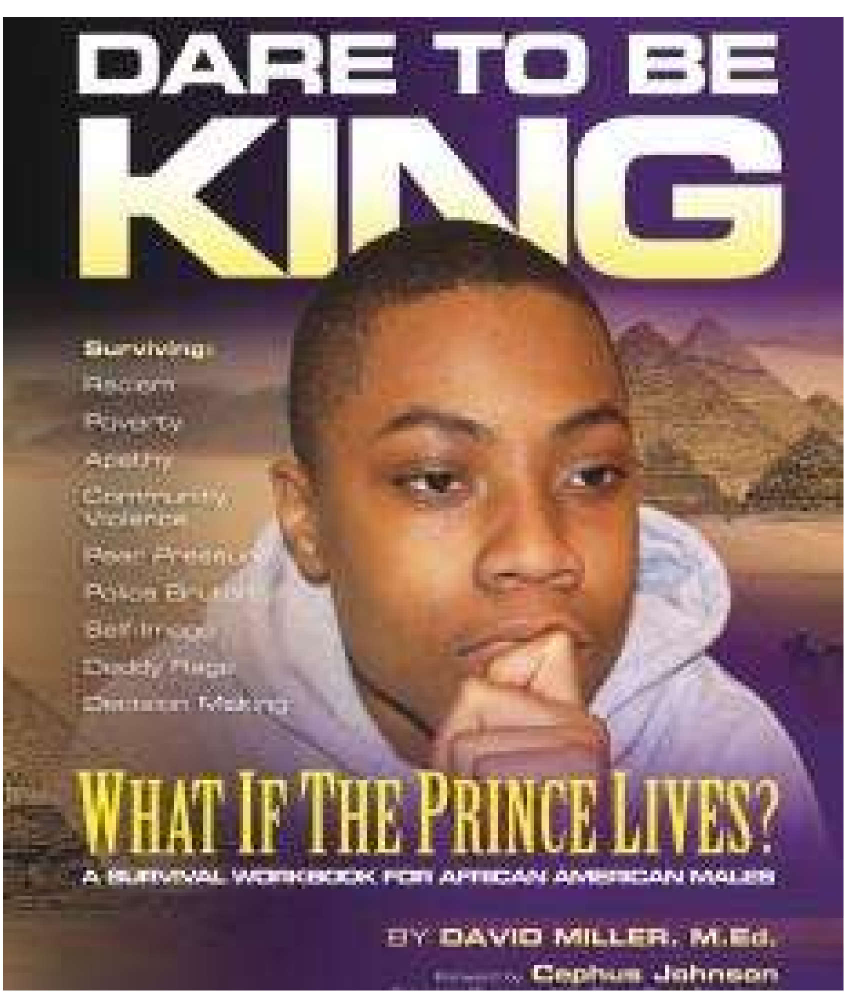

POSITIVE RACIAL IDENTITY

- Incorporate culturally-specific themes, resources, lived experiences
- Address & Acknowledge negative messages about their identity they have received
- Acknowledge (not defend) even how your system/systems responded

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SOCIAL SUPPORTS

- Incorporate them in decision-making and as a part of the treatment team
- Acknowledge reluctance and identify ways to minimize
- Not "Meaning Making" of their experience, but coping strategy for their experience & ongoing challenges they may face within it
- Culturally-specific referrals when appropriate

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THE ARTS

- Music, drumming circles
- Creative Writing

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AFFIRMATION & RESISTANCE

- Resilience+Resistance
- Empowering to engage in social change (when ready)
- Supports & what can do to improve their own community

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COLLABORATIVE

- Identify within communities alternatives to your usual programs that still meet protective factor goals

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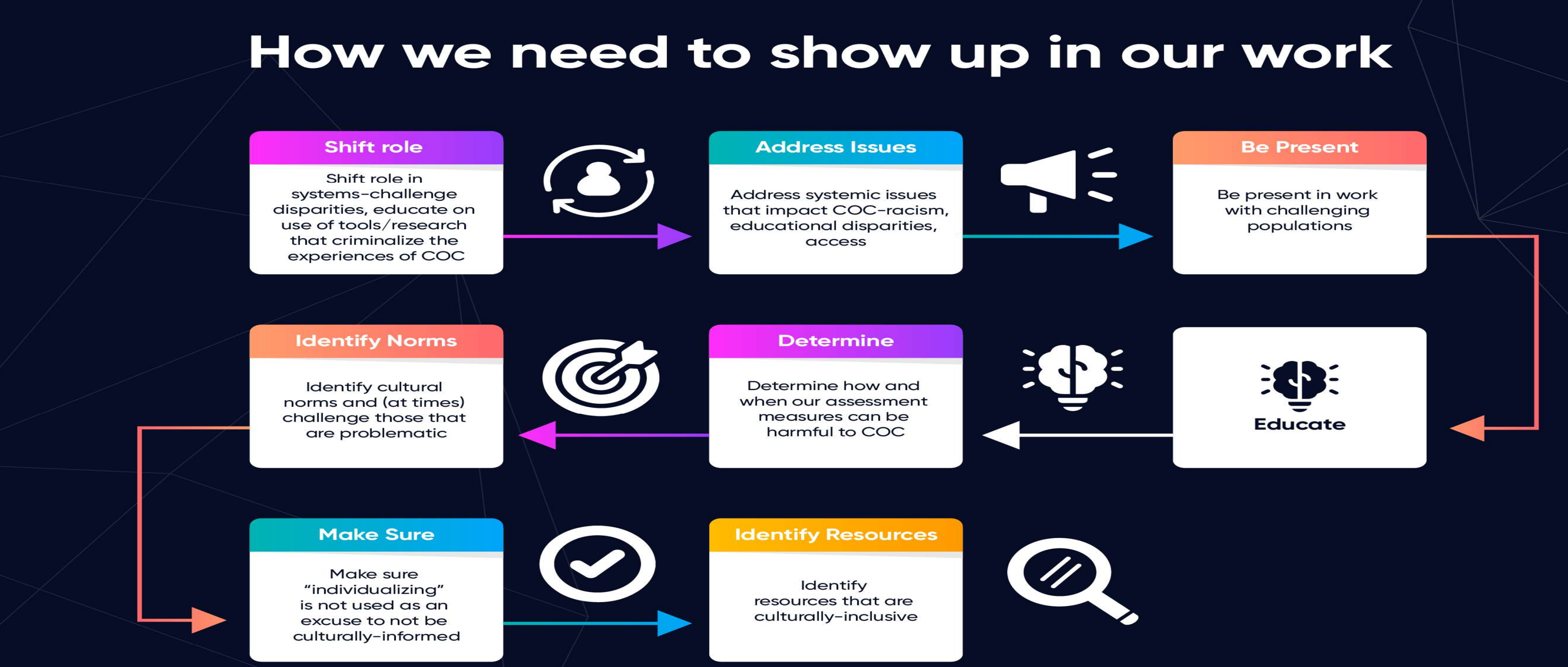
REMINDERS



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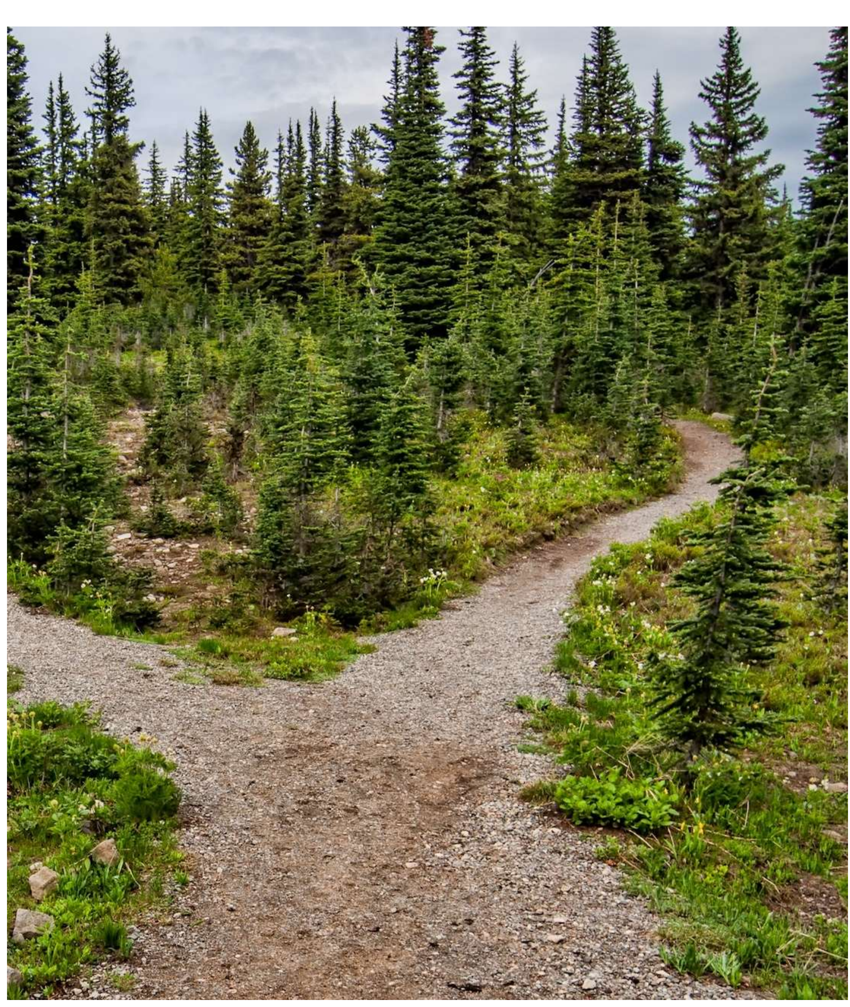

WHERE DO WE GO FROM HERE?

- More research that intentionally includes historically excluded communities
- Examination and development of treatment resources that are culturally-informed
- Assessment tools (national and state) that are checked for biases against certain communities---are certain groups showing up "higher"?
- Educating ourselves
- Creating "safe" spaces for talking about it, even as we have to be willing to feel unsafe about talking about it.—how we define "safety" may be unsafe for those who need it the most
- Diversifying our field—going outside of our normal "mentoring circle" to identify those who are reflective of the communities we serve

ADDITIONAL AGREEMENTS

Our clients are impacted by their intersections

Good work means seeing and treating the full client at their intersections

Great work is seeing how far we have come while working to go further

Think
Own
Learn
Listen

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