UTILIZING CULTURAL HUMILITY-BASED TRAINING FOR ASSESSING RACIAL TRAUMA SYMPTOMS IN AFRICAN AMERICANS

by

Jay Robinson

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As members of the DNP Project Committee, we certify that we have read the DNP project prepared by Jay Robinson, titled Utilizing Cultural Humility-Based Training for Assessing Racial Trauma Symptoms in African Americans, and recommend that it be accepted as fulfilling the DNP project requirement for the Degree of Doctor of Nursing Practice.

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Final approval and acceptance of this DNP project is contingent upon the candidate's submission of the final copies of the DNP project to the Graduate College.

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ABSTRACT

Purpose. This DNP project evaluated impact of culturally humility-based training intervention on motivation, knowledge, and confidence of mental health providers (MHP), delivering patient-centered culturally sensitive (PCCS) care for African Americans with racial trauma.

Background. Addressed significance of assessing for racial trauma symptoms in African American patients within mental health care, with particular emphasis on Trauma Symptoms of Discrimination Scale (TSDS). Existing literature underscores significance of cultural competence and sensitivity in providing effective care to diverse populations. Racial trauma, linked to experiences of discrimination, identified as imperative concern affecting mental health outcomes in African Americans. Gap in provider training regarding racial trauma recognition and management necessitates targeted interventions. Interventions built upon foundation of cultural humility, aimed to enhance PCCS care through structured training programs focused on assessing and addressing racial trauma symptoms in African Americans. utilizing tools: Trauma Symptoms of Discrimination Scale (TSDS).

Methods. Project employed quasi-experimental design assessing effectiveness of cultural humility-based training in enhancing MHP abilities to recognize and manage racial trauma symptoms in African American patients. Asynchronous online training presentation included clinical scenario simulation, and utilized pre- and post-training surveys for quantitative data collection. Statistical analyses (paired-sample t-tests), evaluated shifts in motivation, knowledge, and confidence. Intervention followed Plan-Do-Study-Act (PDSA) model, ensuring iterative refinement based on participant feedback. Data was securely collected and analyzed using Qualtrics and Microsoft Excel.

Results. Three participants completed pre-/post-intervention surveys. Following educational intervention, project data demonstrated consistent knowledge base among participants after cultural humility-based training intervention. Notable positive shifts were observed in provider confidence and motivation. Two out of three participants showed improved confidence scores, with one participant experiencing four-point increase and another a two-point increase. Motivation scores increased for two participants, one by two points and another by one point. Out of nine pre-/post-survey questions, none demonstrated statistical significance which suggests findings may be due to chance.

Conclusions. DNP project highlighted potential of cultural humility-based training to positively impact MHP confidence and motivation in delivering patient-centered, culturally sensitive care for African Americans with racial trauma. Findings underscore need for ongoing education, tailored interventions addressing racial trauma recognition, and management in mental health settings.

INTRODUCTION

Addressing the social determinants of health, such as stigma and racism, is imperative for achieving equity in healthcare. The prevalence of racial trauma and its physical and psychological consequences stemming from experiences of racial bias, discrimination, and hate crimes are critical issues within the healthcare domain. Racial discrimination (RD), a pivotal element of this trauma, has profound implications for the mental well-being of African Americans, including the development of post-traumatic stress disorder (PTSD) (Bird et al., 2021; Centers for Disease Control & Prevention [CDC], 2022).

A comprehensive understanding of the correlation between discrimination and PTSD symptoms can facilitate the identification of populations at risk, the formulation of interventions to foster resilience, and the enhancement of overall health outcomes (Wright et al., 2020). The Diagnostic and Statistical Manual of Mental Disorders Fifth Edition Text Revision (DSM-5-TR) provides criteria for diagnosing PTSD based on the type of traumatic event experienced (American Psychiatric Association [APA], 2022). The literature criticizes standard PTSD assessment tools for inadequacy in assessing traumatic stress reactions to RD (Helms et al., 2010). The Trauma Symptoms of Discrimination Scale (TSDS), established to assess trauma symptoms arising from RD, fulfills an unmet need for a culturally sensitive assessment tool to enhance providers' cultural humility and ability to detect traumatic effects of RD on people of color (Williams et al., 2018).

This Doctor of Nursing Practice (DNP) project aimed to fill knowledge and practice gaps by educating mental health providers (MHP) about the TSDS and the importance of practicing cultural humility to facilitate improved mental health outcomes for African Americans. This

project aimed to increase providers' intent to incorporate the TSDS assessment tool and utilize cultural humility as an effective intervention to identify racial trauma. The purpose was to recognize and address the often-overlooked traumatic effects of RD on the mental health of African Americans, potentially leading to better care and mental health outcomes. Against the backdrop of systemic disparities embedded in various sectors, including the criminal justice system, education, and housing, this project sought to address the unique challenges faced by African Americans in the diverse sociodemographic landscape of Arizona (Arizona Department of Education, 2023; Gentry & Cook-Davis, 2021; Olivet & Whitehead, 2021; FWD.us, 2018). The local context underscored the pressing need for a culturally humble approach to mental health care, emphasizing the significance of this intervention in promoting equitable and effective mental health outcomes.

Background Knowledge and Significance

Rates of Racial Discrimination

RD is defined as any distinction, exclusion, restriction, or preference based on ethnicity, skin color, race, or descent, resulting in inequality of human rights and freedoms (United Nations, 1965). RD affects individuals in various social domains including employment, the criminal justice system, education, and health care (Bleich et al., 2019; Edwards et al., 2019; Fekedulegn et al., 2019; Fisher et al., 2000). Most African Americans experience interpersonal discrimination via microaggressions and racial slurs that occur in various social settings (Bleich et al., 2019). Heightened social status does not provide an escape, as shown by middle- and working-class African Americans' equal likelihood of reporting RD (Kessler et al., 1995).

Approximately half of African Americans report experiencing RD (Bird et al., 2021), emphasizing the prevalence of this issue and its impact on a significant part of the population.

The U.S. Department of Justice (DOJ) reports that hate crimes have increased significantly, and 48.4% of hate crimes were perpetrated against African Americans due to anti-Black or African American bias (Federal Bureau of Investigation [FBI], 2019). African Americans are more likely to be pulled over, killed, or detained with excessive force during traffic stops and interactions with police (Brame et al., 2012; Edwards et al., 2019; Gelman et al., 2007; Kramer & Remster, 2018). Among other ethnic groups, African American men have the highest risk of death by police and face a one in 1,000 chance of death by police within their lifetime (Edwards et al., 2019). In the context of increased violent interactions with police, African Americans are five times more likely to worry about facing discriminatory violence from police (Graham et al., 2020). Most African Americans have perceived unfair treatment by the police and RD against them or a family member (Bleich et al., 2019).

The most common claims filed with the Equal Employment Opportunity Commission (EEOC) are allegations of RD, racial harassment, or retaliation due to opposition to RD (EEOC, n.d.). During the 2006 fiscal year, RD accounted for 36% of complaints received by the EEOC (EEOC, n.d.). The alarmingly high number of RD claims by the EEOC supports findings that African Americans report 60% higher rates of discrimination in the workplace (Fekedulegn et al., 2019; EEOC, n.d.). Discrimination may lead to reduced employment of African Americans who are 50% less likely to receive a callback when submitting a job application with a common "Black name" (Bertrand & Mullainathan, 2004). Most African Americans experience RD when

applying for employment and attempting to obtain equal pay or job promotions (Bleich et al., 2019).

African Americans experience institutional racism within the education system and other settings, with half of African American students experiencing distress from racial incidents occurring in school which dramatically decreases academic performance (Fisher et al., 2000). African Americans with a college degree have higher odds of experiencing discrimination during interactions with police and greater exposure to more types of institutional racism in health care, the criminal justice system, employment, and other settings (Bleich et al., 2019).

Physiological Consequences of Discrimination

Prolonged exposure to RD can lead to physiological alterations in cortisol levels and the functioning of the hypothalamic-pituitary-adrenal (HPA) axis, representing modifications in the endocrine and stress-response systems of the body (Berger & Sarnyai, 2015). Allostatic load refers to the cumulative wear and tear on the body over time, due to chronic stress and other physiological dysregulations, reflecting the strain on various physiological systems, especially those involved in the body's response to stress, and is associated with adverse health outcomes (Berger & Sarnyai, 2015). Allostatic load leads to dysregulation of the sympathetic nervous system, increasing blood pressure, heart rate, blood flow, and immune suppression in response to stress (McEwen, 1998; McEwen & Seeman, 1999; Seeman et al., 1997). Weathering, related to the concept of allostatic load, suggests that long-term exposure to social risk factors such as RD induces accelerated health decline of African Americans by approximately 10 years, increasing their risk for mortality, cognitive decline, dementia, hypertension, diabetes mellitus, and coronary heart disease (Forrester et al., 2019; Geronimus et al., 2006; Thorpe et al., 2016). The

literature further supports weathering, demonstrating increased rates of mortality associated with heart disease, cancer, and stroke in African Americans who live in regions with high degrees of racism (Chae et al., 2015).

C-reactive protein (CRP), produced by the body's stress response, plays a significant role in the relationship between experiences of discrimination and physiological dysfunction (Elbasheir et al., 2023). Elevated CRP levels moderate the link between RD and neural activation, providing a potential mechanism for how RD affects immune system activation and neural responses (Elbasheir et al., 2023). Greater lifetime exposure to discrimination is associated with a higher inflammation burden which impacts sleep quality, sustains stress response, and leads to unhealthy coping behaviors that contribute to chronic health issues (Elbasheir et al., 2023; Ong & Williams, 2019).

Stressful encounters with racism elevate systolic and diastolic blood pressure and significantly increase the risk of hypertension in African Americans, predisposing them to cardiovascular disease (Din-Dzietham et al., 2004). RD contributes to maladaptive behaviors used to alleviate stress such as smoking cigarettes, polysubstance use, and binge drinking (Baiden et al., 2023; Guthrie et al., 2002; Metzger et al., 2018). RD has significant adverse consequences on perinatal outcomes including higher rates of preterm and low-birthweight deliveries in African American pregnant women, potentially due to their increased risk for gestational hypertension (Collins et al., 2004; Mustillo et al., 2004). Negative physical health outcomes and greater rates of chronic health conditions result from RD (Dohrenwend, 2000).

Psychological Consequences of Discrimination

Research shows that RD alone contributes to poorer mental health outcomes in African Americans independent of their personality traits and socioeconomic status (Kessler et al., 1995; Mekawi et al., 2021). RD leads to negative psychological effects by way of increased risks for depression, anxiety, and posttraumatic stress (Mekawi et al., 2021). Psychological distress results from the association between RD and internalizing and externalizing symptoms, lower self-concept, and increased hopelessness (Chae et al., 2011; Nyborg & Curry, 2003). Discrimination potentiates an increase in symptoms of subclinical psychosis mediated by elevated levels of depression, anxiety, stress, and utilization of maladaptive coping mechanisms (Lopez et al., 2022; Taylor & Turner, 2002). Experiences of RD function as a source of traumatic stress leading to the development of stress sensitivity, dissociation, depressive symptoms, and increased risk of suicidal ideations and suicide attempts (Oh et al., 2020; Polanco-Roman et al., 2021).

Various forms of RD such as microaggressions, subtle discrimination, neighborhood harassment, discouragement from education, unfair termination from employment, and police abuse increase the likelihood of developing a suicidal plan and attempting suicide (O'Keefe et al., 2015; Oh et al., 2020). Depressive symptoms are persistent and cause sleep disturbances in African Americans for at least eight months following RD (Hart et al., 2019). Higher levels of RD correlate with increased depressive symptoms and increased severity of depressive symptoms when an African American individual experiences more RD than what is usual for them (Lavner et al., 2022; Oh et al., 2020; Taylor & Turner, 2002).

Neurological Changes

RD alters neuroplasticity via chronic activation of the HPA axis, which increases activity in the brain's hippocampus and prefrontal cortex regions involved in emotion regulation and cognitive processing (Okeke et al., 2023; Radley et al., 2011). RD is associated with structural changes to prefrontal white matter tracts and diminished white matter integrity, thus increasing the risk of cardiovascular disease, stroke, dementia, and death (Debette & Markus, 2010; Okeke et al., 2023; Williamson et al., 2018). African Americans with elevated exposure to both RD and depression show lower than normal total brain matter (Meyer et al., 2019). Those exposed to RD have reduced cingulate gray matter thickness and reduced white matter tracts in the corpus callosum, cingulum, and superior longitudinal fasciculus brain regions (Okeke et al., 2023; Fani et al., 2022a; 2022b). Structural brain changes and neuroplasticity may contribute to African Americans' neurological response to trauma-relevant stimuli with heightened activation in the amygdala and thalamus, which controls cognitive processing, emotion regulation, visual attention, threat inhibition, and stress response (Clark et al., 2018; Fani et al., 2021; Okeke et al., 2023). Transitioning from the exploration of neurological changes induced by RD, we now delve into the manifestation of PTSD symptoms and the intricate interplay between altered neuroplasticity and the psychological impact of traumatic experiences.

Post-Traumatic Stress Disorder (PTSD) Symptoms

Current post-traumatic stress disorder (PTSD) diagnostic criteria present trauma symptoms as intrusive memories, distressing dreams, dissociation, psychological distress, physiological reactions to trauma stimuli, avoidance, negative cognitions and mood, hyperarousal, and reactivity (APA, 2022). With its latest edition, the DSM-5-TR discusses the

role of RD on PTSD onset and severity, highlighting the notion that ongoing and cumulative trauma may reduce the predictive validity of a diagnosis of PTSD in some communities (APA, 2022). Despite the DSM-5-TR's failure to include discrimination as a cause for PTSD, African Americans have an increased risk of developing PTSD, face higher rates of exposure to violence, and show an increased likelihood of experiencing intense fear, helplessness, or horror related to a traumatic event (Alegría et al., 2013; APA, 2022; Sibrava et al., 2019). RD elicits a trauma response and PTSD symptoms of hypervigilance, avoidance, memory impairments, concentration difficulties, and self-blame (Bryant-Davis & Ocampo, 2005; Carter et al., 2005; Holmes et al., 2016; Kirkinis et al., 2021; Morris-Prather et al., 1996; Williams et al., 2018).

Standardized Tools to Measure Racial Trauma

Although African Americans have a significant likelihood of developing PTSD, they are less likely to utilize mental health services and more likely to receive inadequate treatment (Graves et al., 2011; Kessler et al., 1995; Norris, 1992; Perilla et al., 2002). African Americans have higher rates of unmet need for psychiatric care related to treatment barriers including health care costs, health insurance, perceived stigma, minimization of need for treatment, low perceived treatment effectiveness, and inaccessibility (Alang, 2019). African Americans fear experiencing discrimination due to a mental health disorder in addition to their inherent daily experiences with RD and have feelings of invisibility within the mental health care system which is comprised of assumptions and expectations surrounding the African American experience (Alang, 2019). There is a call for anti-racism education for MHP and health systems to proactively seek the perspectives of African Americans in need of care (Alang, 2019).

The literature shows a scarcity of validated tools for MHP to utilize when assessing and treating racial trauma leading to narrow mental health screening that overlooks prevalent psychiatric symptoms experienced by minorities exposed to trauma (Lima et al., 1991; Malcoun et al., 2015). Existing PTSD assessment checklists do not include critical sources of racial traumatization, such as interactions with law enforcement or experiences of incarceration (Malcoun et al., 2015). African Americans commonly attend primary care appointments with somatic complaints of PTSD symptoms which are often unrecognized by the clinician as a presentation of PTSD, leading to a failure to diagnose or treat symptoms that have significant negative consequences for the individual (Graves et al., 2011).

The TSDS assesses discriminatory distress for anxiety-related symptoms of racial trauma and has shown predictive validity and high reliability for assessing African Americans' racial trauma symptoms (Maxie-Moreman & Tynes, 2022; Williams et al., 2018). The TSDS is a reliable tool to assess the cumulative effects of RD in African Americans as it relates more to experiences throughout an individual's entire lifetime than merely assessing recent experiences (Williams et al., 2023).

Cultural Humility

As the United States (US) population becomes increasingly diverse, MHP must receive cross-cultural education to effectively address the healthcare needs of diverse communities (Welch, 1998). A patient-centered care approach considers the patient's diverse experiences, perspectives, and lifestyles, corresponding with culturally sensitive care (Saha et al., 2008). Neglecting sociocultural factors can lead to harmful stereotypes and result in biased or discriminatory treatment of patients (Betancourt et al., 1999; Cooper-Patrick et al., 1999;

Morales et al., 1999; Stewart et al., 1999). Most MHPs lack the training or knowledge for diagnosing and treating racial trauma despite common encounters with individuals with experiences of racial trauma (Hemmings & Evans, 2018). Denial and ignorance of racism as a prevalent issue lead to a lack of awareness about critical racial issues and less empathy for African American individuals (Burkard & Knox, 2004; Carter & Murphy, 2017; Nelson et al., 2013). Enhancing knowledge about racism and increasing exposure to African Americans' discrimination experiences aids in the understanding of and alignment with African Americans' perspectives (Carter & Murphy, 2017; Nelson et al., 2013).

Implicit biases are unconscious and automatic attitudes, prejudices, and discriminatory behaviors toward certain groups that affect healthcare providers' attitudes, beliefs, and behaviors toward patients from different cultural backgrounds (Doris et al., 2020; Stubbe, 2020). Implicit bias can act as a barrier in the provision of patient-centered care that respects and responds to individual patient preferences, values, and cultural traditions, resulting in racial disparities in healthcare outcomes (Stubbe, 2020). Overcoming implicit biases requires self-awareness, reflection, and ongoing education and training to promote cultural humility and sensitivity in healthcare providers (Lekas et al., 2020). In this context, cultural humility emerges as a critical approach for healthcare providers to bridge these gaps in understanding and ensure equitable and sensitive care for an increasingly diverse patient population through a lifelong commitment to self-evaluation and self-critique (Stubbe, 2020; Tervalon & Murray-Garcia, 1998).

Local Problem

RD doesn't merely manifest in the form of hate crimes but is deeply ingrained in various aspects of Arizona's society including the criminal justice system, education, and housing

(Arizona Department of Education, 2023; FWD.us, 2018; Gentry & Cook-Davis, 2021; Olivet & Whitehead, 2021). The criminal justice system reflects an alarming disparity as African American residents face higher incarceration rates, longer prison sentences, and increased criminal fees (FWD.us, 2018; Olivet & Whitehead, 2021). The education system demonstrates racial inequities with African American students facing lower academic performance, which may be directly tied to the racial incidents they experience (Arizona Department of Education, 2023; Fisher et al., 2000). Arizona Department of Education's (2023) data on test scores shows that 31% of African American students passed English assessment tests and 22% passed math compared to their White peers' English and math passing rates of 57% and 51%, respectively. The housing sector contributes to homelessness issues, with African Americans in Maricopa County facing homelessness at four times higher rates than their share of the population, and people of color often facing residential segregation and landlord selection bias (Olivet & Whitehead, 2021).

These systemic disparities extend to the healthcare system, where the Bureau of Health Workforce has identified a shortage of mental health professionals in the state of Arizona (KFF, 2023). This shortage is particularly problematic given that Arizona residents experience substantial unmet mental health care needs, with only 9% of these needs being met, in stark contrast to the national average of 27.2% (KFF, 2023). The shortage of MHP and the limited access to mental health care contribute to a grave situation where African Americans in Arizona have disproportionately higher rates of suicide, report more poor mental health days, and experience elevated drug overdose deaths and opioid overdose deaths when compared to their counterparts on a national scale (KFF, 2021; 2023).

Addressing the unique challenges faced by African Americans in Arizona concerning mental health care, considering the local demographics, the cultural climate, and the disparities in healthcare accessibility is necessary to provide culturally humble care to this population (Saha et al., 2008). MHP in Arizona are key stakeholders in addressing this challenge, as they are at the forefront of providing mental health services to the community. This DNP project aims to provide these providers with the tools and knowledge necessary to effectively identify and address racial trauma and PTSD in African American patients. By educating MHP in Arizona about the TSDS and the significance of practicing cultural humility, this DNP project sought to enhance their capacity to deliver culturally sensitive and effective care (Stubbe, 2020). This leads to better mental health outcomes for African Americans, potentially reducing the disparities seen in suicide rates, mental health reporting, and drug-related deaths (KFF, 2021; Stubbe, 2020).

The local challenges faced by African Americans in Arizona, encompassing disparities in the criminal justice system, education, housing, and notably in mental health care accessibility, underscore the critical need for a targeted intervention (Arizona Department of Education, 2023; FWD.us, 2018; Gentry & Cook-Davis, 2021; Olivet & Whitehead, 2021; KFF, 2021). By bridging the gap between these systemic issues and this intervention, which focused on educating MHP employed by Denova Collaborative Health about the TSDS and instilling cultural humility, this project aimed to empower providers to address racial trauma effectively within the unique context of Arizona. This initiative aligned with the local demographic nuances and disparities, offering a tailored approach to enhance mental health outcomes and bridge the gaps in care accessibility and quality.

Intended Improvement

Project Purpose

The Institute of Medicine (IOM) emphasizes the significance of patient-centered care, which entails delivering healthcare that respects and responds to individual patient preferences, requirements, and values, ensuring that patient values are pivotal in all clinical decisions (Institute of Medicine [IOM], 2003). Interventions centered around patient-oriented communication have improved patient compliance, overall patient contentment, and mental health outcomes (Griffin et al., 2004). To provide patient-centered care for diverse populations, it is essential to use a culturally sensitive approach to understanding the patient's experiences and perspectives (Saha et al., 2008).

This Doctor of Nursing Practice (DNP) project provided cultural humility-based training for MHP to aid in assessing racial trauma symptoms in African Americans to identify and promote healing from RD. This project was dedicated to addressing a pressing need in the field of mental health care – specifically, the assessment of racial trauma using the TSDS and the education of MHP on the principles of cultural humility to improve mental health outcomes in this population. Through the utilization of a culturally sensitive assessment tool for identifying racial trauma, this project aimed to empower providers to offer culturally humble, evidence-based, and patient-centered care for African American patients. Societal awareness of racial disparities and trauma is growing, influenced by movements advocating for racial justice and equity such as "Black Lives Matter" (Watson et al., 2020). In this environment, healthcare providers have a responsibility to address racial trauma and be part of a broader solution to societal issues. By addressing critical issues such as limited training in culturally sensitive

assessment tools and concerns about the appropriateness of standardized measures, this project contributed to a more equitable and efficient healthcare system, with significant benefits for patients and healthcare organizations.

Project Question

The question guiding this DNP project was "Does cultural humility-based training for providers on the use of the TSDS to recognize trauma symptoms improve participants' motivation, knowledge, and confidence to provide patient-centered culturally sensitive care in a community mental health clinic?"

Project Objectives

The specific aims of this quality improvement (QI) project were:

- Aim 1: Measure MHP confidence in employing TSDS to assess racial trauma during diagnostic assessments and follow-up treatment sessions.
- Aim 2: Evaluate MHP pre-/post-intervention knowledge on the culturally humble use of TSDS to recognize and treat the target symptoms of racial trauma.
- Aim 3: Assess if a culturally humble racial trauma assessment enhances providers' confidence to effectively communicate with patients regarding the unique challenges of racial trauma using a self-report questionnaire.
- Aim 4: Evaluate the feasibility and perceived value of integrating TSDS into routine clinical practice to assess the progress of racial trauma treatment and enhance the accuracy of clinical assessments.

Theoretical Framework

To improve health outcomes for diverse patients, providers must be open to utilizing cultural humility to provide patient-centered care (Saha et al., 2008). The Patient-Centered Culturally Sensitive Health Care Model (Model) was developed by Carolyn Tucker, Keith Herman, Lisa Ferdinand, Tamika Bailey, Manuel Lopez, Cristina Beato, Diane Adams, and Leslie Cooper in 2007 to address the lack of empirical research on the link between patient-centered and culturally sensitive health care and patient health outcomes using foundational research, literature synthesis, and insights gathered from a diverse patient population (Tucker et al., 2007). Operationalizing culturally sensitive care based on the expectations and preferences of culturally diverse patients was a focal point (Tucker et al., 2007). This patient-centric model aims to elucidate the intricate connections between patient-centered culturally sensitive (PCCS) health care, health-promoting behaviors, and health outcomes (Tucker et al., 2007). The Model was validated as a framework using structural equation modeling procedures to test and refine the model (Tucker et al., 2007; 2011). Multiple standardized assessment instruments were used to measure the constructs depicted in the model, ensuring empirical demonstration of the linkages among low-income racial and ethnic minority patients (Tucker et al., 2007; 2011). Crucially, the Model underscores the vital role of low-income and ethnic minority patients as authorities in defining the elements critical for their satisfaction, treatment adherence, and adoption of healthy lifestyles in healthcare settings (Tucker et al., 2007; 2011). It has been validated within the setting of community-based primary care clinics with predominantly low-income African American and non-Hispanic White American patients (Tucker et al., 2011). The Model promotes culturally sensitive training for providers/staff and emphasizes the role of

patient-provider interpersonal skills, individualized treatment, effective communication, patient satisfaction, patient trust, adherence to treatment, and perception of the provider's cultural sensitivity in impacting patient outcomes (Tucker et al., 2007).

This project established an evidence-based intervention program that promoted cultural humility and educated providers on the culturally sensitive use of the TSDS to assess racial trauma symptoms in African Americans. Figure 1 depicts relationships among all components of the Model: changes to the physical healthcare environment, provider/patient behaviors, patient perceptions of provider cultural sensitivity and interpersonal control, patient satisfaction, treatment adherence, and a health-promoting lifestyle. While changing the current physical healthcare environment is essential to fostering patient comfort and belonging (Tucker et al., 2007), this component was not used to design this intervention and assessment. In addition, changes to patient behaviors, assessment of patient satisfaction, and treatment adherence were not used to design this intervention and assessment. Instead, this project was guided by components related to providers' behaviors around considering patients' cultural differences when delivering care through cultural humility-based training that identifies the preferences of diverse populations (Figure 2).

This DNP project used an adapted version of the theoretical framework (Model A) to guide its intervention, applying concepts that corresponded with the aims of this project to provide cultural humility-based training for MHP and introduce the TSDS, a diagnostic assessment tool with tested validity in African Americans and to assess for racial trauma not captured by current PTSD checklists or the DSM-5-TR (APA, 2022; Williams et al., 2018). The Patient-Centered Culturally Sensitive Health Care Intervention Program in the Model refers to a

training program conducted by an interdisciplinary counseling health psychology research team to promote PCCS health care in community-based primary care clinics (Tucker et al., 2007). Comprising workshops for both healthcare providers and clinic staff as well as culturally diverse patients, the program is dedicated to instilling behaviors and attitudes that foster patient comfort, respect, and cultural understanding (Tucker et al., 2007). Provider behaviors refer to the actions and attitudes displayed by healthcare providers that make patients feel comfortable, respected, and culturally understood (Tucker et al., 2007). These behaviors are part of the PCCS healthcare intervention program, which aims to train providers to engage in behaviors that promote a positive patient-provider relationship (Tucker et al., 2007). The Model suggests that PCCS health care can influence patients' engagement in health-promoting lifestyles (Tucker et al., 2007). Patient health outcomes refer to the overall health status and results of patient care (Tucker et al., 2007). These outcomes can include physical health improvements, adherence to treatment regimens, and overall satisfaction with their healthcare provider (Tucker et al., 2007). The Model proposes that PCCS health care and engagement in health-promoting lifestyles can directly impact patients’ health outcomes and statuses (Tucker et al., 2007).

Figure 1

Patient-Centered Culturally Sensitive Health Care Model (Model)

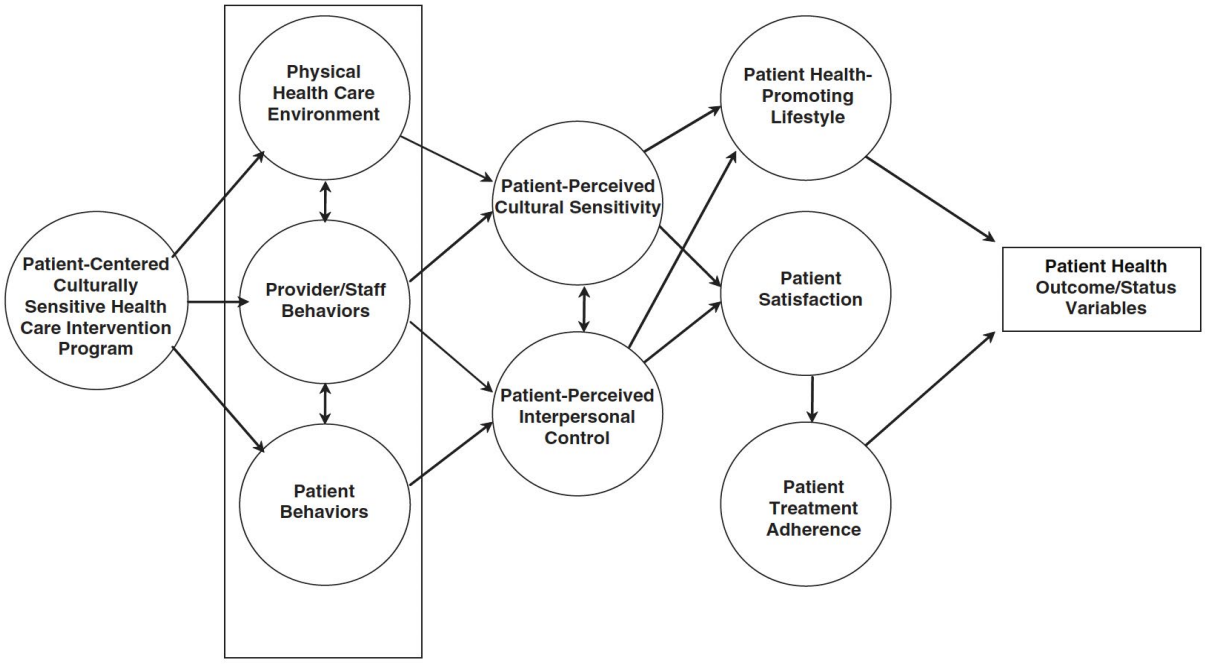


Figure 2

Patient-Centered Culturally Sensitive Health Care Model Adapted (Model A)

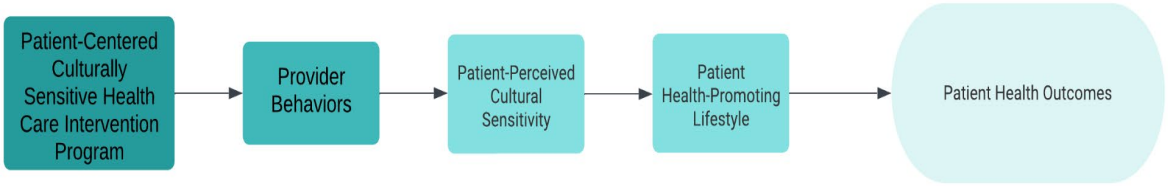


Figure 2 illustrates the focus of this project, which was to influence providers' behaviors by providing training that promotes culturally sensitive behaviors (Tucker et al., 2007). Figure 2 demonstrates the link between provider behaviors, patient perception of providers' cultural sensitivity, patients' health-promoting lifestyle, and patient health outcomes. Patient's perception of cultural sensitivity by their providers increases patient satisfaction, adherence to providers'

treatment recommendations, and health-promoting behaviors and lifestyle (Tucker et al., 2007). Cultural humility-based training can enhance providers' ability to recognize self-bias, take part in effective patient-provider communication, and approach patient care with openness and willingness to understand patients' perspectives, language, and values to promote healthy lifestyle behaviors (Lekas et al., 2020; Stubbe, 2020). Through incorporating the TSDS and cultural humility-based training, providers can identify PTSD symptoms in African American patients and utilize appropriate treatment interventions to improve patient outcomes (Williams et al., 2018).

The significance of employing Model A lies in its intentional design to mitigate cultural humility issues within healthcare interactions, specifically, those occurring between healthcare providers and patients. Models exist that address attitude and behavioral changes in adults and/or organizations (e.g. Lewin's Change Theory, Adult Learning Theory, Social Cognitive Theory, & Trauma-Informed Care models); however, none of these theories or frameworks specifically address cultural considerations in healthcare environments (Bandura, 2001; Burnes, 2004; Knowles, 1978; Substance Abuse and Mental Health Services Administration [SAMHSA], 2023). The power of the Model is that PCCS health models are evidence-based to improve patient perceptions of culturally sensitive care and influence patient health-promoting behaviors, thus improving health outcomes in diverse populations (Dawadi et al., 2022; Tucker et al., 2019; 2022). Multiple studies have demonstrated that patient-centered care models incorporating a cultural competence perspective increase providers' knowledge, awareness, and cultural sensitivity (Renzaho et al., 2013). PCCS programs have outperformed standard healthcare programs, improving health outcomes in African Americans through achieving long-term weight

loss maintenance for obese patients and increasing health literacy and health-promoting behaviors (Tucker et al., 2019; 2022). PCCS care is valuable and relevant to this project's aim to improve health outcomes for African Americans.

Literature Synthesis

The synthesis of literature plays a pivotal role in scrutinizing research evidence within the specific realm of PCCS care, forming a fundamental basis for informed healthcare decision-making (Rycroft-Malone & Bucknall, 2010). In the context of this DNP project aimed at addressing racial trauma and promoting mental health outcomes for African Americans, this literature synthesis systematically examined existing research to unearth pertinent themes and concepts. Within the synthesized literature, models of PCCS care, tailored to diverse populations, systematically integrate the principles of cultural humility and validated assessment tools. In alignment with these insights, the utilization of PCCS models that seamlessly integrate cultural sensitivity emerges as a valuable avenue for fostering practitioners' knowledge, awareness, and sensitivity to cultural differences (Renzaho et al., 2013). This aligned cohesively with the objectives of this DNP project, which sought to enhance mental health outcomes for African Americans by promoting culturally humble care. The resultant data from provider-administered assessments was meticulously evaluated and serves as a crucial element in fostering collaborative clinical decision-making and improving provider-patient communication for effective patient-centered care, aligning precisely with the core objectives of this DNP project (Renzaho et al., 2013). This process of contextualization through literature synthesis stood as an indispensable component of the framework guiding this DNP project.

Evidence Search

A systematic literature search was conducted using electronic journal databases including PubMed and Google Scholar. Search terms included “racial discrimination,” “PTSD,” “African Americans,” “cultural humility,” “patient-centered cultural care,” and “racial trauma symptoms” in different combinations. All five search terms were affixed with the “OR” Boolean operator to allow articles with variations in these terms. The search strategy focused on locating sources specific to mental health care, assessment of racial trauma, and the practice of cultural humility for diverse populations. Multiple searches with varying combinations of search terms through each journal database were completed until repetitious results appeared.

In conducting the evidence search for this DNP project, a snowballing approach was employed. This method involved initially identifying a set of key articles and then systematically exploring their references to uncover additional relevant literature, resulting in approximately 10 additional sources. By cascading through the reference lists of fundamental articles, this snowballing technique enabled a comprehensive and iterative exploration of the available evidence, ensuring a thorough and nuanced understanding of the subject matter. This approach enhances the robustness of the literature synthesis, incorporating a wide array of perspectives and insights from the identified body of scholarly work. A total of 86 articles were retrieved; PubMed yielded 80, and Google Scholar yielded six. After reading the articles’ titles and abstracts, irrelevant papers were excluded. Reasons for exclusion included a focus on non-African American study subjects, articles about other aspects of trauma-related symptomology, language other than English, and non-primary sources older than five years. The final number of

articles included for review was 86. Of the 86 peer-reviewed articles included, the literature synthesis utilizes 11 articles.

Comprehensive Appraisal of Evidence

The careful examination of 11 diverse articles in this comprehensive evidence appraisal reveals several converging themes. Firstly, there is a consistent focus on the validation and utilization of tools designed to assess cultural sensitivity and trauma symptoms within healthcare settings. Secondly, the significance of patient-centered and culturally sensitive care emerges as a key factor in enhancing healthcare delivery. Thirdly, these articles collectively highlight the complex nature and often-underrepresented aspects of racial and ethnic disparities in healthcare. Finally, a resounding consensus is found regarding the imperative for provider training in cultural humility to enhance motivation, knowledge, and confidence.

Racial and Ethnic Disparities in Healthcare

The literature comprehensively examines the intricate issue of racial and ethnic disparities in healthcare, providing insights into contributing factors and proposing effective mitigation strategies. Beginning with Saha et al. (2008), the foundational acknowledgment of lower-quality healthcare for racial and ethnic minorities sets the stage. Renzaho et al. (2013) build on this, emphasizing the expanding diversity in healthcare and advocating for the integration of cultural competence into patient-centered care models to address unique needs. Lekas et al. (2020) critically appraise cultural competence training and highlight its limitations in perpetuating stereotypes and implicit biases, suggesting cultural humility as a more effective approach. Stubbe (2020) further contributes by discussing persisting disparities, citing biases and clinical uncertainties among providers. Tucker et al. (2022) narrow the focus to racial and ethnic

disparities in obesity among Black women, offering evidence-based strategies through culturally sensitive weight loss programs.

Underrepresentation in patient-centered care frameworks is highlighted by Tucker et al. (2007), emphasizing the need for healthcare systems to align services with the diverse needs of patients. Culturally tailored interventions, crucial in addressing disparities (Renzaho et al., 2013; Saha et al., 2008; Tucker et al., 2007; 2017; 2019; 2022; Williams et al., 2018), become essential by fostering cultural competence among providers and promoting inclusivity (Lekas et al., 2020; Renzaho et al., 2013; Saha et al., 2008; Tucker et al., 2017; 2019). The consequences of disparities are extensive, impacting health outcomes and fostering mistrust (Lekas et al., 2020; Saha et al., 2008; Williams et al., 2018). Underrepresentation compounds these issues, challenging minority patients to find culturally competent practitioners (Tucker et al., 2017).

Culturally tailored interventions aim to break this cycle by addressing root causes, promoting cultural competence, enhancing communication, and involving communities in healthcare decision-making (Lekas et al., 2020; Renzaho et al., 2013; Saha et al., 2008; Stubbe, 2020; Tucker et al., 2007; 2011; 2017; 2019). These studies collectively offer a nuanced understanding of racial and ethnic disparities, proposing multifaceted strategies for comprehensive intervention (Carter & Murphy, 2017; Lekas et al., 2020; Renzaho et al., 2013; Saha et al., 2008; Stubbe, 2020; Tucker et al., 2007; 2011; 2017; 2019; 2022; Williams et al., 2018).

Patient-Centered and Culturally Sensitive Care

Patient-centered care and culturally sensitive practices are intricately linked, sharing a common objective of enhancing healthcare quality by prioritizing individual patients' distinct

needs, values, and preferences within their cultural contexts (Saha et al., 2008). This approach actively engages patients in their healthcare journey, promoting shared decision-making and tailoring services to meet specific needs (Saha et al., 2008). Simultaneously, culturally sensitive practices contribute to the tenets of patient-centered care by deeply understanding and respecting patients' cultural beliefs, values, and practices (Renzaho et al., 2013; Saha et al., 2008).

Comprehensively defined in the literature, culturally sensitive practices encompass a spectrum of interventions aimed at respecting and accommodating diverse cultural backgrounds (Renzaho et al., 2013; Saha et al., 2008; Stubbe, 2020; Tucker et al., 2007; 2019; 2022; Williams et al., 2018). These practices involve behaviors, attitudes, and skills exhibited by healthcare providers to meet the cultural needs of diverse patients, requiring a profound shift in the provider's approach (Tucker et al., 2007; Stubbe, 2020). This shift includes interpersonal skills, conscientiousness, sensitivity, self-exploration, self-critique, learning from others, and avoiding behaviors perceived as disrespectful or disempowering (Stubbe, 2020; Tucker et al., 2007; 2017).

Culturally sensitive practices extend beyond surface-level awareness, delving into effective communication and understanding diverse patients' needs (Lekas et al., 2020; Renzaho et al., 2013; Saha et al., 2008; Stubbe, 2020; Tucker et al., 2017; 2022). It also addresses social, environmental, and economic conditions impacting patients' health (Saha et al., 2008; Stubbe, 2020; Tucker et al., 2019; 2022). This multidimensional approach, as highlighted in the selected articles, correlates positively with improved patient care outcomes and healthcare quality (Saha et al., 2008; Stubbe, 2020; Tucker et al., 2007; 2011; 2019; 2022).

Saha et al. (2008) illuminate the positive outcomes associated with culturally sensitive practices, emphasizing improvements in patient experiences, satisfaction, treatment adherence,

and trust in healthcare systems. The principles of patient-centered culturally competent care, emphasizing the recognition of each patient as a unique individual, are reiterated throughout the literature (Saha et al., 2008; Stubbe, 2020). Stubbe (2020) provides insights into fostering healthcare practitioners' ability to recognize individuality and humanity in patients, moving away from stereotypical assumptions towards a more nuanced, person-centered approach. This shift is crucial in overcoming cultural biases and stereotypes that might influence diagnostic and treatment decisions (Carter & Murphy, 2017; Lekas et al., 2020; Stubbe, 2020; Williams et al., 2018). As practitioners create environments that acknowledge and accommodate diverse cultural backgrounds through these practices, healthcare transforms into a more inclusive and patient-centered realm (Renzaho et al., 2013; Saha et al., 2008; Stubbe, 2020; Tucker et al., 2007; 2022; William et al., 2018).

Validation and Use of Assessment Tools

Integrating measurement-based care (MBC), specifically employing the Trauma Symptoms of Discrimination Scale (TSDS), is crucial within psychiatry for various compelling reasons (Rosen et al., 2019; Williams et al., 2018). According to recommendations from the American Psychiatric Association, incorporating quantitative measures, not only during the initial evaluation but consistently throughout treatment, becomes essential for monitoring patient health and symptoms (Rosen et al., 2019). The consistent use of measurement in clinical care has been proven to lead to quicker improvements in client outcomes, encompassing symptoms, interpersonal functioning, and quality of life, particularly for those at risk of deterioration (Rosen et al., 2019). Utilizing standardized assessment tools, such as self-report rating scales, plays a

vital role in increasing accuracy, reducing misdiagnosis, demonstrating progress, and identifying cases where a change in the treatment plan is warranted (Rosen et al., 2019).

In primary care settings, mental disorders often go underdiagnosed, and the implementation of validated brief screening tools, like the TSDS, has been shown to enhance detection and accurate diagnosis (Rosen et al., 2019; Williams et al., 2018). Clinical judgment, being susceptible to cognitive biases, may overlook cases where standardized assessments indicate treatment non-responsiveness or worsening symptoms (Rosen et al., 2019). MBC, characterized by the ongoing administration of validated measures, provides an objective indicator of client progress to guide treatment decisions (Rosen et al., 2019). The benefits of routine outcome monitoring, coupled with patient progress feedback, have been demonstrated to yield superior client outcomes compared to standard care (Rosen et al., 2019).

The application of standardized measures aligns with the best practices in MBC, enhancing clinical judgment and facilitating collaborative decision-making (Rosen et al., 2019). These measures empower clinicians to compare a patient's progress with the broader patient population, thereby enabling more informed decision-making (Rosen et al., 2019). Regularly assessing clinical status allows for early problem identification and prompt acknowledgment of progress (Rosen et al., 2019). Engaging in discussions with patients about the rationale for MBC, selecting outcome measures that align with treatment goals, and consistently providing feedback at each assessment contribute to the effective implementation of MBC (Rosen et al., 2019). Overall, MBC serves as a valuable tool for improving the quality of care, refining case formulation, reducing treatment failure, and fostering shared decision-making between providers and patients (Rosen et al., 2019).

Central to the comprehensive review is the validation and utilization of assessment tools to measure trauma symptoms. The Trauma Symptoms of Discrimination Scale (TSDS) is a self-report measure designed to assess anxiety-related trauma symptoms linked to experiences of discrimination (Appendix E) (Williams et al., 2018). Developed as a concise 21-item instrument, the TSDS concentrates on dysfunctional anxiety and resultant avoidance stemming from fears of discrimination, specifically encompassing negative cognitions, social fears, avoidance, and concerns about the future (Williams et al., 2018). The selection of items for the scale was informed by prevalent PTSD symptoms identified in four categories, with a focus on their potential manifestations as outlined in the discrimination literature (Williams et al., 2018). Participants rate items from '1' (never) to '4' (often), reflecting the distress caused by discriminatory acts (Williams et al., 2018). The total score is obtained by summing all items, with higher scores indicating increased distress (Williams et al., 2018). The TSDS has demonstrated good reliability, convergent validity, internal consistency, and test-retest reliability in preliminary studies with African American undergraduate students, emphasizing its potential utility for ethnic minority populations (Williams et al., 2018). Furthermore, it exhibits good concurrent validity, correlating positively with distress from general ethnic discrimination (Williams et al., 2018). The measure's factor structure comprises four components related to trauma symptoms: uncontrollable distress and hyperarousal, feelings of alienation, worries about the future, and perceptions of others as dangerous (Williams et al., 2018). The TSDS is particularly sensitive to racial trauma in African Americans, capturing various forms of discrimination's traumatizing impact (Williams et al., 2018). It's important to note that the TSDS was specifically examined in the context of monoracial and biracial African American

individuals within an undergraduate setting and findings from this study are crucial for understanding how the TSDS performs within this demographic (Williams et al., 2018).

The TSDS, with its focus on assessing anxiety-related trauma symptoms stemming from experiences of discrimination, provides a valuable tool for incorporating MBC strategies, enabling clinicians to track and respond to the nuanced mental health needs of individuals who have faced discriminatory distress (Rosen et al., 2019; Williams et al., 2018). Utilization of the TSDS in clinical practice reiterates the importance of effective assessment tools, a sentiment echoed by the literature, as they play a pivotal role in enhancing the motivation, knowledge, and confidence of healthcare providers (Tucker et al., 2017; Williams et al., 2018). The TSDS is publicly available and downloadable for free online (*Trauma Symptoms of Discrimination Scale*, n.d.). Dr. Monnica T. Williams, the primary developer, confirmed that permission was not necessary for TSDS utilization in this DNP project.

Provider Training in Cultural Humility

The synthesis highlights the pivotal role of provider training in cultural humility, identifying it as a crucial factor in enhancing competencies for delivering culturally sensitive care (Lekas et al., 2020; Saha et al., 2008; Stubbe, 2020). Cultural humility training is a process-oriented approach that aims to enhance providers' capabilities in delivering patient-centered care, fostering provider awareness, openness, and humility through the recognition of their own bias, privilege, and the limits of their knowledge and expertise (Lekas et al., 2020). Drawing from studies by Saha et al. (2008) and Stubbe (2020), the literature consistently emphasizes the transformative potential of cultural humility-based training, specifically noting its capacity to elevate both provider knowledge and motivation. The literature suggests that cultural humility

training not only enhances provider knowledge and motivation but also significantly contributes to skill development (Lekas et al., 2020; Saha et al., 2008; Stubbe, 2020). Importantly, this training is explicitly acknowledged for its role in cultivating enhanced provider communication and skills, particularly in the adept use of interpreter services—a cornerstone in the realm of sensitive care (Saha et al., 2008; Stubbe, 2020).

Delving into the specifics, as illuminated by Carter and Murphy (2017), Lekas et al. (2020), and Stubbe (2020), the literature moves beyond broad descriptions of training, highlighting a range of interventions. This involves targeted strategies such as specific teaching modalities, interactive educational approaches, and firsthand experiences or relationships with individuals from diverse cultural backgrounds (Carter & Murphy, 2017; Lekas et al., 2020; Saha et al., 2008; Stubbe, 2020). The education encompasses instructional phases, collaborative discussions, and exercises aimed at fostering self-awareness and understanding of others' perspectives (Lekas et al., 2020). Trainees in cultural humility may actively participate in writing about their own culture and habits, engaging in interview practice scenarios, and partaking in role plays guided by diverse trainers to dismantle prevalent racial stereotypes related to health beliefs and behaviors (Lekas et al., 2020). The curriculum may integrate Harvard University's Implicit Association Test (IAT) as a tool for self-reflection, fostering a common language for conversations about cultural and structural differences, exploring the distinctions between implicit and explicit bias, and cultivating humility (Lekas et al., 2020). Expert facilitators, holding advanced degrees in social sciences and/or public health, may lead the training, which may be supplemented by a "booster" session designed to enhance trainees' practical skills (Lekas et al., 2020).

The literature asserts that such training is pivotal in addressing the core features of patient-provider interactions, promoting understanding, and fostering relationships that are sensitive to the unique cultural contexts of patients (Lekas et al., 2020; Stubbe, 2020). This training not only equips healthcare practitioners with a refined understanding of diverse cultural backgrounds but also cultivates the skills necessary for effective communication, breaking down language barriers that may impede care (Lekas et al., 2020; Saha et al., 2008; Stubbe, 2020).

Strengths of Evidence

The synthesis of the literature, drawn from the 11 selected studies, intricately weaves together a narrative of robust findings that collectively explain the intricate dynamics between cultural sensitivity, patient-centered care, and trauma symptom recognition in healthcare settings. A notable strength lies in the methodological diversity across the studies, ranging from systematic reviews to randomized controlled trials and qualitative empirical tests. This diversity enhances the comprehensiveness and applicability of the synthesized insights. The studies collectively recognize the importance of adopting an intersectional lens, considering factors such as race, ethnicity, and socioeconomic status. This intersectional focus ensures that the findings resonate with diverse patient populations.

The validation and utilization of tools for assessing cultural sensitivity and trauma symptoms, particularly the TSDS, contribute to the credibility of these instruments. The studies consistently underscore the positive correlation between culturally sensitive practices and improved patient care outcomes, grounding the literature in a pragmatic understanding of the impact of cultural sensitivity on healthcare delivery. Emphasizing the significance of provider

training in cultural humility, the literature advocates for ongoing self-reflection and awareness as essential components of effective patient-centered care.

A noteworthy dimension is the collective attention to healthcare disparities, with an advocacy for culturally tailored interventions to address these disparities. Several studies adopt a longitudinal perspective, providing insights into the stability and sustainability of interventions over time. The literature, by embracing the concept of cultural humility, contributes to the evolving discourse around cultural competence, recognizing its limitations and advocating for a more progressive approach. Delving into the dynamics of patient-provider relationships, the studies offer nuanced insights that enrich the understanding of the interpersonal aspects of care. Additionally, the integration of expert opinions adds a layer of practical guidance to the academic discourse, providing healthcare professionals with tangible tips and strategies for engaging with diverse patient populations. Collectively, these strengths fortify the literature, offering a multifaceted exploration positioned at the intersection of methodological rigor, patient-centered outcomes, and the imperative for ongoing provider training in cultural humility.

Weaknesses of Evidence

The synthesis of the literature from the 11 selected studies brings to light several notable weaknesses that warrant consideration. A recurring limitation across the studies is the reliance on self-reported measures, introducing the potential for social desirability bias and impacting the accuracy of the findings, underscoring a need for more objective measures to bolster the credibility of the evidence (Carter & Murphy, 2017; Tucker et al., 2011; 2017; Williams et al., 2018). Additionally, the potential for sampling bias is acknowledged, as many studies primarily engage specific populations, such as African American communities or healthcare providers,

raising questions about the generalizability of the findings to broader demographic groups (Tucker et al., 2019; 2022; Williams et al., 2018).

Another pervasive weakness is the scarcity of longitudinal data, which hampers a comprehensive understanding of the long-term effects of interventions (Carter & Murphy, 2017; Tucker et al., 2007; 2011; 2017; 2019; 2022; Williams et al., 2018). This limitation is evident in studies like Tucker et al. (2019) and Tucker et al. (2022), where a focus on short-term outcomes might not fully capture the sustainability and enduring impact of culturally tailored healthcare interventions. The lack of standardized metrics for assessing cultural competence and humility among healthcare providers, as observed in Stubbe (2020), poses a challenge in evaluating the effectiveness of training programs. Without consistent metrics, the comparability and generalizability of interventions across diverse settings remain uncertain (Stubbe, 2020).

Several studies, such as Renzaho et al. (2013) and Saha et al. (2008), indicate a dearth of patient health outcome measures, limiting the assessment of the practical effects of cultural competence on health outcomes. This gap emphasizes the need for a more comprehensive evaluation that extends beyond provider knowledge and attitudes to encompass tangible patient-related outcomes (Renzaho et al., 2013; Saha et al., 2008). Additionally, a lack of exploration into the impact of exposure to discrimination claims from other racial groups, noted by Carter and Murphy (2017), suggests a potential oversight in understanding the broader context of discrimination and its effects on cultural sensitivity.

Methodological heterogeneity across the studies, while offering diverse perspectives, also presents a challenge in synthesizing and comparing results (Renzaho et al., 2013; Tucker et al., 2007). For instance, variations in research designs and the duration of training programs, as seen

in Renzaho et al. (2013), may impact the reliability and consistency of the findings. The paucity of theory and model development in culturally sensitive healthcare research, acknowledged by Tucker et al. (2007), highlights a gap in the theoretical underpinnings guiding interventions, potentially limiting their effectiveness and replicability.

Overall, while the synthesized evidence provides valuable insights, these identified weaknesses advocate for a nuanced interpretation of the findings and emphasize the need for future research endeavors to address these limitations for a more robust understanding of the complex interplay between cultural sensitivity, patient-centered care, and trauma symptom recognition in healthcare settings.

Gaps and Limitations

Despite the strengths identified in the literature, the synthesis reveals certain critical gaps and limitations in the existing body of research including limited exploration of the long-term impacts of culturally tailored healthcare interventions (Carter & Murphy, 2017; Tucker et al., 2019; 2022; Williams et al., 2018). Many of the reviewed studies, exemplified by Tucker et al. (2019) and Tucker et al. (2022), predominantly concentrate on immediate outcomes, neglecting a comprehensive understanding of sustained intervention effectiveness and their contribution to enduring transformations in healthcare disparities.

Moreover, a pervasive sampling bias is evident in the studies, which predominantly feature specific populations such as African American communities or healthcare providers, which raises questions about the applicability of interventions to broader demographic groups (Tucker et al., 2019; 2022; Williams et al., 2018). This limitation, distinct from the weaknesses

of the evidence, underscores the potential challenges in scaling culturally sensitive healthcare practices to diverse populations.

An additional significant gap is the absence of standardized metrics for assessing cultural competence and humility among healthcare providers (Saha et al., 2008; Stubbe, 2020). This becomes apparent in Stubbe's (2020) study, where the lack of consistent metrics complicates the evaluation of the effectiveness of training programs. The field currently lacks universally accepted tools and benchmarks for gauging cultural competence and humility, impeding accurate cross-setting comparisons and the establishment of best practices (Stubbe, 2020).

The research, particularly in Carter and Murphy (2017), also reveals a gap in understanding the broader context of discrimination experiences with limited focus on specific racial or ethnic groups which may lead to an incomplete comprehension of the complexities surrounding discrimination experiences and their effects on cultural sensitivity. A more comprehensive exploration of diverse discrimination experiences is necessary to develop a nuanced understanding of the factors influencing cultural sensitivity (Stubbe, 2020).

Furthermore, the studies consistently highlight the scarcity of patient health outcome measures, restricting the assessment of the practical effects of cultural sensitivity on health outcomes, warranting future investigations that comprehensively evaluate the impact of interventions on patient well-being (Renzaho et al., 2013; Saha et al., 2008). The need for research that delves into the intricacies of patient health outcomes represents a distinct gap beyond the previously mentioned weaknesses (Renzaho et al., 2013; Saha et al., 2008).

In conclusion, while recognizing the strengths of the literature, these identified gaps underscore the necessity for more comprehensive, standardized, and longitudinally oriented

research. Addressing these gaps will enhance the depth and applicability of future interventions aimed at mitigating healthcare disparities and promoting culturally sensitive healthcare practices (Renzaho et al., 2013; Saha et al., 2008).

METHODS

Project Design

This QI initiative sought to implement cultural humility-based training to enhance motivation, knowledge, and confidence for patient-centered culturally sensitive (PCCS) care among mental health providers (MHP) in Arizona. Participants including therapists, case managers, physicians, and mental health nurse practitioners from Denova Collaborative Healthcare, were invited via email (Appendix B) for voluntary participation in an interventional project.

The intervention was presented virtually in an asynchronous format online, allowing participants to complete it at their convenience. At the beginning of the pre-intervention survey, participants reviewed the project disclosure form (Appendix B) and provided voluntary consent for participation in this project by checking a consent box within the survey. Next, participants clicked a link to watch a clinical simulation video with a duration of ninety seconds depicting a male African American patient who presented to a mental health provider for a routine follow-up appointment expressing anxiety symptoms with signs consistent with racial trauma. The simulation video was created using an artificial intelligence-powered animation text-to-video generator available online. This simulation aided in evaluating participants' knowledge, motivation, and confidence in recognizing and managing racial trauma-related symptoms using pre- and post-intervention surveys as a standardized and quantifiable method.

Upon watching the video, participants then completed the pre-intervention survey consisting of five demographic questions, seven Likert-scale questions, and two multiple-choice knowledge-based questions (Appendix D). This survey, created via Qualtrics, assessed baseline knowledge, motivation, and confidence to provide PCCS care and evaluate for racial trauma symptoms. Survey questions assessed whether participants held knowledge of the Trauma Symptoms of Discrimination Scale (TSDS) and perceived it as a valuable tool for assessing racial trauma. Questions addressed participants' perceptions of knowledge, motivation, and confidence to provide PCCS care and recognize racial trauma symptoms. Participants also addressed confidence in effective communication with patients with racial trauma. All questions aimed to measure MHP confidence in employing the TSDS, assess pre-/post-intervention knowledge on the culturally humble use of the TSDS, and evaluate the feasibility and perceived value of integrating the TSDS into routine clinical practice.

The 20-minute cultural humility-based training, presented asynchronously via a pre-recorded slideshow, educated participants on culturally humble approaches, identifying racial trauma symptoms in African Americans, using the TSDS, and managing racial trauma in African American patients. Immediately following the training, participants were prompted to complete the post-intervention survey consisting of seven Likert scale questions, two multiple-choice knowledge-based questions, and one optional question for intervention feedback (Appendix D). Pre- and post-training survey results were compared to gauge shifts in participants' knowledge, motivation, and confidence regarding their ability to assess symptoms and manage the patient's care. Qualtrics software was used for the questionnaires due to its capacity for paired t-test analysis, and Microsoft Excel was utilized for data analysis. Data was stored securely on a

password-protected and encrypted server, accessible only to the principal investigator, ensuring anonymity. This intervention served as a structured and objective method to assess participants' motivation, knowledge, and confidence in recognizing and managing racial trauma-related symptoms, contributing to ongoing QI at Denova Collaborative Healthcare.

Model for Implementation

In applying the Plan-Do-Study-Act (PDSA) cycle to implement cultural humility-based training for healthcare providers in a community mental health clinic, the primary goal was to assess the impact on participants' motivation, knowledge, and confidence in delivering PCCS care. The planning phase initiated the cycle, involving the formulation of questions, predictions, and logistical considerations for the training. This encompassed the design of pre- and post-training surveys as strategies to assess providers' knowledge, motivation, and confidence following a simulated patient interaction and educational presentation, as highlighted in the project design. The data collection methods were outlined to ensure a comprehensive evaluation. Moving to the execution phase, the cultural humility-based training was introduced to a group of MHP, aligning with the asynchronous online format and clinical scenario simulation described in the project design. Data collection proceeded according to the devised plan, including survey assessments. The subsequent study phase engaged in an in-depth analysis of the collected data, emphasizing pretest and test-retest post-training survey results, as discussed in the project design. Participant feedback following the intervention aimed to promote a reflective process that can identify both successes and challenges encountered during the training, integrating valuable participant feedback. In the action phase, modifications to the training program were determined based on the challenges identified, paralleling the adaptive approach described in the project

design. This dynamic adjustment process allows for the refinement of content and delivery methods, ensuring continual improvement. The model encourages the incorporation of successful components into subsequent cycles, potentially expanding the participant group. Simultaneously, less effective elements can be either abandoned or modified, fostering a dynamic and adaptive approach to training enhancement. This iterative cycle ensures an ongoing process of improvement, effectively preparing healthcare providers for PCCS care.

Setting and Stakeholders

This QI project was completed in the dynamic environment of Denova Collaborative Healthcare, a local integrative health facility located in the Phoenix metropolitan region of Arizona. Denova Collaborative Healthcare served as the backdrop for implementing cultural humility-based training among MHP, constituting a multidisciplinary team that includes therapists, psychologists, case managers, psychiatrists, and mental health nurse practitioners. The project setting was characterized by its commitment to integrative health practices and a diverse patient population. Stakeholders encompassed the participating MHP and the leadership and administrative staff of Denova Collaborative Healthcare who supported and facilitated the implementation of the training initiative. Additionally, patients receiving mental health services at Denova Collaborative Healthcare are indirect stakeholders, as the outcomes of this project were anticipated to influence the quality and cultural sensitivity of the care they receive. The success of this project relied on the collaborative engagement of all these stakeholders, ensuring a holistic and patient-centered approach to mental health care within the integrative health facility.

Planning the Intervention

The cultural humility-based training intervention was meticulously designed to enhance the competencies of MHP within Denova Collaborative Healthcare, a local integrative health facility in Arizona. Guided by the "Plan-Do-Study-Act" (PDSA) model, this QI project aimed to gauge and elevate cultural sensitivity and patient-centered care competencies among mental health professionals. Invitations for voluntary participation were extended via email, by a psychiatric supervisor at Denova Collaborative Health, to mental health professionals, including psychiatrists, psychiatric mental health nurse practitioners, psychologists, therapists/counselors, case managers, and social workers within the company. The data collection process involved administering pre- and post-intervention surveys to assess shifts in motivation, knowledge, and confidence related to cultural sensitivity and patient-centered care.

To initiate the intervention, a group of MHPs completed the intervention surveys and educational training. This phase incorporated asynchronous and virtual comprehensive training sessions, leveraging interactive modules to address key facets of cultural humility. The analysis, facilitated using Qualtrics and Microsoft Excel, compared pre- and post-training survey data. Following the analysis, adjustments to training content or delivery were implemented to optimize efficacy, aligning with the adaptive approach inherent in the PDSA model. This systematic and evidence-based planning phase underscores a commitment to continuous QI, reflecting the core principles of the PDSA model.

Participants and Recruitment

The participants recruited for this QI project included MHP operating within the geographical bounds of Arizona and employed by Denova Collaborative Healthcare, a local

integrative health facility. This encompassed a diverse group of mental health professionals, including psychiatrists, mental health nurse practitioners, psychologists, therapists/counselors, case managers, and social workers, each contributing unique perspectives and skill sets to the mental health landscape. Recruitment strategies were designed to facilitate voluntary participation. A key component of this strategy involved reaching out to potential participants through email correspondence. This medium allowed for clear communication of the project's objectives, methods, and the voluntary nature of participation. MHP were given the choice to engage in the project or opt out based on their preferences. To encourage participation, a thoughtful incentive structure was devised. Each participating mental health care provider had the option to enter a lottery raffle, enhancing the potential for recognition by offering a chance to win one of two self-funded $25 gift cards for Amazon. This approach aimed to acknowledge the contributions of the MHP while infusing an element of excitement through the lottery incentive. It was anticipated that these measures would not only maximize recruitment but also contribute to sustained engagement throughout the intervention and data collection phases.

Consent and Ethical Considerations

Ensuring the ethical conduct of this project involved a comprehensive approach to participant consent and protection. All MHP approaches for participation were provided with a detailed disclosure form (Appendix B) before initiating participation in the project. The disclosure form was presented as the first step of the intervention survey embedded in Qualtrics, before pre-intervention questions. This document explicitly outlined the project's purpose, procedures, and potential risks and benefits associated with involvement. Participants were

assured of their voluntary participation and informed about their right to withdraw at any stage without facing consequences.

The principle of confidentiality is paramount, and measures to safeguard participant privacy were meticulously incorporated. All data collected was electronic data, anonymized, and stored securely with password protection, accessible only to the principal investigator. Any published results or presentations resulting from this project maintained the anonymity of participants using pseudonyms or other de-identification strategies.

Additionally, this project adhered to the ethical guidelines and standards set forth by relevant institutional review boards (IRBs) and followed the principles outlined in the Declaration of Helsinki. This project received approval from the IRB, and it was determined to involve non-human subject research as it focused on evaluating the impact of a culturally humility-based training intervention on the motivation, knowledge, and confidence of MHP, rather than directly involving human subjects in experimental procedures. The ethical considerations extended to the respectful treatment of participants, the judicious use of incentives, and the transparent dissemination of project findings. Continuous monitoring of ethical aspects throughout the project ensured that participant welfare was prioritized, and the integrity of the research process was maintained.

Data Collection

The data collection for this project was designed to be comprehensive and robust, utilizing quantitative methods to gather insights into the impact of cultural humility-based training on MHP within Denova Collaborative Healthcare. Quantitative data was acquired through the administration of pre- and post-intervention surveys. To ensure efficiency and ease

of completion for participating MHP, surveys were distributed electronically. The use of secure online platforms for survey responses not only streamlines the data collection process but also guarantees confidentiality and anonymity. In addition to survey responses, essential demographic information was collected. This includes details about the participants' professional background, ethnic/racial identity, years of experience in mental health practice, and any history of cultural humility-based training. Gathering this contextual information was crucial for a nuanced understanding of the findings, providing insights into the diverse backgrounds and experiences of the participating MHP. Providers also had the option to leave open-ended feedback on their post-intervention survey, ensuring that this data was collected confidentially with anonymity.

The collection of quantitative data served the overarching goal of achieving a comprehensive and multifaceted understanding of the impact of cultural humility-based training. By focusing on MHP motivation, knowledge, and confidence in delivering PCCS care, the project aimed to quantifiably assess shifts and improvements in these key areas. Survey responses and demographic information were managed using secure online platforms, ensuring the confidentiality and anonymity of participants. This meticulous approach to data management aligns with ethical considerations, fostering trust among participants and upholding the integrity of the project. In summary, the data collection strategy combined the efficiency of electronic surveys, the richness of demographic information, and the security of online platforms. This holistic approach positioned the project to yield nuanced and statistically sound insights into the impact of cultural humility-based training on MHP competencies and practices.

Data Analysis

The quantitative data derived from the surveys endured an in-depth statistical analysis, aimed to uncover nuanced patterns and identify shifts in participants' motivation, knowledge, and confidence levels. This analysis was conducted with a methodical approach to provide robust insights into the impact of cultural humility-based training on MHP within Denova Collaborative Healthcare.

Descriptive statistics were a fundamental component of the analysis process, offering a comprehensive overview of the sample. Statistics summarized participants' demographic characteristics, utilizing measures of central tendency (e.g., mean & median) and dispersion (including standard deviation). This approach ensured a detailed depiction of score distributions, providing context to the subsequent inferential analyses.

To assess the impact of the cultural humility-based training intervention, inferential statistics, particularly paired-sample t-tests, were applied using Microsoft Excel. This statistical method facilitated a direct comparison between pre-and post-intervention scores, with a standard significance level of 0.05. The statistical analyses were executed using Microsoft Excel, chosen for its precision, reliability, and user-friendly interface. This software ensured a comprehensive interpretation of the intervention's efficacy in enhancing culturally sensitive care among MHPs. By adopting rigorous statistical methods and appropriate software, the data analysis process was positioned to provide meaningful and actionable insights into the outcomes of the cultural humility-based training intervention.

RESULTS

This section illustrates the results of the data analysis, including the quantitative survey results and any responses to open-ended questions. Demographics are described and key findings are highlighted. The educational intervention was emailed to participants on December 14, 2023. Of the 120 eligible MHP at Denova Collaborative Health, three completed the intervention for this data analysis of responses submitted by December 17, 2023. All participants (100%) who provided consent finished the intervention. There were no incomplete submissions recorded in Qualtrics.

Demographic data from the pre-intervention survey demonstrated one participant (33%) was a therapist and two participants (67%) were nurse practitioners (NPs). Two participants (67%) indicated a previous history of CEU/CMEs or other formal training on cultural humility. One participant (33%) had less than one year of experience as a mental health provider, another participant (33%) had between four and seven years, and the third participant (33%) had over 10 years. Two participants (67%) reported their race as White and non-Hispanic and one participant (33%) indicated their race as American Indian or Alaskan native race and Hispanic or Latino ethnicity. Information on participant demographics is shown in Table 1.

Table 1

Participant Demographics

		N=3	%
Role	Psychiatrist (MD, DO)	0	0
	Nurse Practitioner	2	67
	Case Manager	0	0
	Therapist	1	33
	Psychologist	0	0
Years in Practice	<1	1	33
	1-4	0	0
	4-7	1	33
	7-10	0	0
	>10	1	33
Prior Training	Yes	2	67
	No	1	33
Race	White	2	67
	Black or African American	0	0
	American Indian or Alaska Native	1	33
	Asian	0	0
	Native Hawaiian or Pacific Islander	0	0
Hispanic or Latino	Yes	1	33
	No	2	67

Outcomes

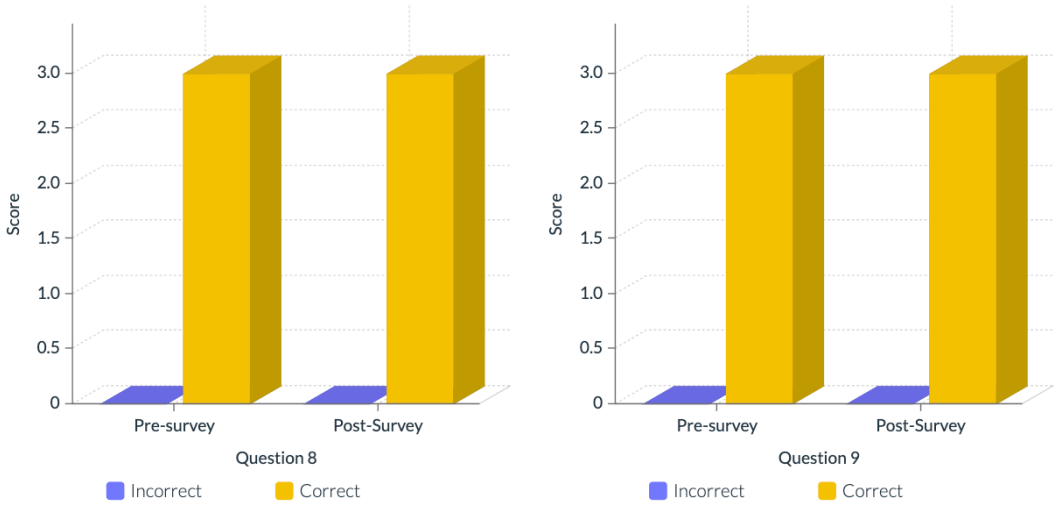
Questions 8 and 9 assessed participant knowledge of the intervention surveys and all three participants (100%) correctly answered both knowledge questions in the pre-intervention survey. The knowledge scores for all three participants (100%) showed no change from pre-intervention to post-intervention. Questions 2, 5, and 6 assessed participant motivation on the intervention surveys. Questions 1, 3, 4, and 7 assessed participant confidence in the intervention surveys. Confidence and motivation scores for two out of three participants (67%) improved on the post-intervention survey.

The pre- and post-intervention surveys each contained two identical knowledge-based questions regarding the Trauma Symptoms of Discrimination Scale (TSDS), questions 8 and 9.

The maximum score that could be obtained was a "2" with a score of "1" for correct answers and a score of "0" for incorrect answers. Figure 3 presents the pre-intervention/post-intervention educational presentation knowledge comparison.

Figure 3

Pre- and Post-Survey Results for Questions 8 and 9



The knowledge scores for all three participants (100%) remained the same on the pre-intervention and post-intervention surveys. The survey results indicated that both knowledge scores for questions 8 and 9 were answered correctly for all participants (100%). In question 8 participants were asked "Evidence-based interventions for managing racial trauma include which of the following" and three out of three participants (100%) answered correctly on the pre-intervention survey and post-intervention survey. Question 9 assessed participants' knowledge with the question "What is the primary focus of the Trauma Symptoms of Discrimination Scale (TSDS) in mental health assessments" with three out of three participants (100%) answering correctly on the pre-intervention survey and post-intervention survey.

Confidence and motivation were measured on the post-intervention survey with a 5-point Likert scale ranging from (1) = “strongly disagree” to (5) = “strongly agree” in addition to a “neither agree or disagree” (3) option. Four out of seven Likert scale questions assessed participant’s confidence: one, three, four, and seven. Participants were assessed using a total score for confidence and motivation questions obtained by adding a point for each change on the Likert scale from “strongly disagree” to “strongly agree.” For example, participants who selected “somewhat agree” on the pre-intervention survey and “strongly agree” on the post-intervention survey gained one point for their respective confidence or motivation score. Participants who selected “neither agree nor disagree” on the pre-intervention survey and “strongly agree” on the post-intervention survey gained two points for their respective confidence or motivation scores. The total confidence scores for two out of three participants (67%) improved on the post-intervention survey: one participant (33%) by four points and one participant (33%) by two points. The confidence score for one participant (33%) did not change on the post-intervention survey. Results for confidence scores on questions 1, 3, 4, and 7 did not demonstrate statistical significance ($p>0.05$) with a p-value of 0.43, 0.43, 0.43, and 0.46, respectively (Tables 2 to 5).

Table 2

Paired t-test for Question 1

	N	Mean	SD	Two-tailed (a=0.05) Df	p-value
Pre-survey	3	4.33	1.92	2	0.43
Post-survey	3	4.67	1.92		

Table 3

Paired t-test for Question 3

	N	Mean	SD	Two-tailed (a=0.05) Df	p-value
Pre-survey	3	4	0.27	2	0.43
Post-survey	3	4.33	0.27		

Table 4

Paired t-test for Question 4

	N	Mean	SD	Two-tailed (a=0.05) Df	p-value
Pre-survey	3	4.33	1.92	2	0.43
Post-survey	3	4.67	1.92		

Table 5

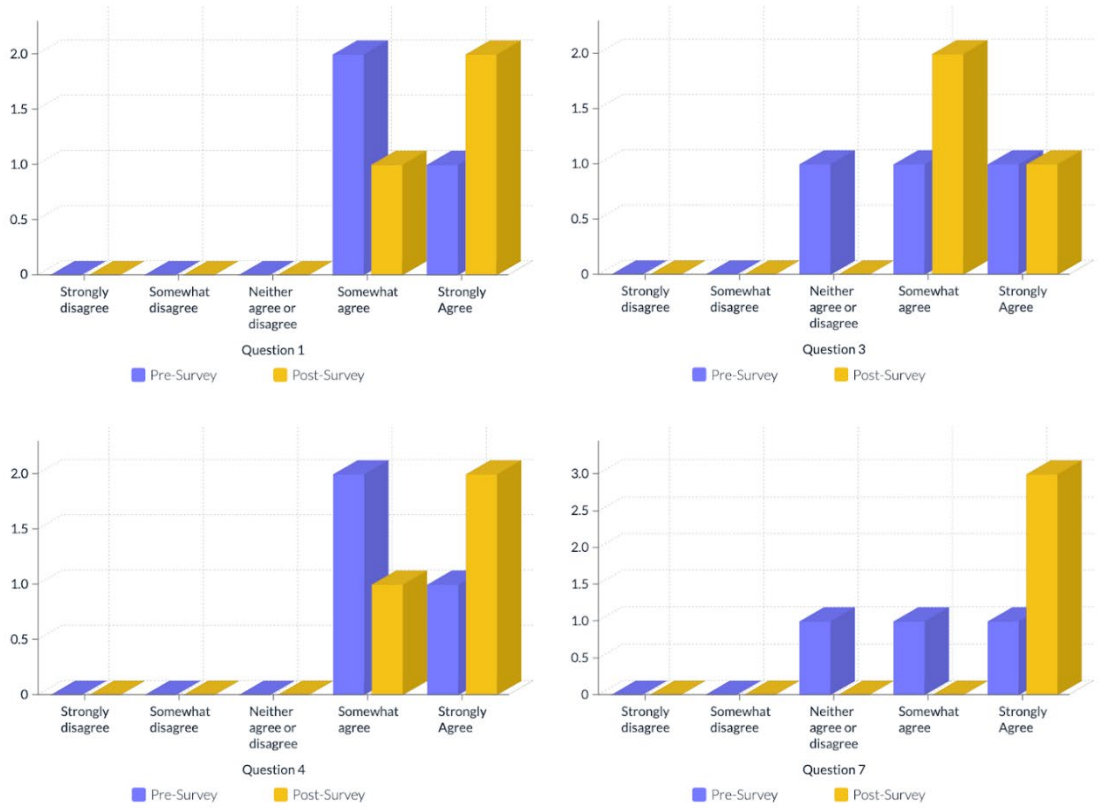
Paired t-test for Question 7

	N	Mean	SD	Two-tailed (a=0.05) Df	p-value
Pre-survey	3	4.33	0.18	2	0.46
Post-survey	3	4.67	0.18		

Figure 4 demonstrates the average shift in participant scores for each question assessing confidence.

Figure 4

Pre- and Post-Survey Results for Questions 1, 3, 4, and 7



In question 1 participants were asked to rate their agreement with the statement "A culturally humble racial trauma assessment can enhance my confidence in discussing unique challenges of racial trauma with patients" and one out of three participants (33%) showed an improvement of one point on the post-intervention survey. Question 3 asked participants to rate their agreement with the statement "I am confident in recognizing and treating symptoms of racial trauma in patients" with one out of three participants (33%) showing a one-point improvement in their score on the post-intervention survey. In question four participants were asked to rate their agreement with the statement "I am confident in effectively communicating

with patients experiencing racial trauma" and one out of three participants (33%) showed an improvement of one point on the post-intervention survey. Question 7 asked participants to rate their agreement with the statement "I am confident in utilizing the Trauma Symptoms of Discrimination Scale to assess racial trauma during diagnostic assessments and follow-up treatment sessions" with two out of three participants (67%) showing a one-point improvement of two points and one point, respectively, for their post-intervention survey scores.

Three out of seven Likert scale questions assessed participants' motivation: two, five, and six. The motivation scores for two out of three participants (67%) improved on the post-intervention survey: one participant (33%) by two points and one participant (33%) by one point. The motivation score for one participant (33%) did not change on the post-intervention survey. Results for motivation scores on questions 5 and 6 did not demonstrate statistical significance ($p>0.05$) with a p-value of 0.47, and 0.47, respectively (Tables 6 &7).

Table 6

Paired t-test for Question 5

				Two-tailed (a=0.05)	
	N	**Mean**	**SD**	**Df**	**p-value**
Pre-survey	3	4.33	0.14	2	0.47
Post-survey	3	5	0.14		

Table 7

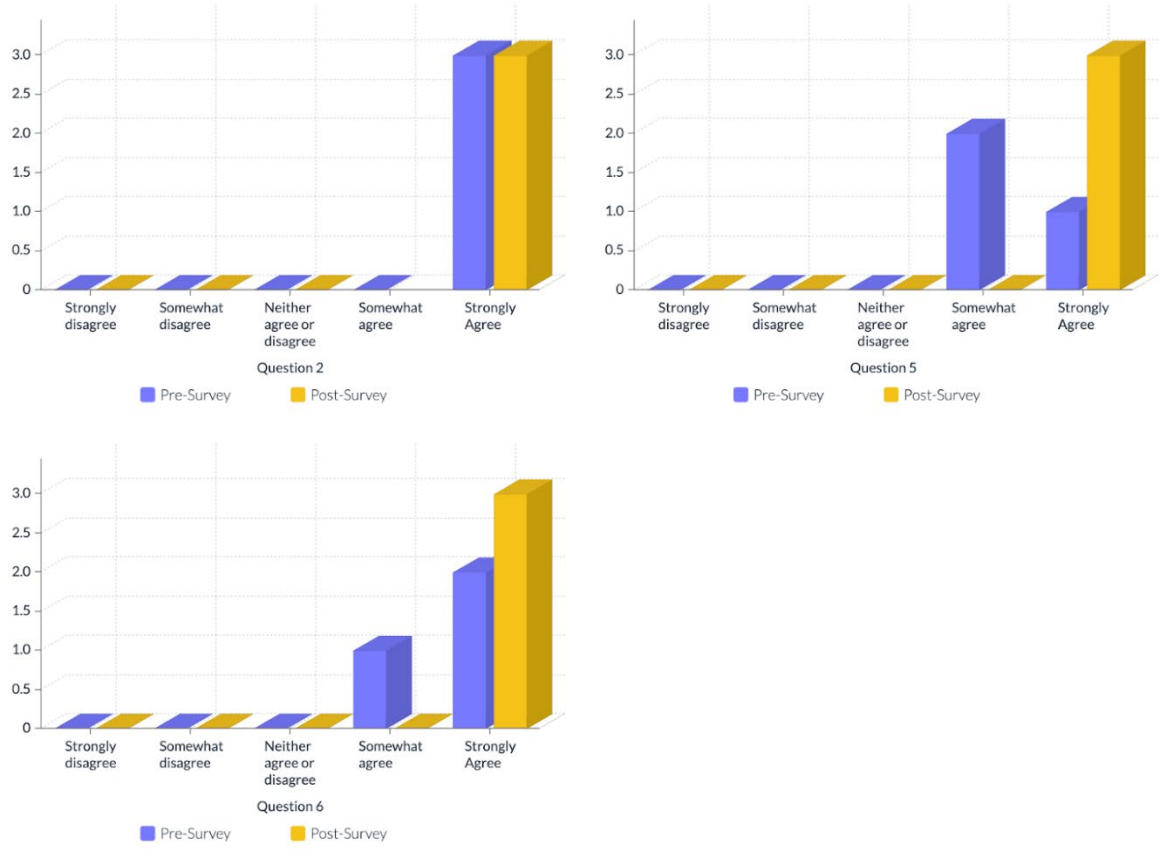
Paired t-test for Question 6

				Two-tailed (a=0.05)	
	N	**Mean**	**SD**	**Df**	**p-value**
Pre-survey	3	4.33	0.33	2	0.47
Post-survey	3	4.67	0.33		

Question 2 showed no change between pre- and post-intervention for all participants (100%). Figure 5 demonstrates the average shift in participant scores for each question assessing motivation.

Figure 5

Pre- and Post-Survey Results for Questions 2, 5, and 6



In question 2 participants were asked to rate their agreement with the statement "Recognizing racial trauma symptoms is essential to providing patient-centered culturally sensitive mental health care" and three out of three participants (100%) showed no improvement on the post-intervention survey. Question 5 asked participants to rate their agreement with the

statement “Cultural humility-based training on the use of a self-report questionnaire to assess patients for racial trauma can improve patient-provider communication” with two out of three participants (67%) showing a one-point improvement in their score on the post-intervention survey. In question 6 participants were asked to rate their agreement with the statement “It is feasible to integrate the TSDS into routine clinical practice to assess the progress of racial trauma treatment” and one out of three participants (33%) showed an improvement of one point on the post-intervention survey.

The post-intervention survey included an additional question 10 that asked participants to optionally leave feedback on the educational training presentation to aid the implementation of future repetitions of this QI project. Three out of three participants (100%) did not choose to leave feedback on the training.

DISCUSSION

Summary

The focus of this intervention was to enhance MHP’s ability to identify and address racial trauma symptoms in African American patients through the utilization of the Trauma Symptoms of Discrimination Scale (TSDS) and cultural humility-based training. The project’s findings offer valuable insights into the potential effectiveness of this educational intervention. In analyzing the outcomes, it’s notable that all participants completed the intervention, demonstrating a high level of engagement and commitment to the training. The demographic data provided a snapshot of the participants, encompassing nurse practitioners and a therapist with varying years of experience and exposure to cultural humility training.

The knowledge assessment, comprised of two identical questions in the pre- and post-intervention surveys, indicated that participants maintained consistent scores. While this suggests that the intervention might not have led to a significant increase in factual knowledge, it's important to note that participants already demonstrated a strong understanding of the specific knowledge areas assessed by the TSDS. Interestingly, the confidence and motivation assessments demonstrated some positive shifts, although statistically insignificant ($p>0.05$). Two out of three participants showed improved confidence scores, indicating an increased belief in their ability to apply TSDS in clinical practice. Motivation scores also exhibited positive changes for two participants, indicating an enhanced commitment to recognizing and addressing racial trauma symptoms. None of the responses to survey questions demonstrated statistical significance which may be due in part to the small sample size of participants.

The project uncovered nuances in participants' perceptions of their confidence and motivation levels. While some aspects showed improvement, others remained unchanged. This variation could be attributed to the individualized nature of confidence and motivation, influenced by personal experiences, attitudes, and perceived relevance of the intervention. While this might indicate satisfaction or a lack of specific concerns, the absence of feedback limits insights into potential areas for improvement in future iterations of the intervention. Future iterations of the intervention should consider refining content based on participant feedback, expanding the participant pool, and incorporating more diverse scenarios to assess the application of knowledge in various contexts. Long-term follow-ups could assess the sustained impact of the training on providers’ clinical practices and patient outcomes.

While the current project provides initial insights into the effects of cultural humility-based training on MHP assessment of racial trauma symptoms, continued research is essential for a comprehensive understanding of its broader implications and long-term effectiveness.

Interpretation

The findings of this QI project shed light on the effectiveness of an educational session centered on cultural humility-based training for MHP. While the results may not indicate a significant shift in participants' factual knowledge, the positive changes in confidence and motivation levels suggest a nuanced impact.

Comparing these results with existing literature on educational interventions aligns with the idea that brief didactic training, like the one implemented in this project, can influence providers' attitudes and self-efficacy (Renzaho et al., 2013; Tucker et al., 2007). This intervention aimed to enhance provider skills in recognizing and addressing racial trauma symptoms. The lack of a substantial increase in knowledge scores may be attributed to the participants' baseline proficiency in the assessed areas. The interpretation of confidence and motivation scores suggests that the intervention may have instilled a greater belief in participants' abilities to apply the TSDS in their clinical practice. However, the varying responses underscore the complexity of influencing provider behaviors, with some aspects showing improvement and others remaining unchanged.

The absence of participant feedback poses a challenge in fully comprehending the perceived effectiveness of the training. Future iterations of the intervention should consider incorporating qualitative methods to capture participants' experiences, providing richer insights into the educational impact. Moreover, the small sample size and potential self-report bias are

limitations that warrant consideration. These factors may influence the generalizability of the findings, emphasizing the need for cautious interpretation.

The interpretation of the results suggests that while the intervention may not have led to a substantial increase in factual knowledge, it positively influenced participants' confidence and motivation. The project emphasizes the multidimensional nature of educational interventions, urging further exploration through qualitative research and considerations for the nuances in provider attitudes and behaviors.

Implications

Practice

The findings of this QI project hold crucial implications for mental health practice, particularly in the context of addressing racial trauma symptoms in African American populations. Despite the modest change in factual knowledge, the observed improvements in confidence and motivation among participants signal a potentially positive impact on their clinical approach. Mental health providers (MHP), equipped with enhanced confidence, may be more inclined to apply the TSDS in their assessments, leading to more accurate recognition and management of racial trauma symptoms. This implies that integrating cultural humility-based training, even in short didactic formats, can contribute to the development of provider skills and attitudes, fostering a more inclusive and culturally sensitive mental health practice.

Education

The educational implications of this project underscore the value of targeted training programs for MHP. While brief interventions may not drastically alter factual knowledge, they play a crucial role in shaping attitudes and confidence levels. Educators and trainers in mental

health settings should consider incorporating cultural humility-based training into their curricula, ensuring that providers are not only informed but also empowered to navigate sensitive areas such as racial trauma. This approach aligns with the broader shift in mental health education towards promoting cultural competence and sensitivity, acknowledging the diverse needs of patient populations.

Research

This project sets the stage for further QI endeavors focusing on the intersection of cultural humility training and racial trauma symptom recognition. The limited existing literature highlights the need for more comprehensive investigations into the effectiveness of similar interventions. Future projects or studies could explore larger and more diverse samples, employ mixed-methods approaches, and delve into the long-term outcomes of such training. Additionally, qualitative research capturing participants' perspectives on the training's impact could enrich our understanding of the nuanced ways in which providers perceive and integrate cultural humility into their practice.

Policy

The implications for mental health policy are tied to the broader goal of promoting equitable and culturally sensitive care. Policymakers should consider the integration of cultural humility-based training into standard mental health education and professional development requirements. This may involve collaborating with accrediting bodies to ensure that training programs incorporate elements that address racial trauma recognition and management. Furthermore, policies could incentivize mental health organizations to prioritize cultural

competence training for their providers, contributing to a more inclusive and effective mental health landscape.

Limitations

Several limitations should be acknowledged, including the small sample size and potential selection bias. The project's findings may not be broadly generalizable, emphasizing the need for larger-scale investigations. The positive shifts in confidence and motivation, despite the absence of significant knowledge gains, prompt further exploration into the nuanced relationship between knowledge acquisition and practical application in culturally sensitive care. Moreover, the absence of participant feedback raises questions about the perceived effectiveness of the training. Future interventions should consider incorporating qualitative methods to gather in-depth insights into participants' experiences and to refine the educational intervention further.

DNP Essentials Addressed

The DNP program, guided by the eight DNP Essentials, establishes the foundation for a practice-oriented curriculum designed to equip professionals with the expertise to deliver specialized advanced nursing practice through innovative and evidence-based methods (American Association of Colleges of Nursing [AACN], 2006). This quality improvement (QI) project aligns with three key essentials integral to doctoral education within the DNP program.

DNP Essential II: Organizational and Systems Leadership for Quality Improvement

This DNP project aligned with Essential II by developing and evaluating cultural humility-based training for MHP, emphasizing communication skills for quality improvement. It incorporated business principles, budgeting, and cost-effectiveness analysis, demonstrating organizational leadership. The project addressed ethical dilemmas in patient care and contributed

to the ongoing improvement of health outcomes, emphasizing the DNP graduate's role in assessing organizations, implementing changes, and ensuring patient safety.

DNP Essential III: Clinical Scholarship and Analytical Methods for Evidence-Based Practice

This DNP project contributed to Essential III by utilizing analytical methods to critically appraise existing literature, employing evidence-based practice, and applying relevant findings to improve practice and the practice environment. It demonstrated competence in designing and implementing processes for outcome evaluation, quality improvement methodologies, and the dissemination of evidence-based findings. This project's use of information technology and research methods aligned to utilize meaningful evidence for nursing practice.

DNP Essential VIII: Advanced Nursing Practice

This DNP project aligned with Essential VIII by preparing to conduct a comprehensive and systematic assessment of health and illness parameters, incorporating diverse and culturally sensitive approaches. It further supported the development, implementation, and evaluation of therapeutic interventions based on nursing science and other sciences. This project demonstrated advanced clinical judgment, systems thinking, and accountability in designing, delivering, and evaluating evidence-based care to improve patient outcomes. Additionally, it contributed to guiding, mentoring, and supporting other nurses to achieve excellence in nursing practice, showcasing the ability to educate and guide individuals and groups through complex health and situational transitions. The project underscores the utilization of conceptual and analytical skills in evaluating the links among practice, organizational, population, fiscal, and policy issues.

Conclusions

In conclusion, this project provides a foundation for understanding the impact of cultural humility-based training on MHP confidence and motivation in assessing racial trauma symptoms. The nuanced findings underscore the complexity of changing provider behaviors and attitudes through a brief educational intervention. Further endeavors should explore tailored approaches, consider qualitative perspectives, and assess the long-term sustainability of the intervention's effects in real-world clinical settings.

Plan for Sustainability

Achieving sustained integration of the cultural humility-based training intervention into MHP practices at Denova Collaborative Health will require iterative cycles of testing and refinement. This project, following the principles of the Plan-Do-Study-Act (PDSA) model, has completed the initial PDSA cycle. Results indicate some enhancement of motivation, knowledge, and confidence among providers in utilizing the Trauma Symptoms of Discrimination Scale (TSDS). To ensure continued success and improvement, a second PDSA cycle is proposed. This next cycle will specifically focus on adapting the intervention to further enhance MHP self-efficacy and confidence in employing standardized measures during clinical encounters. The insights gained from this project serve as the foundational dataset for subsequent PDSA cycles, supporting ongoing refinement and the potential integration of the intervention into the onboarding process for future Denova Collaborative Health mental health professionals.

Plan for Dissemination

Following the DNP project, key findings from the cultural humility-based training intervention and its impact on providers' utilization of the TSDS will be disseminated through

Denova Collaborative Health's monthly email newsletter. Additionally, a detailed presentation of the project results, including observed improvements in motivation, knowledge, and confidence among MHP, will be featured in a monthly staff meeting (Appendix E). This dual approach ensures wide-reaching dissemination and encourages in-depth discussions among mental health professionals within the organization, fostering a collective understanding of the intervention's outcomes and implications for enhancing PCCS care.

APPENDIX A

SITE APPROVAL/THE UNIVERSITY OF ARIZONA INSTITUTIONAL REVIEW BOARD AUTHORIZATION LETTER

Denova Collaborative Health
3033 North Central Avenue 700
Phoenix, AZ 85012

Date: November 22, 2023

University of Arizona Institutional Review Board
c/o Office of Human Subjects
1618 E Helen St
Tucson, AZ 85721

Please note that Ms. Jahmekya Robinson, UA Doctor of Nursing Practice student, has permission of the Denova Collaborative Health to conduct a quality improvement project at our facility for her project, "Utilizing Cultural Humility-Based Training for Assessing Racial Trauma Symptoms in African Americans."

Ms. Jahmekya Robinson will conduct a survey of health care providers at Denova Collaborative Health. She will recruit providers through email. The email will provide a description of the project, what they will be asked to do, the time involved, and a link to the online survey. Ms. Jahmekya Robinson's activities will be completed by February 1, 2024.

Ms. Jahmekya Robinson has agreed to provide to my office a copy of the University of Arizona Determination before she recruits participants. She will also provide aggregate results for the providers at their monthly staff meeting.

If there are any questions, please contact my office.

Signed,

Luis Fong, DNP, PMHNP-BC
Psychiatric Supervisor
Director of Preceptorship and Development
Denova Collaborative Health

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University of Arizona IRB
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Tucson, AZ 85719
Fax: 520-621-9810
VPR-IRB@arizona.edu

NOT HUMAN RESEARCH

December 12, 2023

Jay Robinson

Dear Jay Robinson:

On 12/12/2023, the IRB reviewed the following submission:

Type of Review:	Initial Study
Title:	Utilizing Cultural Humility-Based Training for Assessing Racial Trauma Symptoms in African Americans
Investigator:	Jay Robinson
IRB Submission ID:	STUDY00003953
Sponsor:	None
Prime Sponsor:	None
IND, IDE, or HDE:	None
Documents Reviewed:	• Advisor Attestation, Category: Other; • Data Abstraction Form, Category: Other; • Disclosure Form, Category: Consent Form; • Educational Presentation Outline, Category: Participant Material; • IRB Protocol for Determination of Human Research, Category: IRB Protocol; • Questionnaires, Category: Participant Material; • Recruitment Email, Category: Recruitment Materials; • Site Authorization, Category: External Site Authorization;

The IRB determined that the proposed activity is not research involving human subjects as defined by DHHS and FDA regulations.

IRB review and approval by this organization is not required. This determination applies only to the activities described in the IRB submission and does not apply should any

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Research
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Tucson, AZ 85719
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changes be made. If changes are made and there are questions about whether these activities are research involving humans in which the organization is engaged, please submit a new request to the IRB for a determination. You can create a modification by clicking **Create Modification / CR** within the study.

All Covered Individuals must disclose all sponsored and non-sponsored Research Projects to the Office for Responsible Outside Interests (OROI) prior to Conducting Research if the individual is an Investigator. Please visit the OROI website for more information.

We value your feedback and would appreciate you taking the time to complete our survey about your experience with the IRB staff: https://uarizona.co1.qualtrics.com/jfe/form/SV_ehQ04WxNA06b42i.

If questions arise at any time during your study, please email the general IRB inbox at VPR-IRB@arizona.edu.

APPENDIX B

CONSENT DOCUMENT (DISCLOSURE FORM)

DISCLOSURE FORM

Utilizing Cultural Humility-Based Training for Assessing Racial Trauma Symptoms in African Americans

By: Jay Robinson

This Doctor of Nursing Practice quality improvement project was developed to conduct an educational presentation on the topic of racial trauma screening and how to utilize cultural humility-based principles to address racial trauma in the community's mental health setting.

You are invited to participate in this project. If you choose to take part in this project, you will be asked to fill out a brief pretest survey before the educational presentation and a posttest survey following the presentation. The presentation will take approximately 20 minutes and 5-10 minutes to complete each survey. Your responses are anonymous. Your name will not be collected or linked to your answers. There are no foreseeable risks associated with participating in this project. You will receive no immediate benefit from your participation. Your participation in this study entitles you to the benefit of one entry into a lottery raffle for one of two $25 Amazon gift cards. The lottery raffle winners will be notified via email after the completion of the project, with notifications expected no later than February 1, 2024.

If you choose to participate in the project, participation is voluntary. Refusal to participate in this study will not result in any penalty or loss of benefits otherwise entitled to you, except for the opportunity to enter the lottery raffle for a $25 Amazon gift card. You may withdraw at any time from the project. By participating, you do not give up any personal legal rights you may have as a participant in this project. By taking this survey, you agree to have your responses used for this project. Thank you for your time and attention, your participation in this project is immensely appreciated.

For questions, concerns, or complaints regarding your participation in this project, please email jir@arizona.edu

Jay Robinson, BSN, RN, DNP-PMHNP student
University of Arizona, College of Nursing

APPENDIX C

RECRUITMENT MATERIAL (RECRUITMENT EMAIL)

Recruitment Email

Hello,

You are invited to participate in a Doctor of Nursing Practice (DNP) quality improvement (QI) project involving an educational presentation on the topic of racial trauma screening and utilizing cultural humility-based principles to address racial trauma in the community mental health setting. The 20-minute PowerPoint educational session will be presented asynchronously using a link for viewing the session at your convenience. The project will include a 14-question pretest survey and a 10-question posttest survey. Each survey will take 5-10 minutes to complete. Please complete all intervention materials within 4 business days from receipt of this email for entry into a lottery raffle for one of two $25 Amazon gift cards. The link for the project disclosure statement, pretest survey, educational presentation, and posttest survey is provided here below:

https://uarizona.co1.qualtrics.com/jfe/form/SV_3rcWaBkrjTwXhzg

This project is being conducted by Jay Robinson, a DNP-PMHNP student through the University of Arizona College of Nursing. If you are interested in participating, please complete the disclosure statement and this will indicate your consent to participate in the QI project. The lottery raffle winners will be notified via email after the completion of the project, with notifications expected no later than February 1, 2024. If you have any questions regarding your participation in this project, what it entails, or any other general questions, please email jir@arizona.edu.

Thank you for your time, I look forward to your participation.

Sincerely,

Jay Robinson, BSN, RN, DNP-PMHNP Student
University of Arizona, College of Nursing

APPENDIX D

EVALUATION INSTRUMENTS (PRE-INTERVENTION SURVEY/DEMOGRAPHICS/PRE-INTERVENTION QUESTIONNAIRE/POST-INTERVENTION SURVEY)

Pre-Intervention Survey

Demographics

1. What is your current role or position?
    a. Psychiatrist (MD/DO)
    b. Nurse Practitioner
    c. Case Manager
    d. Therapist
    e. Psychologist

2. How many years have you worked as a mental health provider?
    a. < 1 year
    b. 1-3 years
    c. 4-7 years
    d. 7-10 years
    e. > 10 years

3. Have you previously completed CEUs/CMEs or other formal training on cultural humility?
    a. Yes
    b. No

4. What is your race? Select all that apply.
    a. White
    b. Black or African American
    c. American Indian or Alaska Native
    d. Asian
    e. Native Hawaiian or Pacific Islander

5. Are you Hispanic or Latino?
    a. Yes
    b. No

Pre-Intervention Questionnaire

1. A culturally humble racial trauma assessment can enhance my confidence in discussing the unique challenges of racial trauma with patients.
    a. Strongly disagree
    b. Somewhat disagree
    c. Neither agree nor disagree
    d. Somewhat agree
    e. Strongly agree

2. Recognizing racial trauma symptoms is essential to providing patient-centered culturally sensitive mental health care.
    a. Strongly disagree
    b. Somewhat disagree
    c. Neither agree nor disagree
    d. Somewhat agree
    e. Strongly agree

3. I am confident in recognizing and treating symptoms of racial trauma in patients.
    a. Strongly disagree
    b. Somewhat disagree
    c. Neither agree nor disagree
    d. Somewhat agree
    e. Strongly agree

4. I am confident in effectively communicating with patients experiencing racial trauma.
    a. Strongly disagree
    b. Somewhat disagree
    c. Neither agree nor disagree
    d. Somewhat agree
    e. Strongly agree

5. Cultural humility-based training on the use of a self-report questionnaire to assess patients for racial trauma can improve patient-provider communication.
    a. Strongly disagree
    b. Somewhat disagree
    c. Neither agree nor disagree
    d. Somewhat agree
    e. Strongly agree

6. It is feasible to integrate the Trauma Symptoms of Discrimination Scale into routine clinical practice to assess the progress of racial trauma treatment.
    a. Strongly disagree
    b. Somewhat disagree
    c. Neither agree nor disagree
    d. Somewhat agree
    e. Strongly agree

7. I am confident in utilizing the Trauma Symptoms of Discrimination Scale to assess racial trauma during diagnostic assessments and follow-up treatment sessions.
    a. Strongly disagree
    b. Somewhat disagree
    c. Neither agree nor disagree
    d. Somewhat agree

e. Strongly agree

8. Evidence-based interventions for managing racial trauma include which of the following?
    a. Avoid discussion of racial trauma, this can be retraumatizing.
    b. Recommend lifestyle interventions such as sleep hygiene and increased physical activity to address trauma symptoms.
    c. Utilize culturally humble assessments such as the Trauma Symptoms of Discrimination Scale (TSDS) during diagnostic assessments.
    d. Incorporate standard PTSD checklists as the primary tool for evaluating racial trauma symptoms.

9. What is the primary focus of the Trauma Symptoms of Discrimination Scale (TSDS) in mental health assessments?
    a. Measuring general stress levels
    b. Identifying symptoms related to racial trauma
    c. Assessing symptoms of anxiety disorders
    d. Evaluating physical health outcomes

Post Intervention Survey

1. A culturally humble racial trauma assessment can enhance my confidence in discussing the unique challenges of racial trauma with patients.
    a. Strongly disagree
    b. Somewhat disagree
    c. Neither agree nor disagree
    d. Somewhat agree
    e. Strongly agree

2. Recognizing racial trauma symptoms is essential to providing patient-centered culturally sensitive mental health care.
    a. Strongly disagree
    b. Somewhat disagree
    c. Neither agree nor disagree
    d. Somewhat agree
    e. Strongly agree

3. I am confident in recognizing and treating symptoms of racial trauma in patients.
    a. Strongly disagree
    b. Somewhat disagree
    c. Neither agree nor disagree
    d. Somewhat agree
    e. Strongly agree

4. I am confident in effectively communicating with patients experiencing racial trauma.
    a. Strongly disagree
    b. Somewhat disagree
    c. Neither agree nor disagree
    d. Somewhat agree
    e. Strongly agree

5. Cultural humility-based training on the use of a self-report questionnaire to assess patients for racial trauma can improve patient-provider communication.
    a. Strongly disagree
    b. Somewhat disagree
    c. Neither agree nor disagree
    d. Somewhat agree
    e. Strongly agree

6. It is feasible to integrate the Trauma Symptoms of Discrimination Scale into routine clinical practice to assess the progress of racial trauma treatment.
    a. Strongly disagree
    b. Somewhat disagree

c. Neither agree nor disagree
d. Somewhat agree
e. Strongly agree

7. I am confident in utilizing the Trauma Symptoms of Discrimination Scale to assess racial trauma during diagnostic assessments and follow-up treatment sessions.
    a. Strongly disagree
    b. Somewhat disagree
    c. Neither agree nor disagree
    d. Somewhat agree
    e. Strongly agree

8. Evidence-based interventions for managing racial trauma include which of the following?
    a. Avoid discussion of racial trauma, this can be retraumatizing.
    b. Recommend lifestyle interventions such as sleep hygiene and increased physical activity to address trauma symptoms.
    c. Utilize culturally humble assessments such as the Trauma Symptoms of Discrimination Scale (TSDS) during diagnostic assessments.
    d. Incorporate standard PTSD checklists as the primary tool for evaluating racial trauma symptoms.

9. What is the primary focus of the Trauma Symptoms of Discrimination Scale (TSDS) in mental health assessments?
    a. Measuring general stress levels
    b. Identifying symptoms related to racial trauma
    c. Assessing symptoms of anxiety disorders
    d. Evaluating physical health outcomes

10. Please provide any additional comments or feedback regarding the cultural humility-based training. (Optional)

APPENDIX E

PARTICIPANT MATERIAL (EDUCATIONAL INTERVENTION PRESENTATION LINK/POWERPOINT PRESENTATION/TRAUMA SYMPTOMS OF DISCRIMINATION SCALE – TSDS/EDUCATIONAL INTERVENTION PRESENTATION OUTLINE)

Educational Intervention Presentation Link

https://youtu.be/pkTCP33Yw20

12/18/23

Culturally Humble Care for Diverse Patients

Jay Robinson, BSN, RN, PMHDNP Student
University of Arizona

1

Introduction

The purpose of this training is to empower mental health providers with culturally sensitive approaches to assess and address racial trauma symptoms in African American patients

Fostering cultural humility to bridge gaps in understanding, improve patient-provider relationships, and enhance effective and compassionate mental health care

Training Content:

- Recognizing Racial Trauma
- Utilizing the Trauma Symptoms of Discrimination Scale (TSDS)
- Cultural Humility in Patient-Centered Care

2

Part I: Recognizing Racial Trauma

3

Significance

- > 50% of African Americans experience racial discrimination (Bedard et., 2021)
- Approximately 50% of hate crimes (Federal Bureau of Investigation, 2019)
- Highest rates of incarceration, homelessness, drug overdose deaths, poor mental health days, and suicide (PWD.us, 2018; KFF, 2021; Gentry & Cook-Davis, 2021; Olivet & Whitehead, 2021)

(Edwards et al., 2019; Felitti-Anda et al., 2019; Fisher et al., 2000; US Census Bureau, 2022)

4

Defining Racial Trauma

- Psychological and emotional distress resulting form exposure to racism or discrimination
- Encompasses the cumulative effects of systemic racism (O'Keefe et al., 2015)
  - Microaggressions
  - Overt discriminatory acts
- Leads to anxiety, depression, hypervigilance, and a diminished sense of safety (Mekawi et al., 2021)

5

Identifying Racial Trauma Symptoms

- Hypervigilance
- Emotional Distress
- Avoidance Behaviors
- Intrusive Thoughts
- Physical Symptoms

(Hart et al., 2019; Lopez et al., 2022; Pellancchi Bonanno et al., 2021)

6

Manifestation in Clinical Settings

TRUST ISSUES: PATIENTS MAY STRUGGLE TO TRUST PROVIDERS DUE TO PAST RACIAL TRAUMA

COMMUNICATION BARRIERS: DIFFICULTIES IN OPEN COMMUNICATION ABOUT MENTAL HEALTH CONCERNS

TREATMENT ADHERENCE: SYMPTOMS MAY IMPACT ADHERENCE TO TREATMENT PLANS

(Lelas et al., 2020; Talleyrand et al., 2017; Williams et al., 2018)

7

Addressing Racial Trauma Symptoms

- Unaddressed symptoms contribute to long-term mental health issues
- Recognition and intervention improves quality of life
- Early identification prevents the exacerbation of mental health conditions
- Validating these experiences enhances cultural sensitivity

(Williams et al., 2018)

8

Part II: Utilizing the Trauma Symptoms of Discrimination Scale (TSDS)

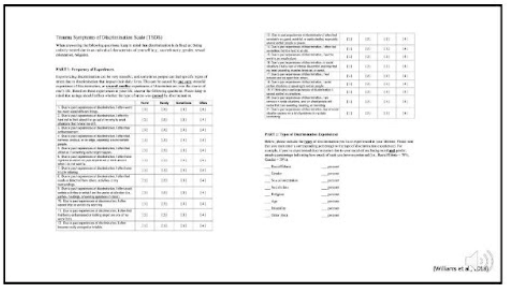
9

Trauma Symptoms of Discrimination Scale (TSDS)

- Developed to measure racial trauma symptoms
- Demonstrates validity, reliability, and sensitivity
- Focuses on dysfunctional anxiety and resulting avoidance

(Williams et al., 2018)

10



(Williams et al., 2018)

11

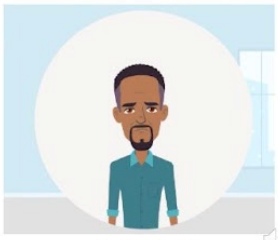
Trauma Symptoms of Discrimination Scale (TSDS)

- All forms of discrimination contribute to traumatization
- Traditional PTSD assessments may not capture the full range of discriminatory experiences
- Culturally sensitive assessment tool for identifying and monitoring changes
  - Elevated scores (61 and above) may indicate substantial distress

(APA, 2022; Williams et al., 2018)

12

Applying the TSDS



[Metzger et al., 2021; Williams et al., 2018]

13

Part III: Cultural Humility in Patient-Centered Care

14

Defining Cultural Humility

Cultural Humility: Lifelong commitment to self-reflection and self-critique with dedication to ongoing learning to understand diverse cultures, acknowledging the dynamic nature of culture

Cultural Competence vs Cultural Humility: Unlike cultural competence, cultural humility recognizes that cultural understanding is a process, requiring continuous growth and adaptation

[Lekas et al., 2020; Saha et al., 2008; Stubbe, 2020]

15

Practical Strategies for Culturally Humble Care

- Open-mindedness
- Respect for Cultural Differences
- Lifelong Learning
- Active Listening and Validation
- Addressing Implicit Biases

[Lekas et al., 2020; Saha et al., 2008; Stubbe, 2020]

16

Integrating Cultural Humility in Patient Care

- Incorporate Cultural Assessments
- Develop Cultural Curiosity
- Regular Self-Reflection
- Seek Patient Feedback
- Be Open to Learning from Patients
- Promote a Culturally Inclusive Environment

[Lekas et al., 2020; Saha et al., 2008; Stubbe, 2020]

17

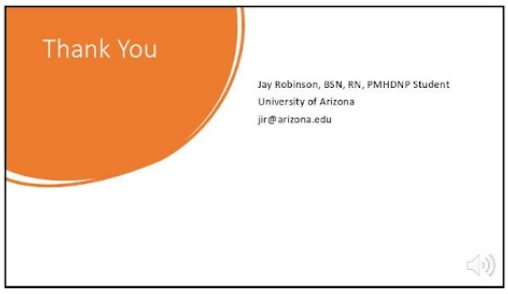
Conclusion

- Racial trauma significantly impacts mental health
- The TSDS is a valuable tool for addressing and managing racial trauma symptoms
- Cultural humility is an ongoing practice that promotes patient-centered care for diverse individuals
- **Reflection:** Consider your interactions with patients or clients from diverse backgrounds. How has cultural humility played a role in these interactions?

18


Resources
• Black Mental Health Alliance
• Cultural Diversity & Ethnic Minority Psychology
• Dr. Monnica Williams official website, Monnicawilliams.com
• National Institute of Mental Health

19


Thank You
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References

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Trauma Symptoms of Discrimination Scale (TSDS)

When answering the following questions, keep in mind that discrimination is defined as: Being unfairly treated due to an individual characteristic of yourself (e.g., race/ethnicity, gender, sexual orientation, religion).

PART 1: Frequency of Experiences

Experiencing discrimination can be very stressful, and sometimes people can feel specific types of stress due to discrimination that impact their daily lives. This can be caused by **one very** stressful experience of discrimination, or **several smaller** experiences of discrimination over the course of one's life. Based on these experiences in your life, answer the following questions. Please keep in mind that ratings should reflect whether the type of stress was **caused** by discrimination.

	Never	Rarely	Sometimes	Often
1. Due to past experiences of discrimination, I often worry too much about different things.	[1]	[2]	[3]	[4]
2. Due to past experiences of discrimination, I often try hard not to think about it or go out of my way to avoid situations that remind me of it.	[1]	[2]	[3]	[4]
3. Due to past experiences of discrimination, I often fear embarrassment.	[1]	[2]	[3]	[4]
4. Due to past experiences of discrimination, I often feel nervous, anxious, or on edge, especially around certain people.	[1]	[2]	[3]	[4]
5. Due to past experiences of discrimination, I often feel afraid as if something awful might happen.	[1]	[2]	[3]	[4]
6. Due to past experiences of discrimination, I often have nightmares about the past experience or think about it when I do not want to.	[1]	[2]	[3]	[4]
7. Due to past experiences of discrimination, I often have trouble relaxing.	[1]	[2]	[3]	[4]
8. Due to past experiences of discrimination, I often feel numb or detached from others, activities, or my surroundings.	[1]	[2]	[3]	[4]
9. Due to past experiences of discrimination, I often avoid certain activities in which I am the center of attention (i.e., parties, meetings, answering questions in class).	[1]	[2]	[3]	[4]
10. Due to past experiences of discrimination, I often cannot stop or control my worrying.	[1]	[2]	[3]	[4]
11. Due to past experiences of discrimination, I often find that being embarrassed or looking stupid are one of my worst fears.	[1]	[2]	[3]	[4]
12. Due to past experiences of discrimination, I often become easily annoyed or irritable.	[1]	[2]	[3]	[4]

13. Due to past experiences of discrimination, I often feel constantly on guard, watchful, or easily startled, especially around certain people or places.	[1]	[2]	[3]	[4]
14. Due to past experiences of discrimination, I often feel so restless that it is hard to sit still.	[1]	[2]	[3]	[4]
15. Due to past experiences of discrimination, I feel the world is an unsafe place.	[1]	[2]	[3]	[4]
16. Due to past experiences of discrimination, in social situations I feel a rush of intense discomfort, and may feel my heart pounding, muscles tense up, or sweat.	[1]	[2]	[3]	[4]
17. Due to past experiences of discrimination, I feel isolated and set apart from others.	[1]	[2]	[3]	[4]
18. Due to past experiences of discrimination, I avoid certain situations or speaking to certain people.	[1]	[2]	[3]	[4]
19. If I think about past experiences of discrimination, I cannot control my emotions.	[1]	[2]	[3]	[4]
20. Due to past experiences of discrimination, I am nervous in social situations, and am afraid people will notice that I am sweating, blushing, or trembling.	[1]	[2]	[3]	[4]
21. Due to past experiences of discrimination, fear of social situation causes me a lot of problems in my daily functioning.	[1]	[2]	[3]	[4]

PART 2: Types of Discrimination Experienced

Below, please indicate the **types** of discrimination you have experienced in your lifetime. Please note that you must enter a corresponding percentage to the type of discrimination experienced. For example, if you've experienced discrimination due to your racial/ethnic background **and** gender, attach a percentage indicating how much of each you have experienced (i.e., Racial/Ethnic = 70%, Gender = 30%).

___ Racial/Ethnic ___ percent

___ Gender ___ percent

___ Sexual orientation ___ percent

___ Social class ___ percent

___ Religion ___ percent

___ Age ___ percent

___ Disability ___ percent

___ Other (list): ___ percent

Educational Intervention Presentation Outline

I. Introduction (1 minute)

A. Welcome and Overview
1. Briefly introduce the purpose and content of the training.
2. Highlight the significance of recognizing and addressing racial trauma in mental health care and cultural humility in mental health care.

B. Objectives
1. Display the learning objectives:
    - Learn to use the Trauma Symptoms of Discrimination Scale (TSDS).
    - Identify racial trauma symptoms.
    - Understand and integrate cultural humility in mental health care.

II. Understanding Racial Trauma (5 minutes)

A. Definition and Context
1. Define racial trauma and its impact on mental health.
2. Discuss the prevalence and unique challenges faced by different racial and ethnic groups (Include statistics or examples for emphasis.)

B. Identifying Racial Trauma Symptoms
1. Provide examples of common racial trauma symptoms.
2. Discuss the importance of recognizing and addressing these symptoms.
3. Discuss how these may manifest in clinical settings.

III. Introduction to TSDS (5 minutes)

A. Overview of TSDS
1. Introduce the Trauma Symptoms of Discrimination Scale (TSDS) as a validated tool for assessing racial trauma.
2. Explain the purpose and structure of the Trauma Symptoms of Discrimination Scale.
3. Emphasize the tool's relevance in identifying racial trauma symptoms.
4. Explain its significance in capturing trauma not covered by traditional assessments.
5. Highlight how TSDS can be a valuable tool in assessing racial trauma.

B. Practical Demonstration
1. Walk through a sample TSDS assessment scenario.
2. Emphasize the importance of using TSDS as part of routine clinical practice.
3. Utilize simulated clinical scenarios for demonstration of using the TSDS, walking through each step with this sample case.

IV. Cultural Humility in Patient-Centered Care (5 minutes)

A. Definition of Cultural Humility
1. Define cultural humility and distinguish it from cultural competence.
2. Emphasize the importance of self-reflection and ongoing learning.

B. Practical Strategies for Culturally Humble Care
1. Outline key components of providing culturally humble care:
    - Open-mindedness
    - Respect for cultural differences
    - Lifelong learning
    - Active listening and validation.
    - Recognizing and respecting diverse cultural backgrounds.
    - Addressing implicit biases.
2. Provide practical tips for integrating cultural humility into interactions with patients.
    - Encourage viewers to apply what they've learned in their clinical practice.
3. Share examples of culturally humble language and behavior.

V. Conclusion and Q&A (2 minutes)

A. Summary
1. Recap key points about TSDS, racial trauma, and cultural humility.
2. Reiterate the importance of incorporating TSDS and cultural humility in mental health practice.

B. Reflection
1. Encourage viewers to pause and engage in a brief reflection.
2. Introduce thought-provoking questions to encourage reflection of experiences and insights.

VI. Resources and Support (1 minute)

A. Provide information on additional resources, literature, or support available for ongoing learning.
    1. Display a list of recommended resources for further learning.
    2. Include readings, websites, or training programs.
B. Reiterate the availability of support within the organization for any questions or concerns.

VII. Closing Remarks (1 minute)
A. Express gratitude for participants' engagement.
B. Acknowledge any contributors or supporting organizations.
C. Reaffirm the commitment to continuous improvement in cultural humility and patient-centered care.
D. PI Contact Information.

APPENDIX F

PROJECT TIMELINE

Planning January – July 2023	Pre-implementation August – November 2023	Implementation November – December 2023	Evaluation December – December 2023
• Research risk/benefits of assessing for racial trauma, PCCS care outcomes, and the Model. • Prepare and finalize participant recruitment and educational training materials. • Conduct needs assessment at Denova Collaborative Health clinic.	• Prepare and defend project proposal. • Acquire IRB approval to implement the project at Denova Collaborative Health. • Recruit Denova Collaborative Health MHP via email. • Obtain site authorization to implement the project.	• Collect pre-intervention and post-intervention data from participants. • Distribute a 20-minute educational training presentation to participants.	• Construct executive summary and sustainability plan for future use of the project to Denova Collaborative Health. • Analyze project data collected from participants. • Present project results at final defense.

APPENDIX G

LITERATURE REVIEW GRID

Project Question: Does cultural humility-based training for providers on the use of the TSDS to recognize trauma symptoms improve participants' motivation, knowledge, and confidence to provide patient-centered culturally sensitive care in a community mental health clinic?

Pub. Year; Author's Last Name	Title of Publication	Type of Study	Main Outcomes of Findings	Support for and or Link to Project
Carter & Murphy, 2017	Consensus and consistency: Exposure to multiple discrimination claims shapes Whites' intergroup attitudes	Case-control & meta-analysis	- Exposure to multiple discrimination claims reduced derogation of a subsequent claimant as a complainer. - High consensus and consistent information about discrimination experiences led to less derogation of Black claimants and a greater perceived prevalence of anti-black bias. - In contrast, high exposure to White discrimination experiences did not affect perceptions of a subsequent White claimant or the prevalence of anti-white bias.	- Exposure to multiple discrimination claims informs Whites about the prevalence of anti-Black bias, potentially enhancing cultural sensitivity. - Understanding the consensus and consistency in discrimination experiences may improve motivation to engage in culturally sensitive practices. - The study suggests that knowledge of minority discrimination experiences can influence attitudes, a key component of cultural sensitivity.
Lekas et al., 2020	Rethinking cultural competence: Shifting to cultural humility	Expert opinion	- Cultural humility training addresses the limitations of cultural competence. - It aims to reduce the risk of stereotyping patients, which can be a consequence of cultural competence training. - The training encourages providers to appreciate patients' lay expertise and share power, which can lead to improved patient-provider relationships. - Feedback from trainees indicates that cultural humility training helps in deconstructing racial biases and stereotypes.	- Encourages self-reflexivity, enhancing provider awareness of their own biases and limits of knowledge. - Fosters open, power-balanced relationships, crucial for patient-centered care. - Aims to improve communication by equalizing the patient-provider relationship.

Pub. Year; Author's Last Name	Title of Publication	Type of Study	Main Outcomes of Findings	Support for and or Link to Project
Renzaho et al., 2013	The effectiveness of cultural competence programs in ethnic minority patient-centered health care: A systematic review of the literature	Systematic review	- Systematic review assessed the effectiveness of cultural competence (CC) within patient-centered care (PCC) models. - PCC models with CC showed increased practitioner knowledge, awareness, and cultural sensitivity. - No significant evidence was found that these programs improved patient health outcomes. - Further research is needed to determine if increased practitioner knowledge leads to better patient-related outcomes.	- Utilization of PCC models incorporating cultural sensitivity can enhance providers' knowledge, awareness, and sensitivity to cultural differences. - Such training may improve communication skills, crucial for effective patient-centered care.
Saha et al., 2008	Patient-centeredness, cultural competence, and healthcare quality	Descriptive, conceptual analysis	- Cultural competence and patient-centeredness share core features and both can improve healthcare quality for individuals and populations. - Defines similarities and differences between patient-centeredness and cultural competence at interpersonal and health system levels. - Overlapping features at the system level include alignment of services with patient needs, community-based healthcare availability, tailored educational materials, and public performance information.	- Promotes a patient-centered approach to care, integrating knowledge of cultural specifics and effective communication for better healthcare delivery. - Increase in providers' skills using interpreter services and understanding cultural significance, crucial for culturally sensitive care.

Pub. Year; Author's Last Name	Title of Publication	Type of Study	Main Outcomes of Findings	Support for and or Link to Project
Stubbe, 2022	Practicing cultural competence and cultural humility in the care of diverse patients	Expert opinion	- Cultural competence and humility are essential for providing effective, equitable, and respectful care to diverse patient populations. - Patient-centered care and cultural competence are linked to improved healthcare quality. - Self-reflection on implicit biases and office practices can enhance the care of diverse patients. - Direct patient engagement in healthcare decisions and understanding their cultural practices can lead to better treatment outcomes.	- Cultural humility training emphasizes self-evaluation and critique, enhancing interpersonal sensitivity and openness. - Cultural humility is a process-oriented approach that complements the product-oriented cultural competence, necessary for effective PCCS care.
Tucker et al. 2022	Promoting weight-loss maintenance among Black women primary care patients: A cluster RCT of a culturally sensitive versus standard behavioral approach	Randomized controlled trial	- The intervention program led to significant weight loss among Black women patients with obesity (2.7 pounds, 1.22 kg). - Participants in both the Patient-Centered Culturally Sensitive Weight Loss Maintenance Program and the Standard Behavioural Weight Loss Maintenance Program maintained their weight loss. - At 18 months, participants in the PCC program had a significantly lower weight than those in the standard program (231.9 vs. 239.4 pounds).	- Intervention program calls for provider behaviors and attitudes consistent with those that are recognized in the published literature as cultural sensitivity indicators.
Tucker et al., 2007	Providing patient-centered culturally sensitive health care: A formative model	Formulating, mixed-methods	- Developed a formative Patient-Centered Culturally Sensitive Health Care Model linking culturally sensitive care to health-promoting behaviors and outcomes. An intervention program based on the model was described, aiming to improve healthcare engagement and outcomes. - Pilot inventories were created to assess PCCS health care in primary care clinics. - Evidence suggests that patients' perceived cultural sensitivity is associated with increased engagement in health-promoting lifestyles.	- The Model promotes enhancements in providers' ability to offer patient-centered care by recognizing and respecting African Americans' cultural experiences. - Increases knowledge of cultural factors that influence health behaviors and outcomes. - Develop skills to communicate effectively and build trust with African American patients.

Pub. Year; Author's Last Name	Title of Publication	Type of Study	Main Outcomes of Findings	Support for and or Link to Project
Tucker et al., 2011	Patient-centered culturally sensitive health care: Model testing and refinement	Qualitative empirical test, cross-sectional	- Empirical support for the Patient-Centered Culturally Sensitive Health Care Model's potential usefulness. - Significant links between patient-perceived provider cultural sensitivity and adherence to provider treatment regimen recommendations.	- Cultural humility training can enhance provider-patient communication, a key factor in patient satisfaction and adherence to treatment among African Americans. - Providers trained in cultural humility are likely to be perceived as more culturally sensitive, fostering trust and satisfaction in African American patients.
Tucker et al., 2017	Validation of an inventory for providers to self-assess Their engagement in patient-centered culturally sensitive health care	Qualitative self-report survey	- The T-CSHCPI was validated with a four-factor solution: interpersonal skills, conscientiousness, sensitivity, and disrespect/disempowerment. - These factors showed reliability and are associated with cultural competence, indicating the inventory's validity.	- The T-CSHCPI can be used to inform training that promotes PCCS health care by providers.
Tucker et al., 2019	A culturally sensitive church-based health-smart intervention for increasing health literacy and health-promoting behaviors among Black adult churchgoers	Non-randomized controlled trial	- Culturally sensitive intervention programs produced significant increases in nutrition label health literacy. - Participants in the intervention group engaged more in health-smart behaviors, particularly healthy eating and healthy drinking.	- By increasing knowledge and skills, such training supports the implementation of culturally sensitive interventions that are effective in African American communities. - Culturally sensitive care, informed by cultural humility, is crucial for interventions like Health-Smart AME, which rely on cultural tailoring to improve health outcomes.
Williams et al., 2018	Assessing racial trauma with the trauma symptoms of discrimination scale	Cross-sectional	- The TSDS identified four components of trauma symptoms: uncontrollable hyperarousal, feelings of	- The TSDS identified four components of trauma symptoms: uncontrollable hyperarousal, feelings of alienation, worries

Pub. Year; Author's Last Name	Title of Publication	Type of Study	Main Outcomes of Findings	Support for and or Link to Project
			alienation, worries about future negative events, and perceiving others as dangerous. - All forms of discrimination were found to significantly predict symptoms of trauma in African Americans. - The TSDS showed positive correlations with various measures of discrimination and psychopathology, indicating its concurrent validity.	about future negative events, and perceiving others as dangerous. - All forms of discrimination were found to significantly predict symptoms of trauma in African Americans. - The TSDS showed positive correlations with various measures of discrimination and psychopathology, indicating its concurrent validity.

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