UNPACKING OPPRESSION AND HOW IT SHOWS UP IN OUR WORK: HEALTH CARE VERSION

The purpose of this exercise is to help us connect the dots between violence and abuse and the ways that oppression informs these experiences. Building a future that is safe and healthy for all people in Oregon requires us to take stock of the ways that we may unintentionally reinforce harm in our work as helping professionals. This worksheet is an opportunity to explore your own case examples and how oppression presents itself in the experiences of your clients, patients, etc. This worksheet is designed to accompany our Oppression in Child Abuse case example resource and we invite you to review that document for additional context prior to working through this worksheet.

What specialty do you work in?
(Ex: emergency, inpatient, outpatient, clinic, rehab, education, etc.)

_____

What is your specific role?

_____

What is the general purpose of your role as defined by your facility?

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_____

What do you personally think of as a general goal of your work with your patients?

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_____

Think of a patient you have worked with in your professional capacity. You will want to choose a patient who experienced violence or abuse as a precursor to working with you. Use this space to jot down a brief summary of what happened and who was involved.

Note: Change names and other personally identifying information or details to align with HIPAA and other policies regarding confidentiality and privacy, especially if you are planning to share or work through this exercise with others.

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Acknowledgement: This document has been adapted from the more broadly applicable "Unpacking Oppression and How It Shows Up in Our Work" resource created by the Oregon Sexual Assault Task Force's Prevention Program. For non-health care professionals, we encourage you to refer back to the original resource, which can be accessed on our website: https://oregonsatf.org/programs/prevention.

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Thinking about your patient who **experienced harm,** let's consider some of the factors that help shape the way they experience the world. We have provided some ideas below and room for some we missed.

Race	Ethnicity	Gender
Sexual orientation	Religion	Primary language
Ability	Socioeconomic Status	Immigration status
Age	Criminal justice history	Other
Other	Other	Other

Now, let's repeat this process with what you know about the person who **caused the patient harm.**

Race	Ethnicity	Gender
Sexual orientation	Religion	Primary language
Ability	Socioeconomic Status	Immigration status
Age	Criminal justice history	Other
Other	Other	Other

We recognize that you may not always have the information listed above regarding your patient and the person who caused them harm. That is ok! Fill out what you know and as you do, consider the following questions.

- How do medical records tend to capture or miss the categories above?
- What changes about the way you provide medical care when you know the kinds of things listed above vs. when you know very little about your patient?
- What does not change about the way you provide medical care when you either do or do not have the information outlined above?

This is also a great opportunity to consider the power and privilege you hold, simply by being in a position to reflect on someone else's experiences in this way. Hold space for that idea as you complete this worksheet. We encourage you to reflect on your own identities and the impact they do or do not have on you and your experience of the world.

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Reflecting on what you have outlined on page 2, what are some stereotypes and biases that exist in regard to these identity factors? Many identities put folks at risk of being targeted, discriminated against or perceived as less-than when compared with dominant culture.

People may harm others because of their attitudes, beliefs and ideas about what is right, wrong, good, bad, desirable, etc.

The experience that someone has when interacting with the health care system, as well as other systems such as criminal justice, child welfare, housing, education, treatment and more, may differ as a direct response to the identities that person brings with them, depending on the norms and biases that have been ingrained in our systems.

People who experience harm likely have internalized ideas about their own identity factors based on the messages they have received at home, at school, in the media, from our law makers and more (for better or worse.)

Use this space below to outline these stereotypes and biases that come to mind. Try to be as honest as you can be with yourself (or whoever you are working with) during this activity.

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Think about the violence or abuse that was perpetrated against your patient. Use the space below to outline the types of violence or abuse present (such as physical, emotional, financial, sexual, trafficking, mental, isolation etc.)

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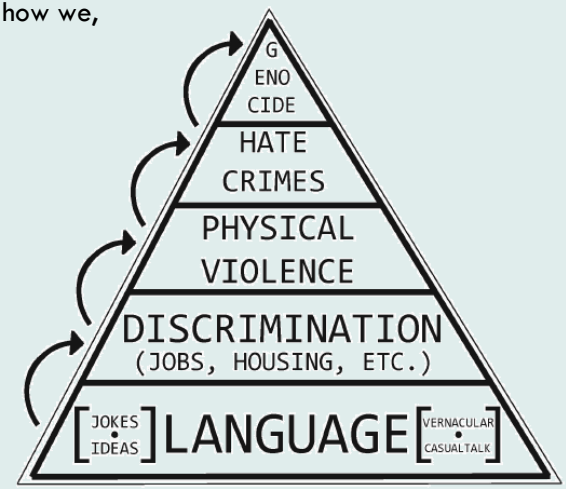
Here are some links that may be helpful as you consider this question. We know that violence and abuse can look different at times and we invite you to explore these resources as you're thinking about your client or patient and their experiences. (We have included two of these wheels at the end of this resource for easy access.)

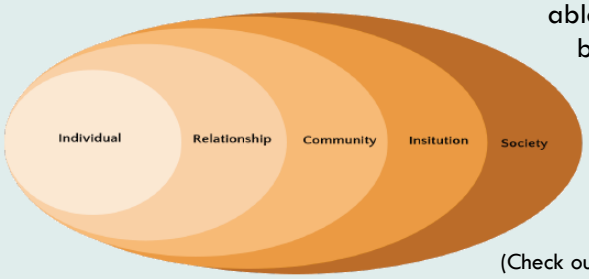
LGBTQQIA+ Power and Control Wheel
Abuse of Children Power and Control Wheel
Elder Abuse Power and Control Wheel
Unhealthy relationships Wheel

Let's think back to the stereotypes and biases that you thought about on page 3. When we as individuals, communities and societies accept harmful ideas and norms related to certain identities, we pave the way for violence and abuse to occur against the people in those identity communities and for that violence and abuse to be accepted and normalized. The roots of violence lie in how we think and talk about differences in our identities and how we, as a result, assign worth or value to those pieces.



Harmful ideas/norms + use of power/control = oppression and marginalization.

Oppression is the systematic and pervasive mistreatment of individuals on the basis of their membership in a disadvantaged group. It involves an imbalance in power, and one group benefiting from the systemic exploitation of other groups.



Oppression manifests in many forms such as racism, sexism, homophobia, transphobia, classism, ageism, ableism, adultism, ethnocentrism, xenophobia, and more. Oppression can be present at any level of the socioecological model which means that it can be experienced as an individual, in relationships, out in the community, within institutions and in the very fabric of our society. The socioecological model (SEM) shows us that we can impact and work to not only prevent violence and abuse at all of these levels, but also prevent oppression as a root cause at all of these levels.

(Check out our Comprehensive Prevention Toolkit, linked to the SEM graphic, for more on this!)

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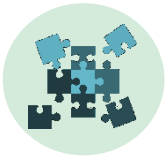

Let's make some connections!

Here we have outlined a few examples of some ways that oppression can turn into violence or abuse at different levels of the socioecological model and pose some questions for further thought.

Ableism → emotional abuse

Jo experiences multiple mental health conditions. Jo's partner Sam learned from their family growing up that mental health is not something to be talked about and is something to be ashamed of. Sam is not supportive of Jo seeking mental health treatment and gets mad at Jo when they show symptoms of their mental health conditions. Jo learns from Sam that it is not ok to need help and starts to believe that Sam is right when they say there is something wrong with them and that no one else would put up with Jo's behaviors or love them if they left.

Q: How would this background affect Jo's interaction with health care? Consider: What overall medical care is Jo likely to seek vs. not seek? How will this affect the way they interact with health care providers? What is likely to show up in their medical record? What is likely to be missed in their medical record?

Q: If you knew that Jo was adopted at a young age out of the foster care system **and** that Jo was raised by same-sex caregivers who were not supported by their community in their relationship: how would this shift your understanding of how Jo's identities impact their experiences?

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Racism & classism → police violence

Avery is Black and currently experiencing homelessness. On a number of occasions Avery has had the police called on them for illegal camping or making others "feel unsafe," even when Avery had not done anything wrong. Every time Avery has a police contact, it increases the negative perception the police have of them. One day, Avery is detained by a police officer who has internalized the idea that Black people are more likely to be violent, due at least in part to a lifetime of consuming media which presents Black and African Americans in this way. The officer believes (subconsciously or not) that Avery does not have the ability to advocate for themselves due to lack of resources and credibility. When the officer detains Avery they use excessive force as they believe that Avery is dangerous, resulting in injury to Avery. Avery is taken to the local Emergency Department to be treated and medically cleared before being transferred to jail.

Q: How would this background affect Avery's experience with health care? Consider: What kind of dynamics exist between staff and Avery, vs. staff and the officer? If Avery has been previously seen at this Emergency Department, what impressions may staff have already? What is likely to show up in their medical record? What is likely to be missed in their medical record?

Q: If you knew that gentrification and a long history of red-lining made housing unaffordable for Avery **and** that lack of access to healthcare to manage an unseen disability made it increasingly challenging for Avery to get a job in the professional sector for which they were trained: how would this shift your understanding of how Avery's identities impact their experiences?

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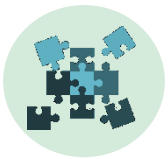

It is time to make some connections of your own regarding your patient and their experiences. For these purposes, we are going to ask you to consider how oppression was present from three different angles: as a root cause, as a tool, and as it was reinforced by systems and responses.

How was oppression a **root cause** for the behaviors of the person who **caused** harm?

1. What harmful *ideas and attitudes* about your patient's identity factors did **the person who caused the harm** hold? (Maybe these came to light either during conversation with the person who caused harm or during retelling by your patient about their experiences. These may be inferences as well, based on behaviors.) If you do not have this information, use this space to think about how **not** having this information may have impacted your work with your patient.

How did the person who **caused** the harm **utilize** oppression to harm your patient?

2. What kinds of things did **the person who caused harm** *say and do* to your patient that were harmful *and* tied to one or more of your patient's identity factors?

If **you are struggling with this question, here are some examples to consider of ways that people may talk about their oppressive beliefs and ideas.**

"She is crazy, I don't listen to anything she says because she is nuts." (Ableism re: mental health.)

"He is just a kid, I know what is best for him regardless of what he says." (Adultism re: youth voices.)

"They are on welfare, probably too lazy to get a job." (Classism re: employment and public benefits.)

"The problem is all these illegal immigrants who do not belong here, do not speak English and bring all their problems with them." (Racism, ethnocentrism and xenophobia re: immigration and assimilation.)

Consider *how* things were said and done. Think about the intention AND the impact.

Refer back to the resource links provided on page 3 (and the power and control wheels at the end of this document) for ideas about how violence, abuse and harm are perpetrated in different ways toward different groups.

Consider the climate that was caused by the things the harm-doer said and did. Often times fear and manipulation are used to keep power and control over a person who is at risk of experiencing harm due to their identities.

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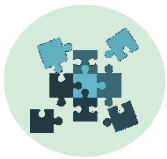

Finally, we are going to take a look at how systems may have reinforced oppression for your patient. Reinforcing harm is often unintentional and may be difficult to see on a surface level. Consider the following examples of how systems can reinforce oppression.

- Police are called to a domestic disturbance and find that the victim is high and has an addiction to methamphetamine. The abuser is able to frame the victim for the violence that occurred. The victim is arrested for possession of a controlled substance and assault. As such the victim's housing, employment, access to health care and ability to see their children is impacted, worsening the victim's addiction crisis.

- A gender-nonconforming person is seeking to establish a primary care provider in a new town. When they begin to fill out paperwork they are asked to choose male or female and there is not an option for another choice. The resources at the doctor's office all use gendered pronouns. When the doctor speaks to them they misgender them based on their appearance and do not ask what pronouns they use. The person does not return for regular medical care because they do not feel safe or valued in the space.

Use the space below to think about the ways that the systems your patient interacted with did, or could have, reinforced oppression. When we are thinking of systems, we are thinking of things like health care, law enforcement, addiction treatment, educational settings, child abuse response/intervention, housing, etc. Some prompts to consider: What was one way the patient's voice was not and/or could not be centered in the process? What do the system responses tell you about who was believed in the scenario, and why? Consider things like service provision, service coordination, cultural responsiveness, and capacity to give adequate time and resources to meet the patient's needs.

Your System:_____

How did/could it reinforce oppression:

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System:_____

How did/could it reinforce oppression:

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System:_____

How did/could it reinforce oppression:

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System:_____

How did/could it reinforce oppression:

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As you reflect on this exercise and the experiences the patient had with oppression in this instance, let's revisit the goal of your work that you identified on page 1. Write it down again here for reference.

What do you personally think of as a general goal of your work with your patients?

Use the space below to brainstorm some ways that you and the other service providers involved (within health care and other systems) could have set up a different experience for the patient in your example. Consider the prompt: What is at least 1 way you can work toward addressing the harm that was caused (intentionally or unintentionally) as outlined on page 7? What could you or the other service providers have done differently? As you complete this section, hold space for the goal of your work and thinking about how shifting your work moves you either closer to or further away from your goal.

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As we wrap up…

Let's take a quick look at prevention and how it connects to your work and provides action ideas for creating a better experience. There are generally three levels that we talk about when we talk about prevention: Primary, Secondary and Tertiary.

Upstream (primary) prevention efforts work to address root causes of violence and abuse and prevent it from ever occurring in the first place. Some examples would be universal access to health care and housing; comprehensive sexuality education for youth; skills training for new parents; and initiatives that aim to strengthen peer relationships and support within communities.

Midstream (secondary) prevention efforts work to increase awareness of violence and abuse concerns that need addressing and change the trajectory for those at high risk. Some examples would be awareness months for different causes; support services that can intervene when red-flags are present; and skills training for things like social and communication skills for teens at higher risk of perpetrating violence.

Downstream (tertiary) prevention efforts work to prevent the reoccurence of violence and abuse after it has occurred. Some examples would be culturally specific response services for those who experience child abuse; and behavior modification programs for those that perpetrate domestic violence.

Where does your work currently tend to fall on the spectrum of prevention? How can you shift your work to include more intentional primary prevention efforts to stop violence and abuse from occurring in the first place?

_____

_____

_____

_____

Violence and abuse are preventable and we all have a role to play.

We must address the root causes that allow violence and abuse to thrive if we want to create a safer, healthier and more just Oregon for all. We believe that oppression is the root cause of violence and abuse, as it teaches us to value some people over others, for many reasons. We also know that it is not enough to simply tell people what not to do- we must replace harmful ideas, behaviors, and norms with healthy ones.

How do you see the ideas above fitting into your work? Use this last space to think about this question and imagine one or more way you can incorporate these kinds of shifts into what you do.

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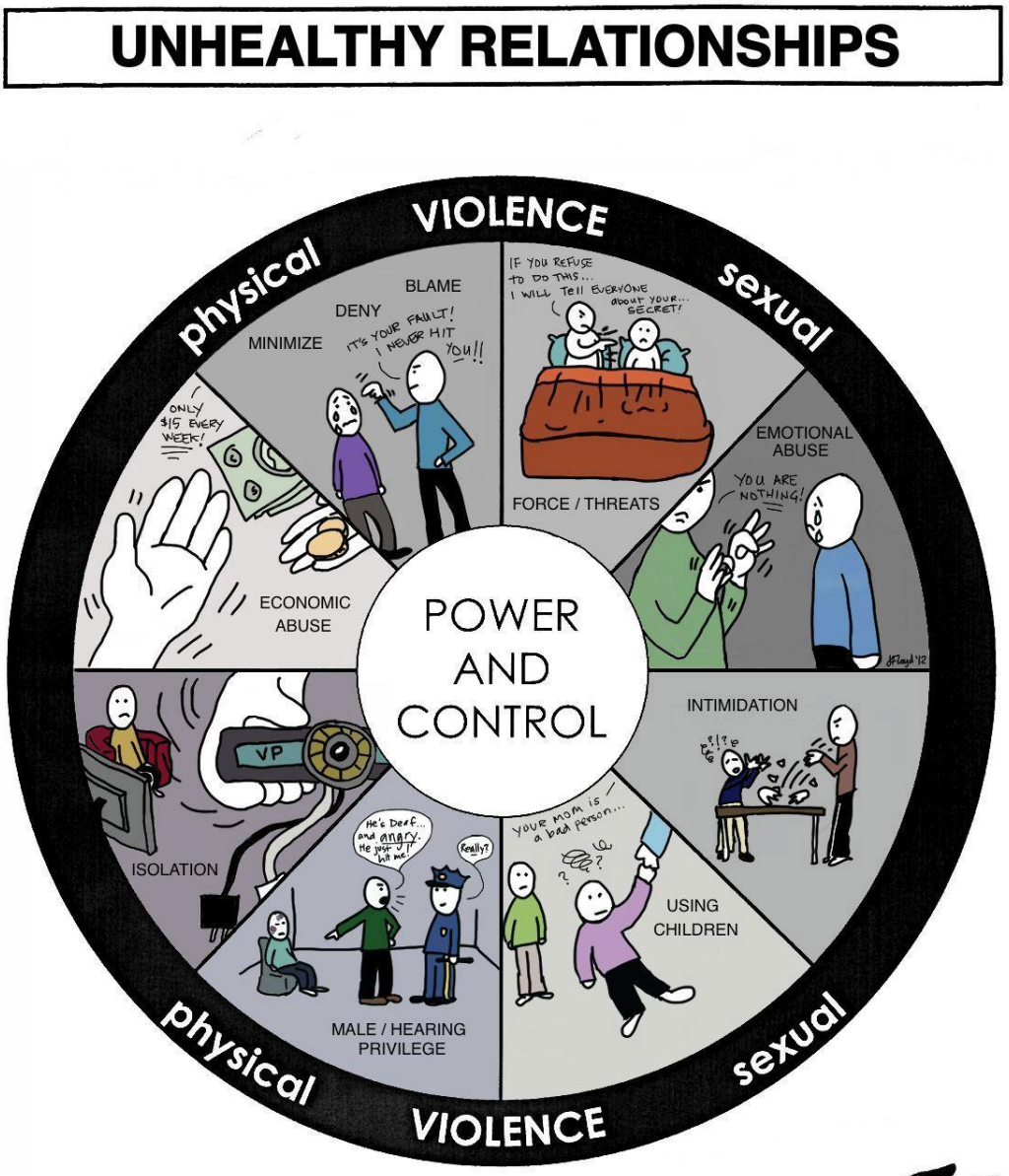

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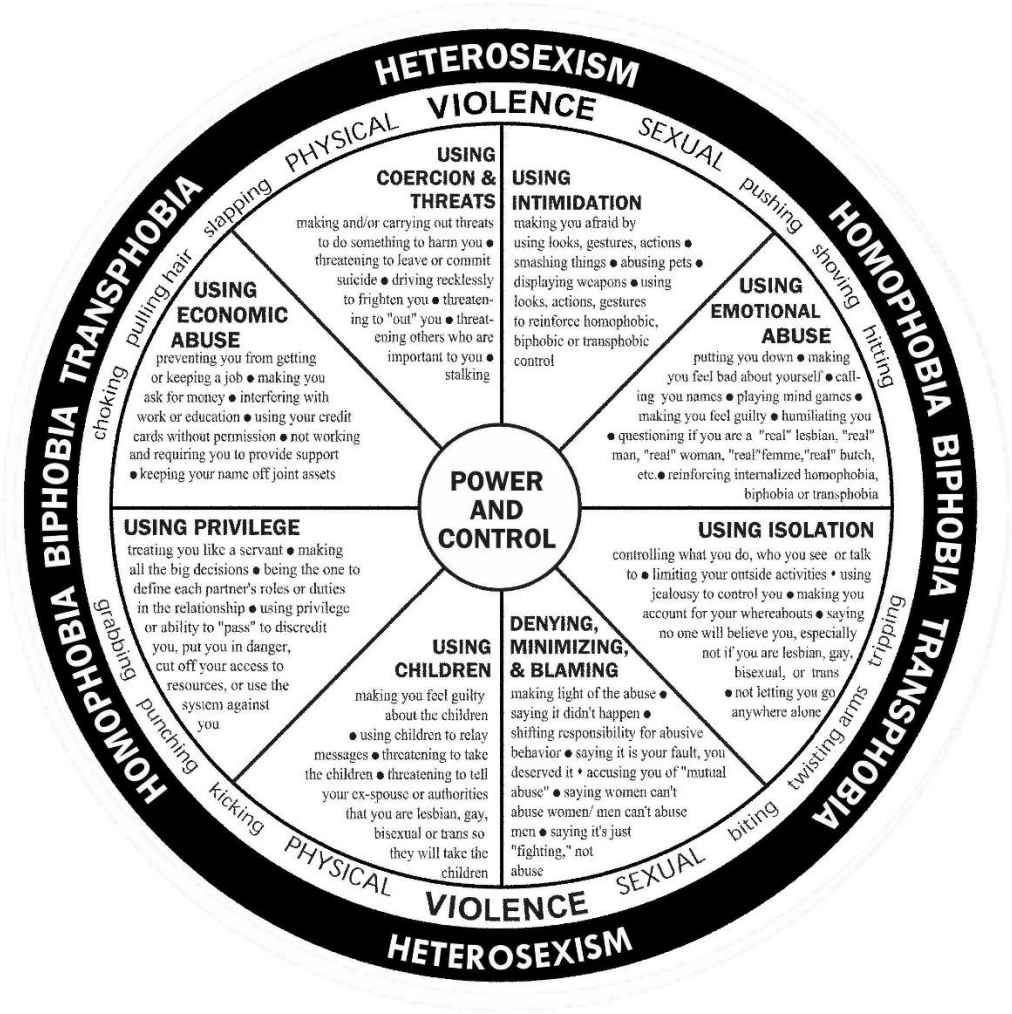
Power and Control Wheel for Lesbian, Gay, Bisexual and Trans Relationships



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