

**C011738 ABSTRACT:** Cultural competency can be defined as a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enable them to work effectively in cross-cultural situations. The cultural appropriateness of mental health services may be the most important factor in the accessibility of services by people of color. Developing culturally sensitive practices can help reduce barriers to effective treatment utilization. This guidebook published by the Hogg Foundation provides recommendations on how providers can improve the delivery of mental health services to culturally diverse groups using appropriate assessments, translators and outreach.

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# Cultural Competency



*A PRACTICAL GUIDE FOR  
MENTAL HEALTH SERVICE PROVIDERS*



*By Delia Saldaña, Ph.D.*

Hogg Foundation for Mental Health

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# **Cultural Competency**

*A PRACTICAL GUIDE FOR  
MENTAL HEALTH SERVICE  
PROVIDERS*

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### **About the Author**

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# What is Cultural Competency?

## *Cultural Competency can be defined as:*

- A set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enable them to work effectively in cross-cultural situations. Cultural competency is the acceptance and respect for difference, a continuous self-assessment regarding culture, an attention to the dynamics of difference, the ongoing development of cultural knowledge, and the resources and flexibility within service models to meet the needs of minority populations (Cross et al., 1989).
- Davis (1997) operationally defines cultural competency as the integration and transformation of knowledge, information, and data about individuals and groups of people into specific clinical standards, skills, service approaches, techniques, and marketing programs that match the individual's culture and increase the quality and appropriateness of health care and outcomes.
- Cultural competency does not refer to the establishment or maintenance of diversity per se. The concept of competency is not related to numbers of representation, either in clients or in service providers.
- Competency refers more explicitly to folkways, mores, traditions, customs, formal and informal helping networks, rituals, dialects, and so forth. In these areas, knowledge about various cultures and the development of specific skills and attitudes in providing services in a manner consistent with the client's needs are essential.

## *Why is Cultural Competency Important?*

- The cultural appropriateness of mental health services may be the most important factor in the accessibility of services by people of color. Developing culturally sensitive practices can help reduce barriers to effective treatment utilization.
- Rapport building is a critical component of competency development. Knowing whom the client perceives as a "natural helper" and whom he/she views as traditional helpers (such as elders, the church) can facilitate the development of trust and enhance the individual's investment and continued participation in treatment.
- America's population is not only growing, it is changing dramatically. Texas is no exception, being one of the most diversely populated states in the country.
- Shifts in ethnic diversity are not just about numbers, but also the impact of cultural differences. New approaches are needed in service delivery to address cultural differences among consumers.
- As managed care processes extend into the public sector through Medicaid and Medicare, the need to identify a relevant conceptual framework to guide service design and delivery becomes even more evident.

# Essential Knowledge, Skills, and Attributes to Developing Cultural Competence

Ensuring the provision of culturally competent services to clients places a great deal of responsibility upon the mental health professional. In particular, there are a number of generally expected levels of knowledge, skills and attributes that are essential to providing culturally competent mental health services. For example:

## *Knowledge*

- Knowledge of clients' culture (history, traditions, values, family systems, artistic expressions).
- Knowledge of the impact of racism and poverty on behavior, attitudes, values, and disabilities.
- Knowledge of the help-seeking behaviors of ethnic minority clients.
- Knowledge of the roles of language, speech patterns, and communication styles in different communities.
- Knowledge of the impact of the social service policies on clients of color.
- Knowledge of the resources (i.e., agencies, persons, informal helping networks, research) available for ethnic minority clients and communities.
- Recognition of how professional values may either conflict with or accommodate the needs of clients from different cultures.
- Knowledge of how power relationships within communities or institutions impact different cultures.

## *Professional Skills*

- Techniques for learning the cultures of ethnic minority client groups.
- Ability to communicate accurate information on behalf of culturally different clients and their communities.
- Ability to openly discuss racial and ethnic differences/issues and to respond to culturally based cues.
- Ability to assess the meaning that ethnicity has for individual clients.
- Ability to discern between the symptoms of intra-psychic stress and stress arising from the social structure.
- Interviewing techniques that help the interviewer understand and accommodate the role of language in the client's culture.
- Ability to utilize the concepts of empowerment on behalf of culturally different clients and communities.
- Ability to use resources on behalf of ethnic minority clients and their communities.

- Ability to recognize and combat racism, racial stereotypes, and myths among individuals and institutions.
- Ability to evaluate new techniques, research, and knowledge as to their validity and applicability in working with people of color.

### ***Personal Attributes***

- Personal qualities that reflect “genuineness, empathy, nonpossessiveness, warmth,” and a capacity to respond flexibly to a range of possible solutions.
- Acceptance of ethnic differences between people.
- A willingness to work with clients of different ethnic backgrounds.
- Articulation and clarification of the worker’s personal values, stereotypes, and biases about his/her own and others’ ethnicity and social class. Also, recognizing ways that these views may accommodate or conflict with the needs of clients from different cultures.

## **Communication is Key**

Obviously, the most fundamental function of any therapeutic session is communication. We all use verbal and non-verbal ways of expressing ourselves that have been influenced by the culture in which we were raised. These styles can vary dramatically for people from other backgrounds. For example:

- **Personal Space:** In the United States it is common for people to stand about 3 feet apart when having a personal conversation. In other cultures, people may typically stand close, which may feel awkward to someone unfamiliar with this style.
- **Eye Contact and Feedback Behaviors:** In the United States, individuals are encouraged to look each other directly in the eye and participate actively in feedback behaviors (leaning forward, smiling, nodding, etc.). In contrast, people from other backgrounds may show respect or deference by not engaging in eye contact or participating more passively in their body language.
- **Interruption and Turn-taking Behaviors:** Most Americans have come to expect a conversation to progress linearly, while in other cultures it may be more natural for several people to be talking at once. Listening skills to deal with different turn-taking rules must be developed.
- **Gesturing:** Hand and arm gesturing can vary quite a bit in different cultural backgrounds. In general, extra gesturing should not necessarily be interpreted as excitement since it can just be an ordinary manner of communication, depending on the speaker.
- **Facial Expression:** Variance in this form of communication is also common, and again it is important to not assume that someone is cold or distressed based solely on one’s own cultural experience.

- **Silence:** Americans often find it harder to tolerate periods of prolonged silence than do others from different cultures, and may try to fill it in.
- **Dominance Behaviors:** In the United States, prolonged eye contact, an erect posture, looking down at someone with lowered lids, hands or hips, holding the head high are all examples of behavior that may be interpreted as assertive or even aggressive but can vary in different cultures.
- **Volume:** Irritation often results when culturally different speakers consider differing levels of volume acceptable. It is important to remember that each individual may be reacting based on the rules learned in his/her own background and considered normal by his/her peers.
- **Touching:** Persons from cultures outside the U.S. mainstream may perceive someone as cold and aloof if there is not much touching and standing close, while the American may find someone from a different culture a bit rowdy, intrusive, or rude.

## **Building Counselor/Client Rapport**

It is important to engage clients and families in a respectful and warm atmosphere. Be sure to pronounce names correctly. Decide if an interpreter or translator is needed. Most importantly, keep the following concepts in mind:

- Determine, given the client's cultural background, who should be present, and who is recognized as a family authority and should be included in key input about the client's current functioning.
- Briefly describe the prescribed treatment and explain the role of each participant. Acknowledge that this may differ from what the client and the family's prior experience with help-seeking would lead them to expect. Also explain confidentiality, what it does/does not cover, and how it will/will not be affected by residency and immigrant status.
- Help the patient/family prioritize their problems and determine what they perceive as the important goals. What are their expectations? How will they know when the goals have been achieved?
- Assess possible problems in light of other factors, such as the need for food, shelter, and employment or stressful interactions with agencies. Provide the necessary assistance in developing and maintaining environmental supports.
- Determine the assets and resources available to the client and family. Has the client, or other family members or friends, dealt with similar problems? What cultural resources have they turned to in the past? What was the outcome? Summarize the problem as you understand it and make sure the client knows you understand it.

- Discuss the possible participation of family members in treatment. Within the family, determine the hierarchical structure as well as the degree of acculturation of the different members. Focus on the problems produced by conflicting values.
- Explain the specific treatment to be used, why it was selected, and how it will help achieve the client's goals. With the client's input, determine a mutually agreeable length of treatment.
- Discuss possible consequences of achieving the goals for the individual, family, and community.

## Potential Failures in Cross-Cultural Therapeutic Process

### Engagement

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#### *Client*

Notices difference  
Perceives social distance  
Assumes therapist won't understand  
Fears being judged  
Exhibits increased anxiety

#### *Therapist*

Notices difference  
Perceives social distance  
Doesn't acknowledge importance  
Sees client as stereotype  
Does not address anxiety

### Therapeutic Alliance

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#### *Client*

Does not develop rapport  
Feels misunderstood  
Shows increased mistrust  
Decreases self-disclosure

#### *Therapist*

Assumes client is resistant  
Does not understand client  
Fails to respond to mistrust  
Sees client as unmotivated or not psychologically minded

### Outcome

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#### *Client*

Shows frustration and anxiety  
Cancels sessions  
Fails to show for appointments  
Terminates treatment prematurely

#### *Therapist*

Shows anxiety and frustration  
Exhibits misalliance; may misdiagnose  
Perceives faulty treatment planning  
Observes failed outcomes

## Is Your Message Getting Through?

It is not condescending to ensure that you are being understood. Here are some suggestions you may want to consider to ensure clarity:

- Communicate your thoughts in an organized fashion. Take a moment to think about what it is you want to get across to the client and present that information in a clear and concise way. For example: "You have to \_\_\_\_\_ because of \_\_\_\_\_. You must do these three things to stop it: 1\_\_\_\_\_, 2\_\_\_\_\_, and 3\_\_\_\_\_."
- Simplify your language. Words common to you can be unfamiliar and confusing to a client and/or family. Be especially careful about using specialized language or jargon that may be unfamiliar to those outside the mental health professions.
- If you choose to use pre-printed pamphlets to help you explain a condition, underline or highlight important passages. This way the client and/or family does not have to read the entire, possibly dense, text in order to refer back to specific information.
- Any information that you write in longhand should be printed, not handwritten. It is preferable to write using both upper and lower case letters, as opposed to all capitals. Also, keep the instructions to short, simple sentences; avoid abbreviations.
- Utilize tools that may help clients and families remember instructions. Prompt the client to repeat your instructions by asking him questions such as, "What will you tell your spouse about your condition?" This way, you will find out if he or she understands the situation.
- Make instructions relevant to the lives of clients and families. For example, if an individual must take medication twice a day, inquire about his/her daily schedule and when he/she expects to be taking it. Then ensure that the person will commit to maintaining that schedule.
- Use a small cassette recorder and blank tapes. Thirty-minute tapes can be purchased for less than a dollar. Record your diagnosis and advice as you are interacting with the client and family so that they will be able to refer back to the information as necessary.

# Conducting Culturally Sensitive Assessments

There are a variety of common pitfalls in assessing people of color that occur frequently in the mental health field.

- **Language:** It is important that an individual be assessed in his/her primary language. This is especially important in the area of mental health, where emotions play such a heavy role in the individual's level of functioning. Obtaining assessment instruments in an individual's primary language is necessary for technical accuracy as much as it is a question of ethical treatment.
- **Vocabulary:** Using instruments that have been translated into another language may help, but should not be assumed to be "enough." Many times, people of color may have used local, idiomatic terms that do not correspond with the version of language used in an instrument (e.g., Castilian vs. Tejano Spanish). It is important to ensure that an individual understands the concept of what is being assessed.
- **Familiarity with Testing:** Many individuals may not be informed about what comprises testing, nor its uses. Testing may bring up old fears about school achievement and anxieties, and the client may feel worried about being seen as inadequate by his/her therapist. Adequate explanation about the purpose of testing, its application to the treatment plan, and general intention to benefit the client is critical.
- **How the Test has been Developed:** Tests that have been developed, validated, and standardized on individuals of specific ethnic groups are of limited validity in their application to others. It is important to not place undue importance on a score that may mean different things for different groups of individuals.
- **Level of Acculturation:** Acculturation taps a variety of areas, including familiarity with mainstream U.S. culture, endorsement of certain values, maintenance of a particular lifestyle, choices of social network, and decisions about how to seek help. These are cultural variants that should be noted in a descriptive, rather than a judgemental, approach. It is important to recognize the diversity that exists within a certain group.

## Suggested Tests for Culturally Diverse Groups

Name	Area	Reference
<b>Center for Epidemiological Studies Depression Scale (CES-D)</b>	Depression	<i>Radloff (1977)</i>
<b>Schedule for Affective Disorders and Schizophrenia (SADS)</b>	Most Disorders	<i>Spitzer and Endicott (1978)</i>
<b>Culture Fair Intelligence Test</b>	Intelligence	<i>Anastasi (1988)</i>
<b>Kaufman Assessment Battery For Children (K-ABC)</b>	Intelligence	<i>Kaufman, Kamphaus &amp; Kaufman (1985)</i>
<b>Leiter International Performance Scale</b>	Intelligence	<i>Anastasi (1988)</i>
<b>Progressive Matrices</b>	Intelligence	<i>Anastasi (1988)</i>
<b>System of Multicultural Pluralistic Assessment (SOMPA)</b>	Intelligence	<i>Mercer &amp; Lewis (1978)</i>
<b>Draw-A-Person Test</b>	Projective	<i>French (1993)</i>
<b>Holtzman Inkblot Technique (HIT)</b>	Projective	<i>Holtzman (1988)</i>
<b>Eysenck Personality Questionnaire (EPQ)</b>	Personality	<i>Eysenck, Eysenck (1975)</i>
<b>Tell-Me-A-Story Test (TEMAS)</b>	Personality & Cognition	<i>Constantino, Malgady, &amp; Rogler (1988)</i>

*Other current references for culturally sensitive psychological assessments are listed in the References section of this manual.*

# Evaluation of Culturally Related Syndromes

Examples of cultural-related syndromes that practitioners are most likely to encounter in their practice include the following:

- *Ataque de nervios* among Latinos (i.e., a neurotic or psychotic episode due to a traumatic event).
- *Amok* and *mal de pelea* among clients from Malaysia, Laos, Philippines, Polynesia, Papua New Guinea, and Puerto Rico (a dissociative disorder involving outbursts of violent and aggressive or homicidal behavior directed at people and/or objects).
- *Dhat* in the Indian, Chinese, and Sri Lankan communities (extreme anxiety associated with a sense of weakness, exhaustion, and the discharge of semen).
- *Falling out* in African American communities (seizure-like symptoms resulting from traumatic events, such as a death in the family).
- *Ghost sickness* among American Indians (weakness and dizziness resulting from the action of witches and evil forces).
- *Hwa-byung* in Asian communities (pain in the upper abdomen, fear of death, and tiredness resulting from the imbalance between reality and anger).
- *Koro* among Asian communities (a man's desire to grasp his penis resulting from the fear that it will retract into his body and cause death).
- *Pibaloktog* in the case of clients from the Arctic and subarctic Eskimo communities (excitement, coma, and convulsive seizures resembling an abrupt dissociative episode; often associated with amnesia, withdrawal, irritability, and irrational behaviors, such as breaking furniture, eating feces, and verbalization of obscenities).
- *Taijin kyofusho* in the case of Asian communities (guilt about embarrassing others and timidity resulting from the feeling that one's appearance, odor, or facial expressions are offensive to other people).
- *Mal puesto*, *hex*, *root-work*, and *voodoo death* among African Americans and Latinos (unnatural diseases and death resulting from the power of people who use evil spirits).
- *Susto*, *espanto*, *espasmo*, and *miedo* among Latinos (tiredness and weakness resulting from frightening and startling experiences).

# Translator and Interpreter Challenges in Cross-Cultural Treatment

The chief concern in communicating across cultures is ensuring that what one person intends is what the other hears. Additionally it is important to consider that communication consists of both verbal and nonverbal transmission of valuable information. It must also be recognized that more than one message is invariably being communicated at the same time.

For communicating across languages, translation is a very difficult task. Problems are often associated with the interpreter's competence and translation skills, lack of familiarity with psychiatric terms, or with counseling knowledge and attitudes. Frequent errors include distortion, deletion, omission or blocking, exaggeration, incorrect translation, inappropriate cultural interpretation, or lack of translatable words or concepts.

### *Common pitfalls to avoid:*

- Using a family friend or relative to convey information.
- Using secretarial, custodial, domestic staff, or children to assist in translation.
- Providing insufficient time for interpreter and patient to be introduced and gain basic rapport.

### *Strategies that can help:*

- Talk to the patient, not the interpreter. Maintain eye contact.
- Use short, simple statements. Ask one question at a time.
- Speak slowly throughout. Try to sit down during the interview.
- Avoid idioms, jargon – speak in plain language.
- Do not raise your voice throughout the interview.
- Plan for more time: using translators usually doubles the length of the interview.

### *Some preparatory questions and ideas to help the interview go smoothly:*

- Do interpreter and patient speak the same dialect?
- How proficient is the interpreter in the desired language?
- Emphasize how confidentiality is practiced.
- Use body language to accomplish the gains you desire.
- Do not take excessive notes in front of the patient.
- Examine the relationship between patient and interpreter – is one or the other embarrassed or hesitant to disclose?
- Is everyone's understanding of the point of the questions clear?
- Use the interpreter as a cultural broker to explain idioms or meanings of particular terms.

# Addressing Cultural Variability

Within each cultural group there is a tremendous amount of variability, or individual differences. It is true that "they are not all alike." Differences arise from a number of factors and should be recognized so that providers can serve clients' individual needs. Examples include:

- **Acculturation:** This factor subsumes many of the other issues addressed in this section, and reflects the extent to which a person is familiar and proficient within mainstream U. S. culture.
- **Poverty:** Some individuals assert that there is a "culture of poverty" that is governed by a different set of resourceful behaviors needed for survival. These do not usually include awareness or compliance with traditional mental health interventions and may override the priority given to emotional health.
- **Language:** Differences exist not only in fluency in the client's native language and English, but also in dialect. For example, among Asians/Pacific Islanders, there are many language sub-groups: Chinese, Japanese, Cambodian, Laotian, Filipino, Hawaiian, Hmong, Khmer, Vietnamese, etc. Latino groups include Mexican Americans, Mexicans, Central Americans (e.g., Salvadorans, Guatemalans, Hondurans, Nicaraguans) and South Americans (Argentineans, Venezuelans, etc.). The Mexican province of Oaxaca alone has 23 regional indigenous dialects, not including Spanish. American Indians consist of more than 600 federally and state-recognized tribes, each accompanied by a distinct language, culture, oral history, and tradition.
- **Transportation, Housing & Childcare:** Often associated with poverty or immigrant status, daily necessities and a lack of available supports can interfere with access to treatment and adherence with provider expectations. It is incumbent on a provider to be culturally competent by addressing these basic needs as part of a treatment plan.
- **Reading Ability/Educational Background:** Individuals can vary substantially in academic experience and aptitude. This is true within each ethnic subgroup (e.g., Mexican Americans), as well as between subgroups (Guatemalans vs. Argentineans).
- **Beliefs:** People from diverse cultures vary in their beliefs about what is considered "illness," what causes the illness, what should be done to promote healing, and what the desired functional outcome should be. Do not assume that the client's views will match your own.
- **Physical Characteristics:** People of color differ in their appearance, even within a particular ethnic group. For example, African Americans can be light or dark skinned, have hazel eyes, and varying hair color. Latinos can have Negroid features, brown skin, or blond hair and blue eyes. Those with Mayan backgrounds often have Asian features.

- **Social History and Previous Experiences:** A client's reaction to mental health treatment can be influenced by prior experiences within his/her family and community. Such experiences can include stigma attached to seeking help from mainstream providers and beliefs about what characterizes illness and how to cope with it. Strong adherence to stoicism, family privacy, fear of deportation, or cultural loyalty can run counter to a provider's expectations about "compliance."
- **Culture Shock:** Recent immigrants often experience disillusionment with their fantasies or expectations of life in America, marital and familial conflict due to changes in roles, financial difficulties, discrimination, and increased mental health problems due to acculturative stress. Furthermore, differences in emigration experience, as well as trauma or oppression experienced in the native country prior to emigration affect a person's sense of vulnerability, trust in others, and behaviors which may appear paranoid.
- **Limited Awareness of Community Resources:** Sometimes clients are unaware of resources that exist within their communities. Providers need to be informed about culturally relevant and responsive networks of supports that include legal, religious, and civic components. Referral and assistance can often become a vital part of empowering the future capacity to prevent or intervene early in a remission.
- **Existing Natural Supports Within Community:** A person's access to supports within his or her ethnic community can differ greatly, depending on factors that may not be under his/her control. For example, Southeast Asians emigrating to the United States typically have more economic capital than Central Americans. This allows them to establish a greater level of resourcefulness in ethnic enclaves and a higher level of business development, whereas Central Americans often rely on service sector jobs to make ends meet.

## **Building Bridges With Families**

Families often form a strong part of a consumer's social network, and when provided with the right information and resources, can often contribute to an individual's well-being. For example, families can:

- Provide baseline information about current symptoms and psychiatric history;
- Give information about other relevant behaviors (e.g., substance abuse, legal history);
- Assist in engaging the family's support in medication and treatment compliance;

- Yield information about other key social supports and consumer resources;
- Help maintain or develop support for the consumer through his/her involvement; and,
- Enhance treatment outcomes through family education and support activities.

Family educators have identified stages in reacting to mental illness (e.g., denial, crisis/chaos/shock, hoping against hope, anger, guilt and resentment, grief and recognition) before they are able to accept and move on. The type of assistance a family will need will very much reflect what type of stage it is in. In general, listening, responding to concerns, offering support and education, and empathizing with the family's feelings, are good places to begin. Research has shown that particular combinations of treatment (e.g., Assertive Community Treatment with psychiatric rehabilitative programs and family management) reduce symptoms and enhance coping in consumers and their families.

What about when families do not seem to want to be involved? They may simply not be a very close-knit or supportive family, or maybe they are "burned out" by prior experiences with the illness or the treatment system. Here are a few basic steps to follow:

- **Outreach:** Pick up the phone. Make a home visit. Find out who is around and what they have been through with the illness and with the treatment system. Find out how they are feeling now.
- **Assess Needs:** Based on the information obtained through outreach, estimate where the person is in the Emotional Stages Chart. Check with the family member to see if your estimate is correct (e.g., say, "Sounds like you're feeling \_\_\_\_\_." Have you been able to get help? Is this why you haven't been involved with your loved one's care recently?
- **Determine Resources Available:** What has the family tried? Has it worked? Is it still available? What other resource options exist? Can staff help? Are there other avenues in the community that have not been tapped?
- **Clarify Staff, Family, and Consumer Roles in Mobilizing Resources:** Clarify how the family's involvement could potentially help the consumer's treatment outcomes. Find out if the family could be more involved in treatment if their needs were addressed. Be specific about who will be doing something (e.g., exploring different resource options). Can the consumer help?

## What About Confidentiality?

Confidentiality certainly prevents providers from disclosing any information about an individual consumer's status without signed consent. However, service providers CAN:

- Listen to family concerns as a way to add to current knowledge about a consumer.
- Explain what steps are taken to obtain consumer consent to release information.
- Provide general education about mental illness.
- List common behaviors associated with mental illness.
- Identify the purpose of medications.
- Provide information about common side effects.
- Discuss options in daily management of problem behaviors.
- Identify other educational or support resources.
- Refer family members to the local chapter of the National Mental Health Association, the National Alliance for Mentally Ill, or church.
- Work with the consumer to explain the benefits of family involvement and seek to obtain consent to release information about him/herself.

Not everything needs to be revealed. The consumer may feel more comfortable with sharing certain aspects of his illness or treatment but not others. This is perfectly acceptable.

## Conducting Effective Outreach

Communities of color often do not have adequate access to mental health treatment because of a variety of barriers. These include lack of knowledge about available interventions, transportation difficulties, competing familial responsibilities such as child care, family privacy or shame, or community stigma associated with seeking help from mainstream providers. Recognizing these barriers and overcoming them is the cultural challenge for providers. The following are some guidelines based on efforts in Texas and elsewhere that have increased a community's use of treatment.

- Enlist the aid of individuals or groups who are local residents of the community. Provide them with a tour of available services and explain the process of treatment, including the role of family and/or community. Ask these individuals to serve as local brokers in their community to inform and facilitate entry to service from their neighbors. This approach has been effectively used with the *promotoras* (local lay workers) who work in the *colonias* along the South Texas border to identify and guide people who need care into the mental health system.

- Use telephone calls and home visits to provide support and education. Although more time consuming than sitting in an office and expecting appointments, this approach is ultimately more cost-effective because it ensures that the contact between provider and client actually occurs. Treat home visits as times to meet other family members and to learn more about the client's life rather than an opportunity for a clinical interview.
- Become knowledgeable about indigenous healing resources. This involves clergy, folk healers such as *curanderos*, or elders within a tribal council. Collaborate with these individuals in the provision of care, especially with more traditional clients.
- Establish a "buddy" or mentor system between volunteers who are familiar with mainstream treatment approaches and individual families. This method is particularly effective for immigrant populations who may be unfamiliar with English, American culture, or local resources. Visits can be casual and involve a variety of fun activities such as going out for ice cream, visiting the zoo, playing basketball, etc. The intent of the visit is to build a relationship that can serve as a bridge to American culture.
- Use innovative methods to provide education. For example, a project called *Programa Mamá* in Boston uses "health circles" to provide community-based peer support and problem solving. Rather than assuming the role of "expert," the service provider acts more as a facilitator to help the group identify the health problem that will be addressed, and then provides information after they have determined the area of focus. This empowering approach to involving clients in their own health care choices also enriches community awareness of mental health needs and available resources.
- Consider basing some interventions in places that represent community gatherings, including schools, community civic centers, beauty shops, grocery stores, and post offices. Educational efforts via pamphlets or brief screenings can identify individuals who are not currently in treatment or unaware that help is available. Forming good relationships with the shop owners and employees at these places also can serve as an effective source for referrals.

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# Cultural Competency

A PRACTICAL GUIDE FOR  
MENTAL HEALTH SERVICE PROVIDERS

By Delia Saldaña, Ph.D.

In recent years, the United States—and especially Texas—has witnessed a phenomenal expansion in the cultural diversity of its population. As can be expected, this abundance of cultures and ethnicities has presented tremendous challenges and opportunities to mental health professionals. *Cultural Competency: A Practical Guide for Mental Health Service Providers* offers mental health professionals a better understanding of the factors which can affect their counseling and suggests ways to improve and enrich services for their ethnically diverse clientele.

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