

Twelve Critical Issues for Mental Health Professionals Working with Ethno-Culturally Diverse Populations

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Our global era increasingly brings together ethno-culturally diverse individuals, families, communities, and nations that differ in religion, economy, beliefs, and histories. Often, these groups also come together under conditions that are plagued by anger, fear, and distrust. Mental health services are the crucible in which many of the issues different groups face must be addressed. Services occur in a broad arena of settings, including hospitals, clinics, courts, prisons, police forces, schools, and workplaces. It is essential that all parties involved in the delivery of mental health services recognize the critical issues that must be considered when encountering international, ethno-cultural diversity.

1. VARIATIONS BETWEEN PROFESSIONAL AND PATIENT

At one point in the history of mental services in the United States, professionals and patients were mainly from the same ethno-cultural groups, with variations in social class, education, and gender emerging as the major sources of concern in service provision decisions. In today's global era, however, mental health services must now consider a new spectrum of patient and professional ethno-cultural variations. These new realities require careful attention to cultural sensitivities and competencies and include a variety of dimensions, including ethnic background, gender, gender preference, age, language preference and fluency, and religion.

2. A NEW SPECTRUM OF PATIENTS

Many unfamiliar high "risk" and high "vulnerability" statuses, identities, and roles are becoming commonplace among mental health services settings, including migratory workers, international workers (skilled and unskilled), immigrants, temporary immigrants, undocumented immigrants, refugees, asylum seekers (war victims, torture victims), and international students. Patients in each of these bring unique needs and problems requiring complex service resources that must be accessible and acceptable. There are problems with culture shock, acculturation, assimilation, uprooting, language competency, and scores of economic, housing, and medical problems. Many service centers are ill-prepared to address and treat these problems.

3. ASSESSMENT AND TESTING METHODS

For valid clinical and psychological assessment to occur, it is essential that there be linguistic, conceptual, scale, and normative equivalence for the clients being tested or assessed. The use of standardized "Western" assessment instruments poses many risks. It is not simply an issue of language, but rather whether concepts are similar, scales (e.g. True/False) are appropriate, and norms are suitable for other populations. Without this equivalence, there can be many errors in service provision decisions, especially those related to classification, diagnosis, therapy, and medications.

The issue of culture-bound or culture-specific disorders and therapies looms as a special problem because of the detrimental consequences of erroneous clinical conclusions. Therapists should ask themselves a few questions: (1) Do I know the range of normal behavior for my patient's group? (2) Do I know the patterns of disorder for my patient's group? (3) Do I know what my patient's group considers the cause of disorder to be? (4) Do I know what treatment preferences my patient may have and whether alternatives are available? In my years of experience, I came to find that the best beginning to any assessment responsibility is to ask the patient to tell you his/her story -- patient narration in their own words, at their own pace, and with their own priorities.

4. CULTURAL COMPETENCY

Excessive reliance on the delivery of mental health services rooted within Western assumptions, knowledge, and practices can have pernicious consequences. Indeed, these can often produce a range of iatrogenic (i.e. treatment-induced) problems. It is essential that mental services be responsive to ethno-cultural differences in etiological and causal models of health and disorder, patterns of disorder, standards of normality, and treatment alternatives. Table 1 lists a brief cultural competency checklist that can assist the therapist/health professional in evaluating the adequacy of their preparation for transcultural mental health work.

5. LOCATIONS FOR SERVICES

While the office, clinic, and hospital were once conventional locations for the provision of mental health services, pressing problems, including funds and personnel shortages, now require services be delivered under challenging locations such as refugee camps, disaster crisis centers, street corners, homeless shelters, and rural outreach centers. These services are often faced with critical challenges because of patient crises, trauma, and emergency needs, as well as the pressures of time, medical complications, and threats to life. New training is needed for rendering effective services in these locations, especially the circumstances under which the services must be delivered.

TABLE 1: Cultural Competence Self-Evaluation Form (CCSE)

Client's Ethno-Cultural Group: _____

Rate yourself on the following items of this scale to determine your "cultural competence" for this client:

VERY TRUE	TRUE	SOMEWHAT TRUE	NOT TRUE	UNSURE
4	3	2	1	U

1. ___ Knowledge of group's history
2. ___ Knowledge of group's family structures, gender roles, dynamics
3. ___ Knowledge of group's response to illness (i.e., awareness, biases)
4. ___ Knowledge of help-seeking behavior patterns of group
5. ___ Ability to evaluate your view and group view of illness
6. ___ Ability to feel empathy and understanding toward group
7. ___ Ability to develop a culturally responsive treatment program
8. ___ Ability to understand group's compliance with treatment
9. ___ Ability to develop culturally responsive prevention program for group
10. ___ Knowledge of group's "culture-specific" disorders/illnesses
11. ___ Knowledge of group's explanatory models of illness
12. ___ Knowledge of group's indigenous healing methods and traditions
13. ___ Knowledge of group's indigenous healers and their contact ease
14. ___ Knowledge of communication patterns and styles (e.g., non-verbal)
15. ___ Knowledge of group's language
16. ___ Knowledge of group's ethnic identification and acculturation situation
17. ___ Knowledge of how one's own health practices are rooted in culture
18. ___ Knowledge of impact of group's religious beliefs on health and illness
19. ___ Desire to learn group's culture
20. ___ Desire to travel to group's national location, neighborhood

TOTAL SCORE: _____

80-65 = Competent

65-40 = Near Competent

40 Below = Incompetent

TOTAL # of U's: _____

**If this number is above 8, more self-reflection is needed*

THERAPIST:

Age: _____ Gender: _____

Religion: _____

Ethnicity _____

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6. SOCIETY AS PATIENT

Most mental services are provided to individual patients, and the problems are located and intervened at intra-psychic and intra-cellular levels. However, transcultural mental health professionals are often in a position to see that the patients they are required to treat are also victims of societal circumstances such as prejudice, racism, oppression, persecution, marginalization, and poverty. These circumstances are often unacknowledged and so the socio-political determinants are ignored. The danger is that the individual becomes a victim who cannot address the very life contexts that are creating their problems and conflicts. In these instances, society is the patient in need of treatment. Transcultural mental health professionals are in a unique position to identify, question, and pursue the resolution of the problems via social activism. Through activism, they can change and influence policies, policy makers, government officials, and business leaders. In many respects, the transcultural mental health professional has a variety of roles and functions to fulfill that go far beyond treating individual patients from different diverse cultural traditions. The socio-political dimension may be new for mental health services, but it cannot be ignored. Table 2 lists a code of behavior for the transcultural mental health professional. It is not simply about ethics. Rather, it is about accepting one's role as a way of life.

7. TREATMENT MUST TAP POSITIVE RESOURCES

For many patients from diverse ethno-cultural backgrounds, effective treatment will require linkages to ethno-cultural community services and resources. If these services are not present, the transcultural mental professional should attempt to develop them by working with community leaders. Community based ethno-cultural services are an essential part of the provision of mental health services. Weekly office or clinic visits are insufficient. A strong social support and community-based network must be a goal of treatment and care when working with ethno-culturally diverse patient populations. The challenge, of course, is whether the needed social and community supports are present given the typical problems of poverty and marginalization.

TABLE 2: The Transcultural Mental Health Professional Code

- It is not an 8:00-5:00 job. It is a way of life.
- It is a world view rooted in empathy, justice, and conscience.
- It is committed to diversity, social justice, and activism.
- It is concerned with promoting and optimizing communication and understanding across ethno-cultural boundaries.
- It is concerned with empowering individuals, groups, and cultures.
- It is concerned with offering hope, opportunity, and optimism to patients in need.
- It is concerned with addressing major societal problems including poverty, oppression, racism, sexism, violence, abuse, and inequality. It locates these problems within the societal contexts in which they are generated, empowered, and sustained.
- It is ecological, historical, interactional, and contextual. It acknowledges the complexity of problems and encourages multicultural, multidisciplinary, multi-sectorial, and multinational understanding and action.
- It is political, revolutionary, and progressive. Injustice is neither tolerated nor accepted.

8. PREVENTION

More needs to be done in the area of prevention for ethno-culturally diverse patients. Prevention is often assigned the last priority due to the burdens of under-staffing and under-funding. Yet, the old adage “A pound of prevention is worth a ton of cure,” remains true. One of the best examples of this is the extensive costs for running our correctional systems when so much more could have been done to prevent many of the problems that characterize the inmates. The three popular levels of prevention remain a standard: (1) Educate to prevent, (2) Identify problems early, and (3) Treat problems effectively once they emerge. In the case of transcultural mental health services, more must be done to develop and offer a full spectrum of patient services (e.g. education, employment training, crisis counseling, meeting emergency needs).

9. AVAILABLE, ACCESSIBLE, & ACCEPTABLE MENTAL HEALTH SERVICES

Because much of the ethno-cultural diversity that mental health services encounter are going to be dealing with poor, undereducated, non-English language speakers who are in urgent need of many services, the therapy encounter must be prepared to render a broad spectrum of services including

medical, educational, financial, transportation, and housing. The service delivery system must be set up to offer services that are available, accessible, and acceptable. Too often the needed services are not available, and when they are available, they are not accessible (e.g. traveling miles to obtain a service). There is then the issue of acceptability, which requires that careful attention be given to the sensitivities of cultural variations in terms of service providers, settings, and demands on the patient. While this concern applies to all mental health patients, the ethno-cultural therapy encounter is especially demanding.

10. LEGAL COMPLICATIONS

Accountability is becoming an increasing concern for mental health care because of increasing legal actions. When we accept ethno-culturally diverse patients, we accept the responsibility to know and to understand them so we do not make serious errors in care. Errors in diagnosis, assessment, treatment, and medications are frequent outcomes for which we must be held accountable, especially when patients suffer painful and harmful consequences. It is essential we work with culture brokers and culture consultants if we are unfamiliar with a patient’s culture. Mental health professionals have the responsibility to know the limitations of their competencies. Good intentions are not enough.

11. FEMINIZATION OF THE MENTAL HEALTH PROFESSIONS

A popularly held view is that the gender of the therapist does not matter in determining therapy success or effectiveness. However, the reality of the situation is that there are a number of gender-related factors that call this assumption into question, including: (1) comfort in discussing certain topics, (2) communication and expressive styles, (3) empathy and understanding, (4) unconscious parental conflicts, (5) preferences for certain therapies or healing principles, (6) gender role perceptions and expectations, and (7) perceptions that therapists may be biased against men. While all of these factors are subject to debate, they assume critical implications when ethno-cultural variations may be present because of the importance of patriarchal cultural norms and expectations. The status of women varies across cultures, and adherences to certain religious or traditional beliefs can present a conflict. The reality of the mental health professions today is that women now dominate all the professions (i.e. psychiatric nursing, social work, teaching, counseling, marriage and family counselors, and psychology). Graduate programs in psychology now have a much higher percentage of female students, and this trend appears likely to increase. Thus, it may be necessary to consider this issue in transcultural locations and settings.

12. TRANSCULTURAL MENTAL HEALTH RESEARCH AND TRAINING

Conventional mental health research and training methods often create problems among ethno-cultural groups. Under the illusion of “good intentions,” dominant populations in

charge of mental health services see their goal as preparing the ethno-cultural patient to accept, adopt, and live according to the dominant group's standards of normality and expectation. In today's world, however, these goals must be reconsidered since they seek to homogenize diversity, and in doing so, destroy critical ethnic identity resources. Indeed, the task of healing may be to help a patient discover their ethno-cultural heritage and roots, and to join their culture's community groups. Emphasis upon using dominant culture norms and expectations can distort, deny, hide, or contribute to patient problems, and interfere with the service needs of minority and marginalized groups.

This list is intended to be open-ended. There are more than twelve critical issues that can be identified and discussed. Others may add their suggestions in an effort to develop a more comprehensive listing. Please send suggestions to marsella@hawaii.edu. Ψ