



**Cultural Competence
Newsletter
April 2014**

Cultural competence is “the ability to provide services to clients that honor different cultural beliefs, interpersonal styles, attitudes and behaviors, and the use of multicultural staff in the policy development, administration and provisions of those services.”

(San Luis Obispo Behavioral Health Cultural Competence Plan, 2010)

IN THIS ISSUE

LGBT Populations

By: Catherine Thomas

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To fully help a member of the lesbian, gay, bisexual, and transgender (LGBT) community it is important to understand the distinct components and language of their population and culture.

What is LGBT?

The abbreviation LGBT is intended to communicate both inclusive and within-group differences (Keystone Pride Recovery Initiative, 2009). Though LGBT groups' experiences and issues may resemble each other, it is incorrect to assume that the group's characteristics are congruous. This is especially important and true with sexual orientation and gender identity. For example, transgender individuals may be homosexual, heterosexual, or bisexual, and should not be assumed to be gay. It is also important to note that a portion of the LGBT population does not identify with any one gender, so understanding of fluidity of discussion of gender identity and sexual orientation is important.

LGBT at Risk

LGBT adults in the United States are at greater risk for substance abuse and mental health problems (Institute of Medicine, 2011).

LGBT populations experience higher rates of victimization than the general population (Herek, 2009; Williw, 2004; Houston & McKirman 2007). Even with advances in awareness, understanding and acceptance of the LGBT community, individuals are subject to negative stereotyping, rejection, and discrimination that can impede help-seeking behaviors. More so, LGBT individuals who have mental health problems, addiction, or both may experience more discrimination related to those conditions as well. The LGBT population frequently experience alienation, invisibility, lack of acceptance, and support from their own families. This can create emotional distress and can become a risk factor for mental health problems and/or use of alcohol or drugs to self-soothe. This stress could negatively affect their mental health and willingness to seek and access care.

Better Treatment

SAMHSA reports that satisfaction with mental health services of sexual minorities showed the LGBT group had a significantly higher percentage of dissatisfaction than the control group. The study concluded perceptions of heterosexism and homophobia were the likely contributing factors for the dissatisfaction.



Redefining Cultural Competence

The term competence does not envelope a sense of acceptance. Looking at some new terms, it is imperative that the title of this newsletter and committee should reflect its mission and goals.

Pg. 2



The LGBT Community

Words of inspiration, art, and other inspiring works by members of the LGBT community.

Pg. 5 & 6

Redefining Cultural Competence

By: Catherine Thomas

Competence: [kom-pi-tuh ns]: noun

1. The quality of being competent; adequacy; possession of a required skill, knowledge, qualification, or capacity.

2. Sufficiency

Definition from Dictionary.com



The California Assembly Bill (2006) defines cultural competency as a set of integrated attitudes, knowledge, and skills that enables health care professionals or organizations to care effectively for patients from diverse cultures, groups, and communities. The primary objective outlined by the San Luis Obispo Cultural Competence Committee is to coordinate training and improve engagement with underserved populations. This is a good starting point for cultural competence programs, but it does not provide guidance for implementation or outline goals, and tends to collapse diversity categories in ways that prohibit quality and meaningful care. Cultural Competence training should not only educate, but contain aspects that create a more integrated approach. Components of a successful Cultural Competence program should include: valuing diversity; having the capacity for cultural self-assessment; being conscious of the dynamics that are inherent when culture interact; have institutionalized culture knowledge; having developed adaptations to service delivery reflecting an understanding of cultural diversity; reduce the stigma associated with particular groups; and try and not create more stigma to the communities being discussed.

Cultural Competence programs are especially important in Mental Health services. Research from

medical anthropologists and cross-cultural psychiatrists has demonstrated that culture is central in nearly all aspects of mental disorders (Carpenter, 2007). Furthermore, with a seemingly endless range of subgroups and individual variations, culture is important because it bears upon what all people bring to the clinical setting. It can account for minor variations in how people communicate their symptoms and which ones they report. Some aspects of culture may also underlie culture-bound syndromes - sets of symptoms much more common in some societies than in others. More often, culture bears on whether people even seek help in the first place, what types of help they seek, what types of coping styles and social supports they have, and how much stigma they attach to mental illness. Culture also influences the meanings that people impart to their illness (NCIB, 2001). Cultural competence programs help create awareness of the dramatic health disparities among minorities in the U.S., that not only bear a disproportionate burden of mental illness, but are less likely to have access to services. Awareness is the first step in identifying a disparity, once that is accomplished the goal would be to ameliorate the disparity.

Cultural Competence models can often present culture as static; treat culture as a variable; conflate culture

with race and/or ethnicity; do not acknowledge diversity within groups; may inadvertently place blame on the patients culture; over emphasize cultural differences; and fail to recognize Western Biomedicine as a culture itself (Carpenter, 2007). These problems can stem from the way in which culture is defined by Western Medicine professionals. Western Medical professional define culture as, (In context of health behavior): "unique, shared beliefs that are directly associated with a health-related behavior, indirectly associated with behavior, or influence acceptance and adoption of the health education message" (Leonard, MD, 2006). This definition views the body as mechanistic, creating a series of false dichotomies. Culture is seen as a mere factor, or ailment of the patient's behavior or illness, but not as a characteristic that influences treatment. It may, however, "influence their acceptance" of treatment methods. Culture seems to be defined as a symptom belonging to the illness, not a trait that makes that patient unique.

Continuing to view/define culture in this way may lead Cultural Competence programs to become ineffective and possibly hypocritical. Culture is not one-size-fits-all. Other factors, such as class, gender, age, and geography may have more impact on the individual's identity than their race or ethnicity. If these factors are ignored, culture continues to be understood as a property of certain individuals, any population is viewed more at risk than another, or ethnically normative behaviors are seen as psychological symptoms, cultural competence programs will only continue to stigmatize those they are trying to help.

Mental Health professionals must recognize Western Biomedicine as a culture construction. Cultural Competence programs must not be limited to considering and learning about the patients background and language proficiency, but ought to recognize the culture of medicine itself. Going beyond the culture of the individual and learning the language from the culture will allow the clinician to communicate more effectively with the patient. This is not about learning other languages, but learning

words and phrases that are commonly used within the community to better understand the messages they are trying to relay. Culture can account for minor variations in how people communicate their symptoms and which ones they report. Understanding this barrier will help the clinician properly diagnose and treat the patient.

Many Cultural Competence efforts construe culture as something to know rather than something to be ready for. Clinicians are experts in biomedicine; patients are experts of their own experience and distress. So, clinical encounters ought to be viewed as two-way learning encounters (Carpenter, 2007). For this to happen, Mental Health professionals must remain open and willing to seek clarification when presented with unusual or unfamiliar complaints.

Sources:

- Carpenter-Song, Elizabeth A., Ph.D, Nordquest Schwallie, Megan, Longhofer, Jeffery, Ph.D, L.I.S.W. (2007). Cultural competence reexamined: Critique and directions for the future. *Psychiatric Services*, 58 (10). Retrieved from <http://ps.psychiatryonline.org/article.aspx?articleid=98596>
- Egede, Leonard, MD, MS. (2006). Race, ethnicity, culture, and disparities in health care. *Journal of General Internal Medicine*, 21 (6). Retrieved from <http://onlinelibrary.wiley.com/doi/10.1111/jgi.2006.21.issue-6/issuetoc>

Note from the Editor:

As the article states, when providing cultural education it is possible to stereotype, and even appear, "possibly hypocritical." It is my intent for this newsletter to contain articles, links, and material that emphasize dynamism and flexibility as key dimensions of culture. It will also contain media, local and personal stories to try and break cultural barriers, discuss the diversity that exists within a group, and personalize the education experience to create a sense of humanity and hopefully a little humility.

TOP STORIES

Sports



Michael Sams, NFL prospect is poised to become the first openly gay player in NFL history.

Unworried and marching forward, Sams says he can handle the spotlight and focus on football.

For the full story and video of his press conference, click [here](#)

Politics



Federal judge strikes down Virginia's same-sex marriage ban

Sating the ban was in violation of rights under the 14th amendment, the ban was immediately stayed, even though an appeal is expected.

Full Story [here](#)

MORE STORIES

(Click on the headline for full story)

Transgender Crowned Queen



For the first time in history a transgender teen was crowned homecoming queen. Orange County, CA

LGBT Have Highest Unemployment Rates



Study finds that LGBT minorities are at greater risk for unemployment, discrimination, and low wages.



LGBT in the News

By: Catherine Thomas

Media is a powerful tool that can invoke feelings of fear, isolation, and hate, or it can bring people closer with humanitarian stories that create empathy and homogeny. News stories, personal interaction, and knowledge of other cultures help individuals to identify with one another, but can often be used to further stigmatize a population or culture. Personal stories of success and failures can humanize an experience, helping to break down cultural, gender, ethnic, and any other barriers between groups and individuals. When we begin to connect with one another and see how similar we really are, stereotypes and biases begin to break down. Media also helps show the diversity that exists within cultures. It creates conversation, discussion, and interactions that continually blur the lines between cultures. Media provides images that can either connect an outsider to an individual or group unlike themselves, or it may provide inspiration and visibility to those who are still uncertain about their own identity, allowing them to connect with a population, and see that they are not alone.

Community ~ Culture ~ Art

Mark David Bieraugel



Born to a Navy family in San Diego County, California, Mark spent most of his childhood moving up and down the West coast. He settled just long enough in Santa Barbara to get his Bachelors of Arts from UCSB, and then decided to pack up and move north to Washington State. There he worked on, and received his Masters in Library science from the University of Washington. After graduating, Mark took a job with a private company, and after a decade in the private industry, Mark decided to take a position at Cal Poly as an academic librarian.



“My work has themes of science, sex, and humor, all done with fabric and thread...Some even glow in the dark!”



In 2007, Mark attended an evening art lesson in embroidery from artist Jenny Hart. Mark instantly was hooked, finally finding a way to express his ideas. He began submitting his pieces to art shows, and the recognition he received only made his passion for art grow.



Mark’s work has been featured in galleries around all around the U.S., including New York and Los Angeles. Mark sees his artwork as a, “type of conversation with the world...I have all these ideas and I want them out there...I have a way to share something interesting, intriguing, and perhaps fun.” His art is intended to create conversation, make the viewer slow down, take a look, and connect with the piece.



An Interview with Jill Rietjens

Often experiences and stories shared in the newsletter are from the perspective of the client, but what about those who work in the Mental Health profession? Jill Rietjens, Prevention and Outreach Program Supervisor, agreed to an interview about her life and experiences working in this field as a lesbian. Jill grew up in a "small, conservative" town in California. When asked about her childhood, Jill simply says, "I had a great growing up experience." When she first started to come out to her family (because this was a process), Jill was about 23. She remembers it being hard for her mom to get used to idea that Jill would not have the exact life experiences her mother envisioned. Jill believes that this is because mothers often have a certain view or path they believe their children will follow in life, and anything that changes that path takes time to accept and adjust. When Jill's mother realized that this news did not change who Jill was as a person, it was easier for her to fully accept Jill's "new" identity and life.

Jill has been a mental health professional for nearly 15 years, and she admits that things have changed dramatically for the LGBTQ community in that time. "Times have changed since entering the workplace," Jill says. When beginning her career, Jill admits to being "more cautious" than now. She says that part of that has to do with her own confidence level, but the other part is due to the growing acceptance of the LGBTQ community. Jill has always been "out" to her coworkers, but used to be careful around the kids and families that she worked with. For over a decade Jill has been "open" with both her colleagues and the students she works with.

Prior to becoming a Program Supervisor, Jill was a therapist working in community schools.

Q. How was working in the schools different from what you do now?

"Working as a therapist in the schools is a little different (than now) because you become part of that school community. You not only saw the kids in session, but in the cafeteria, classroom, all around and throughout the day...So, they saw more of me and my life, my interactions with people. Though they do not know the details of my life, they did know that I was in a long term committed relationship with another woman. I wanted them to see me as someone who is happy and successful, because too often the messages kids get about the LGBT population is negative."

Q. Have you had any experiences or incidences of discrimination in the workplace?

Throughout life, Jill has had the benefit of minimal discrimination. When asked about any negative experiences, Jill alluded to one difficult situation involving a student's family, but stressed that her colleagues, both at the community school and at Mental Health were, "supportive and understanding of the situation."

Q. Do you think your sexual orientation has inhibited your ability to work with the public--whether by your own bias(es) or the bias(es) of a client toward you regarding your values and lifestyle?

"I can see how something like that could get in the way, from either the clients bias or the therapist's, if any level of homophobia existed...having never been a clinic based therapist, I don't really know 'how out' or open I would be with my clients in that situation...I don't know how my friends, who are clinical therapists, are with their clients...I do not think there would be any reason to discuss that...the client comes in for their session and then

they leave.” She continues, “I am super aware of my own biases...We are trained to be aware of our own biases and when our emotions or thoughts get in the way of the therapeutic relationship...I have been fortunate to have colleges who I can consult with and who have all been super supportive.”

Q. Do you think being a lesbian, versus a gay male, has contributed to your experiences?

“Definitely...for whatever reason that is...there may just be more acceptance in our culture for women to be closer with each other, or have emotional/affectionate relationships with one another.” Jill said that being a lesbian has afforded her a certain freedom that straight women do not always have. “There are certain ‘life path’ or time line expectations and societal pressures imposed on straight individuals, especially women...these pressures were taken off me when I came out, allowing me to relax and enjoy life, do what I want when I want... I felt like the ‘real’ Jill once those pressures were removed, I could just be me.”

Q. What do you think tolerance/acceptance looks like, and do you think there are better words to describe Cultural Competence programs and their purpose?

Laughing, Jill replied, “It means ‘I will put up with you’...You may not like me or agree with anything I do, but you’ll tolerate it...But seriously, I think we should aspire to something more than tolerance...I am not sure what that is exactly, or what word is appropriate to express it, but we definitely should try and be/do more.”

I would like to thank Jill for sharing her thoughts and experiences with me, and all of the Behavioral Health Staff.

Cultural Competence Committee

- Nancy Mancha-Whitcomb, LMFT- Chair
- Rebecca Carrol, Consulmer Advocate
- Reggie Holmes, MHT III
- Kati Rose Lorent, Advocate/THMA
- Maria Martinez-Garcia
- Silvia Ortiz, Latino Outreach Program
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