
*INCREASING CULTURAL COMPETENCE
IN SERVICES:
MANAGING DIVERSITY*

Cultural Competence
in Psychosocial and Psychiatric Care:
A Critical Perspective with Reference
to Research and Clinical Experiences
in California, US and in Germany

Dagmar Schultz, PhD

SUMMARY. The impact of culture and ethnicity on the diagnosis and treatment of patients with mental disorders has been of growing interest

Dagmar Schultz is Professor, Alice-Salomon-School for Social Work and Social Pedagogics, and Private Lecturer, Free University of Berlin, Germany.

Address correspondence to: Dr. Dagmar Schultz, Alice-Salomon-Fachhochschule für Sozialarbeit und Socialpädagogik, Alice-Salomon-Platz 5, D-12627 Berlin, Germany (E-mail: dagschultz@aol.com).

[Haworth co-indexing entry note]: "Cultural Competence in Psychosocial and Psychiatric Care: A Critical Perspective with Reference to Research and Clinical Experiences in California, US and in Germany." Schultz, Dagmar. Co-published simultaneously in *Social Work in Health Care* (The Haworth Social Work Practice Press, an imprint of The Haworth Press, Inc.) Vol. 39, No. 3/4, 2004, pp. 231-247; and: *Social Work Visions from Around the Globe: Citizens, Methods, and Approaches* (ed: Anna Metteri et al.) The Haworth Social Work Practice Press, an imprint of The Haworth Press, Inc., 2004, pp. 231-247. Single or multiple copies of this article are available for a fee from The Haworth Document Delivery Service [1-800-HAWORTH, 9:00 a.m. - 5:00 p.m. (EST). E-mail address: docdelivery@haworthpress.com].

<http://www.haworthpress.com/web/SWHC>

© 2004 by The Haworth Press, Inc. All rights reserved.

Digital Object Identifier: 10.1300/J010v39n03_02

231

and concern to professionals in the United States and also in Germany. This contribution intends to give an overview of key aspects regarding competence in intercultural situations using research and clinical experiences from the United States and from Germany. The issue of racism and discrimination as contributing factors in the development of mental disorders will be critically examined from a US and a German perspective. [Article copies available for a fee from The Haworth Document Delivery Service: 1-800-HAWORTH. E-mail address: <docdelivery@haworthpress.com> Website: <<http://www.HaworthPress.com>> © 2004 by The Haworth Press, Inc. All rights reserved.]

KEYWORDS. Cultural competence, psychiatric care, minorities, racism, mental disorders, psychopharmacology, empowerment of patients

CULTURAL COMPETENCE AS A PROFESSIONAL QUALIFICATION

“Globalization” is a much cited and used concept for the internationalization of capital, of media and cultural expressions. These times of globalization are also characterized by voluntary and involuntary migration. Most societies are confronted by the challenge of integrating immigrants and refugees as well as members of ethnic minorities who have lived in these countries for generations, but still experience more or less severe discrimination.

Competence in dealing with intercultural situations has been recognized as a professional requirement by industry and business, and they have begun to develop integrative strategies. Professionals in the area of health, psychology and psychiatry also need to acknowledge *competent behavior in intercultural situations as a necessary professional qualification* so as to avoid harmful and costly deficits in qualified and effective care.

In 1999 and 2000, I studied programs of cultural competence and diversity in community mental health care which were established or funded by the state of California focusing on San Francisco and Oakland. Against the background of concepts of cultural competence and experiences of clinical work in California, I am presently doing research in mental health programs of hospitals and community institutions in Berlin, Germany (Schultz, 2002). Cultural competence, intercultural therapy and counseling, transcultural care—these concepts have been discussed during

the past years on a theoretical level in Germany, but unfortunately have been put into practice only sporadically in individual institutions or by individual psychologists and psychiatrists without any systemic institutional and state planning. In this contribution, I intend to give an overview of key aspects regarding cultural competence using research and clinical experiences from the United States and from Germany.

The following questions will be addressed:

1. How can we define cultural competence in psychiatric care?
2. What are the necessary qualifications and wherein lie the difficulties and pitfalls of becoming a culturally competent professional?
3. Why is cultural competence necessary and who benefits from it?
4. How can concepts of cultural competence be put into practice?

DEFINITIONS OF CULTURAL COMPETENCE IN PSYCHIATRIC CARE

On a general level, cultural competence signifies the ability “to communicate in an appropriate and successful manner in an unfamiliar cultural environment or with persons from another culture” (Hinz-Rommel, 1996, 20). Basically, intercultural competence means the gradual increase of the ability of social interaction. This involves empathy, respect for and appreciation of the other person, sensitivity, clarity and genuineness in the encounter with a client (Koray, 2000, 23). We can see here that the attitude toward another person, a culturally non-specific aspect, is very important.

In relation to psychiatric care, the American Psychiatric Association formulated its view of cultural competence in a section of its guidelines entitled “Considerations for Sociocultural Diversity”:

The process of psychiatric evaluation must take into consideration, and respect, the diversity of American subcultures and must be sensitive to the patient’s *ethnicity, place of birth, gender, age, social class, sexual orientation, and religious/spiritual beliefs*. Respectful evaluation involves an empathic, nonjudgemental attitude toward the patient’s explanation of illness, concerns and background. An awareness of one’s possible biases or prejudices about patients from different subcultures and an understanding of the limitations of one’s knowledge and skills in working with such patients may lead to the identification of situations calling for con-

sultations with a clinician who has expertise concerning a particular subculture. Further, the potential effect of the psychiatrist's sociocultural identity on the attitude and behavior of the patient would be taken into account in forming a diagnostic opinion. (quoted in Lu, 1999a, 13; emphasis by the author)

This definition points out several important aspects:

- Cultural diversity includes gender, social class, sexual orientation and religion/spiritual beliefs. One could add physical disabilities to the list. The focus in the literature and in much of the practice—except in California—has been on a more conventional restrictive view of cultural diversity equaling ethnic diversity. The advantage of the inclusive view is that it encourages a broader sensitization. In addition, people do combine different identities, for instance, a Black German or a Turkish migrant may be gay and/or belong to a religious minority.
- The definition emphasizes self-reflection, namely the clinician's consciousness
 - of her/his own prejudices,
 - of her/his limitations in knowledge and skills,
 - of the potential effect of her/his own sociocultural identity in the interaction with the patient.

What is not mentioned here is a self-critical view of Western medicine and psychiatry. In other contexts, however, alternative treatments and the services of traditional healers have been included in proposed system standards in the U.S., such as by committees of professionals, experts, and users of four underserved/underrepresented ethnic groups, who formulated standards under the tutelage of the U.S. Department of Health (U.S. Department of Health, 1999).

Culturally competent services can thus be defined as a set of congruent behaviors, knowledge, skills, attitudes and policies that work effectively in cross-cultural situations between a system, agency, or the clinician and the patient/family (Lu, 1999a, 12).

NECESSARY COMPONENTS OF CULTURAL COMPETENCE

There is an increasing awareness of the importance of an individual's identity in terms of race, ethnicity, culture, and class as it relates to treat-

ment for mental illness. This awareness, however, needs to feed into the acknowledgement that a euro-centric approach dominating behavioral health services does not take into account the cultural specific needs of the consumer, but oftentimes serves as a barrier to access and appropriate treatment (Lu, 1999b, 18). Self-reflective integration of bio-psycho-social knowledge is a necessary start for change.

Language Capacities

On the clinical level, one basic standard of cultural competence calls for *language capacities*. Lack of language capacity and not using a qualified interpreter can lead to situations as described in the following examples from Germany:

- A Turkish woman speaks with a Turkish psychologist and tells him that this is the first time in 22 years that she can describe her problems in her mother tongue. Before, she always had to speak through a third person, and frequently her children or relatives were asked to translate.
- In a psychiatric ward a Turkish cleaning woman translates a conversation between a doctor and a patient. The doctor asks her why she stops translating what the patient is saying. She says: “Oh, he is just talking nonsense. He keeps repeating that he is hearing voices.”

In at least parts of the United States and in several European countries it is forbidden to use cleaning personnel or relatives as interpreters, which is still common practice in Germany. While it should be a requirement in the training of medical personnel, psychologists and counselors to learn at least one foreign language, there will always be a need for interpreters for certain languages. These interpreters should receive training that gives them sufficient background in psychology and therapy to work as an informed partner with the patient and the psychologist/psychiatrist.

Cultural Knowledge and Sensitivity on a Biological level

Next to language capacities, competence in dealing with intercultural situations involves *cultural knowledge and sensitivity on a biological level*. Ethnic groups vary in the metabolization of certain drugs. Drug metabolizing enzymes called the cytochrome P450 enzyme system and

found mostly in the liver are responsible for breaking down medications. Mutation patterns of these enzymes show “dramatic cross-ethnic differences” (Lin, 1999, 60). These differences can also be responsible for how side effects are experienced. Slow metabolizers, found particularly among Southeast Asians and African Americans, maintain higher blood levels of medication and thus require lower doses. Yet African Americans in particular are more likely to be viewed as violent than Caucasians or Asians and often receive excessive doses of psychotropics (Lawson, 1999, 30). Dr. William B. Lawson, Professor of Psychiatry at the University of Indiana, writes: “As a consequence African Americans, who may be suspicious of mental health providers in the first place, may be less tolerant of medication side effects and less invested in medication compliance.” He also points out: “. . . African Americans are more likely to get antipsychotic medication irrespective of diagnosis . . . Community surveys consistently show that African Americans who have major depression are only treated half the time. When treatment is provided it can often be punitive” (Lawson, *ibid.*). Studies further suggest that African Americans may experience more tricyclic antidepressant side effects and are more likely to develop tardive dyskinesia, a serious movement disorder (Lawson, *ibid.*).

Response to medication is also influenced by environmental factors such as nutrition, smoking, the intake of herbal medicine—factors which are intertwined with social class and with cultural traditions. Clinicians are now developing methods to measure enzyme activity to guide the physician in selecting the right drug and dose. As Michael W. Smith, MD writes: “The best approach is to treat each person as an individual, using information about one’s diet, habits, medication and culture as a guide” (Smith, 1999, 16).

Cultural Knowledge on a Psychological Level

Cultural knowledge on a psychological level implies becoming familiar with the perception of death, age, mental illness, with the meaning of hallucinations, contact with the ancestors, etc., in different cultural groups, and being aware of the fact that psychological problems often are somatized, i.e., described by a patient as physical pain. While white Germans may be more likely to express their psychological symptoms, such as anxiety, depression or suicidal tendencies, Turkish migrants or Asian or Hispanic patients may complain of physical pain. An example from Germany: A Turkish woman describes her depression to the doctor as a state of chronic pain, which results in a false diagnosis, in frequent change of doc-

tors and, on account of lacking cultural and linguistic competence of the doctors, in wrong prescriptions and in generating illness instead of healing.

Diagnosis and therapy require a basic knowledge of the cultural traditions of the client and of the social system the traditions are rooted in. Many Turkish people go to a *hodscha*, a traditional healer, also while seeing German medical doctors. Healing traditions based on Black and White magic may play a significant role, and a Western therapist needs to consider whether and how to integrate them in her/his approach. Dietrich F. Koch, psychologist in Xenion, Psychotherapeutic Counseling Center for Politically Persecuted Persons in Berlin, Germany, writes about working with a patient from Bangladesh by practicing Black and White Magic in his sense with him: "I try to make changes within his system, changes that make sense for him at this particular point in time" (Koch, 1998, 152). Since the ability of understanding often is limited for white Western therapists, Koch relates that working with qualified interpreters from the cultural group of the patient can be a tremendous advantage.

Asians may interpret mental illness in the framework of their medical model, which is far more wholistically oriented than Western medicine. The physical body and emotions are seen as an integrated whole, and the goal is for the human body to be in harmony and balance with the forces of the universe in order to maintain both physical and psychological health (Cheung, 1999, 44). This means that the Asian experience "is a full-bodied one, a large world-view which embraces many aspects of living . . . Symptom removal alone is inadequate," writes Walter Owyang, Professor of Psychology and clinical psychologist in describing treatment programs for the Southeast Asian population in San Jose, California which have existed since the '80s (Owyang, 1999, 46).

Religion may play an important role in the interpretation of mental illness (supernatural forces are the cause) or in overcoming illness. Frequently, religious practice is connected with traditional healing such as the use of herbal medicine. Native Americans revive traditions of sharing emotional frustrations with medicine people during a sweat lodge. The Native American Health Center in Oakland, California brings in medicine people from different tribes who do ceremonies for people in hospitals. It engages patients in cultural activities to help repair marginal identities and address issues such as post traumatic stress, grief of generations over the loss of land and life (interview with Janet King, counselor, Feb. 3, 2000).

The Instituto Familiar de la Raza in San Francisco, directed by Dr. Concha Saucelo, combines indigenous traditions of Latinos, Chicanos and Latino Indios such as “sweats,’ rites of women, dance groups, etc., with Western therapeutic practices. For some of these contexts, it will be absolutely necessary to have a therapist from the particular cultural group. The Instituto also offers a program of training and supervision for interns who are working on their master degree, their PhD and for post doctoral students.

Social Knowledge and Self-Reflection

Generally, the work needs to be regarded as a continuous process of learning. Learning about other cultures requires first of all a self-reflective stance as addressed in the declaration of the American Psychiatric Association cited above. Dr. Ernie Rodrigues of Cañada College in Redwood City, California states that a conceptual understanding of cross-cultural issues is not enough. “What is truly needed is a compassionate level of relational competence which incorporates an understanding of cross-cultural dynamics . . . to actually be able to speak about those cross-cultural issues which impact the client’s experience . . . More typically what seems to occur is a process of avoidance fueled by fear. Under the rubric ‘we are all human’ is the implication that ‘we are all the same’ so there is no need to bring uncomfortable issues of race and ethnicity into the relationship” (Rodriguez, 1999, 6). Rodriguez calls for a practical understanding of the concept of worldview which he defines as one’s experienced reality:

We must be able to recognize that we operate from within a worldview and simultaneously be able to be free of our worldview so that we might be able to understand and appreciate the meaning of another’s worldview perspective . . . Trying to replace another’s reality with our own is a good working definition of oppression. If we are to be oppression sensitive we must work from *within* the person’s experience . . . the critical component in effective cross-cultural work is developing a working knowledge of our own worldview, including the biases we bring to our work with others. Only then will compassionate healing be possible. (Rodriguez, 1999, 7)

Knowledge and skills in these areas in combination with self-reflection can prevent false diagnoses which often occur on account of stereotyped views of certain immigrant groups. An example in a text by two psychologists from California:

. . . it is disturbing to see in a report that a shy, monolingual submissive Latina woman is labeled as 'schizoid' personality, because she 'avoids eye contact' when you know that initial shyness and some reserved attitude is 'culturally' normal for many Latina women. (Valencia, 1999, 35)

At the same time, professionals have to be aware that cultures are not static, but in a constant dynamic process of change. This means, for instance, that the psychological problems of a first generation immigrant most likely are different from those of her/his grandchildren. Class issues, race and gender are closely tied with culture-based experiences and need to be taken into consideration. African American lower class persons, e.g., tend to be viewed as violent, Asians as submissive even when the objective data demonstrates the opposite (Lawson, 1999, 30). In short, when calling for cultural competence we need to be aware of the danger of pigeon-holing people by following limited imaginations of certain cultures. The individual and her/his experiences have to be at the center of attention and concern.

On the social level an understanding of the worldview of a client from a discriminated minority requires an awareness of the impact of socio-economic class and of discriminatory experiences, of family and community structures, of gender and generation issues and of the significance of collective memories of oppression and of (potential) support through cultural traditions.

***EXPERIENCES OF RACISM AND DISCRIMINATION
AND OF WHITE SKIN PRIVILEGE
AS FACTORS IN THE INTERACTION
OF THERAPISTS AND PATIENTS***

While in the United States *research* on the psychological and social effects of racism has also found attention in the field of mental health (see, e.g., Thompson & Neville, 1999), it is significant that in Germany there have been hardly any studies done from this perspective. Jochen Zeiler, Professor of Psychiatry at a Berlin hospital and his colleague Dr. Fuat Zarifoglu, at the time the only Turkish psychiatrist at all of Berlin's hospitals, stated in a paper on "Ethnic discrimination and psychic illness" at the World Congress for Social Psychiatry in Hamburg in 1994:

A series of epidemiological studies of migrant populations have examined how geographic and social mobility and how social disintegration and cultural change influence the manifestation and course of psychic illnesses. Strangely enough, however, discrimination as a psychosocial stress factor has never become the object of psychiatric research . . . And the question is permitted whether science as one of the societal activities dominated by the social majority finds it difficult to devote itself to the central problems of minorities who are largely excluded from the political process of decisionmaking. (see Zeiler & Zarifoglu, 1994, 101)

Acknowledging everyday racism and discrimination, an insecure resident status, economic problems and the lack of a positive vision of the future as possible factors for mental disorders would definitely have consequences for the therapeutic practice. It would require labor intensive cooperation with social services, much more investment in community relations and aftercare, and facing the question how to deal with structural racism as an individual and as an institution. If, for instance, it becomes clear that the psychosis of a migrant woman is directly related to the continuous threat of having to leave the country and her family, this legal insecurity must be ended. Otherwise even the best neuroleptic prophylaxis will not prevent relapses (Zeiler & Zarifoglu, *ibid.*).

Frequently, social conditions and collective (historical) experiences of minority persons cause mistrust and prevent persons from seeking professional help in situations of mental stress. In a big Berlin hospital in an immigrant district, 50% of the persons being received in the emergency ward are immigrants who are diagnosed with psychic disorders. This indicates that people go to the hospital or to a psychiatric institution only in the state of absolute crisis. Persons without a permanent residence status in Germany also fear to lose their tenuous status if they are registered as a “problem case.”

Mistrust of the medical establishment and of psychiatric drugs is widespread among certain minorities and has many reasons:

- For African Americans, the infamous Tuskegee syphilis study in which patients were denied effective treatments in order to study the natural history of syphilis appears to have a lasting effect.
- Fear of false diagnosis: There is considerable evidence that African American patients with mania are more apt to be misdiagnosed as having schizophrenia and receiving antipsychotic medications

(Gray, 1999, 25). In Germany there has not been research on differential treatment of psychiatric patients, but the lack of cultural competence in many institutions suggests that misdiagnoses are taking place.

- Fear of abuse or false application of medications.
- Fear of being even more stigmatized in addition to being marginal already, since the dominant society/culture itself attaches a strong stigma to mental illness.

The white therapist of the dominant group is, therefore, seen as a person of *power*—power on account of white skin privilege and on account of being part of the mental health system. The professional, whether a member of the dominant group or of a minority, has to be conscious of the fact that she/he actually does have power, however little it may be, and that the relationship to a client is a dominance-subordination relationship. The next step can be to use that power in a constructive manner to empower clients. Renée Hatter, pedagogue and psychologist in California, describes this process of transference of power writing about African American counselors. These counselors were inadequately trained and experienced their known powerlessness and marginal position within the mental health system. They demonstrated oppressive behavior toward their African American clients so as to give themselves a sense of power. Their behavior toward the clients changed once they addressed their issues to management: They now could hear the clients' issues and respond to them (Hatter, 1999, 26-28).

The unspoken knowledge of internalized oppression and of the (relative) lack of power of minority professionals may be one reason why members of a discriminated group sometimes do not seek treatment from a member of their community. Presently I am interviewing personnel and patients of mental health institutions in Berlin for a study on the significance of cultural competence. A patient in a residential psychiatric home initially stated in the presence of her counselor that she thought it was very good to have a counselor from her ethnic group and to be able to speak to someone in her mother tongue. Once he left the room, she said: "He is not good—he can't do anything for me. It would be better to have only German counselors." (I later heard that she had been making some requests which could not be fulfilled by anyone.) This is an understandable reaction in a society that allocates power to the dominant group. Generally, however, we can assume that minority clients prefer to be able to relate to someone of their own group—at least until cultural competence has become a self-understood standard for all workers in the mental health system.

Another factor is that patients may deny differences and not talk about experiences of discrimination in an effort not to place themselves in the position of the victim. This attitude may reinforce the tendency of professionals to ignore differences and racist experiences. My interviews in Berlin institutions have shown that the majority of the professionals said they will explore the effects of possible experiences of discrimination only if the patient initiates the subject.

We can, therefore, say that competence in intercultural therapeutical contexts requires professional training in combination with day-to-day learning about cultural and social differences, including differences of gender and sexual orientation and the effects of racism, sexism, homophobia and class discrimination. This implies self-reflection and a critical assessment of one's own worldview—a journey which can only add to personal and professional growth.

CULTURAL COMPETENCE AS A HUMAN RIGHTS AND AN ECONOMIC ISSUE

The cost of not providing appropriate treatment both in dollars and in human lives-is too great for the needs of ethnic minorities to be ignored. (Lu, 1999b, 22)

Cultural competence in health and mental health care

- is a human rights issue, and
- needs to be outcome oriented.

Human Rights Issue

On the basis of the UN Declaration of Human Rights and of the constitution of most Western European countries, each person has the right to equal treatment. This principle is, however, not regularly translated into practice, aside from the fact that refugees and persons without residence status often are not granted these rights.

In Germany, institutions of psychosocial and psychiatric care rarely devote themselves to patients' problems in the context of migration, racism and antisemitism. As the Black German author May Ayim writes: "While white people are faced with of choosing among a confusing range of therapy offers, Black Germans and immigrants have the

difficulty of finding any appropriate therapy offers at all. Most therapists do not feel responsible for their 'special' concerns or feel incompetent and argue that the task is too much for them" (Ayim, 1997, 128).

Furthermore, as we discussed above, migration, especially involuntary migration, can cause psychic, mental and physical stress. Living in a society, where you are not welcome, as is the case for many immigrants and for Black Germans, Roma and Sinti and Jews, means chronic stress. This kind of stress can bring about or add to mental disorder. Professional help in such a situation calls for a person who speaks the language in which you feel most comfortable communicating, who has a basic knowledge of your sociocultural background, who understands the social situation you find yourself in and who has an interest in you as an individual.

For a white person of the majority culture, a mental health institution may offer a protective space, hardly however for black people, for those immigrants who belong to discriminated minorities or for Jews. In a situation in which they can no longer rely upon themselves and feel extremely helpless and dependent, all fears can rise which are based upon a variety of racist experiences. Mechanisms of resistance and survival strategies, which they had used in dealing with a (potentially) hostile and/or ignorant environment, no longer are at their disposal. Not to be understood induces fear and/or calls forth aggressions, especially with immigrants who speak little or no German. To be closed off from public life can cause feelings of panic. Jews, black persons and Roma and Sinti may distrust doctors on account of their knowledge of racism and antisemitism acted out by the medical profession during National Socialism, psychiatrists having practiced the extermination of patients before concentration camps were set up (Schultz, 1999, 156).

Cultural competence is necessary to ensure a situation where the patient can feel safe, understood and can trust people who have the power to influence her/his health and make decisions upon her/his life, a situation which guarantees the human rights of the patient.

Outcome Orientation

Certainly, economic aspects will play a decisive role in the development of culturally competent services. Professionals need to convince management of the fact that patients as well as health insurances and society at large will benefit from qualified and culture-sensitive treatment of minority persons.

The above examples demonstrated clearly the human and the financial costs of cultural incompetencies. From a systemic perspective the development of cultural competence, therefore, is necessary

- to ensure quality standards in diagnosis and treatment, and
- to contribute to cost-effective work results.

Who will then benefit from cultural competence?

- Patients and clients of minority groups.
- Patients and clients of the majority group, since greater sensitivity of professionals will have an effect on their overall performance.
- Professionals.
- Cultural competence will be of benefit not only to patients and clients of minority groups and to families and friends of clients, but also to professionals and for patients and clients of the majority group, since greater sensitivity of professionals will have an effect on their overall performance.
- Health insurances and all financing agents of the medical and social system will profit from practices of cultural competence. In the long run, cultural competence in professional contexts will have a favorable effect on society at large and the next generations.

IMPLEMENTATION OF CONCEPTS OF CULTURAL COMPETENCE

Several different levels and agents of implementation can be identified.

- the government:

Experiences in the US have shown that intervention from governmental agencies is important for implementation. This does not mean that commitment on the part of the community, of consumers and of providers is not important. But it is difficult to ensure structural reforms without governmental support.

In California, the Department of Health is exerting pressure upon institutions receiving public funds. They will have to demonstrate the fulfillment of standards of cultural competence set by the State so as to receive new funds or be refunded. Such standards need to address access and receipt of benefits, treatment of clients, family and community involvement, prevention and after-care, hiring of minority personnel, etc.

Together with educational institutions, the government needs to set up pools of qualified interpreters with basic knowledge in sociopsychology.

- the community:

If the government does not move by itself, it will be the communities which will have to demand changes in the structure and content of psychosocial care. In California, political movements of minority groups put sufficient pressure on the government to start acting.

- consumers/clients:

Certainly, this group is at the lowest level of the power scale. Still, it is important for them to make their voices heard. If they are able to take a strong position, they will put the professionals on the spot. The consumer movement in the United States has been able to impact new developments. In California, for instance, Self Help Agencies (SHAs) have been funded as adjuncts of or referral sources for Community Mental Health Agencies (CMHAs). Cooperation of the SHAs with researchers resulted in studies showing that the CMHAs “primarily deliver treatment-focused services, while the SHAs provide services aimed at fostering socialization, mutual support, empowerment and autonomy” (Segal, Hardiman, & Hodges, 2001).

- professionals:

Professionals can use their position, and academics can bring their research to bear so as to push for change. Professionals benefit in more than one way: they increase their qualifications by important aspects which will be useful in their work with all patients; they avoid making mistakes which are costly on a human and a financial level; they gain the reassurance of providing their patients with a safe setting and a culturally and medically competent treatment.

- mental health institutions including contract and private agencies:

Mental health institutions need to offer continued education in language training and in cultural competence for their personnel. Perhaps most important, they need to hire minority personnel. In the process of dehospitalization, the integration of immigrant and minority patients in resident programs is crucial.

Institutions need to set up effective community boards made up of members of the community they serve. Evaluating these processes and developing control mechanism and incentives for the fulfillment of standards is an important aspect which takes time, but is in the interest of quality management and cost effective work.

- educational institutions:

Educational institutions need to integrate cultural competence into the curriculum. In the U.S., for instance, between 1989 and 1995, the percentage of doctoral programs in counseling psychology requiring a course on multiculturalism rose from 59% to 89% (Kiselica, 1998, 5). They also need to recruit minority students for studies in medicine, psychology, psychiatry, and clinical social work.

In conclusion we can say that everyone involved will benefit from cultural competence. A comprehensive, holistic approach will include the awareness of diversity as well as the consciousness of the need to treat each person as a individual and to seek the empowerment of the individual. This kind of approach will potentially avoid longterm illness, incarceration of patients, frustration on the part of patients and their communities and high costs for the mental health system.

REFERENCES

- American Psychiatric Association guidelines (1995) In: F.G. Lu (1999a) Cultural competence in mental health services and training: A 20-year perspective. *The Journal of the California Alliance for the Mentally Ill*. 10 (1) 12-14.
- Ayim, M. (1997) Weisser Stress und schwarze Nerven. In: Ika Hügel et al. *Grenzenlos und Unverschämt*. (pp. 111-132). Berlin: Orlanda Frauenverlag.
- Center for Mental Health Services, U.S. Department of Health (1998) Cultural Competence Standards in Managed Care. www.mentalhealth.org, search under "cultural competence."
- Cheung, Freda K. (1999) Culture and mental health care for Asian Americans. *The Journal of the California Alliance for the Mentally Ill*. 10 (1), 43-45.
- Gray, G.E. (1999) Providing mental health services to the African American community. *The Journal of the California Alliance for the Mentally Ill*. 10 (1), 24-26.
- Hatter, R.A. (1999) Transference of power: Through the process of empowerment. *The Journal of the California Alliance for the Mentally Ill*. 10 (1), 26-28.
- Hinz-Rommel, W. (1996) Interkulturelle Kompetenz und Qualität. *IZA* (3 + 4), 20-24.
- Kiselica, Mark S. (1998) Preparing Anglos for the challenges and joys of Multiculturalism. *The Counseling Psychologist*. 26 (1), 155-223.

- Koch, D.F. & Schulze, S. (1998) Diagnostik in der interkulturellen Therapie und Beratung. In: M. del Mar Castro Varela et al. (eds.), *Suchbewegungen. Interkulturelle Beratung und Therapie* (149-156), Tübingen: dgvt Verlag.
- Koray, S. (2000) Interkulturelle Kompetenz-Annäherung an einen Begriff. In: Bundesweiter Arbeitskreis Migration öffentliche Gesundheit, *Handbuch zum interkulturellen Arbeiten im Gesundheitsamt*, Berlin/Bonn: Die Beauftragte der Bundesregierung für Ausländerfragen, 23-26.
- Lawson, W.B. (1999) Diagnosis and treatment of African Americans. *The Journal of the California Alliance for the Mentally Ill*. 10 (1), 29-30.
- Lin, K.-M. (1999) Einstein's nemesis: A journey out of the abyss. *The Journal of the California Alliance for the Mentally Ill*. 10 (1), 58-60.
- Lu, F.G. (1999a) Cultural Competence in Mental Health Services and Training: A 20-Year Perspective. *The Journal of the California Alliance for the Mentally Ill*. 10 (1), 12-14.
- Lu, F.G. (1999b) Exemplary practices in mental health cultural competency development. San Francisco, CA: Department of Psychiatry, San Francisco General Hospital, 16-26.
- Owyang, W. (1999) Asian American perspectives on mental health. *The Journal of the California Alliance for the Mentally Ill*. 10 (1), 45-47.
- Rodriguez, E. (1999) The heart of the matter: Worldview as a central concept in effective cross-cultural work. *The Journal of the California Alliance for the Mentally Ill*. 10 (1), 5-7.
- Schultz, D. (1999) Ein Leben, das wir weitertragen werden. May Ayim (1960-1996) In: C. Brügge/Wildwasser Bielefeld e.V. (eds.) *Frauen in ver-rückten Lebenswelten*. (pp. 139.164). Bern: efef Verlag.
- Schultz, D. (2002) Kulturelle Kompetenz in der psychiatrischen Versorgung von Migrant/innen und Minderheiten: Herausforderung und Chance. In: R. Geene/Chr. Hans (eds.) *Armut und Gesundheit. Gesundheitsziele gegen Armut. Netzwerke für Menschen in schwierigen Lebenslagen*. (pp. 240-251). Berlin: Verlag b_books.
- Schultz, D. (2003) Kulturelle Kompetenz in der psychosozialen und psychiatrischen Versorgung ethnischer Minderheiten: Das Beispiel San Francisco, Kalifornien. In: T. Borde/M. David (eds.) *Gut versorgt? Migrantinnen und Migranten im Gesundheits- und Sozialwesen*. (pp. 167-190) Berlin: Mabuse-Verlag.
- Segal, S.P., Hardiman, E.R. & Hodges, J.Q. (2001) New user characteristics in self-help and co-located community mental health agencies. Abstracts of the 3rd International Conference on Social Work in Health and Mental Health, July 1-5, 2001, Tampere, Finland, 136-137.
- Smith, Michael W. (1999) Why sometimes too little is too much and too much is never enough of goldilocks and the three doses. *The Journal of the California Alliance for the Mentally Ill*. 10 (1), 14-16.
- Thompson, C.E. & Neville, H.A. (1999) Racism, mental health, and mental health practice. *The Counseling Psychologist*. 27 (2), 155-223.
- Valencia, M. & Yaniz, M. (1999) Toward a culturally proficient system of care: Implications for mental health services to Latinos and other minority populations. *The Journal of the California Alliance for the Mentally Ill*. 10 (1), 5-7.
- Zeiler, J. & Zarifoglu, F. (1994) Zur Relevanz ethnischer Diskriminierungen bei psychiatrischen Erkrankungen. *Psychiatrische Praxis*. 21, 101-105.