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FOR CHILD HEALTH



# Self-Awareness and Understanding Multicultural Groups

An Introduction to Cultural and Linguistic Competency

Cultural competency is recognizing that we live in a diverse and pluralistic society and that we should demonstrate compassion, respect, authenticity and honor when working with children, youth and families of different backgrounds. Understanding cultural competency beliefs, values and motivating factor bolsters communication and confidence with individuals and allows for a stronger, more connected community to emerge as a result. Cultural responsiveness is reflected in providers when there is a continuous process self-assessment at the individual, organizational and systems levels.

**Providers should ask themselves questions such as the following:**

- Do I judge people based on their accent or language fluency?
- Am I sensitive to the feelings of others and observe their reactions when speaking? Do I make derogatory remarks about multicultural groups?
- Is my organization tracking health outcomes across cultural groups and reviewing the data to inform service delivery practices?
- Are my organizational leadership and staff representative of the populations that are receiving services?
- Does my organization have a process for staff to access language assistance services for individuals with Limited English Proficiency (LEP)?

From an individual perspective, cultural competency requires that providers examine their attitudes and beliefs about various cultural groups. A culturally responsive provider acquires cultural knowledge and skills in working effectively across multicultural differences (Denboba, MCHB, 1993)

## Cross' Model of Cultural Competence Continuum

In 1989, Terry Cross and colleagues developed Cross' Model of Cultural Competence Continuum showing that becoming culturally competent is a developmental process.

Change mandated for tolerance			Change chosen for transformation		
Destruction	Incapacity	Blindness	Pre-Competence	Competence	Proficiency
Eliminate differences	Demean differences	Dismiss differences	Acknowledge differences exist	Understand differences and make accommodations	Learn from and grow because of differences

Cross' Model of Cultural Competence Continuum's most negative end is cultural destructiveness and the most positive end is cultural proficiency or advanced cultural competency. Cultural destructiveness is when one group believes or demonstrates that their group is superior to another group. There are many historical race related examples of cultural destructiveness, from the exploitation and oppression of the American Indians on reservations, Japanese American internment camps

and African Americans living in slavery on plantations. Structural and modern racism continues today through various systemic inequities such as mass incarceration, environmental racism and geographical economic inequities. Cross' Continuum may be applied across marginalized populations including people of color, girls, women, youth, refugee/immigrant populations, religion, the economically disadvantaged and the Lesbian, Gay, Bisexual, Transgender and Questioning/ Queer, Intersex and Two-Spirited

populations. The most positive end of Cross' Continuum, cultural proficiency or advanced cultural competency, is the ability to work effectively across multicultural groups. At this stage, differences are celebrated and cultural strengths are viewed as pathways to solutions for children, youth and families. Providers should assess their beliefs about various cultural groups and determine if implicit or explicit bias are impacting their approach with children, youth and families.

## Implicit Bias

In our deep subconscious, reside attitudes and assumptions that affect the way we understand, behave and make decisions about others. This is referred to as implicit bias. These implicit associations cause us to make generalizations about people based on age, race, ethnicity, socioeconomic status, appearance, geographical location, sexual orientation, gender expression/identity and religion. These assumptions often develop early in life as a result of our experiences, socialization and media exposure.

## Debiasing Strategies

The following strategies may be used to debias providers:

1. Count-stereotypic training, that is training others to develop new associations that are different from the ones they hold through visual and verbal cues;

2. Intergroup contact in a cooperative setting with common goals and support from authority figures;

3. Empathy training or taking on the perspectives of others;

4. Deliberative processing that is countering implicit biases through self-monitoring particularly in high stress situations and limited time constraints.

Providers should avoid using generalizations with children, youth and families but rather use an individualized approach focusing on family strengths.

Providers may complete implicit bias association tests for free at <https://implicit.harvard.edu/implicit/takeatest.html>

## Knowledge of Multicultural Groups

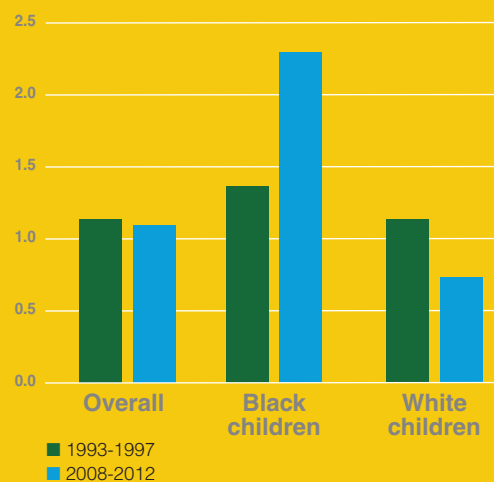
Self-awareness also requires the acquisition of new knowledge about multicultural groups and their health beliefs. For example, there is a pervasive myth in the African American community that mental illness and particularly suicide is not a concern for African Americans. The data says otherwise, the rates of suicide among African-American children have doubled in the last two decades, surpassing the rates among white children, which dropped over the same time period, according to a new study.

Researchers reviewed the suicide rates nationally among children ages 5 to 11 between 1993 and 2012. The rates overall did not change over these years, but the rates among black boys rose from 1.78 to 3.47 per 1 million. In contrast, suicides among white boys declined from 1.96 to 1.31 per million. In just the 5-year period between 2008 and 2012 there were 41 suicide deaths among black boys, and 73 among white boys. Some mental health campaigns in African American communities are focused on redefining the African American cultural identity from struggle to recovery and well-being. This shift is needed to maximize the emotional well-being of families.

Examples of health beliefs related to cultural groups include African Americans whose identity of strength means that you suffer in silence and put the best face forward otherwise you are perceived as personally weak and without faith. Asian Americans may describe mental issues as somatic or as physical symptoms. Hispanics/Latino Americans depending on their generational status may prefer seeking mental health services with their primary care provider or a "curandero," a natural healer as opposed to a psychiatrist or specialist. European Americans (Whites) typically experience much shorter delays in seeking mental health services than minority groups. Though this general cultural information is helpful and supported by studies, it is important for providers to acknowledge the interdiversity that exists within groups to avoid stereotyping. Culturally responsive providers elicit information directly from the youth and family using a cultural assessment to understand the families' individualized cultural context.

### Changes in youth suicide rates by race

Suicide rate among children aged 5 to 11 years, per 1 million



## HELPFUL RESOURCES

**University of South Florida (USF) Cultural and Linguistic Competency Library**  
<http://cfs.cbcs.usf.edu/projects-research/detail.cfm?id=488>

**Ethnomed**  
<https://ethnomed.org/>

For more information regarding implicit bias and multicultural mental health training, please contact The Partnership for Child Health at Jacksonville System of Care **904.630.1072** or visit the [partnershipforchildhealth.org](http://partnershipforchildhealth.org)

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