# Providing Mental Health Services in a Culture Other Than One's Own

*The author's own experience of vulnerability and alienation as a youth attempting to adjust to a culture that was not his own paved a path to his professional involvement in mental health services for ethnic minorities. In this paper, memories of his adolescence and of his professional life inform a discussion of cultural competence both in theory and in the practice of a community mental health agency serving a Latino community in Brooklyn, New York.*

**by**
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Support for this project was provided by the Scholar in Residence Program, NYU, and Ramapo College.


I received an interesting response to the announcement of the seminar on which this paper is based—a response that reminded me of what it means to find oneself in a culture other than one's own. One of my colleagues sent me a friendly note saying that she would be very glad to come to the presentation; she pointed out, though, that the announcement said, "a culture other than one's own," and that grammatically this should be, "a culture different from one's own." I found this a very interesting comment. It may or may not be correct, but on the other hand, it took me back to my feelings as a recent immigrant to the United States. My colleague's response reminded me of how I felt when people corrected me on my use of English, and how these corrections, no matter how well intended, exacerbated my feelings of being an outsider.

I came to the United States from Argentina with my family when I was sixteen years old. Within a few days of arriving in the U.S., we went to Los Angeles and, because it was September, I started attending high school there. All of a sudden, I found myself having to deal with a situation that I was totally unprepared to handle—culturally, socially, emotionally, and psychologically.

At that time, Argentina was a very formal society in which high schools were segregated by gender. I went to an all-boys school, and, throughout my life, I had always attended school wearing a suit and tie. So, in L.A., after being in the country only seven days, I went to Hollywood High School on the first day of class wearing a very dark, pin-striped suit, a beautiful white shirt, and a very nice tie. Not knowing exactly what to expect, I thought I should dress as I had in Argentina—although in Argentina I would smell of cigarette smoke because before going to school I would hang out with my friends, drinking coffee and smoking cigarettes. Here I didn't have any friends, but I did have cigarettes!

So, I went to school and thought I had just arrived in a very strange place. All the students, both boys and girls, were wearing sneakers—in those days, they wore those blue surfer sneakers—with T-shirts and jeans. I felt I was on a completely different planet, one on which I did not belong, not only because I was dressed differently from the others, but because I felt that everybody was looking at me as though I were from a different planet myself.

The experience was one of a reciprocal disposition— reciprocal, I believed—toward mistrust and, to some extent, dislike.

I felt the other students didn't like me because I spoke strangely and often didn't understand those who spoke to me. I didn't know how to maneuver in the culture—how to get around and get things done—and I was

convinced that people thought me odd. Only many years later did I realise that what I had interpreted as manifestations of hostility were more likely expressions of fear; my fellow students were probably as scared of me as I was of them.

On that first day at high school I stayed through the day but I was very uncomfortable and cried a great deal in corners I'd found where I could be by myself. I went home after school and told my mother, "I don't want to be in this place. Send me back." My mother said, "Sure, I could send you back—you could go back and live with your grandparents." I didn't want that, so instead, we went out and bought jeans, T-shirts, and sneakers. But despite my new clothes, I still felt very uncomfortable at school because I spoke hardly any English.

I had taken ten years of classes at the English Institute in Argentina, but these lessons left me ill prepared for day-to-day, conversational use of the language. We studied grammar and vocabulary but had no practice in conversation, and now, in an English-speaking country, I felt mute, unable to speak and unable to make use of what English I had learned. When I did make attempts to communicate, my language was formal and old-fashioned, and I had trouble understanding idiomatic expressions. When I asked the way to the bathroom, for instance, I was surprised to be directed to a restroom—a rest was not what I needed.

To make matters worse, my family spoke no English at all. My parents had invested heavily in my education and were now counting on me to act as the family's interpreter. Their high expectations and my new role as my parents' caretaker in this alien culture only added to my state of anxiety.

As time went by, I found myself in a situation similar to the problem with the clothes on my first day. Now I was wearing the clothes that everybody else was wearing, but I still didn't seem to belong. One of the differences I noticed was that I always seemed to be very overloaded with books. Although I was dressed like everybody else, the other students looked very svelte; they all walked around with one or two books, while I was loaded down with books under each arm.

Finally, I said to someone one day in my broken English, "Why is it that I'm loaded down with books?" He replied; "Don't you have a locker?" "Locker? What is 'locker'?" He pointed to a wall, and said, "Those are lockers! Go into that office and give them your name, tell them you are a student here, and they will give you a locker. After every class you go to your locker, take the books you need, and leave the rest."

Of course, the language barrier was not my only problem as a new immigrant. I felt I was unable to penetrate the culture I was surrounded by. Everything was completely different from what I was used to—the food, the customs, the people, their habits and haircuts—even the very air itself seemed different from the air I had breathed for the first sixteen years of my life.

There were a few Spanish speakers at high school, but they were mainly Chicanos, people of Mexican extraction who had been born in the U.S. and who spoke a mixture of Spanish and English quite unlike the Spanish I knew. These second-generation Mexican-Americans were themselves an oppressed group within the broader population of the high school, and among them I was able to find some empathy and companionship despite our differences.

I found the transit system particularly hard to deal with. My bus trips to school were disrupted by confusion over tokens and exact change, but I was rescued by the sister of a Chicano student,

who offered to pick me up at the corner and drive me to school.

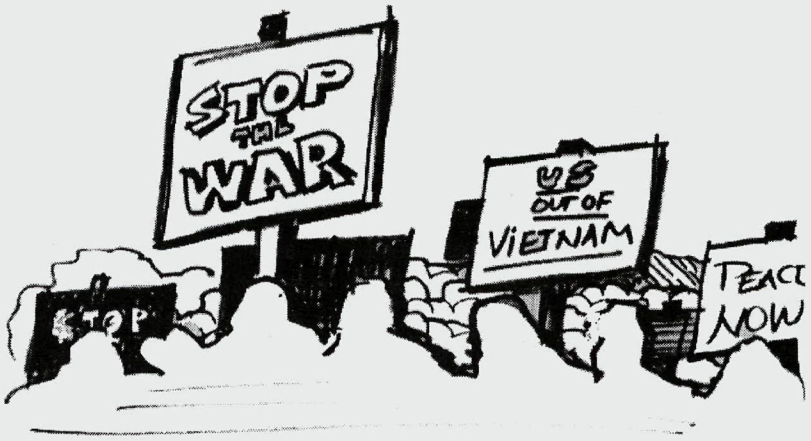
I gradually acclimatized myself to my new home and, indeed, found some aspects of the culture quite fascinating. I was entranced, for instance, by the big, boat-like cars with their flashy fins and chrome fittings. On the whole, though, my high school experiences were of alienation and marginality. I was depressed and in pain from my sense of estrangement; I felt that people treated me coldly, and I resented this treatment—I had done nothing wrong; my only crime was being different.

I became bitter and angry, and my grades dropped. I had been a distinguished student in Argentina, but in L.A. I started skipping school to congregate with groups of youths who were as marginal as I felt myself to be. I met some Argentineans who spent their time fixing up those flashy cars and cruising along Hollywood Boulevard and the Sunset Strip, and I began hanging out with them. My days increasingly revolved around this street scene and car culture—a culture that I felt I could be a part of. Eventually I dropped out altogether and took a job in a gas station.

There I might have stayed, nursing my hurt and alienation, were it not for three aspects of U.S. culture in the mid-1960s: jazz music, the Civil Rights Movement, and the Vietnam War.

I developed a passion for jazz through listening to a local Black radio station, and through jazz I began to find a sense of community. On the day the great saxophonist John Coltrane died, the station urged its listeners to keep their headlights on while driving, and I did so, demonstrating my membership in a fraternity of Coltrane mourners on the roads of L.A. that day.

The radio station also introduced me to the Civil Rights Movement, and in 1965, riots in the Watts section of L.A. brought




questions of racial injustice and oppression close to home. At the same time, demonstrations against the Vietnam War were spreading across the country, and in this atmosphere of unrest and rebellion I began reading, meeting people involved in the civil rights and antiwar movements, and thinking about issues of racial justice and peace. I felt I had found my niche.

I returned to school, first to a local community college, and then to the University of California at Berkeley. In the politicized environment of 1960s campus life I felt embraced; cultural differences were transcended, and I no longer felt that those around me saw me as different. I became integrated within the college culture through the political vehicle and forged a common commitment with people of the U.S. who were opposed to the war.

My anger, hostility, and outsider feelings were channeled against the war, and because I was subject to the draft, the personal and the political came together for me. In particular, I identified personally with the political issues of justice for marginalized populations.

I went on to study sociology and eventually entered the field of social work, where I was struck by the plight of clients suffering from schizophrenia. It seemed to me that their feelings of alienation, of being outsiders in a hostile culture, were similar in some ways to my experiences as a recent immigrant. The concept of a culture other than one's own has been part of my being for a long time, and the experience of a culture other than one's own, or different from one's own, is something that has interested me for personal reasons.

Imagine, now, that my personal experience can be applied to someone who doesn't speak English, has been in the

United States for a short period of time, and for unknown reasons all of a sudden finds herself hearing voices. In high school my perception was that I was on another planet, that people were very hostile to me, that people didn't want to help me. Now imagine that on top of these natural feelings of alienation, this person feels that something is telling her she is no good—she is a very bad person. If she tries to seek help in a big city such as New York, Los Angeles, Washington, or Chicago, she is going to have a pretty hard time; before she gets any help, she could deteriorate further and might even be hospitalized.

To prevent these kinds of outcomes, we've worked very hard in the past twenty years or so in training programs for social work, psychology and sociology to develop cultural sensitivity (Green, 1998; Leigh, 1998; Vega & Murphy, 1990) so that incidents like my high school experience and that of the hypothetical woman who was hearing voices can be dealt with without putting the person at risk and in a manner that is culturally congruent and helpful to that person.

About 1.1 percent, roughly speaking, of the adult American population has been diagnosed as schizophrenic. In the course of a year, 44.7 million people were estimated to have issues to do with major depression, schizophrenia, manic depression disorder, acute anxiety attacks, or addiction—some sort of mental disorder that has required some kind of involvement with the mental health system (Regier, et al., 1993). For those who are experiencing these issues within a culture that is not their own, this involvement can be problematic.

However, after about twenty or twenty-five years of promoting the idea of cultural sensitivity, one could probably ask anybody, "Are you culturally sensitive?" There's a good chance that he or she will say: "Of course I'm culturally sensitive! What do you think, I'm not?" Who's going to admit that he or she is not culturally sensitive? As the theory of cultural sensitivity has been developed and applied by social workers, psychologists, sociologists, and others, a gap has developed between the theoretical concept of cultural sensitivity and implementation of its practice (see Green, 1998; Leigh, 1998; Vega & Murphy, 1990). So I want to dispose, in a way, of the term "cultural sensitivity" and discuss instead something that perhaps approximates: cultural competence.

We have to begin to develop an approach that at least attempts to be culturally competent. Unfortunately, the concept of cultural competence is another recent idea that has suffered from the same gap between theoretical conception of competence and the execution of competence as practiced by social workers, psychologists, psychiatrists, and sociologists (Vega & Murphy, 1990; Leigh, 1998). We need to reframe the idea of competence into something that borrows concepts from anthropology, adopting some of the methodologies and the approaches of the discipline and searching with both a clinical lens and an ethnographic lens to begin to imagine what it must be like to be in the position of a person of another racial/ethnic category or cultural group.

Valle (1986) has described the elements necessary for the development of what he terms "cross-cultural competence." These include:

1. A working knowledge of the symbolic and linguistic "communicational" patterns of the target ethnic minority group(s);
2. Knowledge and skill in relating to the naturalistic/interactional processes of the target population; and
3. A grasp of the underlying attitudes, values and belief systems of the target population.

Questions of diversity, multiculturalism, and cultural competence are issues that have acquired very strong political content. They are the object of current dispute in California in terms of the politics of multiculturalism in affirmative action and also, on a curriculum level, throughout the country. This is not the place to discuss the politics of these issues; nevertheless, I take diversity for granted in the age of globalization, and if we want to be part of the global universe we're entering, we should not have to apologize for diversity or multiculturalism. We have to assert that multiculturalism is an integral part of globalization, of being a part of this universe.

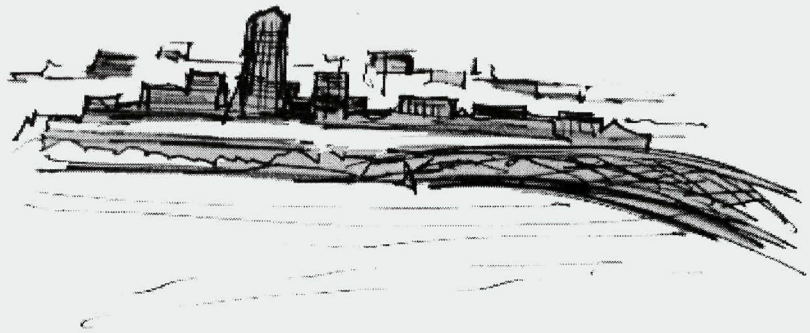
Therefore, I take it for granted that multiculturalism is

something that we should work with, is desirable, and is part of our reality. It is not a debatable issue whether it is desirable to have a diverse population or not. The question, rather is,: What do we do in this community to provide the services? How do we serve this population that is our population?

In order to provide services to a particular population, there has to be a programmatic philosophy on the part of management and administration, as well as the staff, that defines what we ought to be doing. There has to be the intellectual preparation to be able to do this competently, and a political-philosophical disposition to allow policy to be carried out directly with as little conflict as possible.

The concept of an inclusive Latino population has a somewhat contradictory meaning. On the one hand, there are all those issues that unite people who identify themselves as being Hispanic or Latino; on the other hand, there's a great deal of disparity and difference between Latinos from different nations, and indeed, from different backgrounds, classes, gender, sexual orientation, and so on.

There is a common language and a similar history among Latinos, and I can talk to another Spanish speaker very easily (although there are differences in the various forms of Spanish spoken in the western hemisphere), but there is a whole range of personal experiences that I have, coming from Argentina, that are completely different from those of someone coming from, say, Mexico. Our experiences don't speak to each other spontaneously without any kind of prior understanding. So it's difficult to talk about providing services and support for the Latino population without contextualizing commonality and differences.



Once I'd completed my training, I wanted to work where I could use many of my skills, including my language skills, and I was recruited as an intern at a mental health center in downtown Brooklyn, New York, an area with a large Spanish-speaking population. After my graduation, I was offered a position as Director of Outpatient Services for this diverse client group and spent fifteen years working as the Director of Outpatient Services in a downtown Brooklyn mental health center. The largest group that I worked with as team leader in the mental health center was Puerto Rican. However, the following is an example not of a Puerto Rican person because this particular story speaks to other aspects of the Latino experiences in the U.S.

The New York State Office of Mental Health now has units that are exclusively Spanish speaking. I visited a state facility where a wonderful program called La Casita had been developed; La Casita was a little house on the grounds of the facility that catered to long-term Latino patients. Latino meals were prepared, primarily from Caribbean cuisine, with lots of rice and beans and chicken. Both staff and clients were Spanish speaking.

I became very interested in the case of a young Latino woman of about thirty-four or thirty-five who sat in a corner and was always very quiet. I asked someone on the staff about her. "Oh, it's a wonderful story," the staff member said. "Let me tell you the story." This woman had been there for about three years. She had been brought in by the police, who had found her in the street, homeless, very poorly groomed, very depressed. She was catatonic; she didn't talk, she didn't establish eye contact, her affect was extremely flat. She first came to the hospital prior to the establishment of this Latino unit and was interviewed by a male

psychiatrist who didn't speak Spanish. The woman just sat with her head down, didn't make eye contact, and didn't answer any questions, probably because she didn't understand. But even if the interview had been in Spanish, she might not have answered.

The diagnosis that emerged from the psychiatric interview done by the male, non-Spanish-speaking psychiatrist was that she was schizophrenic because her affect was very flat. Affect describes the mood and the disposition in terms of emotion of an individual, and schizophrenics usually present with a flat affect. If you are in a healthy mental state, your affect and your mood ought to be congruent. If you say something sad, you should show some sad emotion; if you say something happy, you should show a smile. This woman showed no change in emotion. The psychiatrist noted that she didn't establish eye contact and therefore had poor interpersonal relations, probably as a part of the schizophrenic process and caused by some internal stimuli which took her away from interpersonal contact.

Within treatment one is limited by categories established by the Diagnostic and Statistical Manual (DSM). If one is working in an agency, one has to follow these categories in order to claim Medicaid and Medicare funds for reimbursement on clients. And yet those categories are very limiting and don't allow for an approach based on clinical cultural competence; they narrow down the available choices to the point where this psychiatrist felt perfectly comfortable with a diagnosis of schizophrenia.

Because the symptoms of schizophrenia include withdrawal, isolation, and flat affect, the woman was given antipsychotic medication, which is supposed to bring schizophrenics out of this state and make them more sociable. In the case of this woman, the medication sedated her more. She became more isolated, more depressed, and for two years she sat, doing absolutely nothing.

During the process when the unit was being converted to the Latino unit, a Puerto Rican nurse took an interest in the woman and started to talk to her, without expecting any answers: "Hello Juanita," "Juanita, how are you today?" "Nice to see you," "Nice day." The nurse took as many opportunities during the day as she could to talk to her, to establish a personal relationship of concern and nurture. After six or eight months this woman began to give brief replies, and after a year or so she started talking to the nurse—very little, but she was talking. And within two years, around the time when I saw her, she was talking to people around her.

So what had happened to this woman? The people who were working with her were not working as clinical ethnographers. They made a terrible mistake—they didn't pay attention to where she came from. They put in her chart, "Place of origin: El Salvador" without exploring the implications of this. When the nurse started looking at the chart, she noticed that the woman was in El Salvador in the 1980s. It turned out that this woman had seen her whole family—her husband and children—killed by the Salvadoran military in front of her. She was the only survivor. Somehow she was smuggled out of the country, brought to New York, was with somebody for just three months, and then got lost. She was experiencing extreme depression and post traumatic stress disorder, among other things, yet she was diagnosed as schizophrenic.

If the staff treating this patient had known that El Salvador was torn by civil war in the eighties and that she was from El Salvador and had been smuggled out of the country, they might have made a much better connection with her and she might not have been warehoused for years in the back of an inpatient unit somewhere on Long Island. As a visitor to the unit, I had little to do with her treatment, but I was struck by how a lack of cultural competence among the professionals she first came into contact with had impeded her progress to such a degree.

If we are going to work particularly with a population that comes from Latin American countries, we have to begin to see the commonality, the common aspects, of the culture as well as the differences in terms of origin, class, ethnicity, race. This sociological approach to clinical work, "clinical ethnography," requires being very careful as to place of origin, and within place of origin I include race, ethnicity, gender, and rural or urban background.

However, in order to develop these programs there has to be the philosophical disposition on the part of administration and staff to be able to do it and, once

that's there, one has to study the community. Is it primarily Puerto Rican? Or is it a mixture of Puerto Ricans, Ecuadorians, Colombians, Salvadorians, Mexicans? Are they legal or illegal immigrants? Are they rural? Are they urban? Are there local leaders in the community who may have emerged over a period of years? And one has to make a needs assessment of that community: Are they being served by anybody? Who's providing services?

In downtown Brooklyn, we provided services to about 400 or 500, sometimes 600, people a week. The 1980 census said that about twenty percent of people were of Latino origin in the area we were supposed to be serving, and yet only about four to five percent of our clients were Latino. We were falling short of our mandate. Our client base did not match the demographics of the area, and we had failed in all our efforts to encourage Spanish-speaking clients to take advantage of the services we offered.

Disposition is not something that emerges naturally. In our case, the disposition changed when someone made a complaint to the New York State Department of Health in Albany, saying, "I live in this particular area of Brooklyn and I feel that this particular state agency is not providing services for the Latino community." And the hospital administration's disposition changed right away. The office of the commissioner of mental health demanded changes, and the administration in turn gave the orders to us—we have to provide services to this at-risk population.

Once we had the disposition, we had to learn about this community. I started to go out in a van with a nurse driving around the neighborhood to all the places where we could meet the people; we went to the churches, and I spoke with a local priest who turned out to be the one who had leveled the complaint to Albany because he was treating people for mental illness. The people didn't know where to go for help, but they trusted him, so he was the one they approached in their distress. He, however, felt he didn't have the training or the ability to help them, and felt overwhelmed by this role. Consequently, he welcomed our outreach.

In addition to going to the priest, people were using the emergency room as their treatment facility, and the priest's complaint had alerted the state government to this situation. The state wanted us to remove the burden from the emergency room because it was very costly; people who felt they were about to have a psychotic episode or were going to try to commit suicide were encouraged to come to our clinic so we could prevent an expensive emergency room visit. The disposition changed because there were very powerful political forces telling the administration and management to move in this direction.

So we started going around the community in the van, doing ethnography and participant observation. It was summer, people were in the street, and the men would bring out a table and put it down in the street to play dominoes. We would stop and say, "My name is so-and-so; I work for a psychiatric service and we're interested in doing psychoeducation." "Psycho! No, we don't need psycho! We don't need any of that—no one's crazy in my family!"

Back in the van we asked ourselves, "What did we do wrong? No one's crazy there!" We went back two or three weeks later: "How are you? If anyone has problems—fighting with their husband, anything like that—we'll leave you these pamphlets—you know, if anything's wrong with the kids—it happens in families, right?" "Oh yeah, it happens—nothing psycho, no one crazy, but problems—it can happen." I spoke in Spanish, of course, and many people didn't know what to make of this Spanish speaking Sam Rosenberg; I felt some of the same dislocation I had experienced back in high school.

Other changes were made in our services: we expanded our staff, we received a grant and developed a psychoeducational program, and we took on more Spanish speakers. We were able to assemble an excellent team and within three or four years we had a full-fledged service with twenty to twenty-five percent of our clients being Spanish-speaking.

So there has to be training, disposition, and the right approach; outreach has to be where the clients are. We have to overcome resistances, which are cultural to some extent and expressed in religious terms, medical terms, and so forth. We have to take our cultural differences and convert them into pluses.

A great deal of work was already being done by providers in the community such as the

priest and the *curandero* or *santero* (traditional healers). These people become natural providers because they share the common cultural and ethnic background of these populations; they also live in the community. It's necessary to bring these people in as resources but also to expand and make connections. When clients came to our community mental health agency, they came not just with problems of mental health but with questions: "How do I get my SSI?" or "How do I go for an interview to get my permanent residence?" or "How do I become a citizen?" And so a whole network of community contacts evolved that allowed us to be perceived by the Latino community as a reservoir of help. Shortly after we started going around with the van getting the initial process going, it snowballed. We really didn't have to do much more. There were entire buildings where the word of mouth was, "Go to Flatbush." People would come by and ask, "Is Rosenberg here?" (Never Sam Rosenberg—alwaysjust "Rosenberg"!)

We realized that local *curanderos* or *santeros* within the Puerto Rican community practice their own brand of healing arts. They believe that spirits can penetrate the phenomenal world and inhabit human beings; disembodied spirits can communicate with spirits inhabiting bodies through mediums, who have spiritual faculties (Colon, 1996, p. 85). So what do you do when your client comes in and tells you, "I went to see my *santero*, and he told me that it's okay to be here but that I should be careful." How do you work with that client? After many years we decided not to fight it. In most cases it wasn't damaging and might even have been helpful.

We started inviting *santeros* to come to our clinic and join us in helping our patients. "We have the same end in mind," we said. "You want to help this person; we want to help this person; how can we do this together?" At first the santeros were willing to talk but reluctant to come to the clinic; but a Puerto Rican member of the staff offered to coordinate between the clinic and the *santeros*, and soon they were our allies in the community. They were able to reassure our clients that treatment at the clinic would not violate any spiritual duty or obligation and could persuade patients to continue taking their medications while also taking part in traditional treatments.

The participation of the *santeros* was symbolically important as an acknowledgment of their cultural place within the community, and our contact with them allowed us to discourage the more extreme practices, such as animal sacrifices, that could have exacerbated the condition of mentally fragile clients. Our approach transcended the cultural schism by offering community-based services which utilized culturally based realities of the population.

The points relevant to developing adequate services for working with the Latino population and developing a competence based on this community are the following: 1) study the demographic profile of the community to be served; 2) work in the community as a participant observer to gather as much information as possible; 3) get intimately acquainted with the neighborhoods; 4) participate in social and educational activities as a member of that community as much as they will let you; and 5) build working relationships for referral and work (Lum, 1997; Valle, 1986).

One more issue which has to do with the question of matching resources with client needs goes back to the common cultural base of Latinos and an interesting interplay that one obtains more in exile than in one's own culture. About thirty years ago I interviewed for a job at a university in Ohio and asked them, "Are there any Spanish-speaking students here—any Latinos?" And they looked at me and said: "Chico! Let's get Chico!" Yet Chico and I may have had nothing in common—from his name, he was presumably Mexican or Mexican-American and from a very different background to my Argentinean origins. Similarly, and within the Latino community, we found that just putting together a group of people who are Latinos who speak Spanish wouldn't necessarily mean that they would be able to work well with each other.

An example of this is the story of a twenty-nine-year-old Ecuadorian, an extraordinary dancer who was doing very badly in the United States because his type of dance was avant-garde native ballet. He was therefore working as a construction worker. He had been exposed to some political injuries in his country of origin and came to our clinic com-

plaining of feeling persecuted. He was also expressing concern that he had some gender issues of a kind psychiatrists call "homosexual panic." He felt attracted to men but was afraid this was a symptom of mental disorder. His life experiences had made him very distrustful. He was an undocumented immigrant, he had been exposed to some political troubles in his own country, and now that he was in this country he was experiencing persecutory delusions, perhaps with some legitimacy since he was here without papers.

The cultural sensitivity, as opposed to cultural competence, model told us to give him a Spanish-speaking therapist or social worker. This is what we did, and it failed miserably. We matched him up with a Puerto Rican woman in her forties who had been here all her life, had worked as a social worker for about 25 years, and felt that at this point in her life she was very much middle-class, professional, heterosexual, and in the mainstream of American society. These people were both Latinos, but they talked two different languages—their cultural experiences were at variance, and they found no common ground for communication. There was no match. This man didn't want to work with her, and she didn't want to work with him, even though she didn't want to admit it.

We eventually found the solution in this case by placing the Ecuadorian with a gay man, an Anglo, but nevertheless someone who was able to help him work through his fears of homosexuality. So again, competence and sensitivity in this case needed to be reinterpreted to mean something that took into account the complexity and multidimensionality brought into the treatment situation.

**Conclusion**

Valle (1986) has noted that mental health practitioners have advocated in the past what Rohman et al. (quoted in Vega & Murphy, 1990) have called "spontaneous" change: it is presumed that practitioners can put forward "some knowledge relevant to the target population and then hope that cross-cultural competencies will emerge as serendipitous outcomes of the effort" (p.44). This approach has been demonstrated historically to be a dismal failure in generating either a reliable information base or a training model for a transcultural mental health intervention (Vega & Murphy, 1990). The arguments discussed in this paper are based on the aforementioned historical reality and on my personal experiences of alienation in a culture other than my own; they point to the need for a move toward a reformulation of multicultural community mental health services. The suggested approach transcends the cultural schism by suggesting community services, which utilize the culturally based practices of the target population. For that perspective to succeed, and to promote political alternatives and advance culturally competent knowledge, a flexible theoretical framework must be utilized which incorporates the personal and cultural nuances of different populations and understands cultural communities as the beginning and end of practice.

Upon reflection, writing this story makes me feel rather uneasy. On the one hand, I have re-experienced the sadness and alienation of my early years in the United States. I discovered the intensity of those lonely years and realized that wounds that appeared to have been healed remain dormant. Time and the bumps and grinds of growing up have tempered those memories, but I realize that the uncertainty and vulnerability of marginality have permanently colored the tint of the lenses I use to look at life. On the other hand, a great deal of my uneasiness has to do with the fact that to those reading the story it may look like a success story. After all, I overcame the injuries of otherness and went on to become a culturally competent professional. However, once one commits oneself to public discourse, one relinquishes control over the myriad interpretations readers may have concerning the narrative. In other words, the story belongs to everybody for whatever purpose they may want. It is here where the problem looms large. I am uncertain, and probably will remain so for the rest of my life, about the meaning of adversity. I know that the not totally known forces of history and biography have shaped my trajectory. I also know that those whose daily existence is characterized by vulnerability and marginality are condemned to a life of oppression and exploitation, an existence of exclusion due to no fault of their own. In that light, I believe that respect and culturally competent approaches towards those falling

outside of the mainstream may be a much more desirable experience than exclusion and adversity. □

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