

CLOSING THE GAP:

Cultural Perspectives on Family-Driven Care



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Contents

Introduction	1
What's in a Word?	2
Framing a <u>Big</u> Issue	3
Origin and Intent of the Substance Abuse and Mental Health Services Administration	
Definition of Family-Driven Care	4
Some History	4
Dispelling Misconceptions About What Family-Driven Care <u>Really</u> Means	5
Family-Driven Decision Making in Programs	6
A Definition Is Good but Not Sufficient	6
Putting the Definition of Family-Driven Care Into Practice.	7
How Is Family Defined in Different Cultures?	8
<u>Our</u> Definition of Family	8
An Asian Perspective	9
A Black Perspective	9
A First Nations Perspective	9
A Latino Perspective	10
How Does Immigration Status Influence a Family's Cultural World View?.	11
An Asian Perspective	12
A Black Perspective	13
A First Nations Perspective	13
A Latino Perspective	13
Historical Trauma	15
Definition	15
An Asian Perspective	15
A Black Perspective	16
A First Nations Perspective	17
A Latino Perspective	18
How Does Culture Influence the Way Families View Behavior, Share Information, and Make Decisions?.	19
Different World Views	19
Intersecting Cultures and Code Shifting	20
An Asian Perspective	21
A Black Perspective	22
A Latino Perspective	22
A First Nations Perspective	23
Discovering a Family's Culture	25
Developing a Partnership	26
Discovering Culture and Earning Trust	27
Infrastructure to Support Culturally and Linguistically Competent Family-Driven Care	27
Policies and Procedures.	27
Environments	28
Workforce Development	28
Community Relations.	29
Governance	29
Telling Our Stories	30
An Asian Community's Story.	30
A Black Family's Story	31
A First Nations Family's Story	32
A Latino Parent's Story.	33
Summary	35

Introduction

“ We must reframe our professional thinking about culture, and we must move from thinking of diversity as a problem to solve to seeing culture as one of our greatest assets for healing and mental wellness... I challenge you to tap into the richness of culture as a resource and to meet people where they are most closely engaged in meeting their needs. I also challenge you to help our children find the strengths, positive emotions, and mental wellness that are part of every culture. ”

– Terry Cross¹

This paper is about the interaction between family involvement in behavioral health systems of care and cultural and linguistic competence. It describes “family-driven-care” from four cultural perspectives—the world views, beliefs, values, traditions, customs, and languages of Asian, Black, First Nations, and Latino families living in the United States. It discusses the role and importance of incorporating “family culture” as defined by the family in the process of outreaching to, engaging, and involving families in care.

Behavioral health care in the United States, including systems of care for children and youth, is grounded in and operates within a western cultural perspective and framework. This orientation toward treatment and what is expected of families are not always congruent—indeed they sometimes clash—with the cultural orientation and expectations of the children, youth, and families receiving services. This paper is intended to begin the discussion about how to close this gap and build trust through better cross-cultural respect and understanding.

This paper has been written by a team of family members with different cultural, linguistic, and ethnic identities. Each of us has approached this task from our own personal world view and cultural background and from our professional experience and knowledge. All of us have personal experience with systems of care. Each of us has taken a journey of self-reflection and sought wisdom and guidance from elders and peers in our respective communities. Our collaboration has been rich and enriching, humbling and uplifting. We have been deeply conscious of the great responsibility we have in representing the vast diversity within the cultures in which we were raised and live. And we hope we have done justice in representing our people, while recognizing our limited ability to speak for all. We have endeavored to be culturally specific without reinforcing stereotypes or perpetuating discrimination. We hope that our readers will respond to this paper in the same spirit.

¹ Cross, T. (2003). Culture as a resource for mental health. *Cultural Diversity and Ethnic Minority Psychology*, 9(4), 354–359.

WHAT'S IN A WORD?

“ There’s an old children’s saying, “Sticks and stones may break my bones, but words can never hurt me.” If only that were true, but it’s a fable that needs to be laid to rest. Words can hurt a lot more than sticks and stones. They may not break bones, but they can surely break hearts. Words can devastate. Words can wound; words can kill. Words can ruin reputations and destroy relationships. There’s just no doubt about it—words hurt.² ”

– Lonnette Harrell

The words we use to identify culture, race, ethnicity, and language can be very powerful or very disempowering. Choosing and using identifying descriptors is a sensitive subject. The United States is very heterogeneous, and we use many different words to “label” people. Some of these words have personal, political, or nationalistic connotations. These words can be positive or negative depending on who is using them, who is hearing them, who is interpreting them, and in what situation they are being spoken or written.

Many words are used to identify a person’s culture, race, or ethnicity. Some of these words or terms are self-identifiers, whereas others are assigned by people or agencies from the dominant culture. For example, among Spanish-speaking populations and cultures, some terms derive from political or historical contexts. Chicano, Raza, Mestizo, and Atzlan are example of this. Other terms reflect national origins, such as Puerto Rican, Cuban, and Mexican. More generic labels, such as Hispanic and Latino, have also been adopted, adapted, or assigned. For the purpose of this paper, and with due respect to all, we use the term *Latino* to refer to people who (currently or in the past) identify with the Spanish language or any of its accompanying diverse and rich cultures.

Similarly, Asian cultures are numerous and diverse. Each has its unique cultural ways of being and unique immigration experience. Although some values or practices may be found in most of these cultures, no single overarching Asian culture exists. With due respect to all, *Asian* is the term we use in this paper.

For the past 25 years, African American or Afro-American has been the politically correct way to identify black American individuals, replacing the derogatory term Negro. However, African American does not account for the full range of black- or brown-skinned ethnicities that exist in the United States. Individuals and families who have emigrated from Jamaica, Haiti, the West Indies, and a variety of African nations all have different cultures and languages and celebrate different beliefs. Not all these individuals consider themselves African Americans. At the same time, many have some values and practices that they share. For example, most have a familial decision-making hierarchy. For the purpose of this paper, and with due respect to all, we use the term Black to refer to people who (currently or in the past) identify themselves as African American, African, and Afro-Caribbean.

American Indians, Alaska Natives, and other Indigenous peoples such as Native Hawaiians hold a unique place in our society because they were the original inhabitants of this continent and the Pacific Islands before these places were colonized by Europeans. Native American is deemed to

² Harrell, L. (2008). Sticks and stones may break my bones—and words hurt, too! Available at <http://www.helium.com/items/868412-sticks-and-stones-may-break-my-bones-and-words-hurt-too>. See also McClellan, L. (n.d.). Sticks and stones may break my bones but words can hurt much worse. Available at <http://peacefulplanetcommunication.com/2011/01/22/sticks-and-stones-may-break-my-bones-but-words-can-hurt-much-worse/>

be a politically correct way of referring to the original people of North America within the boundaries of the continental United States, parts of Alaska, and the island state of Hawaii. Native American has replaced American Indian, although many government agencies continue to use American Indian/Alaska Native. American citizens who are from India are more frequently referred to as Indian Americans, adding to the confusion when using American Indian. To be more inclusive and to honor all people indigenous to North America, we use the term First Nations People to mean those original inhabitants of Canada, Mexico, and the United States.

FRAMING A BIG ISSUE

There is no such thing as “color blindness” when it comes to race or ethnicity. We are all biased in one way or another and to one degree or another, whether we admit to it or not. To not acknowledge our own racism or ethnocentrism is to do a disservice to respectful dialogue and relationship and trust building. All relationships should be based on truth. No matter how many friends from different cultures we have, we may still be biased or prejudiced against other individuals or groups that are different from us. At the same time, many of us believe that we all are children of God, a Creator, Allah, or another higher natural or spiritual power. Within these frameworks, we are all the same regardless of the way we dress, the color of our skin, the language we speak, the food we eat, and a myriad of other things we do.

Nevertheless, we believe that it is important to note how our cultures differ from the dominant culture as well as the diversity internal to the culture, race, ethnicity, or language groups with which we identify. We believe that we all must acknowledge that the interaction between our own culture—with its beliefs, traditions, world view, rituals, values—and the society in which our culture resides shapes us and how we self-identify. As the authors of this paper, we cannot speak for all people of any one group but only share the experiences that we and others have had from our personal world views.

Although we do not want to be prescriptive or stereotypic in this paper, we present the experiences and views of one individual from each of four populations in the United States: Asian, Black, First Nations, and Latino, presented from the perspective of one member of each group. We also offer insight into discovering the strengths of families from these four diverse groups and involving families in decision making about the treatment and services for their children and youth.

Origin and Intent of the Substance Abuse and Mental Health Services Administration Definition of Family-Driven Care



A system of care, or any other program serving children and their families, cannot be family driven without being culturally and linguistically competent. To put it another way, when interaction with families is not in tune with their culture and world view, it is not family driven.

SOME HISTORY

The concepts behind family-driven care originated with families. In the 1990s, families struggling to find helpful mental health care for their children talked about being driven by the system. We felt disenfranchised by providers, and systems blamed us for our children's problems. Many providers, at that time, viewed families as dysfunctional and were trained to exclude families and make all decisions about treatment without any input from us. Providers and systems expected us to follow their treatment directives. Families that disagreed with these plans, did not understand them, or simply did not have the resources to follow them were labeled noncompliant, were often denied services, or, in the worst case, were determined to be unfit to raise our children. Leaders in the family movement believed that it was time for us to take back control and drive the planning and service delivery process ourselves.

Naomi Tannen, writing in 1996 about the development of a system of care created and led by families in Essex County, New York, defined a family-centered system as one in which “families have voice, ownership and options on every level.”³ In the Essex County system of care, family members were in control of interventions, gave significant input to program development, and were given support for advocacy groups so that their voices would be heard in policy arenas.

In 2002, making the paradigm shift to family-driven care was a key strategy to achieve Target Four of the National Agenda for Achieving Better Outcomes for Children and Youth with Serious Emotional Disturbance.⁴

The term *family-driven* was formally introduced in the mental health policy arena in 2003 by the President's New Freedom Commission on Mental Health. Goal 2 of the commission's report, *Achieving the Promise: Transforming Mental Health Care in America*, called for “consumer and family driven care.” The report did NOT define these terms, but the commissioners insisted that families “must stand at the center of the system of care.” They also said that the needs of children, youth, and families must “drive the care and services that are provided.”⁵

To support making the shift to family-driven care and practice, the term needed to be defined. During the next two years, the search for a definition took the form of a sequence of activities, which always

³ Tannen, N. (1996). *Families at the center of the development of a system of care*. Washington, DC: National Technical Assistance Center for Children's Mental Health.

⁴ Osher, T. W., & Osher, D. (2002). The paradigm shift to true collaboration with families. *Journal of Child and Family Studies*, 11(1), 47–60.

⁵ President's New Freedom Commission on Mental Health. (2003). *Achieving the promise: Transforming mental health care in America* (pp. 27–47). Rockville, MD: Author. Available at <http://store.samhsa.gov/shin/content/SMA03-3831/SMA03-3831.pdf>

included asking for feedback, which was then incorporated into a new draft of the definition and used for the next round of activities. These activities included convening an expert panel, interviewing recognized leaders in the family movement, holding open forum discussions at national meetings, receiving input from a variety of audiences around the country, and holding webinars.⁶

In November 2005, at the National Federation of Families for Children's Mental Health's 17th annual conference, the eleventh version of the working definition of family-driven care was released (see Figure 1).⁷

Figure 1

Working Definition of Family-Driven Care November 2005
Family-driven means families have a primary decision making role in the care of their own children as well as the policies and procedures governing care for all children in their community, state, tribe, territory and nation. This includes: ▪ Choosing supports, services, and providers; ▪ Setting goals; ▪ Designing and implementing programs; ▪ Monitoring outcomes; ▪ Partnering in funding decisions; and ▪ Determining the effectiveness of all efforts to promote the mental health and well being of children and youth.

DISPELLING MISCONCEPTIONS ABOUT WHAT FAMILY-DRIVEN CARE REALLY MEANS

Much of the training in human psychology and behavioral health adheres to a medical model that places the professional in the position of an expert who has the special knowledge and skills to determine what is wrong with a patient and prescribe the right treatment to cure the problem. It is, therefore, not surprising for professionals to be skeptical and anxious when first introduced to the concept of family-driven care. The image that is likely to come to mind is being run over by a bulldozer. However, once professionals fully understand the intent behind the definition and they experience the benefits of practicing their craft in accordance with the principles of family-driven care, they typically find greater satisfaction with their work and see better outcomes for the children and families with whom they work. Their mental image changes to one of taking a journey together. They see themselves in a car with the family in the driver's seat as they themselves read the maps and guide books, look out for landmarks and hazards, feed the passengers in the back seat, and make suggestions to get safely to the destination.

There really is nothing remarkably new about this definition. The role it assigns to families, “**a primary decision-making role in the care of their children,**” is the most basic expectation we have of ALL families. In fact, when parents do not follow through with this role, society steps in to protect the child. Stigma about people with mental illness has pervaded history and has been directed at the parents of children with behavioral health needs, excluding us from making decisions about our children's care. This definition restores these basic rights and responsibilities to us.

⁶ Blau, G., Osher, T. W., & Osher, D. M. (2005). *Ambassador's guide to family-driven care and practice*. Rockville, MD: National Federation of Families for Children's Mental Health.

⁷ National Federation of Families for Children's Mental Health. (2005). *Working definition of family-driven care*. Rockville, MD: Author. Available at <http://www.tapartnership.org/docs/workingDefinitionFamilyDrivenCare.pdf>

The definition gives families a primary decision-making role, but we are not the only ones making decisions. The intent of the definition is for families and professionals to equally share BOTH responsibility for making decisions and accountability for the outcomes. This intent puts us on equal footing with professionals. We and those providing services to our family cannot make these decisions alone. And we cannot refuse to take some responsibility for making changes when things are not going well.

Families bring life experience and cultural wisdom to the process. Professionals bring expertise based on training and years of work in their field. Later in this paper we will explore in much greater detail the role of culture and the challenges of reconciling differing world views in making this partnership work.

FAMILY-DRIVEN DECISION MAKING IN PROGRAMS

The definition specifically assigns a primary decision-making role to families beyond obtaining the appropriate care for their own children. Families also assume a significant role in designing and implementing programs, monitoring outcomes, partnering in funding decisions, and evaluating program outcomes.

The challenges are for systems to actually share decision making with families, for families to have the confidence to share in making decisions with professionals, and for everyone to feel respected and safe when contributing their views, expertise, and experiences in the decision-making process, both for individual families and for programs and systems as a whole. Culture and language influence how families, programs, and systems resolve these challenges.

A DEFINITION IS GOOD BUT NOT SUFFICIENT

Having a definition alone is not sufficient to change how people think and act and interact with one another. Throughout the process of developing the definition, family members, practitioners, policymakers, and others worried that only the vocabulary would change—practice would continue on as usual. Feedback, comments, and suggestions provided during the development often addressed underlying principles for its implementation. From this rich feedback came ten principles to further clarify what family-driven care meant (see Figure 2).

Figure 2

Guiding Principles of Family-Driven Care	
1.	Families and youth are given accurate, understandable, and complete information necessary to set goals and to make choices for improved planning for individual children and their families.
2.	Families and youth, providers and administrators embrace the concept of sharing decision making and responsibility for outcomes.
3.	Families and youth are organized to collectively use their knowledge and skills as a force for systems transformation.
4.	Families and family-run organizations engage in peer support activities to reduce isolation, gather and disseminate accurate information, and strengthen the family voice.
5.	Families and family-run organizations provide direction for decisions that impact funding for services, treatments, and supports.
6.	Providers take the initiative to change practice from provider driven to family driven.
7.	Administrators allocate staff, training, support, and resources to make family-driven practice work at the point where services and supports are delivered to children, youth, and families.

Figure 2 (continued)

Guiding Principles of Family-Driven Care	
8.	Community attitude change efforts focus on removing barriers and discrimination created by stigma.
9.	Communities embrace, value, and celebrate the diverse cultures of their children, youth, and families.
10.	Everyone who connects with children, youth, and families continually advances their own cultural and linguistic responsiveness as the population served changes.

PUTTING THE DEFINITION OF FAMILY-DRIVEN CARE INTO PRACTICE

The developers of the definition anticipated that the Substance Abuse and Mental Health Services Administration (SAMHSA), and eventually other federal agencies, would incorporate the definition of family-driven care into guidelines or requirements for programs for children and youth with behavioral disorders and their families. SAMHSA program officials, as well as grantees and practitioners, expressed their need for guidance about how the implementation of family-driven care might be reviewed and evaluated. Seven characteristics of family-driven care, derived from the definition and incorporating suggestions from the field, were appended to the definition in response to this need (see Figure 3).

Figure 3

Characteristics of Family-Driven Care	
1.	Family and youth experiences, their visions and goals, their perceptions of strengths and needs, and their guidance about what will make them comfortable steer decision making about all aspects of service and system design, operation, and evaluation.
2.	Family-run organizations receive resources and funds to support and sustain the infrastructure that is essential to ensure an independent family voice in their communities, states, tribes, territories, and the nation.
3.	Meetings and service provision happen in culturally and linguistically competent environments where family and youth voices are heard and valued, everyone is respected and trusted, and it is safe for everyone to speak honestly.
4.	Administrators and staff actively demonstrate their partnerships with all families and youth by sharing power, resources, authority, responsibility, and control with them.
5.	Families and youth have access to useful, usable, and understandable information and data, as well as sound professional expertise so they have good information to make decisions.
6.	Funding mechanisms allow families and youth to have choices.
7.	All children, youth, and families have a biological, adoptive, foster, or surrogate family voice advocating on their behalf.

All these characteristics are essential, although in practice some seem easier to implement than others. This paper focuses on the third characteristic, which addresses **cultural and linguistic competence**. The perspectives and experiences of families from four cultures—Latino, Black, Asian, and First Nations—are presented, along with suggestions about what can be done to make family-driven care and practice culturally and linguistically competent.

The family, according to Article 16 of the Universal Declaration of Human Rights,⁸ is the fundamental and natural element of the society and has the right to the protection of the society and the state. The word *family* speaks to the connections and loyalty that develops between two or more persons. Whatever the type of relationship we prefer, it is important that we recognize its value.

⁸ See <http://www.un.org/en/documents/udhr>.

How Is Family Defined in Different Cultures?



The Merriam-Webster dictionary includes eight definitions of *family*.⁹ We agree that most families more or less fit somewhere within the scope of the first three:

1. A group of individuals living under one roof and usually under one head (household)
2. A group of persons of common ancestry (clan); or a people or group of peoples regarded as deriving from a common stock (race)
3. A group of people united by certain convictions or a common affiliation (fellowship)

But there is much more to understanding what our personal family is and what being part of our family means. In this section we explore how family is defined from our four different cultural perspectives. We start with our collective definition of family.

OUR DEFINITION OF FAMILY

A family is the group of individuals who share a cultural world view and take responsibility for one another. Families support each member emotionally, physically, and financially and raise their children and youth within that cultural framework. A family is defined by its members, and each family defines itself. A family can include people of various ages who are united through biology, marriage, or adoption or who are so closely connected through friendships or shared experience that they are taken to be family members.

A family unconditionally provides love, guidance, care, and support and otherwise nurtures all of its members. Roles in a family are sometimes assigned (such as grandmother or clan mother). Sometimes a person's place or position in the family is based on the particular abilities or gifts of that person (such as the bread winner, the housekeeper, the spiritual guide, the chauffeur, the nurse). Individuals may take on one or more of these roles to varying degrees at different times. The process of acculturation into a new or different culture can sometimes disrupt the natural development of these roles and patterns, as families work to sustain their cultural values and history. Families are dynamic and constantly evolving, redefining roles and relationships, welcoming in new members, and taking on new ideas and world views as diverse cultures intersect.

Each family has a unique culture of its own in addition to the external cultures with which it and individual members affiliate. Each family's culture influences how the family approaches the tasks of daily living (such as food, dress, work, or school). This culture can also direct how a family deals with conflict and makes decisions. Culture influences how a family views wellness and illness (and ways to treat it), including coping with the challenges of raising a child with mental, emotional, and behavioral health care needs. Families function in different ways and have different resources at their disposal, which affects their success in meeting the needs of all their members.

⁹ See <http://www.merriam-webster.com/info/about-our-privacy-policy.htm>.

AN ASIAN PERSPECTIVE

For Asians, family includes a very strong emphasis on the extended family, with grandparents, aunts, uncles, and cousins often playing an important role in psycho-social support and decision making. Children are cherished, and many family members collaborate to raise the children with a great deal of protective, supportive care. Most Asian families place a high value on collectivism, holistic processes, and respect for tradition and elders.

Family may also be defined to include a whole community. Community solidarity and community support are very important in many Asian American communities. The tradition of *koden* is an example of how this sense of community is realized in the Japanese American community. When a Japanese person dies, the Japanese families in the community contribute to the *koden*, which is money given to the family of the deceased to support a community funeral event. Originally a Buddhist tradition, this custom is widespread among Japanese Americans of non-Buddhist religions as well. *Koden* encourages community solidarity and community connectedness. It is not offered out of pity for the poor. If all the *koden* is not spent by the bereaved family, the balance of the money is donated to community charitable organizations or is saved and passed from one bereaved Japanese family to the next.

A BLACK PERSPECTIVE

From a Black perspective, family includes everyone from the oldest living and deceased relatives to the youngest living and deceased relatives. Relatives include but are not limited to grandparents, mothers, fathers, aunts, uncles, cousins (both close and distant), siblings, and children. This family group may share a common lifestyle, as well as eating, cooking, and housekeeping practices. They may have the same spiritual beliefs and engage in the same rituals. For the most part, members of a family have some genealogical linkage, either known or told. However, people who do not share the same blood or ancestry may also be considered members of a family, such as children taken in by the family when their own parents are not able or available to care for them. It is not uncommon to hear a Black person consider someone “family” because of the experiences they endured together. Often we say that someone is our brother or sister or cousin or mother or father. The person to whom we are referring may not share our last name or blood.

A FIRST NATIONS PERSPECTIVE

The Thanksgiving Address of the Haudenosaunee (Longhouse People) of the Iroquois includes giving thanks for the instructions from the Creator on how to live while on Earth. These instructions include love and family. “He intended that we should have love for one another as we are walking about on this earth... He intended that we should all have family as we walk about on the earth...and so now we will give it our thought and carefully give thanks.”

As this Iroquois prayer reveals, among First Nations People, whether we live traditionally or are assimilated into mainstream United States culture, family is a powerful concept. Family goes beyond bloodlines and can be defined by tribe, clan, genetics, spiritual connections, and those whom we take as family. It is not unusual to refer to cousins as auntie, uncle, brother, sister. Aunts and uncles are often referred to as grandparents, or friends as brother or sister.

First Nations People define family as those who have meaningful connections to us; who connect us to our culture, our history, our family stories and lineage, and our future; and who can be with us in the present. A family guides us, is there to help us out of crisis, listens to us when we have “secrets” that need to be kept to protect us. Family members are the people we can trust to cry in front of and to laugh with. They are the people whom we can trust when we feel that we are not being treated fairly or when we feel frustrated by other family members or the system. Family sustains us.

A LATINO PERSPECTIVE

The family is a person or people who are ever present in our minds and the ones to whom we respond during the good and bad moments in our life. Latinos do not distinguish between immediate or extended family; all are family.

The family in the Latino culture is the center of its existence. Family signifies everything for Latinos and is the foundation of the Latino culture. The Latino community is known for its rich traditions and the importance we give to the family. The tradition of living with grandparents and close to family has been a custom for many Latinos living in the United States or in their countries of origin. Festive days and special occasions are celebrated with the entire family.

The cultural norm of *familismo* includes both the obligation to provide support to members of the family and the knowledge that we can depend on kin for encouragement and support. The emphasis in Latino families is on interdependency. Always present among Latinos is a real concern about the welfare of the family. Latinos are focused on the stability and the unity that family gives us. We celebrate and we suffer together as a family.

Cultural traditions unite the Latino family for life and therefore connect family members to their heritage reflecting their ethnic, racial, or national origins. Maintaining cultural traditions in the Latino family can give a child a sense of identity and of being part of a more extensive community—one with strong roots. This helps the child comprehend his or her own culture and is the first step in learning peaceful co-existence with and among other cultures.

How Does Immigration Status Influence a Family's Cultural World View?



People and families leave their country of origin and come to the United States for a variety of reasons and under a variety of circumstances. They could be escaping from a crisis or a conflict in their country. They could be fleeing violence to save their own lives, and the lives of their family members, or be seeking political asylum. They could be looking for a better life and hoping for opportunities to work or study.

Regardless of how or why they come, when families immigrate to another country, their lives change drastically. It is not easy to leave the place where unforgettable memories of their childhood and upbringing remain. They also leave part of their heart behind with beloved family and friends. The pain of separation contributes to feelings of loneliness, melancholy, worry, fear, and isolation. All this has an emotional effect on a person or a family. As one of our authors has stated, “The nostalgia [for what we left behind] accompanies most of us for a lifetime.”

When discussing cultural and linguistic competence, and when endeavoring to be culturally responsive, we must consider the immigration experience as well as its causes and effects. To immigrate signifies a change of culture, to come to a different country with a language, customs, and laws that in many cases are completely different from what families have known and experienced. Sensitizing ourselves to these experiences can help us have compassion. It can help us know better how we can offer support to help immigrant families understand and adapt to the demands of life in the United States.

Immigration also has significant impacts on health and mental health. Recent research reveals that White European immigrants tend to report better health after living five or more years in the United States, but the majority of other immigrants, especially Latinos, have the opposite experience.¹⁰ Unfortunately, Latinos, especially recent immigrants and those who do not speak English, get sicker the longer they are here. This is particularly true for mental health.¹¹ Adolescent Latinas, for example, have the highest rates of suicidal behavior.¹²

Each family experiences immigration through the lens of its own culture. And the experience of coming to the United States has not been the same for every cultural group. Sometimes what immigrant families experience is discrimination, racism, or cultural stereotyping.

¹⁰ Allen, A. (2006, March 8). *Home is where the heart is healthy: Why immigration makes you sick*. Retrieved August 22, 2011, from <http://www.slate.com/id/2137730/>

¹¹ Vega, W., Rodriguez, M. A., & Ang, A. (2010). Addressing stigma of depression in Latino primary care patients. *General Hospital Psychiatry*, 32(2), 182–191; Vega, W. A., Alderete, E., Kolody, B., & Aguilar-Gaxiola, S. (1998). Illicit drug use among Mexicans and Mexican American in California: The effects of gender and acculturation. *Addiction*, 93(12), 1839–1850; Vega, W. A., Kolody, B., Aguilar-Gaxiola, S., & Catalano, R. (1999). Gaps in service utilization by Mexican Americans with mental health problems. *American Journal of Psychiatry*, 156, 928–934; Vega, W. A., Kolody, B., Aguilar-Gaxiola, S., Alderete, E., Catalano, R., & Caraveo-Anduaga, J. (1998). Lifetime prevalence of DSM-III-R psychiatric disorders among urban and rural Mexican Americans in California. *Archives of General Psychiatry*, 55, 771–778; Atdjian, S., & Vega, W. A. (2005). Disparities in mental health treatment in U.S. racial and ethnic minority groups: Implications for psychiatrists. *Psychiatric Services*, 56(12), 1600–1602.

¹² Zayas, L. H., Lester, R. J., Cabassa, L. J., & Furtuna, L. R. (2005). Why do so many Latina teens attempt suicide? A conceptual model for research. *American Journal of Orthopsychiatry*, 75(2), 275–287.

War plays an important role for immigrants to the United States. The events of September 11, 2001, for example, have led to increased racial profiling. People who represent or even look like groups with whom the United States government is in conflict face cultural or racial stereotyping resulting in discrimination, oppression, and emotional pain. This is not a new phenomenon. Following the bombing of Pearl Harbor, United States citizens who were of Japanese descent were imprisoned in internment camps. Even after their release at the end of World War II, Japanese Americans suffered the loss of their homes, property, language, economic well-being, and sense of safety.

Direct and personal exposure to the ravages of civil war or invasion by an aggressor in their home country may cause psychological and physical trauma. Some immigrants who arrive in a new country suffering from post traumatic stress not only are faced with the culture shock of entering a new country and society with a new language but also need help to heal the deep traumatic wounds of war.

AN ASIAN PERSPECTIVE

The experiences of Asian immigrants in the United States has varied over time and has differed depending on our country of origin. Some, such as many Japanese and Chinese families, came to the United States two or three generations ago. These families have had time over several generations to find harmony between mainstream American culture and our own cultural traditions. Many of us have found the “American Dream” we were seeking in the form of social and economic success in this country. But this story also has a downside. The desire to fit in to mainstream American culture and, in some instances, to avoid discrimination and oppression by speaking only English with their children has led to the loss of their native language in many families and with it the ability to communicate with elders or pass it on to the next generation.

However, some of our more recent immigrants, such as Laotian, Cambodian, and Hmong immigrants, have been refugees of war and have experienced a great deal of violence and traumatic loss. The more traumatic the family’s experience in immigrating to the United States, the fewer the economic and social resources they are likely to have at their disposal. The circumstances that stimulated their flight to the United States have taught many not to trust governments. They are likely to be cautious of or totally avoid seeking help from community systems that in any way are perceived to be related to government entities.

The history of Hmong immigrant families is illustrative. Hmong people fought a secret war on behalf of the United States during the Vietnam War. When the American troops pulled out, the Hmong people were left to fight on their own. Because they were no longer safe in their own land, they were allowed to come to the United States. But they faced a great many restrictions and governmental red tape when they arrived here. On the heels of great violent trauma in their war-torn homeland, they faced additional discrimination and oppression. Instead of being honored as a people who helped the United States fight a war, Hmong immigrants were stereotyped as “the enemy.”

The consequences of war, human rights oppression and economic distress in some Asian countries have resulted in many Asian orphans being adopted into mainstream American families. In some countries, male gender preference is an additional factor driving families to the desperate act of relinquishing their girl children for adoption. These immigrant children are especially in need of a connection with their homeland and cultural roots to understand their biological, genetic, and cultural ways of looking and being. On the inside they may feel quite different from their adoptive family and its cultural circles.

A BLACK PERSPECTIVE

The Black experience for many in the United States is rooted in the forced immigration known as slavery. Slavery has inflicted historical trauma on generations of Black people in America. During slavery, original names and languages were stolen and replaced and new religion was imposed. Enslaved Africans were reprogrammed to accept European culture. The values, morals, and spirit of our enslaved ancestors were severely damaged. The residue of slavery today still influences the way Black people trust and interact with systems and society and the way mainstream culture treats them. For example, it has played a role in the way Black parents approach disciplining their children. For generations, slaves of all ages were often beaten, sometimes in forced public spectacles, to make them work harder or conform to the behavioral expectations of their masters. The result is that some Black parents today question whether or not to use corporal punishment (spanking or whipping) on their children.

More recently, Black people have voluntarily immigrated to the United States for other reasons. Some left African or Caribbean countries to flee civil wars and natural disasters and seek safety for their families. Some left because of extreme poverty and the food and water shortages that accompany it. Some left because they had the means and opportunity to do so. The African or Caribbean people who choose to come to the United States have a determination and will to survive and succeed. They do not identify with the experience of slavery in the United States, but they may experience, and perhaps not understand, some of the prejudice and discrimination against Black people that still exist in the United States.

A FIRST NATIONS PERSPECTIVE

First Nations People, in spite of being the original inhabitants of this country, are not immune from immigration issues. Several tribes live on the border between the United States and Mexico or Canada. Indigenous people from Central and South America have immigrated to the United States. First Nations People face challenges related to citizenship and language very much like those of families who come here from other continents.

The Indigenous immigrant may not be readily accepted by a First Nations, mainstream, or any other cultural or ethnic community. Assumptions about race or language can lead to a misunderstanding of expectations and behaviors, making adjustment to a new place stressful. For example, Indigenous people are often assumed to speak Spanish when in fact they speak their own language, which is neither English nor Spanish. The consequence can be an imbalance within individuals and families.

A LATINO PERSPECTIVE

From a Latino perspective, it is important to understand and have compassion for individuals and families who flee their home country for safety or economic reasons. The immigration experience does not always live up to the hopes and aspirations of the family members who are fleeing their homeland. Some immigrants find more doors closed to them than open, and they ask themselves, “Why did I immigrate to the United States?” Nevertheless, most Latino immigrant families and their descendants are happy they are in the United States. They recognize the immense cultural wealth in their new community while maintaining aspects of their original culture that give identity to their family.

Latino immigrants face economic hardship when first arriving in the United States. Those who leave families back in their country have difficulty paying their expenses here and also having money to send to their families back home. Latinos help one another by sharing living space and expenses. At times, two or more families live together, resulting in little to no privacy.

The dynamic between parents and children in Latino immigrant families changes because children learn to speak English more quickly. When the family or the system uses children to interpret for their parents or caregiver, the children learn things, such as the economic state of the family and other worrisome family issues that they would not normally have to deal with. Sometimes children get information about a situation they do not understand or cannot resolve. When parents become more dependent on their children to interpret for them and to communicate and connect them to services, children inadvertently take on a more prominent role in family decision making.

A related issue is the loss of language with each succeeding generation. Some communities and educational systems do not value understanding and speaking more than one language. Consequently, parents need to make difficult decisions about teaching and using a second language while still emphasizing the need to speak English, which is always valued by Latino immigrants.

Historical Trauma

DEFINITION



Historical trauma is the cumulative emotional and psychological wounding, over the lifespan and **across generations** [emphasis added], stemming from massive group trauma experiences.¹³ When this past trauma is unacknowledged or is not resolved, it gets passed on to the next generation and creates psychological loss. The response to historical trauma can show up in a variety of ways—depression, self-destructive behavior, suicidal thoughts and gestures, anxiety, low self-esteem, anger, and difficulty recognizing and expressing emotions. It may include

substance abuse as a way to avoid painful feelings through self-medication. Historical trauma response has been experienced by many First Nations People, Jewish Holocaust survivors and descendants, Japanese American internment camp survivors and descendants, the survivors of slavery and their descendants, and other exploited and persecuted populations over time.

Trauma can also be generated and perpetuated in more subtle forms. Consider what is included and, more important, what is left out of school textbooks.

Nieto and Bode (2008)¹⁴ express that “Ethnocentrism is found in our history books, [and] mono-cultural education is the order of the day in most of our schools. Because viewpoints of so many are left out, mono-cultural education...deprives all students of the diversity that is part of our world (pp. 48-49). When delivered from a viewpoint that does not integrate all students’ cultural worldviews, education has been a tool for destroying indigenous cultures.¹⁵

AN ASIAN PERSPECTIVE

Historical trauma for Asian families is closely linked to their immigration experiences, including both why they came to the United States and how they fared once here. The internment of Japanese Americans during World War II and the treatment of the Hmong people after the Vietnam War are two examples. More recently, war orphans from Asian countries are being adopted by mainstream American families. Here we briefly describe how these kinds of historical traumas have an impact on Asian children and their families in the United States today.

One consequence of the Japanese internment, as well as the racial profiling typified by the treatment experienced by Hmong immigrants, has been the stereotyping of Asians as enemies who are potentially very dangerous and violent. This stereotype is extremely painful for Asian people, who value harmony, peace, and goodwill. For example, in school, Asian youth do not want to attract any negative attention. They feel the pressure to be academic high achievers and to be good classroom citizens. We may quietly sit and do our work, but we may not understand what is expected of us. We are afraid to speak out because we may not speak English perfectly. Our silence and good behavior sometimes lead to our being overlooked as having any need for additional assistance.

¹³ See <http://www.historicaltrauma.com>.

¹⁴ Nieto, S. & Bode, P. (2008). *Affirming diversity: The sociopolitical context of multicultural education* (5th ed.). Boston: Pearson Education, Inc.

¹⁵ Stavenhagen, R. (2008). Building intercultural citizenship through education: A human rights approach. *European Journal of Education*, 43(2), 161–179.

Asian children recently adopted by American families most likely came to the United States having experienced the trauma of violence, war, and loss of family. These traumas may lead to early attachment issues. Adoptive families need help and support to develop healthy, caring, and trusting relationships with their Asian children. Schools and behavioral health systems of care have great potential to play a vital role in these children's healing. To accomplish this, teachers, behavioral health workers, and administrators need to learn about Asian cultures and understand Asian values. They need to build on the strengths in their students' cultures and refrain from imposing mainstream American values on them.

Children are resilient and can, when given the necessary support at home, in school, and in the community, learn to adapt to life here and take advantage of the many opportunities it offers them without disconnecting from their cultural roots.

A BLACK PERSPECTIVE

Historical trauma for Black communities and families is rooted in the forced immigration of ancestors through slavery. To destroy African beliefs and culture, European religion and values systems were imposed on slaves. However, during slavery, many continued with ritualistic African practices while still adopting a semi-European value system. Examples of these practices are calling out and praying to ancestors, dancing, storytelling, and retaining some language used in that period. This spirit has continued beyond enslavement and has contributed to a unique world view in the Black American community.

Historical trauma for Blacks did not end with the abolition of slavery. Segregation, racial discrimination, social and medical abuse, and violence targeting Black people continued to affect every aspect of our lives and limit the opportunities of our children for generations well into the 20th century. The Tuskegee Experiment, named for the Tuskegee Institute, an institution that Black people trusted and where the experiment was actually conducted,¹⁶ offers a dramatic example.

In 1923, the United States Public Health Service began a long-term study of syphilis, claiming that it would reveal differences in how the disease affected White and Black men. Investigators enrolled 600 impoverished African American sharecroppers from Macon County, Alabama, who thought that they were receiving free health care from the U.S. government. About 400 had syphilis at the start of the study. Another 200 did not but were deliberately infected with syphilis by the researchers. None was ever told he had syphilis, and none was ever treated for it. The secret of this unethical study, including efforts to prevent subjects from seeking medical treatment elsewhere, was finally revealed in the early 1970s and the study was terminated. This historic event created mistrust of the American medical system and specifically of medical and clinical trials.

The civil rights era yielded great change and movement for Black people in the United States. As the Great Depression ended and Black communities began to form, civil rights activity began to ignite to remedy inequalities in the justice and education systems. Black Americans wanted equal opportunity to learn and socialize. The great marches and protests of the 1950s and 1960s were the springboard for the fight for equality for Black people and their families. In 1961, John F. Kennedy coined the term *affirmative action* in an effort to level the playing field to address

¹⁶ For a reader-friendly, detailed, and accurate account of this experiment, go to <http://www.infoplease.com/ipa/A0762136.html>.

discrimination in the workforce and access to government services. The term was further developed and enforced by Lyndon Johnson through national civil rights legislation. Although opportunities and particularly public assistance for such things as food and child care became readily available, these new benefits tended to create some dependency on governmental help, which, some believe, has led the Black community to expect these entitlements instead of taking the initiative to become self-dependent.

Blacks are sometimes caught by the tension between what we feel and what we are experiencing. On the one hand, we have an innate spirit, an internal vibration, telling us to believe in our ability to come together in circles and pray for healing of the mind, body, and soul. This spirit gives us the power to forgive, survive, and believe that some force beyond this world is present. On the other hand, we continue to seek and struggle to find our place in a system that was not originally designed to include us. It is not a coincidence that legislation and government programs were needed to “level” the playing field so that we could have the same opportunities for education, health care, housing, and employment as all other citizens. Blacks contributed to building this country, and generations believe in and trust its constitution. We believe, as Langston Hughes wrote, “I, too, am American.”

A FIRST NATIONS PERSPECTIVE

Maria Yellow Horse Braveheart conceptualized historical trauma in the 1980s as a way to understand why life for many Native Americans is not fulfilling “the American Dream.” She explains that First Nations People have experienced physical, emotional, social, and spiritual trauma for over 500 years.¹⁷ These traumatic experiences include genocide, ethnocide, forced removal from tribal lands, and loss of livelihood. They also include children being taken from the care of their families and tribes to be placed in boarding schools where they experienced emotional, physical, and sexual abuse.

The impact of this historical trauma and unresolved grief continues to affect our First Nations communities and families today. We identify with the traumatic events that happened to our ancestors and internalize the response as though it happened to us, carrying on the suffering in our own lives and passing it on to our children. This historical grief can manifest as depression, anxiety, self-destructive behavior, substance abuse, anxiety, guilt, and difficulty maintaining relationships. Historical trauma and unresolved grief can contribute to our reluctance to seek help or to trust in providers from mainstream American society.

The boarding school experience offers a powerful example of historical trauma and its devastating effects. Generations of First Nations children who were torn from their families and forced to live in boarding school suffered emotional, physical, and sexual abuse. “Spiritually and emotionally, the children were bereft of culturally integrated behaviors that led to positive self-esteem, a sense of belonging to family and community, and a solid American Indian identity. When these children became adults, they were ill-prepared for raising their own children in a traditional American Indian context.”¹⁸

¹⁷ See <http://www.historicaltrauma.com>.

¹⁸ Braveheart, M. Y. H., & DeBruyn, L. M. (1998). The American Indian holocaust: Healing historical unresolved grief. *Journal of the National Center of American Indian and Alaska Native Mental Health Research*, 8(2), 60–82.

The world view of First Nations People dictates a holistic approach to healing. Many professional healers are offered little to no training on our history and culture. Rarely are professionals trained by the First Nations People they are hired to serve and help heal. Wisdom should guide practitioners to check out the myths and assumptions they hold about the people with whom they work or the community in which they practice.

A LATINO PERSPECTIVE

When compared with other racial and ethnic groups, Latinos have had similar experiences of historical trauma. However, what is unique for us is that trauma continues to be experienced today. Latinos, like First Nations People, inhabited the “new world” before it was discovered by Columbus and colonized. Many Latinos, like Blacks, were forced to immigrate to here as indentured servants or slaves. Beginning in the 1940s, Latinos emigrated from the Caribbean Islands to work in the textile industry and on tobacco farms and from Mexico to work in the fruit and vegetable fields during World War II under the Bracero program. And, like Asians, many Latinos fled the trauma of civil wars and violence in their home countries. Latino families from South and Central America, Mexico, and the Caribbean experienced the trauma of public executions, kidnappings, and assassinations perpetrated by rebels or sanctioned by governments in power, law enforcement, or the military. One of the scars of such experiences is fear and reluctance to trust those in authority.

Mexicans make up more than 60 percent of all Latinos in the United States. They have long sought to immigrate to the United States for economic reasons. The poverty in Mexico is tremendous and work opportunities are scarce. More recently, the war on drugs has seen the deaths of many Mexican people, affording a more immediate motivation to cross the border into the United States. The need for an agricultural and construction workforce as well as food and hospitality service workers has provided work for Latinos. But it has also exposed them to new modern traumas in the form of abuse and exploitation at the hands of their employers and the owners of the farms, businesses, hotels, and construction and food services companies where they work.

Economics has made Latino immigrants vulnerable to abuse in other ways as well. Many support families in their home country, sending back well over \$12 billion a year. They have to pay exorbitant interest rates to send this money and high prices for calling cards to keep in touch with loved ones.^{19,20}

Trauma can also be associated with the level of respect afforded to a culture or a group. Respect is very important to Latinos, and its absence can lead to self-deprecating behaviors and attitudes that are passed down, thus creating cultural trauma.

¹⁹ Southern Poverty Law Center. (2009). *Under siege: Life for low-income Latinos in the South*. Montgomery, AL: Author. Available at www.splcenter.org/get-informed/publications/under-siege-life-for-low-income-latinos-in-the-south

²⁰ Bauer, M., & Ramírez, M. (2010). *Injustice on our plates: Immigrant women in the U.S. food industry*. Montgomery, AL: Southern Poverty Law Center. Available at www.splcenter.org/get-informed/publications/injustice-on-our-plates

How Does Culture Influence the Way Families View Behavior, Share Information, and Make Decisions?

DIFFERENT WORLD VIEWS



Each of us grows up within cultures that shape how we understand and make sense of the world. Our cultural identities encompass our world views, values, customs, traditions, symbols, beliefs, and ways of behaving. These identities put all that we have learned from our ancestors and our environment into practice. We know that culture influences how families make sense of and interpret the world. Culture guides us in knowing what is acceptable and admired behavior and helps us define what is “normal.” Our family culture generally directs how we interact with others (both inside and outside our family and

our culture), share information, and make decisions. Members of the four cultural groups that are the subject of our paper have to function in two different cultures—their own and the surrounding mainstream American culture. One way of understanding the challenge this presents is through understanding the basic elements of both the relational and linear world views and how they differ.

The following brief overview will introduce our readers to the major elements of the relational and linear world views. Table 1 summarizes these elements. For a deeper understanding of the concept of world view and the characteristics of these and other world views, we direct our readers to <http://www.nicwa.org/services/techassist/worldview/worldview.htm>.

Generally speaking, First Nations, Latino, and Asian world views tend to be relational. The same is true for many cultures originating in Africa, although many Black people in the United States incorporate some elements of the linear world. Mainstream American culture, with its European roots, is considered to be predominately linear.

We must emphasize that world views are not absolute. One world view is not better or worse than another. Further, for many people, their world view may include both relational and linear elements. We believe that it is helpful to think of cultures as operating from a “more” or “less” relational or linear world view rather than exclusively from one or the other.

Table 1: Comparison of Relational and Linear World Views²¹

Relational World View	Linear World View
Values group and collective survival, with a focus on working interdependently toward the good of all in the community	Values individual survival, with a focus on achieving independence as a hallmark of success
Values a holistic, ongoing process of growing and learning, where grey areas are well tolerated and accepted	Tends toward arriving at the right and definitive answers to questions, and sees grey areas as uncomfortable and perhaps signifying indecisiveness or even weakness
Tends to value being as one with nature	Tends to value having power, ownership, and control over nature
Tends to value being in the here and now	Tends to value doing, with a focus on planning for the future
The underlying question is “How?” as in how can things be better or how can I help	The underlying questions is “Why?” as in why did you do that or why did something happen

The linear world view has dominated professional training in the United States for teachers, counselors, therapists, physicians, nurses, social workers, and just about every other helping profession. The differences in world view present challenges for First Nations, Black, Latino, and Asian families when interacting with agencies and providers of services their children need. For those of us with a linear world view, being independent is one of the hallmarks of a successful, healthy adult. For those of us with a relational world view, seeking balance among dependence, interdependence, and independence is often viewed as healthy and appropriate. An example from the life experience of one of our authors illustrates this point.

A White therapist “diagnosed” our author as “overly dependent” and “dysfunctional.” This same therapist told our author that she should focus on “autonomy,” claiming that she would be much healthier and happier once she learned to care less about how her family members felt about what she did. This advice did not “fit” or “feel right” for her. She did not return to this therapist. Years later, when studying multicultural counseling in graduate school, our author finally understood that the counselor’s direction came from a linear mainstream American and Western world view that valued independence much more than the collective view of the relational culture in which our author had grown up and lived. The cultural values that the therapist attempted to impose on our author did not fit with her world view.

INTERSECTING CULTURES AND CODE SHIFTING

First Nations, Asian, Latino, and Black people, no matter how strongly connected they are to their own culture, by necessity are likely to come into contact with mainstream American culture. They need to function within its cultural and societal framework—sometimes even daily. Finding the delicate balance to manage this intersection is an ongoing challenge. Our children, especially once they start school, become adept at knowing which behaviors are culturally appropriate at school and which behaviors are culturally appropriate at home. But this code shifting can become precarious and stressful. Consider what it must be like for a teenager who wants to fit in at school

²¹ This table is based on the work of Ivey, A., Ivey, M., & Simek-Morgan, L. (1997). *Counseling and psychotherapy: A multicultural perspective* (4th ed.). Needham Heights, MA: Allyn & Bacon and Sue, D. W., Ivey, A. E., & Pedersen, P. B. (Eds.) (1996). *A theory of multicultural counseling and therapy*. Pacific Grove, CA: Brooks-Cole.

but knows that some of the behaviors that are normal in mainstream culture are disapproved of in her or his family's world view. How does this student reconcile these two world views and decide whether to risk popularity with peers or censure in the family?

AN ASIAN PERSPECTIVE

The Asian population in the United States includes many groups who differ in language, culture, country of origin, and length of residence here. Although each Asian culture is unique, we may have some values in common, as described here.

Many Asians value a collective, family, group, and community-oriented, or relational, world view. We tend to put others' needs ahead of our own. If we are sick or hurting emotionally, we may feel guilt about how this condition affects others. We work hard to be well or healthy, hoping not to affect others. For example, during flu season, Asian people often wear a mask in public to avoid passing our germs to others.

Asian people tend to value following the rules of family, community, and society, not wanting to bring negative attention to ourselves. Indeed, Asian children, and even adults, may be expected to respectfully obey and honor parents and elders in the extended family and community. When we lived in our homelands, the norms of community and society fit with our family norms. In the United States, however, these collective family values may differ from the individualistic values of mainstream American society. Some young Asian people can find it a challenge to navigate both world views. Others are acculturated into both ways of being. Our value of striving to achieve balance may help us as we work toward this integration.

Asian people tend to avoid family shame and value emotional restraint, holding our pain inside and putting a happy face on the outside. Asian children are often expected to achieve. We expect to accomplish things on our own. Believing that if we just apply ourselves to a challenge we can succeed can lead us to suffer in silence rather than ask for help. Pressures like these can lead to depression and anxiety. However, we also try to address our psychological pain on our own, sometimes delaying seeking help.

We have a holistic view of body and mind. When we do seek help, we are more likely to visit a medical doctor or to try alternative and holistic methods rather than a mental health professional. We may be more open to getting help for school and career than mental health care.

Our natural deference to authority may initially make us uncomfortable with family-driven care where we are expected to share responsibility for making decisions. We typically view health care providers as the absolute authorities. Our way of being agreeable and our value of harmony may prevent us from speaking up and expressing what we feel or want. The resulting behavior could be smiling and going along with the suggested plan even if it is not what we feel we need.

Asian children understand that their family is of highest importance, above all else, in their lives. Asian families have a strong intergenerational and extended family connection, and we are very close to our grandparents, uncles, aunts, and cousins. The expectation to achieve and not bring shame to our families pertains to the extended family, to the community, and even to other Asians whom we do not know. We are representing all Asian people when we go out into the world.

A BLACK PERSPECTIVE

Although Black people may share the same skin color, their specific cultures are varied. Practitioners need to read literature about the cultures they want to serve and to identify individuals who understand or are members of the culture to function as liaisons or cultural guides. The key to understanding how culture influences what Black families expect, how they share information, and how they make decisions is to routinely and respectfully ask them.

In many Black families, behavior is extremely important. Elders and older individuals should receive the highest respect. This code of conduct applies to people of all ages. Adults should be able to control their actions, too. This is particularly important when families and their children are out in the community, such as at a store, at a social event, and most important at school. We often teach children to control their actions, emotions, and language. We expect our children to have good table manners, interact well with others, and play well with other children. Children should have fun, but when they are participating with adults or other grownups in a serious or important event, they are expected to be resolute, to listen, and to display patience. These events can be traumatic, such as sickness or death, or social, such as a wedding or a birthday party. Sharing these experiences and seeing their family celebrate with determination builds character in children and instills faith.

Authority for making decisions in Black families depends, in large part, on the structure of the household. For example, married parents make decisions jointly. Generally, decisions are made from the top down, and information is kept from children until they are deemed old enough to understand the situation and the implications of decisions. Among single parents, the mother, the father, or the guardian makes decisions and may consult older children for their opinions and perspective. This happens more so when parents are working. At times when parents are absent, brothers, sisters, and cousins come together and offer to plan and lend a helping hand.

Black families typically share information orally through stories and music. Their history and legacy are passed down from the oldest to the youngest at family gatherings such as barbecues, birthdays, and other significant milestones. Many Black people may not know their ancestry beyond their immediate family members. Although many know that their families can be traced back to slavery, they may not know what part or whether their ancestry is African or Caribbean or from other origins. Finding ancestry has gained popularity recently. Family reunions are often organized to identify and talk about a family's common ancestry.

A LATINO PERSPECTIVE

Cultural sensibility is the core to understanding cultural differences in behavior. The Latino child and his parents or caregivers do not understand the standards of conduct of mainstream American culture. We feel intimidated, disrespected, and sometimes discriminated against. Similarly, mainstream American culture and other cultural communities in the United States do not understand the social interaction models of Latinos and find them inappropriate.

Latino family behavior is rooted in the values, customs, traditions, symbols, and beliefs of the country we came from. The behavioral expectations may be different from those of mainstream American culture. For example, it is commonly reported that Latinos do not look a person in the eye when he or she speaks to us. This is a sign of respect and deference, not a gesture of disrespect as is sometimes assumed.

The familial atmosphere of Latino families motivates our children to develop their own capacities and take advantage of opportunities to reach goals that are valued both inside our culture and in the community and country where we live.

Many Latino parents and caregivers of children with behavioral health care needs are not fluent with English or speak Spanish only. And sadly, some Latinos have never had the opportunity to learn to read or write in any language. This language barrier makes it difficult for Latino families to participate in school activities, meet with teachers, and help their children with homework. It also limits their ability to seek services for their children. Lack of participation because of communication problems and language barriers often gives educators, behavioral health care workers, and others the false impression that Latino families do not care about their children or are not taking responsibility for supporting their education.

The Latino cultural value of *simpatía* highly values help-seeking behavior. *Simpatía* stresses the importance of behaviors that promote social relations and harmony with others. This cultural value encourages Latino families to seek help, to break the barriers restricting our ability to get services for our children, and to replace negative stereotypes about us with behaviors that demonstrate our caring and our good intentions.

Generally, Latinos do not take action or make a decision without first consulting with our family members. The dialogue and discussion within our family prior to making a decision sometimes include a religious or spiritual advisor, a good friend, or someone else we believe has wisdom to help us make a decision that favors the well-being of our children.

A FIRST NATIONS PERSPECTIVE

The behavioral framework of First Nations People can be understood only in the context of the historical trauma they have endured. Before the arrival of Christopher Columbus in 1492, the land base that is now recognized as North America was occupied by estimates of up to 30 million people who lived in complex societies with roadways, government structures, language, religion, medicine, and art. Colonization, wars, and genocide drastically reduced the population. Today, fewer than 5 million First Nations People remain, according to the most recent United States Census.

Even more devastating have been the forced assimilation and loss of language and culture caused by United States policy and the efforts of missionaries. Missionaries converted First Nations People to Christianity by telling them that their own spiritual practices were evil. Broken treaties and federal laws, such as the Indian Education Act, the Indian Relocation Act, and the Indian Termination Act and Adoption Act, tore our families apart and destroyed our society and communities. These acts have deeply affected the soul of our people.

First Nations People suffer from the stereotype perpetuated in movies in which “Indians” live in a tipi, teepee, or wigwam on reservations in the Midwest; always have long dark hair and tan skin; wear beads or turquoise; ride horses, paddle canoes, hunt, and fish; and are stoic. The reality is that we exist in all shapes, sizes, hair colors, and eye colors. We live in both cities and rural places. Our degrees of acculturation are as diverse as our tribes. Another myth we need to dispel is that all tribal people openly practice or share their spirituality. Spirituality is often very private for us, in part to protect our religious ceremonies. Historically, First Nations People were punished for practicing our ceremonies. Laws were created that banned some of our religious practices. Freedom to practice our religion has been protected only since 1978.

The diversity of First Nations People in this country is endless, with variations in culture, language, and spirituality, but we all share a relational world view and values. First Nations People value the following:

- Our elders because they hold wisdom and help preserve our culture and pass it to new generations
- Decisions and behaviors that benefit our community or our tribe as a whole versus any one individual
- Interconnectedness because we believe that everything has life force and all life force is related
- Balance that produces a strong, positive sense of well-being that leads to harmony
- Redistribution of wealth and material possessions because we must help take care of one another
- Spirituality that connects us all to compassionate spirits
- Knowledge that everything is meant to be, including those experiences that hurt us

We also share a particular orientation toward time and space. We see time in terms of everything happening when it is to happen. For example, we never start a meal, a meeting, or a ceremony until the most important person, such as a grandmother or a faithkeeper, is present. We frame the events and the natural activities around us as cycles with no beginning or end. Life is a circle, as are our connections to others. We value the present moment while always honoring the past and being aware of what it contributes to life in this moment.

First Nations People believe that imbalance with the emotional, physical, social, mental, and spiritual domains of our life can lead to symptoms of illness, addictions, difficulty maintaining relationships, and an overall sense of disconnection. Imbalance may be caused by neglecting our duties as human beings, such as being thankful, kind, and loving, or by failing to follow a cultural protocol. It is also possible to become ill through spiritual intrusion resulting from another person using medicine with the intention to harm. We seek guidance from our elder, trusted spiritual healer, or family member when imbalance is present. Or, if we do not recognize this sense of soul loss, our family or clan may come to tell us about the imbalance and offer help in restoring us to a complete and happy life.

Discovering a Family's Culture

DEVELOPING A PARTNERSHIP



A partnership in business usually begins with the parties getting to know each other personally by talking about themselves and their talents, accomplishments, and goals in a comfortable setting. They listen carefully for things they share in common and are careful to avoid conflict or controversial topics. If they are favorably impressed with each other, they plan to meet again to speak further and begin to establish the terms of the relationship. They have taken the first steps toward discovering each other's business culture. Trust follows as they negotiate responsibilities, make commitments to each other, and

follow through on them. Friendships often develop with similar sharing but in a more informal way.

Unfortunately, very few relationships between the mental health system and the families of children and youth with behavioral health care needs begin with this kind of reciprocity and equality. Instead, intake, as the first encounter is usually called, is typically held in a very impersonal setting. The parents are asked a series of direct and personally intrusive questions about themselves, their child, and others in the family. They are not allowed to choose what to say—unless they choose to leave out some details or to remain silent—and they do not get to ask questions of the person interviewing them. Forms are filled out and signatures are obtained. The family leaves anxious about the next step and hoping they are on the right track.

DISCOVERING CULTURE AND EARNING TRUST

Learning about the culture of the community and the families you are working with—and revealing your own—is the first step in making the shift to a culturally and linguistically competent and family-driven system of care or program. Here we offer some ways to discover a family's culture. The examples from our four cultural perspectives are by no means exhaustive and are meant to be illustrative only. They are not the only ways to approach this delicate process in which the first rule is to do no harm.

- Find a cultural guide, someone who is a member of the culture you want to get to know and is willing to enlighten and mentor you, introduce you to people in the community who are trusted by others, show you their strengths, and be your liaison.
- Behave like a guest. Keep an open mind and be respectful as you watch and listen. Ask for permission to participate. Apologize for mistakes and misunderstandings. Thank your families for what they share with you.
- Politely ask people what makes them comfortable and uncomfortable; how they prefer to communicate; and whom they want to include in discussions and decision making. Show that you are trustworthy by accommodating these needs.
- Be aware of your world view—whether it be linear, relational, some combination of the two, or another construct entirely—and refrain from imposing it on others or using it to pass judgments about behaviors that are valued in another culture.

- Share some of yourself. Be willing to help others understand how your world view works. Find common ground between your world view and that of the community and families you are trying to get to know.
 - For example, a therapist grounded in mainstream American culture might conclude that the quiet demeanor of Asian women and children means that they are oppressed and would benefit from learning to speak out for themselves, express their emotions, and seek freedom and independence from the elders in their family and community. Suggesting this course of action to Asian teenagers who are struggling to find harmony and to fit into two cultures might only increase their stress as they try to maintain a connection to their roots and families.
- Invite storytelling in creative ways that fit with the culture you are getting to know and allow people to feel safe rather than threatened or exposed. Encourage people to share their reality, including the trauma they have experienced, their unresolved grief and pain, and ways their view clashes with your own.
 - For example, one of our authors puts large sheets of paper on the table with a variety of colorful drawing implements. She invites family members of all ages and abilities to tell their story by drawing on the paper. She notes that many First Nations People communicate easily through drawing pictures and using images to describe relationships.
- Be yourself, be genuine and sincere, and show interest. We do not have to be from the community or share the same culture, gender, skin color, or language. Be patient and move at the pace of the families and community. Orient and prepare the family for each step in the processes you must follow. Explain what you are doing AND what families and the community will get in return.
 - For example, Latinos greatly appreciate their personal relations and often seek to connect to people who understand their needs and motivations and really care about them. Family-driven care is like a bridge for Latino families because it connects them with the system where the services are culturally competent and reflect their culture.

Infrastructure to Support Culturally and Linguistically Competent Family-Driven Care



Professional partnerships and shared decision making with families do not happen in a vacuum. Agencies and systems have to actively and intentionally support family-driven care and promote cultural and linguistic competence in their policies, programs, and administrative functions. Strong agency or organizational ties to the community and relationships with community leaders are also essential. The combination of supportive infrastructure and connections to the community make it possible for program staff to look through the cultural lens of the communities they serve. Through this collaboration, services can be synchronized with the lives and needs of the families being served.

Infrastructure includes both physical assets, such as buildings and equipment, and nonphysical assets, such as the rules and regulations governing programs and systems and their financing. It also includes the ways the workforce is trained and supervised. Here we offer a few things that agencies and organizations can use to strengthen the key elements of their infrastructure and community relations. This list is neither comprehensive nor exhaustive because each organization or agency will need to consult and collaborate with local families and community leaders to know what will work best for them.

POLICIES AND PROCEDURES

Let everyone know what is expected of them and what they can expect from the agency or organization. We suggest that policies should be in place to provide basic protections to families. Here are a few examples of such policies:

- Meetings about a child's, youth's, or family's care can ONLY be held if they or their designated representatives are present. Families are allowed to invite whomever they want to meetings. Families are able to participate by phone or video conference if their physical presence is not feasible.
- A certified and qualified interpreter who is knowledgeable about technical behavioral health terminology in both languages is available whenever the staff to do not speak the family's language. The use of children, friends, other family members, or noncertified personnel to interpret is prohibited. All forms and written notices are printed in the languages of the families served, taking into account regional language differences.
- Privacy and confidentiality are guaranteed. All personnel are trained in how to be trustworthy and treat sensitive information disclosed by families with respect. Families understand that what they talk about and provide in writing will be protected and not shared anywhere with anyone without their explicit consent.

ENVIRONMENTS

Every agency or organization in a community, intentionally or not, presents an image of how it feels about the people it serves. Families will not feel welcome in places where they see nothing that relates to their own culture or lives. We suggest that your facilities have comfortable furniture and basic amenities for families when they come to your building. Include a safe play area with appropriate toys and bilingual books for children. Magazines and other reading materials for adults should be in their own languages as well as English.

The culture of the community should be reflected in the setting. For example, decorate the walls with the work of local artists and hang posters of the community and its people, their festivals, or favored foods. Make sure that brochures, business cards, and notices on bulletin boards are in English and the languages spoken by the families you serve.

WORKFORCE DEVELOPMENT

It is the staff of an organization or agency who develop relationships with families and the surrounding community. Make an effort to recruit and hire professionally qualified, bilingual and bicultural staff who are from the communities and speak the same languages as the families being served. Hire family members from the community to be liaisons by providing peer-to-peer support to new families. Family navigators can serve as a bridge to help families understand and navigate the system. More important, family navigators can help families understand an organization's culture so that they can effectively participate in decision making.

A key element of a culturally and linguistically competent workforce is ensuring that all individuals at every point in the continuum of care have the capacity to function effectively in cross-cultural situations and encounters, regardless of the culture of the provider or the consumer or the family member.²² A useful mnemonic for education and training efforts is to just A.S.K. (Awareness, Skills, & Knowledge). Cultural awareness, both of oneself and of others, is key to eliminating behaviors that promote or reinforce bias, stereotyping, prejudice, or discrimination. Cultural knowledge is the ability to understand and empathize with a culture different from one's own. Cultural awareness increases effective cross-cultural communication and opens the door for mutually respectful and sensitive relationships and partnerships. Cultural skills are the capacity to provide a service or support that meaningfully integrates the culture of the service recipients and involves, encourages, and empowers them to participate in culturally based decision-making. Cultural skills are essential to increase safety, satisfaction, quality of care, and, most important, health outcomes.

In culturally competent, family-driven systems of care, all staff members receive initial and ongoing training and supervision that do the following:

- Help staff understand the culture of the families they serve and how it influences their approach and response to the services being provided
- Help staff understand their own world view and how it influences their own behavior and what they expect of others

²² Cross, T., Bazron, B., Dennis, K., & Isaacs, M. (1989). *Towards a culturally competent system of care: Vol. 1. A monograph on effective services for minority children who are severely emotionally disturbed*. Washington, DC: Georgetown University, Child Development Center, National Technical Assistance Center for Children's Mental Health.

- Develop the listening and communication skills of staff, particularly as they relate to really hearing what families say and earning their trust
- Teach about evidence-based, practice-based, and community-defined evidence models that are matched to the population being served and that are known to be effective and appropriate for the population served

COMMUNITY RELATIONS

A culturally competent, family-driven organization or agency has good relationships with the community and is a good neighbor. We recommend seeking input from community leaders and representatives of the diverse populations in the community when making program and policy decisions.

What the community knows about the agency or program influences how readily families use its services. Reaching out and in to the community with useful information and offering educational activities on topics of interest or importance to families help build confidence in the agency or organization and can foster family leadership within the community. We suggest offering forums where families—and youth—are encouraged to speak from their cultural perspective and about issues of importance to them, such as the challenges of living in two cultures that value different (sometimes opposing) behaviors.

GOVERNANCE

Families should have some stake in the governance of the agencies and organizations serving them. When families sit on the board of directors, advisory groups, and working committees, the resulting policies and practices incorporate and reflect the history and world views of the community and the cultural and linguistic norms of the community. Compensating family members for their time and the expenses they incur (such as time off from work, travel, and child care) to be on governing boards is very important. Most members of other groups are paid to be there. Compensation puts family members on equal footing with everyone else and makes it possible for families with limited finances to participate. Operations should be transparent so that everyone knows what is happening and why. Evaluation and continuous quality improvement efforts should always include the end users—families, youth, and the community—and examine the cultural and linguistic competence of the agency or organization and the extent to which its programs are family driven.

TELLING OUR STORIES



Storytelling has always been a powerful way to transmit and sustain cultures. The spirit, history, homeland, values, traditions, language, and way of viewing the world are preserved in the stories passed from generation to generation. Each person's story is important. Each of us must tell our own story and listen to the stories of others. Sharing our stories enables us to journey together toward healing and wellness. When everyone—help seekers and helpers, teachers and students, parents and youth—comes together in equality and safety, we celebrate the wisdom we each bring to the table of gifts. In such an atmosphere, the possibilities for well-being multiply. We heal through

connections and relationships with others. The authors of this paper have been given the gift of a safe place to tell our own story. We offer our stories as gifts to our readers in celebration of how family-driven care can be practiced in the spirit of cultural responsiveness.

AN ASIAN COMMUNITY'S STORY

Mary, a youth coordinator, and Tom, a cultural and linguistic competency coordinator, worked in a system of care program where care teams and systems change were family driven. The program had been operating for four years. Mary and Tom, who are both White and from upper middle socioeconomic backgrounds, attended a workshop at a national Federation of Families for Children's Mental Health conference. The workshop, called "Just Because You Don't Serve Us Doesn't Mean We're Not Here: Reaching Hidden Populations in Systems of Care," prompted them to assess the number of non-White families their program was serving.

Mary and Tom discovered that there was a need to connect with the Asian families in their community. But they were not sure how to begin. Mary called the Asian Youth Center in the community and asked for an in-person meeting to learn more about the culture, needs, and concerns of Asian youth and families. She brought information about the system of care to share with the director of the center.

The Asian Youth Center director, Kioshi, a young Japanese man, was very enthusiastic about meeting with Mary and Tom. The three of them engaged in a lively and positive discussion about the available services in the system of care, and they brainstormed about how to connect with the Asian youth and families. Kioshi invited Mary and Tom to attend the youth leadership team meeting taking place that afternoon. Mary and Tom joined the youth for their leadership meeting, which quickly evolved into an impromptu focus group. Mary and Tom learned a great deal about Asian culture and the concerns of the Asian youth at this meeting. A partnership began to form in one short afternoon visit. Over the next four months, this relationship blossomed into an Asian community digital storytelling project.

Youth, parents, counselors, teachers, the faith community, and others used photography and video to share their perspectives of the concerns and needs of the Asian community's youth. The project provided a creative way to communicate—youth with their parents as well as parents and adults in the community with one another. Projects were shared with system of care leaders, community youth and families, and leaders within the Asian community. The resulting community conversation and dialogue led to developing a plan for first steps in creating a family-driven system of care in the Asian community.

Kioshi offered space at the Asian Youth Center for the system of care steering committee for the Asian community to hold meetings. The Asian Youth Center also provided space where initial workshops on topics of addressing academic anxiety, career planning, and youth-parent communication strategies were held. At these workshops, cards containing contact information for individualized assistance were handed out. Everything was done in collaborative leadership with the youth and families. Youth and families began to feel safe contacting the system of care program for help.

A BLACK FAMILY'S STORY

The system has never been totally user friendly for my family. We found it hard to navigate the system and find a means to pay for the care of our mother. Eventually, by working together, seeking out credible information, and getting guidance from a trustworthy family advocate, we found a pathway to acceptable care and service.

Our mother never really accepted the challenges that she experienced with her own behavioral health. Throughout our childhood, she had severe depression and delusions. At the beginning of our lives, she found it easier to leave my three sisters and me with relatives than to raise us herself.

Approximately twelve to fifteen years later, our mother had physical illness associated with age, and she needed to be cared for at home. My sisters and I took her home and worked together to provide living arrangements and the things that she needed to survive. Our mother needed to consistently see a doctor, take medicine, and participate in therapeutic activities. Her entire care plan was good and it cost a great deal of money.

My sisters and I took our mother to see trained care givers and submitted the paperwork to the agencies that could provide funding. We visited office after office. We were directed to “go here,” “do this,” and “submit that.” It was a maze of confusion. Information provided to us was not always clear. Literature was not written at a basic reading level. It was full of clinical terms that we could not understand. Services were disconnected. It would take months to get a response. Personnel in system offices were sometimes rude and impersonal. At times, our mother and family felt disrespected and discouraged. Nothing was presented in a family-centric manner. It did not take into consideration the norms of our Black family and our cultural values.

In time, we found a good care manager and were able receive financial assistance for the care that our mother needed. The care manager broke down the barriers within the system and made appropriate calls and appointments to places that she knew would provide support and excellent service. She explained some of the clinical language and gave us the chance to make informed decisions. She seemed to listen rather than push us through the system without care or concern.

I believe the system was effective for us because after our mother accepted her challenges and we broke through barriers. Within the system, we moved from denial and miseducation to acceptance and informed decision making. We found an advocate who understood our needs and embraced our cultural perspective and dove into our case with joy and love. Trust and rapport were built and the circle of care was complete. Most important, our mother is now living a life that she is comfortable with and that we, as her family and closest supporters, accept.

A FIRST NATIONS YOUTH'S STORY

Clarissa's life of twenty-five years is like that of many other First Nations People—speckled with poverty, chronic illnesses, death in the family, inconsistent living arrangements, racism, discrimination, and a life lived in both mainstream and tribal cultures. Clarissa is connected to the positive aspects of being from the Original People and knows how to pray, how to respect elders, and how to care for children. She knows firsthand the power of spirituality in making sense of the world as well as healing.

Clarissa did not know her father and he did not know her. Her young mother was using drugs and drinking during her pregnancy and married a man who was abusive to everyone in the household. He initiated sexual assaults on his stepdaughter, Clarissa, when she was seven years old. He threatened her by promising that gruesome things would happen to her and those she loved if she dared tell anyone. Clarissa held strong to her beliefs that if her biological father and mother were still together, she would not have been harmed, her family would not be so plagued with illness, and she would look forward to waking up every day. The raping and molesting continued until Clarissa was eleven and finally felt brave enough to tell her aunt.

Clarissa's grandmother took over legal custody of Clarissa when she was thirteen. Her grandmother's sister taught her how to sew their tribal regalia. They would sew and sit with auntie, telling Clarissa ways to keep strong and to look forward to living. All of Clarissa's extended family loved her and encouraged her. They took her to the Longhouse for social dances, for feasts, and, most important, for healing during their Midwinter's Ceremony. Clarissa could speak her tribal language, which made her and her family proud. Her family would listen to her, they would laugh with her, and they would talk about how to forgive. Nobody ever told her that she was silly for wanting to know her dad. They encouraged her to stay in school and get an education.

Revelation of the rape initiated Clarissa's entry into the behavioral health system. Services were designed to stop her desire to cut on herself, ability to dissociate, repeated attempts at suicide to end the painful memories, frequent mood swings, and abuse of drugs and alcohol and to help her stop wishing so much to meet her father and to know why her parents did not stay together. What puzzled Clarissa and her family is why the system did not seem to offer much relief. Why did it discount the family's beliefs that were so important in Clarissa's life?

When Clarissa was nineteen, in the safety of a therapist's office, she was finally able to talk with her mother. Clarissa learned that because her mother had had a similar childhood, she knew of nothing different and thought that it was normal for such things to happen to children.

This therapist was different. She stood out because she would let Clarissa say whom she wanted to be included in her care, asked her what she dreamed about, did not judge or blame members of her family, and encouraged her to include her tribe's traditional healing ways in her treatment plan. This therapist told Clarissa that she did not always understand or know all the answers, but she would support what helped. This therapist also laughed and joked about herself. She expressed her hope that because she was White, she did not remind Clarissa's grandmother of the boarding school matrons.

This therapist helped Clarissa do an Internet search for her father. Three years after making her first contact, Clarissa felt ready to meet him in person. She prepared by talking to her aunts, her grandmother, her mother, and her father's family. The medicine man helped her let go of her trauma and gain protection in a sweat lodge.

When they met, her father shared his story and said he was sorry. He explained that he wanted to protect them from the dangerous things in his life. She saw a tattoo of her mother on his forearm—Clarissa’s image and name will be added to his collection of body art. Her father expressed his rage over her stepfather’s actions, his appreciation for those who helped her stay well, and his hope to one day seek ceremonial healing on the reservation.

After Clarissa returned home, her therapist never judged the family for its choices, behaviors, or beliefs. She focused on how they are so grounded in their faith. She reminded Clarissa that the historical trauma the Original People have survived is a sign that she too will survive what has happened in her lifetime and go on to be an old storyteller with children gathered around, listening to her stories. Clarissa often said she liked going to see her therapist because she was “real.”

Clarissa stopped cutting, drinking, and attempting suicide when she was twenty-two.

A LATINO PARENT’S STORY

This story is part of the treasure of my life and a reality for many parents and caregivers today. Being a mother of a child with mental health needs is an experience that never stops. I was a single mother with three children, and the oldest had mental health needs. Because I did not speak English, language and culture were barriers to finding what I needed to help my son. As my son grew, I realized that something was happening with him. His learning was slow and he was delayed in walking and pronouncing his first words. I did not know what to do or with whom to talk about this. It got worse when he began school.

He could not stay still for even a second, anywhere. One day his second-grade teacher called to say, in English, that she needed to speak with me. I went to the school where the teacher and other people talked about my son’s academic level and his behavior. The English teacher served as interpreter. To be honest, I understood nothing. All I knew was that something was wrong, but I did not know what it was. That is why I signed all the documents to do the evaluation to determine whether my son needed to be in a special program.

My son’s evaluation was not good but his grades improved so he did not qualify for a special program. The problems, however, persisted both in school and at home. I went to the school and was told to look for help elsewhere. My pediatrician referred me to a psychologist for an assessment. I still understood nothing. Alone I cried inconsolably, because I thought that my son was not normal and I was afraid that they would put him in a mental health institution.

He was diagnosed with attention deficit and hyperactivity disorder (ADHD), a learning disability, and an emotional disorder. I was determined to learn more about mental health issues and how to get help for my son. Participating in a parent support group in my community was the key that unlocked the door. Peer support helped me find people who could orient me about mental health and the system.

I was in a battle with the school system. I received notes almost daily with complaints about my son’s behavior. He was suspended many times. One day my son was sitting on the floor trying to loosen his shoelaces, but he could not. He started to say, “I’m stupid, no good, I’m not important to anyone, I don’t know why I am living in this world; I want to die.” My heart was struck with anguish and great pain, because at home something so horrible was never said to anyone. I sat next to him, and as we talked I helped him loosen the laces and he began to tell me his story. He said that the teacher and others said things like this and made fun of him; other children were

allowed to do it, too. My son said, “Tomorrow I am not going to school and if you tell me I have to go I am going to kill myself.” I said to him, “Do not worry, son, tomorrow I’ll go to school with you.” He said, “No, Mom, I do not want you to see me. I have to pick up the book of stories and read it to the kindergarten class because I’m dumb, I am Latino, I do not know how to talk, and I do not behave like a fifth grader, but like a kindergartner.” I hugged him and told him that he was nothing like those things, but that he was very important to me and to God and that I loved him with all my soul. He got relief from all that he carried deep inside by crying and hugging me real hard. This was the drop that filled the cup.

The next day I went to the school and the whole truth was uncovered. I still was not sure how to navigate the system, but I took a chance and acted as if I knew and demanded that they take immediate action. Suddenly things changed and all the resources of the school were available to my son.

His mental health needs could not be fully addressed by the school. I kept asking questions at the support groups and that is how I learned—from other parents and caregivers! I met people from the system of care who were trying to include family members in all decision-making processes when their child received mental health services. Later the local university gave me the opportunity to receive more education and training to be part of the leadership of Latino parents in the community. I learned that I could work at the same level with a team of professionals and providers of services to children with mental, emotional, and behavioral needs *and to help other families*.

Finding people who can speak their language, understand their culture, and, above all, take into account their values, beliefs, and opinions is the best thing that could happen to a family. On my journey there were many tears and fears and much anger, helplessness, rejection, frustration, and loneliness before we found what we needed. However, today, my son is a young adult who is respected and accepted by society and living a fulfilling life. He has a job and is studying; he has an apartment, is independent, and is very responsible.

SUMMARY

At one time, many newcomers from other countries to the United States wanted to forget their origins and the pain associated with it. Although some did not, many newcomers had a strong desire to fit in by learning English and behaving like Americans. Service organizations everywhere sought to help Americanize them—especially the children—into the great “melting pot.” The consequence was the loss of many languages, family histories, and cultures. The United States today is rapidly becoming increasingly diverse, and many people whose roots were torn from them or forgotten are seeking to heal by reconnecting to the culture of their ancestors. Recent immigrants are holding on to their culture, language, customs, traditions, values, and behavioral expectations. The concept of a melting pot no longer seems to accurately describe us. We can no longer seek a common denominator. Instead of fitting in, we all—original peoples, descendants of European settlers, immigrants from past centuries and today—are struggling to find a way to fit together and create a new vibrantly colorful social and political fabric.

Systems of care, wonderful as they are, have their roots in the linear world view of mainstream American culture. Systems of care value being family driven. It is impossible to be family driven without respecting a family’s culture.

All of us are influenced by our families, our communities, our peers, and the cultures in which we were raised and with which we choose to identify as adults. We hope that what you take away from this paper is a deeper understanding that a family’s culture is the foundation of its strengths, guiding the way it functions routinely and responds to novel situations. We hope our stories and examples inspire you to honor, even more, the values, customs, rituals, language, beliefs, myths, history, and traditions of the families who partner with you and share responsibility for making decisions about their children. Being culturally competent in family-driven systems of care requires that we discover each family’s culture—one by one—and thus expand our own world view as the journey progresses.

