

Why Cross-Cultural Competence Must Inform Trauma Treatment of Children and Families

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Introduction

Ethnic minority clients/people of color experience the same kinds of trauma and horrors that others do. Traumatic stress is an additional major detriment to the health and well-being of people who have experienced chronic poverty, injustice or discrimination. Discrimination is indeed a significant source of stress. Many (Marsella, Friedman, Gerrity & Scurfield, 1996) have conceptualized these experiences as either direct or insidious trauma. The relevant research literature about the traumatic effects of discrimination has been evolving. Maria Root (2003) conceptualized how people of color experience insidious, chronic trauma through the experience of discrimination. This has a long term effect, documented by work such as Claude Steel's (1997) stereotyped threat. Stereotyped threat is a phenomenon that happens for people when they believe that there are certain negative stereotypes about their abilities—they tend to get threatened, anxious, and to underperform. Shame, anxiety and fear may lead to attempts to try harder, “choke under pressure” and perform significantly lower than they would under non-threatening conditions.

Research has begun to emerge to identify vulnerabilities of certain groups, as well as protective factors for these groups. Pole, Best, Metzler, Marmar (2005) for example, found that Hispanic American police have higher rates of posttraumatic stress disorder than non-Hispanic Caucasian and Black American police, and that greater perceived racism was one of the important variables in explaining the elevated PTSD symptoms. What might be the protective factors for Black American police?

I would like to refer to the APA “Guidelines on Multicultural Education, Training, Research, Practice and Organizational Change for Psychologists,” (APA, 2003) hereinafter referred to as the “Multicultural Guidelines,” to provide suggestions for developing competency in the trauma treatment of multicultural families and children. The Multicultural Guidelines were developed because a fact is that racial and ethnic diversity among clients/patients presents challenges for all of us **PPT**. We tend to relate most easily, in our lives, as well as in our practices, to those most similar to us, including in regard to the major variables of gender, ethnicity, and social class. I would like to focus on two of the Multicultural Guidelines that inform practice.

Self-Awareness and Cultural Knowledge

The first two Multicultural Guidelines inform all the other four guidelines, and are designed to apply to all psychologists from two primary perspectives. **PPT** The first guideline states, “Psychologists are encouraged to recognize that, as cultural beings, they may hold attitudes and beliefs that can detrimentally influence their perceptions of and interactions with individuals who are ethnically and racially different from themselves.” (APA, 2003, p. 382). Our worldviews, including the way we perceive our lives, our experiences, and those of others are shaped in large part by our cultural experiences. Every single one of us has a set of cultural experiences and backgrounds, both conscious and subconscious. Self-awareness is thus a key competency.

PPT The second Guideline states, “Psychologists are encouraged to recognize the importance of multicultural sensitivity/responsiveness to, knowledge of, and understanding about ethnically and racially different individuals” (APA, 2003, p. 385). Psychologists and counselors are encouraged to learn how cultures differ in basic premises that shape worldview of individuals from those cultures. The risk in not being aware of one’s worldview *as well as* that of a racial/ethnic minority client is that one may unconsciously and automatically judge the client negatively, and perhaps in a pathological manner. One common example has to do with the degree of value of independence of White, Western culture (which has in turn has influenced the evolution of theory and practice of psychotherapy), versus that of various other groups, such as Asian American or Latina/o. A cultural facet of mainstream American culture is a

preference for individuals who are independent, focused on achieving and success, who have determined, and are in control of their own personal goals, and who value rational decision-making (APA, 2003, Fiske, 1998). From this perspective, a basic developmental task for all individuals, based on our psychological theories, is the individuation process. We often assess whether a young adult, for example, is appropriately involved in the process of individuation, or separation from one's primary family, and a client can be labeled pathologically "dependent" if we judge that they are still relying on their family of origin to an abnormal degree.

By contrast, individuals with origins in different cultures, such as Latina/o cultures tend to have a preference for those who have a group/community identity, tend to be very family oriented, and are cooperatively oriented. Latina/o sons and daughters tend to live at home longer than White counterparts in young adult hood (Vasquez and de las Fuentes, 1999). They also make all kinds of decisions based on primacy of family identity and closeness. This includes, for example, choosing to live at home or not move far away to attend college, prioritizing amount of vacation time spent with family, etc. These choices, from some racial/ethnic minority worldviews, do not necessarily constitute pathological dependency.

Disclaimer: Details have been changed to protect the confidentiality of clients.
Ex: Last week, I had a Latina client whom I saw for the 2nd time. She entered therapy in distress about various issues, then had a crisis situation when a younger brother (married, four children) was arrested. In our second session, my client called in crisis, partly because of her brother's crisis, but especially because when she explained to the psychiatrist why she cancelled the appointment to fly to another state, and spend time, effort and energy to raise bond monies and find an attorney for her brother, this psychiatrist "yelled" at her, called her "codependent" and too easily manipulated by her "evil, good-for-nothing bum of a brother." My client wept and wept as she described her shock and offense at the depiction of her beloved brother. While he had certainly made a mistake, she was incredibly hurt, traumatized, and then enraged that this white woman could say such horrible things about someone she didn't know. She felt that she and her family had been stereotyped and disparaged unfairly. She refused to return to this psychiatrist, and was not ready to return and provide feedback. She felt too unsafe, and

unfortunately, was traumatized by someone who was supposed to be providing help. The psychiatrist no doubt was coming out of her models of the importance of separation from one's family of origin, and possibly from her own personal issues as well.

The reality is that generally, women of color tend to support loved ones who get into trouble, partly because of family values, but also because we know that the justice system is often biased in the treatment of people of color. I worked to support her, validate her feelings, but also acknowledge her confusion about split loyalties and provide hope that we would sort out how to help without violating her own complex needs.

Other examples of White culture that could lead to inappropriate negative pathological conceptualizations include strict adherence to time schedules, as well as to a priority of achievement and success. For various cultural groups, including Latinas/os, the value of "Personalismo," or personal relationships and connections are more important than other aspects of life, such as time orientation, success, and achievement; this is related to the value of being cooperatively oriented, as well. Latina/o children, for example, may have tendencies to be more focused and motivated when competing as a group than when competing as individuals. Several studies have indicated that Mexican-American children develop stronger group enhancement and altruism motives (in completing a number of games) than Anglo-American children, who develop stronger competitive motives (Kagan, 1977). Research has identified the mechanisms, socialization and children's ethnic identity by which children's ethnic behaviors are socialized; such studies continue to confirm that the ethnic identity of the Mexican-American children, taught by mother's teaching about the Mexican culture, is related to the more cooperative and less competitive preferences compared to samples of Anglo American children (Knight, Cota & Bernal, 1993).

The issue is not that there is lack of time orientation or value of achievement and success, but that at times, relationships and relationship oriented activities may take priority, perhaps to a greater extent for some racial/ethnic minorities than in the dominant White culture. At the same time, it is important to remember that there is great heterogeneity within racial/ethnic groups. Many Latina/o individuals, while very cooperation oriented and great team players, can also be as achievement/success oriented,

and competitive as any White colleagues! The key message here is that one should not automatically pathologize such a person. Instead, look for the cultural difference and variations. An important strategy, in addition to being aware of one's values/worldview, and that of diverse clients, is to listen to the client's narrative to determine the extent of cultural value versus degree and nature of problem. For example, a Latina graduate student who reports frustration with getting negative feedback about her chronic lateness, could be conceptualized as being passive aggressive and/or ambivalent in her behavior. An alternative perspective, applying a cultural lens, would lead to exploring her daily experiences and priorities, and supporting her in her perspective (if this is the case) that attending to her children and other family members is indeed very important, and a key value to her than being on time for class and appointments in certain circumstances. A therapist could also help her explore the consequences to her in the world of academia or in the work world, and consider whether those consequences are worth her choices, and/or whether she might wish to adjust to the expectations in "that world". Focusing on skills of adaptability and flexibility in moving in and out of her family values and expectations and those of the White work/academic world might be a helpful conceptualization for her. I would suggest that this is a subtle, but significantly important difference in conceptualization and intervention from a cultural context.

Perception of Bias and Insidious Trauma

I'd like to say more about the effects of insidious trauma on people of color. Steele's "stereotyped threat" research indicates that when ethnic minorities are asked to perform on a task that where ethnic minorities stereotypically underperform, they end up underperforming, due to the threat/fear/anxiety of underperforming. Ethnic minority clients may experience negative judgment, rejection, and criticalness on the part of White therapists, without the White therapist being aware of this.

For example, I was talking to a neighbor who is fairly "liberal" about social issues, about my reaction to a clothing company who allegedly produced a batch of t-shirts reading "Visit New Mexico—it's cleaner than old Mexico" (a few months ago). The issue was being discussed on the listserv of the National Latino Psychological Association. My neighbor asked, "does that t-shirt bother you?" I said, "absolutely—it's offensive." I saw her purse her lips in a response that I read as a version of eye rolling:

“she’s overreacting and overly sensitive.” I felt myself flush; I felt a combination of anger and shame and disappointment from the lack of support. This was a neighbor friend, not a therapist. I could have shrugged it off and just tucked away the knowledge about this area in which I could not trust her.

I felt the need to have her understand what happens to those of us who were raised to feel like second class citizens. To be called “dirty Mexican” on the playground while growing up, even if not directly, is traumatic and hurtful. I did explain some of the following to my friend; it helped that we were walking. Vasquez and de las Fuentes (2000) wrote a chapter in Mary Brabeck’s book on feminist ethics, entitled “Hate speech or freedom of expression? Balancing autonomy and feminist ethics in a pluralistic society”. In that discussion with my neighbor, I pulled on the basic premise in that chapter to explain myself. I see the t-shirt as a version of hate speech. I renounce hate speech of any kind, not because I support censorship, but because *I want an elimination of those attitudes, beliefs and behaviors that contribute to oppression, marginalization, and disempowerment of traditionally disenfranchised groups. Hateful comments and jokes can lead to physical violence, but more often has negative emotional impact, including what Maria Root calls “insidious trauma” that shapes worldview and identity. This in turn leads to anxiety, depression, paranoia, heightened sensitivity, irritability, anger or hostility. Even those of us who are resilient must expend energy to deal with the reactions that result from various forms and levels of hate speech, negative comments, negative judgments, and various forms of rejection. The essential experience of being treated unfairly by virtue of belonging to an identity group is traumatizing for most of us.* Ruth Fassinger (2003) speaks of a “thousand points of slights” that people from marginalized groups experience regularly, and the toll it takes. When these attitudes are pervasive in society, we suffer tremendously. In the words of Greenwald and Banaji (1995), “*social structure creates cognitive structure.*” *Policies to limit biases alter our social structure and this has a compounding effect on our cognitive structures, and ultimately our social attitudes and our beliefs about people. The way society constructs societal representations of groups affects the social order, and has tremendous impact on the identities of individuals in various groups, both ethnic minority and White majority.*

I earlier mentioned several studies that found that Hispanic Americans or Latinos/as have higher rates of posttraumatic stress disorder (PTSD) than non-Hispanic Caucasian and African Americans (Pole, Best, Metzler, Marmar, 2005). Future research is needed to understand the extent to which this is true for the population of Latinos/as at large, as these studies are conducted with Hispanic military veterans or police officers. Pole et al (2005) found that Hispanic officers with higher PTSD exhibited greater wishful thinking, more self-blame coping, less social support, and greater perceived racism. Faith-based, avoidant, and self-punitive coping combined with depleted social resources and workplace racial discrimination seemed to leave Hispanic police officers more deeply affected by exposure to trauma, according to this particular analysis. I believe that people of color in general, and perhaps Latinos/as in particular, respond to the perception of mistakes or failures or rejections or biased treatment with humiliation and shame. Transforming those reactions to anger is theoretically a more effective response; the authors of this study hypothesize the Black Americans are provided with more coping strategies to deal with discrimination by their families and communities, and are thus not as significantly effected by trauma as are Latinos/as.

Interventions

Attend to the Client's Experience of Oppression in the Psychotherapeutic Process

PPT In our provision of services, what are the interventions that can help? One of the major issues that presents an “overlay” to the general problems presented is that most racial/ethnic minority clients will have an historical and/or personal experience of oppression and biases. Historical experiences for various populations differ. This may be manifested in the expression of different belief systems and value sets among clients and across age cohorts. For example, therapists are strongly encouraged to be aware of the ways that enslavement has shaped the worldviews of African Americans (Cross, 1991). At the same time, the within-group differences among African Americans and others of African descent also suggest the importance of not assuming that all persons of African descent will share this perspective. Thus, knowledge about sociopolitical viewpoints and ethnic/racial identity literature would be important and extremely helpful when working with individuals of racial/ethnic minority descent. Culturally centered practitioners assist clients in determining whether a “problem” stems from institutional or

societal racism (or other prejudice) or individual bias in others so that the client does not inappropriately personalize problems (Helms & Cook, 1999). Consistent with the discussion in Guideline #2, psychologists are urged to help clients recognize the cognitive and affective motivational processes involved in determining whether they are targets of prejudice.

Unique Issues of Assessment

Assess the individual's experience of oppression, and their coping strategies, and whether those coping strategies to deal with discrimination are constructive or destructive, or perhaps somewhere on the continuum. For example, anger is a normal, healthy reaction to the experience of discrimination, but anger can be destructive (turned inward, or expressed in ways that "burn bridges," or interfere with goals in school or in the workplace, or in personal relationships). Anger, on the other hand, can serve as fuel for motivation to achieve goals. Another major strategy in dealing with discrimination involves knowing how to seek support and process experiences with friends, family, mentors or other professionals, as opposed to internalizing experiences with shame and humiliation. Do not blame the victim

A Case Example. A Latina client came in for the first session. Her presenting concern included that she was overwhelmed by a failure on a major review of a project that, if she had passed, would have advanced her to candidacy in her doctoral program. She was filled with humiliation, shame, and confusion. As I explored her perceptions, she was very aware that her failure had little to do with her competency. Two of her three examiners made very racist and derogatory remarks about the cultural aspects of her project throughout the exam. Other members of her department were outraged; she had been caught in a political struggle about emphasis of cultural issues in the department. She had already initiated an appeal, and other students and faculty were very supportive of her and her work. Yet, she still felt at fault, as if she should have somehow been able to avoid such a situation and experience. She expressed deep feelings of failure. I led with questions and statements that indicated that I believed and assumed that discriminatory practices in her department existed, and that she had suffered as a result. I was able to be present, as we talked through the pain, hurt, frustration and anger of yet

another situation of discrimination, which so affected her life. It became important to explore other traumatic experiences of discrimination, that had become the source of Post Traumatic Stress reactions.

The client definitely heard me as I expressed sorrow for her experience. In the next few sessions, we moved on to strategies of managing her acute Post Traumatic Stress Disordered symptoms (panic, anxiety at thought of retaking exam, or even entering the hall where her exam was held); as well as validated her need to not define herself by this experience. She was not a failure; she had experienced an unfortunate, painful event that she simply had to get through.

We began to explore the various choices she had for her future (to retake the test and stay in the program, retake the test and leave or transfer to another university, not take the test, etc.). With this client, and others who have experienced oppression, it was important for me to: 1) believe and help identify the oppressive aspects of her experience; 2) focus on the client's resourcefulness and survivability; and 3) convey how lucky and honored I felt to share her process of recovery from this trauma. We also explored how she could have presented material that was less provocative to biased individuals.

One of the important values in most of our models of psychotherapy is for the client to take responsibility for their actions and behaviors. I reconceptualize this value as the importance of helping the client become empowered to control as many aspects of their situation as possible, and to learn from mistakes. However, it would be potentially damaging, if with this client, for example, I led with that line of questioning or intervention too early in the intervention process. "What part of this problem is yours?" "What was your role in the circumstances that you experienced?" While these questions may be appropriate at some stage in the therapeutic process, the timing and how these issues are addressed can be shaming and humiliating with clients who have had difficult, shaming and biased experiences of oppression throughout their life.

Identify Areas of Strength and Resilience

PPTOne of the most important strategies in working with persons of color is to identify strengths and resilience of the client. Future research will hopefully shed light

on the strengths and survivorship of various ethnic groups, despite various challenges (Vasquez & de las Fuentes, 2000). Just as all trauma victims need to feel safe again, so do survivors of racial bias and discrimination. It is important to be familiar with group strengths as well as the individual's strengths.

A 1992 report, for example, indicated that despite enduring poverty-level income, Latinos exhibit values and behaviors which included a strong belief in marriage and family, a vigorous work ethic and a desire for education (Hayes-Bautista, 1992). California's fast-growing Hispanic population also had a historically low rate of welfare dependency, a high rate of participation in the labor force, good life expectancy rates, and a high percentage of healthy babies. In Texas, according to the Texas Department of Health's Bureau of Vital Statistics (Austin American Statesman, December 11, 1996, p. B4) Hispanic baby girls born in 1995 will have the highest life expectancy of any racial or gender group; they are expected to live an average 80.3 years. The hypotheses for this finding include that because extended families provide emotional support, Hispanic women are less likely to live alone; they are less likely to be smokers or drinkers, may have a better diet, and their infant mortality rate is lower than other groups.

A study conducted to determine women's level of comfort with the appearance, by The Downing Street Group and the University of Michigan (2004), reported in *Marketing to Women*, found that most women are relatively satisfied with their appearance. More than half (51%) of Caucasian women, 59% of African American women, and 60% of Hispanic women like the way they look! The expectation that women of color would use a White woman standard of beauty, and report higher dissatisfaction than White women is certainly erroneous in this study! We should thus be open to considering and exploring aspects of positive strengths in our clients of color.

Attend to the Setting you Provide

PPT Psychologists are also encouraged to be aware of the environment of their setting (neighborhood, building, and specific office) and how this may appear to clients from diverse backgrounds. For example, bilingual phone service, receptionists, magazines in the waiting room, and other signage can demonstrate cultural and linguistic sensitivity (Arredondo, 1996).

Summary

Self-awareness and cultural knowledge, including about the experience of the trauma of discrimination are important cultural competencies. The “Guidelines for Providers of Psychological Services to Ethnic, Linguistic, and Culturally Diverse Populations” (APA, 1993) includes a definition of cultural mutuality. **PPT** The definition describes, in part, the importance of relating to women, clients of color, and other oppressed groups in a respectful, connecting manner based on our knowledge of the clients’ culture and also tuning into aspects of the clients’ needs that our therapeutic processes may help. Cultural mutuality is an important value for therapists who wish to be competent in working with persons of color and others who have historically been disenfranchised.

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Resources -- Diversity and Cultural Competence—

Compiled by Juneau Mahan Gary, Psy.D. (Retrieved from

<http://www.kean.edu/~jgary/bytopic/diversity.htm> on August 6, 2006).

National Women's Health Information Center, Minority Women's Health offers resources and hotlines on domestic violence, dating violence, and sexual assault to minority women (www.4woman.gov/minority/violence.htm).

National Center for Cultural Competence, Georgetown University Center for Child and Human Development, University Center for Excellence in Developmental Disabilities focuses on topics of interest to mental health and public health specialists to promote cultural awareness and sensitivity, including

curriculum enhancement modules. Spanish language resources are offered (<http://gucchd.georgetown.edu/nccc>).

National Center for Missing and Exploited Children, Minority Outreach Program, increases awareness about problems associated with missing and exploited African American and Latino children

(http://www.missingkids.com/missingkids/servlet/ServiceServlet?LanguageCountry=en_US&PageId=1561).

Advocates for Youth provides a Youth of Color site to address the disproportionate rates of health and sexual health issues among these youth and plan culturally appropriate interventions to meet their needs

(<http://www.advocatesforyouth.org/yoc.htm>).

Committee for Children, International Programs offers culturally appropriate programs for children and educators worldwide about bullying prevention, appropriate touch, and violence prevention. Multilingual resources are available (www.cfchildren.org/about/cfcintl).

Office of Refugee Resettlement (ORR), Refugee Health Promotion and Disease Prevention (RHPDP) Initiative sponsors a free health and mental health promotion and disease prevention initiative, Points of Wellness, to assist organizations concerned with the well-being of refugees, including children. It provides technical assistance on how to develop, fund, manage and implement mostly health-related prevention programs for refugees. A Health Promotion and Disease Prevention Toolkit will be available soon. It will offer guidelines for developing and implementing mental health/community health programs using an ethnic-based model (<http://www.refugeewellbeing.samhsa.gov/about.asp>).

National Sexual Violence Resource Center (NSVRC) is a comprehensive collection and distribution center for information, statistics, and resources related to sexual violence for educators, health care providers, policy-makers, media, and rape crisis centers. Resources include information on types of sexual violence, prevention strategies, and a database of print and electronic materials. Diversity resources address topics relevant to Native Americans (<http://www.nsvrc.org/resources/orgs/native.html>), diverse ethnic groups (<http://www.nsvrc.org/resources/orgs/cultural.html>), gay/lesbian/bisexual/transgendered survivors, (<http://www.nsvrc.org/resources/orgs/lgbt.html>), and male survivors (<http://www.nsvrc.org/resources/orgs/male.html>).

Maternal and Child Health Training Network offers the Cross Cultural Health Care Case Studies program. This interactive self-study program consists of a series of tutorials in cultural competence, aimed at familiarizing professionals (mostly health care workers but other professions may benefit) with common issues that arise while working with people of diverse cultures. Each tutorial consists of a home page to introduce the topics and define concepts, a case study to illustrate the topic, a multimedia lecture about the topic, and a series of learning activities to engage the learner in applying the concepts in case story. Case stories illustrate emotional and cultural factors that affect non-adherence; interpreter services and limited English language proficiency issues; folk health; and cultural and religious factors that affect decision-making (http://ppc.mchtraining.net/custom_pages/national_ccce/).