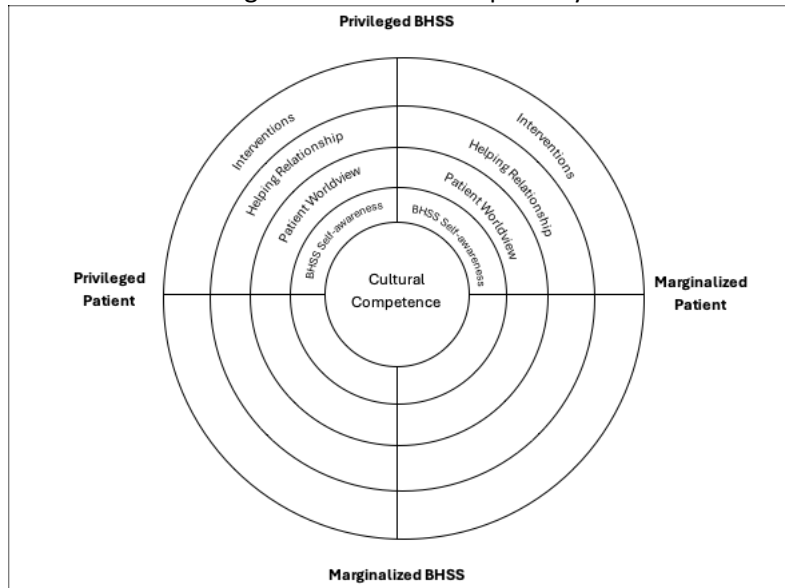


Cultural Competency Helping Framework

Figure 1: Cultural Competency



Cultural Competency

At the heart of the CCHF is the recognition that every attitude, belief, and action taken by a BHSS must be firmly rooted in cultural competence. This framework rests on the belief that cultural competence is not optional but essential to ethical practice. Moreover, cultural competence requires the BHSS to embody core values that guide one's attitude, beliefs, and interaction. Chief among these values is a genuine openness to others, a deep respect for cultural differences, and a continual commitment and curiosity to learning from and about diverse perspectives. Together, these principles ensure that care is not only clinically effective but also inclusive and responsive to the lived realities of all patients.

Cultural competency must be cultivated in both one's personal and professional life. There is a symbiotic relationship between the personal and professional that cannot be ignored. Personal self-awareness, growth, and openness can enhance professional practice, while professional experiences around cultural diversity can deepen a BHSSs understanding of themselves in relation to the world. Without alignment between personal attitudes and professional practice, cultural competence risks becoming superficial; when practiced holistically, however, it builds authenticity, reduces bias, and strengthens the foundation for trust and meaningful authentic connections with patients.

BHSS Self-Awareness

The process of cultural competence begins with developing self-awareness. Implicit in this is the belief that self-awareness must come before awareness of others. Self-awareness encompasses an understanding of one's own identities, cultural values, beliefs, history, social group identities, and positionality relative to the patient. If BHSSs are unaware of their cultural assumptions, biases, and privileged or marginalized statuses, they may inadvertently impose their beliefs onto patients or they may utilize strategies that are not culturally relevant to the patient. Thus, creating potential irreparable harm.

Patient Worldview

Being grounded in self-awareness enables BHSS to more effectively understand a patient's worldview. The worldview of patients encompasses their lived experiences, identities, and the ways privilege and marginalization shape patient realities. Understanding patient worldview requires the ability to see things through a patient's cultural lens, which includes being aware of the culturally healing practices of the patient. This approach not only deepens cultural empathy but also helps BHSS avoid potential pitfalls. Moreover, it helps reduce unintended assumptions and biases, while reducing the likelihood of inappropriate interventions. Being familiar with a patient's worldview allows BHSSs to connect on a deeper level that resonates with a patient's unique context. By honoring the patient's worldview, BHSS strengthen trust, foster more authentic helping relationships, and it creates the conditions for more ethical and effective care.

Understanding a patient's worldview is critical. Yet, it is a process that is far more challenging in practice than in theory. A patient's worldview is shaped by complex layers of culture, identity, lived experience, privilege, and marginalization, many of which may not be immediately visible or openly expressed. This makes it important for BHSS to approach patients with humility, curiosity, and a willingness to engage in ongoing dialogue, rather than assuming understanding from surface-level observations. BHSS must be willing to challenge their own assumptions, adapt their strategies, and remain open to perspectives, experiences, and cultural healing practices that may differ from their own.

Helping Relationship

BHSS play a pivotal role in shaping the strength and quality of the helping relationship. The helping relationship between BHSS and patients is a cornerstone of effective healthcare. When the helping relationship between BHSS and patients is built on trust it directly influences engagement and health outcomes. Developing trust requires BHSS to cultivate self-awareness and gain a deeper understanding of a patient's worldview. The combination of insight into oneself, coupled with familiarity for a patient's worldview helps BHSS understand the ways in which the helping relationship is shaped by cultural values, power dynamics, lived experiences, and the intersecting realities of privilege and marginalization. Such BHSS are not threatened by the differences in perspective that patients bring to the helping relationship. Instead, BHSS who are comfortable in their own skin focus their efforts on fostering mutual trust, cultural humility, and creating more authentic connections.

Conversely, neglecting the importance of the working alliance between the BHSS and patient can have a direct negative impact on health outcomes (cite). Patients are far less likely to engage in treatment if they perceive bias or a lack of cultural understanding from the BHSS. Such perceptions, even when they are not based on reality, may erode trust and create unintended barriers to care.

Interventions

BHSS who cultivate self-awareness, develop familiarity with their patient's worldview, and recognize how intersecting aspects of identity shape the helping relationship are better equipped to design interventions that are both culturally responsive and ethically grounded. By integrating these competencies, BHSS not only tailor care to the patient's lived experiences but also address systemic inequities, reduce the risk of bias, and promote more equitable health outcomes. This intentional approach ensures that interventions resonate with patients' cultural contexts while strengthening trust and authenticity within the therapeutic alliance.

Interventions necessarily vary according to the unique needs of the patient and the specific circumstances of care. BHSS may recognize that traditional office-based interventions are insufficient for addressing the complexities of a patient's lived experience, requiring them to extend their practice into community-based contexts. In other cases, the office setting may remain the most appropriate and effective environment for service delivery. Regardless of the setting, culturally responsive BHSS engage

in a collaborative process with patients to assess and determine which mode of intervention is most suitable. This intentional, patient-centered approach ensures that care is contextually relevant, ethically sound, and aligned with the patient's cultural values and circumstances.

Intersectionality

Developing cultural competence requires an understanding of intersectionality. Intersectionality, a term coined by Kimberlee Crenshaw, a legal scholar in 1989, refers to how issues of oppression such as racism, sexism, and classism, intersect to create advantages (privilege) and disadvantages (marginalization) for people. Both BHSS and patients bring to each interaction their complex identities as well as positions of privilege and marginalization. Understanding identity and marginalization can be important to understanding how systems of power, privilege, and oppression influence the helping relationship. These dynamics are captured in the four quadrants of the CCHF figure:

- Quadrant I: Privileged BHSS and Marginalized Patient
- Quadrant II: Privileged BHSS and Privileged Patient
- Quadrant III: Marginalized BHSS and Privileged Patient
- Quadrant IV: Marginalized BHSS and Marginalized Patient

Quadrant I represents a BHSS who holds a privileged social identity engaging with a patient who shares the same social identity category but from a marginalized position. For instance, this may involve a White BHSS working with a Black patient, or a male BHSS providing services to a female patient. Quadrant II represents a privileged BHSS working with a patient who also holds the same privileged identity. For example, this might involve a heterosexual BHSS interacting with a heterosexual patient, or both BHSS and patient identifying as Christian. Quadrant III occurs when a BHSS from a marginalized group interacts with a client from a privileged social group. Such situations may arise when a gay BHSS works with a heterosexual patient. Quadrant IV occurs when both BHSS and patient are members of the same marginalized social group. This situation could occur when BHSS and patient are both from poverty.

The quadrants reflect a given moment in time (Ratts et al., 2016). It is possible that BHSS and patient experience multiple quadrants at any given moment in time. For example, a BHSS may hold privilege in terms of gender while simultaneously experiencing marginalization related to sexual orientation, just as a patient may hold privilege in socioeconomic status while facing marginalization due to race. Relatedly, a patient's awareness of their own social group identity and status may not align with what a BHSS perceives or acknowledges at a given moment in time. This disconnect underscores the importance of BHSS approaching each interaction with cultural humility, curiosity, and openness, recognizing that identity is complex, context-dependent, and often fluid. Without this awareness, providers risk making assumptions that overlook or misinterpret the lived realities shaping a patient's worldview.