Cultural Competency: The Effects of Culture Shock and Language Stress in Health Education

Lucia Buttaro, PhD
Adelphi University
United States

Abstract

Diversity among refugee and immigrant populations in American schools has made it necessary for health educators to understand the health needs and health-seeking behaviors, attitudes, cultural nuances, and perceptions about health of various groups. Two strategies to accomplish this are the Ulysses Syndrome and Cultural Competency Continuum. The Ulysses Syndrome focuses on the often-misunderstood psychosocial challenges and stress experienced by immigrants in their departure from the home country, and the adaptation to a different environment. The Ulysses Syndrome forms the gateway between mental health and mental disorder. The other means is through developing cultural competency. Understanding the 6 levels of the cultural competency continuum enables health educators to integrate cultural proficiency practices into individual health education practices. Understanding diversity and the Ulysses Syndrome and developing cultural competence is a long-term and on-going process. This process is complex, but essential in order to build at framework from which to address the health needs of a diverse society.

Keywords: diversity, cultural competence, Ulysses Syndrome, immigrants, culture, health education

Diversity and Health Education

There are currently significant demographic changes taking place in the United States that are having a direct impact on health education and public health. Data from the Census Bureau (2010)show that minority populations have grown dramatically with immigrants coming from all over the world. This diversity among immigrant populations in American schools has made it necessary for health educators to understand the health needs and health-seeking behaviors, attitudes, cultural nuances, and perceptions about health of various groups. To gain this understanding requires acknowledgement of the Ulysses Syndrome and awarenessof cultural competency. The Ulysses Syndrome focuses on the often-misunderstood psychosocial challenges and stress experienced by immigrants in their departure from the home country, and the adaptation to a different environment. The process of utilizing the principles of the Ulysses Syndrome and developing cultural competence is complexand on-going, but crucial to building a framework to address the health needs of a diverse society.

Diversity and Culture

It is important to begin bydefining both diversity and culture. Diversity is a dynamic philosophy of inclusion based upon respect for cultures, beliefs, values, and individual differences of all kinds. Diversity respects and affirms value in differences in ethnicity and race, gender, age, sexual orientation, socio-economic status, linguistics, religion, politics and special needs(Betancourt, Green, &Carrillo, 2002).Diversity is also viewed as a commitment to understanding and appreciating the variety of characteristics that make individuals unique, promoting an atmosphere that embraces and celebrates individual and collective achievement. (The University of Tennessee Libraries Diversity Committee, 2003).A new vision for diversity is needed that also examines not only the typical racial/ethnic or gender composition of a population, but also how different groups perceive and interact with the environment, political and ideological beliefs, and equity in access to opportunities and care (Clayton-Pedersen, Parker, Smith, Moreno, & Teraguchi, 2007).

Culture is a concept that is organic and constantly evolving. Culture is essential for the existence of a societyand is an integral part of every society (Tylor, 1871).Culture is comprised of values and beliefs (Kroeber & Kluckholn, 1952); is learned, shared, and transmitted from one generation to next (Beyer, 2003; Chamberlain, 2005) and helps organize and interpret life It includes thoughts, styles of communicating, ways of interacting, views on roles and relationships, values, practices, and customs (Robins, Fantone, Hermann, Alexander, & Zweifler, 1998; Donini-Lenhoff & Hendrick, 2000).

Culture also includes a number of additional influences and factors, such as socioeconomic status, physical mental ability, sexual orientation, and occupation (Betancourt et al., 2002).According to Cross, Bazron, Dennis, and Isaacs, (1989), culture impacts our lives as it determines on the most fundamental level the way in which we perceive our world, how we assign meaning to what we see, and how we respond to it. People of one culture share a specific language, traditions, behavior, perceptions and beliefs respective of their culture. Culture gives them an identity, which makes them unique and different from people of other cultures.

Our understanding of our own culture and cultures other than our own will impact how we interact with people not of our culture. Limited understanding can lead us to making mistaken assumptions, judgments and placing unclear expectations on others. Cultural misunderstandings and conflicts arise mostly out of culturally-shaped perceptions and interpretations of each other's cultural norms, values, and beliefs. Although many dimensions of culture are universal, there are many dimensions along which cultures differ. This variance in basic values results in cross-cultural miscommunication and strife. Each culture also defines health in a unique way. Health is defined by cultures as a group's view of the physical, mental, emotional, and social components required in a healthy person (Cushner, 2002; Giger & Davidhizar, 1991).Culture is a very important aspect and significant part of our lives, personally and professionally, and a crucial factor for ensuring effective and efficient services to our communities. Therefore, it is essential for health educators to understand the effects of culture on health and educate themselves further about the particular needs of various ethnic groups.

Immigrant Populations

Of major concern to health educators in the United States are the health needs of immigrant populations. According to the International Organization for Migration an immigrant is a non-national who moves into a country for the purpose of settlement (2004). When examining immigrant groups, it is important to determine whether the individual is a migrant, first generation immigrant, or refugee; the length of time he or she has lived in the country and the reason precipitating the immigration. Immigrant populations are very diverse; originating from different regions of the world, representing many cultures and languages, migration patterns, legal status and reasons for migrating. Immigrants' education levels and occupations range from the illiterate manual laborer to the high-skill professional.

Not surprisingly, this diversity translates into different health profiles for sub-populations of immigrants (UNSD, 2013). The increasing population growth of cultural and ethnic communities and linguistic groups, each with its own cultural traits and health profiles, presents a challenge to health education. A major way to address this challenge is by improving health educators' understanding of the health needs of newly arrived immigrant populations.

Migration and the Ulysses Syndrome

Migration is a complex undertaking with often-profound impact on humans. For all immigrants, there is an adjustment process with specific stages they experience as they strive to integrate into a new cultural setting (Cushner, 2002). Atkinson, Morten, & Sue (1989) identify specific stages of adjustment. Newcomers first enter the honeymoon or conforming phase where the new intercultural experience appears to be heaven. Experiencing and adjusting to the physiological and psychological changes moves the individual into the conformity stage. In this stage, cultural differences result in tensions and frustrations which may lead into the stage of dissonance. This is a critical stage as ethnocentric reactions emerge and subjective cultural factors collide (Trifonovitch, 1977). Then, there is a stage of resistance and immersion, characterized by hostility, or by a strong withdrawal and search for a sense of identity. Immigrants begin to emerge from this reactive, hostile stage as they begin to understand and accept cultural subjectivity. In the next phase, the stage of introspection there is a concern and empathy not only toward own self, others of the same minority group, but also toward others of different minority groups (Atkinson, et.al., 1989). It is considered a relief phase, accompanied by humor and joy and helps individuals begin to understand subjective cultural aspects. In the final stage, the stage of integrative awareness, there is a selective appreciation and selective trust towards some of the members of the dominant group. This is known as the stage of home or adaptation, when people are able to interpret and interact from both cultural perspectives (Cushner, 2002).

It is important to recognize that people travel through these stages in multiple ways and varying timeframes. Most people require sufficient time to move through the stages and understand subjective cultural changes in enough depth to live effectively. Understanding this process is essential for health educators.

Educators should expect that families and individuals will experience multiple changes and reactions that will impede their learning and full functioning.

For millions of individuals, immigration today, presents stress levels of such extreme intensity that they exceed the human capacity of adaptation (Achotegui, 2009). These persons are, therefore, highly vulnerable to the immigrant syndrome with chronic and multiple stress, known as the Ulysses Syndrome. The term Ulysses refers to the Greek hero who spent ten years living in a distant land suffering countless adversities, and another ten seeking to return to his home city. (Homer, 700 BC). The significance of Ulysses' story is such that the term Odyssey is defined as a complex and treacherous journey in multiple languages and multiples cultures around the world.

The Ulysses Syndrome is an emerging health concept that focuses on the often-misunderstood psychosocial challenges, including varied forms of recurring and protracted stress experienced by immigrants in their departure from the home country and in the adaptation to a different environment. The key contribution of this concept is the elucidation of the direct correlation between the extreme levels of stress and the onset of psychological and psychosomatic symptoms. The delimitation and denomination of the Ulysses Syndrome contributes to the avoidance of the incorrect diagnosis of many immigrants as depressive (Achotegui, 2009).

According to Achotegui, the most important stressors faced by newly arrived first generation of migrants are: a) social isolation, loneliness and forced separation, especially in the case when an immigrant leaves behind his or her spouse or young children; b) the sense of despair and failure of the migratory goals and absence of opportunity; c) the survival factor to feed oneself, to find a roof to sleep under; d) the afflictions caused by the physical dangers of the journey undertaken, and the typical coercive acts associated with journeys by groups that extort and threaten the immigrants; and e) discriminatory attitudes in the receiving country including in the case of undocumented immigrants, the constant fear of detention and deportation (Achotegui, 2009). This combination of loneliness, the failure to achieve one's objectives, the experiencing of extreme hardships and fear forms the psychological and psychosocial basis of the Ulysses Syndrome.

As new immigrants deal with these factors they move through seven levels of grief: 1) grief for the family and loved ones; 2) grief due to encounter with a different language and the subsequent inability to communicate needs, feelings and ideas; 3) grief of culture, especially customs, sense of time, religion, values; 4) grief of homeland, landscape, the light, the temperature, the colors, smells; 5) grief of social status; 6) grief in relationship to the peer group along with prejudices, xenophobia or racism; and 7) grief due to risk regarding physical integrity such as dangers in the migratory journey, dangerous jobs, or changes in diet (Achotegui, 1999). These seven levels of grief can be lived in simple, complicated or extreme way, as the response to the efforts of the migrant to adapt to the new environment (Achotegui, 2012).

As they undergo these various levels of grief, the lives and livelihoods of first generation migrants are often threatened by various health problems that arise from the migratory and adaptation processes. The health effects are multiplied because the stressors are intense, multiple and chronic,appear out of their control,occur with little social support and result in symptoms such as sadness, recurrent nervousness, irritability, migraines, weariness, insomnia, fatigue, gastric and osteo-physical complaints. The stressful experiences during migration, the experience of becoming a racial/ethnic minority, subjected to discrimination and racial conflict with other groups, damages the mental health of migrants and appears to have long lasting effects on the mental health of immigrants (Ornelas & Perreira, 2013).The health system often does not provide adequately for these patients: either because this problem is dismissed as being trivial, or because this condition is not adequately diagnosed.

In the United States, biomedical approaches view these symptoms not as a reactive response to the predicaments met by the newcomers, but as signs of depression. First generation immigrants are treated as being depressive or psychotic with a series of treatments that instead of mitigating, may turn into additional stressors for the immigrant. Standard diagnostic criteria applied to members of different cultural groups pose various levels of discriminatory practices. While in ethno-medicine the existence of the spiritual world is widely considered, standard diagnoses fail to capture the knowledge, attitudes, practices, values, and beliefs of those from other cultural groups. The diagnosis of depression fits into a particular Western medical and cultural model, which reduces the psycho-social problem to that of an individual who in the diagnosis, is abstracted from a socio-economic content, and then held solely responsible for his/her mental wellbeing (Foucault, 2005).

It is of paramount importance to state that the symptoms suffered by these immigrants pertain to the mental health sector of healthcare, which is broader than the psychopathology. The table below highlights how understanding of the Ulysses Syndrome forms a gateway between mental health and mental disorder.

Table 1: Ulysses Syndrome

Mental Health	Ulysses Syndrome	Mental Disorder
Mental health is a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community. In this positive sense, mental health is the foundation for individual wellbeing and the effective functioning of a community.	A series of symptoms that affects migrants confronted with multiple and chronic levels of stress. Note that if they are offered a job or an opportunity to move out of these levels of stress, they respond positively and take the opportunity. Therefore, they are not "depressed". The objective of intervention would be avoiding the worsening conditions, so that they do not suffer a standard mental disorder.	A mental disorder or mental illness is a psychological or behavioral pattern generally associated with subjective distress, anxiety, depression, or disability that occurs in an individual, and which is not a part of normal development or culture. Such a disorder may consist of a combination of affective, behavioral, cognitive and perceptual components.

Achotegui, J. (2008).

Social support becomes increasingly more important in maintaining the mental and physical health of immigrants and their communities. Migrants lacking the necessary healthy support are exposed to a higher risk of moving into severe mental disorders (Achotegui, 2012). Although, in comparison to first generation immigrants, second generation immigrants in the United States are more likely to achieve higher earnings and are less likely to live in poverty(U.S.Census Bureau, 2010) increased health does not always follow. For example, depression in Latinos is highly correlated with the amount of years spent in the United States. Latinos have very strong family bonds which, in spite of economic, educational, and lower socioeconomic status, help them move forward in life. However, as Latino immigrants acculturate it becomes increasingly harder to maintain those family connections, stress levels rise, and the children begin to lose their cultural connection in favor of developing an American lifestyle, and the incidence of illness increases (Chang, Garcia, Huang & Maheda, 2010). Building social cohesion in communities is essential in maintaining better health. Social support has a protective effect in preventing or decreasing the risk of development of illness, especially in second generation immigrants confronted with acculturation and the impact of oppression and marginalization (Unnatural Causes, 2008; Marmot & Wilkinson, 2006).

The Ulysses Syndrome poses a powerful challenge to dominant approaches. It is a non-clinical and more comprehensive assessment of the plight of newly arrived immigrants who suffer from chronic and multiple stress syndromes. This calls for prevention, not just at the individual level, but also at the community level at large. Within each community, the health educator must utilize programs and resources that address the cultural values, beliefs and practices of that group or groups. A key strategy is to utilize the experts in the community and develop community with their input. The Community Health Workers (CHWs)/Promotoras model utilizes natural leaders in each community. CHWs act as cultural "bridges" between communities and institutions. They are trained to deal with the health problems of community members, and to work in close collaboration with the health services. The CHWs / *Promotoras*, many of whom have had the same or similar experiences, have developed strong levels of resilience and play a vital role in supporting those going through the migratory process, to achieve their goals without compromising their health condition (Waitzkin, 2006). Based on their own experiences, CHWs can fortify the personal resilience of newly arrived migrants, by employing relevant techniques from their common culture to alleviate grief and generate a sense of empowerment (Schoeller-Diaz, 2012).

With the culturally and linguistic appropriate approaches used by Community Health Workers (CHWs) / Promotoras and culturally competent health educators, the first generation of immigrants are not left in isolation, but integrated and made aware of the importance of keeping and maintaining strong ties with his/her language and culture as the most empowering factors in the overall wellbeing (Diaz-Cuellar, 2007).

By identifying community problems, developing innovative solutions and translating them into practice, "CHWs/Promotoras can respond creatively to local needs and achieve dramatic improvements by reaching the "hard to reach" community members and linking them to resources and advocating on their behalf" (Diaz-Cuellar, 2007, p.197).

Finally, to work most effectively in immigrant communities, health educators must develop a basis of trust with immigrants and families.To develop that trust, health educators must first understand the stages of an immigrant's journey to adaptation in a new country and acknowledge the multiple and chronic stressors associated with the immigrant experience. Educators must attain "an ethno-relative perspective, an expectation that one will have significant adjustments to make when living and working with others as well as an ability to understand components of one's own and others' subjective culture" (Cushner, 2002, p. 88). Health educators who are working with immigrant populations need to advocate for a socio cultural approach using culturally sensitive health educators alongside indigenous linguistically and culturally competent community health educators or Promotoras for the identification and help to newly arrived migrants experiencing the Ulysses Syndrome. It is imperative that the health issues related to high levels of stress associated with immigration and the right to health be addressed.

Developing Cultural Competence

Cultural competence is based on the core principles of culture. These principles include that culture is a predominant force in peoples' lives so a person cannot, not have culture; people are served in varying degrees by the dominant culture; people have personal identities and group identities; diversity within cultures is vast and significant; each group has unique cultural needs that cannot be met within the boundaries of the dominant culture. Cultural competence manifests in individuals, communities, schools, and organizations and occurs developmentally in all settings. The role of the health educators is to help individuals and entities move positively forward towards cultural competency. Health educators, in fact, have an inherent responsibility to become culturally competent (Luis & Perez, 2003).

With those understandings, culturally competent health educators first need to be aware of their own cultural identity, cultural values and cultural assumptions, and determine how their identity and value orientation might affect their professional practice and relationship with other health educators from different ethnic groups.

As cultural competence is having the capacity to function effectively within the context of the cultural beliefs, behaviors, and needs of clients and their communities, establishing relationships with the individuals and family before, during and after care are essential. Communication is essential, but communication can be inhibited by language barriers, literacy levels, cultural beliefs and alternative health beliefs or practices. Since cultural competence is a developmental process, it requires an understanding of the several key social determinants including socioeconomic status and its impact on health disparities from a racial and ethnic vantage point; understanding treatment-seeking behaviors based on diversity and cultural nuances specific to cultural and ethnic groups; and taking into account how language can be a barrier to optimal health care, requiring linguistic competence (Chamberlain, 2005).

The need for cultural and linguistic competence is compelling. First, it is a necessary response to the increasing ethically, culturally and linguistically diverse populations and changing immigrant patterns within the United States. Second, it is a tool to eliminate long standing disparities of the health status of people of diverse backgrounds while helping to improve the quality of care and health outcomes. Cultural competency is one of the main ingredients in closing the gap disparities in health care practices. "Quite simply, health care services that are respectful of and responsive to the health beliefs, practices and cultural and linguistic needs of diverse patients can help bring about positive health outcomes" (USDHHS, 2012, p.23). Culture competency practices influence health, healing, and wellness belief systems; how illness, disease, and their causes are perceived; the behaviors of patients/consumers who are seeking health care; the delivery of services by the provider who looks at the world through his or her own limited set of values. Finally, cultural competence is necessary to meet regulation and mandates of the Federal government.

Cultural and linguistic competence can be taught and learned and requires a commitment to individual personal growth. Challenging one's social conditioning and cultural incompetence is the essence of the cultural competence as a dynamic developmental process (Goode, 2004). The core principles mentioned above are embedded in the six levels of the cultural competence continuum.

They include cultural destructiveness, cultural incapacity, cultural blindness, cultural precompetence, cultural competence, and cultural proficiency. Not intended to be viewed in a linear fashion, the benefits of using the cultural competence continuum is that it enables healthcare educators and public health entities to determine their level of cultural competence and what steps should be considered to achieve cultural proficiency.

The first level, cultural destructiveness, is focused on seeing differences and stomping them out. Any perceived or real differences from the dominant mainstream culture are punished or suppressed and viewed as destructive to cultures and the individuals within these cultures. At this level, it is assumed that one's race or culture is superior, views other cultures as sub-human and focuses on the elimination of other people's cultures. In essence it is using one's power to eliminate the culture of another. Examples include the genocide or to the lesser extentex clusion of a group within a health education curriculum.

The second stage of cultural incapacity involves seeing the differences and making them wrong. It is based on the belief in the superiority of one's own culture and in behavior that disem powers another's culture. At this stage cultural differences are neither punished nor supported and there is no attention, time, teaching, or resources devoted to understanding and supporting cultural differences. At this stage, individuals believe in the superiority of one's own culture and behaving in ways that disem power another's culture. This can be seen in disproportionate allocation of resources to certain groups, expecting "others" to change, avoidance or exclusion of groups from the health curriculum, or a lack of an equal representation of staff/administrators that reflect diversity in the community. The system remains extremely biased and assumes a paternal posture towards "lesser" races. Such agencies may support discriminatory hiring practices and convey subtle messages to people of color that they are not valued or welcome.

The third stage is cultural blindness where one sees the difference, but acts as if he/she doesn't. Here, people do not recognize cultural differences among and between cultures; act as if the cultural differences do not matter or are inconsequential. No resources, attention, or time are devoted to understanding cultural differences making the ability to effectively work with a diverse population severely limited. Examples include health educators who experience discomfort in noting differences or who believe their program does not need to focus on cultural issues as they have no diversity. These educators believe everyone learns the same way and that they are not prejudiced as they so not see color in their students. Culturally blind agencies are characterized by the belief that approaches traditionally used by the dominant culture are universally applicable and no changes or adaptations are needed.

The next stage, cultural precompetence, involves seeing the differences, but responding inadequately to redress non-liberating structures, teaching practices, and inequities. Here individuals have an awareness of the limitations of their skills or an organization's practices when interacting with other cultural groups and attempt with limited skills. At this stage, the health educator might delegate diversity work to others or use a quick fix, packaged short-term program, like an activity during Black History month. Often there are unclear rules, and/or expectations for all staff.

The fifth stage, cultural competence, involves seeing the differences, and understanding the difference that difference makes. Here individuals interact with other cultural groups using the five essential elements of cultural proficiency; assessing culture; claiming the differences and valuing diversity; reframing the differences or managing the dynamics of difference; adapting to the differences and diversity; and changing practices for differences. At this stage, individuals learn to value and respect cultural differences, and attempt to find ways to celebrate, encourage, and respond to differences within and among themselves, while they pursue knowledge about social justice, privilege and power relations in our society. The culturally competent educator seeks advice and consultation from the minority community. At this stage, the health educator supports on-going education of self and others, models behaviors that look at another's perspective through another lens, and serves as an advocate for all constituencies. There is continuing self-assessment regarding culture, careful attention to the dynamics of difference, and use of multiple adaptations to prodder models to better meet the needs of minority populations.

The final stage of cultural proficiency involves seeing differences and responding positively and in an affirming manner. Individuals focus on esteeming culture, knowing how to learn about individual and organizational culture, and interacting effectively in a variety of cultural environments. Individuals recognize and respond to cultural differences and successfully redress non-liberating structures, teaching practices, and inequities.

Here the health educator supports personal change and transformation, serves in alliance for groups other than one's own; differentiates to the needs of all learners, and incorporates the community in planning and implementing appropriate programs and services.

Cultural competency is an ongoing journey that can be led by health educators who use the cultural knowledge, prior experiences, and performance styles of diverse learners to make learning more appropriate and effective for them. The degree of cultural competence a health educator achieves is based on growth in attitudes, policies, and practice. Attitudes change to become less ethnocentric and biased, policies change to become more flexible and culturally impartial, and practices become more congruent with the culture of the client. To be a culturally competent educator involves that one acknowledges the legitimacy of the cultural heritages of different ethnic groups, as worthy content; builds bridges of meaningfulness; uses a wide variety of instructional strategies connected to different learning styles; recognizes and utilizes the learners' culture and language in instruction; respects the learners' personal and community identities; acknowledges learners' differences as well as their commonalities; promotes equity and mutual respect among learners; and motivates learners to actively participate in their learning (Gay, 2000). Likewise, according to Robins, et al (2011), there are six essential elements of culturally proficient instructors. These are assessing culture by being aware of ones' own culture; valuing diversity by developing a community of learning with students; managing the dynamics of difference by appreciating the power of conflicts and being able to resolve them, adapting to diversity by committing to continuous learning; and institutionalizing cultural knowledge by working to influence public health organizations and systems.

Conclusion

Understanding diversity and developing cultural competence is a long-term and on-going process. To be culturally competent, individuals need to learn about themselves, to learn specific information about a community, and simultaneously learn how to treat each person as a unique individual who is not necessarily representative of his or her whole group. Health educators need to examine specific cultural values of groups as well as individual information about a person's status as a newcomer, immigrant or refugee. This delicate balance is not easy to learn, but it is essential in order to build a cultural competent framework from which to address the needs of multicultural communities in the United States and it is our best hope for a better future.

Integrating cultural proficiency practices into individual practices of health educators and public health organizational policies is a call to action. When an individual adopts cultural proficiency, the essential elements become the standard practice. People and their organizations become culturally proficient when specific strategies and behaviors are practiced consistently (Robins, et al, 2011). Cultural proficiency is an inside- out approach as it first involves primarily learning about oneself. Consequently, educators who are working to become culturally proficient must continue to learn, seeking information about the people they teach and integrating the culture and context of people with whom they work. One of the most difficult parts of this growth is processing one's own issues regarding power and oppression. This involves developing the capacity to confront personal issues with power and oppression, to recognize these issues and process feelings, acknowledge biases and prejudices, and draw new conclusions about one's self (Robins, et al, 2011). In addition, health educators need specific skills and techniques to manage the dynamics of difference to facilitate effective cross-cultural communication and to develop facilitation skills to foster healthy communication, to encourage critical reflection and to engage with the learners as a community of practice.

References

Achotegui, J. (2012). How to assess stress and migratory mourning. Scales for risk factors in mental health. Application to stress and migratory mourning. The Ulysses Scale. Ediciones El Mundo de la Mente. Llançá . Spain.

Achotegui, J. (2009).Emigrar en el siglo XXI: Estrés y duelo migratorio en el mundo de hoy. El Síndrome del inmigrante con estrés crónico y múltiple-Síndrome de Ulises.Editions El Mundo de la Mente. Llançá, Spain.

Achotegui, J. (1999). Los duelos de la migración: una perspectiva psicopatológica y psicosocial. Medicina & Cultura. E. Perdiguero y J.M. Comelles (comp). 88-100. Editorial Bellaterra. Barcelona, Spain.

Atkinson, D. R., Morten, G., & Sue, D. W. (1989). A minority identity development model. In Dr. Atkinson, G. Morten, & D. W. Sue (Eds), Counseling American Minorities (pp. 35-52). Dubuque, IA: W. C. Brown.

Beyer, C. K. (2003). An investigation of multicultural transformation: Success of culturally diverse students in integrated school, International Journal of Diversity in Organizations, Communities and Nations, 3, 445-46.

Brislin, R. (2000). Understanding culture's influence on behavior. Fort Worth, TX: Harcourt Brace.

Chamberlain, S. P. (2005). Recognizing and responding to cultural differences in the education of culturally and linguistically diverse learners. Intervention in School &Clinic, 40(4), 195-211.

Chang, D., Garcia, M., Huang, S., & Maheda, P. (2010). The effect of assimilation on depression rates among generations of Latino immigrants. Paper presented at Stanford

Medical Youth Science Program 2010 Summer Residential Program. Retrieved March 6, 20113 from http://smysp.stanford.edu/documentation/researchProjects/2010/effectsOfAssimilationAmongLatinoImmigrants.pdf

Clayton-Pedersen, A.R., Parker, S., Smith, D.G., Moreno, J.F., & Teraguchi, D.H. (2007). Making a real difference with diversity: A guide to institutional change. Washington D.C.: Association of American Colleges and Universities Press.

Cross, T., Bazron, B., Dennis K., & Isaacs, M. (1989). Towards a culturally competent system of care. Washington, D.C.: Georgetown University Child Development Center.

Cushner, K. (2002). Human diversity in action: Developing multicultural competencies for the classroom, 2nd ed. Boston, MA: McGraw Hill.

Diaz-Cuellar, A.L. (2007).The effectiveness of indigenous community health workers: International perspective. Dissertation: (Ed.D.) University of San Francisco, CA.

Donini-Lehn off, F. G., Hedrick, H.L. (2000). Increasing awareness and implementation of cultural competen ceprinciplesin health professional education. Journal of Allied Health, 29(4),241-245.

Foucault, M., (2005) El poder psiquiátrico, Buenos Aires, Fondo de Cultura Económica.

Gay, G. (2000). Culturally responsive teaching: Theory, research, and practice. New York, NY: Teachers College Press.

Giger, J. N., & Davidhizar, R. E. (1991). Transcultural nursing, assessment and intervention. St. Louis, MO: Mosby Year Book.

Goode, T., & Jones, W. (2004). Increasing awareness and implementation of cultural competence principles in health professions education. Journal of Allied Health, 29(4), 241-245.

Homer. (700 BC). The Odyssey.

International Organization for Migration(IOM). (2004). International migration law n°1 –Glossary on migration. Retrieved March 10, 2013 from http://www.iom.int/cms/en/sites/iom/home/about-migration/facts--figures-1.html

Jervis, N. (2011). What is culture? China Institute. Retrieved July 6, 2012, from http://emsc32.nysed.gov/ciai/socst/grade3/whatisa.html

Luquis, R.R. & Perez, M.A. (2003). Achieving cultural competence: The challenges for health educators. American Journal of Health Education 34(3), 131-138.

Marmot, M. & Wilkinson, R.G. (2006). Social determinants of health. London: Oxford University Press.

Office of Minority Health and Health Disparities (OMH). (2009). Black or African American populations. Retrieved July 19, 2011, fromhttp://www.cdc.gov/omhd/Populations/BAA/BAA.htm.

Orneles, I. J., Perreira,K. M. (2013). The role of migration in the etiology of depression among Latino immigrant parents. Retrieved March 11, 2013, from http://paa2011.princeton.edu/papers/110066

Robins, K. N., Lindsey, R. B., Lindsey, D. B.; & Terrell, R. D. (2011). Culturally proficient instruction: A guide for people who teach. Thousand Oaks, CA: Corwin Press.

Robins, L., Fantone, J., Hermann, J., Alexander, G.,& Zweifer, A. (1998). Improving cultural awarenessand sensitivity training in medical school. Academic Medicine, 73(10), S31-S34.

Schoeller-Diaz, D. (2012).Hope in the face of displacement and rapid urbanization. A Study on the factors that contribute to human security and resilience. Working Papers Series, September 2012 Harvard Humanitarian Initiative. School of Public Health, Harvard University Press.www.HHI.Harvard.edu

Trifonovitch, G. (1977). Cultural leaning/cultural teaching. Educational Perspectives, 16(4), 18-22.

Tylor, E. B. (1871). Primitive culture and anthropology. Cambridge, LN: Cambridge University Press.

Unnatural Causes. (2008). California Newsreel. National Association of County and City Health Officials. Retrieved March 4, 2013 from http://www.unnaturalcauses.org/episode _descriptions.php?page=3.

United Nations Statistics Division (UNSD. (2013). International migration. United Nations. Retrieved March 10, 2013 from http://unstats.un.org/unsd/demographic/sconcerns/migration/.

U.S. Census Bureau. (2010). Census redistricting data (Public Law 94-171) summary file—technical documentation. Retrieved March 9, 2013, from www.census.gov/prod/cen2010/doc/pl94-171.pdf.

U.S. Census Bureau, Population Division, Social & Demographic Statistics. (2003). U.S. Census Bureau guidance on the presentation and comparison of race and Hispanic origin data. Retrieved May 21, 2013 from: http://www.census.gov/population/www/socdemo/compraceho.html

U.S. Department Of Health And Human Services, (USDHHS). (2012). Office of Minority Health Retrieved June 12, 2013 from: http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=11.

University of Tennessee Libraries Diversity Committee. (2003). What is diversity? Retrieved July 24, 2014 from: http://www.lib.utk.edu/diversity/diversity_definition.html

Waitzkin H, et al. (2006). Promotoras as mental health practitioners in primary care: a multi-method study of an intervention to address contextual sources of depression. Journal of Community Health. 36(2), 316-31.