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# Culture Counts: Cultural and linguistic competence in mental health care settings

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# Objectives

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The goals of this presentation are to:

- ❑ Understand the importance of culture in mental health service delivery
- ❑ Understand barriers to cross cultural communication
- ❑ Learn strategies for effective cross cultural and linguistic communication
- ❑ Discuss barriers to cultural competence



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■ Why is culture important to mental health care?

■ How does it affect access to, and utilization of mental health services?



Working definition by the Office of Minority Health,  
US Dept. of Health and Human Services:

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*“Culture is the thoughts,  
communications, actions,  
customs, beliefs, values, and  
institutions of racial, ethnic,  
religious, or social groups.”*

# What is Culture?

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- “Values, family history, rituals and social conditions that you identify with and are influenced by.”
- “Culture is fluid. It is the past and it is the present.”
- “A self identified group with shared vocabulary, values, and customs.”



# Key Points about Culture:


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- ❑ Culture is NOT homogenous or static
- ❑ Culture is NOT a single variable, but comprises of multiple variables

# Why is it so important?

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1. As the United States becomes more diverse, clinicians will increasingly see patients with a broad range of perspectives regarding health, often influenced by their social or cultural backgrounds.
2. Research has shown that provider-patient communication is linked to patient satisfaction, adherence to medical instructions, and health outcomes.
3. Poorer health outcomes may result when sociocultural differences between patients and providers are not reconciled in the clinical encounter. **These barriers do not apply only to minority groups but may simply be more pronounced in these cases.**

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- The changing US demographics
  - National Reports on Racial and Ethnic Mental Health Care Disparities
  - US Government response to racial and ethnic disparities to mental health care



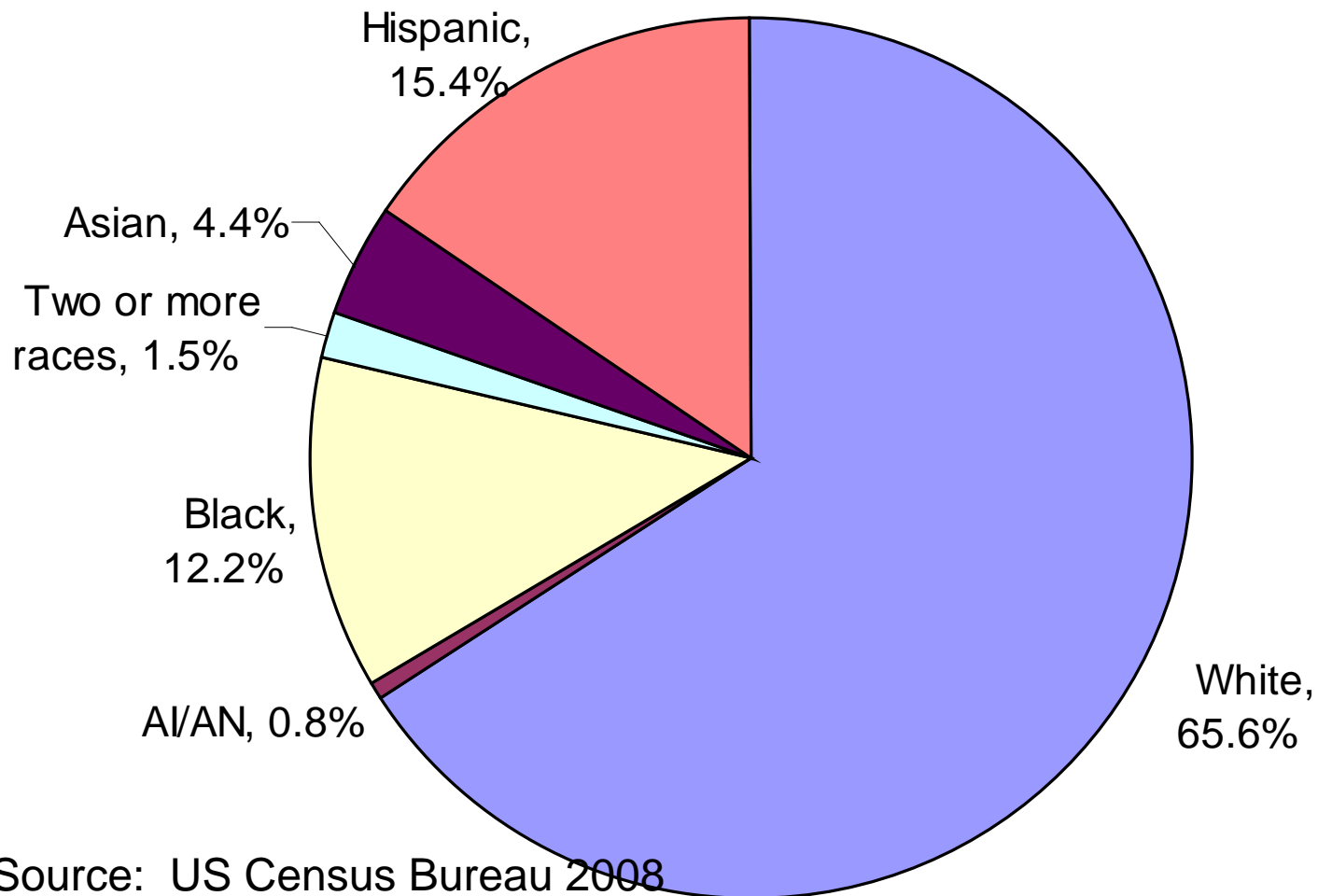
# Our Multicultural Nation

## U.S. White Population Will Be Minority by 2042.

- “Minorities” will make up 54 percent of the U.S. population in 2050, compared with 34 percent of the population in 2008.
- More than half of all U.S. children are expected to be from minority ethnic groups by 2023.
- Source: Bloomberg.com, *August 14, 2008*



## US Population: Race/Ethnicity



Source: US Census Bureau 2008

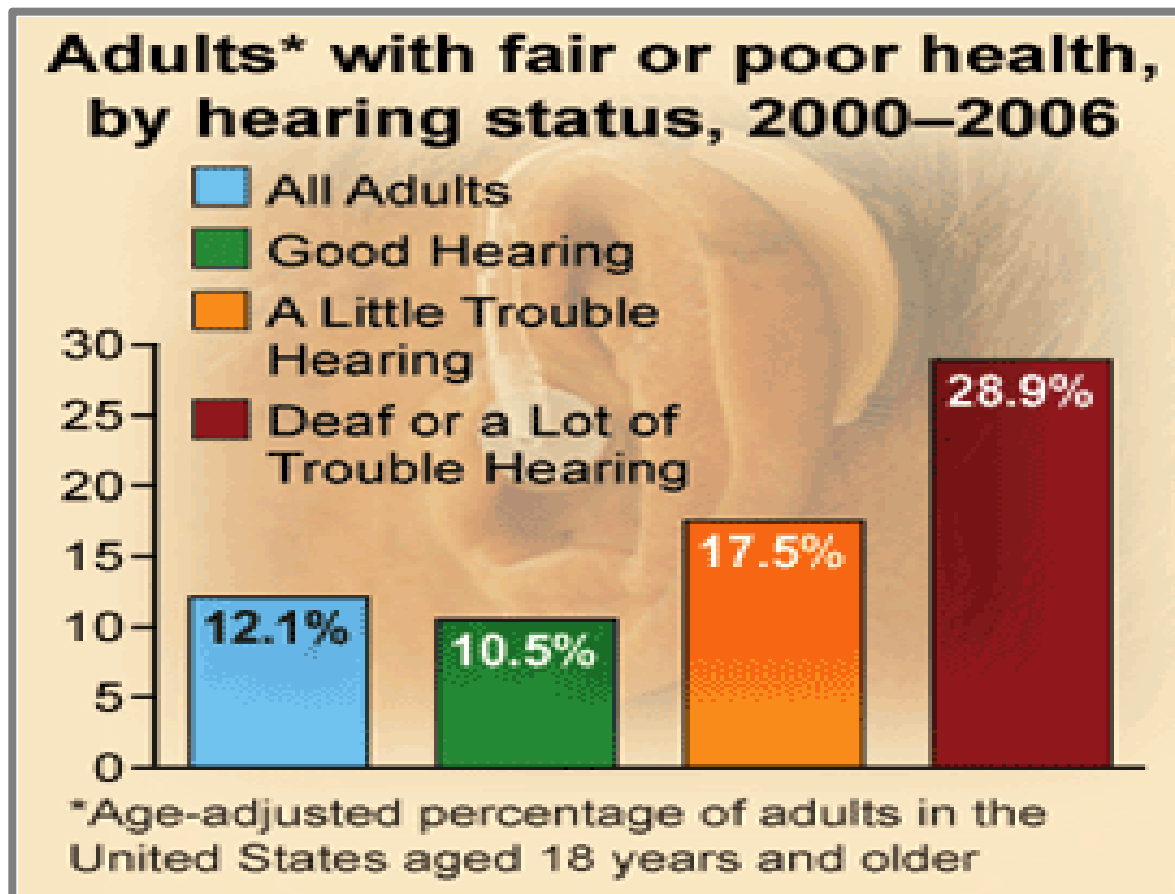
# Deaf and Hard of Hearing Population


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- **According to the National Health Statistics 36 million (17%) Americans have some degree of hearing loss (ranging from a little trouble to being deaf) (CDC 2006).**
- **Adults who were deaf or had a lot of trouble hearing were about 3X as likely as adults with good hearing to be in fair or poor health and to have difficulty with physical functioning (such as walking, bending, reaching, etc).**

# Deaf and Hard of Hearing Population

Adults with hearing loss had poorer health and increased risk of engaging in health risk behaviors than adults with good hearing. 2





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The growth of racial, ethnic and linguistic groups, each with its own cultural traits and health profiles presents a challenge to the health care system.

Increasing diversity demands more cultural understanding

# Culture and Language influence mental health care:

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- How health care information is received (doctor-patient interaction)
- What is considered to be a health problem
- How symptoms and concerns about the problem are expressed
- Who should provide treatment for the problem (help seeking behaviors)
- What type of treatment should be given (medication vs. psychosocial therapy)
- Communication (verbal and non-verbal)
- How people perceive and cope with mental illness (spirituality)
- Stigma and shame associated with mental illness



# Disparities in Mental Health Care

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*The Surgeon's General Report in 2001 indicated that racial and ethnic minorities:*

- Are less likely to receive services
- Receive poorer quality of care
- Are underrepresented in mental health research
- *The IOM (2003)* reported that minorities were less likely to receive the health care they needed even after taking into account health insurance coverage and other economic and health factors.



# Disparities in Mental Health Care

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## *Deaf and Hard of Hearing Population:*

- Lower satisfaction with health care quality of care
- Communication difficulties posing major impediments to mental health care
- Mental health terms varied widely (e.g., in one study the term “addiction” was recognized by 80% of patients and “psychosis” was recognized by 22% of patients)
- Causes of mental health varied (e.g., external causes) (Steinberg et. al. 1998: pp.982-984).



# Racial and Ethnic mental health disparities: Key Studies

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- Minorities in the US are more likely than whites to **delay or fail to seek mental health treatment** (Sussman, Robins, and Earls 1987; Kessler et al. 1996; Zhang, Snowden, and Sue 1998).
- After entering care, minority patients are less likely than whites to receive the best available treatments for depression and anxiety (Wang, Berglund, and Kessler 2000; Young et al. 2001).
- African Americans are more likely than whites to **terminate treatment prematurely** (Sue, Zane, and Young 1994).
- \*from “Mental Health: A Report of the Surgeon General” (DHHS 1999) and its supplement, “Mental Health, Culture, Race and Ethnicity” (DHHS 2001),



# Cultural and Linguistic competence. . .

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Cultural and Linguistic Competence has gained acceptance from health care policymakers, providers, insurers, and educators as a strategy to improve and eliminate racial/ethnic disparities in health care.



# Cultural and Linguistic Competence

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- What is it?
- How can it help reduce the barriers to mental health care?
- What are some pitfalls of this construct?

# Cultural and Linguistic Competence

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- ❑ **Linguistic Competence:** Providing readily available, culturally appropriate oral and written language services to limited English proficiency (LEP) members through such means as bilingual/bicultural staff, trained medical interpreters, and qualified translators.
- ❑ **Cultural Competence:** A set of congruent behaviors, attitudes, and policies that come together in a system or agency or among professionals that enables effective interactions in a cross-cultural framework.  
<http://www.ahrq.gov/populations/cultcompdef.htm>) (Cross, Bazron, Dennis, & Isaacs, 1989).

**Cultural and Linguistic Competence:** The ability of health care providers and health care organizations to understand and respond effectively to the cultural and linguistic needs brought by the patient to the health care encounter

Source: Campinha-Bacote Model of Cultural Competence. <http://www.transculturalcare.net/>



## **Culturally and Linguistically Appropriate Services (CLAS) Standards:**

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- ❑ Guidelines established by the federal Health and Human Services Department, Office of Minority Health
- ❑ Mandated for all health care organizations receiving federal funds.

# Culturally and Linguistically Appropriate Services

## (CLAS) Mandates

“Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.”

“Health care organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer).”

“Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.”

Health care organizations must provide to patients/ consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.”<sup>1</sup>



# US Dept of Health and Human Services, HRSA grants:

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- All Health Resources and Services Administration (HRSA) grant applications require addressing cultural competence



# Ideally, Cultural Competency in Psychiatry would...

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- Enable patients and doctors to come together and communicate effectively
- Lead to health care services that are respectful and responsive to culture.
- Improve patient satisfaction and patient outcomes.





# Barriers to Cross-Cultural Communication

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- ❑ Assumed similarity
- ❑ Non-verbal communication
- ❑ Language itself
- ❑ Cultural perceptions
- ❑ Preconceptions
- ❑ Stereotypes
- ❑ Fear of government and police
- ❑ Fear of deportation
- ❑ Fear of bringing shame to the extended family/clan/community
- ❑ Source: [http://www.enpmagazine.com/Magazine/Issue\\_Archives/2006/05-05/bridging\\_the\\_culture.html](http://www.enpmagazine.com/Magazine/Issue_Archives/2006/05-05/bridging_the_culture.html)

# Communicating with Culturally Diverse Populations

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- Effective communication depends on how all parties in the interaction behave and how the behavior is perceived by the viewer, listener, or speech partner.
- This takes place when participants in the interaction have developed not only respect for diverse interaction styles, but when they have developed multiple interaction skills.



# Multiple Interaction Skills

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- ❑ Multiple speech styles
- ❑ Good talker and good listeners (i.e., putting yourself in the other person's shoes)
- ❑ People can speak directly and indirectly
- ❑ Involves communication through verbal speech and nonverbal speech.
- ❑ Paralinguistic elements of speech as pitch, stress, intonation and speed of speech
- ❑ Keep in mind that concepts may be interpreted differently by diverse groups

# Factors to Consider in Developing Diverse Speech Styles

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- In cross cultural interactions: speech reciprocity, conversation structure and turn taking are particularly important:
- **Speech reciprocity:** To what extent do different speech partners initiate the conversation? Who initiates subsequent questions or topic changes? Does each speaker pause or talk about the same time

# Factors to Consider in Developing Diverse Speech Styles

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## **Conversation Structure:**

- Do people present their main point first, followed by elaboration and supporting information, or do they present a general picture first, saving the main point until sufficient background information has been given?
- Developing skills of directness and indirectness as appropriate to different cultural situations, decreases negative judgments about interactions with others.

# Factors to consider in cross cultural communication

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Examples that can be viewed as shameful to some cultures...


- ❑ Any reference that suggests that the person speaks poor English
- ❑ Treatment of an elder without the proper degree of respect
- ❑ Any expression of displeasure or irritation at the patient's health beliefs or behavior



# Other considerations...

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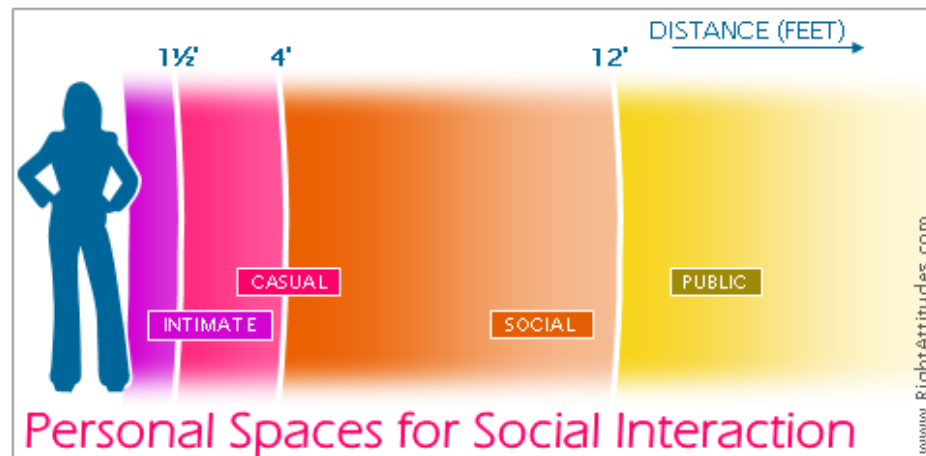
- ❑ Addressing the patients chief complaints and reducing symptoms (within the context of socioeconomic and cultural scripts, e.g., mal de ojo). In Latin cultures, children are most vulnerable to the evil eye.
- ❑ Framing family challenges in a supportive and nonjudgmental manner is more effective than addressing them immediately and directly, nonverbal cues
- ❑ Understanding the patient's narratives (e.g., trauma, poverty and discrimination);
- ❑ Fostering empowerment (e.g., incorporating sociohistorical context)

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- ❑ Issues around space, e.g., Latin American and Arabic patient may feel that he needs to get closer to the physician
  - ❑ The use of eye contact in communication also varies among cultural groups.
  - ❑ Differences in the belief of the causes of the health-related problem



# Considerations When Interacting with People of Other Cultures

- Personal Space: A person from one subculture might touch or move closer to another as a friendly gesture, whereas someone from a different culture might consider such behavior invasive.



Source: *Transcultural Nursing: Assessment and Intervention* (Giger and Davidhizar, 1999). <http://mentalhealth.samhsa.gov/publications/allpubs/SMA03-3828/sectiontwo.asp>

# Considerations When Interacting with People of Other Cultures: Personal Space

Nation of Origin	Desired Space
Asian	Non-contact people
African	Close personal space
European	Non-contact people;
American Indian	Distant
Hispanic	Space important; no boundaries
African Americans	Tactile relationships; close
Caucasian Americans	Non-contact

Source: *Transcultural Nursing: Assessment and Intervention* (Giger and Davidhizar, 1999).

<http://mentalhealth.samhsa.gov/publications/allpubs/SMA03-3828/sectiontwo.asp>

## Perspectives of Latino Clients

- Latinos felt that it was important that the clinician could communicate in Spanish. Even those who spoke English, felt there were times when switching to Spanish would get the point across more effectively.

## Perspectives of Latino Clients – The Centrality of Language

- *“The language is the most important thing. Nothing replaces the language.”*
- *“They mistreated patients because there was no one that spoke Spanish.”*
- *“The doctor told my interpreter that I need to learn English.”*
- *“I was in a treatment where I was not able to communicate well and that affected the treatment.”*

## Perspectives of Latino Clients – Understanding Cultural Idioms

- Not only do clinicians need to understand the language in a general sense, they need to understand the specific meanings of cultural idioms that people use to describe their emotional problems
- *“I told my doctor that my nerves were bothering me a lot and he didn’t understand.”*

## Perspectives of Latino Clients – Being Able to Share Emotions

- Latinos felt like they and clinicians needed to be able to share their emotions with each other; they needed a personal connection.
- *“Therapists can cope if you are mentally imbalanced, but can’t cope if you pour your heart out. The best way to deal with emotion is with emotion.”*

## Perspectives of Latino Clients – Collectivism is Not Dependence

- Extended family is central in Latino culture. There is a tendency for intensive involvement with family to be viewed as dependence and to judge it negatively.
- *“Therapists need to understand the value systems of the culture because what may seem to be an unhealthy dependence, you know, may be just a natural value like, a culture that prizes collectivism. We belong all to the bigger group as opposed to just being very independent.”*

## Perspectives of African American Clients

### Treat Me as an Individual and Understand My Context

- African American clients felt that European American clinicians could not fully understand the lived realities of their lives
- *“My therapist can identify with me as a woman, but not as a Black woman. My brothers could be shot on the street at any time. I know she would glaze over it. But if I had an African American therapist, they would appreciate it.”*



## Findings from Qualitative Research on American Indians, Vietnamese, Hmong and African Americans (Fu et. al. 2007)

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- **Counseling**
- – Women generally had more positive reactions to counseling than men.
- – Among African Americans and American Indians preferences tended to be for group over individual counseling.
- – **Greater levels of acculturation appeared to be associated with more positive attitudes toward counseling among Vietnamese participants.**  
Vietnamese men preferred individual over group counseling.

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- **Views of doctors**
  - – **Few sought out doctors or perceived doctors to be a resource for help to quit smoking.**
  - – **Doctors' expertise was generally seen as restricted to knowledge about medication.**
  - *African Americans and American Indians*
  - – Mixed views about using doctors for help with cessation. Men especially had very negative opinions of doctors and the medical profession.
  - – Explanations for not seeing doctors tended to focus on negative qualities of particular doctors or of the medical establishment. Doctors were viewed as impersonal, blaming and confrontational.
  - – Some believed doctors could be effective if they used a personal and nonconfrontational approach.



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□ *Hmong and Vietnamese*

- – Positive attitudes toward doctors, who were seen as a trusted source of expertise.
- – There was little awareness, especially among the Hmong, that doctors could provide cessation services.
- – The cultural value of mental control and self-determination, especially among the Vietnamese, was seen as the most important determinant of quitting smoking.

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## ❑ **Attitudes and beliefs about medications**

- ❑ – Except for Hmong-speaking men, most were aware of over-the-counter medications (e.g., nicotine patch and gum); less awareness with prescription medications.
- ❑ – Most had low levels of knowledge about the functional benefits of pharmacotherapy. Participants did not understand that pharmacotherapy could be used to help them with cravings and withdrawal symptoms.
- ❑ – Concerns about side effects (e.g., overestimation of risks of side effects compared to risks of smoking).

*“Why would you take something to stop smoking and then get three or four different side effects? When you only got one with smoking. Give up one and get three or four side effects.”—African American male smoker*

- ❑ – Skepticism about the effectiveness of medications. Participants expressed skepticism about the benefits and effectiveness of medication, especially African Americans and American Indians.

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- **The idea of taking pills met with more resistance than other modalities.**
  - *“...I would be kind of hesitant about the patch because now it's like they have a patch for everything... There's a patch to stop smoking, a patch to not get pregnant, it's like you know, and it doesn't seem believable.”—African American female former smoker*
  - – Cost of medications and lack of accessibility perceived as major barriers to their use. Cost emerged as a significant obstacle to pharmacotherapy, with many participants unaware that insurance or other programs were available to pay for treatment.
  - *“All those products, right, cost too much. To the average smoker you rather pay \$4 for a pack of cigarettes than \$25, \$95 for Nicoderm or \$20 for Nicorette and they say, ‘what's the use?’.”—African American male smoker*



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- **Receptivity toward medications**

- – “Word of mouth” was a powerful influence on decisions to use or not use pharmacotherapy.
- – The use of “personal testimonies” was suggested by participants as a way to increase acceptance of pharmacotherapy.



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## □ **Concerns about side effects**

- Participants expressed concern about smoking adversely affecting their health but appeared to underestimate the risks associated with smoking relative to the risks associated with medication. Participants believed that the side effects of medications would likely be worse than the effects of smoking. Perceived side effects included such severe conditions as “bleeding liver”, blood clots, stroke, heart attacks, hallucinations, depression as well as headaches, stomach cramping, and drowsiness.
- Further, participants recounted stories of friends and family members who experienced side effects while taking stop-smoking medications. Related to this were a number of accounts of people smoking while using medication, and getting sick as a result.

# Observations from Persons who are Deaf or Hard of Hearing

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- Conflicting Assumptions about deafness: Physicians seemed unaware that American Sign Language has grammar and syntax different from English. ‘The medical community holds a pathological view of deaf people....they don’t see us as a linguistic minority...I don’t identify myself as disabled. There’s a certain kind of pity on us as deaf people.’ (Iezzoni et. al. 2004, p.358).



# Observations from Persons who are Deaf or Hard of Hearing

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- **Conflicting Perceptions of Communication Modalities:**  
Patients reported that physicians frequently require them to use inadequate modes of communication, such as reading lips, writing notes, or bringing family members to interpret. ‘Once we got into the doctor’s office, we did introductions, and communication was at the right pace. It was wonderful. I signed whatever I wanted to say, and if the interpreter was confused by medical terms, she stopped me, and I wrote down the medical thing. So often it’s ‘hurry up, get in, and get out.’ This doctor took the time to explain everything to me, and I was pleasantly amazed.’ (Iezzoni et. al. 2004 p. 359)

# Observations from Persons who are Deaf or Hard of Hearing

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- Inadequate Communication Has Consequences:  
Inadequate information can embarrass patients. ‘You write back and forth...’ and the doctor wrote ‘C-O-K-E.’ I said, yes a lot. Suddenly, there were three people trailing me to the bathroom for a urine test. I thought they were trying to keep me from running away....I thought he meant do I drink Coca-Cola. Why didn’t he write the whole word ‘cocaine’? It’s not just coke (Iezzoni et. al. 2004, p.359).

# General Intervention Guidelines

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- **Use open-ended questions to gather more data.**
  - Open-ended questions cannot be answered with a simple “yes” or “no.”
  - Avoid complex sentences
- **Use audience-centered language.**
  - When you speak, focus on your audience’s values, needs, and preferences. Avoid talking from your perspective.
- **Employ reflective listening.**
  - Repeating or paraphrasing what you heard allows the person you are talking with to clarify or add more information if necessary. This technique also forces you to really think about what was said.
  - Speak slowly
- **Be assertive, not aggressive.**
  - Make your point strongly, without attacking the other person of a different opinion.

# General Intervention Guidelines

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## □ **Be flexible**

- Alter your communication strategies as the situation necessitates.

## □ **Recognize and respect differences**

- Do not assume the majority's way is the only way.
- Do assume that there is more to a person than meets the eye.

## □ **Be honest**

- Acknowledge any discomfort, hesitation or concern you may have.

# General Intervention Guidelines

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- **Learn from cultural informants...**
  - Values, family norms, traditions, community politics, etc.
- **Involve bilingual and bicultural staff.**
- **Establish rapport. Gain acceptance.**

# Use interpreters/translators with caution

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- Translators may help as well as hinder the communication process. In some cases the patient might withhold embarrassing information from family member. Try to seek a trained, highly-skilled translator.
- A review of meeting between doctors and non-English speaking patients revealed that language interpreters make many mistakes, more than half of which could have a negative impact on patient's health (McCook 2003)
- An analysis of 13 doctor-patient visits that included a Spanish-English interpreter (e.g., “ad hoc” interpreters such untrained family members, friends or people at the hospital) found interpreters made an average of 31 mistakes per visit, 19 of which could have negative consequences for the patient (McCook 2003)

# List 1. Hard of Hearing Patients: Communication Guidelines

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## Greeting

- Ask the patient how best to communicate with him or her.

## Environment

- Background noise is minimized.
- Interviewer's face is well lit.

## Expressive communication

- Eye contact is established before speaking.
- View of mouth is not obscured (by hands, pens, charts, etc.).
- **Adjust voice pitch if this helps.**
- Topic changes are stated explicitly.
- Repeat information that is not understood. Rephrase if it is still not understood.
- **Use assistive listening devices (e.g., hearing aids, one-to-one communicators) if they help.**
- Note writing may be helpful.
- Ask the patient periodically about the quality of the communication.
- Ask the patient for periodic summaries to check accuracy of communication.

## Receptive communication

- Summarize the patient's story to check accuracy.

## List 2. Deaf Patients who communicate orally:

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### **Greeting**

- Ask the patient how best to communicate with him or her.

### **Environment**

- Interviewer's face is well lit.

### **Expressive communication**

- Eye contact is established before speaking.
- View of mouth is not obscured (by hands, pens, charts, etc.).
- Topic changes are stated explicitly.
- Repeat information that is not understood. Rephrase if it is still not understood.
- Note writing may be helpful.
- Ask the patient periodically about the quality of the communication.
- Ask the patient for periodic summaries to check accuracy of communication.

### **Receptive communication**

- **When uncertain, ask the patient to repeat or clarify.**
- **Repeat the patient's statement to confirm comprehension.**
- **If still unclear, note writing may help.**
- Summarize the patient's story to check accuracy.



# List 3. Deaf Patients Who Communicate with a Sign Language:

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## **Greeting**

- **Welcome the patient with a sign-language greeting (or ask the patient to teach you one).**
- Ask the patient how best to communicate with him or her.

## **Environment**

- Room is well lit, and the light is not shining in the patient's eyes.
- **People are positioned so that the deaf patient can see the doctor and the interpreter.**

## **Expressive communication**

- **Work with a qualified interpreter.**
- **Speak to the patient, not the interpreter.**
- Topic changes are stated explicitly.
- Note writing and written materials may have limited usefulness.
- Ask the patient periodically about the quality of the communication.
- Ask the patient for periodic summaries to check accuracy of communication.

## **Receptive communication**

- **Look at the patient while listening to the interpreter.**
- **When uncertain, ask the patient (not the interpreter) for clarification.**
- Summarize the patient's story to check accuracy.



# Concerns of Cultural Competency:

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- ❑ Cultural competency has become a series of “do’s and don’ts”
- ❑ This suggests culture can be reduced to a technical skill
- ❑ Another problem is that cultural factors are not always central to a case.
- ❑ Attention to cultural differences can be interpreted by patients and families as intrusive, and might even contribute to a sense of being singled out and stigmatized



# Self Reflection – a place to start:

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Clinicians should start by recognizing their own culture and how the culture of medicine and psychiatry might lead to unconscious:

- Biases
- Inappropriate and excessive use of medical or psychopharmacological interventions
- Stereotyping

# What really matters?

## A good place to start.

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- What we want to understand is **WHAT REALLY MATTERS** to the patient.
- Ask: What is really at stake for the patients, their families, and at times for themselves or communities
- Routinely ask patients (and where appropriate family members) what matters most to them in the experience of illness and treatment.
- This information can then be used in thinking through treatment decision and negotiating with patients.

# Wise Words



“Main thrust (of culturally informed care) is to focus on the patient as an individual, not a stereotype; as a human being facing danger and uncertainty, not merely a case; as an opportunity for the doctor to engage in an essential moral task, not an issue in cost-accounting.”

- Arthur Kleinman

# Similarities Between Racial and Ethnic Minority Groups and the Hearing Impaired

## **SOCIAL:**

- Use of non-English language
- Socialize and partner/marry within community
- Cultural norms different than those of majority community
- Children often become bicultural/bilingual



## **SOCIAL POWER:**

- Lower education level, SES, and literacy than the general population
- Encounter prejudices that limit opportunities
- Limited access to English-based information

## **HEALTHCARE:**

- Infrequently encounter a doctor from their own cultural group
- Language differences and health knowledge limitations are often barriers to appropriate health care. (Barnett 1999)

# Take Home Message

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- *“To be culturally competent doesn’t mean you are an authority in the values and beliefs of every culture. What it means is that you hold a deep respect for cultural differences and are eager to learn, and willing to accept, that there are many ways of viewing the world.”*
- ~ **Okokon O. Udo** ~ Ph.D., CPCC founder and president of Distinctive Leader Options, Inc. former Executive Director of the Center for Cross Cultural Health.
- [http://www.newahec.org/Cultural\\_Competency.html](http://www.newahec.org/Cultural_Competency.html)

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