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Culture, Health Promotion, and Cultural Competence

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Chapter Objectives

On completion of this chapter, the health promotion student and practitioner will be able to

- Define and discuss the concepts of health education, health promotion, and disease prevention as these relate to working with multicultural population groups
- Define and discuss at least five common terms associated with working with diverse population groups, including the terms *culture*, *ethnicity*, *acculturation and assimilation*, *ethnocentrism*, and *cultural competence*
- Identify and discuss at least five potential barriers to multicultural health promotion and disease prevention activities designed for diverse cultural groups

Activities for promoting health and preventing disease in any population, whether directed at individuals, groups, or communities, are a formidable task. Such endeavors require an organized effort characterized by an understanding that *culture* and *cultural forces*, among other social forces,

are powerful determinants of health-related behaviors. Culture, in any group or subpopulation, can exist as a total or partial system of interrelationships of human behavior guided and influenced by the organization and the products of that behavior. Indeed, the beliefs, ideologies, knowledge, institutions, religion,

and governance, as well as nearly all activities (including efforts to achieve health-related behavior change), are affected by the forces of culture.

Culture is a dynamic, fluid, ever-changing, and complex force in the lives of individuals, groups, and communities. And it is this complexity that has made it difficult to formulate a universally accepted definition of culture. Kreuter, Lukwago, Bucholtz, Clark, and Sanders-Thompson (2003) note that no single definition of culture is universally accepted. But there is “general agreement that culture is learned, shared, and transmitted from one generation to the next, and it can be seen in a group’s values, norms, practices, systems of meaning, ways of life, and other social regularities” (p. 133). The definition of culture will be dealt with in greater depth later in the chapter. It is also important, where possible, to be aware that ethnic and cultural factors may be connected with a target group’s vulnerability to certain communicable and chronic diseases and other health-related problems. Such knowledge can provide the planner with many clues during the assessment process. Students and practitioners should be aware that many of a target group’s health risk factors are amenable to behavior change, thus reducing risk. Efforts to promote health and prevent disease within culturally different ethnic subgroups, as in any target group, will entail influencing the health behavior of individuals, families, groups, or communities. This will require identifying and changing those factors that are associated with accomplishing the desired health-related behavior. Also, these efforts probably will require some type of sustained collaboration between the public, private, and voluntary sectors and the people most directly affected by a defined health concern or problem. Cultural considerations ultimately may determine whether a particular population or target group will choose to participate in health promotion and disease prevention (HPDP) programs. There will be the need for

a continuing communication between these stakeholders that establishes and maintains working relationships characterized by mutual understanding, trust, and respect (see Hodge, Hodge, & Palacios, Chapter 16, this volume, for a discussion reflecting this process).

There are many settings in the community where activities are conducted for promoting health and preventing disease in a population. These include a myriad of work sites, schools, health care program sites, and the community itself. Comprehensive health promotion activities at a work site consisting of a large, culturally diverse employee population may, for example, carry out employee-risk assessments (including screenings and appraisals) as well as establish and maintain an appropriate variety of educational programs, services, and activities to reduce or eliminate identified areas of health risk. In this setting, a work site must carry out culturally sensitive and effective interventions that meet the needs of their employees. This sensitivity must be carried over in the group as well as in one-to-one counseling or educational encounters. Awareness and sensitivity to cultural diversity, then, must be reflected in the planning, design, implementation, and evaluation phases of such a complex undertaking.

This chapter will distinguish between the concepts of health promotion and health education and briefly examine the implications and impact of culture at these two overlapping levels. We will also provide an overview of culture, particularly as cultural differences affect HPDP efforts, and discuss current paradigms that have been proposed to improve practitioner skills in working in multicultural health care settings. Finally, we will describe potential barriers to effective multicultural HPDP efforts.

HEALTH PROMOTION AND DISEASE PREVENTION

The terms *health promotion* and *disease prevention*, when used in this text, encompass

a similar range of interests and concerns as expressed long ago in the Joint Committee on Health Education Terminology (1991) report. The committee defined HPDP as “the aggregate of all purposeful activities designed to improve personal and public health through a combination of strategies, including the competent implementation of behavior change strategies, health education, health protection measures, risk factor detection, health enhancement, and health maintenance” (p. 102). Central to this conceptualization, it should be noted, is the need to achieve different levels of outcomes (e.g., individual, family, group, organization, community) through a combination of health promotion and health education strategies and intervention activities.

Another ageless definition of health promotion is “any planned combination of educational, political, regulatory, and organizational supports for actions and conditions of living conducive to the health of individuals, groups, or communities” (Green & Kreuter, 1991, p. 432). Explicit in this definition is the need for interventions that respond to a broad level of community concern relating to stimulating, establishing, and sustaining an appropriate combination of educational, organizational, and political support needed to facilitate actions aimed at achieving desired community health outcomes. These definitions of health promotion provided above serve the purpose of this text well because they are valid in today’s context; they are succinct, readily understandable, multidimensional; and they focus on the reality and need for several different levels of specific and needed program activities and outcomes (e.g., individual, family, group, organization, community) in HPDP program planning.

Health education has been defined as “any planned combination of learning experiences designed to predispose, enable, and reinforce voluntary behavior conducive to health in individuals, groups, or communities” (Green & Kreuter, 1991, p. 432). Intervention efforts

from this particular vantage point concentrate on facilitating the voluntary acquisition of specific health-related knowledge, attitudes, and practices associated with achieving specific health-related behavior changes. Health education is mentioned here because health promotion emerged out of health education and designates a broader level of outcome than does health education. However, health education is considered a primary instrumentality for achieving health promotion outcomes. For example, the focus of health education interventions in a cervical cancer education and screening program targeting African-American women living in a specific geographical area may be concerned with making educational programs more available and accessible to this group. Such programs can enable the target group to develop skills for carrying out defined voluntary screening behaviors related to reducing the risk of this life-threatening disease. However, the planning of interventions and related activities at this level, then, usually focus on reaching only one target group among the many possible groups of women at risk and in need of specified educational programs. On the other hand, the planning of strategies and interventions at the health promotion level goes beyond a single cervical cancer education program focus. For example, interventions may focus on the need to establish and sustain a more accessible and equitably distributed system of women’s health screening and education programs for enhancing the overall health of all poor and underserved women in that particular community. The complexity of health promotion program efforts requires a greater scope of coordination, participation, commitment, and expense than does the cervical cancer education and screening aimed at a single target group. Indeed, many community participants representing a diversity of public, private, and voluntary agencies, organizations, and institutions will need to be involved in this endeavor.

Health promotion efforts also may be conducted at a broader community level and may seek health and health-related behavior changes or social outcomes through ecological or environmental approaches intended to result in permanent structural changes or supports in the form of policies, regulations, and expanded access to resources affecting people where they work and live (Green & Kreuter, 1991, 2005; Green, Richard, & Potvin, 1996; McLeroy, Bibeau, Steckler, & Glanz, 1988; Richard, Potvin, Kischuk, Prlic, & Green, 1996).

It is seen, then, at one level, health education programs, for example, might concentrate on facilitating the voluntary acquisition of specific health-related knowledge, attitudes, and practices for reducing the specific target group's health risk for certain chronic or communicable diseases. It is important to recognize that interventions designed to achieve change on only the individual level will not be as effective as those that can achieve broader change on the community level. Thus, program efforts at other levels (i.e., the health promotion level) may seek social or environmental changes (supportive structures) for reducing population health risk. These changes are in the form of new risk-reducing policies, laws, and regulations and new or increased organizational or structural arrangements that encourage, enable, and reinforce the acquisition and practice of certain health-related behaviors (Green & Kreuter, 1991, 2005).

HPDP programs, through their assessment and diagnosis processes of community needs (discussed in Chapters 6 and 7 of this volume), must be able to identify at-risk target groups in the community and specifically the kinds of *disease prevention* efforts (by particular target group) that need to be included in their health promotion activities. The following identifies the specific focus and types of activities generally conducted under the different levels of *disease prevention*:

(1) the *primary prevention level* (providing specific protection that prevents the onset of the disease itself or reduces exposure or risk levels to the disease processes, e.g., immunizations against a variety of childhood diseases, disease screening, smoking prevention and cessation programs, HIV/AIDS education and screening programs); (2) the *secondary prevention level* (providing activities related to early diagnosis and prompt treatment of a disease that is already present, (e.g., syphilis, HIV/AIDS, gonorrhea, diabetes, cervical cancer); and (3) the *tertiary level of prevention* (activities implemented through treatment and rehabilitation efforts to minimize disability after the damage has been done from existing illness (e.g., alcoholism, diabetes, cirrhosis of the liver, chronic obstructive pulmonary disorder, emphysema, high blood pressure) (Turnock, 2001).

Finally, the focus of all HPDP efforts must of necessity include an awareness and sensitivity to culture and the many cultural differences reflected in the population to be targeted. And within their own cultural milieu, all planning participants (e.g., planners and community participants) need to recognize that any HPDP interventions contemplated must consider the personal experiences, knowledge, health practices, and problem-solving methodologies that are acceptable within the framework of the individual, group, or community to be targeted.

HEALTH PROMOTION AND CULTURE

Promoting health and preventing disease is a challenging goal that, to many, might seem straightforward, logical, and highly scientific. After all, we know about germ theory, diseases of lifestyle, medications, radiation, surgery, and other Western approaches to preventing and/or diagnosing and treating health problems in the general population. However, this process is not always what it seems. Indeed, there are many different ways of perceiving,

understanding, and approaching health and disease processes across cultural and ethnic groups with which health practitioners need to become better acquainted.

Cultural differences can and do present major barriers to effective health care intervention. This is especially true when health practitioners overlook, misinterpret, stereotype, or otherwise mishandle their encounters with those who might be viewed as different from them in their assessment, intervention, and evaluation-planning processes.

There is not a day that goes by that we are not exposed to a variety of sights, sounds, and tastes reflecting influences coming at us from a multitude of sources including the news media, our work settings and contacts in the community, and the foods we choose to eat. From these, we form opinions, make judgments, and take actions perceived to be appropriate to the situation and setting in which we find ourselves. When these choices involve our efforts to improve the health of the many “publics” we encounter in our health care roles, our perceptions of how these publics relate to and respond to our efforts may be colored by our own ethnocentric views of the world. In turn, our publics may view us in a similar manner. That is, whereas we might view a client as delusional if the individual comes to us for help and tells us he or she has been seeing a traditional folk healer because they believe someone has put a “hex” on him or her, that client might view us as ignorant and inexperienced when we offer him or her counseling and medication as the treatment for the problem. In both cases, cultural beliefs and practices born out of years of enculturation and socialization in divergent worldviews have gotten in the way of the communication and treatment possibilities.

Brislin and Yoshida (1994) note that health care professionals’ lack of knowledge about health beliefs and practices of culturally diverse groups and problems in intercultural

communication has led to significant challenges in the provision of health care services to multicultural population groups. They also observed that the cultural diversity of the health care workforce itself could present problems that can disrupt the provision of services because of competing cultural values, beliefs, norms, and health practices in conflict with the traditional Western medical model. For example, Putsch (1985) describes a situation in which an elderly Navaho patient with a mild senile dementia has returned for an outpatient visit after several long hospitalizations. He greets his physician in Navaho, shakes hands, and embraces him. He then turns to greet the nurse’s aide, who will act as an interpreter, and extends his hand to her. She flees from the room visibly frightened. When later questioned about her behavior, she relates that she had been warned by her mother never to shake hands with gray-haired people because they might “witch you.” She also noted that she knew about this man through her husband’s family and that he was “no good” (p. 3346). In exploring cultural differences in more detail, a discussion of what we mean by *culture*, *ethnicity*, *acculturation*, and other related terms will help set the scene for how these may affect our ability to assess, plan, implement, and evaluate HPDP programs for a variety of multicultural population groups.

CULTURE

The term *culture* has been defined in many ways over the years and continues to be a concept that is hotly debated among anthropologists even today. In 1871, E. B. Tylor defined culture as “that complex whole which includes knowledge, belief, art, morals, law, custom and any other capabilities and habits acquired by man as a member of society” (quoted in Bock, 1969, p. 17). Stein and Rowe (1989) define culture as “learned, nonrandom, systematic behavior that is transmitted from

person to person and from generation to generation” (p. 4). Kagawa-Singer and Chung (1994) describe culture as “a tool which defines reality for its members” (p. 198) and note that within this perception of reality, the individual’s purpose in life emerges through a process of socialization in which he or she learns the appropriate beliefs, values, and behaviors shared by society. Thus, culture is seen as both integrative and functional in that the beliefs and values transmitted to the individual provide a sense of identity as well as the rules the individual must follow to enable his or her culture to survive over time (Kagawa-Singer & Kho, Chapter 12, this volume; Tseng & Streltzer, 2008). Kagawa-Singer (2012) also notes that it is unclear what the actual contribution of culture is to health outcomes and that “culture is rarely defined or appropriately measured” (p. 356). She suggests that, for researchers working with diverse population groups, better operationalizing what they mean by the term will lead to more scientifically relevant and better results for the communities they are studying.

Slonim (1991) identifies five basic criteria for defining a culture: having a common pattern of communication, sound system, or language unique to the group; similarities in dietary preferences and preparation methods; common patterns of dress; predictable relationship and socialization patterns between members of the culture; and a common set of shared values and beliefs. No matter how it may be defined, culture can be seen as a dynamic template or framework a society uses to view, understand, behave, and pass on its culture to each succeeding generation. Culture helps specify what behaviors are acceptable in any given society, when they are acceptable, and what is not acceptable. It also provides some guidance for dealing with the basic problems of life (Rani, 2007). Anderson and Fenichel (1989) caution, however, that this cultural framework is only a set of tendencies or possibilities for behavior, and individuals

within any given society are essentially free to choose from all the available possibilities within this frame.

What do the above issues have to do with HPDP? Consider, if you will, what possible barriers one might encounter if he or she were designing a health program for a community primarily composed of first-generation Hmong who were recent immigrants to the United States. Certainly, language could be a problem, but so too could the many cultural differences at nearly every level, from the basic nuances of communication to the significant differences in their worldview of what constitutes health and disease, from cause and prevention to treatment and cure. In fact, the Hmong health belief system is primarily based on the supernatural, and much of their traditional treatment is based on spiritual appeasement (Brainard & Zaharlick, 1989; Fadiman, 1997; Kalantari, 2012). A failure to understand and appreciate these “differences” would have serious implications for the success of any HPDP effort. Even with this caveat, we must also recognize that culture groups are fluid, dynamic, and change over time in response to the environments they exist in. Thus, first generation peoples will differ from second, and second from third and so forth. This makes it imperative that health promoters/health care practitioners carefully assess before designing interventions or treatments in order to ensure that what they do is effective, relevant, and appropriate to those they are working with.

ETHNICITY

Ethnicity relates to the sense of identity an individual has based on common ancestry, national, religious, tribal, linguistic, or cultural origins. It generally implies that there are shared values, lifestyles, beliefs, and norms among those claiming affiliation to a specific ethnic group (Henderson, Spigner-Littles, & Milhouse, 2006; Nunnally & Moy, 1989;

Office of Minority Health, 2001; Paniagua, 1994; Spector, 2013). Ethnic identity provides a sense of social belonging and loyalty for the individual and often is used by others outside the ethnic group to identify or label “difference” (Kagawa-Singer & Chung, 1994; Kagawa-Singer & Kho, Chapter 12, this volume). Unfortunately, ethnicity also is used to stereotype diversity in human populations and frequently leads to misunderstanding and/or distrust in all sorts of human interactions. In fact, the use of an ethnic label by someone outside the ethnic group may lead to a partial or complete shutdown of the learning curve for both parties in this process. For example, it can be seen that once the stereotype has been identified, one or both parties often cease to look beyond the stereotype to find out who each really is.

Slonim (1991) distinguishes between culture and ethnicity but notes that they tend to overlap with respect to how they are defined and used. She notes that culture is concerned with symbolic generalities and universals about social and family groups, whereas ethnicity is concerned with one’s sense of identification and belonging to a specific reference group within any given society. Ethnicity, then, helps shape the way we think, relate, feel, and behave within and outside our reference group and defines the patterns of behavior that provide an individual with a sense of belonging and continuity with his or her ethnic group over time.

Ethnicity is a word that often is used in the same breath as the term *race*. It is important, however, not to confuse ethnicity with race, the latter of which is a biological term used to describe ethnic groups on the basis of physical characteristics such as skin color or shape of the eyes, nose, and mouth (Helman, 2007; Montague, 1964; Rani, 2007; Tseng & Streltzer, 2008). Nelson and Jurmain (1988) note that *race* is an ancient concept that in more recent times has been used by scientists to place human populations into “racial”

categories for purposes of classification. This form of classification, although convenient, ignores the issue of genetics, which is concerned with heredity and biological variation in all living things. Nelson and Jurmain regard the term *race* as a sociocultural concept rather than a biological one. Thus, people often are classified along racial lines regardless of their genetic traits, and these racial categories have long been used as a basis for promoting discrimination, hatred, and divisiveness among human groups all around the world. Disreali (1849) commented that “The difference of race is one of the reasons why I fear war may always exist; because race implies difference, difference implies superiority, and superiority leads to predominance” (The Quotations Page, 2013). In this book, the term *race* is not used to describe the various multicultural groups discussed. The exceptions are where contributors are reporting epidemiological data presented by federal, state, or local health agencies that gather and report health statistics using race as a variable. The editors prefer the terms *ethnic*, *multicultural*, and *culturally diverse*. They believe that these terms reflect a more accurate description of human populations. For the health practitioner, reframing the term *race* to *multicultural*, *ethnic*, or *culturally diverse* may serve to promote a greater sensitivity to the challenges, potentialities, and rewards of working with diverse cultural groups in HPDP activities.

ACCULTURATION AND ASSIMILATION

Acculturation is a term used to describe the degree to which an individual from one culture has given up the traits of that culture and adopted the traits of the dominant culture in which he or she now resides (Celenk & Van de Vijver, 2011; LaFromboise, Albright, & Harris, 2010; Lazarevic, Pleck, & Wiley, 2012; Wallace, Pomery, Latimer, Martinez, & Salovey, 2009). Locke (1992) identifies four levels of acculturation: the “bicultural”

individual, who can function equally well in his or her own culture and the dominant culture; the “traditional” individual, who holds on to most, if not all, of his or her traits from his culture of origin; the “marginal” individual, who seems not to have any real contact with traits from either culture; and the “acculturated” individual, who has given up most of his or her traits of origin for those of the dominant culture. Locke notes the importance of assessing the degree of acculturation when working in a multicultural setting, as there is a natural tendency on the part of many culturally diverse individuals to resist acculturation. This resistance can lead to significant misunderstandings and the inability to establish meaningful and mutually beneficial working relationships between the health care practitioner and those he or she may be seeking to help or influence. An example might be the practitioner who encounters a Latina mother with a newborn who feels that the child is ill because of the *mal de ojo* (evil eye), that is, the belief that a sudden change in the emotional or physical health of an infant or young child is caused by the jealousy (or admiration) of a person with powerful eyes (de Paula, Lagana, & Gonzales-Ramirez, 1996). A failure to recognize the significance of this problem for the patient, and the prescribing of a treatment that seems out of order in the mind of the mother, might result in her not following through or even engaging in an active way in the clinical encounter.

Enculturation is a similar process as acculturation yet is also different. While acculturation is concerned with taking on the traits of a new culture one has moved into, enculturation has to do with learning and practicing the culture one is born into. That is, the language, behaviors, food practices, religion, dress, social and gender roles, and other values, beliefs, and mores of the family and society in which they are reared. Of importance here also, is that a child undergoing enculturation within his or her family will

also be undergoing acculturative forces from outside the family. This can, and often does, lead to a culture clash between the child and his or her parents and other relatives.

Assimilation is a closely related process to acculturation and is viewed as the social, economic, and political integration of a cultural group into a mainstream society to which it may have emigrated or otherwise been drawn (Casas & Casas, 1994). Generally, for assimilation to occur, there must be at least some minimal acculturation with respect to the language, values, laws, customs, and other major features of the dominant society. As Locke (1992) notes, however, there may be a genuine resistance and rejection of many of the values of the dominant culture with only a minimal level of cultural assimilation into mainstream society. Like acculturation, then, the level of an ethnically diverse client's assimilation into mainstream society might need to be assessed by the health practitioner to better understand and perhaps predict how well that person will accept and/or participate in HPDP recommendations and behaviors. One has only to pay a visit to areas of his or her city where recent immigrants have settled or where there is a long-established but insular population characterized by the maintenance of the culture-of-origin behaviors, including language, customs, food practices, and other social conventions that keeps its members isolated from mainstream society.

ASSESSMENT OF ACCULTURATION

The measurement of acculturation levels in the clinical setting has been the focus of a number of investigators studying a diversity of multicultural groups (Celenk & Van de Vijver, 2011; Cuellar, Harris, & Jasso, 1980; Hoffman, Dana, & Bolton, 1985; Lazarevic et al., 2012; Mendoza, 1989; Milliones, 1980; M. Ramirez, 1984; Smither & Rodriguez-Giegling, 1982; Suinn, Rickard-Figueroa, Lew, & Vigil, 1987). Paniagua (1994) comments

on the variety of acculturation scales that can be used, depending on the ethnic group in which one is interested, and describes the Brief Acculturation Scale suggested by Burnam, Hough, Karno, Escobar, and Telles (1987). This scale uses three variables: generation in the United States, preferred language, and preferences for whom the individual most often socializes with. The assumptions underlying these variables hold that (a) the longer the individual is exposed to the dominant culture or the younger the individual is at the time he or she enters this culture, the more the individual communicates in the language of the dominant culture and (b) the more the individual socializes outside his or her primary cultural group, the more acculturated the individual is likely to become within the dominant society.

In general, assessment of acculturation has been used in clinical research settings rather than in HPDP programs, but this has been changing in recent years as researchers and interventionists look more closely at the effects of acculturation on other variables influencing HPDP activities (Abraido-Lanza, Armbrister, Florez, & Aguirre, 2006; Clark & Hofsess, 1998; Dolhun, Munoz, & Grumbach, 2003; LaFromboise et al., 2010; Rojas-Guyler, Ellis, & Sanders, 2005; Wallace et al., 2010). Incorporating assessment of acculturation in the formative stages of HPDP program planning could prove quite valuable to the practitioner. For example, A. G. Ramirez, Cousins, Santos, and Supic (1986) devised and tested a four-item Media Acculturation Scale (MAS) for use with Mexican Americans that focused on media and language preferences and were able to demonstrate that the instrument could identify subsets of their study group by their distinct media usage patterns and demographic characteristics. The ability to identify specific target group media preferences and sources is a much more efficacious way to reach one's audience than guessing at them and expending resources that might have little payoff. Marin

and Gamba (1996) developed and validated a Bidimensional Acculturation Scale (BAS) for use with Hispanics that they note works very well with Mexican Americans and Central Americans. They argue that acculturation is bidirectional in that as the individual is learning and taking on characteristics of the new culture (acculturation), the individual is simultaneously doing the same within his or her culture of origin (enculturation). Marin and Gamba note that understanding this process can help the practitioner be more aware of what Hispanics go through as they acculturate. It also would seem that the practitioner who is aware of where his or her target group is with respect to acculturation might be better able to tailor interventions that integrate health-promoting strategies into the learning that is occurring in both the culture of origin and the new culture as that acculturation process proceeds.

Although acculturation scales have been primarily used in research and clinical settings, what seems clear is that these scales have the potential to be included within needs assessment instruments used in the early stages of program plan development. For example, Castro, Cota, and Vega (1999) present a scale that they have found quite useful in a variety of settings working with Hispanics in health-promoting efforts. Thus, the use of acculturation scales for HPDP activities represents a relatively new and innovative tool the practitioner can employ to better understand the culturally diverse population groups with which he or she may be working.

ETHNOCENTRISM

Ethnocentrism is a concept that often plays a part in confusing an already difficult situation when working with ethnically diverse individuals or cultural groups. Ferguson and Browne (1991) describe ethnocentrism as the assumption an individual makes that his or her way of believing and behaving is the

most preferable and correct one. She notes that often the health practitioner is unaware of his or her own ethnocentric behavior and that this can lead to dysfunctional treatment encounters. Leddy (2003) terms this behavior *medicocentrism*, that is, “the bias produced by viewing health through the lens of medicine as it is currently found in modern society” (p. 100). Rani (2007) notes that cultural bias in combination with ethnocentrism can lead us to not being able to see alternative viewpoints. For example, the practitioner/health promoter may directly or indirectly discount or ignore the client’s cultural orientation and belief system, considering them unimportant, incorrect, or in conflict with their own perceptions or worldview of how best to treat the client’s health problem or issue. This can leave the client feeling angry, frustrated, and uncooperative. Of equal importance is the awareness that whereas health care practitioners/health promoters may be caught in their own ethnocentric dance, so too may be the culturally diverse client they are serving. That is, the culturally diverse client may view the health professional as foreign, ignorant of illness or disease causality, or uneducated to proper social customs, forms of address, and nonverbal behaviors deemed appropriate by the client for dealing directly or indirectly with his or her health problem or concern. For example, Kramer (1992) notes that Native American elders find such behaviors as getting right down to business; speaking to strangers in loud, confident tones; and frequently interrupting the speaker as intolerably rude. This, in turn, may lead to the withholding of important information the health professional needs for an accurate assessment and intervention plan.

One can argue, then, that there is a need for both the health professional/health promoter and the culturally diverse client to develop a modicum of cultural sensitivity and cultural competence with respect to each other’s values, beliefs, and health practices. This would

be a major step forward in achieving a more balanced and respectful partnership in any health-related encounter.

CULTURAL COMPETENCE AND ETHNOSENSITIVITY

There is a large body of literature emerging from the social, behavioral, and health sciences promoting a philosophy of cross-cultural competence to which all persons working with multicultural groups should subscribe. Cross, Bazron, Dennis, and Isaacs (1989), examining how health care agencies serve culturally diverse clients, view the process of cultural competence among these agencies on a continuum ranging from “culturally destructive” to “culturally competent.” On this continuum, agencies that provide health care services may be seen as moving through a number of phases as they become increasingly more aware of how it is that they serve culturally diverse groups. Agencies that do not consider that culture is an important factor when delivering services can be seen as “culture blind,” whereas agencies that accept, respect, and work with cultural differences can be seen as being “culturally competent.”

Campinha-Bacote (1994) defines cultural competence as “a process for effectively working within the cultural context of an individual or community from a diverse cultural or ethnic background” (pp. 1–2). She proposed a Culturally Competent Model of Health Care, which encompassed four levels: Cultural Awareness, Cultural Knowledge, Cultural Skill, and Cultural Encounter. Cultural Awareness is concerned with the process of becoming more sensitive to differences manifest in culturally diverse clients and of the health professional’s own biases and prejudices toward different cultural groups. Cultural Knowledge is the process of gaining an understanding of different cultural groups, including their beliefs, values, lifestyle practices, and ways of solving problems in their

world. Cultural Skill is concerned with the process of cultural assessment as the first step in designing treatment interventions for culturally diverse clients. Through this process, the practitioner seeks to identify his or her client's specific values, beliefs, and practices in an effort to include these in the planning of a mutually acceptable treatment plan. Cultural Encounter is the last stage of the model and is the process of directly relating to culturally diverse groups in an effort to refine one's knowledge and skills for working in culturally diverse settings. The model reflects a process that is ongoing in that the health professional always should be on a continuous quest to increase and improve his or her abilities to work in a variety of cross-cultural settings. Kachingwe and Huff (Chapter 3, this volume) note that cultural competence must of necessity also include an understanding of cultural ethics and a conviction that an understanding of culture and its inclusion in any HPDP intervention is a critical element in effective and appropriate multicultural encounters whether at the clinical or community levels. Betancourt, Green, Carrillo, and Ananeh-Firempong (2003), in a review of the literature on cultural competence in health care, proposed a new framework for cultural competence that included *organizational cultural competence*, *structural cultural competence*, and *clinical cultural competence*. At the organizational level, they note the need for a diverse work force at all levels that is representative of the populations being served by an agency. At the structural level, they note that the health care delivery system must guarantee quality care and full access to all who come seeking care. At the clinical level, they feel that there must be serious efforts to educate and provide the tools and that skills providers need to better understand and work with the diverse sociocultural factors impacting the health beliefs and practices of the clients they serve.

In concert with cultural competence is the concept of *ethnosensitivity*, which is concerned

with the process of becoming more sensitive and respectful of cross-cultural differences. Borkan and Neher (1991) describe a Developmental Model of Ethnosensitivity, which can be used to help train physicians to improve their cross-cultural communication and practice skills. Their model proposes a seven-stage developmental continuum that can be used to assess a health care provider's ethnosensitivity. These stages range from fear or mistrust of different cultural groups, denial of cultural differences, feelings of superiority over other cultural groups, minimization of cultural differences, cultural relativism (acceptance and respect for differences), empathy, and cultural integration in which the practitioner becomes a multicultural person able to relate well to several different cultural groups. For example, once the developmental stage is identified, specific interventions can be tailored to help the physician move forward in the learning process. This is only one of a number of models being used in medical school and hospital-based training programs that hold promise for improving the cross-cultural skills of health care providers (Dolhun et al., 2003; Purnell & Paulanka, 2008; Spector, 2013). For those interested readers, the following brief exercise is offered as a way to begin looking at one's own ethnosensitivities. Consider the last time you saw or interacted with someone you categorized as representing a particular ethnic group. How did you come to categorize that individual as representing a particular ethnic group? How have you come to your knowledge of the specific characteristics you employed to categorize that individual? How accurate do you think these characteristics are with respect to that specific individual? What do you actually know or not know about that specific individual in terms of his or her cultural heritage, lifestyle, and the like? What more did you seek to learn about that individual? How would you feel knowing that others may be categorizing you in similar ways? Your honest answers to these questions may provide

a better understanding about how easy it is to stereotype or otherwise categorize people whom you know little. Often, these categorizations are quite inaccurate and insensitive. As noted earlier, once they are employed, they generally decrease one's interest in learning much more about a particular individual or group.

The need to develop an awareness of one's own interpersonal and communication style is of equal importance in becoming competent and sensitive to cultural differences. These areas have been identified by a number of investigators as potential barriers to working with culturally diverse population groups (Helman, 2007; Luckmann, 1999; Spector, 2013). Bell and Evans (1981) discuss the need for the practitioner to become aware of the interpersonal style he or she is operating from when dealing with persons from other cultures. They note five interpersonal styles: overt hostility, covert prejudice, cultural ignorance, color blindness, and cultural liberation. The first four of these styles fail to respect or openly consider cultural differences in the health care consultation, whereas cultural liberation reflects a lack of fear of cultural differences, awareness of one's own attitudes toward different cultural groups, acceptance of and encouragement of client expressions regarding his or her feelings about their ethnicity, and the ability to use these feelings as shared learning experiences.

It is easy for practitioners to quote models and recommendations, and even easier to pay lip service to their value in becoming more culturally competent and sensitive. However, if practitioners are to improve their skills in these areas, then they must be willing to step out of their current frames of reference and take the risk of discovering their own biases and stereotypes, thus opening themselves up to new and perhaps quite divergent points of view about the world in which they live. In taking these steps, practitioners will also need

to consider the challenge of learning to more effectively communicate across cultures.

CROSS-CULTURAL COMMUNICATION

Brislin and Yoshida (1994) comment that the typical Western medical model for communication in the health care encounter is the direct question-and-answer method, which seeks to quickly establish the facts of the case and often relies on the use of negative and double negative questions, for example, "You don't want to get heart disease, do you?" For the culturally diverse individual (or family), this approach to the communication process may be seen as cold and too direct or otherwise in conflict with his or her more traditional beliefs, values, and ways of seeking, communicating, and receiving health care. For example, Kramer (1992) notes that there are significant differences in how Native Americans perceive the initial visit with a health care provider. They might expect the initial visit to begin with a brief, light handshake rather than the typical firm handshake of the Westerner, which is seen as a sign of aggressiveness. Furthermore, behaviors such as staring, excessive eye contact, and direct questioning are considered rude and an invasion of privacy and dignity.

Northouse and Northouse (1992) and others (Dainton & Zelle, 2005; Rothwell, 2004) have defined communication as a process of information sharing in which those involved in the communication share a common set of rules. These rules may prescribe how the communication will take place, through what channels, when it will occur, and even how feedback may or may not be provided between the message communicator and the message receiver. For example, in a traditional Japanese family, it is often the head of the household who will be the primary individual communicating with the health care practitioner in the event a family member needs medical care. Likewise, the head of the household is the one who will make the

decisions about treatment options and even what the ill family member should be told about his or her medical condition. Northouse and Northouse further divide communication into two subsets: human communication and health communication. Human communication relates to the interactions between and among people through the use of common symbols and language. Health communication is human communication primarily concerned with health-related interactions and processes. Here, the common symbols and language may be obscured by special professional jargon, including the use of medical terms to describe the condition and treatment options available to a client or patient. All these communication processes are dynamic, ongoing, and ever-changing transactions that involve human feelings, attitudes, knowledge, and behavior. Thus, in an interaction between two or more individuals representing divergent cultural orientations and where different rules may govern the communication process, the opportunity for miscommunication is significant.

A review of the many models of interpersonal communication advanced over the past 40 to 50 years suggest that there are a variety of factors affecting communication in general and in cross-cultural encounters specifically. These factors include the communication skills, attitudes, knowledge, social systems, and culture of both the sender and the receiver of communication transactions; the framing of the communication with respect to structure, content, and coding; the communication channel that will involve one or more of the five senses; "noise," which refers to auditory, perceptual, or psychological factors that can affect and influence the communication anywhere along the channel; and feedback mechanisms, which ensure that all parties to the communication transaction heard and understood the communication as it was intended. In addition, human interaction factors including dominance-submission or love-hate relationships, communication

transactions, and the contexts in which they occur have all been identified as important to understanding and improving the communication process (Brislin & Yoshida, 1994; Dainton & Zelle, 2005; Kreps & Kunimoto, 1994; Northouse & Northouse, 1992; Rothwell, 2004). Given the incredible diversity of multicultural populations in the world today, the potential for miscommunication in any human encounter is staggering.

For the health professional seeking to develop an increased sense of cultural competence and sensitivity as well as improved communication skills, the task might seem daunting. However, patience and persistence are the keys to unlocking these skills, and many recommendations have been posited in the literature for improving the entire cross-cultural experience in health care. Among these are a series of recommendations made by Kreps and Kunimoto (1994). They urge health professionals to develop a genuine interest in and respect for cultural differences, including the development of communication attitudes and skills that demonstrate an appreciation for and sensitivity to cultural differences. This process can begin by reading about other cultural groups, learning a new language, attending multicultural events, or spending time in communities representative of the cultural or ethnic group of interest. Kreps and Kunimoto also recommend that health professionals become aware of the many different interpretations of reality that exist in the world, especially where health and health care issues are concerned. Here again, a patient's interpretation of what might be causing his or her problem (e.g., a witch, ghost, fate) might run totally counter to what the health care professional thinks is going on. Reading about different cultures and talking with willing members of the group of interest can provide valuable insights into these multiple realities. Finally, the practitioner should be ready and willing to endure uncertainty and discomfort when working in cross-cultural

health care settings. It is, after all, those times we are most uncomfortable that we have the greatest opportunity for learning and growth. We just have to be open to that possibility. Along with the need for better cross-cultural communication skills is the need to understand the concept of *health literacy*. It is concerned with how well the client/patient/community understands, processes, and is able to utilize health information, be it verbal or written, and includes numeracy skills and speaking and listening skills needed to make informed health decisions (Sheridan et al., 2012). Chapter 8 provides a discussion of health communication and health literacy that will elaborate in much more detail the issues involved in cross-cultural communication and health literacy with multicultural population groups.

BARRIERS TO MULTICULTURAL HPDP

As it will no doubt be evident to the reader by this time, there are a multitude of factors that can act as barriers or impediments to successful HPDP efforts. For purposes of this discussion, a *barrier* is defined as any obstacle that might interfere with the ability of the health practitioner or his or her culturally diverse client (to whom they are intending to provide interventions) to be able to fully achieve the intended assessment, intervention, and/or evaluation objectives. The range of potential barriers is extensive and not necessarily easily categorized, though some attempt will be made here to cluster some of these variables for purposes of discussion. Table 1.1 presents a partial listing of demographic, cultural, and health care systems barriers that have been identified in the literature as having the potential to impede HPDP efforts.

As can be seen in Table 1.1, there are a variety of demographic factors that can play a role in impeding multicultural health-promoting efforts, and no doubt the reader can add many more items to this list. It is

important to recognize that many of the barriers identified heretofore will be mediated by the degree of acculturation and assimilation of the client being targeted for health promotion interventions, and it is incumbent on the health practitioner to assess these levels before implementing programs. Although many of these barriers are fairly self-explanatory, a quick look at several of these might help highlight the importance of demographics when working with or planning health promotion programs and services for the culturally diverse. For example, gender may become an issue when seeking to provide health promotion services such as screening mammography. Mo (1992) described the problems that arose in providing this type of service to Chinese women and noted that cultural values associated with modesty and sexuality, coupled with institutional barriers such as the unavailability of educational materials written in Chinese, along with a lack of female physicians played a significant role in the low number of women in her study who accessed breast health services. Ohmans, Garrett, and Treichel (1996) recognize that social class can be a significant barrier, particularly for new immigrants where their social status or class distinction may have been radically altered since leaving their country of origin. They caution that we should be particularly careful with health education and not assume that immigrant or refugee status equates with poverty or lack of education. Kramer (1992) comments that older Native Americans report a fear of non-Native American health professionals, expect to be treated unfairly by them, and anticipate negative contact experiences when they do encounter these health professionals. Uba (1992) reports that many Southeast Asians have difficulties in accessing health care services (even if they know about them) because of language difficulties associated with making appointments or even understanding the process. Furthermore, they often lack health insurance benefits because

many of these people are poor and are working in low-paying jobs. Stevens, Cousineau, and Vane (Chapter 5, this volume) present an extensive discussion of health disparities and barriers to access that the reader is encouraged to review. Geographic factors including a lack of hospitals or private physician offices in their communities, as well as difficulties in accessing public transportation or getting a driver's license, also complicate their access problems. By now the reader may have noticed how these demographic factors cross over into the other categories identified in Table 1.1. There are, in fact, many gray areas to be considered when looking at barriers, and this makes the process that much more difficult to understand.

Cultural barriers include a number of factors of importance to the HPDP process. Like the demographic barriers, some of these seem readily understandable whereas others need clarification. For example, Uba (1992) notes that many Southeast Asians are reluctant to seek health care services because of their attitudes regarding the nature of life and the inevitability of suffering. She comments that suffering and illness are seen as an unavoidable part of life, so seeking health care services early may be considered inappropriate. She cites the Hmong as an example of a cultural group who believe that life is predetermined, so lifesaving medical intervention is worthless (see Fadiman, 1997). With respect to communication patterns and customs, Ramakrishna

Table 1.1 Potential Barriers to Health Promotion and Disease Prevention

<i>Demographic Barrier</i>	<i>Cultural Barrier</i>	<i>Health Care System Barrier</i>
Age	Age	Access to care
Gender	Gender, class, and family dynamics	Insurance or other financial resources
Ethnicity	Worldview/perceptions of life	Not always valued as useful
Primary language spoken	Time orientation	Orientation to preventive health services
Religion	Primary language spoken	Perceptions of need for health care services
Educational level and literacy level	Religious beliefs and practices	Ignorance and/or distrust of Western medical practices and procedures
Occupation, income, and health insurance	Social customs, values, and norms	Cultural insensitivity and competence
Area of residence	Traditional health beliefs and practices	Western vs. folk health beliefs and practices
Transportation	Dietary preferences and practices	Poor doctor-patient communications
Time and/or generation in the United States	Communication patterns and customs	Lack of bilingual and bicultural staff

and Weiss (1992) describe nonverbal communication patterns among East Indian patients where the patient may not know how to respond to the American physicians' social smiles or may use lateral motions of the head to indicate a positive affirmation. In India, smiles are only exchanged between social equals, and East Indians use head shaking to denote "yes" which might confuse a Western physician.

Health beliefs and practices are the subject of Chapter 2, but a few brief comments may be of value here. Uba (1992) and others (Erwin, n.d.; Fernandez, Lin, Leong-Wu, & Aday, 2009; Kagawa-Singer & Kho, Chapter 12, this volume) comment that many Southeast Asians view disease and illness etiology as arising from a variety of possible sources. These include organic problems, an imbalance between the yin and yang, an obstruction of *chi* (life energy), failure to be in harmony with nature, a curse from an offended spirit, or a punishment for immoral behavior. Riser and Mazur (1995) discuss folk illnesses among Hispanics and comment that the most common ailment in their study population was *mal ojo*. This folk illness was attributed to someone with "strong eyes" looking at a child (often unintentionally). The result of this "look" was felt to heat up the child's blood and lead to inconsolable crying, fever, diarrhea, vomiting, and gassy stomach. They also described *empacho*, a folk illness attributed to certain foods such as swallowed gum, grape skins, and poorly mixed powdered milk or formula that sticks in the intestines. Obviously, there are significant differences in perception of disease causality as well as treatment that must be understood and worked with if health-promoting efforts are to be effective. In addition, there are a variety of common yet divergent values among multicultural groups that the health promotion practitioner should consider in his or her practice efforts. For instance, in the Anglo-American world, competition, self-help, mastery over the

environment, a focus on time and the future, and materialism can be contrasted with other culture groups where cooperation, harmony with the environment, a past or present focus, fate, hierarchy, group welfare and community over individualism are the important values.

It is obvious that the practitioner engaged in health promotion efforts is likely to be confronted by any number of divergent viewpoints regarding the nature of life and social interaction. As May (1992) notes, this will require the practitioner to be flexible in his or her design of programs, policies, and services to meet the needs and concerns of the diverse cultural groups he or she is likely to encounter.

Health care system variables present yet another level of potential barriers that the health promotion practitioner will need to be aware of when working in multicultural contexts. As Table 1.1 demonstrates, access to health care services, insurance or financial resources, and other demographics play a role in health care systems barriers; but as Mull (1993) comments, there are a number of other systems issues that need to be considered. For example, the concept of preventive health is not one that is well known or understood among peoples from developing countries. Although they may know about immunization, the rationale for Pap smears, mammography, and other screening procedures might elude them. In fact, they may not even perceive that there is a need for preventive or other health care services unless more traditional methods of care have been found to be ineffective in dealing with a health issue or problem. Fear of Western medical procedures, including common practices such as drawing blood, can also present as a barrier. Among people from Third World countries, the fear of loss of blood is quite real. They believe that this blood cannot be replaced and will result in weakening the body. Uba (1992) notes that among Southeast Asians, such as rural Cambodians, there is a strong distrust of Western medicine that is often associated

with death. This attitude can be traced to accessing health care services late in the course of an illness often resulting in death at the point the patient enters the health care system for treatment. Uba also notes that services, such as dietary counseling, that discuss typical Western food choices will be considered irrelevant or inappropriate by many whose cultural or ethnic preferences conflict with the recommendations they may be given.

Given the number of potential barriers that may be encountered in HPDP efforts, what can be done to help overcome some of these impediments?

STRATEGIES TO OVERCOME BARRIERS

As noted in earlier sections of this chapter, improving one's cultural competence and sensitivity to differences can be a significant step forward in overcoming many of the problems that have been identified in this chapter. This includes learning about and practicing cross-cultural communication skills and adding questions to the usual assessment tools that seek to better understand the target group's orientation toward health, disease, and folk treatment practices; acculturation levels; and other related assessment items (see Chapter 6 for questions and strategies that can be incorporated into the assessment process). In addition, taking more time to explain Western concepts of health, disease, prevention, and treatment in terms that are culturally understandable and relevant to the target group, as well as seeking to learn those of the groups you are serving, designing and employing educational materials that are relevant and culturally appropriate to the target group, using well-trained bilingual/bicultural staff, employing indigenous health workers when working in and with diverse multicultural communities, and seeking ways to improve access to services for multicultural populations are but a few strategies that can be used to overcome barriers to HPDP efforts.

Chapter 2 will expand on some of the issues presented in this chapter as well as lay a foundation focused on traditional concepts of health and disease among a variety of multicultural populations discussed in this text.

CHAPTER SUMMARY

The United States often has been described as a melting pot in which immigrants arrive, become acculturated, and assimilate into American society and culture. As May (1992) points out, however, this blending is a very inaccurate and potentially destructive way to view American culture and society. A more accurate metaphor would be to view America as a rich and complex tapestry of colors, backgrounds, and interests. Having an understanding of this tapestry and its implications on health and disease patterns can enable the health promotion practitioner to be much more effective in reducing morbidity and mortality among the many multicultural population groups residing in the United States and elsewhere in the world.

This chapter has not sought to provide a comprehensive overview of culture; rather, it has sought to provide insights into the complex nature of culture with respect to the potential impact of cultural diversity on HPDP efforts. Culture was defined as a template or framework that a society uses to make sense of and to organize its world. A variety of terms including *acculturation*, *enculturation*, *assimilation*, *ethnocentrism*, *cultural competence*, *ethnosensitivity*, *cross-cultural communications*, and *health literacy* were defined and discussed to make overt the implications of these factors on HPDP practices. Barriers to promoting health among multicultural populations were described and a number of recommendations were made for improving the efficacy of health-promoting efforts when working with multicultural population groups.

Chapter 2 will expand on the concept of culture presented in this chapter and will focus on health-related cultural concepts as

defined by the “explanatory models” that different multicultural groups use to describe and make sense of health, illness, and disease. It will also include a brief discussion of health beliefs associated with traditional peoples living in the United States and elsewhere. This foundational information can help us to better understand the relationship of culture to health beliefs and practices in a variety of multicultural settings.

DISCUSSION QUESTIONS AND ACTIVITIES

1. Find a journal article that reports on a HPDP project and look for how terms related to working with diverse cultural groups are defined. What barriers to HPDP were reported, and how were these overcome? Report your findings to the class or write an abstract to be turned in to the course instructor.
2. Consider the family you were raised in. What values, traditions, languages, religious practices, and related ways of living were you enculturated to? How, if at all, did these ways of living conflict with the broader culture you were raised in? How did you compromise or otherwise adapt your family’s cultural traditions to those of the broader culture? Report your findings to the class or write a report to be turned in to the course instructor.

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