

An Introduction to Cuban Culture for Rehabilitation Service Providers

Alejandro Brice



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**Culture Brokering: Providing Culturally Competent
Rehabilitation Services to Foreign-Born Persons**

**An Introduction to Cuban Culture
for Rehabilitation Service Providers**

By Alejandro Brice, Ph.D., CCC-SLP

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Center for International Rehabilitation Research Information and Exchange

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Center for International Rehabilitation Research Information and Exchange
(CIRRIE)
515 Kimball Tower
State University of New York, University at Buffalo
Buffalo, NY 14214
Phone: (716) 829-3141 x 125
Fax: (716) 829-3217
E-mail: ub-cirrie@buffalo.edu
Web: <http://cirrie.buffalo.edu>

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AN INTRODUCTION TO CUBAN CULTURE FOR REHABILITATION SERVICE PROVIDERS

Preface

Cuba is one of the United States' closest neighbors, geographically, if not politically. Cuba has been a source of immigration to the U.S. over a long period of time. Currently, Cuba is one of the top ten countries of origin of foreign-born persons in the U.S.

Cuban-born persons in the U.S. arrived during different periods and for somewhat different reasons. Persons who came to the U.S. in the aftermath of the Castro-led revolution were often political refugees with professional careers. More recent arrivals may have come primarily for economic reasons. Second generation Cuban Americans are usually bi-lingual. Many first generation Cuban Americans speak limited English.

Rehabilitation providers who work with Cuban Americans may benefit from an introduction to the main themes and values of Cuban culture, especially as they relate to disability and rehabilitation. This monograph was written to provide such an introduction.

The author, Alejandro Brice, Ph.D., was born in Santiago, Cuba. He holds Bachelor's and Master's degrees in Speech and Language Pathology from the University of Florida and a Ph.D. in Instruction in Curriculum, with a major in Multicultural/Multilingual Education. He is currently an Associate Professor in the Department of Communicative Disorders at the University of Central Florida.

An earlier monograph in this series, *Culture Brokering: Providing Culturally Competent Rehabilitation Services to Foreign-Born Persons*¹, introduced several concepts that comprise different worldviews - individualism versus collectivism and monochronic versus polychronic time views. Dr. Brice applies these concepts, as well as low context versus high context communication, to contrast Cuban culture with the majority U.S. culture.

¹ Jezewski M.A. and Sotnik, P. 2001. *Culture Brokering: Providing Culturally Competent Rehabilitation Services to Foreign-Born Persons*, Buffalo, N.Y.: CIRRIE

This monograph on Cuban culture is part of a series developed by CIRRIE -- the Center for International Rehabilitation Research Information and Exchange -- at the University at Buffalo, State University of New York. The mission of CIRRIE is to facilitate the exchange of information and expertise between the U.S. and other countries in the field of rehabilitation. CIRRIE is supported by a grant from the National Institute on Disability and Rehabilitation Research of the U.S. Department of Education.

In addition to developing this monograph series, CIRRIE conducts workshops on providing rehabilitation services to foreign-born persons. We hope that this monograph will be useful to you in your work with persons born in Cuba. We welcome your comments that will help us to deepen our understanding of ways to increase the effectiveness of rehabilitation services for persons born in other countries.

*John H. Stone, Ph.D., Director,
Center for International Rehabilitation Research Information & Exchange (CIRRIE)
Series Editor*

AN INTRODUCTION TO CUBAN CULTURE FOR REHABILITATION SERVICE PROVIDERS

INTRODUCTION

Cuba is the largest island in the Antilles archipelago in the Caribbean. It is approximately 145 kilometers or 90 miles south of Key West, Florida. The total land area is approximately 110,860 square kilometers or 42,803 square miles, slightly bigger than Pennsylvania. Its climate is tropical, moderated by trade winds. The dry season is from November to April. The rainy season is from May to October. (World Atlas, 1991; World Factbook 2001)

In 2001, the Cuban population was estimated to be 11 million while, the U.S. population was estimated to be 278 million. By the year 2020, it is projected that the Cuban population will reach 12,795,000, while U.S. population may reach 294,364,000. Demographic and population health figures are presented in Table 1.

Table 1.
Demographics and Health: Comparison Between Cuba and the United States
(World Atlas, 1991; World Factbook 2001).

	Cuba	United States
Population	11,184, 023 (July, 2001 estimate)	278,058,881 (July, 2001 estimates)
Birth Rate	12.36 births /1,000 population (2001 estimate)	1.42 births /1,000 population (2001 estimate)
Death Rate	7.33 deaths/1,000 population (2001 estimate)	8.7 deaths/1,000 population (2001 estimate)
Infant Mortality Rate	7.39 deaths/1,000 live births	6.76 deaths/1,000 live births
Life Expectancy at Birth	76.41 years	77.26 years
Male Life Expectancy	74.02 years	74.37 years
Female Life Expectancy	78.94 years	80.05 years
Fertility Rate	1.6 children	2.06 children
HIV/AIDS Adult Prevalence Rate	0.03% (1999 estimates)	0.71% (1999 estimates)
HIV/AIDS People living with HIV/AIDS	1,950 (1999 estimates)	850,000 (1999 estimates)
HIV/AIDS Deaths	120 (1999 estimates)	20,000 (1999 estimates)

Physicians per 10,000 persons	19.1 per 10,000 persons (1991)	21.14 per 10,000 persons (1991)
Nurses per 10,000 persons	35.4 per 10,000 persons (1991)	137.2 per 10,000 persons (1991)
Literacy Rate	95.7%	97%
Ages of Compulsory Education	6 to 11 (1991)	6 to 16 (1991)
Educational Expenditure	18.4% of government expenditure (1991)	6.7% of U.S. GNP (1991)
Ethnic Divisions	Mulatto 51% White 37% Black 11% Chinese 1%	White 83.5% Black 12.4% Asian 3.3% Amerindian 0.8% (1992)
Religions	Roman Catholic 85% (prior to Castro assuming power; also present include: Protestants, Jehovah's Witnesses; Jewish, and Santería practitioners)	Protestant 56% Roman Catholic 28% Jewish 2% Other 4% None 10%

Cuba's main industries are tourism and agriculture. Agriculture consists mainly of sugar, citrus, tobacco and coffee; it is the world's largest sugar exporter. It also exports shellfish and nickel. Cuba's industries include sugar milling, petroleum refining, food and tobacco processing, textiles, chemicals, paper and wood products, metals (particularly nickel), cement, fertilizers and agricultural machinery. Eleven percent of Cuba's gross national product (GNP) is comprised of fishing and forestry. It should be noted that Cuba is not self-sufficient in food production.

HEALTH AND REHABILITATION SERVICES IN CUBA

Cuba was once said to have had the best health care among all Latin American countries, in spite of its economic hardships (Cardelle, 1994). However, Cuba's health care has declined since 1992. Since 1960, health care in Cuba has been the government's top priority (Strum, 2001; Warman, 2001). Throughout the 1970s and 1980s, Cuba's leader, Fidel Castro, pledged to make the nation a medical superpower (Strum, 2001). Thus, the high quality of care of health care during those times was widely acknowledged. Cuba, when compared to the United States, boasted comparable statistics in terms of life expectancy, infant mortality, and literacy rates. Even today Cuba boasts a ratio of physicians and nurses per 10,000 persons which is comparable to the ratio in the United States. Strum (2001), stated that, "Cuba compares more or less on a par with the industrialized world, and, in fact, fares considerably better when compared to the rest of Latin

America. Cuba's ratio of physicians to population is one of the highest in the world (p.2)."

In Latin America, Cuba has been noted for its preeminent health care. Cuba has sent many medical doctors abroad, voluntarily or through a barter exchange program, i.e., as part of its medical diplomacy program. Since October 2001, Cuba has had a special agreement with Venezuela whereby Cuba supplied medical services to Venezuela in return for oil. In addition, Cuba has sought to increase income by virtue of its medical achievements, thus attracting patients or "health tourists." A further review of Cuba's health tourism will be discussed later.

However, since 1992, Cuba's health services to its own people have decreased dramatically (Barry, 2000; Garfield & Santana 1997; Waitzkin, Wald, Kee, Danielson & Robinson, 1997). This reduction in health care can be attributed to two major factors: 1) the dissolution of the Soviet Union and the subsequent decline in its economic assistance to Cuba, and 2) the increased U.S. embargo and bans on subsidiary trade with Cuba (Garfield, 1997; Krinsky & Golove, 1993).

Specifically, the U.S. embargo became more stringent with the passage of the Cuban Democracy Act. Under this provision, all U.S. trade with Cuba, including food and medicine, was prohibited. In addition, ships coming from other countries were disallowed from docking at U.S. ports for six months after visiting Cuba, even if the ship was on a humanitarian mission (Garfield, 1997). Thus, the question remains, what effect has the embargo had on the provision of health care services to Cubans today?

Half of all Cubans' protein and calories was from imported food during the 1980's. Importation of food declined by half from 1989 to 1993 (Garfield & Santana 1997). Consequently, this food shortage has led to increased caloric intake of refined sugar. Caloric intake from refined sugar increased from 18% to 26% between 1989 and 1992 (Perez-Cristia & Fleites-Mestre as cited in Garfield, 1997). As a result of this under-nutrition, Cuba suffered from an epidemic of optic neuropathy affecting more than 51,000 people, beginning in 1992 (Cuba Neuropathy Field Investigation Team, 1995; Tucker & Hedges, 1993).

In addition, the Cuban people have suffered from less obvious health consequences as a result of the decline in Soviet (and subsequent Russian) aid, and impacts of the embargo. For example, Warman (2001) noted that many patients suffered from Cuba's economic problems resulting in "nervous conditions."

It is not known how rehabilitative services have been affected by the general decline in the health of Cubans. However, it is known that poor health indirectly affects cognitive and language abilities of developing and maturing children. As

indicated by a number of studies in Central America, South America, Africa, and the U.S., children who are malnourished perform lower on intelligence tests than well-nourished children, who are matched for socio-economic status (SES) (Brown & Pollitt, 1996 Pollitt, 1995). It is presumed that declines in nutrition have also affected the physical, mental and cognitive capability of adults in Cuba.

Provision of Health Care Services in Cuba

The Cuban health care system is free of charge and provided locally to its population. Cuba has employed a system of family and neighborhood medical doctors and clinics (Cardelle, 1994; Warmen, 2001). Health care workers are expected to live and work in the same community. Doctors and nurses in the local neighborhood clinics provide services for obstetric, pediatric, gynecological, and general medicine to the population.

Cuba has sought to capitalize on the provision of health services to tourists (Perez, 2001; Robinson, 1997). "Health tourism" earns Cuba \$25 million U.S. dollars a year (Robinson, 1997). According to Perez (2001), a journalist for the Cuban newspaper Granma, Cuba offers rehabilitation services in physiotherapy (i.e., physical therapy), speech therapy and "defectology", the Russian form of special education for children and adolescents with learning disorders and possible handicapping conditions.

Cuban rehabilitation centers claim to offer innovative treatments for certain neurological conditions. However, Robinson (1997) stated that "some of the cutting edge treatments may be less effective than claimed" (lines 20-21)... "Others are concerned that Cuba is charging exorbitant prices and violating accepted procedures in its rush for dollars," (lines 43-44). Hence, without direct observation of current practices, we are incapable of ascertaining the exact nature of rehabilitation services being offered in Cuba.

Rehabilitation services are not community-based nor provided in neighborhoods, as is primary medical care treatment. According to a speech-language pathologist, who recently immigrated to the U.S. from Cuba, rehabilitative services are provided in the following manner. Children and adults are referred to a provincial or city clinic. The child or adult is then evaluated by a interdisciplinary team, which may consist of a pediatrician, neurologist, psychologist and rehabilitation professional. The client is then referred to a school or hospital clinic depending on the client's age, needs and type of therapy to be provided. In the case of a child needing speech-language services, the child may be referred to a special school or regular school where he or she is provided therapy in the classroom.

Speech-language pathologists receive five years of college or university training,

whereupon they become licensed to complete diagnostic evaluations and provide therapeutic services. The speech-language pathologist may elect to receive a master's degree; in Cuba, the entry-level degree is a bachelor's degree. In the U.S. it is the masters degree. If speech-language pathologists or logopedists work with a medically-involved population in a hospital setting, then they must receive orders from a logofoniatra, a medical doctor who has specialized in speech and language disorders. Logofoniatras complete the differential diagnostic evaluations in areas of voice, aphasia, laryngectomies, dysphagia (swallowing difficulties) and other medically related areas.

It should be noted that not all rehabilitative services in Cuba are offered by rehabilitation professionals. According to Tabolski (1999) and Madriz (2001), there are no audiology degree programs in Cuba. Audiological services are provided by otolaryngologists. The otolaryngologists are trained on the job by other otolaryngologists, who were trained in the same manner (Tabolski, 1999).

HISTORY AND IMMIGRATION OF CUBAN AMERICANS

First Wave: The Educated Class

The push-pull theory states that persons are pushed from an area because of negative factors, and are pulled to another area due to positive influences.

The wave theory, as first applied by Stein (1981), stated that people leaving their native country during different periods may display different characteristics. High-level government and military officials, the educated, and the urban elite usually are those who emigrate out of the country first (thus, first wave immigrants). The second wave includes lower level officials from the government and military, less educated merchants, and those wishing to be reunited with those from the first wave. Third wave immigrants include rural poor farmers and the least educated of the immigrants. These least educated immigrants may have low levels of literacy in their own language, and may be ill equipped for formal schooling in an urban environment.

It was reported by Becerra and Shaw (1984) that, "many Mexican Americans and Puerto Ricans return to their homelands in their late year, while many Cuban Americans are political refugees and remain in the U.S." (p. 2). Refugees leave their homeland for political reasons and usually are not able to return.

First wave Cuban American refugees came to the U.S. between the years of 1959-1962. "In the 13 years following the revolution, Miami's Cuban population rose from 29,500 to 247,000" (Cobb, 1992, p. 100). "Mass migration from Cuba began during the Cuban revolution in 1959. The first large-scale migration

brought principally middle and upper-class Cubans seeking political asylum" (Becerra & Shaw, 1984, p. 7).

Many of these Cuban refugees believed that they would return to Cuba. Hallman and Campbell (1983) stated that

... influenced by this belief, Cuban exiles created a strong Hispanic community and remained proud of their heritage, and actively struggled to keep their identity. The possibility of becoming Cuban Americans, however, is much more evident (for this group) today, since 20 years of exile have eroded many Cubans' hopes of returning to the island (Greco and McDavis, 1978, p. 69).

The Second Wave: The Working Class

Between 1970 and 1980, the Cuban American population in the United States grew from 483,369 to 722,243. This represented a total growth of 238,874 over the period of a decade (McCoy & Gonzalez, 1986). This period constituted the second wave of Cuban American refugees. Bercerra and Shaw (1984) stated that, "... a second wave of immigration brought a greater proportion of skilled, semi-skilled, and unskilled workers" (p. 7).

The Third Wave:

The Communist Government-Influenced Class

The third wave of immigrants can be said to have arrived in the United States from 1980 to the present. Hallman and Campbell (1983) stated

The third group consists of the post-1980 refugees who have had more limited impact by the American culture. In this group especially are children and adolescents who were raised and attended school in post-revolutionary Cuba. Many had been raised under communist ideology to view North America and American culture in a 'yankee imperialist' framework (p. 70).

The reason that many of the more recent refugees are coming to the United States may have less to do with political ideology, and more to do with the poor economic situation in Cuba today. Hence, the third wave of Cuban American immigrants may be regarded less as refugees and more as immigrants. Whitfield (1993) stated that, "In another sign of spiraling shortages in Cuba, only Havana residents who have babies under two years old will be allowed to receive laundry soap this month, and no one will get the ration of bath soap" (p. 24A).

The tremendous exodus from Cuba in the last two decades has been significant

in number. During the spring and summer of 1980, 124, 779 Cubans migrated to the United States from Mariel.

Bercerra and Shaw (1984) stated that, "The most recent immigrants (since 1978) have been of lower socioeconomic background and possessed fewer marketable skills than their predecessors. These newer immigrants will probably change the sociodemographic profile of the Cuban-American to more closely reflect that of both the Mexican American and the Puerto Rican" (Becerra & Shaw, 1984, p. 8).

CULTURAL INFLUENCES OF CUBAN AMERICANS

Cultural influences include such sociological variables as the average age of the group and subgroup, family size and income, the individual's attained educational level, and type of occupation. Other variables such as language, religion, family values, and the various varieties of Spanish as spoken by Cuban Americans also affect Cuban American culture. These features will be discussed.

The Hispanic population of the United States tends to be younger than the overall non-Hispanic U.S. population. The median age of Hispanics is 26.5 years and the mean age is 28.8 years, while the median white, non-Hispanic U.S. population age is 38.1 years and the mean age is 38.5 years (U.S. Bureau of the Census, 2000). Cuban Americans have the oldest average age, 39 years. Puerto Ricans, and Central and South Americans have an average age of 27 and 28 respectively, while Mexicans have the youngest at 24 years. The largest group of Cubans in the United States is within the range of 15 to 44 years of age (463,000 or 43.9%), followed by the 45 to 64 age group, (287,000 or 27.2%).

Only 12 % of the elder Hispanic population is over 65, while the overall non-Hispanic U.S. population tends to have more elder adults, (approximately 19%). Cuban Americans tend to have more elder adults, (14%) than all the other Hispanic subgroups (U.S. Bureau of the Census, 1998; U.S. Bureau of the Census, 1990).

Income and Educational Attainment

More Hispanics live in poverty (22.8%) than those in the white, non-Hispanic U.S. population (7.7%) according to the U.S. Bureau of the Census, 2000 figures. As of 1990, only 15% of Cubans lived in poverty (more closely resembling the 1990 United States average of 12%), while 33% of Puerto Ricans, and 28% of Mexicans were living in poverty.

The lack of opportunity for education contributes to poverty. The 2000 popula-

tion survey (U.S. Bureau of the Census for the year 2000) showed that 51.7% of all Hispanics received a high school education, compared to 77.6% of the total U.S. population. Cuban Americans more closely approximated education levels of the non-Hispanic U. S. population (Langdon & Cheng 1992). Becerra and Shaw (1984) note that "within the Hispanic population, older Cubans had a significantly higher level of education than did older Puerto Ricans or Mexican Americans" (p. 3). Only 11% of all Hispanics completed four years of college, while 25% of the white U.S. population completed a four-year college program (U.S. Bureau of the Census, 1998). It should be noted that, with a 20% college graduation rate, Cuban Americans more closely approximated that of the non-Hispanic population, (Current Population Reports, 1990).

Hispanics tend to hold jobs according to their specific subgroup identity (i.e., Mexican American, Puerto Rican, or Cuban American). More Mexican American men than other Hispanic males have been employed in farming, forestry, and fishing. Cuban Americans have been more inclined to be employed in managerial and professional positions. Cuban Americans and Puerto Ricans tend not to be employed in farming, forestry, or fishing (Langdon & Cheng, 1992).

Cuban American Values

Awareness of some Cuban American values may assist rehabilitation service providers. Most Cuban Americans have obtained a high level of education, yet may display some particular cultural values that are different from mainstream America. The following are some general guidelines about Cuban Americans, and should not be over-generalized.

1. Earlier wave Cuban Americans may prefer to organize into extended family support systems, while later arrivals, influenced by the Cuban communist government, may prefer a group or community level system of support.
2. Some Cuban Americans may be more oriented to the present than some Anglo-Americans are. Immediate reinforcement may have to be built into rehabilitation plans.
3. Some Cuban Americans may seek help only when they perceive the situation to be a crisis. Their desire to have control over the immediate environment may not be sensed as strongly (i.e., an external locus of control is displayed) as with Anglo Americans (Levine & Padilla, 1980; Queralt, 1984).
4. Use of the Spanish language is an important social tool (Garcia & Lega, 1979).
5. Attending Cuban social events and exposure to Cuban-theme media events are important in maintaining Cuban American social identi-

ty (Garcia & Lega, 1979). Relationships are important in all interactions, particularly when it involves a rehabilitation therapist and the family. Masin (1999) stated that, "The importance of having the therapist develop a relationship with the child is clear..." (p. 348). The relationship with the rehabilitation professional/therapist is almost as important or even more important than what the therapist actually does (Masin, 1999).

6. Cuban Americans value *personalismo* (social relations) more than their Anglo-American counterparts. Therefore, Cuban Americans tend to spend more leisure time in social activities. Friendship is valued highly (Queralt, 1984). Participation in a Cuban American network of friends is exceedingly important (Garcia & Lega, 1979). *Personalismo* seems to affect the way that Cuban American mothers interact with their handicapped children. Masin (1999) stated that the "Cuban-American cultural beliefs do affect maternal perceptions of physical therapy. For example, *personalismo* appears to play an important role in the success of the therapy intervention" (p. 347). Specifically, Cuban American mothers focused almost exclusively on having a handicapped child.
7. Cuban Americans treat one another informally, even when two persons are not acquainted (Queralt, 1984).
8. To be *simpático* (charming) is important as is the use of *choteo* or *relajo* (humorous) (Queralt, 1984). To be judged *pesado* (disagreeable) is a cultural sin (Queralt, 1984).
9. Mental agility in the use of language is also highly valued. Cuban Americans like the use of puns (Queralt, 1984).
10. Cuban Americans may fall into more of a "being" orientation, i.e., giving more importance to activities involving spontaneity than Anglo Americans do. Anglo Americans fit more into a "doing" orientation, where the primary emphasis is on work, competition and achievement (Queralt, 1984). Queralt maintained that, "It should be understood, however, that 'doing' or 'being' orientations have little to do with activity level; in fact, among Hispanics, Cubans are noted for their hyperactivity" (Queralt, 1984, p. 118).
11. Cuban American males may display machismo or display very traditional role types of interaction. Traditionally, they may perceive their role in the household as one of provider and disciplinarian. Sharing of roles and flexibility of the roles is definitively not machismo. It should be noted that the Cuban American mother's devotion to her children may be compensatory and not dysfunctional. As they get less attention from their male husbands, they may focus or concentrate their energies on their children. Child-rearing practices are influenced by machismo and the particular structure of the Cuban American families .
12. Loudness of voice is culturally determined and it may be perceived

by others as being excessively loud. Cuban Americans tend to speak with increased vocal volumes.

Cuban American Adolescents and Youth

Cuban American youth have been reported to have a strong sense of cultural identity, yet demonstrate a sense of loss for their native homeland (Alvarez, Bliss & Vigil, 2001). Cuban Americans also seem to display a strong sense of political identity (Smith & Diven, 2002) and have relatively good sense of self worth. Oquendo, Ellis, Greenwald, Malone, Weissman, and Mann (2001) compared depression and suicide rates among whites, Mexican Americans, Cuban Americans, Puerto Ricans and African Americans. It was found that when one-year prevalence rates for depression were compared among these five ethnically diverse groups, Cuban Americans were found to be average. Specifically, the prevalence rates were 3.6% for whites, 2.85% for Mexican Americans, 2.5% for Cuban Americans, 0.9% for Puerto Ricans, and 0.5% for African Americans (Oquendo, Ellis, Greenwald, Malone, Weissman, & Mann 2001). Hence, Cuban Americans scored in the middle of the distribution.

Jane, Hunter and Lozzi (1998) found that young Cuban American women showed lower incidence of eating disorders when they used Spanish as the primary language in the home. Spanish language use seemed to indicate a close tie to the family and one's culture of origin. Thus, language seems to generate a strong sense of support and may add to the Cuban American youths' sense of self-worth.

Language and Cuban Spanish

Communication and language are at the core of all health service delivery. Language and communication are a vital component of the interaction between clients and health care professionals. Since communication involves language, which is culturally bound and influenced, it is important to understand the role and significance of language in understanding and delivering clinical services.

Castilian or American Spanish is spoken by more than 200,000,000 persons. (American Spanish refers to new world Spanish spoken in South, Central and North America). It is estimated that by the year 2,000, there will be approximately 400,000,000 Spanish speakers worldwide (Canfield 1981).

One out of every two Hispanics in the United States speaks Spanish in the home. This figure rises to 72% among Puerto Ricans and 87% among Cuban Americans (Szapocznik, Scopetta, Kurtines, & Arnalde, 1978). Virtually all older Cuban Americans in the Miami area use Spanish and speak almost no English (Szapocznik, Scopetta, Kurtines, & Arnalde, 1978). Language exacerbates difficulties associated with adapting to life in the United States in old age

because Hispanics are less likely to know about and use health and social programs for the elderly (Szapocznik, Scopetta, Kurtines, & Arnalde, 1978).

Language, Communication, and Culture

Language, communication and culture are intertwined and inseparable. Scweder and Levine (1984), stated that culture is an "inherited system of ideas that structures the **subjective** [added emphasis] experience of individuals" (p. 20). Haslett (1989) maintains that "culture and communication are acquired simultaneously: Neither exists without the other" (p. 20). Haslett (1989) has also said that "culture constrains what is acquired and how it is acquired" (p. 20). Hence, culture as viewed through communication can be ethnocentric and act as a barrier to providing health care.

Communication involves unconscious scripts that are habitual. The individual is oblivious to the scripts, unless they are continually examined (Gudykunst, 1991). These unconscious scripts may become barriers to communication in the health care community. Health care professionals are often unsuspecting of how the scripts are used and to what degree culture influences their use. Gudykunst (1991) emphasizes this point, "When we engage in habitual or scripted behavior we are not highly aware of what we are doing or saying" (p. 26). He also maintains that when communicating with others of differing cultures, professionals base their interpretations on their own cultural symbolic systems, which involve speaking-listening and verbal-nonverbal behavior scripts. Thus, ineffective communication may result. As Gudykunst states (1991), "Our culture and ethnicity influence the attributions we make about others' behavior" (p. 30).

Individualistic (I) versus Collectivistic (We) Cultures

As communication is both a cultural and language phenomena, one must carefully study the patient's culture. It is necessary in order to provide culturally appropriate therapy services, and to be able to retain patients in therapy (Anderson, 1997). Ting-Toomey (1994) refers to individualism as

the broad value of tendencies of a culture to emphasize the importance of individual over group identity, individual over group rights, and individual needs over group needs. In contrast, collectivism refers to the broad value of tendencies of a culture to emphasize the importance of the 'we' identity over the 'I' identity, group obligations over individual rights, and in-group-oriented needs over individual wants and desires (pp. 360-361).

In individualistic cultures, the self is defined independent of the group, and one should do what is enjoyable and required by contacts with others. The focus is on the person and individual. Individualists rely on internal attributes to explain

behaviors (Triandis, 1995). There is an importance of the "autonomous self" (Ting-Toomey, 1994) while, "face," the outer portrayal of oneself, is self-oriented for individualistic cultures (Gudykunst, 1991).

Direct communication is more predominate in individualistic cultures than in collectivistic cultures. Strangers or outsiders establish communication relationships more easily (Gudykunst, Ting-Toomey & Chua 1988). Highly individualistic values have been found in the United States, Australia, Great Britain, Canada, the Netherlands, New Zealand, and Italy (Gudykunst et al. 1988; Ting-Toomey, 1994).

By contrast, collectivism stresses the importance of the connected self or connectedness to the group (Ting-Toomey, 1994). High collectivistic values have been found in Cuba, Indonesia, Columbia, Venezuela, Panama, Ecuador and Guatemala. China, Korea, Japan, Hong Kong, Indonesia and Mexico have also been identified as collectivistic group oriented cultures (Gudykunst et al. 1998; Ting-Toomey 1994). First generation immigrants from all of these countries, such as Cuban immigrants in the U.S., may keep their group-oriented values (Ting-Toomey, 1994).

Ting-Toomey (1994) identifies several aspects of collectivistic cultures. First and foremost is the concept of face, being other-oriented, for collectivistic cultures. The concept of giving face to others with higher status is important in collectivist cultures (Gudykunst 1991). An example of face is not to embarrass the family or group though one's actions.

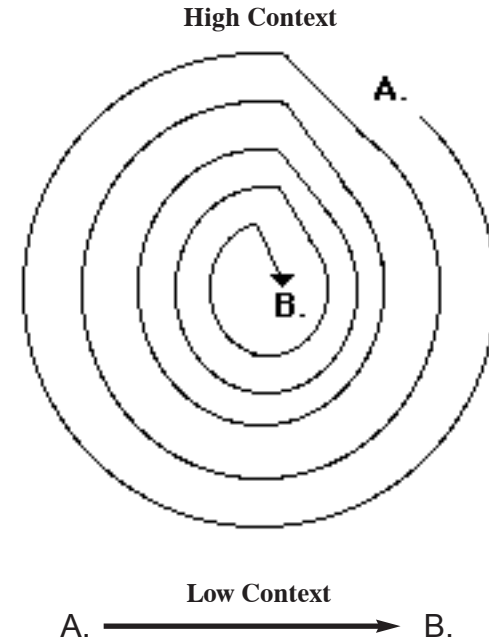
Collectivists see ambiguous groups as outsider or out groups (Triandis, 1995). Membership in a collectivistic group includes the right to get involved in the affairs of others (Triandis, 1995). Collectivists also may use the norm of arriving late for appointments as the expected behavior. Collectivists use norms to explain behaviors. A sense of fate is common and prevails. Collectivistic cultures show tendencies to be closely connected (Triandis, 1995).

———— *Low Context versus High Context Communication* ————

To understand cultural variability, health care professionals need to consider the concept of low-context and high-context communication, initially introduced by Hall (1983). Low-context communication relies little on the surrounding context for interpretation; rather, most of what is communicated is found in the verbal message. Low-context communication reflects linear logic, direct verbal interactions and styles of speech, overt intention, and sender-oriented values and is typically found in individualistic cultures (Ting-Toomey, 1994). Individualistic, low-context cultures tend to be more sensitive to a person's values, attitudes or dispositional characteristics, and attribute behavior to their individuality and personality.

By contrast, high-context communication and cultures are highly sensitive to situational and context features of communication. High-context cultures tend to attribute behavior according to the situation or factors that are external to the person (Gudykunst 1991). High-context communication refers to a spiral logic or interaction approach that uses indirect styles of speech. It consists of indirect verbal negotiation, use of subtle nonverbal nuances, and a receiver-listener focus. Diagram 1 presents an illustration of a linear-low-context communication versus a high-context spiral communication pattern.

Diagram 1.
High Context Versus Low Context Communication Patterns



Collectivistic cultures tend to use more high-context communication patterns. Brice (1993) notes that Cubans and Cuban Americans reflect the spiral method of communication. In particular, "social greetings are exceedingly important within the Cuban society. A more indirect approach of getting to the topic is exhibited with the Cuban society, i.e., more spiral versus linear. Discussions of family, friends, and employment always precede any formal discussion" (p.4). This approach has also been noted in other Hispanic cultures (Langdon, 1992).

Indirect communication is also used in collectivistic cultures. For example, Cuban American medical doctors will typically not inform a patient that they have a life-threatening disease if they do not see that such knowledge is in the

patient's best interests. They may, however, inform a family member.

Monochronic versus Polychronic Time Views

Time is yet another set of cultural differences affecting communication. Monochronism is the orientation that events happen in chronological order and that adherence to schedules is important. Monochronic views predominate in individualistic, low-context cultures. Monochronic cultures, exemplified by the U.S. or Germany, subdivide time schedules and individual needs from group needs (Hall, 1983). Task orientations (e.g., work) are separated from social orientations (e.g., socializing). Monochronic cultures are more future-conscious than present or past-conscious.

Polychronism is the orientation that events can happen concurrently and that fixed adherence to schedules is not important. Polychronic views predominate in collectivistic cultures. The focus is on people and on completing transactions rather than adherence to specific time schedules. For example, it is often expected that a Cuban therapist will periodically pause to converse with the client about non-therapy related topics, or a client's daughter may bring coffee for an anticipated break during the therapy session. Polychronic cultures are more conscious of past and present than future. Polychronic cultures include Latin American (e.g., Cuban), Middle Eastern, Asian, French, and Greek cultures (Hall, 1983).

Folk Beliefs in Cuba (Santería)

Cuba was 85% nominally Roman Catholic before Castro assumed power. Santería is a recent combination of Roman Catholicism and African religions. There are an unknown number of practitioners of Santería, although it is believed to be widespread in Cuba and among recent refugees to the United States. It is not known how many Cuban Americans practice Santería, but it is probably most prevalent with those in the communist government era orientation. Those who came in the first and second waves of immigration are probably Roman Catholic practitioners.

The Santeria cults have been entrenched since the eighteenth century when African slaves began practicing their religion on Cuba's sugar plantations. Three major Afro-Cuban cults exist: the Yoruba, the Bantu Palo Monte and the Abakuá societies. The priests are known as Babalaos. Animal sacrifices of goats, cocks and doves are not uncommon in Cuba. The blood is offered in soup plates to the Orichas - African gods, like the saints (Oppenheimer, 1992).

The Yoruba gods are identified with the Catholic saints. The Afro-Cuban pantheon consists of the supreme god Olodumare-Olorun-Olofin, and the Orichas beneath him (Sandoval, 1979). The spirits of the dead follow next in rank, and

the animistic talismans are at the lowest point.

The Yoruba belief is that God created woman and man in two parts. These consist of the being on earth and the spiritual double being of Eleda in heaven. Every person makes a contract with Eleda before being born. Their plans for life are then designed. If they live according to the contract, then they are rewarded. However, if they do not live according to this contract, they are punished.

Central to this belief is the dual nature of humans, i.e., a separation of body and soul. The supernatural is responsible for illnesses and their cures as well. Diagnosis and treatment by a physician, therapist or other health care professional is seen as supplementary. According to Hallman and Campbell (1983), Santería serves several psychological functions:

1. Reduces feelings of despondency and helplessness. The Catholic saints have abandoned the people. Although the catholic saints are closer to God, they are too good, and one needs protections of the *santos* to survive.
2. Gives protection in a world that is chaotic.
3. Contributes to an improved sense of mastery over one's life.
4. Reduces uncertainty in life.
5. Alleviates certain physical conditions.

Santos are seen as doing good and evil. The *Santos* are just like people. Therefore, people can relate to them more easily.

Illness Beliefs

Beliefs about illness or disabilities can often be attributed to external causes among Cuban Americans (Brice, 2002). For example, a visible disability such as cerebral palsy can often be attributed to an external and non-medical cause such as *brujeria* (witchcraft or sorcery). Some Cuban American parents or family members may believe that if the patient has a disability, the family members are being punished for their sins, (i.e, an external locus of control is present) (Zuniga, 1998). Other Cuban American family members may accept disabilities as part of a larger divine plan designed by God to make them better persons. Family members who hold these beliefs may be less open to utilizing the services of a health care professional.

Roseberry-McKibbin (2002) stated that "some families believe that 'invisible' disabling conditions do not exist" (p. 202). Hence, it is extremely challenging for therapists, nurses and other health care professionals to help families see that invisible disabilities merit treatment as much as a visible disability does.

Cuban Americans have been influenced by two separate orientations: before the Castro, communist government (pre-communist era) and after the communist revolution in Cuba (communist era). Therefore, the following discussion will focus on each group and their orientations.

Extended Family

Szapocznik, Falleti, and Scopetta, (1977) stated

In Cuba, the elderly enjoyed a central and well respected position within their extended family. At the most materialistic level, the elders of the family are usually the owners of the important possessions the family may have held. Even with the poor, in a fisherman's family, for example, it was the grandparent who owned the fishing boat in which family members fished. So that economically, the elders were able to make financial contribution to the family (p. 7).

Leiner (1974) also supported this view and mentioned that, "Cuba has always been characterized by the extended rather than the nuclear family. Such large, rural families embrace not only the parents and their offspring, but grandparents and often aunts, uncles, cousins, and other relatives" (p. 20). Klovern, Maderra and Nardonne (1974) said that Cubans "value highly family ties and their family units, which extend in many cases to include grandparents, cousins, aunts and uncles" (p. 255).

Grandparents

Becerra and Shaw (1984) reported that the adjustment to life in the United States for the Cuban American elderly has not been easy and that they face unique hardships.

While corresponding figures for elderly Cubans are not available, Szapocznik, et al., (1977) find that, because older Cubans were forced to leave their homeland as political exiles, they were stripped of all financial resources. Their economic situation in concert with their advanced age made it difficult for them to launch or resume remunerative careers. This radical revision of financial status from their situation in Cuba (in which elders own most family-held resources and properties) has made life in the U.S. extremely traumatic for older Cuban immigrants. These circumstances make it unlikely that older Cubans have been any more able than other Hispanics to accumulate significant personal savings (p. 26).

Greco and McDavis (1978) declared that a priority of Cuban American families was to accommodate the work situation for the father in such a way that it enhanced the family as a unit. Family-oriented goals play a significant role when family members make vocational plans or make decisions regarding rehabilitation for a family member in need.

Escovar and Escovar (1981) reported that Cuban American fathers were perceived as significantly higher than Anglo American and Latin American fathers in the area of achievement. They observed that Cuban American parents are perceived by others as using more contingent reinforcement than Anglo American parents. Escovar and Escovar reported that, "Hispanic and Latin parents may make more use of threats, but are less likely to follow them with actual punishment, thus appearing to use less physical punishment" (p. 15). They continue:

It appears that although Cuban-American women acculturate at a lower rate, as far as their personal behavior is concerned, they do tend to adopt those child rearing patterns which they believe will help their children be more successful in the host culture... Notably Cuban-American mothers use the same disciplinary mechanism (i.e., affective punishment, deprivation of privileges, and physical punishment) as Anglo mothers. Interestingly Cuban American mothers are perceived as being the most protective and using the highest level of achievement pressure (pp. 17-18).

Prior to the 1959 Castro revolution, Cuban women had achieved a higher level of equality in Cuba than in most other Latin American countries. Their level of participation in the labor force was among the highest in Latin America. Cuban women's level of literacy was higher than that of Cuban men (Queralt, 1984). This high level of achievement among Cuban women has been maintained. By 1990, 48% of all medical practitioners and 64% of all family doctors in Cuba were women (Warman, 2001).

Children

It is common in the Cuban culture to accommodate children's needs. In the North American Anglo culture, this would be perceived as pampering and possibly babying (Queralt, 1984). In a study by the State of Florida, it was found that "young Cuban children are not allowed to explore the community as freely as their American counterparts. Such activities as crossing streets, going to stores alone, going out at night alone, or going unaccompanied to school are generally not permitted" (State of Florida, 1981, p. 41-42).

Older sons in the traditional Cuban American family are seen as the next heir to family responsibilities. Older daughters in traditional Cuban American families have the responsibility of taking care of and assisting with the children.

Sandoval (1979) mentioned that, "on the other hand, the United States orientation to youth and the future has also unfavorably affected the Cuban family by undermining the authoritarian roles of the parents, which are openly and aggressively challenged by some children" (p. 143).

Concept of Disability

Cuban and other Latino cultures typically have very strong beliefs regarding children and adults with handicapping conditions and disabilities (Madding, 2002). Beliefs about what constitutes a disability, its cause and the concurrent conditions related to the disability often have an effect upon the entire family. North Americans and health care professionals typically espouse a medical model orientation towards disabilities and illness. Cuban families and their beliefs may run counter to the medical or etiological approach. Juarabe (1996) stated that Puerto Ricans often believe that the mother is culpable when a child is born with a genetic defect such as Down Syndrome. This may also be applied to Cubans and Cuban Americans. The mother is blamed for not using proper pre-natal care during pregnancy (i.e., taking care of herself). The illnesses or disabilities can be attributed to past sins. Thus, the punishment is carried out on the child. If a child is severely disabled, then she/he typically will be taken care of in the home with the women of the household (e.g., mother, grandmother, aunt, older sister, etc.) taking responsibility.

Although Cuban Americans are reported to have higher education than some other Latino groups, there may be some who hold onto Santería beliefs. Varela (1996) stated the Cuban idea that evil spells or magic may be the cause for such disabilities. It is sometimes believed that a mother who looks at a handicapped child during her pregnancy will deliver an infant with the same handicap.

There is social stigma to having a disabled child. The parents may hide the child at home from outsiders. Parents may seek the help of *curanderos* (folk healers) or Santero priests to heal the sick or cleanse souls (de Paula, Laganá & Gonzalez-Ramirez, 1996). Latino Catholic parents may resign themselves to the child's disability and possible handicap. This is seen as God's hand in that the parents must endure this cross to bear. In some instances, it is seen as a blessing to be the parents of a special child.

Since Cuba follows the Russian model of rehabilitative services, it follows a segregated and institutional approach to how rehabilitative services are provided (Rosenthal, Bauer & Hayden, 1999). It should be noted that the Cuban government segregates and quarantines individuals with HIV and AIDS into sanatoriums (Hansen, 2001; Johnston, 1992). Hence, it is recommended that the segregationist model not be advocated, and that in its place a family and client oriented rehabilitation model be used.

A family and client oriented rehabilitation model allows for family participation. This approach is characterized by shared problem solving. All participants, the family and professionals, are involved in determining if a problem exists, its nature, intervention goals and roles for implementing the solutions (Creaghead, 1994). Characteristics of a successful family-oriented model includes the following characteristics:

1. Team members share common goals
2. All members contribute equally
3. Leadership is distributed equally
4. Responsibility for implementing team decisions is shared

Luterman (1991) stated that "the basic notion underlying all family therapy is that the family is a system in which all components are interdependent.. any time a change occurs in one member of the family, everybody in the family is impacted" (p. 137). Involving all family members in their therapy process is part of the holistic and family oriented model that can result in the following (adopted from Luterman 1991):

1. A greater understanding of impairments and people in general for the client and family
2. Increased compassion for the client
3. The family gaining an increased appreciation of their own health and well-being
4. Increased sensitivity to prejudice (as a result of experiencing or seeing prejudice toward impaired individuals) for the family
5. The family coming closer together

CASE STUDIES

The following two case studies, (albeit from a speech-language pathology perspective), may illustrate some of the concepts previously discussed as they relate to Cuban Americans in need of rehabilitation services. Case Study One involves

a 69 year old, Spanish speaking, Cuban American female who had recently suffered a stroke (at the time of the evaluation) and was in need of speech and language therapy. Case Study Two involves a Cuban American, Spanish-English speaking, 14 year old female with a confirmed diagnosis of vocal nodules.

Case Study One

Mrs. G a Spanish speaking Cuban American female was accompanied to an evaluation by her husband who, in addition to the patient, served as the case history informant. It was reported that Mrs. G. suffered a left cerebral vascular accident (CVA) or stroke approximately two months prior to the evaluation. Her husband said that she did not receive any speech or language therapy while in the hospital or afterwards. It was reported on the case history form that she had difficulty with eating, sleeping and speaking. Mrs. G. was reported to be a functional communicator prior to her stroke.

Formal results indicated a Broca's type aphasia with decreased abilities to name, decreased verbal fluency, poor auditory comprehension and poor repetition abilities. Her language abilities were severely disordered. After an oral peripheral examination, it was recommended that she receive speech and language therapy.

Interpretation of Case Study One

The first notable observation was that Mrs. G. did not receive any speech, language or swallowing evaluations or treatment during her hospital stay. The reasons for this obvious lack of services were not made clear during the separate speech and language evaluations two months after her stroke. It was not known whether this oversight was due to the patient and spouse's Cuban American illness beliefs including their perspective of disabilities and handicapping conditions. Did they not seek services for her hidden disabilities (speaking and thinking) because in the Cuban American culture only the most obvious aspects are addressed (walking versus speaking)? Or did the oversight occur because in the Cuban American culture one does not appear demanding and ask for services from expert medical professionals?

It should be noted that Cuban Americans typically see the rehabilitation professional as the expert whom the patient does not question (Masin, 1999). Thus, the patients and family members need to be re-educated regarding this aspect of the relationship. Rehabilitation professionals must encourage patients and their family members to seek all assistance and help from relevant rehabilitation professionals. Rehabilitation professionals may also need to advocate for their patients, since the patient or the family member may not seek additional help.

Family members will accompany their respective spouse, child or parent to therapy and participate in the therapy sessions (once therapy sessions are provided). This familial involvement comes from a collectivistic cultural perspective. Thus, the expectation is that all family members will be included in all aspects of diagnoses and provision of therapy, particularly those involving decision-making aspects.

In conclusion, Mr. G. should be made aware of the therapy objectives being carried out in the sessions. It should be stressed that his assistance, outside of the therapy session, is crucial to his wife's recovery. His therapeutic help can assist with carry-over and generalization of learned skills in the home. His assistance has the added benefit of speeding up her recovery as she will receive many hours of therapy beyond the specific sessions.

Case Study Two

C., a 14-year-old female presented with a severe voice disorder secondary to vocal nodules. She exhibited normal articulation, fluency and language for a person her age, gender and cultural background.

C. was accompanied to the evaluation by her parents, who also served as informants for the case history. C. is attending school and was enrolled in the 8th grade at C. E. Academy. It was reported that a voice problem began two to three years prior to the evaluation, and was getting worse. No treatment was given to correct her hoarse voice. Her voice did not seem to change much from morning to night. It was reported by C. that it is the same during the day and that she experienced no pain. No allergies were reported. Dr. R. P. (an otolaryngologist) examined her and noted the presence of vocal nodules through video endoscopic examination. It was recommended by Dr. P. that she receive voice therapy to address the hoarse voice and the vocal nodules.

Interpretation of Case Study Two

As with the previous case study, C's family was present in the evaluation room during the diagnostic evaluation (showing collectivistic cultural traits). Her parents also served as informants regarding her problem. In addition, it should be noted that voice therapy was not sought until the problem had reached an exacerbated level, that is, the client was practically non-vocal. This cultural trait of waiting until the problem reaches an acute level has been noted with Mexican Americans (Madding, 2002) and also appears to be common among Cuban Americans. Thus, the rehabilitation professional should counsel Cuban American patients and their family on the importance of early intervention and continued therapeutic intervention.

This particular client has discontinued therapy after two sessions, even though her speech is practically unintelligible and there are nodules.

CONCLUSION

As the Cuban and Cuban American client populations continue to increase dramatically, health care professionals repeatedly face the challenge of how to best provide services. The health care professional's role of diagnostician-clinician is challenged when different languages and cultures are involved. Thus, health care professionals need to understand the interrelationship of language and culture used by the clients and their families in order to provide the most appropriate services.

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