Review Article

Developing Culturally Competent and Emotionally Intelligent Social Work Leaders

Gary B Bailey[1]*, Christina Crow Cruz[2], Alissa Mallow[3] and Angela Alvarado[4]

[1]Alamance Life Works EAP, PLLC, USA

[2]Simmons University, USA

[3]School of social Work, Adelphi University, Garden City, NY, USA

[4]Gentiva Health Services, USA

Abstract

Based on previous research studies, the authors explored the relationship between social work leaders' emotional intelligence and cultural competence. They examined how historically marginalized populations are negatively affected by systemic issues on micro, mezzo, and macro levels, leading to healthcare disparities. The writers address four major questions in this paper:

a. How has oppression in medicine impacted healthcare and health outcomes?

b. How do emotional intelligence and cultural competency relate to each other and health outcomes?

c. What are the significant components of cultural competence in health care from a social work perspective? And

d. How do we incorporate emotional intelligence and culturally competent interventions into healthcare delivery as social workers?

The authors propose a model for integrating the ethical practice of emotional and cultural competence and suggest a model for training leaders on emotional intelligence, cross-cultural awareness, and social impact.

Introduction

Emotional intelligence (E.I.) and cultural competence are essential for social work leaders to understand their team and clients with different backgrounds and intersectional identities to provide culturally appropriate services. Social work leaders must understand the needs and values of the clients they partner with in their care and tailor services to address client needs best. This is accomplished through the leader's awareness of historical and contemporary systemic issues and ability to understand and apply culturally competent frameworks and models for E.I.

The authors address four major questions in this paper

a) How has oppression in medicine impacted healthcare and health outcomes?

b) How do E.I. and cultural competency relate to each other and health outcomes?

c) What are the significant components of cultural competence in health care from a social work perspective?

d) How do we incorporate emotional intelligence and culturally competent interventions into healthcare delivery as social workers?

The authors propose a model for integrating the ethical practice of emotional and cultural competence for clinicians, managers, and leaders on micro, mezzo, and macro levels. The authors suggest this model for training social workers and other health care professionals in emotional intelligence to ensure providers are aware of specific cross-cultural social issues and health beliefs in all cultures.

Method

The writers completed a literature review to explore health disparities based on systemic oppression in medicine and the relationship between emotional intelligence and cultural competence of social work leaders. The literature search focused on the keywords "social work leadership in health care," "emotional intelligence," "cultural competence," "health disparities," and "racism." Additionally, the literature search focused on addressing the role of social work practice in managing racism and other forms of oppression from a social justice perspective using a health equity and justice lens.

History of Oppression in Medicine

In the United States, we have yet to ensure that every individual has an equitable opportunity to achieve their full potential in all aspects of health and well-being. Dr. Daniel Dawes [1] stated: "According to the World Bank, half the annual expenditures worldwide on medical care are spent in the United States (U.S.). The U.S. represents fewer than 5% of the world's population but consumes one-half of its medical resources, yet the U.S. still ranks near the bottom of industrialized countries for health.

SHRINE PUBLISHERS
Crafting your Achievement

Advance Research in Psychology and Behavioural Sciences (ARPBS)

Volume 1, Issue 1

Article Information

Received date: August 07, 2024

Published date: August 20, 2024

***Corresponding author**

Gary B Bailey, Alamance Life Works EAP, PLLC, USA

Key Words

Emotional Intelligence; Culturally Competent; Social Worker Leaders; Historical Oppression and Racism

How to cite this article: Bailey GB, Crow Cruz C, Mallow A, Alvarado A (2024) Developing Culturally Competent and Emotionally Intelligent Social Work Leaders. Adv Res Psych & Behav Sci 1.

" Disparities in racial/ethnic groups within the United States healthcare system have been well documented in the literature [2]. Leadership shapes and designs these systems of disparities along with the workforce to carry them out. These processes within those disparities are then perpetuated by the healthcare leadership and the forces that carry them out.

In the "Organizational Strategic Plan to Embed Racial Justice and Advance Health Equity," published by the American Medical Association (AMA) in 2021, the AMA recognizes and highlights various ways in which racism and other forms of oppression have been embedded and perpetuated in medicine. For example, in 1876, J. Marion Sims, also known as the "father of modern gynecology," served as president of the AMA. Sims' procedures, developed through non-anesthetized surgeries on enslaved women, reinforced racist misconceptions regarding the biological differences in pain tolerance between Blacks and whites that persist to this day. From the 1870s through the early 19th Century, the AMA excluded integrated delegations from meetings of the AMA House of Delegates, leading to racial segregation of constituent societies, creating a model for racial segregation, and producing barriers to specialty training for Black physicians. The Flexner Report (1910) was supported by the AMA, contributing to the closure of all but three women-only and two African American medical schools nationwide and cementing an unequal system for Black medical education and health care delivery. Through 1964, the AMA continued to reject attempts to change discriminatory policies and practices [3], reinforcing health inequities.

Although healthcare organizations are positioned to be leaders in addressing health equity, systemic and institutional oppression remain embedded in healthcare organizations. Healthcare delivery in the United States is also affected by the effects of implicit bias in the treatment of patients along the care continuum, affecting patient care, including communication, prescribed medication and treatment, mental health, and maternal and child wellness, among other things [4]. Achieving more significant equity will require a concerted effort to reduce health disparities and the measurable difference in health-related outcomes by addressing health's social and political influencers.

Role of Social Work

According to the International Federation of Social Workers (IFSW) policy on human rights (1996), the role of social workers is to "prevent or alleviate individual, group and community problems, and to improve the quality of life for all people." NASW [5] reports that the role of social workers "is to enhance human well-being and help meet the basic needs of all people, with particular attention to those who are vulnerable, oppressed, and living in poverty" [5]. Problems of racism, discrimination, and social justice occur across continents, social classes, and cultures. For this reason, the role of social workers is of utmost importance when challenging issues of racism, discrimination, and social justice.

Social workers in healthcare specifically combat extrinsic and intrinsic racism, discrimination, and social justice within professional systemic environments through advocacy efforts along with learning and professional development programs. The Code of Ethics, created by the National Association of Social Workers [6], articulates the standards by which social workers identify racism and discrimination and promote social justice. This guidance allows social workers in healthcare to remain aligned with the core values of social work practice. Richard L. Edwards, a social work leader in the late 1980s and early 1990s, was part of early initiatives that evolved into the Affordable Care Act [7].

According to the Bureau of Labor Statistics (BLS), there are more than 173,000 healthcare social workers in the United States [8]. Industries with the highest levels of healthcare social workers in the United States include hospitals, individual and family services, home health organizations, skilled nursing facilities, and outpatient care centers. To support the growing number of social workers entering the healthcare field, the National Association of Social Workers [9] has developed toolkits, educational and training opportunities, and increased lobbying efforts to promote an end to systemic racism, and discrimination, and to promote social justice.

Despite increased efforts by social workers, there remains much work to do. This is acknowledged by NASW in their statement that "despite visible leadership in our nation's most important social justice movements and in creating our country's social safety net, the social work profession has also contributed to ongoing discrimination and oppression of people of color through its systems, policies, and practices" [9]. Examples provided by NASW that reflect this include Progressive Era social workers who built and ran segregated settlement houses, social work suffragists who blocked black enfranchisement, social work government leaders who wrote regulations that excluded Black workers, and bias among social work professionals that negatively influenced health care, mental health, and social service delivery for people of color. In 2021, NASW published a 2-year plan to address systemic racism while acknowledging that the social work profession has historically fallen short in pursuing social justice for all populations they serve [9]. With this awareness that the profession has traditionally fallen short, it is incumbent on all social workers, particularly those who enter management positions, to lead with emotional intelligence and cultural competence. Furthermore, professional social workers should promote programs and curriculums that ensure anti-oppressive and anti-racist practice is paramount and not derailed by white professionalism, which may underscore processes in some organizations and derail leaders.

The Emotional Intelligence and Cultural Competence Relationship

Studies of emotional intelligence (E.I.) have generally conceptualized culture as potentially significant in defining what it means to be emotionally intelligent [10,11]. Culture has complex compositions and dynamic dimensions of being a part of a social group. These dimensions may include systems of belief, morality, values, interests, customs, and behavior, as illustrated below [12]. A more complex understanding of E.I. will require understanding leaders' cultural framework [10], which may be enhanced on a micro level by looking at self-perceptions of leaders' social identities previously mentioned from a cultural humility perspective [12]. These dimensions include age, abilities, life paths, ethnicity, and gender. These dimensions are not only self-identified but also societal influences on self-perspectives from mezzo and macro levels. Past research has revealed considerable variation in individuals' conceptions across cultures but had some common themes involving individuals' propensity for more proactive, creative, and reflexive use of cultural knowledge in competent (cross-) cultural behaviors.

Cultural competency is an ongoing growth process that should be distinct from an endpoint goal. Given the complexities of culture, this term is more aspirational than a set point of competency one would attain. For example, The Association of American Medical Colleges (AAMC) and The American Medical Association's guidebook to advancing health literacy recommended other replacement terms such as "cultural humility, cultural safety, or structural competency, [13]. The authors discussed these terms in determining the use of the title of "cultural competency" to be aligned with the social work aspirational social work code of ethics—section "1.05 Cultural Competence" [6]. In contrast, there is a question of whether, to be culturally competent, does an individual have to have a high degree of E.I.? These writers explored literature from researchers to understand better the role of culture and E.I. on cultural competency skills. This exploration revealed evidence that interventions to improve cultural competence could improve patient/client health outcomes [14,15].

Accordingly, emotions are understood as dependent on cognitive appraisals of experiences and are thus necessarily a culturally grounded process [6] (Lutz & White, 1986). The lack of E.I. is evident on an institutional level, as seen in organizational barriers in health care systems and structural processes of care. For example, a meta-analytic study of 44 effect sizes based on the responses of 7898 participants found that higher E.I. was associated with better health (Schutte et al., 2007). Research on the association of E.I. and transformational

leadership with job satisfaction among social work leaders has revealed a significant relationship between the three concepts of E.I., transformational leadership, and job satisfaction in an extensive study of 812 social work leaders [6].

The movement toward cultural competence in health care has gained national attention [16], and health policymakers, managed care administrators, academicians, providers, and consumers see eliminating racial/ethnic disparities in health and health care as an aspirational goal. Models for operationalizing cultural competence have emphasized aspects of the healthcare delivery system, especially the provider-patient interaction. For example, the framework mentioned previously was the AMA health equity guide, which offers frameworks for cultural competence for healthcare providers [13]. This model is referred to as "cultural competence, has been a component of medical education for the past 30 years. The cultural competence framework seeks to promote "culturally sensitive" practice and describes the trained ability of a clinician to identify cross-cultural expressions of illness and health" [13]. The NASW uses "cultural competence" with the intention that it is a lifelong journey. This more dynamic perspective highlights the imperative that providers understand not only their own positionality and social location but are aware of their clients as well.

Although these conceptual frameworks have legitimate arguments for their different models, they do not capture the individual responsibility of the individual leader as the model proposed here, which considers the social work framework of the person-in-environment perspective recognizing the micro, mezzo, and macro levels of intervention. Only a relatively small fraction of the literature addresses a more comprehensive approach to thinking about and implementing cultural competence in healthcare systems at multiple levels and from multiple perspectives [16-18]. Organizations that use cultural competency lenses to reflect the demographic changes of clients or patients within their organizations have improved the quality and delivery of programs and services to constituents and clients. The common thread is recognizing that multicultural/cultural organizations are culturally competent is a diversity management orientation.

The diversity management orientation is built on the strengths and perspectives of beliefs that individuals from diverse cultures can positively contribute to the organization or public agency [17-19]. The objective is to establish culturally appropriate internal and external programs, service delivery strategies, and approaches. In addition, several theoretical frameworks comprise a comprehensive cultural competency model [16-19]. Cultural competence in healthcare is viewed from several perspectives in the literature. Understanding oneself in a diverse cultural environment is essential at the beginning of this journey. Furthermore, being sensitive, embracing openness, wanting to know other cultures, and actively seeking cultural knowledge are all crucial aspects of being culturally competent. Moreover, cultural competence is enhanced and sustained by possessing a high level of moral reasoning, which may come from the E.I. added component. Then finally, cultural competence results in improved health outcomes, perceived quality healthcare, satisfaction with healthcare, and treatment adherence and advice [20].

Cultural competency consists of three distinctive areas: awareness from an E.I. perspective, then knowledge, and skills [10,19]. This focus enables a system, agency, or professional to work effectively in cross-cultural settings and to deliver services and programs to diverse constituents and communities. Campinha-Bacote's model of cultural competence [21] had an expanded version of these concepts related to the healthcare field [14]. These five areas include cultural awareness, cultural knowledge, cultural skill, cultural encounters, and cultural desire. The last two address the need to be motivated enough to acquire the skills required to be proficient in cultural diversity competency. According to Shafritz, cultural awareness leads to cultural knowledge, and cultural knowledge contributes to the acquisition of cultural skills [19]. These three areas are addressed further so that the knowledge, skills, and abilities (KSAs) can be understood in greater detail.

To begin with, cultural awareness considers those values, attitudes, and assumptions essential to collaborating with individuals, mainly staff members of leaders or consumers who are culturally different from the leader or professional respectively [21]. The second area is self-awareness, an essential aspect of cultural awareness and E.I. [10,21,22]. The third area pertains to self-evaluation and reflection on one's cultural orientation concerning another individual's cultural orientation, which is another aspect of E.I. [10]. Importantly, self-awareness stresses understanding an individual's personal beliefs and attitudes and one's cultural conditioning. Moreover, understanding cultural awareness and E.I. consider a desire to understand various worldviews, perspectives, and cultural differences [21] (Goleman, 2012 & Sue, 2011). Furthermore, these writers view cultural knowledge as understanding the worldviews of various cultural groups and possessing knowledgeable, professional expertise relevant to persons in other cultures. Relevant research studies reveal the need for professionals to gather information about the cultural groups they are working with and learn how cultural constructs influence how these groups respond to the helping process. Specifically, according to Campinha-Bacote's model of cultural competence [21], knowledge competencies regarding cultures presume a wide range of knowledge are assumptions that begin with a sense of one's cultural humility. This model will be explained under the author's E.I. and cultural competence EICC model.

Cultural skills consist of those attributes that allow professionals to effectively apply cultural awareness and the knowledge they have learned. For this to occur, professionals would need to perform a cultural assessment. In other words, what do the leaders or professionals know and need to learn about the cultural orientations of the individuals or groups of people they serve? Campinha-Bacote references the inability to acknowledge that this will prevent what is defined as the "cultural blind spot syndrome" (CBSS). CBSS is when healthcare providers "assume there are no cultural differences or potential barriers to care because the clients look and behave much the same way they do" [21].

Overall, culturally competent professionals should be able to adjust assessments and recommendations regarding clients to the culture-specific needs of the clients. This means considering both the client's and the professional's culture and a cultural understanding of how the service fits in the client's cultural context [19]. Individual healthcare leaders should begin with a sense of cultural humility to summarize the importance of the relationship between E.I. and CC. An assessment of oneself using the tools such as EQi-2,0 developed out of Bar-On, et al.'s [23] work would be a beginning point. Then, the cultural competence component would begin using the assessment tools developed by Campinha-Bacote J. 2018 for health care delivery. This proposed model will be explained in more detail after detailing what is incumbent on social workers.

Significant Components of Cultural Competence in Health Care from a Social Work Perspective

"The Council of Social Work Education (CSWE) and the National Association of Social Workers (NASW) mandate that social workers engage diversity and difference to practice cultural competence. Because the social work profession serves a diverse population that includes humanity's extensive list of intersecting backgrounds and identities, the essence of cultural competence comprises fundamental complications in its overall conceptualization, construction, and application of theory to practice. This study aimed to explore the challenges newly employed social workers faced in practicing cultural competence relative to their experiences as novice professionals. The sample included 20 participants who recently graduated from accredited CSWE MSW programs and were newly employed in the field of social welfare. Qualitative research methods collected data through in-depth semi-structured interviews and one focus group. The findings emphasized the multifaceted nature of cultural competence and highlighted

a) areas for growth in feelings of inadequacy
b) frustration with fundamental organizational barriers
c) prejudice from clients [24]

This was not explicitly addressed in the literature but was indirectly discussed generally in the health care system through a methodical literature review by the authors.

Ethical Implications of Cultural and Emotional Competence for Social Workers

The Behavioral Diagnostic and Statistical Manual; DSM-5-TR acknowledges the importance of looking at cultural issues when diagnosing psychiatric illnesses and behavioral disorders. As indicated previously in this article, the term' cultural competence' is being rejected for other terms like cultural humility, cultural safety, and structural competence. This was based on the notion that one could never attain a proper cultural competence level due to culture's ever-evolving complexities. However, the writers here are grounded in the social work code of ethics, which has more aspirations and goals. Thus, an argument for medical and behavioral healthcare professionals must examine their ethical principles concerning the need for aspirational and dynamic cultural competence. The NASW Code of Ethics references cultural competence under section "1.05 Cultural Competence".

The authors of this paper have proposed an outline for increasing cultural and emotional competencies. This model will be called the E.I. and cultural competency model or EICC. To go into detail here regarding each of these domains and their subcategories would go beyond the scope of this article. However, the E.I. and CC models are explained in this section.

The E.I. portion of this model focuses on five domains: self-perception, self-expression, interpersonal, decision-making, and stress management. Within each domain are fifteen subdomains of E.I. competencies, learned and learnable capabilities. Under self-perception would be self-regard, self-actualization, and emotional self-awareness. Under the self-expression domain, emotional expression, assertiveness, and independence. Under the interpersonal domain would be social responsibility, empathy, and interpersonal relationships. Under decision-making would be impulse control, reality testing, and problem-solving. Finally, flexibility, stress tolerance, and optimism would be under stress management [23] (Figure 1).

Self-perception	Self-expression	Interpersonal	Decision Making	Stress management
Self-regard	Emotional expression	Social responsibility	Impulse control	Flexibility
Self-actualization	Assertiveness	Empathy	Reality testing	Stress tolerance
Emotional self-awareness	Independence	Interpersonal relationships	Problem-solving	Optimism

Figure 1: Emotional Intelligence Model

The cultural competence portion of the model is taken from Campinha-Bacote's model of cultural competence [21]. However, to briefly summarize or capture some of what it may involve includes the following five constructs:
a) cultural awareness (a self-reflection of one's own cultural and professional background)
b) cultural knowledge (obtaining information about different cultures)
c) cultural skill (conducting an assessment of cultural data of the client)
d) cultural encounters (personal experiences with clients of different backgrounds)
e) cultural desire (the process of wanting to be more culturally competent).

Moreover, an EICC Model suggested for training healthcare professionals and leaders would be depicted as follows (Figure 2):

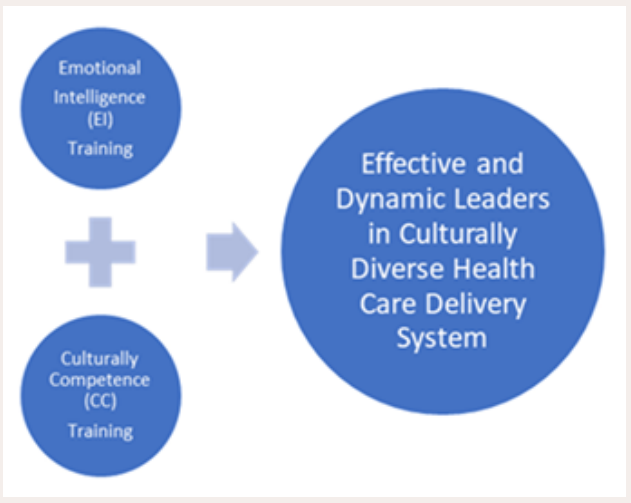

Figure 2: An EICC Model.

The model illustrated above by the authors suggests an approach that focuses on the communication process around E.I. that trains providers to be aware of certain cross-cultural and social issues and health beliefs present in all cultures. Leaders should focus on themselves first as the learner and the client-patient as the teacher and on developing essential attitudes and skills for social work providers. In addition to their assigned job responsibilities, social workers in health care also serve to end racism and discrimination and promote social justice through education, training, and practice efforts each day.

In conclusion, training the types listed under suggested questions and discussions addressing cultural and emotional competency dimensions mentioned previously should be incorporated into cultural diversity training. An approach focused on identifying and negotiating unique styles of communication, decision-making preferences, roles of family, sexual and gender issues, and issues of mistrust, prejudice, and racism, among others. Ultimately, some balance of cross-cultural knowledge and communication skills is the best approach to cultural and E.I. competency education and training. However, the basic premise of a social work training program begins with the use of self. And assessing one's level of "emotional-social intelligence.'

Discussion and Conclusion

Health disparities have been well documented throughout history and persist today, disproportionately affecting historically marginalized individuals and communities. To address this, the authors have provided a conceptual framework for improving healthcare delivery, focusing on the social worker and other healthcare providers as leaders. Social work leaders must have well-developed E.I. to effectively lead their teams, clients, and communities by understanding their feelings and emotions, empowerment, and advocacy. Social workers, guided by ethical principles, should then be able to respond effectively and sensitively to micro, mezzo, and macro challenges and opportunities for positive change.

Utilizing a health equity lens and culturally competent approaches to healthcare have been recognized as impactful ways to close the health gaps. Social work leaders must have strong cultural competence, inclusive of the health equity perspective, to understand the needs of their clients from different backgrounds. Cultural competence is essential to be able to work with clients from diverse backgrounds and to be able to provide culturally appropriate services. This approach begins at a micro-level, utilizing an emotionally intelligent social competency training approach. Social work leaders must be able to partner with their clients to understand the needs and values of the individuals and communities they serve and be able to provide services that are tailored to those needs. E.I. and cultural competence are essential skills for social work leaders and must be developed to be effective. Social Work is rooted in structural change efforts and social justice, with social workers being trained to navigate the various dimensions on the micro, mezzo, and macro levels that impact health.

Limitations, Opportunities, and Call to Action

Despite the National Association of Social Workers' call to engage in social and political action as part of the Code of Ethics, social work continues to utilize a multicultural approach in social work education. This falls short in the pursuit of health equity and justice in that it focuses on helping an individual or population function within their environment versus seeking to change the environment that may be perpetuating oppression. The CSWE's focus on improving social work education in addressing and ensuring competency in the next generation of social workers to be aware of diversity, privilege, systemic oppression, and intersectionality moves anti-racist practice beyond theory to application [25]. It is important to acknowledge that this conceptual framework may need empirical research to support the underrepresentation of minorities in social work. Assumptions about E.I. must be assessed regarding social work students with EQi-2.0 emphatically based assessment tools. These tools, along with demonstrating cultural competency, will be a process of moving beyond a multicultural approach to disrupt and change practices, systems, and environments [26-29].

References

1. Dawes D (2020) Political Determinants of Health. Johns Hopkins University Press.
2. National Academies of Sciences, Engineering, and Medicine, Health and Medicine Division, Board on Population Health and Public Health Practice, Committee on Community-Based Solutions to Promote Health Equity in the United States. In: Baciu A, Negussie Y, Geller A, Weinstein JN (Eds.) (2017) Communities in Action: Pathways to Health Equity. National Academies Press (U.S.).
3. American Medical Association (2021) Organizational Strategic Plan to Embed Racial Justice and Advance Health Equity.
4. Joszt L (2018) Implicit Biases Have an Explicit Impact on Healthcare Outcomes. American Journal of Managed Care.
5. National Association of Social Workers (2020) Social Workers Must Help Dismantle Systems of Oppression and Fight Racism Within Social Work Profession.
6. National Association of Social Workers (2021a) Code of Ethics.
7. Pace P, Clayton L (2020) 65 Years of Advocacy. Social Work Advocates p. 22-27.
8. (2021) Bureau of Labor Statistics, U.S. Department of Labor, Occupational Employment and Wage Statistics.
9. National Association of Social Workers (2021b). Undoing racism through social work.
10. Bailey GB (2021) The association of emotional intelligence and transformational leadership to job satisfaction of social work leaders (Order No. 28317253). Available from ProQuest Dissertations & Theses Global.
11. Emmerling RJ, Shanwal VK, Mandal MK (2008) Emotions and the ability model of emotional intelligence. In: Emotional intelligence: Theoretical and cultural perspectives. (Eds.) New York: Nova Science Publishers, Inc. p. 1-16.
12. Nickerson M (Ed.) (2017) Integrating cultural concepts and terminology into the aip model and emdr approach. Cultural competence and healing culturally based trauma with emdr therapy. New York, NY: Springer Publishing Company, LLC p. 15-27.
13. American Medical Association and Association of American Medical Colleges (2022) Advancing Health Equity: a guide to language and narrative concepts.
14. Jongen C, McCalman J, Bainbridge R (2018) Health workforce cultural competency interventions: a systematic scoping review. BMC Health Serv Res Apr 2 18(1): 232.
15. Truong M, Paradise Y, Priest N (2014) Interventions to improve cultural competency in healthcare: a systematic review of reviews. Health Services Research.
16. Betancourt JR, Green AR, Carrillo JE, Ananeh FIIO (2003) Defining cultural competence: A practical framework for addressing racial/ethnic disparities in health and health care. Public Health Reports 118(4): 293-302.
17. Morgan A, Shah K, Tran K, Chino F (2021) Racial, Ethnic, and Gender Representation in Leadership Positions at National Cancer Institute-Designated Cancer Centers. JAMA Netw Open 4(6): e2112807.
18. Lee TH, Volpp KG, Cheung VG, Dzau VJ (2021) Diversity and inclusiveness in health care leadership: Three key steps.
19. Shafritz JM, Ott JS, Jang YS (2016) In Classics of organizational theory (8th ed.), pp. 340-346.
20. Henderson S, Horne M, Hills R, Kendall E (2018) Cultural competence in healthcare in the community: A concept analysis. Health and Social Care in the Community 26(4): 590-603.
21. Campinha BJ (2002) The Process of Cultural Competence in the Delivery of Healthcare Services: a model of care. J Transcult Nurs. Jul 13(3): 181-184.
22. Wall BED, Hedge AV, Craft K, Oberline A (2018) Using Campinha-Bacote's Framework to Examine Cultural Competence from an Interdisciplinary International Service Learning Program. Journal of International Students 8(1): 274-283.
23. Bar On R, Handley R, Fund S (2005) The impact of emotional intelligence on performance. In Linking emotional intelligence and performance at work: Current research evidence with individuals and groups p. 3-19.
24. Melendres M (2022) Cultural competence in social work practice: Exploring the challenges of newly employed social work professionals. Journal of Ethnic & Cultural Diversity in Social Work 31(2): 108-120.
25. CSWE (2022) www.cswe.org/getmedia/70e9bf4f-9cd4-4b6b-9bf6-55ada583f024/2022-EPAS-ADEI-Information.pdf
26. International Federation of Social Workers (1996) Human Rights. IFSW General meeting.
27. Jaiswal J (2019) Whose responsibility is it to dismantle medical mistrust? Future directions for researchers and Health care providers. Behavioral Medicine 45(2): 188-196.
28. https://www.socialworkers.org/About/Ethics/Code-of-Ethics/Code-of-Ethics-English
29. Venkatachalam D, Mishra G, Fatima A, Nadimpally S (2020) Marginalizing' health: employing an equity and intersectionality frame. Saude em Debate 44 (1): 109-1199.