Family Medicine in a Culturally Diverse World: A Solution-oriented Approach to Common Cross-cultural Problems in Medical Encounters

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Background: *Using cultural sensitivity in the training of family practice residents generally results in positive consequences for patient care. However, certain potential problems associated with cross-cultural educational efforts deserve examination, including patient stereotyping, assumptive bias, and the confounding of ethnicity with class and socioeconomic status. Even awareness of these pitfalls may not guarantee physician avoidance of other barriers to effective patient care, such as communication difficulties, diagnostic inaccuracies, and unintentional patient exploitation. Despite these complications, future family physicians must continue to participate in educational activities that increase sensitivity toward and understanding of patients of different ethnicities. This article discusses certain features characteristic of the ways in which cultural variables operate in the doctor-patient encounter and identifies specific ways in which residents can successfully elicit and use cultural knowledge to enhance patient care.*

(Fam Med 1996;28:249-55.)

As the population of the United States becomes increasingly diversified, sensitivity to cultural factors in family medicine can only benefit patients, their families, and their physicians.[1-3] Demographic data pointing to major population shifts, especially in certain border states,[4] make it imperative that family physicians are adequately trained to deal with patients in a multiethnic, culturally diverse society. Further, there are encouraging indications of increasing ethnic diversity among residents in family practice residency programs,[5,6] reminding us that cultural differences are a two-way street.

Despite the importance of cultural sensitivity in effective patient care, curricular time to provide this cross-cultural training is extremely limited. As Burkett[7] points out, culture is marginalized in most interpretations of the biopsychosocial model, which is one of our main teaching paradigms of patient behavior and patient-physician interaction. Further, there is significant controversy about what type of training to employ.[8]

Universalist Versus Culture-specific Models

Historically, a universalist perspective in approaching patients of different cultures and ethnicities dominated educational efforts.[9,10] In this model, one of two assumptions was made. Either Eurocentric methods of doctor-patient interactions were considered appropriate for all patients, regardless of cultural background (eg, behavior modification strategies to alter unhealthy lifestyles were assumed to be equally effective with all patients regardless of cultural background), or the emphasis fell on identifying human processes similar to all peoples regardless of ethnicity or culture (eg, patient desire to be well rather than sick or maternal concern for child welfare). The obvious limitations of this model were that it ignored real cultural differences and often attempted to impose interpretations and interventions inconsistent with a patient's belief system.

More recently, the culture-specific model has risen to prominence. In this model, values, beliefs, and orientation of different groups are learned, and residents are encouraged to become familiar with a vast array of cultural variations. Differences between the groups being studied and the majority culture are stressed.[11] Yet this model also has significant limitations, most notably its tendency to promote desperate attempts at superficial mastery of a seemingly endless list of concrete culture-specific characteristics.[12] This approach is seen as mechanistic and reductionistic.[9]

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New Teaching Approaches

As growing numbers of residents are trained in managed care settings, with pressures to maximize patient volume, it has become apparent that while the old universalist model remains inappropriate, significant modifications in the culture-specific model are necessary to ensure its relevance to contemporary clinical practice. Because residents do not have time for in-depth immersion in the multiplicity of cultures that comprise the patient populations of today, we must begin to develop efficient, solution-oriented ways of introducing cross-cultural principles to guide patient-physician interactions. This paper identifies general strategies that can be applied by residents in approaching most difficult cross-cultural encounters. Then, through specific examples derived from our own training experiences, we illustrate how these approaches can be applied to common mistakes made by residents in attempting to practice cross-cultural medicine. This approach has the advantage of providing general principles to guide resident behavior in specific clinical situations, while honoring the existence of innumerable patient-physician cultural variants.

Cross-cultural Strategies

Evidence-based Evaluation of Cultural Information

Although teaching evidence-based approaches to clinical decision making is on the rise,[13,14] it remains neglected in the area of cross-cultural medicine. Yet, the empirical basis for understanding differences in culture is steadily growing. For example, Triandis et al[15] have written extensively about the Hispanic cultural script of "simpatia" which, according to their research, results in higher frequencies of positive social behaviors, lower frequencies of negative social behaviors, attitudes of dignity and respect toward others, and efforts toward social harmony. Their studies lend empirical validation to this construct through identification of clear behavioral differences in Caucasian and Hispanic subjects. In a related line of investigation, Betancourt et al[16] have demonstrated provocative differences between Hispanic and Caucasian samples on a worldview dimension they have conceptualized as control over vs subjugation to nature. More traditionally oriented Latinos tend to adopt the latter view, whereas Caucasians endorse statements that reflect a desire to establish control over the external world. These and other similar studies are particularly useful because they move beyond broad generalizations about cultural differences and instead attempt to specify particular cultural constructs that have clear behavioral and social implications. Such research is a vast improvement over the earlier positing of "cultural elements,"[17] since it establishes clear empirical linkages to social behavior.

Familiarity with currently available literature-searching techniques[18,19] enables residents to quickly retrieve and evaluate knowledge held about a particular cultural group (ie, cultural generalizations). A well-trained resident should be able to find answers in the literature to these key questions: 1) How accurate is a cultural generalization? Depending on the existing empirical database, residents may feel more confident regarding some assertions about culturally derived differences than about others. 2) How current is a cultural generalization? In light of rapid patterns of acculturation and evolution in cultures themselves, information may quickly become dated and must be kept current. 3) What are the limitations of a specific cultural generalization? How well does a particular cultural stereotype translate to a specific patient? Understanding the literature will provide residents with important qualifications about the generalizability of information. Valid empirical research findings may not be relevant to a given patient because of acculturative, socioeconomic, educational, or individual variations. 4) What data exist for helping the clinician understand how to make adjustments in professional practice style in light of empirically validated new knowledge? Even if a piece of knowledge appears to be true in general, and even if it appears relevant to a particular patient in a general sense, physicians must still question whether the literature can provide empirically based guidance regarding clinical applications.

Inductive Models for Learning About Cultural Differences

Most of our educational models about culture, like other models of learning, are "top-down" approaches. In other words, we attempt to discover broad rules and generalizations (in this case, about a specific group or groups), and then apply the general rule to a particular situation. This deductive model is useful in helping us organize and assimilate vast quantities of information. However, in contemplating innovative educational methodologies, we should also consider the utility of using inductive methods of learning as an authoritative source for developing understanding of patients from other cultural backgrounds. In an inductive model, the patient, rather than the theory, is the starting point for discovery.[20] The resident is taught to apply an ethnographic approach[21,22] by becoming a skilled observer of patient behavior in clinical settings and thus form conclusions that apply primarily to the patient and family, secondarily to the patient's immediate social and community context, and only tentatively and indefinitely to the patient's larger ethnic grouping. This approach establishes differential hierarchies for information obtained depending on proximity to the primary source (ie, the patient). Thus, information obtained from patients about their relation to cultural variables is given greatest importance. Information from family, relatives, and

friends also carries great weight. Information obtained from the immediate social context of community is significant but somewhat less so. General information about the patient's culture and/or ethnicity is regarded as potentially having some bearing but requires further validation to be considered immediately useful.

Narrative Approaches

One inductive method for assessing the dynamic, evolving quality of culture and the meaning it plays in the lives of patients is to elicit their personal stories.[23-24] Building a life-history review[25] is admittedly a time-consuming process, but in a continuity care context it may be developed over time, little by little. Even the resident with little initial background will eventually be able to establish a fairly complete sense of the values, assumptions, and expectations that inform the life of his or her patient. Soliciting such patient narrative also effectively communicates respect for the dignity and human worth of the patient.[26]

Cultural Flexibility

The resident needs to be encouraged to develop a culturally flexible patient interaction style. This means that the resident cultivates an ability to adapt his or her practice style to acknowledge a specific patient's position on a "traditional"/ "modern" continuum.[27] Patients with a traditional orientation, who may be from a variety of different specific cultures, nevertheless may share similarities on several dimensions. For example, in terms of gender roles, a traditional orientation will emphasize more strict distinctions, whereas a more modern sensibility allows somewhat flexible boundaries. Traditional cultures generally stress a strong family identity and loyalty, whereas modern cultures frequently emphasize individual autonomy and centrality. Traditional cultures also tend to be characterized by a stronger past and present time orientation, whereas modern cultures reflect a stronger orientation toward the future. Being able to match one's cultural style to that of a patient creates a reassuring sense of congruence and familiarity for the patient. In mastering cultural flexibility, residents learn to move back and forth between traditional and modern orientations and situations and develop a respect for both traditional and modern cultures.

Common Resident Mistakes in the Practice of Cross-cultural Medicine

Stereotypes and Assumptive Bias

Residents often stereotype and make assumptions about patients based on limited or inaccurate information. Time constraints on current teaching of cross-cultural medicine unintentionally may leave residents with a series of broad generalizations taken from a laundry list of cultural specifics. What is inevitably lost in such brief encapsulations of culture is the enormous variation due to age, gender, income, education, acculturation, individual differences, and multiple other factors. In their attempts to tailor treatment ostensibly to accommodate specific cultural characteristics, residents unwittingly may recapitulate negative biases and stereotypes.[28]

PROBLEM: Resident notices she tends to think about specific patients in terms of generalizations: "People like Senora Hernandez just don't care about being prompt."

SOLUTION(S): 1) Evidence based: The resident should consider researching time orientation and how this expresses itself in Latin cultures. The resident should also examine the literature on factors contributing to lateness and high no-show rates in disadvantaged populations. 2) Narrative: The resident should try listening to the patient's story—a few minutes at a time. Developing an appreciation for the unique events that have shaped the patient's life, as well as the cultural values in the patient's heritage, will help the resident place specific behavior in a more appropriate cultural context. 3) Inductive: The resident should practice inductive reasoning, putting aside preconceived notions about a particular culture and letting the patient and family (and the next patient and family) teach the resident about their culture.

PROBLEM: Resident sees Senora Alvarez's name on his patient schedule and recalls that she seems stiff and ill at ease whenever she comes for an appointment. The resident has just learned about the concept of personalism[29] in a cross-cultural medicine lecture and remembers one implication is that successful professional relationships should have a personal component. Now the resident decides to be friendlier and engage in a minute of social chitchat before moving to the reason for the patient's visit. Is this a stereotypic decision?

SOLUTION: Probably not. The resident should enter into this type of clinical experiment with an empirical hypothesis: Senora Alvarez will act and appear more relaxed if the resident behaves more personally. If the resident's altered behavior produces no concomitant change in patient behavior, the analysis of the problem should be reexamined (evidence-based empiricism).

Exoticism of Culture

The culture-specific approach in resident training often results in the exoticism of culture, reducing it to a remote and precious construct. By continually emphasizing differences and folk practices, cross-cultural training may reinforce the bias that culture refers only to the rare and quaint practices of unsophisticated peoples.[30] In this way, residents run the risk of relying on outdated and often historically inaccurate generalizations when approaching patients of different ethnicities.

A perhaps unintended consequence of this exoticism of culture is that many residents tend not to regard themselves as having a clear cultural identity. "Culture" refers to "others," not "self," "them," not "us."[2] It is important to teach residents that they must be willing to locate themselves, as well as their patients, within a cultural context. The physician's relationship to his or her own culture of origin, as well as to the dominant culture in which he or she currently is functioning, are crucial in forming a physician's views of health care, personal responsibility for wellness behaviors, the proper role to assume in relation to patients, and many other aspects of medical practice.

PROBLEM: The resident admits she knows very little about her own background and culture of origin.

SOLUTION: The resident might consider doing a three-generational genogram of her own family[31] (ethnographic), videotaping parents and grandparents recounting their personal histories (narrative), or even paying a visit to her ancestral homeland or region (ethnographic fieldwork).

PROBLEM: The resident reads an interesting article about curanderos, but when he asks his Mexican-American patients, no one can help him identify one in the local community, and they deny consulting with such traditional healers.

SOLUTION: Culture, like time, moves on. While recent immigrant Latinos may well seek out the services of a curandero, third- and fourth-generation Chicanos are likely to have abandoned this practice.[32] Further, the resident should recognize that factors of acculturation interact strongly with traditional values and practices to produce modifications and change (evidence based).[33] By attending to within-group differences in his own patient population (ethnographic and inductive), the resident should come to appreciate the flexibility and variety inherent in any given ethnic group.

Pseudo-explanatory Models

Another disturbing consequence of current teaching on cultural differences is that it may unwittingly produce the assumption that culture somehow accounts for all unexplained differences among groups.[3,17] In and of itself, culture is a vague and overgeneralized explanatory term. Yet, superficial exposure to cultural awareness may lead residents to make false cultural attributions or to see evidence of cultural implication where none exists. Although offered up as an explanation, in most cases this culture-specific approach remains nothing more than an intriguing hypothesis.

PROBLEM: Whenever the resident's patient exhibits a bizarre or irrational behavior, she makes a statement to the effect: "I guess that's just how these people are."

SOLUTION: The resident should consider alternative diagnoses, ie, schizophrenia or paranoia (evidence based).

Confounding Ethnicity, Culture, and Class

One of the clinical consequences of social inequities and injustice in contemporary American society is that individuals who are African-American, Latino, and recent immigrants are more likely to have a lower socioeconomic status than Caucasians. Thus, attributions made about the role of culture in patient behavior may be due to class differences. Indeed, in studies of racial and ethnic differences that control for socioeconomic status, many group differences previously explained by culture disappear.[34]

PROBLEM: Resident attended an elite, private medical school where several of his classmates came from families with ties to the ruling oligarchies in various Latin American countries. Based on this experience, he frequently makes statements suggesting he believes he has a fairly good sense of the cultural context of the indigent Mexican farmworkers who seek care at the family practice clinic.

SOLUTION: This resident needs to think again. It is a common mistake to confuse ethnicity with class as an explanation for patient belief or behavior. Often, people of different ethnicities but similar socioeconomic status have more in common with each other than with individuals from the same cultural background but very different socioeconomic standing (evidence based).

Cultural Mismatch

The resident's natural style of interaction and analysis may not match the patient's style. Either the patient is more traditional than the physician or possibly vice-versa. In either case, misunderstandings and discomfort are likely to result.

PROBLEM: The resident can't identify the problem clearly, but she reports feeling awkward when treating patients from different cultural backgrounds.

SOLUTION: Possibly there is a mismatch in cultural styles, with one individual being more modern and the other being more traditional. Initially, the resident should try to adjust her interaction style to that of the patient's (evidence based). If the patient is more formal, the resident should be sure to address her by her last name. If she prefers a more authoritative interaction, the resident should not hesitate to take charge of the interview (inductive, ethnographic; cultural flexibility). Later, the resident may try to explain more modern expectations for the doctor-patient relationship that exist in the American medical system.

PROBLEM: The resident complains that her patient is too deferential and always agrees with everything she says, even though she knows that the patient is not usually compliant with medical instructions.

SOLUTION: The resident should reassure the patient that she is in charge and knows what she is doing. Later she should try to educate her patient about the importance of patient feedback, being careful to distinguish this from criticism or disagreement (cultural flexibility).

PROBLEM: The resident complains that the patient is too fatalistic and passive and won't take responsibility for her own health. The resident states that the patient seems totally unfamiliar with the concept of a therapeutic alliance.

SOLUTION: The resident should remind himself that fatalism and an external locus of control are characteristic of many traditional cultures (evidence based). Sometimes, passivity is a corollary of racism and poverty, which engender feelings of powerlessness (evidence based). While acknowledging cultural and societal foundations of the patient's behavior, the resident should encourage her that in small, specific ways she can exercise control that may improve her own or her family's health (cultural flexibility).

Lack of Shared Language/ Communication Difficulties

The obvious difficulties in communication that arise when a shared language is absent in the doctor-patient encounter have been widely documented and do not need to be reviewed here.[35,36] Inaccurate or simply wrong translations of information and knowledge frequently occur when interpreters are used or when physician and/or patient struggle to communicate in a language in which they are not wholly proficient. Further, the use of primary vs secondary language may influence diagnostic outcome. This has been clearly established in terms of psychiatric diagnoses[37,38] but may have implications for categorizations of other medical illness as well.

PROBLEM: The resident wants to know what to do when no skilled interpreter is available to translate or only a family member can serve as the interpreter.

SOLUTION: The resident should be encouraged to restrict the interview, focus on short, yes/no answers, and invest the time in telling the interpreter exactly what type of information is needed. The resident should be prepared to rephrase questions that neither the patient nor the interpreter appear to understand. The resident should probably avoid highly sensitive questions about sex or money, since she will probably not get any useful information anyway. Finally, the resident should try to use more repetition and paraphrasing of important points than usual (evidence based).

Culture-bound Meaning of Symptoms

Even beyond the obvious misunderstandings and confusions resulting from imperfect interpretation, residents also need to realize that the descriptions of symptoms themselves may have a culture-bound meaning.[39] For example, some research suggests that the apparently higher-than-normal incidence of depressive symptomatology in Latino patients[40] actually may be an artifact of normal cultural expression, a permissible way to present one's current situation rather than a reliable marker for true clinical depression.[41] Thus, it is essential to evaluate not only the accuracy of observed or reported patient data but also its culturally connected meaning and significance.

PROBLEM: The resident wonders whether his Latino patient, whose wife recently died, is psychotic because the patient "saw" his wife standing at the foot of his bed the other night.

SOLUTION: The resident should be reminded that symptoms have culture-bound meanings. While seeing visualizations of people not present is commonly thought of as a hallucination, it is considered culturally appropriate among certain Latin American and Native American groups for the dead to revisit the living (evidence based).

Differences in Health Belief Models

Sometimes residents and patients hold widely divergent beliefs about the causes and treatments of a specific disease. Medical anthropology[1] has pioneered exploration of some of these differences and their implications for health care. Perhaps the crucial element to convey in resident training is that, unless such differences are made explicit, they may have an unintended deleterious effect on patient care.

PROBLEM: The resident wants to know how to handle a patient whose newborn is colicky. The mother does not seem interested in either the resident's explanation for why the baby fusses or what she might do to relieve the infant's symptoms.

SOLUTION: The resident should find out how the mother explains the infant's behavior (inductive, narrative). Perhaps she is convinced that the symptoms are caused by susto, or a fright[42] the mother experienced while pregnant. Perhaps she is simultaneously consulting a healer, whose ritual remedies are traditionally regarded as the most appropriate cure for susto. If such treatment appears harmless, the resident will do well to support it, since in all likelihood the mother will continue to take the child to the healer anyway. By eliciting strongly held belief systems, the resident clarifies and simultaneously legitimizes differences in explanatory models. Because both models are now explicit and open for discussion, the resident has also increased the likelihood that his patient will better understand and eventually accept his treatment recommendations as well (cultural flexibility).

Patient Exploitation and Oppression

In interacting with, and attempting to therapeutically treat, patients from different cultural backgrounds, there is also the danger for residents of un-

intentional patient oppression. It has long been a tenet of sociological analysis that, in any unequal power relationship (for which the doctor-patient relationship certainly qualifies), the possibility of exploitation exists.[43] When the professional-lay person power disparities are compounded by inequalities in socioeconomic status, education, and differences in cultural perceptions, the risk of such oppression is significantly increased.

Most obviously, the resident unwittingly may behave in an exploitive way, eg, taking advantage of a patient's confusion or discomfort to ignore patient concerns or to impose treatment protocols without obtaining truly informed consent. There is also a tendency to stigmatize patients from different cultural backgrounds. Studies show that patients of low socioeconomic status and minority patients are often seen by health care professionals as nonparticipatory, uncooperative, poor historians, and basically untreatable.[44,45]

A crucial element is that the resident have a clear awareness of his or her own cultural sophistication in relation to a particular patient. Borkan[46] has provided an excellent developmental model of ethnosensitivity, enabling us to place ourselves on a continuum of cultural understanding. Residents must be taught to ask themselves, "What are my biases and assumptions about individuals with this cultural background? Is my knowledge of this culture superficial or deep? Is my understanding personal and experiential, or academic and theoretical?" Physicians must honestly attempt to take into consideration issues not only of ignorance but also racism and prejudice.[47]

PROBLEM: The resident typically makes patients of color wait longer than Anglo-European patients. Even when the resident seems aware that her patients of color haven't fully understood her explanations and instructions, she rarely gives opportunities for clarification.

SOLUTION: The resident needs to take a hard look at herself. Her behavior suggests both patient exploitation and oppression. By taking advantage of a patient's fear, unfamiliarity with the system, or lack of options, the resident is behaving in a disrespectful and possibly patient-endangering manner (evidence based).

PROBLEM: The resident confides he worries he might be prejudiced against certain ethnic minorities.

SOLUTION: The resident should ask himself these questions: 1) Does he generally adopt an etic approach (making universalist assumptions about people in general) rather than an emic perspective (culture-specific assumptions)? 2) Does he tend to emphasize group homogeneity more than individual differences? 3) In his heart of hearts, does he believe certain groups are inferior to others? 4) Does he believe that people who live here should become "Americanized," rather than "cling" to the beliefs and behaviors of their culture of origin? If he answers yes to any of the above, he may need a short course in ethnosensitivity (cultural flexibility).

When Cultures Clash

A serious study of different cultures will help reduce misunderstandings and unintentional affronts. Many apparently conflictual situations can be resolved through dialogue, trust, and exploration of the meaning ascribed to different alternatives. However, cultural relativism inevitably has its limits, and in certain circumstances, cultural conflict becomes unavoidable. For example, most Western physicians are rightly loathe to accept the still-prevalent practice in certain African countries of female circumcision as simply an expression of cultural difference. In culture clashes occurring in this country, such as seeking an abortion based on gender or the permissibility of spousal abuse, an understanding of both the laws and the value system of this country is essential in guiding treatment. The resident must learn to distinguish between judgments about patients of different cultural backgrounds that merely reflect bias or misunderstanding and those that are deeply rooted in a carefully examined personal and societal ethical code. In these problematic situations, it is clear that the resident must make decisions based on existing laws and the underlying humanitarian principles that inform them. At the same time, communication about different value assumptions on the part of resident and patient is important to allow the possibility of a professional relationship between the two to persist.

PROBLEM: A resident learns that her Latina patient's husband hits her when he is drinking, which happens on a regular basis. Because she has heard this story from many of her other Latina patients, she wonders whether this is culturally acceptable behavior.

SOLUTION: This resident should stop wondering and encourage her patient to seek refuge in a battered woman's shelter. There are definite limits to cultural relativity and not acting when someone's life is in danger one of them.

Summary

This article has argued for a realistic appraisal of the role of culture in patient care and in the doctor-patient relationship. At the same time, it cautions against indulging in a simplistic "cultural elements" approach, which reduces patients of diverse backgrounds to a collection of stereotypes and generalizations. Rather, educators would do well to train residents to a more systematic understanding of the role of cultural variables in the doctor-patient interaction. Specifically, residents need to use developments in evidence-based medicine to evaluate the

quality and integrity of cross-cultural information to which they are exposed or need to learn. Secondly, they need to know how to consider and apply inductive, heuristically derived strategies that place the patient and family at the center of a culture-based analytic schema. Further, residents need to be trained to identify patient situations in which it is strategic to adopt narrative, ethnographic approaches to interaction that will communicate appreciation of the individual patient while gradually building culture-specific expertise in the resident. Finally, residents need to develop cultural flexibility to match their interactive style with that of culturally different patients. Developing these types of specific skills will recognize in a useful and meaningful way the centrality of culture in the lives of both patients and residents.

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