Cultural Health Attributions, Beliefs, and Practices: Effects on Healthcare and Medical Education

Lisa M. Vaughn*[,1], Farrah Jacquez[2] and Raymond C. Baker[3]

[1]*University of Cincinnati College of Medicine (UCCOM), Department of Pediatrics, Divisions of General and Community Pediatrics and Emergency Medicine, Cincinnati Children's Hospital Medical Center, Cincinnati, Ohio, USA*

[2]*University of Cincinnati College of Arts and Sciences, Department of Psychology, Cincinnati, Ohio, USA*

[3]*UCCOM, Department of Pediatrics, Division of General and Community Pediatrics, Cincinnati Children's Hospital Medical Center, Cincinnati, Ohio, USA*

Abstract: Health attributions influence health beliefs and subsequent health behaviors. Health attributions are partly shaped by culture. In turn, cultural health attributions affect beliefs about disease, treatment, and health practices. Likewise, culture influences health and healing practices. Certain cultures have culture-bound syndromes about which medical practitioners should be trained. Other sociocultural factors such as immigration, acculturation, and social support play significant roles in health attributions and medical adherence. Culturally diverse patient populations require that medical educators learn new methods of cultural assessment and treatment in order to be effective. Medical educators also need teaching and learning approaches and philosophies that consider health attributions, beliefs, and practices of patients.

Keywords: Cultural health attributions, health beliefs, cultural diversity, culture and medical education, culture and healthcare.

INTRODUCTION

Medical educators have wide ranging responsibilities in the education of physicians and other healthcare providers. Keeping current in the rapidly growing body of scientific knowledge in medicine is one of these responsibilities that requires extensive self-directed learning and continuing medical education activities. These activities provide the core medical knowledge that is required to accomplish the task of educating and training the next generation of healthcare providers. Of equal importance in this education is teaching the interpersonal interaction which must occur between physicians and patients and is critical to diagnosis and treatment of the diseases and conditions that initiated the encounter. This interaction requires communication and interpersonal skills which will build a trust between physicians and patients that will encourage them to accept and follow the medical advice (medical adherence) that will restore or maintain wellness.

This interaction in the medical setting is complex and requires shared knowledge about each other. This shared knowledge requires active give-and-take communication, empathy, and time to develop so that each party is comfortable with the other so the physician can provide the most appropriate advice and care. Shared knowledge is the key to establishing trust, which research shows to be an important factor in medical adherence. When there are significant differences between physician and patient, this process takes more work and more understanding. Differences in culture in its broadest sense (e.g. race, ethnicity, country of origin, socioeconomic status, gender) are present in virtually all interactions and these differences must be acknowledged and considered as healthcare decisions are made. This process is a learned process and a key role for the medical educator to teach.

In order to effectively address these issues, medical educators must have knowledge about cultural differences and how those differences affect treatment decisions and they must know how to obtain this information from patients. This article will address several aspects of how culture affects the health and well-being of patients, which will arm medical educators with the information needed to effectively teach this critical aspect of medicine. We will discuss several specific cultures, but it is not within the scope of this article to be inclusive. Healthcare providers who provide medical care to patients or groups of patients with cultural backgrounds unique to their practice need to learn from the patients the details of those cultures and how those culture's indigenous medical beliefs and practices might affect health outcomes and interactions with the services provided in the medical care setting.

Topics that will be covered in this article include 1) health attributions and the effects of different cultures on those health attributions; 2) models of common cultural health beliefs; 3) cultural practices of health and healing; 4) culture-bound syndromes (conditions found only in certain cultures; 5) effects of immigration and other sociocultural factors on health; 6) assessment of cultural background *via* treatment and therapy approaches; and 7) cultural considerations in medical education (relative to theories of adult learning).

*Address correspondence to this author at the Cincinnati Children's Hospital Medical Center, ML 2008, 3333 Burnet Avenue, Cincinnati, Ohio 45229-3039, USA; E-mail: lisa.vaughn@cchmc.org

1876-519X/09

ATTRIBUTIONS AND HEALTH

Like any behavior, the heart of health behavior is attributions - the causal explanation process used to understand the world. Attributions have long been a focus for social psychologists, who have determined that attributions play an important role in both deciding to act and in decision-making among alternative courses of action [1, 2]. Individuals tend to have a consistent attributional style, but research shows that attributional styles differ cross-culturally (e.g., [3-6]). One example of cultural differences in attribution-making is found in one of the most well-documented facets of attributional theory, the self-serving bias, or the tendency to make dispositional attributions for successes and situational attributions for failures (in other words, we take responsibility for the good and deny the bad [7, 8]. Although the tendency to look into the mirror with rose-colored glasses exists across cultures, the self-serving bias is more pervasive in the West than in more collectivist cultures[1] [9]. Research from Western cultures has shown that having self-biases has been linked to improved health practices, better coping strategies, greater achievement, better health overall, and improved mental outlook [10, 11].

People of diverse cultural backgrounds often make different attributions of illness, health, disease, symptoms and treatment. Cultural differences in health attributions have major implications for medical professionals because over time, attributions play an essential role in the formation of beliefs concerning health and illness (e.g., [12-14]). This relationship in turn becomes reciprocal and health beliefs form a cognitive schema that influences the way that people make attributions. For instance, with regard to health beliefs in the U.S., African Americans may be likely to attribute illness externally to destiny or the will of God (equity attributions) and believe in the healing power of prayer [15, 16]. As compared to ethnic minorities in the U.S., Anglo Americans are likely to hold more traditional Western health beliefs such as individual responsibility for health and illness [17, 18] and more "empirical" explanations of illness [12]. Because of the emphasis on micro-level and natural causes of illness, many White Americans believe that illness can be treated without reference to family, community or deities [17].

Although very diverse, Latino populations as a whole are likely to believe in attributional equity as the cause of illness (e.g., God is punishing me for bad behavior and making me ill) and utilize ethnomedical approaches to healthcare such as *santeros* (practitioners/priests of Santería who combine indigenous rituals with the saints of the Catholic church), *herbalista* (herbalists), and folk remedies [19]. Among the U.S. Latino populations, Murguía and colleagues found that U.S. acculturated Latino adults were less likely to make equity attributions about illness, and those Latinos who made equity attributions were more likely to delay seeking healthcare when sick [19]. Flores reported that Latino parents sometimes have false beliefs about the cause of certain illnesses and therefore are more likely to delay vaccinations in children and use home remedies [20].

[1]Collectivist cultures are those in which people tend to think of themselves as members of groups such as families, work teams, tribes, and nations. People in collectivist cultures are likely to put greater emphasis on the needs of the group rather than the needs of individuals. Most Asian cultures are collectivist.

In comparison to Western populations, African patients may be more likely to attribute illness to a spiritual or social cause rather than a physiological or scientific cause [21]. As such, medical practitioners in many African countries emphasize the whole person-body, mind and soul [21]. African patients are more likely to expect health practitioners to provide an experiential and a spiritual reason why they have been afflicted with illness. For example, one study found that Ethiopians were more likely to attribute mental illness to cosmic or supernatural causes, including curses or spirit possession [22]. In order to effectively treat these illnesses, remedies must be both material (e.g. herbal remedy) and spiritual (e.g., amulets) explanations and techniques. Chipfakacha [23] notes that most black Africans attribute illness to superstitious causes and therefore believe that disease is due to 1) magic and evil spirits; 2) conditions for which causes have been empirically determined; and 3) psychological phenomena. For many Africans, the cause of disease relates to conflict and tension between good/evil and harmony/disharmony [23].

MODELS OF CULTURAL HEALTH BELIEFS

Different cultural groups have diverse belief systems with regard to health and healing in comparison to the Western biomedical model of medicine. These belief systems may include different disease models, wellness/illness paradigms (e.g., Chinese medicine, magico-religious thinking), various culturally-specific diseases and disorders, feelings about healthcare providers and seeking Westernized healthcare, and the use of traditional and indigenous healthcare practices and approaches. Helman suggests that people attribute causes of illness to: 1) factors within individuals themselves (e.g., bad habits or negative emotional states); 2) factors within the natural environment (e.g., pollution and germs); 3) factors associated with others or the social world (e.g., interpersonal stress, medical facilities, and actions of others); and 4) supernatural factors including God, destiny, and indigenous beliefs such as witchcraft or voodoo [24]. Westerners tend to attribute the cause of illness to the individual or the natural world whereas individuals from non-industrialized nations are more likely to explain illness as a result of social and supernatural causes [12]. In a study comparing African Americans, Latinos and Pacific Islanders with White Americans on causal attributions of illness, the ethnic minority groups rated supernatural beliefs as significantly more important than White Americans [25]. There was no difference between the groups about illness causation due to interpersonal stress, lifestyle, environment and chance.

Stainton Rogers describes eight "theories" that people use as a basis in thinking about health and illness: body as machine, body under siege, inequality of access, cultural critique, health promotion, robust individualism, God's power, and willpower [26]. In a study of British lay perceptions on health and recovery from illness, Furnham found that strength of religious beliefs tend to predict fatalistic or supernatural health-related beliefs; older people and those with left wing political beliefs were more likely to emphasize external causes and cures for illness; and people who believed in alternative medicine were more likely to endorse controllable or internal causes of health, illness and recovery and less likely to believe in fatalistic or external causes [27]. Overall, the British participants emphasized psychological

and behavioral determinants of health and illness. Furnham also examined health beliefs across the three cultures of Britain, Uganda and South Africa and found that the African participants were more likely to attribute illness to "evil others" but all of the groups rated interpersonal stress as a potential source of illness [12]. The British participants rated fatalistic factors as extremely unimportant while both African groups rated them as a marginally important contributor to illness [12].

More recently, Jobanputra and Furnham [28] tested Helman's model of health beliefs [24] in British Caucasians and British Gujarati Indian immigrants and found general support for the four domains with the Gujarati Indian immigrants being more likely to endorse supernatural explanations of ill health as compared to the British Caucasians. There was no significant difference in the two groups in terms of attributions made to psychological factors, social factors, and the external environment.

CULTURAL PRACTICES OF HEALTH AND HEALING

All cultures have disease theory systems which include attributional concepts to explain illness causality. Three commonly held paradigms of disease across cultures are naturalistic, personalistic and emotionalistic [29-31]. Naturalistic disease theories explain disease in objective, scientific terms and have the core concept that illness occurs when the body is out of balance. For instance, the Western biomedical model views disease as originating inside the body due to a specific, identifiable "medical" cause or pathogen (viral, bacterial, etc.). In the traditional biomedical model, the pathogens need to be eradicated so that the person is without disease and only then are they considered healthy. The humoral system is another naturalistic disease theory originating from Greek and Roman philosophers and popularized by Hippocrates. According to Hippocrates, the body contains four elements (humors): blood, phlegm, yellow bile and black bile and health comes from an equal balance of the four humors. In this theory, healing occurs by restoring the proper balance of humors through removal (bleeding, starvation) or replacing (special diets, medicine) the deficiency [24].

Personalistic disease theory attributes illness to intervention by an agent such as another human, witch, sorcerer, non-human, or supernatural force. Emotionalistic disease theories explain illness as caused by strong emotional states (e.g., intense anger, jealousy, shame, grief or fright). The personalistic and emotionalistic disease theories are easily applied to patients of non-Western cultural backgrounds who are familiar with and have faith in the medical beliefs and practices from their own cultures [29, 30]. These health attributions and beliefs, however, are significantly different from those of Western medicine. Some Asian cultures believe in the yin and yang principle in which there is a balance between opposite forces (e.g. positive and negative, light and dark, hot and cold) that reflect the difference between health and illness. Others believe that illnesses are caused by spirits or ghosts [32].

In order to more effectively treat naturalistic, personalistic, and emotionalistic aspects of illness, there has been an increasing interest and training in osteopathic medicine and complementary and alternative medicine in North America and Europe (see for example, the article by Grossoehme *et al.* in this supplement). Two well known cultural systems of medicine and healing considered to be alternative by Western standards of medicine are Chinese Medicine and Ayurvedic Medicine. Traditional Chinese Medicine (TCM) is based on the concept that the human body has interconnected systems/channels (*meridians*) that need to stay balanced in order to maintain health. TCM healing practices include herbal medicine, acupuncture, dietary therapy, and Shiatsu massage. Qigong (breathing and meditation practice) is also closely associated with TCM [33]. Ayurvedic Medicine is native to India. The Ayurvedic system is based on the idea that every human contains a unique combination of *Doshas* (the three substances of wind/spirit/air, bile, and phlegm) that must be balanced for health. In addition, healthy metabolism, digestion, and excretion are thought to be vital functions of the body. Similar to TCM, Ayurvedic Medicine also uses herbs, massage, meditation and Yoga as healing practices [34].

The Western world has become more interested in alternative healing practices such as acupuncture, homeopathy, herbal medicines, and spiritual healing [35]. Depending on the model of health and cultural health beliefs, there are a variety of possibilities for the treatment approach.

CULTURE-BOUND SYNDROMES

There are some physical and mental illnesses that are unique to particular cultures and are influenced directly by cultural belief systems and other cultural factors. In 1994, the DSM (Diagnostic and Statistical Manual of the American Psychiatric Association) added culture-bound syndromes (i.e., troubling patterns of behavior/ experience that may not fall into one of the traditional Western DSM diagnostic categories). Culture-bound syndromes are considered within the specific culture to be illnesses or at a minimum afflictions and the majority have local names. For example, *dhat* is a disorder affecting Indian males that involves an intense fear that losing semen will result in the depletion of vital energy. *Dhat* is thought to occur through intoxicants, eating heated foods, having a fiery constitution, and sexual excesses which can cause fatigue, weakness, body aches, depression to the point of suicidal feelings, anxiety, and loss of appetite [36]. *Susto* (magical fright) and *mal de ojo* (evil eye) are common afflictions in Latin America. *Susto* is a disorder occurring when the soul leaves the body after a frightful episode. Symptoms include sleep disturbance, easy startling, palpitations, anxiety, involuntary muscle tics, and other depressive symptoms. *Mal de ojo* is an affliction caused by an admiring glance from a more powerful/stronger person and usually affects children. The symptoms of evil eye are fussiness, refusal to eat or sleep, fever, and seizures. Prevention includes wearing special amulets and shielding babies from direct eye contact. Treatment for evil eye can include physical contact from the perpetrator on head or prayer and ritual with egg [37].

Eating disorders span both physical and mental boundaries of cultural health. Eating disorders especially in highly industrialized societies continue to rise [36]. Although in some cultures, being stout and plump is associated with good health and prosperity, and certain historical time periods

have celebrated more voluptuous women (consider the Rubenesque woman) being thin and fit as a cultural ideal for women has increased in popularity [36, 38, 39]. In the Western world, especially with young women, the cultural notion of the thin ideal makes it is clear that culture has a definite influence on attitudes toward body size, body shape, and eating behaviors [38, 40].

Somatization, or physical ailments due to stress or emotional distress, is common especially in collectivistic societies perhaps because people avoid expressing psychological complaints to families and friends [36]. In other words, a person suffering from depression or anxiety might use somatization as a culturally sanctioned way to signal distress [41]. Recognizing that there are culture-bound syndromes and that the expression and formation differs culturally paves the way for practicing culturally sensitive medicine and psychotherapy. Otherwise, misdiagnosis can occur when ethnic and cultural differences are not taken into account.

OTHER SOCIO-CULTURAL FACTORS RELATED TO HEALTH ATTRIBUTIONS, BELIEFS, AND PRACTICES

Cultural influences on health attributions and beliefs and practices are well recognized. Shifts have occurred both in the goals and approach of health and the definition of health itself. Rather than curing being the end-goal of health, now there is more emphasis on prevention of disease and promotion of health internationally (e.g., appropriate diet and exercise). Also increasing in importance has been the inclusion of social and behavioral sciences to understand health problems and supplement the biological and medical technology emphases [42]. This has underscored the importance of context *via* community-based approaches [43] and the important role that sociocultural, behavioral and environmental factors play in health such as poverty, social support, medical adherence/compliance with treatment regimen, resilience, acculturation, immigration, and shared water sources. The definition of health has been extended to include other aspects of well-being—"state of complete physical, mental, and social well being, and not merely the absence of disease or infirmity" [44]. This extension of the definition of health encompasses well-being including quality of life, positive mental health, and the consideration of culturally sensitive approaches to healthcare as well as indigenous and alternative forms of healing as legitimate forms of treatment.

Immigration can have a significant effect on cultural health beliefs and practices. Immigrants may have certain infectious diseases which are endemic to the patient's country of origin. Immigration itself can cause illness and disease due to disrupted family and social networks, financial hardship, and discrimination that prevent the maintenance of a healthy lifestyle. Immigrants leave their countries for a variety of reasons including violence, economic hardships, or natural disasters all of which cause extreme stress and even physical injury [32]. Immigrants frequently work in low-paying jobs, face poverty, lack health insurance, have limited access to healthcare and social services, and have communication difficulties due to language differences [32].

Immigrant families may have trouble accessing healthcare services for a variety of reasons. Language and cultural barriers (including lack of cultural competent healthcare providers), distance to care, cost of treatments, lack of transportation, perceptions of lack of respect, discrimination or racism, and a complex Western healthcare system can all contribute to reduced access to healthcare [45]. Immigrant families from collectivist countries in which kinship is a strong value may view the role of caregiver as an expected way of showing gratitude and love when a family member is ill [46]—this may cause families to delay seeking professional healthcare. Mir and Tovey note that some immigrant families may not seek healthcare because they lack awareness of the healthcare services offered or they may find the services culturally inappropriate or insensitive [47]. Compared to the U.S. born population, foreign born immigrants are twice as likely to lack health insurance [48]. Recent immigrants to the U.S. have less contact in general and less timely contact with the healthcare system [49] and are more likely to have infectious diseases, especially tuberculosis, Hepatitis B, and parasitic infections, as compared to U.S. natives [50-53].

Immigrant children can have infectious diseases that Western pediatricians are not used to diagnosing and treating, and immigrant children often lack adequate immunization. The psychosocial factors of immigration may impose additional stressors on immigrant children (e.g., disparities in social, economic, and professional status from family's country of origin). Immigrant children may experience ongoing mental health issues due to relocation and potential atrocities experienced in home country and because of adaptation issues with school and peer groups. Like their parents, immigrant children may lack of a larger social support network of family and friends which was present in their country of origin [54]. As compared to U.S. born children, immigrant children may experience more dental problems and be more at risk for nutrition problems which result in growth deficiencies [54].

Much of the health-related information about immigrants paints a bleak picture. However, immigrants in the U.S. are generally better off on measures of health risk factors, chronic conditions, and mortality as compared to U.S. natives [55]. Recent immigrants to Westernized countries such as the U.S. seem to have a health advantage in certain areas which is known as the "healthy migrant" phenomenon. Interestingly, this health advantage, however, disappears dramatically and moves to health disparity. Length of time in the U.S. is positively correlated with increases in low birth weight infants, adolescent risk behaviors, cancer, anxiety and depression, and general mortality [55]. Such a phenomenon may be due to the loss of healthy resources from the country of origin including social networks, cultural practices and appropriate level of employment commiserate with education [56]. Social support offers people a mechanism to cope with stressful life events. Social support networks act as a buffer mitigating the adverse health effects of physical and mental stress [57]. Few studies have considered cultural differences when it comes to the role of social support and patterns of social relationships. One article by Kim and colleagues examines social support of Asians and Asian Americans [58]. In this study, Asians and Asian Americans, as compared to European Americans, were more reluctant to ask for support from close others (extended family, friends, etc.). This finding along with other similar findings suggests that social support is culturally mediated and must be viewed

within the context of cultural beliefs about social relationships. Social support has been shown to reduce psychological distress during difficult times and has a variety of health benefits including resilience to life threatening diseases. Social support can act to prevent illness, speed recovery from illness, and reduce the risk of death from serious disease [58]. If social support is defined as the "explicit seeking and receiving of support," it appears that people from collectivistic cultures are less likely to utilize social support than people from individualistic cultures [58, p. 522].

While trying to adjust to a new culture, most immigrants undergo a shared experience dealing with "unexpected obstacles of poverty, discrimination, language, ambiguous immigration or legal status" [59, p. 282]. In most situations, immigrants have been parted from family, friends, and are estranged from the inherent security one attains with being a member of a community [60]. Immigrants may also feel burdened by the necessity of learning and/or enhancing non-primary language skills and overcoming bias when seeking employment, living arrangements, and schools. This process is often hampered by an overwhelming sense of ineptness in a new and different social environment. These cultural hurdles add to the "confusion and conflict, anomie, personal disorganization, and a variety of other problems related to social marginality…." [61, p. 78].

Immigrants and other non-dominant individuals can be affected by acculturation. Smart and Smart define acculturative stress as "the psychological impact of adaptation to a new culture" with potential effects on physical health and self-esteem [62, p. 25]. Acculturative stress occurs as immigrants lose touch with self-identifying constants, values and social institutions of their former homeland. Theorists have suggested that this process of acculturation may lead to higher rates of mental disorders especially depression, adjustment, and general psychosocial dysfunction [42] all of which result from "the processes of adaptation, accommodation, and acculturation which involve dynamic and synergistic changes in the immigrants' intrapsychic character, their interpersonal relationships, and their social roles and statuses" [61, p. 78]. Uncertainty about the future along with heightened levels of anxiety may contribute to family dysfunction which can manifest as strict and authoritarian child-drearing practices including harsh disciplinary methods (spanking) and possible severe, physical abuse [60]. Additionally, households in which both parents work means children may be left unsupervised or neglected, and in some cases, parents have left children behind in their native country. Both of these circumstances can increase conflicts surrounding relationships, gender roles, and respect issues [60].

According to Berry, individuals and/or groups develop one of four strategies toward acculturation [63, 64]. He delineates these strategies on two dimensions: 1) maintenance of heritage, culture and identity and 2) relationships sought among groups, including both dominant and non-dominant groups. Berry postulated that the four strategies of ethnocultural groups include integration (maintain one's original culture and have regular interactions with dominant culture), separation (maintain cultural identity and avoid interactions with dominant culture), assimilation (seek out interaction with dominant culture and do not maintain cultural identity), and marginalization (do not maintain cultural identity and exhibit little interest in interactions with dominant culture). The acculturation strategies chosen by individuals or groups depend on the socio-cultural context of the larger society. For instance, the integration strategy will only work in societies that value cultural diversity and have relatively low levels of prejudice [42]. The dominant group and larger society play an essential role in how acculturation occurs. Assimilation when desired by the dominant culture is termed "melting pot" indicating a blending into the dominant group. When separation is demanded by the dominant group, it is "segregation". Integration occurs when the dominant society endorses mutual accommodation now widely called "multiculturalism". In several studies, Berry's acculturation strategies have been examined in non-dominant acculturating groups. Across these studies, the strategy of integration is generally preferred over the three other strategies and marginalization is the least preferred. However, exceptions do occur such as some Turks in Germany and Canada [42] who prefer separation over integration.

Managing psychological acculturation is challenging given the complexity of situational and personal factors that contribute to the process [42]. First, there is the society of origin and the society of settlement both of which have unique cultural factors. The cultural characteristics of the individual (developed from the society of origin) and the cultural characteristics present in the society of settlement (including political, economic, and demographic conditions) must be understood in order to estimate cultural distance between the two societies. The "migration motivation" of the individual needs should be considered in order to understand the individual's degree of reactive (negative, constraining) versus proactive (positive, enabling) factors toward the migration experience [42]. The presence or absence of a multicultural ideology in the society of settlement gives important information about openness to cultural pluralism and thus acceptance of new members. Societies that support cultural pluralism generally provide a better context for immigrants due to the presence of multicultural institutions and corresponding resources (i.e., culturally sensitive healthcare and multicultural education curricula and services) and because of less pressure to assimilate or be excluded [42].

Although the process of acculturation is fraught with variability due to moderating factors that occur before or during the process, Berry has outlined five primary features that affect the process of psychological acculturation [63]. First, there is the stress or demand of dealing with and participating in two different cultures. Second, individuals evaluate the meaning of dealing with the two cultures and depending on the appraisal, the changes that follow will either be relatively easy or more challenging and problematic. Third are the coping skills and strategies used by individuals if the situation is deemed problematic. The fourth feature of acculturation is the physiological and emotional reactions to the situation. The fifth and last feature is the long term adaptation that may or may not be achieved depending on how the other aspects of acculturation have been addressed.

Other factors related to cultural health attributions, beliefs, and practices include poverty and medical adherence. Poverty remains pervasive and is a causal factor affecting health and health disparities of vulnerable populations across the globe. In 2005, The World Bank estimated that one

fourth of the population of the developing world lived below the international poverty line of $1.25/day considering 2005 prices [65]. Because of the generational aspects and relation to other cultural categories (i.e. race, ethnicity), some view socioeconomic status and poverty as the key disadvantages in society trumping other cultural categories such as gender and race/ethnicity alone [66]. According to the World Health Organization and other international groups, there is an extremely high rate of malnutrition of children under the age of five in developing countries, and this is intimately tied to socioeconomic status [67]. Socioeconomic status and poverty have profound effects on children's development. The effects of poverty contribute to deficiencies in cognitive outcomes, school achievement, emotional or behavioral outcomes, and other areas like teenage pregnancy, increased child abuse and neglect, increased violent crimes, and fear of neighborhoods [68]. Poverty can seriously play a significant role in health risks and barriers to care. One consequence of poverty is substandard housing which can be a factor causing stress and illness and may be even worse for immigrants because of language barriers, large family sizes, and lack of awareness about housing rights.

Patients' health attributions and beliefs are also considered to be a major factor in medical adherence [69]. Depression, social support, and disease severity all play a significant role in predicting adherence. This suggests that approaches to medical care need to effectively understand, assess, and manage "language, culture, ethnicity and social class to enhance patient adherence" [69]. Medical adherence is second only to gaining access to appropriate healthcare in directly affecting health outcomes of children and adults.

CULTURAL CONSIDERATIONS IN TREATMENT AND THERAPY

One aspect of healthcare is how a culture organizes the health system in terms of public or private access to care. In some countries, access to healthcare is mediated by socioeconomic factors, and only the wealthy receive quality care. In other countries, healthcare is widely accessible by all regardless of income level or insurance status. Many aspects of culture can affect successful and effective treatment approaches including religion and spirituality, social support networks, beliefs and attitudes about causes and treatments, socioeconomic status, and language barriers [40]. There is no one perfect program that is culturally relevant for all involved, however, approaching treatment and healing from a culturally competent perspective should be paramount.

There is an undeniable need for culturally competent healthcare services in order to address the health needs of an increasingly diverse pluralistic world, eliminate existing health disparities for minorities, mend a fragmented system of care where some receive better services than others, and meet the required cultural competency standards of accreditation bodies within medical training. Within medicine, the notion of cultural competency originated from medical anthropology with emphasis on the universality/relativity of distress and disease. Kleinman described medicine as a cultural system which requires careful cultural analysis to determine disease and illness (e.g., what is considered illness in one culture may be considered idiosyncratic or even divine in another) [70]. Historically, most Western healthcare initiatives in cultural sensitivity have emphasized immigrants and refugees with limited dominant language proficiency and "buy-in" to Western norms. This approach became somewhat problematic because stereotyping was common and therefore the unique experiences and perspectives of the various immigrant and refugee groups were not recognized.

Cultural issues have increasingly become incorporated into medical care as there has been greater recognition of the intimate tie between cultural beliefs and health beliefs. Perceptions of good and bad health and the causes of illness are formed in a cultural context—what is acceptable in one culture is not in another. For example being overweight is viewed as acceptable in some cultures—it may even be seen as a sign of health and wealth. Many healthcare institutions and community sites have incorporated linguistic competence into their services and have employed skilled interpreters to manage linguistic diversity in their patients. However, being linguistically competent is not the same as being culturally competent. For example, although a site may have interpreters available for patients, the site may still impose a Western values-based healthcare and environment (e.g., certain feeding practices and dietary mandates, lack of religious accommodation such as non-denominational spaces for prayer, particular grieving expectations, non-recognition of extended family members or "tribal" connections as immediate family, etc.).

In medical education, the most commonly cited approaches to cultural competence are a combination of culture specific information with enhancements to communication and assessment skills. Some of the more popular models include the L-E-A-R-N model [71], Kleinman's questions [70], cultural assessments [72, 73] and the ETHNIC framework [74]. Green, Betancourt, and Carillo recommend a social context review of systems to examine the factors of social stressors, support networks, changes in environment, life control, and literacy to understand cultural differences from a deeper perspective [75]. Coming from international business and sojourner work, Brislin uses critical incidents in order to provoke thinking as participants reason through different responses [76]. Many of the techniques/strategies share similarities but concentrate on different aspects/dimensions of cultural competence. Given the array of models and approaches, four main categories of culturally competent approaches to health and healing are suggested: 1) Collaborative Approaches; 2) Personality Approaches; 3) Assessment Techniques; and 4) Partnership/ Empowerment Strategies. This classification is discussed in detail elsewhere [77].

The "life domains" approach is a nontraditional model for healthcare that incorporates cultural health attributions, beliefs and practices [78]. Life domains include language, social affiliation, daily living habits, media, education, work, intimate relations, childrearing, celebrations and events, identity, values, religion/ spirituality, and health practices. By examining life domains, healthcare providers can better understand a family's acculturation level and their worldview which will assist in future healthcare provision.

Because physicians often lack time to do a thorough cultural assessment or go to the depth that may be necessary with some families or patients, other intermediaries such as cultural brokers and lay health workersshould be considered. *Cultural brokers* in the healthcare context are patient

advocates who act as liaisons, bridging, linking, or mediating between the healthcare provider and the patient whose cultural backgrounds differ in order to negotiate and facilitate a successful health outcome [79]. "A cultural broker program has the potential to enhance the capacity of individuals and organizations to deliver healthcare services to culturally and linguistically diverse populations, specifically those that are underserved, living in poverty, and vulnerable" [79, p. 6].

Lay health workers (LHW) or promoters, sometimes referred to as *Promotores* when working with Latinos, and by many other names[2], provide public health services to those who have typically been denied equitable and adequate healthcare in many different cultures and countries. LHW typically come from the communities in which they work. They do health promotion, education and service delivery within a limited scope of practice. "Lay health workers are effective because they use their cultural knowledge and social networks to create change" [81, p. 516]. There is good evidence that these type of models work because they are culturally appropriate and integrated into communities [82].

As globalization continues to increase, other international approaches to therapy should be considered especially ones which consider trauma and violence at a cultural level. One developmental approach to therapy is the HEARTS Model [83]. The HEARTS model is not linear and should be adjusted according to client's needs. The steps include:

H (Listening to History) - providing the opportunity for client to safely communicate their story; compassionate connection necessary keeping in mind the honor of a survivor's willingness to relay their story to you

E (Focus on Emotions and Reactions) - focusing on the emotions experienced throughout their experience; allowing survivor to put words to his/her feelings about what took place; increasing "feeling vocabulary"

A (Asking Questions about Symptoms) - discussing behaviors and physical symptoms

R (Explaining the Reasons for Symptoms) - helping survivor make sense of symptoms; discussing physical and psychological symptoms as related to experience of trauma; normalizing; helping establish sense of control; symptoms as method employed by body for protection

T (Teaching Relaxation and Coping Strategies) - increasing sense of mastery and reducing symptoms; imagery and focused breathing; identifying coping skills used during times of trauma, stress

S (Helping with Self-Change) - identify ways in which survivor is the same and different after trauma; positive changes; river example

Folklore therapy or the use of Spanish *dichos*/*refranes* (sayings or folklore) may be helpful to mental health practitioners working with Spanish-speaking clients. Dichos/refranes are proverbs and sayings that use folk wisdom to convey helpful information [84]. Dichos therapy groups and individual therapies have been used successfully by some psychotherapists [85]. Dichos often draw clients in whereas other efforts fail because the sayings are relevant to cultures and families, are associated with positive imagery, and offer flexibility in the approach [85].

Ubuntu therapy [86] comes from the South African Zulu Ubuntu philosophy which contains three dimensions: 1) psychotheological; 2) intrapsychic; and 3) interpersonal and "humanness"—(e.g., Zulu saying "umuntu ngu muntu nga bantu" which means I am because we are). The psychothelogical dimension views god as creator who breathed life into all people. The intrapsychic dimension signifies the human essence enabling a person to become abantu (humanized being). The interpersonal dimension emphasizes relationships with others (kindness, good character, generosity, hard work, discipline, honor, respect, ability to live in harmony with others). The overall goal of Ubuntu therapy is to address conflicts within these three dimensions as related to ubuntu values. The therapeutic process consists of hearing the client's story and determining at what level their conflict exists and at what level to address the problem. Therapeutic techniques and approaches include "burning platform," eclectic approaches and art.

Such alternative models to health and healing bring a fresh perspective to cultural awareness and challenges. They do not rely on traditional methods which tend to focus either on improving the cultural competence of the provider, such as through training, or improving the patient, such as through culturally relevant informational materials. Making either party to the healthcare transaction more competent is laudable but addresses only the individual competency of persons and does not address the interaction between family and provider or the systemic competency of the organization. More creative and comprehensive approaches are required that do not rely on the traditional approaches of changing the persons involved but instead focusing on the system as a whole.

CULTURAL CONSIDERATIONS IN MEDICAL EDUCATION

A culturally diverse patient population requires that medical educators modify their teaching and learning approaches and philosophies in order to take into account cultural health attributions, beliefs, and practices of patients who medical learners will encounter. This diversity mandates medical educators to teach medical learners how to approach and manage illness in patients with different backgrounds from their own. In order to emphasize the importance of the role that cultural attributions, values, beliefs and practices play in health and healing, medical education programs need a teaching philosophy and curriculum in order to incorporate approaches, interventions and models which take such factors into account. Training in medical education must incorporate the changing demographics, globalization, and technology as sociocultural conditions that shape the learning needs in today's world [87]. Although changes and

[2]"Lay Health Promoters have gone by many names including: Village Health Workers, Primary Healthcare Workers, Indigenous Healthcare Workers, Community Health Workers, Community Health Assistants, Community Health Representatives, Medical Auxiliaries, Rural Health Assistants, Community Health Aides, Brigadistas, Promotores y Promotoras de Salud, Indigenous Health Aides, Lay Health Advisors, Auxiliary Health Workers, Front Line Health Workers, Barefoot Doctors, Feldsher, Community Health Promoters, Kaders, Prokesa. These terms are not necessarily interchangeable, since each has its own practical, historical and political significance" [80] Nuestra Comunidad Sana. Lay health promoters. [cited 2008 November 21]; Available from: http://community.gorge.net/ncs/background/promoters.htm.

diversity bring new possibilities for global interaction and expanding learning modalities, they also may have a "splintering" and "fragmenting" effect on society in which minorities and marginalized people may have less access to educational resources and may experience oppression from the dominant groups [87]. Critical theory and social change education offer important insights for medical education and learning concerning the political realm including sociocultural issues, globalization, oppression, and power within society.

Critical theory originated from the Frankfurt School, an informal name given to members of the Institute for Social Research (*Institut für Sozialforschung*) at the University of Frankfurt in Germany. The designees of the Frankfurt School were considered neo-Marxist and therefore ardently anti-capitalist. The School emphasized social theory, sociocultural research, and philosophy and became known for critical theory, which focused on radical social change, and was the antithesis of "traditional theory" in the positivistic and scientific ideologies . The emphasis of critical theory in general is the analysis and critique of power and oppression in society. At its root, critical theory aims for human emancipation from any circumstances that cause enslavement. Critical theory emerged as a critique of capitalism and the social inequalities (that result from capitalism), the dominance of a single ideology, and the potential impact of critical thought in the world [88].

There are many "critical theories" that have been developed as a result of various social movements all of which attempt to eradicate domination and oppression. All critical theories share the emphasis on decreasing hegemony and increasing human freedom with "utopian hopes for new social responses in an alienated world" [89, p. 135]. As such, approaches like feminism, critical race theory, post-colonial theory, and queer theory can all be considered critical theories. Social change education, an educational application of critical theory, concerns itself with challenging injustices across social, economic, and political realms [90]. Much of the theoretical basis of critical theory and social change education comes from Jürgen Habermas and Paulo Freire.

German philosopher and sociologist, Jürgen Habermas was a later student of the Frankfurt school and is said to be one of the more activist members from that school. Drawing heavily on the ideas of Marx and yet rejecting some of Marx's work, Habermas's approach is described as a creative blend of systems theory, pragmatism, and analytic philosophy all with the intent of application to society [89]. Habermas was interested in a more equitable society and he believed that this could be achieved by empowering the members of society to action through self-reflection and dialogue. His writings promoted the idea that that we lack freedom in society and that powerful "systems" (government, corporations, media, etc.) are manipulating individuals and therefore not meeting our needs. He believed that communication has become a controlling tool primarily used to satisfy the selfish interests of the communicator regardless of the recipient's needs or interests [91]. Habermas advocated that we should engage in "communicative action" (a coming together to engage in dialogue for the purpose of common action) in order to become empowered against the hegemonic system. This theory of communicative action includes everyday communication practices and proposes that reason comes out of mutual understanding within ordinary human communication.

Welton and others have brought Habermas's version of critical theory to adult education and have pointed to the applicability of his ideas like reflective discourse and learning communities [87]. The ideal conditions that Habermas proposes for authentic reflective discourse (dialogue, discussions) to occur are comprehensibility, sincerity, truth, and legitimacy. A key element of his notion of discourse is that it should involve an honest attempt to put aside bias and be open to all sides of an argument in order to come to consensus [87]. In terms of learning communities, Habermas advocates determining whether institutions and adult educators are enabling us to reach our full potential by not being too concerned with planning classes or arranging classrooms and failing to consider more "political" issues like accessibility of education [87].

Paulo Freire was a Brazilian educator and activist who proposed a social emancipatory view of learning. This is sometimes called popular education, liberating education, social change education, or critical pedagogy. He follows in the footsteps of Habermas because the basis of his approach is "critical" in nature and critiques the oppressive systems of society. Freire rose in distinction during the 1960s and 70s when anti-colonialism was strong in the Third World. He examined education in terms of its emancipatory potential which appealed to the oppressed masses in Third World countries. His theory emphasized that "knowledge" came from those in power, so people need to deconstruct that knowledge and create new knowledge that is liberatory in nature. Freire found traditional educational practices constraining and non-liberating because he believed the oppressed have been conditioned to identify with the oppressor and view them idealistically [92]. He reasoned that if the oppressed wanted freedom they had to use critical consciousness to examine things as they truly exist in society.

Freire is well known for his participatory model of literacy described in his well-known book, *Pedagogy of the Oppressed*, first published in 1970. Overall, Freire critiques the dominant "banking model" of education and says that education in general is suffering from "narration sickness" [93, p. 71]. He says that traditional education is one-way with the teacher narrating the content to the students who are passive recipients of content who are required to memorize and repeat it back to the teachers. The "banking" metaphor derives from the teachers who "deposit" ideas into the students who become "depositories" and "automatons" waiting to be filled with the knowledge and wisdom of the all-powerful teachers. Freire views this as an inherently oppressive model and insists that such a banking model goes directly against the idea of dialogue and gets in the way of a critical orientation to the world [93]. Students are controlled, knowledge is static, the teacher is the authority, and the realities of life are trivialized which results in a dehumanized and paternalistic model that reinforces the inequalities and injustices of society.

Instead Freire calls for a "problem-posing" (authentic or liberating) education where "men and women develop their power to perceive critically the way they exist in the world with which and in which they find themselves; they come to see the world not as a static reality but as a reality in the

process of transformation" [93, p. 83]. Problem-posing education starts with a transformation of the teacher-student relationship whereby teachers become both teachers and learners and vice versa. Dialogue is an essential process within this model and the relationship between teachers and students is "horizontal" rather than hierarchical. In this model, the educational situation is marked by posing problems that relate to the real world which encourages critical reflection about these problems resulting in a continual creating and recreating of knowledge by both teachers and students. According to Freire, problematizing is a three-phased process that involves asking questions with no predetermined answers. Phase one is a naming phase where the problem is identified. Phase two is the reflection phase to discover why or how the situation can be explained. The third phase is an action phase marked by questions about changing the situation or considering options.

Prabhu summarizes the primary differences of the banking model and the problem-posing model in terms of world, teacher, student, teacher/student relation, style of communication, social function of education, and application to extra classroom situations [92]. He indicates that problem-posing education is dynamic and malleable. The teacher is a co-learner; the student is actively engaged in the process of learning; the teacher/student relationship is equalized; communication is dialogical and democratic; the social function of education is questioning for the purpose of transforming social reality; and learning is seen as lifelong and complex.

Ultimately such a model, according to Freire, is a "revolutionary futurity" because teachers and students learn that dominant ideas can be challenged and oppressive systems transformed which helps them move forward and transcend the past [93, p. 84]. Although some scholars have mistakenly labeled Freire's educational ideas as too laissez-faire, he asserts that problem-posing education is purposeful and rigorous. The teacher still gives structure and helps to facilitate the direction of learning through constructive feedback and goal setting.

Although critical theory and social change education certainly have their critics, the approaches bring more to the table compared to other theories that address diversity and the socio-cultural-political issues within education and learning. The intent of critical theory and social change education is "to extend democratic socialist values and processes, to create a world in which a commitment to the common good is the foundation of individual well-being and adult development" [94, p. 21]. The strength of such approaches is that they challenge the existing hegemony in hopes of transforming society for the better for all people even the disenfranchised or marginalized. The main weaknesses seem to be that such approaches are not always pragmatic. Although they call for change, they do not always offer specific strategies to effect change [87].

CONCLUSION

Given the increasing diversity of cultural health attributions, beliefs and practices, it is crucial that the field of medicine prioritizes such factors in healthcare and medical education. The following aspects of culture suggest ways to contribute to successful and meaningful interactions with culturally different individuals and groups at both the patient/provider and the medical education levels:

- *Culture is multi-faceted, complex and pervasive.* Culture encompasses more than nationality, race or ethnicity and is intimately related to beliefs and practices.
- *Many external factors impact culture*. These include immigration, acculturation, discrimination, economic status, and social support/networks.
- *Many cultural factors impact health*. These include health attributes, culture-specific health and healing practices, and access to culturally competent healthcare.
- *Bi-lingual does not mean bi-cultural and multilingual does not mean multicultural.* Language is one aspect of culture, but for many people it is not the most important. Do not make assumptions about an individual's cultural experience based on the language they speak on initial presentation.
- *Be humble, humanistic and hopeful.* We are all more similar than we are different especially when it comes to basic human needs and rights. Admit to what you do not know and be open to learning from those of different backgrounds than your own. (e.g., patients, students, parents, local leaders).
- *Collaborate WITH people rather than ON them!* Programs, interventions and healthcare are more successful if members of the target population are involved from the beginning and contribute to program development.
- *Cultural competency is a lifelong endeavor.* Because culture is fluid and constantly developing, it is impossible for even the most dedicated medical professional to know everything about every culture for every person.
- *Seek information to help your understanding of traditional health beliefs* and practices including religious practices that impact health and well being.
- *Relationships, relationships, relationships*. Building relationships based on mutual trust will enable cultural information sharing.
- *If you have questions about someone's cultural background and beliefs, ASK.* Most people welcome the opportunity to talk about themselves and their background and appreciate your interest.

REFERENCES

[1] Anderson CA. Motivational and performance deficits in interpersonal settings: The effect of attributional style. J Pers Soc Psychol 1983; 45: 1136-47.
[2] Kelley HH. The process of causal attribution. Am Psychol 1973; 28: 107-28.
[3] Anderson CA. Attributional style, depression, and loneliness: a cross-cultural comparison of American and Chinese students. Pers Soc Psychol Bull 1999; 25(4): 482-99.
[4] Lee F, Hallahan M, Herzog T. Explaining real-life events: How culture and domain shape attributions. Pers Soc Psychol Bull 1996; 22(7): 732-41.
[5] Miller J. Cultural and the development of everyday social explanation. J Pers Soc Psychol 1984; 46(5): 961-78.

[6] Morris M, Peng K. Culture and cause: American and Chinese attributions for social and physical events. J Pers Soc Psychol 1994; 67(6): 949-71.
[7] Harvey JH, Weary G. Perspectives on attributional processes. Dubuque, IA: Wm. C. Brown 1981.
[8] Hastorf A, Scheider D, Polefka J. Person perception. Reading, MA: Addison-Wesley 1970.
[9] Kitayama S, Rarasawa M. Implicit self-esteem in Japan: name letters and birthday numbers. Pers Soc Psychol Bull 1997; 23(7): 736-42.
[10] Taylor SE. Positive illusions: creative self-deception and the healthy mind. New York, NY: Basic Books 1989.
[11] Seligman MEP. Learned optimism. New York: Alfred A. Knopf 1991.
[12] Furnham A, Akande D, Baguma P. Beliefs about health and illness in three countries: Britain, South Africa and Uganda. Psychol Health Med 1999; 4(2): 189-201.
[13] Kleinman A. Concepts and a Model of the Comparison of Medical Systems as Cultural Systems. In: Currer C, Stacey M, Eds. Concepts of health, illness, and handicap. Geneva: Harwood Academic Publishers 1986.
[14] Murguía A, Peterson RA, Zea MC. Use and implications of ethnomedical health care approaches among Central American immigrants. Health Soc Work 2003; 28(1): 43-51.
[15] Gregg J, Curry RH. Explanatory models for cancer among African American women at two Atlanta neighborhood health centers: the implications for a cancer screening program. Soc Sci Med 1994; 39(4): 519-26.
[16] Klonoff E, Landrine H. Belief in healing powers of prayer: prevalence and health correlates for African-Americans. West J Black Stud 1996; 20(4): 207-10.
[17] Landrine H, Klonoff A. Cultural and health-related schemas: a review and proposal for interdisciplinary integration. Health Psychol 1992; 11(4): 267-76.
[18] Landrine H, Klonoff A. Cultural diversity in causal attributions for illness: The role of the supernatural. J Behav Med 1994; 17(2): 181-93.
[19] Murguía A, Zea MC, Reisen CA, Peterson RA. The development of the cultural health attributions questionnaire (CHAQ). Cultur Divers Ethnic Minor Psychol 2000; 6(3): 268-83.
[20] Flores G. Culture and the patient-physician relationship: Achieving cultural competency in health care. J Pediatr 2000; 136(1): 14-23.
[21] Madge C. Therapeutic landscapes of the Jola, The Gambia, West Africa. Health Place 1998; 4(4): 293-311.
[22] Mulatu MS. Perceptions of mental and physical illness in Northwestern Ethiopia: causes, treatments and attitudes. J Health Psychol 2000; 4: 531-49.
[23] Chipfakacha V. The role of culture in primary health care. S Afr Med J 1994; 84(12): 860-1.
[24] Helman CG. Culture, health and illness. London: Arnold 2001.
[25] Landrine H, Klonoff EA. Cultural diversity in causal attributions for illness: The role of the supernatural. J Behav Med 1994; 17: 181-93.
[26] Stainton Rogers W. Explaining Health and Illness: An Exploration of Diversity. London: Wheatsheaf 1991.
[27] Furnham A. Explaining health and illness: Lay perceptions on current and future health, the causes of illness, and the nature of recovery. Soc Sci Med 1994; 39(5): 715-25.
[28] Jobanputra R, Furnham A. British Gujarati Indian immigrants' and British Caucasians' beliefs about heath and illness. Int J Soc Psychiatr 2005; 51(4): 350-64.
[29] Foster GM. Disease etiologies in non-Western medical system. Am Anthropol 1976; 78(4): 773-82.
[30] Foster GM, Anderson BG. Medical Anthropology. New York: McGraw Hill 1978.
[31] Kottak CP. Cultural Anthropology, 12th ed. Boston: McGraw Hill 2008.
[32] Bigby J. Cross-cultural Medicine. Philadelphia: American College of Physicians 2003.
[33] Holland A. Voices of Qi: An Introductory Guide to Traditional Chinese Medicine. Berkeley, CA: North Atlantic Books 2000.
[34] Chopra AS. Ayurveda. In: Selin H, Shapiro H, Eds. Medicine Across Cultures: History and Practice of Medicine in Non-western cultures. The Netherlands: Kluwer Academic Publishers 2003.
[35] Eisenberg DM, Davis RB, Ettner SL, *et al.* Trends in alternative medicine use in the United States, 1990-1997: results of a followup national survey. JAMA 1998; 280: 1569-75.
[36] Gardiner HW, Kosmitzki C. Lives Across Cultures: Cross-cultural Human Development, 4th ed. Boston, MA: Allyn & Bacon 2008.
[37] Spector RE. Cultural Diversity in Health & Illness, 6th ed. Upper Saddle River, NJ: Prentice Hall 2004.
[38] Adams PJ, Katz RC, Beauchamp K, Cohen E, Zavis D. Body dissatisfaction, eating disorders, and depression: a developmental perspective. J Child Fam Stud 1993; 2(1): 37-46.
[39] Crawford M, Unger R. Women and gender: A feminist psychology, 4th ed. Boston: McGraw-Hill 2004.
[40] Matsumoto D, Juang L. Culture and Psychology, 4th ed. Florence, KY: Wadsworth, Cengage Learning 2008.
[41] Draguns JG. Applications of Cross-Cultural Psychology in the Field of Mental Health. In: Brislin R, Ed. Applied cross-cultural psychology. Newbury Park, CA: Sage 1990; pp. 302-24.
[42] Berry JW, Poortinga YH, Segall MH, Dasen PR. Cross-cultural psychology: research and applications, 2nd ed. Cambridge, UK: Cambridge University Press 2002.
[43] Peat M. Community-based Rehabilitation. London: Saunders 1997.
[44] World Health Organization. Primary Health Care: Report of the International Conference in Alma Ata. Geneva: WHO 1978.
[45] Bernal H. Delivering Culturally Competent Care. In: Barry P, Ed. Psychosocial Nursing: Care of Physically Ill Patients and their Families, 3rd ed. Philadelphia: Lippincott 1996.
[46] Srivastava R. The healthcare professional's guide to clinical cultural competence. Toronto: Mosby Elsevier 2007.
[47] Mir G, Tovey P. Cultural competency: Professional action and South Asian carers. J Manag Med 2002; 16(1): 7-19.
[48] Thamer M, Richard C, Casebeer AW, Ray NF. Health insurance coverage among foreign-born US residents: the impact of race, ethnicity, and length of residence. Am J Public Health 1997; 87(1): 96-102.
[49] Leclere FB, Jensen L, Biddlecom AE. Health care utilization, family context, and adaptation among immigrants to the United States. J Health Soc Behav 1994; 35(4): 370-84.
[50] Institute of Medicine. From Generation to Generation: the Health and Well-being of Children in Immigrant Families. Washington, DC: National Academy Press 1998.
[51] Liu Z, Shilkret KL, Tranotti J, Freund CG, Finelli L. Distinct trends in tuberculosis morbidity among foreign-born and US-born persons in New Jersey, 1986 through 1995. Am J Public Health 1998; 88(7): 1064-7.
[52] Centers for Disease Control and Prevention. Screening for hepatitis B virus infection among refugees arriving in the United States, 1979-1991. MMWR Morb Mortal Wkly Rep 1991; 40(45): 784-6.
[53] Gavagan T, Brodyaga L. Medical care for immigrants and refugees. Am Fam Physician 1998; 57(5): 1061-8.
[54] Committee on Community Health Services. Providing care for immigrant, homeless, and migrant children. Pediatrics 2005; 115(4): 1095-100.
[55] Fennelly K. State and local policy responses to immigration in Minnesota. Report to the Century Foundation 2006 [Retrieved 2007 Oct 3] Available from: www.hhh.umn.edu/img/assets/3755/slp_immigration_ in_mn.pdf.
[56] Noh S, Kaspar V. Diversity and Immigrant Health. In: Anisef P, Lamphier M, Eds. The World in a City. Toronto: University of Toronto Press 2003.
[57] Seeman TE. Social ties and health: the benefits of social integration. Ann Epidemiol 1996; 6: 442-51.
[58] Kim HS, Sherman DK, Taylor SE. Culture and social support. Am Psychol 2008; 63(6): 518-26.
[59] Gloria AM, Segura-Herrera TA. Somos! Latinas and Latinos in the United States. In: Atkinson DR, Morten, G, Sue, DW, Eds. Counseling American minorities. Boston: McGraw-Hill 2004.
[60] Thomas TN. Acculturative stress in the adjustment of immigrant families. J Soc Distress Homeless 1995; 4(2): 131-42.
[61] Warheit GJ, Vega WA, Auth J, Meinhardt K. Mexican-American Immigration and Mental Health: A comparative analysis of psychosocial stress and dysfunction. In: Vega WA, Miranda MR, Eds. Stress and Hispanic mental health: relating research to service delivery. Bethesda, MD: National Institute of Mental Health 1985.
[62] Smart JF, Smart DW. Acculturative stress: the experience of the Hispanic immigrant. Couns Psychol 1995; 23: 25-42.

[63] Berry JW. Immigration, acculturation and adaptation. App Psychol Int Rev 1997; 46: 5-68.
[64] Berry JW. A psychology of immigration. J Soc Issues 2001; 57(3): 615-31.
[65] Chen S, Ravallion M. The developing world is poorer than we thought, but no less successful in the fight against poverty: Policy Research Working Paper. Report No.: WPS 4703. The World Bank 2008; vol. 1.
[66] Payne RK, DeVol PE, Smith TD. Bridges Out of Poverty: Strategies for Professionals and Communities, Revised ed. Highlands, TX: Aha Process, Inc. 2006.
[67] Van de Poel E, Hosseinpoor AR, Speybroeck N, Van Ourti T, Vega J. Socioeconomic inequality in malnutrition in developing countries Bull World Health Organ 2008; 86(4): 241-320.
[68] Brooks JB. The Process of Parenting, 6th ed. Boston: McGraw-Hill 2004.
[69] DiMatteo MR, Haskard KB, Williams S. Health beliefs, disease severity, and patient adherence: a meta-analysis. Med Care 2007; 45(6): 521-8.
[70] Kleinman A. Patients and Healers in the Context of Culture. Berkeley, CA: University of California Press 1981.
[71] Berlin EA, Fowkes WC, Jr. A teaching framework for crosscultural health care--Application in family practice. West J Med 1983; 12(139): 93-8.
[72] Isaacs MR, Benjamin MP. Towards a Culturally Competent System of Care: Washington, DC: CASSP Technical Assistance Center, Georgetown University Child Development Center 1991; Vol. II.
[73] Miller NB. Social Work Services to Urban Indians. In: Green J, Ed. Cultural awareness in the human services. Upper Saddle River, NJ: Prentice-Hall 1982.
[74] Levin SJ, Like RC, Gottlieb JE. ETHNIC: A framework for culturally competent clinical practice. In Appendix: Useful clinical interviewing mnemonics. Patient Care 2000; 34(9): 188-9.
[75] Green AR, Betancourt JR, Carrillo JE. Integrating social factors into cross-cultural medical education. Acad Med 2002; 77(3): 193-7.
[76] Brislin R. Understanding Culture's Influence on Behavior, 2nd ed. Fort Worth, TX: Harcourt Brace Jovanovich 2000.
[77] Vaughn LM, Phillips R. Intercultural adjustment for cultural competence in shared context: "The company we keep". Int J Interdisc Soc Sci 2009; 3(11): 1-12.
[78] Arends-Tóth J, van de Vijver FJR. Assessment of Psychological acculturation. In: Sam DL, Berry JW, Eds. The Cambridge Handbook of Acculturation Psychology. Cambridge, UK: Cambridge University Press 2006; pp. 142-60.
[79] NCCP, 2008 [Retrieved 2008 Oct 27]. Available from: http: //www.nccp.org/about.html.
[80] Nuestra Comunidad Sana. Lay health promoters. [Retrieved 2008 November 21] Available from: http: //community.gorge.net/ncs/background/promoters.htm.
[81] Lam TK, McPhee SJ, Mock J, *et al.* Encouraging Vietnamese-American women to obtain pap tests through lay health worker outreach and media education. J Gen Intern Med 2003; 18(7): 516-24.
[82] Lewin SA, Dick J, Pond P, *et al.* Lay health workers in primary and community health care. Cochrane Database Syste Rev 2005 (1, Art. No.: CD004015).
[83] Hanscom KL. Treating survivors of war, trauma and torture. Am Psychol 2001; 56(11): 1032-9.
[84] Zuñiga ME. "Dichos" as metaphorical tools for resistant Latino clients. Psychother: Theor Res Pract Train 1991; 28: 480-3.
[85] Aviera A. "Dichos" therapy group: A therapeutic use of Spanish language proverbs with hospitalized Spanish-speaking psychiatric patients. Cult Divers Ment Health 1996; 2: 73-87.
[86] Van Dyk GAJ, Nefale MC. The split-ego experience of Africans: Ubuntu therapy as a healing alternative. J Psychother Integr 2005; 15(1): 48-66.
[87] Merriam SB, Caffarella RS, Baumgartner LM. Learning in Adulthood: A Comprehensive Guide, 3rd ed. San Francisco: John Wiley & Sons, Inc. 2007.
[88] Brookfield S. The Power of Critical Theory: Liberating Adult Learning and Teaching. San Francisco: Jossey-Bass 2005.
[89] Sorrell JH. The Pleasure of Dissent: A Critical Theory of Psychotherapy as an Emancipatory Practice. Am J Psychother 2006; 60(2): 131-45.
[90] Choules K. Social change education: Context matters. Adult Educ Q 2007; 57(2): 159-76.
[91] Heslep RD. Habermas on communication in teaching. Educ Theor 2001; 51(2): 191-207.
[92] Prabhu J. Some challenges facing multiculturalism in a globalized world. Revision 2001; 24(1): 30-8.
[93] Freire P. Pedagogy of the Oppressed, 30th anniversary ed. New York: Continuum 2006.
[94] Brookfield S. Repositioning ideology critique in a critical theory of adult learning. Adult Educ Q 2001; 52(1): 7-22.

Received: February 10, 2009 Revised: May 21, 2009 Accepted: May 30, 2009