

# Illness and Treatment Perceptions of Ethiopian Immigrants and Their Doctors in Israel

## ABSTRACT

**Objectives.** Patient-provider misunderstandings arising from disparate medical and cultural concepts can impede health care among immigrant populations. This study assessed the extent of disagreement and identified the salient problems of communication between Israeli doctors and Ethiopian immigrant patients.

**Methods.** Semistructured interviews were conducted with 59 Ethiopian immigrants. Self-reports of health status and effectiveness of treatment were compared with evaluations by the primary care physician and supplemented by qualitative data from descriptions of illness, observations of medical visits, informant interviews, and participant observations conducted by the anthropologist.

**Results.** Health status and effectiveness of treatment were rated significantly higher by the doctor than by the patients. Low doctor-patient agreement occurred mainly for illnesses with stress-related or culture-specific associations. Qualitative data suggested that more long-term immigrants may alter their expectations of treatment but continue to experience symptoms that are culturally, but not biomedically, meaningful.

**Conclusions.** Misunderstandings between immigrant patients and their doctors emerge from the biomedical system's limitations in addressing stress-related illnesses and from culture-based discrepancies in concepts of illness and healing. Including trained translators in medical teams can reduce medical misunderstandings and increase patient satisfaction among immigrant populations. (*Am J Public Health* 1999;89:1814-1818)

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Immigrants throughout the world commonly report feeling misunderstood by their doctors.<sup>1</sup> This perceived communication gap between immigrants and doctors refers not only to language barriers but also to differences in defining illness and in beliefs about health. Immigration and acculturation, particularly in conjunction with minority ethnic status, are stressful processes that have been shown to be associated with increased risk of mental and physical health problems in several different resettlement countries.<sup>2-7</sup> Because the somatic expression of social stress is not sufficiently understood in the medical system,<sup>8</sup> patients are likely to feel misunderstood by their doctors and dissatisfied with treatment.

The biomedical system is influenced by Western cultural assumptions about mind-body duality and scientific objectivity, whereas in many non-Western cultures, illness is viewed and treated in an integrated way that involves the body, mind, spirit, community, family, and cosmos.<sup>8,9</sup> Cultural disparities in conceptions of illness come to the fore in medical encounters, creating friction in patient-provider relationships.<sup>10</sup> This study aimed to assess the extent of doctor-patient discrepancies in perceptions of health and treatment, elucidate the sources of misunderstanding, and identify strategies to improve communication between health providers and immigrant populations.

Between 1980 and 1992, approximately 50 000 Ethiopian Jews migrated to Israel. Like many immigrants and refugees worldwide, they had suffered the stresses of war, famine, disease, loss, and separation,<sup>11,12</sup> and their health beliefs were distinctly different from those of the Israeli system,<sup>13</sup> which is based on Western science. Insights gained into the sources of medical misunderstanding in this community may, therefore, be applied to health care involving similar populations in other resettlement countries.

## Methods

To discover the nature and extent of the communication problem between doctors and immigrant patients, a doctor's evaluations of health and treatment were compared with patients' self-reports elicited in interviews with an anthropologist. The sample included 59 men and women between 20 and 70 years of age in 2 sites (39 in temporary housing in a caravan site and 20 in apartments in a residential community). The residents of the caravan site arrived in Israel in 1991, and those in the residential site arrived before 1989; the interviews were conducted in 1993. All respondents were in the care of the same family physician, who served General Health Fund clinics in each site. Respondents were selected from lists of residents and clinic records, and they were contacted through community workers or at the clinic and interviewed in their homes. Subsequently, the doctor provided evaluations of the health status, diagnosis, and medical treatment of each respondent. A number of evaluations were missing: out of 59 respondents interviewed by the anthropologist, the doctor provided 51 health status ratings and 55 definitions of illness (the doctor was not familiar with some patients new to the prac-

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tice, or medical notes were unavailable), and 16 treatment evaluations (18 patients were not prescribed treatment and 21 who did not return for a follow-up visit could not be assessed).

Ethnographic fieldwork conducted by the anthropologist between 1991 and 1993, before the study reported here, included naturalistic observations of medical visits (approximately 200 visits at 7 different clinics); informant interviews with Israeli and Ethiopian health professionals, immigration experts, and Ethiopian traditional healers; and participant observation in absorption centers, caravan sites, hospitals, and clinics. On the basis of the ethnographic research, a semistructured interview schedule was constructed to elicit information about demographics, employment, family, Hebrew language fluency, health status, symptoms, causation of illness, health beliefs, utilization of health services and nonconventional treatments, satisfaction with care, acculturation, social support, and general well-being.<sup>14</sup>

The semistructured interviews were conducted with the assistance of a translator and lasted approximately 2 hours. Medical visits were observed in clinics where translation was provided variously by professional translators, family members, or others, depending on availability. Since many participants were illiterate, oral informed consent was obtained for all interviews and observations.

This report focuses on health status, illness concepts, and satisfaction with treatment, and it integrates qualitative and quantitative data in the presentation and interpretation of the results. The quantitative data include the following 2 items from the semistructured interviews with respondents and the corresponding doctor's evaluations:

1. Evaluation of overall health status was measured by the question "How is your/the patient's health?" The scale ranged from 1 (poor) to 5 (excellent). This item demonstrated patterns of association similar to those of a 6-item scale used in the semistructured interview based on the MOS Short-form General Health Survey,<sup>15</sup> and it correlated with other measures of health and with life expectancy.<sup>16-19</sup>

2. Evaluation of the effectiveness of treatment was measured by the question "Did the treatment help your/the patient's problem?" The scale ranged from 1 (not at all) to 4 (very much), where "treatment" referred to the entire medical intervention.

The nonparametric sign test was used to evaluate the extent of doctor-patient disagreement regarding perceptions of health status and treatment effectiveness. In addition,

the doctor assessed the patient's problem as primarily medical or psychosocial (stress related) on the basis of knowledge of the patient's medical and social condition.

Qualitative data provided expansion and validation of the quantitative results, explaining the sources of the patient-doctor disagreements. Definitions and attributions of illness that were elicited during the interviews were categorized by procedures described by Carey and others.<sup>20,21</sup> Narrative descriptions of illnesses, medical visits, and treatments were coded to determine definitions and concepts of illness and treatment.

## Results

Almost half (48%) of the patients self-reported "poor" health; the median score was 2 ("fair";  $n = 59$ ). In contrast, the doctor reported poor health for only 6% of the patients, while the median score was 3 ("good";  $n = 51$ ). The sign test showed that the difference between the doctor's assessment and the patients' assessment was statistically significant ( $P > .001$ ;  $n = 51$ ), with the doctor reporting healthier status than the patients.

Thirty-seven percent of respondents who reported having received treatment perceived that treatment as "not at all" helpful, with a median score of 2 ("somewhat";  $n = 46$ ). The doctor reported that treatment was "not at all" helpful for only 6% of the patients, with a median score of 3 (treatment helped "a lot";  $n = 16$ ). The sign test showed that the doctor's median treatment effectiveness rating was significantly higher than that of the patients ( $P = .04$ ;  $n = 16$ ).

These quantitative data suggest that there were patient-doctor discrepancies in perceptions of health status and effectiveness of treatment. The qualitative data (derived from the semistructured and informant interviews and observations of medical visits) support these findings. The following case demonstrates how an Ethiopian patient's definition and expression of her subjective illness experience, and consequent expectations of treatment, differed from standard medical definitions familiar to doctors.

A woman in her 40s complained of headaches, burning in the heart and stomach, nausea, vomiting, dizziness, lack of appetite, losing control, and falling down, but investigative tests found no organic pathology. She considered the illness to be serious because it affected her daily life, and she persisted in seeking medical care. "The doctor said: 'You're okay,'" she said. "But I'm sick. What can I do? . . . They [the clinic

staff] tell me: 'The clinic is a second home for you. You take pills like candy.'"

In Ethiopia, she saw a traditional healer (*debtera*), but she did not approach one in Israel because "In Ethiopia they said: 'In Israel you'll be healthy . . . and if you get sick, you go to doctors.'"

However, the medical treatment in Israel fell short of her high expectations: "They didn't help me with anything. They didn't give an answer. They didn't give enough attention to my problems. So now I don't ask, because I know there is no help."

In the informant interviews prior to the study, doctors reported that Ethiopian patients tended to seek care inappropriately, overutilizing for trivial complaints and underutilizing for severe chronic illnesses. Doctors also were concerned that some conditions could be misdiagnosed; for example, in one case the severity of depression was not detected until too late, when a patient committed suicide.

Doctor-patient discrepancies arising from different cultural norms may affect the course of treatment, as one informant remarked.

Sometimes people don't feel good because the approach of the doctors is not what it should be. The most important thing is being received well. We say that reception of guests is more important than food, because if someone is received well, the food will taste better. . . . When the patient first comes [to the clinic] they give him a thousand words that he doesn't understand. . . . "Why are you late?" and "You can't come today!" In any case they see him in the end, so why not receive him well? The person is sick. They should ask what hurts, talk to him calmly. That will help to make him well. For example, I went to a doctor, and she didn't touch me. She should examine me and explain, so I'll feel good. I went out with a curse in my stomach and got the pills she prescribed. I took the pill and all night I threw up. I don't know if it was because of the pill or because I took it with a curse.

The data presented thus far demonstrate the existence of doctor-patient discrepancies in defining illness and in expectations of treatment. We examined 2 interrelated explanations for misunderstandings: stress-related illness and cultural disparities in the meaning of symptoms.

### Stress-Related Illness

Migration-related stress affects practically every dimension of life, including family, work, community, housing, diet, and religion. Cultural conflicts over the value of community and work, for example, can be distressing for immigrants, as seen in one informant's remarks: "With us, people participate in troubles and in celebrations. There is respect and togetherness. A week after I started work some-

**TABLE 1—Proportion of Respondents (n = 55)<sup>a</sup> Self-Reporting Each Complaint and Percentage of Complaints Identified by Doctor, Categorized by Biomedical, Culture-Specific, and Both Biomedical and Culture-Specific Meanings of Complaints**

Biomedically Meaningful Complaints			Complaints With Both Biomedical and Culture-Specific Meanings			Complaints With Culture-Specific Meanings		
Complaint	Respondents, % (n) <sup>b</sup>	Identified by Doctor, % (n) <sup>c</sup>	Complaint	Respondents, % (n) <sup>b</sup>	Identified by Doctor, % (n) <sup>c</sup>	Complaint	Respondents, % (n) <sup>b</sup>	Identified by Doctor, % (n) <sup>c</sup>
Cold/cough	33 (18)	39 (7)	Head pain	44 (24)	33 (8)	Weakness/tiredness	18 (10)	0 (1)
Asthma	13 (7)	71 (5)	Stomach pain	27 (15)	67 (10)	No appetite	16 (9)	33 (3)
Disability/injury	9 (5)	80 (4)	Back pain	16 (9)	56 (5)	Heart pain/pressure	15 (8)	15 (1)
Anemia/ "lack of blood"	9 (5)	40 (2)	Eyes watering/ ingrown lashes	16 (9)	67 (6)	Limb pain (no injury)	15 (8)	50 (4)
Tooth pain	9 (5)	40 (2)	Problems sleeping	7 (4)	0 (0)	Fear/anger/jealousy	11 (6)	0 (0)
Vomiting	7 (4)	50 (2)	Neck swelling	4 (2)	50 (1)	Nerves	11 (6)	0 (0)
Indigestion	5 (3)	33 (1)	Thinking a lot	11 (6)	0 (0)			
Allergy	4 (2)	100 (2)	Falling down	9 (5)	0 (0)			
Malaria	4 (2)	100 (2)	Sensations on face	7 (4)	0 (0)			
Infertility	4 (2)	50 (1)						
Pain in ear	4 (2)	50 (1)						
Travel sickness	3 (2)	0 (0)						
Total complaints	57 <sup>d</sup>	51 (29) <sup>e</sup>		63	49 (30)		62	14 (9)
Total number of respondents reporting 1 complaint	64 (35)			56 (31)			96 (53)	

<sup>a</sup>Includes only the 55 respondents evaluated by the doctor.

<sup>b</sup>Percentage (number) of respondents self-reporting complaint.

<sup>c</sup>Percentage (number) of self-reported complaints identified by doctor.

<sup>d</sup>Total number of complaints self-reported; some respondents made more than 1 complaint.

<sup>e</sup>Percentage (number) of total complaints identified by doctor.

one died. I went to the funeral. Two weeks later, another disaster happened to someone I know, I participated in his trouble. So they said: 'You're not serious about work.'"

In the semistructured interviews, 26% of respondents attributed symptoms to post-migration changes in air quality (asthma), diet (tooth and stomach problems), work activities (injuries), and social problems that included family and work conflicts, the burden of child care, and separation from relatives in Ethiopia (head, stomach, and heart pain, lack of appetite, weakness). An Ethiopian informant explained the association between illness and difficulties of adjustment: "If someone has a lot of patience we say, 'His stomach is as wide as a country.' The problem in Israel is that people shout and rush around. We have to make a big effort to adjust. Sometimes the stomach doesn't hold any more. Then people have pain."

Patients often reported that doctors had failed to detect or treat their illnesses appropriately. As one informant said, "If a patient says his stomach is full, or he thinks a lot, the doctor may say, 'Well, eat less, or think less.' . . . The doctors need to understand the concept and not just the literal meaning of the words."

Several informants who were doctors also expressed the view that migration stress could be expressed as illness. As one such informant said, "The medical referrals are

because of a failure in integration. They translate all their emotional problems into physical problems."

However, even when physical symptoms are recognized as stress related, medical interventions are of limited value in alleviating the underlying stress. The doctor in the study classified 12 patients as having a primarily psychosocial or stress-related problem and rated their health status as "fair" or "good"; 11 of these patients self-reported "poor" health. These findings suggest that stress-related disorders were experienced as "illness" by patients but were not defined as such by the doctor, leading to disagreements over medical diagnoses and treatments.

#### *Cultural Disparities in the Meaning of Symptoms*

In informant interviews, health professionals reported that even with translators present, they (the health professionals) failed to communicate to patients the nature of chronic disease (such as heart disease that required daily medication) and failed to understand the meaning of many "nonspecific" complaints. Consequently, they feared mishandling serious illnesses and relied heavily on costly diagnostic tests. For example, a nurse reported, "Even when we know

someone is sick, he doesn't know how to say his specific complaints about what hurts him. It's all 'head heart stomach.' It's very difficult to get from them the definition of exactly where it hurts."

Table 1 shows the proportion of respondents self-reporting each complaint (in the semistructured interviews) and the percentage of those complaints identified by the doctor (in the doctor evaluations). We divided the complaints into 3 categories: (1) biomedically meaningful complaints—generally understandable by doctors as conveying relevant information in terms of the biomedical framework (e.g., cold, cough, asthma, injury, vomiting, allergy); (2) complaints with culture-specific meanings—conveying information on illness relevant for Ethiopians but generally perceived by doctors as unrelated to a medical condition (e.g., "thinking a lot"); and (3) complaints with both biomedical and culture-specific meanings, such as stomach pain, which doctors may interpret as symptomatic of an ulcer and Ethiopians may interpret as "full of problems." As expected, biomedically meaningful complaints tended to be identified by the doctor in this study more frequently (51%) than culture-specific complaints (14%).

If it were possible to directly translate culture-specific complaints into medical terminology, we would expect that self-

**TABLE 2—Proportion of Respondents (n = 55)<sup>a</sup> in Each Site Reporting Complaints and Percentage of Complaints Identified by Doctor, Categorized by Biomedical, Culture-Specific, and Both Biomedical and Culture-Specific Meanings of Complaints**

	Biomedically Meaningful Complaints Self-Reported by		Both Biomedically Meaningful and Culture-Specific Complaints Self-Reported by		Culture-Specific Complaints Self-Reported by	
	Respondents, % (n) <sup>b</sup>	% Identified by Doctor <sup>c</sup>	Respondents, % (n) <sup>b</sup>	% Identified by Doctor <sup>c</sup>	Respondents, % (n) <sup>b</sup>	% Identified by Doctor <sup>c</sup>
Caravan site (n = 39)	56 (22)	39	54 (21)	50	95 (37)	12
Settled community (n = 16)	81 (13)	70	62 (10)	47	100 (16)	21

<sup>a</sup>Includes only the 55 respondents evaluated by the doctor.

<sup>b</sup>Proportion (n) of respondents self-reporting 1 complaint in this category.

<sup>c</sup>Percentage of self-reported complaints in this category identified by the doctor.

reported complaints such as fear, anger, jealousy, nerves, and thinking a lot would be identified by doctors as psychological or emotional problems. However, although a total of 13 respondents reported complaints in any of these categories, only 2 were evaluated by the doctor as having depression or anxiety. In medical visits, symptoms that did not fit into a viable medical category were frequently ignored and omitted from medical records or else redefined by the doctor in biomedically meaningful terms; for example, "It's not your heart, it's your stomach. You have indigestion." When patients persisted in seeking treatment for medically unrecognized complaints, investigative tests tended to confirm the doctor's view that the patient was "healthy" (had no disease pathology), frequently exacerbating the misunderstanding over defining illness.

To assess the effect of time since immigration, which is a marker for cultural and social adaptation, we compared doctor-patient discrepancies in health status and treatment effectiveness ratings in the 2 sites. In the caravan site (mean of 2.1 years since immigration), the sign test showed that patients' ratings were significantly lower than the doctor's for both health status (medians of 1.0 vs 3.0;  $P < .001$ ;  $n = 35$ ) and treatment effectiveness (medians of 2.0 vs 3.0;  $P < .05$ ;  $n = 9$ ). In the residential site (mean of 7.4 years since immigration), patient and doctor ratings were more similar for both health status (2.5 vs 3.0;  $P = .79$ ;  $n = 16$ ) and treatment effectiveness (2.0 vs 2.5;  $P = 1.00$ ;  $n = 6$ ). While these results suggest that patient-doctor discrepancies decreased with time, conclusions cannot be drawn owing to the small sample size and inability to control for other factors such as increased familiarity between doctor and patient, changes in the types of illnesses, and socioeconomic factors. However, the trend is supported by the patient and doctor symptom reports summarized in Table 2, showing that

there was less discrepancy in the settled community than in the caravan site for all 3 categories of complaints. Table 2 also shows that respondents in the settled community were more likely than those in the caravan site to report biomedically meaningful complaints (81% vs 56%). It is interesting to note that culture-specific complaints seemed to persist for all respondents, but they tended not to be recognized by the doctor even for patients who had spent more time in Israel.

The qualitative data validate and further elucidate these findings. Rather than altering their conceptions of illness over time, many of the immigrants in this study appeared to change their expectations of doctors' capacity to heal certain ailments. For example, a respondent from the residential area reported her experience of several symptoms (including chest pressure, breathing difficulty, dizziness, and eye problems) caused by worry over a family member in Ethiopia: "I had many thoughts. . . . I held it in my stomach for a long time." She reported that the doctor did not understand this illness: "Although the doctor understands many illnesses, she does not understand that one. If I still had that situation I would still be sick like that."

These data suggest that with increased acculturation, Ethiopians seek medical care for illnesses that they have learned are medically recognized and treatable but not for complaints, such as "heart" pain and emotional or metaphysical disturbances, that do not fit into biomedically meaningful categories. They may adjust their expectations to fit local service provisions, but their underlying views about the definition and causation of illness seem to persist.

## Discussion

In this study, we have tried to establish the extent of the misunderstanding between immigrant patients and their doctor and to

examine some of its sources. The results indicate that misunderstandings result from limitations of the medical system in treating stress-related disorders, as well as cultural disparities in defining illness and in expectations of treatment. Doctors are trained to differentiate between psychological distress and organic diseases, and even those who adopt a biopsychosocial approach may ignore symptoms experienced by patients that do not conform to standard medical diagnoses. This conflict between patients' perception of themselves as sick and the doctor's judgment that they are healthy can contribute to patients' feelings of disorientation and dissatisfaction.

Even when doctors acknowledge that their patients' physical complaints are caused or exacerbated by social stress, they are usually unable to treat the patients effectively and typically resort to medicating the symptoms. In this way, social problems are redefined as medical problems and "treated" in the individual body rather than addressed in the social context.<sup>22,23</sup> Patients participate in this medicalization process by persisting in seeking a medical solution, thereby putting pressure on doctors to medicate. This may be seen as part of the acculturation process, whereby the immigrants adopt Western society's propensity to medicalize human suffering. With acculturation, immigrants may alter their expectations of medical care to alleviate many of their ailments, while their underlying concepts of illness continue to differ from those of their doctors. It is likely that similar processes occur among non-Western immigrant populations in developed countries, but further investigation of variation between cultural groups is warranted.

Sensitivity to the patient's culture is a prerequisite for effective cross-cultural care.<sup>24</sup> It seems from our results that even such sensitivity may be insufficient, however, given that the physician who provided the evalua-

tions in this study had considerable previous experience with Ethiopian patients, made efforts to bridge the cultural gap with practices she believed to be culturally appropriate, and could therefore have been expected to respond well to her patients' needs. For example, physical examinations were routinely performed even if the symptoms did not strictly call for them—an acknowledgment that patients perceived bodily contact as an important part of healing.

Cultural awareness is no substitute for adequate translation during medical visits, however. Interpreters are not always available in clinics; in such cases, relatives—often children—provide translation, resulting in poor standards of translation and the invasion of the privacy and sensibilities of the adults. The anthropologist's interviews, on the other hand, were carried out with the help of a professional adult interpreter. It seems that the rudimentary communication that takes place without an interpreter is quite inadequate for obtaining the type of information that must flow in the context of a medical encounter.

Our findings also suggest that patient–doctor misunderstandings are greater when patients suffer from illnesses that are not clearly defined biomedically and that patients have cultural propensities to experience such illnesses long after their immigration. Interpreters therefore need to function as a bridge between 2 cultures and convey the intended meaning of the message, not just the literal translation.<sup>25</sup> Our findings support the conclusion drawn from research conducted with diverse immigrant populations in several countries: that immigrants tend to use services and take treatments more appropriately when their cultural beliefs are addressed and when clinics are adequately provided with bicultural and bilingual staff.<sup>26–29</sup> Translators in health clinics require specialized training to elicit biomedically meaningful information, to explain treatment and prevention to patients unfamiliar with biomedical concepts, and to inform medical staff about the meaning of cultural expressions of illness.<sup>30–32</sup>

Since different cultures do not always share the same medical paradigm, symptoms considered important in one culture may be irrelevant in another. Improving doctor–patient communication would prevent misdiagnosis, increase patient satisfaction, and facilitate the delivery of more effective health care services, and it may reduce the costs of unnecessary medical procedures. Including trained translators in medical teams would create links between health services and immigrant communities, helping to identify and address some of the underlying social problems of minority immigrant populations that affect their health and medical care. □

## Contributors

M. Reiff planned and implemented the study, analyzed the data, and wrote the paper. H. Zakut examined and provided medical evaluations of the study participants. M. A. Weingarten assisted with the medical evaluation questionnaire and evaluation. Both H. Zakut and M. A. Weingarten contributed to the writing of the paper.

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