

Intercultural Communication Between Patients and Health Care Providers: An Exploration of Intercultural Communication Effectiveness, Cultural Sensitivity, Stress, and Anxiety

Kelsy Lin Ulrey and Patricia Amason

*Department of Communication
University of Arkansas-Fayetteville*

Cultural diversity is becoming increasingly more important in the workplace. This is particularly true in health care organizations facing demographic shifts in the patients served and their families. This study serves to aid the development of intercultural communication training programs for health care providers by examining how cultural sensitivity and effective intercultural communication, besides helping patients, personally benefit health care providers by reducing their stress. Effective intercultural communication and cultural sensitivity were found to be related. Health care providers' levels of intercultural anxiety also were found to correlate with effective intercultural communication.

In today's culturally diverse world, intercultural communication becomes increasingly important (Collier, 1989) as many workers must learn how to communicate effectively with people from other cultures (Schneider, 1993). For many businesses, effective intercultural communication stands to bring them increased business and profits; however, in the health care industry, effective intercultural communication carries greater importance as it affects patients' physical and mental well being (Voelker, 1995).

Although much has been done in both the areas of intercultural communication and patient-health care provider communication, these two areas are rarely exam-

ined together (e.g., Anderson & Sharpe, 1991; Campbell, 1996; De Young, 1996; Lipkin, 1996; Perry, 1994; Skorpen & Malterud, 1997).

EFFECTIVE INTERCULTURAL COMMUNICATION

Created by people and transmitted across generations, culture involves the ideas, beliefs, values, and assumptions about life that are widely shared among a group of people and guide much of their behavior (Brislin, 1993). Within each culture, people are connected to one another through a common system of encoding and decoding messages. Each culture does this through its own verbal and nonverbal behaviors (Kim, 1988) and has its own way of expressing and interpreting messages. It is easy to see how problems can result when individuals of different cultures come into contact with each other. So what can be done in these increasingly common situations of contact among people of different cultures? Gudykunst (1995) suggested that we choose, although perhaps not always consciously, whether we want to communicate effectively. When we do choose to communicate effectively, we then need to know when and how to do so.

CULTURAL SENSITIVITY

Brislin (1993) suggested that health care providers can effectively communicate with clients from other cultures if they are "culturally sensitive," whereas other health care research confirms that cultural sensitivity is important in working with patients (Bronner, 1994; Majumdar, 1995; Moore, 1992). Cultural sensitivity involves a willingness to use cultural knowledge while interacting with patients and considering culture during discussions and recommendations for treatment (Brislin, 1993; Dennis & Giangreco, 1996; Jackson & Haynes, 1992). It further involves understanding and respecting the values, beliefs, and attitudes of others (Bronner, 1994; Moore, 1992). Cultural sensitivity with people who may not even value their services can be a difficult task for health professionals who are also striving to offer the best possible services (Brislin, 1993).

In working with patients from other cultures, health care providers can learn as they go, but this is dangerous when dealing with people's health and can lead to misunderstandings and costly mistakes, including misdiagnosis and violating patients' own ethical beliefs. As a result, health care providers need to learn about the cultures of their patients and be sensitive to the importance of culture in health care provision (Wohl, 1989). Professionals must recognize the importance of cultural sensitivity in their practices and work to increase their own intercultural competence (Dennis & Giangreco, 1996). Wohl reminded us that all interactions in health care are intercultural as patients, at the very least, do not share the terminol-

ogy, assumptions, and norms of the health profession culture. Lack of cultural sensitivity leads to miscommunication, which causes dissatisfaction and stress for both providers and patients (Kreps & Thornton, 1984). For instance, people from different cultures do not always report pain in the same ways, which easily leads to miscommunication regarding diagnosis and treatment (Lee et al., 1992).

Cultural sensitivity also has become a big issue in terms of informed consent. The United States judicially requires that all patients receive full information enabling them to freely make decisions about their own health care (Gostin, 1995). People who are part of the dominant European American culture may see this as completely reasonable and ethical, but it can actually be in contrast to the cultural norms and beliefs of many subcultures present within the United States (Blackhall, Murphy, Frank, Michel, & Azen, 1995; Carrese & Rhodes, 1995; Gostin, 1995). With this in mind, even informed consent needs to be culturally sensitive and reflect patient-centered beliefs.

Bernal, Bonilla, and Bellido (1995) and Dennis and Giangreco (1996) operationalized the construct of cultural sensitivity in health care settings. Cultural sensitivity included using culturally appropriate language, having cultural knowledge, understanding cultural values, considering culture in assessment of patients, and adapting treatment according to the cultural knowledge they have regarding a patient.

PATIENT-PROVIDER COMMUNICATION

Although the term *health care provider* often illicit images of doctors, it really encompasses many more people. A health care provider refers to anyone working in health care, whether in hospitals or in the community, who comes in contact with clients or whose work influences care (Schott & Henley, 1996). This includes nurses, pharmacists, physician's assistants, ward secretaries, and so on.

Starting with the need to determine a patient's medical history and current symptoms or concerns (Harlem, 1977), the delivery of health care depends on communication (Buller & Street, 1992; Kreps & Kunitomo, 1994). However, the awarding of a professional degree does not confer the ability to communicate effectively (Smith, 1991). In fact, although medical science has advanced rapidly, the doctor-patient relationship has deteriorated (Todres, 1993). Scientific knowledge is of no help if the provider-patient relationship is caught up in misunderstanding (Fisher, 1992).

Both the patient and the provider are responsible for the communication that takes place; however, professionals are especially responsible for accurate communication because they are expected to use their training and competence to develop positive relationships for effectively diagnosing and treating patients (King, Novak, & Citrenbaum, 1983; Lee et al., 1992). Most people go into the health care

profession to help others, and this can be greatly aided through communication (Gazda, Childers, & Walters, 1982; Ruben, 1992).

Furthermore, effective communication gains the trust of the family and facilitates the use of health promotion strategies (Meadows, 1991). Using effective communication to help others can also be exciting and personally satisfying (Gazda et al., 1982). Smith (1991) found that today's pharmacies dispense as much information as they do products and that community pharmacies emphasizing patient counseling greatly increase their clientele.

Furthermore, using effective communication can be challenging for health care providers as dealing with patients often becomes routine. Providers must put forth special effort to approach each situation and each person as unique (Ruben, 1992). Through communication, they can help people feel less like patients and more like capable human beings (Gazda et al., 1982; Thompson, 1986).

As we have seen, patient-provider communication is a vital part of health care regardless of the cultural backgrounds of those involved. However, culture does add another dimension to an often already difficult communication situation. Therefore, intercultural patient-provider communication must be further explored.

INTERCULTURAL PATIENT-PROVIDER COMMUNICATION

Obviously, hospitals serving non-English speaking patients need strategies to improve communication with those patients. Unfortunately, most health care facilities do not have interpreters, and even posters and pamphlets are aimed only at English-speaking patients (Schott & Henley, 1996). An exit interview of 314 emergency room patients who were treated and released found that overall, patients only understood 59% of what they were told, and, not surprisingly, this percentage was significantly lower for Spanish-speaking patients.

There are many barriers to intercultural communication in health care. Patients are often too scared and sick to focus on communication, whereas providers are pressed for time or too focused on technology (Kreps & Kunimoto, 1994). Cultural differences can also become exaggerated for doctors in health care settings due to the added status differences as doctors are often seen as possessing a position of power (Lee et al., 1992). Health care providers also suffer from medical ethnocentrism as they are only trained to deal with the dominant culture (Fisher, 1992). Members of the Hispanic community may find this particularly troublesome due to the complex nature of health care systems in the United States coupled with cultural differences in personal modesty and comfort in disclosing personal information (Burgos-Ocasio, 1996).

Health care providers must be perceptive of cultural differences (Harlem, 1977) and be flexible in treating patients how they want to be treated (Burgos-Ocasio,

1996; Gropper, 1996). Health care providers need to know themselves and their culture as well as the culture of their patients. They need to be sensitive to patients' beliefs and values and even learn their languages, if possible. They also need to adapt their verbal and nonverbal communication behaviors (Kreps & Thornton, 1984).

As we have seen, many studies suggest that effective health care provider communication aids patients in their recoveries and increases patient satisfaction (e.g., Hamilton, Rouse, & Rouse, 1994; Smith, 1991; Thompson, 1990). However, health care providers both may need and deserve to know that being effective intercultural communicators aids more than just their patients. Successful communication should also positively affect health care providers. One way in which providers may benefit from greater cultural sensitivity is through the relief of stress.

STRESS AND ANXIETY

Selye (1983) defined stress as "a nonspecific response of the body to any demand" (p. 2). Intercultural research has shown that communicating with people from other cultures is one situation often causing anxiety and stress (Olaniran, 1993; Redmond & Bunyi, 1993). Kreps and Kunitomo (1994) and Schott and Henley (1996) specifically suggested that intercultural communication contributes to stress for health care providers. Specific situations may produce emotional, physical, and behavioral reactions associated with stress. As a result, communicating in specific situations is one type of stressor (Seyle, 1983). As interacting with people from other cultures is a novel situation for most people, it tends to cause high levels of uncertainty and anxiety (Hofstede, 1991). Uncertainty is our inability to explain others' behaviors, whereas anxiety involves feeling uneasy, tense, worried, or apprehensive. In general, our anxiety stems from this uncertainty in dealing with others who are culturally different. We may feel uncertainty because we can not predict or explain others' behavior, and we may feel anxiety because we are worried about negative consequences that may result (Gudykunst, 1993).

Learning new communication rules and behaviors is generally accompanied by stress (Olaniran, 1993). Similarly, completing more complex tasks leads to higher levels of stress. Lack of control in work situations is also strongly related to stress (Fisher, 1984; Miller, Ellis, Zook, & Lyles, 1990). All three of these stress-producing aspects are present during intercultural communication in health care.

Unfortunately, studies of stress tend to focus on eventful experiences such as death or divorce. Although these situations certainly cause stress, repeated and chronic stress-producing events may have a greater overall effect on people's lives, yet such events are rarely studied (Pearlin, 1982). Intercultural communication may be one such event for health care providers and, therefore, needs further research.

Negative health consequences often result from unanticipated or underestimated sources of stress for registered nurses. Such sources of stress for nurses correlate with lower job satisfaction, lower self-esteem, and higher levels of depression (Dytell, 1990). It is quite possible that dealing with clients from other cultures would likely lead to high levels of anxiety, therefore, being an additional source of unanticipated or underestimated stress for nurses.

Other proof of the dangers of stress for workers exists. Cooper (1983) suggested that working women are at greater risk for stress-related illnesses, and Freudenberg (1983) maintained that stress is related to burnout for people in human services professions. Kreps and Kunimoto (1994) further suggested that stress from being unable to adapt to those from different cultures is a specific factor in burnout for health care workers.

As stress is unhealthy for all individuals, we should endeavor to reduce it whenever possible. The reduction of stress is especially important for health professionals such as nurses (Landsbergis, 1989; Miller et al., 1990). Being a culturally sensitive and effective intercultural communicator should lower stress for health care providers when dealing with clients from other cultures. We can reduce stress by gaining knowledge of other cultures, having positive contact with individuals from other cultures (Gudykunst, 1988; Kim, 1978; Redmond & Bunyi, 1993), and having social support and feedback (Adelman, 1988).

This study endeavors to show that culturally sensitive health care providers are indeed better communicators. In addition, the relations among cultural sensitivity, intercultural communication effectiveness, and anxiety are tested.

- H1: An intercorrelation will be found among perceptions of cultural sensitivity, intercultural communication effectiveness, and anxiety.

METHODS

Research Design and Instrument Development

Data were collected through surveys administered in a community health system. Surveys were in written format.

Cultural sensitivity. As there was no current measure of cultural sensitivity, questions were developed out of Bernal et al.'s (1995) definition. Cultural sensitivity was measured using three 5-point Likert-type questions.¹ The questions were constructed for the health care organization context along the following issues: pro-

¹Items assessing cultural sensitivity included, "I know a lot about my patients' cultures," "I adapt my treatment for patients of other cultures according to the knowledge I have of their culture when making recommendations," and "I consider patients' cultures when making recommendations for their care."

viders' use of the client's native language and demonstration of knowledge of the client's particular culture as well as recognition of the client's cultural values in patient assessment and treatment recommendations. Cronbach's (1951) alpha for these items was .68. As the measurement for cultural sensitivity was just developed for this study, this alpha was considered acceptable, and these items were combined to form the variable of cultural sensitivity. Two other items developed for the measure of cultural sensitivity were discarded as the confirmatory factor analysis of scales showed they did not load on the same factor as the other items, thus lowering the reliability of the overall measure (see Table 1).

Effective intercultural communication. The measure for effective intercultural communication was adapted from Redmond and Bunyi's (1993) measure consisting of six items. Redmond and Bunyi reported Cronbach's (1951) alpha of .85. The alpha for these items based on the study presented in this article was comparable at .83. The adapted measure included six 5-point Likert-type questions.²

The confirmatory factor analysis of scales (see Table 1) further shows that the items of this measure all load on the same factor. The factor analysis also shows that cultural sensitivity and effective intercultural communication are loading on different factors.

Anxiety. The measure for anxiety was adapted from the Social Evaluation Scale of the S-R Inventory of General Trait Anxiousness, shown to be the most useful in measuring interaction situations (Endler, 1980). The measure was adapted to involve an intercultural communication situation and used 10 of the original 15 statements to measure respondents' feelings regarding the situation. This measure told respondents to imagine that they are communicating with a client from another culture.³ Cronbach's (1951) alpha for this measure was .87.

Participants

The sample for this study consisted of the employees of a large health care system in a southern state, which included two hospitals as well as four clinics. At the time of this study the organization was a not-for-profit corporation for which management duties had just recently been taken over by a health care management firm. As a re-

²Items assessing effective intercultural communication included, "I understand the feelings of patients from other cultures," "I communicate well with patients from other cultures," "I can easily resolve misunderstandings with patients from other cultures," "I understand the point of view of patients from other cultures," and "I can empathize with patients from other cultures."

³Items assessing anxiety resulting from communication with people from other cultures included, "I seek experiences like this," "I feel relaxed," "I feel nervous," "I feel self-confident," "I feel anxious," "I enjoy these situations," "I feel tense," "I feel comfortable," "I have an 'uneasy' feeling," and "I get a fluttering feeling in my stomach."

TABLE 1
Confirmatory Factor Analysis of Scales

<i>Questions</i>	<i>Factor</i>	
	<i>1</i>	<i>2</i>
Cultural sensitivity questions		
Know about patients' culture	.125	.793
Adapt treatment for patients	.082	.804
Consider culture when making recommendations	.345	.648
Change my language	.332	.283
Understand patients' values	.666	.134
Effective intercultural communication questions		
Understand patients' feelings	.812	.059
Communicate well	.669	.301
Easily resolve misunderstandings	.768	.208
Understand patients' point of view	.816	.239
Empathize with patients	.651	.091
Interpret patients' nonverbals	.608	.246

sult, the organization was in a period of change and uncertainty during the time this study was conducted. Shortly after the study was completed, the management firm began procedures to purchase the health care organization.

Procedures

Permission to conduct research with the health care system was approved by top administration 3 months prior to the survey administration. The surveys were administered to directors and unit supervisors who then distributed the surveys to employees. Each survey came in an envelope labeled with the employees' name and included a return envelope. The surveys were attached to a cover letter including a statement of support from top administration.

Not all employees were provided the opportunity to complete surveys. Surveys were originally planned to reach all 1,100 employees but it was discovered that administration had provided an employee list that failed to include names of all employees. The names found on the list were typed onto labels that were attached to envelopes containing the surveys. Therefore, employees whose names were not on the list did not receive a survey. In addition, surveys were distributed only on 1 day. Therefore, employees not scheduled to work on the distribution day did not receive surveys. Employees working part time on an as-needed basis, such as some nurses, also were not surveyed. These constraints lowered the percentage of employees surveyed and the response rate. A total of 391 surveys were completed and returned. Although this only suggests a 36% response rate, as mentioned, the rate of return from those who actually received the surveys was probably higher.

RESULTS

The means and standard deviations for the questions making up the cultural sensitivity, effective intercultural communication, and anxiety variables can be seen in Tables 2, 3, and 4. Table 5 shows the means and standard deviations for the variables. The frequency data for the four training questions is listed in Table 6.

TABLE 2
Cultural Sensitivity Questions

<i>Question</i>	<i>M</i>	<i>SD</i>	<i>N</i>
I know a lot about my patients' culture	2.69	0.99	360
I adapt my treatment according to patients' culture	3.25	1.19	343
I consider patients' culture when making recommendations	3.72	1.06	230

TABLE 3
Effective Intercultural Communication Questions

<i>Question</i>	<i>M</i>	<i>SD</i>	<i>N</i>
I understand the feelings of patients from other cultures	3.55	.90	280
I communicate well with patients from other cultures	3.21	.93	279
I can easily resolve misunderstandings with patients from other cultures	3.19	.84	258
I understand the point of view of patients from other cultures	3.30	.87	275
I can empathize with patients from other cultures	3.69	.92	287
I can interpret the nonverbals of patients from other cultures	3.41	.84	280

TABLE 4
Anxiety Questions

<i>Question</i>	<i>M</i>	<i>SD</i>	<i>N</i>
I seek experiences like this	3.25	1.44	373
I feel relaxed	3.63	1.54	371
I feel nervous	3.78	1.41	365
I feel self-confident	3.24	1.38	365
I feel anxious	3.76	1.37	364
I enjoy these situations	4.01	1.33	364
I feel tense	3.75	1.35	365
I feel comfortable	3.64	1.32	363
I have an uneasy feeling	3.70	1.40	363
I get a fluttering feeling in my stomach	3.25	1.27	360

TABLE 5
Cultural Sensitivity, Effective Intercultural Communication, and Anxiety Variables

<i>Variable</i>	<i>M</i>	<i>SD</i>	<i>N</i>
Cultural sensitivity	3.06	.91	370
Effective intercultural communication	3.39	.67	300
Anxiety	3.63	.98	379

The hypothesis examining the intercorrelation among perceptions of cultural sensitivity, intercultural communication effectiveness, and anxiety was confirmed. Pearson product correlations were computed to test the hypothesis. Cultural sensitivity and effective intercultural communication were positively correlated, $r = .377, p < .01$. Anxiety and intercultural communication effectiveness were negatively correlated, $r = -.343, p < .01$, also supporting the hypothesis. Health care providers' cultural sensitivity and levels of anxiety were negatively correlated, $r = -.378, p < .01$ (see Table 6).

DISCUSSION OF RESULTS

This study examined the relations among cultural sensitivity, effective intercultural communication, and anxiety for health care providers. A positive relation was found between cultural sensitivity and effective intercultural communication. Negative correlations were found between health care providers' intercultural communication effectiveness and their levels of anxiety and providers' cultural sensitivity and their levels of anxiety. These findings fit the theoretical prediction that these terms are related and suggest that studies regarding these concepts can be linked and possibly united.

The .68 Cronbach's (1951) alpha for cultural sensitivity was considered acceptable for a first-time measure of a concept, but obviously more work needs to be done to develop a more reliable measure of cultural sensitivity. As the concept of cultural sensitivity was developed specifically for doctors and nurses, the measure may have been inadequate as it was used for all health care providers and not limited to just doctors and nurses. In addition, too many studies regarding cultural sensitivity have neglected to measure the concept, and this must be changed by developing an accurate measure for cultural sensitivity.

In addition, the effective intercultural communication measure developed for use with international students, immigrants, and sojourners was a reliable measure for host culture members such as health care providers. Thus far in intercultural communication, the focus has been on individuals present in foreign cultures, but in today's increasingly multicultural world, it is necessary to look at the intercultural communication abilities of host culture members as well.

Limitations

The measure of cultural sensitivity was not as reliable as desired. More extensive pretesting would have possibly helped to create a more accurate measure. The measure of cultural sensitivity may also prove more accurate if its use is limited to doctors and nurses rather than used for all health care providers. In addition, the measures for cultural sensitivity and effective intercultural communication may have suffered from response bias as all statements were worded positively at the request of the health care system involved in the study.

The sample was also limited to one health care system in one geographic location. Consequently, these results may not be fully generalizable to all health care providers. In particular, this study was conducted during a period of extreme change for the health care system studied. It is possible that structural changes taking place in the organization may have affected individuals' responses. As management in the health care system was completely changing, many employees were certainly worried about their own job stability. Although it is hard to know for certain if these circumstances affected responses, it certainly affected the response rate, which was perhaps a bit low considering the size of the organization.

Contributions to the Literature

The contributions of this study to the literature include the development of a measure for cultural sensitivity. This study also shows that cultural sensitivity and effective intercultural communication are related concepts. This suggests that these two distinct bodies of literature can be united in the future. Finally, this study shows that the measure for effective intercultural communication is valid for members of a host culture as well as for international students, immigrants, and sojourners. This finding may expand the use and importance of the measure for effective intercultural communication.

TABLE 6
Correlation Table for Cultural Sensitivity, Effective Intercultural Communication, Anxiety

<i>Variable</i>	<i>1</i>	<i>2</i>	<i>3</i>
Cultural sensitivity	—		
Effective intercultural communication	.377*	—	
Anxiety	-.378*	-.343*	—

* $p < .01$.

Implications for Providers

These findings also show that health care providers who perceive themselves as high in cultural sensitivity or effective intercultural communication report experiencing less anxiety in intercultural situations. As anxiety is a common measure for stress, this finding is good news for health care providers who are already in stressful jobs involving care for increasing numbers of patients from other cultures. By enhancing their cultural sensitivity and intercultural communication effectiveness, health care providers may reduce the anxiety they encounter when dealing with patients from other cultures. Reduced anxiety may lead to better quality care.

This study also suggests that anxiety and stress are factors in intercultural situations for many people. Pearlin (1982) stated that chronic, repeated stress-producing events, such as interacting with patients from other cultures, are rarely studied in comparison to more catastrophic events like divorce or death. However, chronic events such as interacting with members of other cultures are occurrences that are increasingly experienced by people in the health care professions. The direct relations among anxiety levels, cultural sensitivity, and intercultural communication effectiveness suggest that health care providers can benefit from learning new coping skills for such situations.

By explaining the personal benefit of reduced anxiety and stress, we may better persuade health care providers of the importance of training to help them in increasing their cultural sensitivity and intercultural communication effectiveness. It is important for health care providers to know that by increasing their own cultural sensitivity and intercultural communication effectiveness they not only help their patients, but they can also ease their own anxiety and job stress.

Recommendations for Further Research

As mentioned earlier, a better measure of cultural sensitivity needs to be developed. Furthermore, intercultural communication for members of host cultures needs continued study. The world is becoming too diverse to just isolate sojourners, immigrants, and international students. We all have responsibilities to be able to communicate effectively with individuals from other cultures.

Finally, training programs need to be implemented focused on improving health care providers' intercultural communication. Extant training programs largely are focused on situations involving international students (Ulrey, 1998). These models may need serious modification to make them appropriate to health care contexts and the most useful in aiding to relieve the stress and anxiety associated with communicating with people from other cultures.

REFERENCES

- Adelman, M. B. (1988). Cross-cultural adjustment: A theoretical perspective on social support. *International Journal of Intercultural Relations*, 12, 183–204.
- Anderson, L. A., & Sharpe, P. A. (1991). Improving patient and provider communication: A synthesis and review of communication interventions. *Patient Education and Counseling*, 17, 99–134.
- Bernal, G., Bonilla, J., & Bellido, C. (1995). Ecological validity and cultural sensitivity for outcome research: Issues for the cultural adaptation and development of psychosocial treatments with Hispanics. *Journal of Abnormal Child Psychology*, 23, 67–82.
- Blackhall, L. J., Murphy, S. T., Frank, G., Michel, V., & Azen, S. (1995). Ethnicity and attitudes toward patient autonomy. *Journal of the American Medical Association*, 274, 820–825.
- Brislin, R. (1993). *Understanding culture's influence on behavior*. Orlando, FL: Harcourt Brace.
- Bronner, Y. (1994). Cultural sensitivity and nutrition counseling. *Topics in Clinical Nutrition*, 9, 13–19.
- Buller, D. B., & Street, R. L., Jr. (1992). Physician–patient relationships. In R. S. Feldman (Ed.), *Application of nonverbal behavioral theories and research* (pp. 119–141). Hillsdale, NJ: Lawrence Erlbaum Associates, Inc.
- Burgos-Ocasio, H. (1996). Understanding Hispanic community. In M. C. Julia (Ed.), *Multicultural awareness in the health care professions* (pp. 111–130). Boston: Allyn & Bacon.
- Campbell, G. (1996). Patient finds communication is managed care advantage. *Wisconsin Medicine Journal*, 95, 222–225.
- Carrese, J. A., & Rhodes, L. A. (1995). Western bioethics on the Navajo reservation. *The Journal of the American Medical Association*, 274, 826–829.
- Collier, M. J. (1989). Cultural and intercultural communication competence: Current approaches and directions for future research. *International Journal of Intercultural Relations*, 13, 287–302.
- Cooper, C. L. (1983). Problem areas for future stress research: Cancer and working women. In C. L. Cooper (Ed.), *Stress research: Issues for the eighties* (pp. 103–146). New York: Wiley.
- Cronbach, L. J. (1951). Coefficient alpha and the internal structure of tasks. *Psychometrika*, 16, 297–334.
- Dennis, R. E., & Giangreco, M. F. (1996). Creating conversation: Reflections on cultural sensitivity in family interviewing. *Exceptional Children*, 63, 103–116.
- De Young, M. (1996). A review of the research on pharmacists' patient-communication views and practices. *American Journal of Pharmaceutical Education*, 60, 60–77.
- Dytell, R. S. (1990). The effects of unanticipated work stressors on registered nurses. In H. Humphrey (Ed.), *Human stress: Current selected research* (Vol. 4, pp. 47–58). New York: AMS Press.
- Endler, N. S. (1980). Person-situation interaction and anxiety. In I. L. Kutash & L. B. Schlesinger (Eds.), *Handbook on stress and anxiety: Contemporary knowledge, theory, and treatment* (pp. 249–266). San Francisco: Jossey-Bass.
- Fisher, S. (1984). *Stress and the perception of control*. Hillsdale, NJ: Lawrence Erlbaum Associates, Inc.
- Fisher, N. L. (1992). Ethnocultural approaches to genetics. *Pediatric Clinics of North America*, 39, 55–64.
- Freudenberger, H. J. (1983). Burnout: Contemporary issues, trends, and concerns. In B. Farber (Ed.), *Stress and burnout in the human service professions* (pp. 23–38). New York: Pergamon.
- Gazda, G. M., Childers, W. C., & Walters, R. P. (1982). *Interpersonal communication: A handbook for health professionals*. Rockville, MA: Aspen.
- Gostin, L. O. (1995). Informed consent, cultural sensitivity, and respect for persons. *Journal of the American Medical Association*, 274, 844–845.
- Gropper, R. C. (1996). *Culture and the clinical encounter: An intercultural sensitizer for the health professions*. Yarmouth, ME: Intercultural Press.

- Gudykunst, W. B. (1988). Uncertainty and anxiety. In Y. Y. Kim & W. B. Gudykunst (Eds.), *Theories in intercultural communication* (pp. 123–156). Newbury Park, CA: Sage.
- Gudykunst, W. B. (1993). Toward a theory of effective interpersonal and intergroup communication: An anxiety/uncertainty management (AUM) perspective. In R. L. Wiseman & J. Koester (Eds.), *Intercultural communication competence* (pp. 33–71). Newbury Park, CA: Sage.
- Gudykunst, W. B. (1995). Anxiety/uncertainty management (AUM) theory. In R. L. Wiseman (Ed.), *Intercultural communication theory* (pp. 8–58). Thousand Oaks, CA: Sage.
- Hamilton, M. A., Rouse, R. A., & Rouse, J. (1994). Dentist communication and patient utilization of dental services: Anxiety inhibition and competence enhancement effects. *Health Communication*, 6, 137–158.
- Harlem, O. K. (1977). *Communication in medicine: A challenge to the profession*. New York: Karger.
- Hofstede, G. (1991). *Cultures and organizations: Software of the mind*. London: McGraw-Hill.
- Jackson, C., & Haynes, T. (1992). *Cultural sensitivity: A working model*. Atlanta, GA: Southern Council on Collegiate Education for Nursing.
- Kim, Y. Y. (1978). Communication approach to the acculturation process: Study of Korean immigrants in Chicago. *International Journal of Intercultural Relations*, 2, 197–224.
- Kim, Y. Y. (1988). *Communication and cross-cultural adaptation: An integrative theory*. Philadelphia: Multilingual Matters.
- King, M., Novak, L., & Citrenbaum, C. (1983). *Irresistible communication: Creative skills for the health profession*. Philadelphia: Saunders.
- Kreps, G. L., & Kunimoto, E. N. (1994). *Effective communication in multicultural health care settings*. Thousand Oaks, CA: Sage.
- Kreps, G. L., & Thornton, B. C. (1984). *Health communication: Theory and practice*. New York: Longman.
- Landsbergis, P. A. (1989). Occupational stress among nurses: New developments in theory and prevention. In J. H. Humphrey (Ed.), *Human stress: Current selected research* (Vol. 3, pp. 173–195). New York: AMS Press.
- Lee, M. E., Matsumoto, D., Kobayashi, M., Krupp, D., Maniatis, E. F., & Roberts, W. (1992). Cultural influences on nonverbals in applied settings. In *Applications of nonverbal behavior theories and research* (pp. 239–261). Hillsdale, NJ: Lawrence Erlbaum Associates, Inc.
- Lipkin, M., Jr. (1996). Patient education and counseling in the context of modern patient–physician–family communication. *Patient Education and Counseling*, 27, 5–11.
- Majumdar, B. (1995). *Culture and health: Culture-sensitive training manual for the health care provider*. Hamilton, Canada: McMaster University.
- Meadows, J. L. (1991). Multicultural communication. *Physical and Occupational Therapy in Pediatrics*, 11, 31–42.
- Miller, K. I., Ellis, B. H., Zook, E. G., & Lyles, J. S. (1990). An integrated model of communication, stress, and burnout in the workplace. *Communication Research*, 17, 300–326.
- Moore, S. E. (1992). Cultural sensitivity treatment and research issues with Black adolescent drug users. *Child and Adolescent Social Work Journal*, 9, 249–260.
- Olaniran, B. A. (1993). International students' network patterns and cultural stress: What really counts. *Communication Research Reports*, 10, 69–83.
- Pearlin, L. I. (1982). The social contexts of stress. In L. Goldberger & S. Breznitz (Eds.), *Handbook of stress: Theoretical and clinical aspects* (pp. 367–379). New York: Free Press.
- Perry, K. (1994). Increasing patient satisfaction: Simple ways to increase the effectiveness of interpersonal communication in the OPS/PACU. *Journal of Post Anesthesia Nursing*, 9, 153–156.
- Redmond, M. V., & Bunyi, J. M. (1993). The relationship of intercultural communication competence with stress and the handling of stress as reported by international students. *International Journal of Intercultural Relations*, 17, 235–254.
- Ruben, B. D. (1992). *Communicating with patients*. Dubuque, IA: Kendall/Hunt.

- Schneider, K. (1993). *The impact of individual differences and training on the acculturation of international students*. Unpublished master's thesis, University of Houston, Texas.
- Schott, J., & Henley, A. (1996). *Culture, religion, and childbearing in a multiracial society: A handbook for health professionals*. Oxford, England: Butterworth-Heinemann.
- Seyle, H. (1983). The stress concept: Past, present, and future. In C. L. Cooper (Ed.), *Stress research: Issues for the Eighties* (pp. 1–20). New York: Wiley.
- Skorpen, J. B. J., & Malterud, K. (1997). What did the doctor say—What did the patient hear? Operational knowledge in clinical communication. *Family Practice*, 14, 382–386.
- Smith, D. L. (1991). Patient counseling: Your competitive edge. *American Pharmacy*, 31, 53–56.
- Thompson, T. L. (1986). *Communication for health professionals: A relational perspective*. Lanham, MD: Harper & Row.
- Thompson, T. L. (1990). Patient health care: Issues in interpersonal communication. In B. Ray & L. Donohew (Eds.), *Communication and health: Systems and applications* (pp. 27–50). Hillsdale, NJ: Lawrence Erlbaum Associates, Inc.
- Todres, I. D. (1993). Communication between physician, patient, and family in the pediatric intensive care unit. *Critical Care Medicine*, 21, 383–386.
- Ulrey, K. L. (1998). *Intercultural communication between patients and health care providers: An exploration of intercultural communication effectiveness, cultural sensitivity, stress and anxiety, and the fundamental attribution error and their implications for training*. Unpublished master's thesis, University of Arkansas.
- Voelker, R. (1995). Speaking the languages of medicine and culture. *Journal of the American Medical Association*, 273, 1639–1641.
- Wohl, J. C. (1989). Integration of cultural awareness into psychotherapy. *American Journal of Psychotherapy*, 43, 343–355.

Copyright of Health Communication is the property of Lawrence Erlbaum Associates and its content may not be copied or emailed to multiple sites or posted to a listserv without the copyright holder's express written permission. However, users may print, download, or email articles for individual use.

Copyright of Health Communication is the property of Taylor & Francis Ltd and its content may not be copied or emailed to multiple sites or posted to a listserv without the copyright holder's express written permission. However, users may print, download, or email articles for individual use.