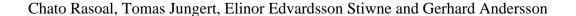
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Ethnocultural Empathy Among Students in Health Care Education



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Ethnocultural empathy among students in healthcare education
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Abstract

In a multi-cultural society, ethnocultural empathy has become an important element in most

health settings and develop this capacity has become a central component for health care

professionals in their interactions with patients and clients. In this study, differences in basic

empathy and ethnocultural empathy were explored in a sample of 365 undergraduate students

at the beginning and end of four Master's programmes in healthcare (Medicine, Psychology,

Nursing and Social Work). Results showed that it was mainly Psychology students in the first

semester who had significantly higher general empathic skills and ethnocultural empathic

skills compared to students in the other study programmes. Few signs of differences between

students in their first and in later semesters were obtained. The observed differences may be

explained by: (a) levels of admission grades and applications requirements or (b) different

cultures and expectations from the surrounding milieus in the investigated study programmes.

Key Words: empathy, healthcare, culture, ethnocultural empathy, education

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Empathy is an important component in professional encounters (Reynolds & Scott, 1999). It can be of particular importance for health care professionals to develop empathic skills in their interactions with patients, clients and significant others. If patients and clients are to receive fair professional treatment, the care providers must be able to communicate effectively with the patient or client (Fields, Hojat, Gonnella, Mangione, & Kane, 2004). Hardee (2003) argued that empathy is a powerful communication skill for health care professionals which facilitates clinical interviewing.

There have been several studies indicating inequalities in health and health care between patients and clients from different ethnic and cultural backgrounds compared with the majority of population (Albin, Hjelm, Ekberg, & Elmstahl, 2006; Essen, Hanson, Ostergren, Lindquist, & Gudmundsson, 2000; Gadd, Johansson, Sundquist, & Wandell, 2003; Robertson, Iglesias, Johansson, & Sundquist, 2003; Robertson, Malmstrom, & Johansson, 2005). While the importance of empathy is often put forward in literature on health care and in training programmes, there is relatively little empirical research on differences in empathy between different professions. There have been many studies on students in Medicine, Psychotherapy, and Nursing with regard to basic empathy (Dyche & Zayas, 2001; Kim, Kaplowitz & Johnston, 2004; Ridley & Lingle, 1996). To our knowledge, research on ethnocultural empathy of students in health care programmes has not been studied to any greater extent. One exception is research on cultural competence in mental health and nursing, which suggests that empathy plays an important role (Mercer & Reynolds, 2002).

In research on empathy, there has been a tradition of focusing on basic empathy, broadly defined as global empathy not specifically targeting any one group (e.g. age, gender, and ethnicity) or context (Rasoal, Eklund & Hansen, 2008). In research, basic empathy is often measured with the Interpersonal Reactivity Index (IRI) (Davis, 1996). The IRI targets

four components of empathy, all of which deal with imagining oneself in the place of fictitious characters.

Several authors have argued that empathic skills are not universally applicable in a multi-cultural society, as cultural background and encounters with different ethnic groups are likely to influence empathy (Batson, 1994; Green, 1998; Hoffman, 2000). Moreover, empathy towards others probably increases if the other is similar to oneself in terms of ethnicity, gender, age, or cultural background. In line with this notion, Wang et al. (2003) coined the term 'ethnocultural empathy' and operationalised the concept by developing a scale to measure 'ethnocultural empathy'. Ethnocultural empathy is defined as empathy directed towards people from racial and ethnic cultural groups who are different from one's own ethnocultural group, and is a relatively new concept. Wang et al. (2003) developed the ethnocultural empathy scale (SEE) based on four components: Empathic Feeling and Expression, Ethnocultural Empathy Awareness, Acceptance of Cultural Differences, and Empathy Perspective Taking. Wang et al. (2003) found acceptable internal consistency and construct validity of the scale and the subscales. Test-retest reliability obtained from the American sample was high (Cronbach's alpha: .91). Using the SEE, Wang and co-workers showed that non-white individuals reported significantly higher levels of general and specific ethnocultural empathy than their white counterparts. Furthermore, results showed that women had significantly higher total scores than men on three of the four SEE subscales: empathic feeling and expression, empathic awareness, and acceptance of cultural differences. We have recently translated and validated the SEE for Swedish conditions (Rasoal, Hau, Edvardsson-Stiwne, Carlbring & Andersson, 2008). A principal components factor analysis resulted in four factors, which were similar to the original study. In addition, internal consistencies for the subscales were largely replicated, with Cronbach's alpha coefficients ranging between .69 - .79, and .89 for the SEE total score.

Knowledge concerning the cultural and ethnic background of patients or clients could be important for a number of reasons (Dysart-Gale, 2006; Ivey, Ivey & Simek-Downing, 1997; Lawrence & Luis, 2001; Rasoal et al., 2008). Firstly, professionals in health care, such as physicians and psychologists, need competence in this domain because in many countries patient groups are increasingly diverse in terms of ethnic background. Secondly, it is important to integrate knowledge of the significance of culture and ethnicity already in study programmes in health care, given that we live in a globalised and multicultural world. In the Swedish setting in which our research was conducted multicultural issues are relevant as well, as 20% of the population has a non-Swedish ethnic background (Robertson et al., 2003; Statistical Central Bureau in Sweden, 2005). While previous studies have sought to explore the effect of training psychotherapists to work with ethnically diverse populations (Dyche & Zayas, 2001), we are not aware of any studies in which ethnocultural empathy has been studied among students in health care programme.

In this study, we measured levels of basic empathy and ethnocultural empathy among students in four healthcare education domains (i.e. the undergraduate programmes in Medicine, Psychology, Nursing, and Social Work). In the Swedish system all of these are masters' programmes, which range between 3.5 to 5.5 years. Basic empathy was defined as a set of constructs regarding the responses of an individual to the experiences of other persons (Davis, 1996). The IRI was used because it measures basic empathy and is a robust and frequently used instrument with robust reliability and validity (Cliffordson, 2001). The SEE was used because it is the only published instrument measuring ethnocultural empathy. In order to examine whether the levels of empathy of the students differed at the beginning and at the end of the studies, empathy was measured in the first semester and by the end of the study programmes.

The overall purpose of the current study was to explore differences between students in four health care study programmes, using the IRI and the SEE including its four subscales. The research questions that we address were: (a) Are there differences in the levels of SEE including its subscales and IRI, between students in the programmes of the first semester? (b) Are there differences between students in the programmes of the later semesters? and (c) Are there differences between early and late semester students in the programmes? We also investigated if demographical variables were associated with empathy scores.

Method

Participants and procedure

The participants were 365 undergraduate students in four study programmes at Linköping University, Sweden. Participants studied in graduate programmes in Medicine (N=76), Psychology (N=89), Nursing (N=93), and Social Work (N=107). The students were enrolled in their first and in a later semester, ranging between the sixth and ninth semester (Table 1).

Table 1. Number of respondents, in relation to study programme and semester.

Semester	Study programmes				
	Medicine	Psychology	Nursing	Social Work	Total
First semester	45	46	45	55	191
Later semesters (6 th to 9 th)	31	43	48	52	174
Total n for each study	76	89	93	107	365
programme					

Measures were administered during the autumn semester of 2007 and spring semester of 2008. Participants completed a questionnaire package in large groups in association with regular lectures. The response rates for Psychology and Social Work were 95%, whereas the response rate for Medicine and Nursing were 66% for both. In all 286 participants were females (78%) and 79 were males (22%). The proportion of female students in the

programmes was 87% in Nursing, 88% in Social Work, 63% in Medicine, and 71% in Psychology. Ages ranged from eighteen to forty-four years (M= 25.2, SD = 5.7). For each study programme, the average ages were as follows: 23.6 years (SD = 4.3) for Nursing, 26.3 years (SD = 6.8) for Social Work, 23.7 years (SD = 4.2) for Medicine, and 27.4 years (SD = 6.2) for Psychology. Most of the respondents described themselves as ethnic Swedes (91.8%, n = 353). Only 1.4% had Nordic ethnic origins other than Swedish, and 1.9% were Bosnian, while the remaining respondents had ethnic backgrounds such as Kurdish and Persian. The anonymity and confidentiality of the respondents was guaranteed and participation was on a voluntary basis. Moreover, the students could withdraw from the study if they wished. The questionnaire package took approximately twenty minutes to complete.

Instruments

The questionnaire booklet consisted of 64 items in total, and consisted of three parts. The following sections were included:

- (a) Questionnaire on demographics.
- (b) The Scale of Ethnocultural Empathy (SEE: Rasoal et al., 2008; Wang et al., 2003) is a 31-item forced choice self-report measure that produces an overall score and four subscale scores. The first subscale, *Empathic Feeling and Expression (EFE)*, consists of twelve items, focus on communicative empathy and is directed towards the verbal expression of ethnocultural empathic thoughts and feelings toward members of other ethnic groups (e.g. 'I share the anger of those who face injustice because of their racial and ethnic backgrounds'). The second subscale, *Ethnocultural Empathy Awareness (EA)*, consists of seven items, and focuses on the way in which ethnocultural empathy is expressed as awareness of how society, media and the job market treat other ethnic groups (e.g. 'I feel irritated when people of different racial or ethnic background speak their language around me'). The third subscale,

Acceptance of Cultural Differences (AC), consists of five items and targets the acceptance of cultural differences. It aims to focus on the understanding of why people of other ethnic groups behave as they do, for example wearing traditional clothing, or speaking their own language (e.g. 'I am aware of institutional barriers [e.g. restricted opportunities for job promotion] that discriminate against racial or ethnic groups other than my own'). The fourth subscale, Empathy Perspective Taking (EP), consists of seven items, and focuses on intellectual empathy, which is defined as the ability to understand how persons with a different ethnic background think or feel (e.g. 'It is easy for me to understand what it would feel like to be a person of another racial or ethnic background other than my own'). Scores for the SEE were obtained by summing the item scores. Higher scores indicated a higher level of ethnocultural empathy. The SEE questionnaire has been validated in an earlier study on an independent sample (Rasoal et al., 2008).

(c) In addition, respondents also completed the Interpersonal Reactivity Index (IRI) which includes 28 items. The IRI is designed to measure basic empathy (Davis, 1996). All of the items on the SEE and IRI were rated on a five-point Likert-type scale (1 = strongly disagree to 5 = strongly agree). Negatively phrased items were reversed in the scoring.

Statistical analyses

Differences between students in health care professions were tested with univariate analyses of variance (ANOVA). Post hoc tests were performed with Tukey's HSD test (Honestly Significant Difference). Between-group differences (first vs. later semesters) were also tested with ANOVAs and subsequent Tukey's HSD tests. Data were analysed using SPSS 16.

Results

Role of gender, age and Ethnicity

Empathy variables were correlated with background variables and results are presented in Table 2. Ethnicity was coded as a dummy variable. There were several small to moderate correlations (r = .12 to .33), where gender had the highest correlation with empathy. Gender was associated with higher empathy scores.

Table 2. Correlations between demographical variables and the dependent variables.

	SEE-Total	SEE-AC	SEE-EPT	SEE-EFE	SEE-EA	IRI
Gender	.28**	.17**	.03	.36**	.30**	.34**
Age	.10	16**	.13*	.04	.01	.05
Ethnicity	.06	.03	.05	.05	.15*	.07

^{* =} p<0.05, ** = p<0.01, IRI = Interpersonal Reactivity Index, SEE = Scale of Ethnocultural Empathy, SEE Factor 1 AC= Acceptance of cultural differences, SEE Factor 2 EPT = Epmathic Perspective Taking, SEE Factor 3 EEE= Empathic Feeling and Expression, SEE Factor 4 EA= Empathic Awareness.

Results for the first semesters

The means and standard deviations of the variables measured at the first and later semester of the study programmes are presented in Table 3. For the measure of ethnocultural empathy (SEE-total), there was a significant between group effect F(3, 191) = 10.3, p < .001. Post-hoc analyses showed that Psychology students had significantly higher mean values than students in Medicine, Nursing (p < .001), and Social Work (p < .05).

Differences between the different study programmes were also calculated on a subscale level. While the subscales were correlated (r = .18 to .63), they are relatively distinct (Wang et al., 2003) hence meriting separate analyses for the subscales. There was a significant effect on group level F(3, 191) = 6.02, p < .001 in the SEE-AC. Further analyses showed that Psychology students had significantly higher mean values than students in Medicine and Nursing (p < .001). Furthermore, there was a significant effect on the SEE-EPT, F(3, 191) = 7.30, p < .001, with Psychology students scoring higher than students in Social Work (p < .001) There was also a significant effect on SEE-EFE, F(3, 191) = 7.36, p < .001. Psychology students had significantly higher mean values than students in Medicine and

Nursing (p < .001). Finally, on the SEE-EA there was an effect F(3, 191) = 12.54, p < .001, with Psychology students scoring higher than students in Medicine and Nursing (p < .001). Students in Social Work had a significantly higher mean score on the SEE-EA than students in Nursing (p < .001) and Medicine (p < .005).

For the scale measuring general empathy (IRI) there was a significant between group effect F(3, 191) = 5.82, p < .001. Further post-hoc analyses showed that the Psychology students scored higher than the Medical students (p < .01).

Table 3. Means and standard deviations of the variables in both first and later semesters and for the total group. P-values for the between-group differences are presented as well as in

subscript. Interactions cohort x programme are presented in text.

First and later semester	Medicine	Psychology	Nursing	Social Work	<i>p</i> -value
	M (SD)	M (SD)	M (SD)	M (SD)	
SEE-Total First	3.71(0.47)	4.11(0.41)	3.66(0.43)	3.85(0.39)	<.001 ^{a***} ,b***,c***
SEE-Total Later	3.80(0.42)	3.99(0.47)	3.83(0.38)	4.00(0.39)	002
SEE-Total All	3.75(0.45)	4.05(0.44)	3.75(0.41)	3.92(0.40)	<.001 ^{a****,b***} ,c***
SEE-AC First	3.93(0.65)	4.33(0.40)	3.89(0.54)	4.09(0.55)	<.001 ^{a***,b***}
SEE-AC Later	4.10(0.59)	4.27(0.52)	4.10(0.50)	4.07(0.45)	555
SEE-AC Total All	3.98(0.62)	4.30(0.46)	3.98(0.53)	4.12(0.51)	<.001 ^{a***,b***}
SEE-EPT First	3.43(0.74)	3.66(0.69)	3.23(0.59)	3.05(0.67)	<.001 ^{c***}
SEE-EPT Later	3.48(0.60)	3.60(0.72)	3.11(0.65)	3.38(0.72)	.074
SEE-EPT Total All	3.45(0.68)	3.63(0.70)	3.17(0.62)	3.21(0.71)	<.001 ^{b***} ,c***
SEE-EFE First	3.66(0.60)	4.09(0.55)	3.65(0.54)	3.92(0.45)	<.001 ^{a***,b***}
SEE-EFE Later	3.80(0.51)	3.92(0.57)	3.94(0.44)	4.03(0.42)	.567
SEE-EFE Total All	3.71(0.57)	4.01(0.56)	3.80(0.51)	3.98(0.44)	<.005 ^{a*,d*}
SEE-EA First	3.88(0.54)	4.35(0.41)	3.85(0.47)	4.22(0.48)	<.001 ^{a***,d***} ,e**
SEE-EA Later	3.86(0.64)	4.18(0.57)	4.10(0.43)	4.35(0.42)	< 001 ^{d***}
SEE-EA Total All	3.87(0.58)	4.27(0.50)	3.96(0.46)	4.28(0.45)	<.001 <.001 ^{a***,b***,d***} ,e**
IRI First	3.45(0.40)	3.70(0.28)	3.50(0.30)	3.63(0.32)	<.001 ^{a***}
IRI Later	3.47(0.25)	3.44(0.33)	3.43(0.34)	3.67(0.27)	<.001 ^c
IRI Total All	3.46(0.34)	3.57(0.33)	3.47(0.32)	3.65(0.30)	<.001 ^{d***} ,e**

^a Psychology > Medicine, ^b Psychology > Nursing, ^c Psychology > Social Work, ^d Social Work > Medicine, ^e Social Work > Nursing. * = p < .05, ** = p < .01, *** = p < .001

Results for the later semesters

Means and standard deviations for the later semesters are also presented in Table 3. There was no significant between group effect for the SEE. As there could be differences on the subscales of the SEE these data were further analysed. There was a significant between group effect on the EA, F(3, 174) = 7.02, p < .001. Students in Social Work had significantly higher mean values than students in Medicine (p < .001). There were no significant differences between the programmes on the other subscales of the SEE. There was a significant difference between group effect on the IRI, F(3, 174) = 6.73, p < .001. Students in Social Work had significantly higher mean scores on the IRI than students in Nursing (p < .001).

.001) and Medicine (p < .005). Finally, students in Psychology had significantly higher mean

Differences between cohorts within each programme

score on the IRI than students in Social Work (p < .05).

Differences between students in different cohorts (first and later semesters) were calculated (see results in Table 3). We conducted 4 x 2 ANOVAs for each of the measures with group and cohorts as between group factors. All main effects for programme were replicated in this larger dataset (all F's > 6.02, p <.001). There were no main effects of cohort. However, there were three interaction effects. One was for SEE-EFE F (3, 364) = 3.12, p< .05, the second for SEE-EA F (3, 364) = 2.67, p < .05, and the third for IRI F (3, 364) = 4.39, p < .005. Post-hoc tests showed that the later semester Nursing students had higher scores than early semester students on the SEE-EFE (p<.01) and on the SEE-EA (p<.05). Social Work students in the later cohort had higher scores then the first cohort on the SEE-EPT (p<.05). For the IRI later semester Psychology students scored lower (p<.001) than early semester psychology students.

Discussion

The results of this study showed that students in the first semester of the Psychology programme reported both higher general empathic skills as well as higher ethnocultural empathic skills compared to students in the other programmes. Differences between the study programmes were less marked in the later semesters. Overall, results did not show that students in the later semester had higher empathic skills than students in the first semester. However, there were three interactions between cohort and study programme. Nursing students in the later cohort had higher mean values on subscales measuring "emphatic feeling and expression" and "empathic awareness". Finally, psychology students in the later semester unexpectedly had lower values on the measure of basic empathy (IRI) than students in the early cohort.

Demographical variables were correlated and in particular gender was correlated with the SEE ratings. As the gender differences could interact with our findings we re-analysed all significant differences in our paper using gender as a factor. This did not alter the findings as there were no interactions with gender in the ANOVAs. This could of course be due to the preponderance of female participants, but this is representative of the gender composition in the study programmes.

Several possible explanations of the findings could be considered. The first possibility concerns selection. Application requirements, grades needed for acceptance, gender differences, previous contact with persons from other cultures, and various other aspects could potentially explain at least part of the differences which we observed as already present in the first semester. Since the picture rapidly becomes very complex we decided to focus on differences between study programmes per se, and not all possible explanations why certain programmes are preferred over others by some students. The differences between first semester students in the various programmes were greater than for students in the later

semester of the various programmes. It is not likely that the education (for example training in empathic skills) would influence the ratings of empathic competence at such an early stage as the first semester.

The second explanation concerns culture. Expectations from the surrounding milieu and society concerning what skills are important for students to acquire could differ between study programmes. For example, students in Medicine and Nursing may have expectations to learn more about the biological aspects of human needs, whereas Psychology students and Social Work students may be less required to have this focus. However, this could even out in later semesters. In many health programmes the emphasis in the early semesters are on biology and anatomy, whereas clinical work and internship is much more a part of the later semesters. It is possible that this shift in focus may explain the relative lack of differences between the programmes in the later semesters. This may also explain why the post-hoc tests for interaction effects showed that students in Nursing and Social Work had significantly higher skills in some of the subscales in the later cohort. Another issue relates to values and the fact that empathy was self-reported. While empathy is often valued in many cultures, it is not necessarily the case that it is equally valued in different health professions. It could very well be that at least for some professions, such as physicians, practical and theoretical skills are equally if not even more highly valued than empathic skills.

Implications for practitioners and educators

Since ethnocultural diversity is becoming more prevalent in many health care settings, we believe that it is important to consider what implications Ethnocultural empathy may have for health care relations. Indeed, training students in health care education in Ethnocultural empathy is of great importance. When preparing for future clinical work, cultural aspects should be considered. While we do not know if a highly 'ethnoculturally empathic' clinician is doing a better job, it is at least plausible that a person with little or no empathy for persons from a different cultural background will have problems in patient consultations (Mercer & Reynolds, 2002).

Limitations

Before we reach our conclusions, some limitations of this study must be addressed. First, as students in different cohorts were compared we cannot conclude whether the empathic skills of the students have developed over time. We can only determine whether these skills are different between the cohorts. Obtained differences may depend on different backgrounds and expectations of the cohorts, and the year in which the students enrolled in their programmes. Furthermore, teachers and student counsellors may change in the programmes over the years, which may have an impact on the empathic skills of the different cohorts. Holm (2000) found that students may identify themselves with teachers who are perceived as highly empathic, and that this may increase the student's level of empathy. Research on empathy suggests that it is possible for people to learn how to improve their empathic skills (Batson et al., 1997; Decety & Lamm, 2006). However, we only included students at one university. It should be noted that the curricula of students in Psychology, Medicine and Nursing in Linköping are based on problem based learning which means that they are trained to work with different people in groups. It would be interesting to investigate if empathic skills would be different in

a more conventional study programme where the opportunities to collaborate with peer students and to reflect upon their own learning probably are more limited. Generalisations to study programmes in other universities should be performed with caution.

Finally, in the data collection, only self-report measures were used. Empathy and ethnocultural empathy are highly complex phenomena, and people may desire to present themselves as highly empathic. It would thus be of great interest to combine the research method in this study with interviews and observations in order to capture the phenomenon in full.

Future research

Future research could investigate the levels of ethnocultural empathy with a longitudinal design in order to explore how this skill develops over time during the course of studies. It could also potentially include interviews and structured observations as data collection methods, and include programmes at other universities and in other countries where the designs and curricula differ more so that conclusions may be generalised to a larger context.

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