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Kim P. Corfman and John G. Lynch, Jr., Editors

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# The Health Care Consumption Patterns of Asian Immigrants: Grounded Theory Implications for Consumer Acculturation Theory

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## ABSTRACT

Since cultural beliefs about the body, health, illness, and social norms do not suddenly disappear when immigrants arrive in a new country or culture, understanding such beliefs is important for anyone attempting to serve their health care needs. The authors of this paper use grounded theory to investigate the health care consumption patterns of recent Asian and Pacific Islander immigrants to the United States. Utilizing participant observation, focus groups, and interdisciplinary secondary data, the authors explore the sociocultural dimensions of health care consumption among such immigrants before and after migration to the United States. Unique consumption patterns are revealed which offer conceptual departures from traditional consumer acculturation theory and its notions of a linear progression towards Anglo-conformity. Recommendations are made for future research on consumer acculturation, health care consumption, ethnicity as a construct in consumer research, and methodological pluralism in cross-cultural consumer research.

## I. INTRODUCTION

In the decade between 1980 and 1990, the Asian and Pacific Islander population in the United States experienced a dramatic increase of 107.8%, compared to a total U.S. population increase of only 9.8% (*U.S. Department of Commerce, 1983, 1992*). In spite of this dramatic increase, virtually no scholarly research in marketing or consumer behavior has been conducted on understanding or targeting this important consumer group. This neglect is further accentuated when one considers the burgeoning percentage of immigrants who comprise an increasing proportion of the ethnic groups in this population. For instance, it includes, but is not limited to ethnic groups such as the Chinese, Filipino, Japanese, Asian Indian, Korean, Vietnamese, etc. (*U.S. Department of Commerce, 1992*).

Although this rich cultural and ethnic diversity presents challenges to any group who is attempting to introduce new ideas, products, or practices to these emerging consumers, some groups encounter extraordinary challenges. In particular, the multitude of marketers who deliver health care services to such consumers are among those who face these challenges on a daily basis. In order to design and implement culturally-appropriate health care services, these change agents are charged with the often overwhelming agenda of understanding such emerging consumers when information about their health care consumption patterns is either sparse, superficial, or fragmented. For instance, existing health-related statistics on Asians and Pacific Islanders in the United States disclose significant problems in a number of health-related areas. Lack of awareness in these communities is one of the causes for such reported problems as higher cervical cancer rates, higher hepatitis B rates, and dramatic increases in reported AIDS/HIV cases (*Lin-Fu, 1988; Mo, 1992; Easterlin, 1988*). However, cultural barriers have been shown to contribute much more significantly to the ineffective diffusion of health promotion and health care delivery programs (*Lin-Fu, 1988; Mo, 1992; Easterlin, 1988*).

The specific objective of this study is to explore the sociocultural dimensions of health care consumption among recent Asian and Pacific Islander immigrants in the United States. These sociocultural dimensions are investigated within the context of the consumer acculturation process. Accordingly, this study explores

the consumption patterns of such immigrants as they adapt to the cultural framework of the U.S. health care delivery system. The basic research questions that will be investigated are as follows:

- 1) What cultural influences exist in the health care consumption patterns of Asian immigrant consumers?
- 2) What indigenous health beliefs are still practiced by Asian immigrants after migration to the U.S.? When and why are they practiced?
- 3) How do Asian immigrant consumers integrate indigenous health beliefs and practices with mainstream health practices and services?
- 4) What lessons can consumer researchers learn from the study of marginal populations such as recent Asian immigrants?

## II. RESEARCH METHODOLOGY

This study utilizes a grounded theory approach of investigation. This type of approach involves a systematic set of procedures to develop an inductively-derived grounded theory about a phenomenon. The research findings constitute a theoretical formulation of the reality under investigation, rather than consisting of a set of numbers or a group of loosely related themes. The purpose of the grounded theory method is to build theory that is faithful to and illuminates the area under study. As a result, the researcher does not begin with a theory, then proceed to prove it. Instead, the researcher begins with an area of study. In grounded theory, the intent is to explain phenomena in light of the theoretical framework that evolves during the research itself, not to be constrained by theory that has already been developed (*Strauss and Corbin, 1990*).

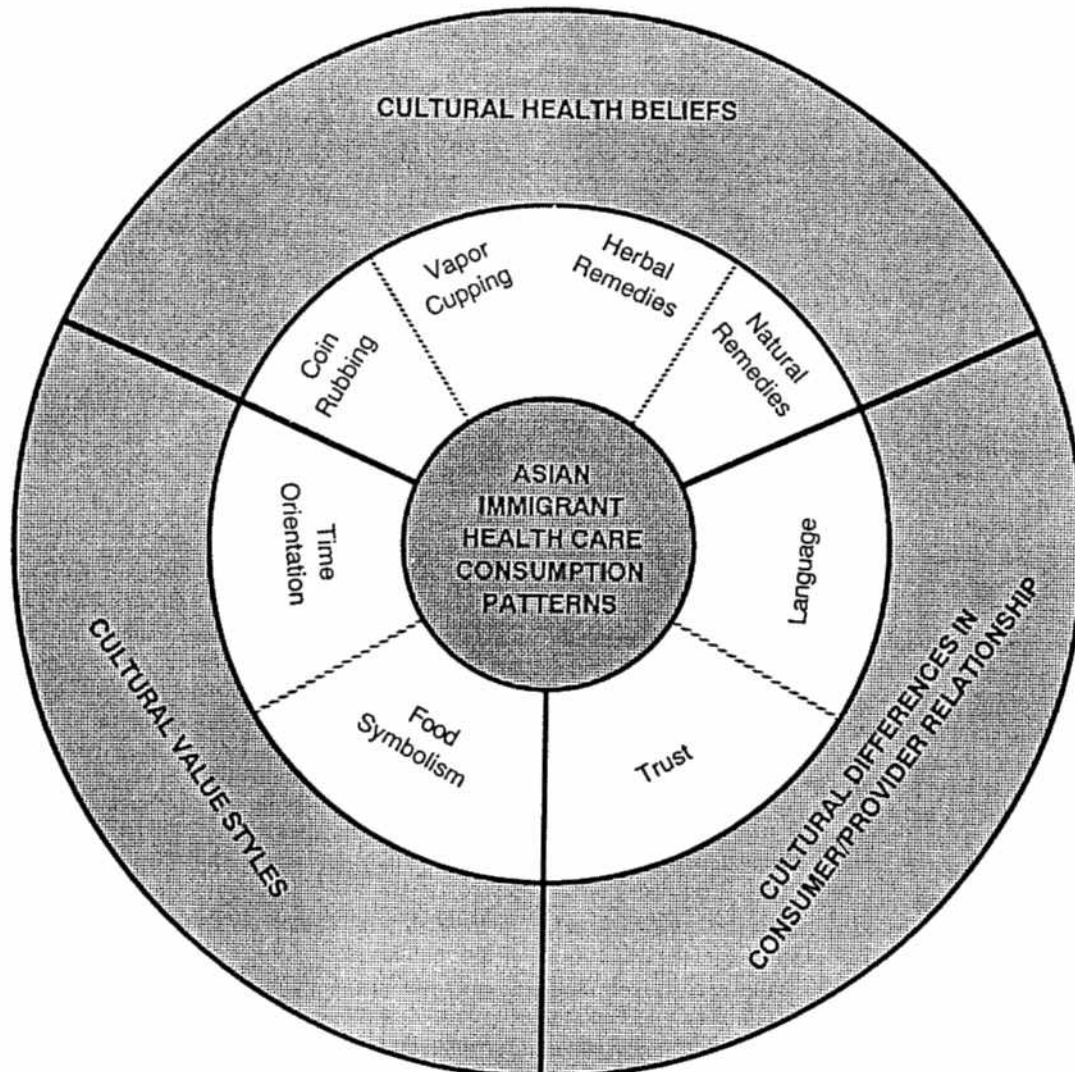
During the months of July 1993 through February 1994, extensive field work was conducted in cooperation with two leading community-based organizations in southern California. The first organization is a leader in providing culturally and linguistically appropriate primary health care services and health prevention programs to immigrants in the Cambodian, Chinese, Filipino, Japanese, Korean, Laotian, Samoan, Tongan, Thai, and Vietnamese communities. The second organization is a leader in serving the needs of the Southeast Asian immigrant and refugee community in southern California.

The source documents for this study consisted of field notes gathered during the eight months of participant observation conducted from July 1993 through February 1994, interview transcripts from in-depth interviews conducted in the field when possible, translated interview transcripts from a focus group of Vietnamese refugees/immigrants, and relevant interdisciplinary data gathered during the course of the field work and during concurrent secondary research efforts. In order to maintain confidentiality, the real names of informants and participants have not been used.

## III. RESEARCH FINDINGS

Informants and participants revealed three major categories of culturally-based or culturally-different health care consumption patterns during the course of the field work. Cultural health beliefs,

**FIGURE 1**  
The Health Care Consumption Patterns of Asian Immigrants



cultural value systems, and cultural differences in the consumer/provider relationship were all revealed as critical factors in their consumption experiences (see Figure 1).

### 1. Cultural Health Beliefs

Indigenous or native health beliefs, since they are often significant in the health care consumption experiences of many Asian immigrants, can provide tremendous insights into understanding why and how alternative approaches are still practiced after migration to a new country of residence. Informants and participants in the Vietnamese refugee community discussed the use of indigenous health beliefs for various illnesses and ailments, as well as for the ongoing maintenance of good health.

The cultural health beliefs of vapor cupping (*giac hoi*) and coin rubbing (*cao gio*) arose numerous times during a focus group discussion of cultural health beliefs in the Vietnamese refugee community. Thi Cuc, A Vietnamese refugee participant in her late 40s, discussed the use of vapor cupping to "suck out the poisonous air." As a health practice, vapor cupping was deemed more effective than prescription medicine for ailments such as headaches.

...you take a glass tube, put a burning piece of paper in it, and put the cup on the skin. When the skin swells up, it sucks out the poisonous air. In Vietnam, it is called vapor cupping...when we have a headache, we drink medicine but it has no effect. Cupping will help...it is very good. *Vietnamese Immigrant Community, Focus Group Interview, February 1994.*

Participants also discussed the use of coin rubbing (*cao gio*) as a cultural health belief still in practice. This indigenous health practice involves rubbing the skin with a coin to alleviate common symptoms of illness. The back, neck, head, shoulders, and chest are common sites of application (Yeatman and Dang, 1980). Nguyen, a Vietnamese informant in his late 40s, agreed that the use of coin rubbing was still prevalent among Vietnamese in the United States.

Headaches need coin rubbing. If we are sick, we drink medicine and we don't get over the sickness. Without coin rubbing, we have the feeling that we are still sick. Even drinking Tylenol again and again the sickness isn't gone. The next day, I had to use coin rubbing then it was gone. *Vietnamese Immigrant Community, Focus Group Interview, February 1994.*

In addition to alternative health practices such as vapor cupping and coin rubbing, participants also discussed the use of alternative health remedies, both of an herbal and non-herbal origin. Tu, a Vietnamese woman in her early 40s, discussed the use of certain herbs to steam out poisonous sweat from a person's body. Several participants described the consumption of urine to maintain or regain strength, especially after childbirth.

In Vietnam, there are all sorts of herbs...mint leaves, lemon grass, lemon tree leaves. We boil a pot of water then put in some salt. We boil the water very carefully, let all of the steam out, and wipe up the poisonous sweat. *Vietnamese Immigrant Community, Focus Group Interview, February 1994.*

(After childbirth) the mother-in-law went and asked for urine from small children...small boys. They put hot pepper in the urine and made their daughter-in-law drink it. It is really good. Urine with saffron in it. Three months later, the daughter was really in good health. *Vietnamese Immigrant Community, Focus Group Interview, February 1994.*

While the consumption of urine, regardless of what spices are used to disguise its apparently bitter taste, may not seem appealing or acceptable to the average American health care provider or consumer who does not practice traditional Vietnamese health beliefs, these comments reveal an obvious trust in the reliability and value of doing so for the purposes of gaining or maintaining a healthy physical condition. From the Vietnamese immigrant or refugee perspective, therefore, this alternative belief system is viewed as being more valid or at least as valid as opposing medical remedies which may be offered by the U.S. biomedical health care system.

## 2. Cultural Value Systems

Cultural values can be viewed as emotionally-charged priorities which direct the people of any certain culture to selectively attend to some goals while subordinating other ones (Terpstra and David, 1991). Such value systems can consist of such concepts as optimism, frugality, and attitudes toward time, change, work, wealth, and achievement (Terpstra and David, 1991). They are often rooted in underlying assumptions about power, rank, and often religion (Terpstra and David, 1991). During the course of this study, two primary cultural values were revealed by participants. In particular, participants displayed differences in time orientation and food symbolism which could present challenges to the traditional health care delivery system in the United States.

**Time Orientation.** On a variety of occasions during the course of field work, informants expressed their frustrations in coping with inflexible scheduling within the U.S. health care delivery system. One informant, a Tongan health care professional in her late 20s, expressed great frustration when she attempted to schedule a mobile health outstation on adolescent pregnancy prevention in her community. While such health education programs are implemented routinely with few complications in the mainstream community, trying to schedule them in the Tongan community involves a thorough understanding of the Tongan concept of time.

In the next week or so, she anticipated conducting an outstation in the Tongan community. She did not, however, have a date, place, or time. She was unnecessarily apologetic about this lack of details and expressed her frustration on my behalf that "this is how Tongans live...we don't plan ahead." *Tongan Immigrant Community, Field Notes, August 1993.*

Existing literature strongly supports the existence of this cultural difference in time orientation (Hall, 1959, 1966, 1976, 1983; Chung, 1992). People from low context cultures, such as those in the dominant culture of the United States, tend to have a monochronic time orientation (Hall, 1959). This orientation towards time includes a preference for controlling time through schedules, evaluating outcomes according to efficiency of time, and attaching a sense of urgency to whatever singular task one is doing at the time (Hall, 1959, 1966, 1976, 1983; Chung, 1992).

In direct contrast, as the results of this exploratory study confirm, people from high context cultures such as the majority of Asian and Pacific Islander cultures, tend to have a polychronic orientation towards time. This orientation towards time includes believing that time is a natural cycle that cannot be controlled, evaluating outcomes according to their ability to respect the interpersonal relationships involved, and attaching importance to the long-term process rather than immediate results (Hall, 1959, 1966, 1976, 1983; Chung, 1992). With such a sharp contrast in the monochronic time orientation of health care providers and the polychronic time orientation of Asian immigrant health care consumers, it is no wonder that frustration, miscommunication, and low utilization of services often results.

**Food Symbolism.** During the course of field work, food as an aspect of culture was observed and discussed as an important variable in the health care consumption experience of informants and participants. Community health outstations, regardless of their health care focus, utilized food as a subtle attraction factor and sometimes blatant promotional incentive. Maria, a Filipino informant in her mid 20s, discussed how food symbolized love in the Filipino community. Filipino senior citizens, she conveyed, are somewhat obsessed with the idea of feeding everyone else. Food is a constant part of daily life and it symbolizes love. Therefore, the rejection of it is considered as a personal insult.

We discuss the events of the day and laugh about being "forced" by the seniors. Food, she comments, is love in Asian cultures...they all want you to weigh 200 pounds. If you don't you are always too skinny. *Filipino Immigrant Community, Field Notes, August 1993.*

At one mobile health outstation for hypertension screening, food as was used as an incentive to attract target consumers to the private home where the outstation was conducted.

The food is set up on the table...a rich assortment of pork, beef, noodles, salads, and rice provide vivid pictures of dietary concerns...a strange dichotomy to observe the hypertension screening equipment on one table and a roasted pig (a native delicacy) on the next table. *Filipino Immigrant Community, Field Notes, August 1993.*

According to Hartog and Hartog (1983), food has great symbolic importance. While the symbolic nature of food exists in all cultures to some extent, however, the specific symbolism in each culture or ethnic group within can vary substantially. As these data suggest, health care providers should pay considerable attention to the specific nature of the role food symbolism plays in the both the direct delivery of health care services, as well as the indirect aspects of health care delivery such as the effectiveness of promotion and outreach. Furthermore, food symbolism may have considerable impact on important issues such as compliance with recommended medical treatment and even confidence in the competence of health care providers (Hartog and Hartog, 1983).

### 3. Cultural Differences in the Consumer/Provider Relationship

Cultural differences in the consumer/provider relationship encompass all the culturally-based nuances in the relationship between a health care consumer and a health care provider. In addition to the critical issue of rapport or trust this key relationship may require, cultural differences also address the complexities of the communication process that takes place between a health care consumer and provider.

*Trust.* During the participant observation phase of this study, informants and participants repeatedly emphasized the need to establish a high level of trust with potential consumers before an effective consumer/provider relationship could be established. Gabriella, a Filipino informant in her late 30s, discussed the difficulty that mainstream health care providers encountered when attempting outreach to ethnic consumers, especially Asian immigrant ones. She said such health care providers were strangers to the community and they were not trusted.

Sala, a Tongan informant and health care provider in her early 30s, described the ease at which she could access consumers in the Tongan community. Everyone already knew her through long-term relationships she had established with members of her church. These church-based relationships were particularly important because the church was and is the center of almost all social activities in the Tongan immigrant community.

The evidence in this study supports this cultural difference in commitment or trust. Informants confirmed that health care providers could not make any progress toward attracting or gaining access to the targeted immigrant communities until they had invested a considerable amount of time and effort in establishing relationships and developing trust.

*Language.* During the course of the field work, informants and participants frequently expressed concerns for the language barriers they encountered as immigrant consumers in the U.S. health care delivery system. They often viewed the communication process as problematic and as a strong hindrance towards establishing the high level of trust required in the health care consumer/provider relationship. Although interpreters were often utilized to assist with this process, their involvement rarely resolved the communication difficulties.

While aspects of verbal communication and translation alone are overwhelming, few things can test the boundaries of the health care consumer/provider relationship more than the non-verbal communication process. At a permanent clinic site, a nurse was observed in an interaction with a patient. The nurse assumed that the consumer simply did not understand the verbal instructions, when in fact, the nurse was misreading the non-verbal message from the patient.

She (*the Tongan immigrant consumer*) seemed to be attempting to explain that something was wrong. The (*Anglo American*) nurse shook her head and insisted that she had offered the correct course of action. The woman (*consumer*) did not respond. She only looked down at the ground and became silent. Her cues of silence were being misunderstood and ignored by the nurse. Finally, in frustration, the nurse went to find the Tongan (*bilingual, bicultural*) staff person...*Tongan Immigrant Community, Field Notes, July 1993.*

The role of non-verbal communication in high context cultures is an important one. Hall (1959) provides excellent, in-depth insights into the nature of "the silent language" of non-verbal communication. In the communication process, significant meaning is attached through non-verbal elements such as phrasing, tone

of voice, gestures, posture, social status, history, and social setting (Hall, 1959; Chung, 1992). During the course of the field work, informants and participants strongly emphasized the communication process between the health care consumer and the health care provider. It required an understanding of non-verbal communication cues and underlying, alternative cultural values which far exceeded the boundaries of mere bilingual interpretation.

## IV. DISCUSSION AND IMPLICATIONS

While prevailing stereotypes may suggest otherwise, the extreme diversity of the Asian and Pacific Islander immigrant population in the United States cannot be overemphasized. These emerging immigrants come from many different countries and each country has its own language(s), culture(s), and experiences. They differ in terms of the historical background in their native countries and in the United States, the number of years of residence in the United States, English language skills, level of urban experience, socioeconomic status, educational achievement, and religious affiliation (Ross-Sheriff, 1992; Nah, 1993). In addition, the speed and ease at which they adapt to their new home in the United States varies according to their place of origin, pre-migration occupation and education, traditional values, and socialization experience (Kessler-Harris and Yans-McLaughlin, 1978). Without a doubt this complex picture of migration and adaptation creates an emerging population of dynamic, unpredictable American consumers that are hard to understand and even harder to target.

On the topic of health care consumption alone, the challenges seem endless and overwhelming. Recent research on the health status and challenges of Asian and Pacific Islander ethnic groups in the United States, while scarce and inadequate, has established such significant factors as low utilization of health care services, high rates of emergency room usage, lack of prenatal care, and a disproportionately high incidence of disease and socially-deviant conditions (Zane, et al., 1994; U.S. Commission on Civil Rights, February 1992). As stated earlier, lack of awareness among Asian and Pacific Islander immigrant consumers of health care services is only one of the causes for such pervasive and continuing problems. In actuality, cultural barriers have been shown to contribute more significantly to the ineffective diffusion of health promotion and health care delivery programs which can help to alleviate or eliminate this disproportionate share of health challenges (Lin-Fu, 1988; Mo, 1992; Easterlin, 1988).

Since cultural beliefs about the body, health, illness, and social norms do not suddenly disappear when immigrants arrive in the United States; they can and do create problems in communication, rapport, behavior, and compliance (Hartog and Hartog, 1983). Indeed, cultural factors have been shown to influence the way individuals define and evaluate their health problems, seek help for their problems, present their problems to the physician, and respond to treatment (Zane, et al., 1994). It is only through a greatly increased awareness and understanding of these cultural beliefs and differences that health care service providers, as marketers and change agents, can begin the daunting task of affecting these emerging populations in a constructive and effective manner.

The findings of this exploratory investigation have provided important insights into the existence and nature of the role of culture in the health care consumption patterns of recent Asian immigrant consumers. Viewed within the critical context of the consumer acculturation process, these findings point to timely issues regarding the study of consumer subcultures and the consumer acculturation theory which encompasses it. Traditionally, consumer acculturation theory has embraced a linear progression of assimilation by which immigrants change their behavior from that of their culture

of origin to that of their culture of residence (Gordon, 1964; Wallendorf and Reilly, 1983). Based on research about Europeans who migrated more or less voluntarily to the United States, one of its underlying assumptions is the persistent, overwhelming desire of immigrants to fully assimilate with the dominant, Anglo American culture, especially when such immigrants are members of racially or ethnically subordinate groups (Gordon, 1964; Feagin and Feagin, 1993). This assumption is manifested in the popular notion of the American "melting pot" which fosters the idealistic image of diverse racial and ethnic groups blending into a new "American blend" through a mutual adaptation process (Penaloza, 1994; Venkatesh, 1995). In reality, however, this notion is more accurately represented by a socialization process of progressive Anglo-conformity by immigrants rather than mutual adaptation among all groups (Feagin and Feagin, 1993). Within this challenging context, the idealistic image of the American "melting pot" instead becomes the more realistic one of the American "tossed salad" or "boiling cauldron" (Venkatesh, 1995).

The findings of this study confirm the previous conclusions of Wallendorf and Reilly (1983), Penaloza (1994), and Venkatesh (1995). In particular, they draw special attention to the need to expand traditional consumer acculturation theory to reflect unique patterns of consumption that challenge traditional notions of Anglo-conformity. The Asian and Pacific Islander immigrant consumers observed and interviewed in this particular study demonstrated hybrid patterns of health care consumption. These immigrant consumers adapted certain aspects of the mainstream health care system such as the use of over-the-counter medication. However, these same consumers simultaneously maintained many of the cultural health beliefs of their cultures of origin such as coin rubbing, vapor cupping, and herbal remedies for ailments. In spite of the pervasive yet seemingly transparent demands of the monocultural, mainstream health care delivery system, many of the informants and participants displayed ongoing resistance to mainstream health care system requirements such as appointment scheduling, English-language competence, and conformance to the biomedical model of health care itself. Instead, they chose to maintain traditional cultural values concerning time orientation, language, and health practices.

These findings are important ones which present important implications for consumer acculturation theory. The traditional view of acculturation forces immigrant consumption patterns into a process of linear conformity whereby the adoption of consumption patterns belonging to the culture of residence require the gradual surrender of those belonging to the culture of origin. These unique, hybrid patterns of consumption propose a conceptual departure from this process. As revealed by the findings of this study, a linear progression clearly does not take place. In many instances, these immigrant consumers intentionally retain the cultural health beliefs, practices, and expectations of their cultures of origin. In other instances, they adopt new ones learned in their cultures of residence. In a unique way, however, these immigrant consumers often devise hybrid patterns of consumption which are creative reactions to the cultural and social pressures generated by life in a new country. Within this complex social reality, therefore, they hold fast to cultural health beliefs and practices from their original countries, while integrating only those new practices which offer convenience or comfort without threatening the integrity of their cultural traditions.

## V. FUTURE RESEARCH

The findings of this study suggest several avenues for future research. Specifically, they suggest the need for future research

which expands consumer acculturation theory, investigates new patterns of consumption in a health care context, further develops ethnicity as a construct in consumer research, and approaches consumer research in a more methodologically pluralistic manner.

*Consumer Acculturation Theory.* As already mentioned above, the findings of this study suggest the need to expand consumer acculturation theory to appropriately reflect and understand new patterns of consumption among recent immigrants. Future research should further explore the complex, hybrid process of acculturation observed in this study and challenge traditional notions of Anglo-conformity. It should also investigate how and why the acculturation process differs for different groups of immigrant consumers. Finally, it should begin the difficult, but intriguing process of understanding the impact such notions have for marketers who pursue consumers in the ever-changing cultural landscape of the American market place.

*Health Care Consumption.* In the area of health care consumer research, the results of this study expand existing health care consumption theory to demonstrate how culture influences the health care consumption experiences of immigrant consumers and other marginal populations. Previous theories on health care consumption confirm the role of modifying factors such as age, race, ethnicity, social class, and reference groups in the health care consumption patterns of consumers (Dawson, 1989; Burns, 1992; Neergaard, 1994). However, they do not directly or specifically address the influence of culture. They also fail to address the health care consumption patterns of immigrant consumers.

The results of this study also disclose the existence of pluralistic patterns of health care consumption which integrate the traditional, indigenous health beliefs of immigrant consumers with those of the mainstream health care system. Asian immigrant consumers observed and interviewed often practiced traditional healing methods such as coin rubbing and herbal remedies in conjunction with "Western" healing methods prescribed by an American doctor. For instance, some participants discussed the use of coin rubbing for headaches while concurrently using "Western" over-the-counter medication such as Tylenol for the same ailment.

*Ethnicity as a Construct in Consumer Research.* The findings of this study provide evidence of the important role of culture in general, and ethnicity in particular, in consumption. Future research should continue efforts such as these to increase empirical and conceptual knowledge of these phenomena among Asian immigrant consumers, as well as other emerging and/or marginal consumer populations. When such research focuses on Asian immigrant consumers, it should be expanded to understand the many differences among and between ethnic subgroups, as well as regional differences with respect to the country of origin. Ethnicity, in this sense, should not be viewed simply as a monolithic construct or independent variable (Venkatesh, 1995). It should instead be viewed as a complex, cultural condition with profound consequences upon the consumption experiences of immigrants, as well as the members of other subcultural and marginal groups (Venkatesh, 1995).

*Methodological Pluralism in a Cross-Cultural Consumer Research.* The findings of this study demonstrate the benefits of subjective, interpretive approaches to knowledge production, especially when the researcher is investigating emerging consumer populations such as Asian and Pacific Islander immigrants (Bellenger, et. al., 1976; Jorgensen, 1989; Mo, 1992; Strauss and Corbin, 1990). Methodologies such as participant observation, for example, are extremely appropriate for the study of certain kinds of human behavior, especially when the social phenomenon in question suggests important differences between the views of outsiders



compared to those of insiders (Jorgensen, 1989). It can be strongly argued that research methodologies such as these are more appropriate in certain circumstances than more traditional, quantitative ones. One such circumstance occurs when the social phenomenon in question is an emerging one and therefore little or no theory exists as a starting point to suggest either confirmation or departure. A second circumstance occurs when the objective of a study is to gain a deeper understanding of the social phenomenon within the cultural context of the consumer. For instance, Penalosa (1994) presents an exemplary ethnographic account of the consumption experiences of Mexican immigrants in the United States. Finally, a third circumstance occurs when the consumer's perspective is important, but quantitative methodologies such as survey research or experimental research are an operational impossibility. Future research should address these important methodological concerns and seek to approach cross-cultural consumer research in a more methodologically pluralistic manner.

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