

6-2014

Guidelines for Culturally Based Interventions with Healthcare Professionals

Ifeanyi Anthony Onyemenem

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LOMA LINDA UNIVERSITY
School of Behavioral Health
in conjunction with
The Department of Psychology

Guidelines for Culturally Based Interventions
with Healthcare Professionals

by

Ifeanyi Anthony Onyemenem

Project submitted in partial satisfaction of
the requirements for the degree of
Doctor of Psychology

June 2014

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Each person whose signature appears below certifies that this doctoral project in his/her opinion is adequate, in scope and quality, as a doctoral project for the degree Doctor of Psychology.

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ACKNOWLEDGMENTS

I would like to express my heartfelt appreciation to Drs. Betancourt and Flynn for their guidance and mentorship. I would also like to thank my lab partners and friends for helping me get through those late nights and my in-laws for opening their hearts and homes to us.

I am grateful to my parents Dr. and Mrs. Onyemenem and to my siblings Ngozi, Nkechi and Emeka for their prayers and for cheering me on when I needed it the most. Finally I would like to thank my wonderful wife Onyinye for her unconditional love and my baby girl Sonma whose smile makes this all worth it.

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ABSTRACT

Guidelines for Culturally Based Interventions with Healthcare Professionals:
The Case of Perceived Mistreatment and Continuity of Cancer Screening Care.

by

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Loma Linda University, June 2014
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Early detection is critical to surviving breast and cervical cancer. Unfortunately, Latin American (Latino) women in the United States are more likely to be diagnosed at later stages of cancer and have poorer rates of repeat screenings when compared to non-Latino White (Anglo) women. One factor identified through research that negatively affect continuity of cancer screening is perceived mistreatment. Guided by Betancourt's integrative model of culture, psychology and behavior, the current project proposes guidelines for developing culturally informed interventions with healthcare professionals that take into account the socially shared values, beliefs and norms that negatively impact breast and cervical cancer screening. These guidelines and proposed interventions utilize a bottom up approach and are based on recent research dealing with cultural factors found to influence cancer screening among Anglo and Latino women in Southern California (Betancourt, Flynn, Riggs & Garberoglio, 2010; Betancourt, Flynn, & Ormseth, 2011). It is expected that the development and implementation of such interventions with health care professionals would increase rates of cancer screening continuity of care among culturally diverse patients.

CHAPTER 1

INTRODUCTION

Breast cancer is the leading cause of cancer death among Latin American (Latino) women in the U.S despite data indicating that they have lower incidence rates compared to non-Latino White (Anglo) women (Clegg, Li, Hankey, Chu, & Edwards, 2002; Sheppard, Figueiredo, et al., 2008). Latino women also suffer from a higher incidence of cervical cancer compared to Anglo women and non Latino Black populations (Carozza & Howe, 2006). According to The United States Institute of Medicine report 'Unequal Treatment' some of the reasons for the observed disparities in health behaviors and outcomes amongst racial, ethnic and socioeconomic groups are related to continuity of care and the patient's perceptions of discrimination or mistreatment (Smedley, Stith, & Nelson, 2003)

Positive quality of interaction between a patient and their healthcare professional (HCP) is vital. It is related to better Continuity of Care, improvements in health outcomes, cancer screening, and early cancer detection (Doescher, Saver, Franks, & Fiscella, 2000a; Hall, Horgan, Stein, & Roter, 2002; Mainou et al., 2004; Saultz & Albedaiwi, 2004; Saultz & Lochner, 2005; Sheppard, Wang, Yi, Harrison, Feng, Huerta, Mandelblatt, et al., 2008) In fact, visit satisfaction has been found to be associated with the intention to keep follow up healthcare appointment (Freed, Ellen, Irwin, & Millstein, 1998).

The discovery that continuity of care is associated with improved cancer screening rates (Menec, Sirski, & Attawar, 2005) is important because minorities in the United States are less likely to have a usual source of health care (Zuvekas & Taliaferro,

2003). In the U.S, the cultural orientation of the medical care system is less congruent with the cultural perspectives of some patient groups than others (Taylor, 2003).

Consequently, patient treatment is typically approached from the perspective of the dominant culture and based on Anglo American cultural assumptions (Roosa, Dumka, Gonzales, & Knight, 2002

Perceptions of disrespect are therefore likely to influence health care utilization and thereby contributing to existing health disparities (Lillie-Blanton, Maddox, Rushing, & Mensah, 2004). For example 15% of Latinos report that their health professionals treated them with disrespect (KFF, 1999). With regards to breast and cervical cancer screening, Latino women have reported discourteous behavior on the part of health professionals as a barrier to repeat mammography screening (Moy, Park, Feibelmann, Chiang, & Weissman, 2006).

Healthcare mistreatment is especially detrimental in cancer screening because of the stakes involved. A negative experience between a Latino woman and her HCP during breast or cervical cancer screening could result in a refusal to seek follow up care or return for further screening (Marshall, 1994). This is vital because detection at the precancerous stage and early treatment are necessary for improved survival (Ell et al., 2002). The goal of the HCP must therefore include the ability to provide an effective interpersonal and working relationship that recognizes the effects of various aspects of culture such as the cultural beliefs of the patient about the healthcare professional, the healthcare professional's (HCPs) beliefs about the patient, as well as about the healthcare system.

Consistent with this view the first purpose of this project is to provide a set of evidence-based guidelines for developing culturally informed interventions with healthcare professionals who serve culturally diverse patients. These interventions are designed to educate the HCP and enhance their awareness about their patients culturally shared beliefs. To this end, an illustration of these guidelines is provided along with the key aspects of the research methodology and theoretical model based on which the guidelines were developed. The second purpose of this project is to discuss how similar methodologies can be used to identify the HCPs cultural beliefs about their patients and the healthcare delivery system that impact the care that they provide. It is expected that the development and implementation of such interventions with health care professionals would increase rates of cancer screening continuity of care among culturally diverse patients.

Disparities in Breast Cancer Screening

Based on data from 2005, Latino women were less likely to report mammography screening as compared to Anglo women (Sabatino et al., 2008). Foreign born Latino women also appear to fare worse as they have been shown to have the highest rate of never receiving mammograms, clinical breast exams and pap smears when compared to U.S born Latino women and Anglos (Goel et al., 2003; Rodriguez, Ward, & Perez-Stable, 2005). Latino women are also more likely to be diagnosed at later stages of breast cancer and have lower survival rates than their Anglo counterparts (Aparicio-Ting & Ramirez, 2003; Baquet & Commiskey, 2000; Smigal et al., 2006).

The incidence and mortality rates for cervical cancer are equally troubling. Latino women report higher rates of invasive cervical cancer at diagnosis as compared to Anglo women (Carozza & Howe, 2006; Jemal et al., 2009) (Howe, Delfino, Taylor, & Anton-Culver, 1998) and are less likely to screen for cervical cancer (Hewitt, Devesa, & Breen, 2004) or obtain repeat pap smear (Fernandez-Esquer, Espinoza, Ramirez, & McAlister, 2003). These studies highlight the concern that high incidence, late diagnosis and poor adherence to screening are primary factors in breast and cervical cancer mortality among Latino women.

Continuity of Care and the Patient-Professional Relationship

Continuity of care generally refers to an established relationship between a patient and a HCP. It is understood to be care over time by a single individual or team of HCPs (Cabana & Jee, 2004) and implies a sense of affiliation between a patient and a HCP often expressed in terms of an implicit contract (Haggerty et al., 2003).

Continuity of care has been shown to lead to improved compliance, reduced use of resources in primary care, increased patient and healthcare provider satisfaction (O'Connor et al., 1998) and trust (Doescher, Saver, Franks, & Fiscella, 2000b). Emphasis in continued care also translates into better preventive care access including breast and cervical cancer screening (Ettner, 1996; Mandelblatt et al., 1999; O'Malley, Forrest, & Mandelblatt, 2002). The relationship between the patient and the HCP is implicitly sacred and partly based on trust. Trust in the HCP fosters the increase in continuity of care, which improves the possibility of early detection of breast cancer (Mainous et al., 2004).

When a patient feels mistreated or treated poorly, the trusting relationship between that patient and the HCP is adversely affected. Lack of culturally sensitive care creates obstacles to effective communication between patients and physicians; which can in turn jeopardize patient outcomes (Siminoff, Graham, & Gordon, 2006). Studies indicate that Latinos may experience more instances of perceived mistreatment when they interact with the healthcare system. For example, physicians tend to engage in more relationship building with White than non-White patients (Siminoff et al., 2006). Latino's are also more likely than Anglos to report being looked down upon or treated with disrespect by their health professional (Blanchard & Lurie, 2004). Moreover, Latino women report being treated in a harsh and/or cold manner as a barrier to repeat mammography (Moy et al., 2006). Recent research with Latino women indicates that those with negative cultural beliefs about their HCPs are more likely to perceive healthcare mistreatment (Betancourt, Flynn, & Ormseth, 2011)

Perceptions of mistreatment are detrimental to the patient-professional relationship because they impede continuity of care. The implications are especially severe for Latino women because medical discrimination has been linked to lower breast cancer screening rates among this population (Crawley, Ahn, & Winkleby, 2008). More importantly Latino women who reported less healthcare discrimination and higher trust in their professional, were more satisfied with their healthcare relationships; this in turn translated to higher rates of mammography adherence (Sheppard, Wang, Yi, Harrison, Feng, Huerta, & Mandelblatt, 2008).

The Cultural Divide

One explanation for the difference in how patients and providers perceive each other is the *out-group Homogeneity bias*. According to this premise, people view members of the out-group as more homogenous than members of their in-group (Linville, Fischer, & Yoon, 1996). This inevitably leads to premature assumptions about the patient. In cases where the available information is minimal, health professionals often rely on heuristics or shortcuts that lead to biased assumptions (van Ryn & Burke, 2000). For example, mental health professionals that have a superficial knowledge of the patient's background tend to come up with more stereotypical based diagnoses (Abreu, 1999). This means that clinicians are actively encoding, interpreting, making causal attributions, using their memory, generating hypotheses, etc, and each of these processes can be influenced by patient variables such as ethnicity (Lopez, Grover, Holland, Johnson, Kain et al., 1989).

Furthermore, the U.S medical system is largely based on Anglo American cultural assumptions (Roosa et al., 2002). As a result, its cultural orientation may be less congruent with the cultural perspective of some patient groups compared to others (Taylor, 2003). This disconnect ultimately creates an environment where HCPs may not be culturally adept at interacting with their patients. This may lead to a breakdown in communication and negative interaction. When working with culturally diverse populations, it is necessary that the HCP recognize the role of culture. Professionals that lack cultural awareness regarding their diverse ethnic and socio-economic patients may subsequently provide sub-optimal care (Betancourt & Flynn, 2009).

It is also important to note that a power differential exists between the HCP and the patient, and emphasizes the need for HCPs to recognize their own cultural values, beliefs, expectations and stereotypes and how it affects the healthcare they provide. This makes it imperative that HCPs be educated about the cultural values, beliefs, expectations, and norms of their culturally diverse patients so they are better prepared to deliver effective and appropriate healthcare services.

Current Studies and Interventions

Most of the interventions currently available primarily focus on increasing the cultural competency of the HCP. Cultural competency is broadly defined as congruent behaviors, knowledge, attitudes and policies that enable the professional to work effectively in cross cultural situations (Ladson, Lin, Flores, & Magrane, 2006; Melamed, Wyatt, Padilla, & Ferry, 2008). The primary mode of training HCPs in cultural competency is in a classroom or seminar setting. Studies indicate that the increase in cultural competency training can be attributed to the need for institutions to achieve accreditation (Ferguson, Keller, Haley, & Quirk, 2003; Melamed et al., 2008). These programs are offered as required sections in university curricula for healthcare providers. There is also an increased use of questionnaires and tools that assess the HCPs level of cultural competency. The problem with this approach is that it adopts a mechanized approach for dealing with minority populations based on stereotypical views. A majority of the training encourages the HCPs to make broad stroke conclusions about a particular patient based on their race and/or language spoken. It ignores the subtle differences that exist within each group.

For example current methods assume that a U.S born Latino woman (whose parents are from Mexico), and a Latino woman who recently emigrated from Mexico will respond similarly to their HCP because they both speak Spanish. A common approach is to use a staff member as a translator. This erroneous assumption equates linguistic competency with cultural competency. In other words if the HCP can speak the language then they can understand the patients beliefs, values, norms and expectations. Language proficiency by itself is an insufficient tool for understanding the values, beliefs, norms and expectations of any group. Furthermore, a majority of institutions design and implement programs that encourage language competency without proper methodology and lacking a theoretical basis. The entire focus is on teaching the HCP how to communicate in the language of the minority population (e.g. Spanish). This method risks recreating the out group homogeneity bias whereby differences in the out-group are minimized while ignoring within group variations. It is important to note that these interventions rarely address the importance of the HCPs culture and how it influences the care they provide or the actual knowledge or understanding of the culture of the patient.

Need For Evidence-Based Culturally Informed Interventions

There is a structural need to develop and implement evidence-based interventions in health care delivery. In recent years, health care policy has incorporated evidence based interventions as a central tenet of health care delivery (America & Medicine, 2001). Subsequently, theory and scientific evidence have become crucial components of any health intervention (Glanz, 2002). Without a sound theory and evidence based understanding of the cognitive, emotional and behavioral aspects of an intervention, the

result becomes poor insight into what needs to be done to effect change and increase continuity of care (Bos, Schaalma, & Pryor, 2008).

In this case the focus is on the HCP because a poor understanding of their patients' culture is bound to affect how they treat and interact with their diverse patients and subsequently affects the effectiveness of the care that they provide (Betancourt et al., 2011). Due to the limited research and lack of instruments to measure the cultural beliefs of the HCPs, one method proposed in this case (and used in recent research) is the bottom up approach (Betancourt, Flynn, Riggs, & Garberoglio, 2010). The bottom up approach allows for improved identification and measurement of the cultural beliefs, values, norms and practices that are shared by the members of a community. For example Betancourt and associates using this approach found that Latino women were significantly more likely than Anglo women to report socially shared unfavorable beliefs about HCPs performing breast and cervical cancer screening exams (2010). Then those factors were found to be related to perception of mistreatment and continuity of care (Betancourt et al. 2011).

This current project proposes guidelines for developing culturally informed interventions with HCPs that take into account the socially shared values, beliefs and expectations that negatively impact breast and cervical cancer screening amongst their diverse patients. It also proposes steps for developing and identifying the HCPs own beliefs about their patients and the healthcare delivery system that impact cancer treatment. These guidelines include step-by-step methodology and are illustrated with research previously conducted using the bottom up approach to identify cultural and psychological factors relevant to cancer screening among Latino and Anglo women in

Southern California. The illustrations explain how these identified cultural and psychological factors can be utilized to intervene with health care professionals so as to increase continuity of cancer screening care.

CHAPTER 2

DEVELOPING EVIDENCE-BASED CULTURAL GUIDELINES FOR INTERVENTIONS WITH HEALTHCARE PROFESSIONALS

The guidelines below are based on a systematic research approach and could be used to identify the cultural factors influencing behavior within a particular group.

Guidelines must be Based on Research Grounded in Theory that take into Account the Role of Culture, Psychological Processes, and the Consequent Health Behavior

Theories provide direction for research, intervention and evaluation, thus enhancing quality (Pick, Poortinga, & Givaudan, 2003). They provide an explanation for what is observed and for data to be measured and tested so that predictions can be made (Strong, 1991). Furthermore, researchers can better understand observed behaviors and the mechanisms to change them when their work is guided by theory (Rajaram & Rashidi, 1998).

Health theories can further explain behaviors relevant to health issues by addressing culture. Examining the cultural variables can provide the beliefs, values, expectations, and social context influencing the studied behavior (Rajaram & Rashidi, 1998). Similarly, theoretical models that address the mentioned factors at the group level can better assess the socio-cultural elements contributing to the behavior in question (Ashing-Giwa, 1999). Therefore, there is a need for theories in health psychology to include culture in their framework to increase understanding of a group's behaviors, cultural relevance, applicability, and effectiveness (Ashing-Giwa, 1999).

Illustration: Step 1

To effectively study how culture influences psychological process and subsequently behavior, Betancourt and associates propose a model for the study of culture in psychology (Betancourt, Hardin, & Manzi, 1992; Betancourt & Lopez, 1993). This model adapted for the study of health behavior (Betancourt & Flynn, 2009) has guided research in such areas as adherence to cancer screening among Latino and Anglo women in the United States. The model explains how culture influences the behavior of health personnel (e.g. interaction with Latino women), as well as health behaviors of their patients (e.g. screening, treatment adherence) both directly and indirectly through psychological processes. The relationship of the variables is presented from distal to more proximal (moving from A to D) with proximity to behavior having a greater impact.

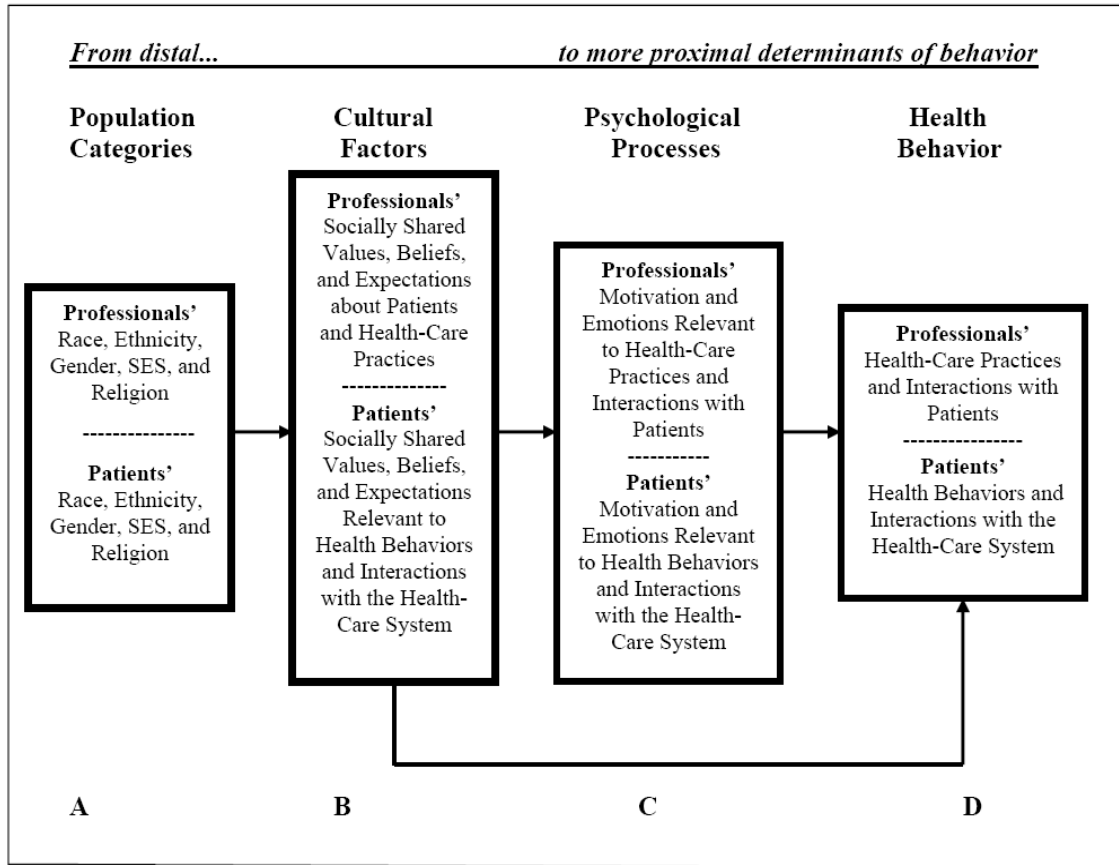


Figure 1. Betancourt's model of culture and behavior adapted for the study of health behavior (Betancourt and Flynn, 2009)

According to the model, health behavior (D) is a function of psychological processes (C), which are the most proximal determinants and therefore have the greatest impact on behavior. More critical to this study is the assertion that health behavior (D) is also associated with such aspects of culture as values, beliefs and expectations (B). These aspects of culture may be directly or indirectly associated with behavior through mediating psychological processes (C). The model also recognizes that population categories such as race, ethnicity and SES (A) represent sources of cultural variation. Nonetheless, these categories are more distal and are not necessarily directly associated

with a particular health behavior. The model underscores the concept that culture, influences health behaviors both directly and/or indirectly through psychological processes. Defining culture in psychologically relevant terms, such as socially shared beliefs, values, and norms provides a better understanding of its effect on behavioral phenomena such as health behavior and outcome. This model therefore provides a framework not only for testing hypotheses relevant to the target health behavior, but also for guiding interventions.

Guidelines Must be Based on Research that Utilize Culturally Appropriate Methodology to Identify the Cultural Factors Relevant to Health Behaviors as well as Across Populations

The top-down approach, stipulates that hypotheses are guided by theory which are subsequently tested and confirmed or rejected (Betancourt & Lopez, 1993). A top-down approach can provide data on the validity of hypotheses, instruments, and interventions. It is relevant to note that using only a top-down approach can be detrimental when it produces extraneous information and as a result should be tailored to the population that is being studied. To ensure relevance, the targeted population informs research by identifying their own socially shared beliefs and norms. This can be accomplished by using the bottom-up approach.

The bottom-up approach allows researchers to begin with specific observations and eventually be able to make broad generalizations. These observations lead to the testing of patterns, creating potential hypothesis, and finally to deriving theory (Betancourt & Lopez, 1993). One benefit of using the bottom-up approach is that culturally relevant factors (i.e. beliefs, values, expectations and norms) can be identified

among a particular population of interest. Culturally relevant instruments can then be developed based on the identified cultural factors. The resulting instrument can be used to assess the degree to which individuals or groups endorse a particular cultural factor. In the case of the Model for the Study of Culture, the bottom-up approach is the most coherent because its principle is in identifying the socially shared cultural values, expectations, and norms of the population of interest.

Illustration: Step 2

To illustrate the development and application of a culturally based methodological approach, the development of the Cultural Cancer Screening Scale (CCSS) as well as one application of it to test the role of cultural factors in Latino and Anglo women See (Betancourt et al., 2010) for complete data. Using the bottom-up approach, the development of the CCSS required identifying the cultural factors relevant to breast and cervical cancer screening. Open-ended, semi-structured interviews with Latino and Anglo women (in Southern California) were conducted to identify the cultural factors relevant to cancer screening. In line with (Triandis, 1972) mainstream Anglo women were included as a means to identify ethnic-specific and ethnic-general cultural elements. The interviews collected were content coded to identify these ethnic-specific and ethnic general cultural elements. Close-ended items were then developed based on the emerging cultural factors. The resulting instrument was psychometrically validated with Latino and Anglo Women.

Within Group Differences

When developing interventions health professionals should consider between and within group differences. One of the characteristics of the bottom up approach is that it recognizes within-group differences. In the case of Latinos, (Betancourt & Fuentes, 2001) affirm that Latinos are often misperceived as a culturally homogenous group, when in fact they possess great intragroup variability. Individual differences on immigration status, income, and education level can contribute to cultural variations within the Latino population. One source of cultural variation is ethnicity and its interaction with income and education (Powe, 2001). In one study, Anglo women of lower income were found to hold the value of “family” more than those of middle and higher income levels (Argueta, 2008).

Due to within group differences, interventions aimed at any population should avoid making the assumption that all members of that group share particular cultural beliefs, values, or norms. Interventionists can benefit from assessing within group differences through instruments designed to capture cultural variations. By taking this step practitioners can tailor their interventions more precisely in order to maximize cultural relevancy and effectiveness for group members or individuals.

Illustration: Step 3

Recognizing that population categories are sources of cultural variations, development of the CCSS utilized multistage-stratified sampling; the sample included varying demographic characteristics such as age, education, income and religion. This allowed for cultural factors that are salient to a subgroup (e.g. younger women) but not to

other individuals of the same ethnic group to be included. Future interventions may use the CCSS to assess the extent to which a particular patient endorses one or more factors of the scale relevant to cancer screening.

Utilize the Developed Instrument(s) to Assess the Extent to Which the Cultural and Psychological Factors are Relevant to a Population

Using a validated instrument will facilitate the identification of what is most relevant for individuals of a given population or community. This allows the population to guide the content of the intervention and lead to an increased understanding of the cultural beliefs of the population of interest.

Illustration: Step 4

The CCSS can be used to assess individual patients cultural beliefs about breast and cervical cancer screening, as well as related cognitions and emotions. The CCSS is comprised of five factors that include: *Negative Cultural Beliefs about Health Professionals*. This factor captures socially shared negative beliefs about health professionals (such as lack of compassion and concern). A second factor is *Cancer Screening Fatalism*. This factor represents the belief that life events are inevitable. The patient therefore believes that cancer screening is unnecessary. The *Catastrophic Disease Expectation* factor indicates socially shared negative expectations regarding cancer diagnosis. The *Symptomatic Deterrents* factor suggests the belief that screening is unnecessary when symptoms are absent or test results are negative. Lastly, the *Sociocultural Deterrents* factor reflects socially shared beliefs about social and structural barriers to cancer screening. Since the CCSS was developed for Latino women in

Southern California, it can be used for communities with similar compositions. However, researchers would have to investigate the validity and applicability of the CCSS and possibly the need to develop an instrument specific to other groups as needed.

CHAPTER 3

INTERVENTION WITH HEALTHCARE PROFESSIONALS

For the purposes of this project, the recommended interventions are based on current research that identifies the cultural and psychological factors that affect breast and cervical cancer screening using a sample of Latino and Anglo women in Southern California. This research is used to propose ways to educate and intervene with HCPs involved in breast and cervical cancer screening so as to increase continuity of cancer screening care.

Healthcare Professional Assessment

First and foremost, it is important to identify how much health providers know about the cultural factors that impact the targeted health behavior amongst their diverse patients. In order to assess the HCPs knowledge of the cultural factors relevant to breast and cervical cancer screening amongst their diverse patients, a health psychologist, researcher or equivalently trained personnel may administer a short survey to determine the extent to which the HCP(s) is familiar with these socially shared factors relevant to breast and cervical cancer screening. For example the survey could ask; - Are you familiar with the term *Catastrophic Disease Expectation*? Do you know what it means? (See appendix B). Alternatively, three short scenarios could be included and the HCP asked to identify which scenario indicates a socially shared belief about breast and cervical cancer screening.

Which of the following scenarios indicate *Catastrophic Disease Expectation*?

- A. Jane is terribly afraid of getting breast cancer. She believes that cancer is the worst thing that can happen to a woman. As a result, Jane has decided not to get a mammogram.
- B. Jane does not like hospitals. As a result, Jane has decided not to get a mammogram.
- C. Although Jane has never had a mammogram, she believes that they are extremely painful. As a result, she has decided not to get a mammogram
(See appendix C).

These surveys could be administered to HCPs in paper form, or electronically using email or using a web based survey service such as survey monkey. This would be done to evaluate their knowledge of the cultural factors that impact breast and cervical cancer screening amongst their diverse patients. The goal is that this will increase breast and cervical cancer screenings and subsequently improve the relationship between the HCP and the patient and increase continuity of care.

Administering the CCSS

Next, the HCPs could be trained by a health psychologist (or equivalently trained professional) to administer the CCSS (or similar instrument) either to an individual patient or a group. It may be effective to have a health psychologist (or equivalently trained professional) as part of the training team during the initial stages. For example, the HCP or frontline staff (such as a Medical Assistant) could be trained to administer the CCSS by having the patient complete it while in the waiting room. The scores are then

entered into the patients profile and available to each subsequent HCP at the point of care.

The HCP could also be trained to mail the instrument to the patient and to score and enter it into the patient's medical record before their next visit. If the latter option is used, the HCP must have additional copies available incase the patient forgets to mail it back. Classroom training and web based refreshers could be designed and used for follow up training for HCPs within that particular clinic or location. The CCSS can be used in this case because it has demonstrated predictive validity such that women who scored higher were less likely to comply with mammography and clinical breast exams (Betancourt et al, 2010).

CCSS Based Intervention and Training for Healthcare professionals

When the CCSS is administered and any of the cultural factors are elevated for a patient, the health psychologist (or trained personnel) could intervene with the HCP as follows:

Screening Fatalism

Based on the scores from the CCSS, It appears that the *Screening Fatalism* factor is elevated for this patient. This factor represents the belief that life events are inevitable. It suggests that this patient subscribes to the belief that "if I am going to get cancer, I will get cancer and there is nothing I can do about it". This belief reduces the likelihood that this patient will return for a follow up. If the patient is Latino or low SES, it is important to recognize that on average Latinos and low SES patients are more likely than higher

SES Latinos and Anglo-Americans to think that chronic disease is determined by God and therefore must be accepted and endured as a punishment for personal sins or sins of the family members (Baquet & Hunter, 1995; Falicov, 1996). Subsequently, Latinos with this belief are less likely to seek medical attention or comply with treatment recommendations. These fatalistic attitudes lead to greater psychological distress and anxiety for the patient (Ross, Mirowsky, & Cockerham, 1983). It may be helpful for the HCP to take a moment to thoroughly explore this belief with the patient (see appendix C). It may also be helpful to discuss spirituality as it relates to cancer prevention as this has been shown to be helpful as well (Kreuter et. al., 2002).

Increasing awareness about this belief could translate to increased self-monitoring and subsequently improved patient satisfaction and continuity of care (DiMatteo, Hays, & Prince, 1986). At this point, the health psychologist can provide a detailed script of how the HCP can intervene directly with the patient (see Espinoza, 2011).

Negative Cultural Beliefs about Healthcare Professionals

To address the *Negative cultural beliefs about health professionals* the health psychologist could provide information about this cultural factor, explore the relationship between the patient and the HCP, as well as educate the HCP about this socially shared belief. For example, based on the scores from the CCSS, it appears that this patient holds *Negative cultural beliefs about health professionals*. This cultural factor reflects socially shared unfavorable beliefs about HCPs, including lack of concern, compassion and trustworthiness (Betancourt et. al., 2010). This factor suggests that this patient feels that HCPs are not compassionate or trustworthy. It will be beneficial to acknowledge this

belief and take a minute to explore the patient's prior experiences with HCPs while emphasizing that HCPs are very different. It will also be beneficial to this patient to acknowledge and educate the patient about the Anglo American cultural perspective and the cultural script of going to see a doctor as ways to challenge this belief. At this point, the health psychologist can provide a detailed script of how the HCP can intervene directly with the patient.

Catastrophic Disease Expectations

When the *Catastrophic disease expectations* factor is elevated, the health psychologist can intervene with the HCP by first explaining that this factor indicates highly negative socially shared expectations associated with a cancer diagnosis. The health psychologist can provide education materials about survival rates, benefits of early detection etc, to the HCP to be shared with the patient if needed. The health psychologist could also advise the HCP to involve the patients family members (with permission from the patient) and/or refer the patient to a breast cancer awareness group, as this has been shown to promote mammography screening (Erwin, Spatz, Stotts & Hollenberg 1999). The health psychologist can provide a detailed script of how the HCP can intervene directly with the patient if needed.

Symptomatic Deterrents

When the *Symptomatic deterrents* factor is elevated, the health psychologist could explain to the HCP that this factor reflects the socially shared belief that screening is not necessary when someone is feeling healthy. In other words, this particular patient does

not feel the necessity for a breast or cervical exam because she is asymptomatic. The health psychologist could educate the HCP about the importance of assessing the patients' knowledge about breast and cervical cancer, as well as provide the HCP with easy to read, culturally appropriate data on screening and mortality rates. The health psychologist could also discuss the common misconceptions about breast and cervical cancer screening. The health psychologist can provide a detailed script of how the HCP can intervene directly with the patient if needed.

Sociocultural Deterrents

Finally, when the *Sociocultural deterrents* factor is high, the health psychologist explains that this factor represents socially shared beliefs concerning social and structural barriers to cancer screening. This patient may have difficulty locating low/no cost cancer screening locations; have difficulty getting transportation to appointments etc. The health psychologist could provide a short resource list of locations for low/no cost screening; transportation options and other culturally appropriate referral materials to the HCP. The health psychologist could also use role play (acting as the patient) with the HCP to help the HCP practice problem solving techniques that can be later applied to the patient. This is bound to increase self-efficacy for the HCP and the patient. Increasing self-efficacy (Bandura, 1986) challenges the individuals' cognition and empowers them to participate in positive health behaviors such as breast and cervical cancer screening.

The above illustration depicts a targeted intervention for individual HCPs. Nonetheless; the intervention components can be adapted into a training program for a group of HCPs. Once the relevant cultural factors and related psychological processes are

identified for a particular patient or group, similar guidelines and training could be instituted dealing with factors that are salient but tailored specifically for the HCP. Educating the HCP about the effect of these negative cultural beliefs on the patient-professional interaction is imperative.

Post Intervention Evaluation

Post-intervention evaluation provides information on the effectiveness of the intervention. If desired results are not achieved, the evaluation nonetheless provides valuable information that can guide the health psychologist to make appropriate changes. After the above intervention has been implemented with HCPs, the sample surveys (such as appendices B or C) or a psychometrically derived scale could be administered at regular intervals such as every three months. This would be done to evaluate any changes in their understanding or knowledge of the cultural factors relevant to breast and cervical cancer screening. If the HCP(s) continues to show poor knowledge of these cultural factors, then one recommendation would be to refer the HCP for a one on one coaching with a health psychologist as well as mandatory web based and/or classroom training.

Another alternative to evaluate change in the HCP is to use patient actors. An actor could be trained to fake their unwillingness to engage in breast or cervical cancer screening. The HCP would then be evaluated by the health psychologist on their understanding and knowledge of the cultural factors and their ability to use the intervention relevant to the patients.

A third alternative is to monitor the patients' scores on the CCSS. For example if a patient continues to show elevations on the *Negative Cultural Beliefs about Health*

Professionals associated with poor adherence and directed at a particular HCP, then the health psychologist can use a similar intervention by referring the HCP for a one on one coaching with a health psychologist or equivalently trained professional. It is expected that these interventions should lead to an increase in breast and/or cervical cancer screening.

CHAPTER 4

GUIDELINES FOR DEVELOPING AN INSTRUMENT THAT IDENTIFIES HCPS BELIEFS THAT NEGATIVELY IMPACT CANCER CARE

These recommended guidelines are based on a systematic research approach and could be used to identify the cultural factors that negatively influence the behavior of HCPs involved in breast and cervical cancer treatment.

Guidelines Must be Based on Research Grounded in Theory that Take into Account the Role of Culture, Psychological Processes, and the Consequent Health Behavior

Betancourt's model of culture and behavior (Betancourt et al., 2009) provides a guide and explains how culture influences behavior. This model underscores the concept that culture influences health behaviors both directly and/or indirectly through psychological processes behavior (Betancourt & Flynn, 2009).

Guidelines must be Based on Research that Utilize Culturally Appropriate Methodology to Identify the Socially Shared Cultural Factors Among Healthcare Professionals.

Step One: Stratified Sampling

The health care profession is stratified and compensated based on profession (Physician Vs Nurse), specialty (Oncology Vs Family medicine) and rank (Attending physician Vs Staff physician). Based on the Model for the Study of Culture, it is important to consider the effect income, ethnicity and gender can have on an individual's cultural beliefs, values, and norms to best understand the behavior being targeted. To capture these subtle variations a multistage-stratified sampling technique may be utilized. Any instrument developed for HCPs involved in breast and cervical cancer treatment

should involve a stratified sampling approach so that different professionals (Radiologists, Oncologists, Registered Nurses, Radiology Technicians etc.) are included in the sample.

Step Two

Open-ended, semi-structured interviews with HCPs involved in patient care should be conducted to identify the cultural factors relevant to effective cancer treatment. Sample questions for this interview might include ‘What are your thoughts about women who have breast cancer?’, ‘What are your thoughts about breast and cervical cancer treatment?’ (See Appendix E). Health care professionals from other specialties may be included as a means to identify culture specific and culture general elements. The interviews collected will then be content coded to identify these culture specific and culture general elements. Close-ended items will then be developed based on the emerging cultural factors. This bottom-up approach will make it possible to identify the culturally relevant beliefs, expectations and norms among HCPs.

Step Three

The resulting instrument can then be administered to HCPs involved in breast and cervical cancer treatment. It will be relevant to the population because it has been developed in a systematic process and validated psychometrically.

Utilize the Developed Instrument(s) to Assess the Extent to which the Cultural and Psychological Factors are Relevant to a Population

The resulting instrument will be comprised of cultural beliefs that influence the HCPs such as : HCPs beliefs about cancer patients for example, believing that the patient is responsible for developing cancer because they did not participate in routine screening or Fatalistic beliefs about Latino breast cancer patients such as the belief that Latino women are more likely to have a poorer outcome due to poor adherence. Another example is HCPs negative beliefs about cancer treatment such as the belief that breast cancer treatment is expensive and time consuming. These are simply examples of factors that could be identified that could negatively impact breast and cervical cancer treatment. This process is critical because the HCPs must be aware of their own personal beliefs about their patients and the healthcare system because the research indicates that this will impact the care that they provide.

CHAPTER 5

DISCUSSION

Betancourt's model for the study of culture and health behavior provides a framework for designing and implementing culturally based interventions. It specifies that an intervention should consider population characteristics such as ethnicity, SES and culturally shared beliefs, values and expectations. The model outlines when a bottom-up or a top-down approach is most efficient. It proposes a framework for designing culturally relevant interventions and guides research to inform such interventions with culturally diverse populations.

This document contains guidelines on how to research and develop culturally sound instruments guided by Betancourt's model and informed by the applicable research. It emphasizes the importance of conducting research that is based on theory and that takes into account culture, psychological processes, and how these influence behavior. It illustrates the use of the bottom-up approach as an asset in the development of culturally sound instruments and interventions. The illustrations included the use of the CCSS as a guide to theory based, cultural interventions with HCPs. These recommendations aim to enhance patient-professional relationships and improve continuity of cancer screening care among culturally diverse patients and their HCPs. This document goes a step further by broadening the strategies used in the development of the CCSS for Latino women in Southern California and illustrating how the same strategies may be implemented with HCPs. The interventions are expected to reduce or eliminate instances of perceived mistreatment in cancer screening and treatment. The goal is that HCPs will have an increased awareness of their patients' values, beliefs and

expectations and lead to improved patient-professional relationships, and increased continuity of cancer screening care. These interventions will subsequently serve as catalysts for an increase in breast and cervical cancer screening rates, and a reduction in cancer mortality due to early detection.

The increased cultural diversity in urban areas make culturally based interventions essential. In the U.S, Latinos are the fastest growing population, as they currently account for 15.4% of the total population and 36.6% of the population in California (U.S. Census, 2008). This group is not homogenous, thus researchers must take into account within group differences such as income, ethnicity, education, age, gender and acculturation level (natural born or recent migrant).

Research suggests that Latino patients often indicate a poor interaction with their HCP. Thus, utilizing culturally informed interventions is essential because it increases the relevance between an intervention and the patients' background. The HCP can administer the instrument, like the CCSS, as part of an individual office visit or as part of a larger intervention directed towards a target community.

Future research may focus on generating an empirically validated instrument that can be administered to the HCP to assess their *own* values, beliefs, expectations and norms about a relevant health behavior or their attitude towards a particular group or individual. The insight gained by the HCP about their own values, beliefs and expectations will increase self monitoring and subsequently improve communication between the HCP and their patient. HCPs and researchers can use these specific illustrations to design and implement an intervention with HCPs that will subsequently increase continuity of cancer screening care. Researchers are advised to follow the general guidelines provided and use

the CCSS (or any other instrument) to tailor recommendations more appropriate to their population.

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Appendix A

Cultural Cancer Screening Scale (CCSS)

Cancer Screening fatalism

It is not important to screen regularly because everyone will eventually die of something anyway.

It is not necessary to screen for breast/cervical cancer regularly because it is in God's hands anyway.

If nothing is physically wrong, then you do not need to screen.

Negative Beliefs about Health Professionals

Health professionals are not compassionate for what their patients are going through.

Health professionals are always in a hurry and do not have time for the patients.

I do not feel comfortable with health professionals doing the screening examination.

Some health professionals inappropriately touch their patients during the screening examination.

Health professionals performing screening examinations are not trustworthy.

Catastrophic Disease Expectations

Breast/cervical cancer is the worst thing that can happen to a woman.

Breast/cervical cancer is a deadly disease.

Symptomatic Deterrents

Feeling healthy is a reason for not screening for breast/cervical cancer regularly.

Having several normal screening tests results is a reason for not screening regularly.

Not feeling anything abnormal is a reason for not screening regularly.

Sociocultural Deterrents

Having problems with making an appointment is a reason for not screening regularly.

Not knowing where I can be screened for breast/cervical cancer is a reason for not screening regularly.

Not being able to get time off work is a reason for not screening regularly.

Not having transportation to get to my appointment is a reason for not screening regularly.

Not receiving a reminder postcard is a reason for not screening for breast/cervical cancer regularly.

Not having health insurance or the money to pay for the exam is a reason for not screening regularly.

Appendix B

Sample Survey of Healthcare Professionals Knowledge of Factors Relevant to Breast and Cervical Cancer Screening.

The following questions assess your knowledge of the cultural and psychological factors that have been identified to negatively impact breast and cervical cancer screening.

Please check “Yes” if you are familiar with the identified concept or “No” if you are not.

Are you familiar with the term *Cancer Screening Fatalism* as it relates to cancer screening? YES____ NO____

Do you know what it means? YES____ NO____

Are you familiar with the term *Negative Beliefs about Health Professionals* as it relates to cancer screening? YES____ NO____

Do you know what it means? YES____ NO____

Are you familiar with term *Catastrophic Disease Expectation* as it relates to cancer screening? YES____ NO____

Do you know what it means? YES____ NO____

Are you familiar with the term *Symptomatic Deterrents* as it relates to cancer screening? YES____ NO____

Do you know what it means? YES____ NO____

Are you familiar with the term *Socio-cultural Deterrents* as it relates to cancer screening? YES____ NO____

Do you know what it means? YES____ NO____

Appendix C

Sample Scenarios to Determine Healthcare Professionals Knowledge of Factors Relevant to Breast and Cervical Cancer Screening.

The following scenarios will assess your knowledge of the factors that have been shown to influence breast and cervical cancer screening.

Please circle the option you feel that best illustrates the identified factor.

1. Which of the following scenarios indicate *Cancer Screening Fatalism*?
 - A. Jane believes that if she is destined to get cancer, she will get cancer and there is nothing she can do about it. As a result, Jane has decided not to get a mammogram.
 - B. Jane believes that mammograms are painful and as a result she has decided not to get a mammogram.
 - C. Jane does not like hospitals. As a result, Jane has decided not to get a mammogram.

2. Which of the following scenarios indicate *Negative Beliefs about Health Professionals*?
 - A. Jane does not like hospitals; As a result, Jane has decided not to get a mammogram.
 - B. Jane believes that health professionals are always rude, always in a hurry and lack compassion. As a result, Jane has decided not to get a mammogram
 - C. Jane does not have a ride to the clinic. As a result, Jane has decided not to get a mammogram.

3. Which of the following scenarios indicate *Catastrophic Disease Expectation*?
 - D. Jane is terribly afraid of getting breast cancer. She believes that cancer is the worst thing that can happen to a woman. As a result, Jane has decided not to get a mammogram.
 - E. Jane does not like hospitals. As a result, Jane has decided not to get a mammogram.
 - F. Although Jane has never had a mammogram, she believes that they are extremely painful. As a result, she has decided not to get a mammogram.

4. Which of the following scenarios indicate *Symptomatic Deterrents*?
 - A. Although Jane has never had a mammogram, she believes that they are extremely painful and has decided not to get a mammogram
 - B. Jane does not have a ride to the clinic. As a result, she has decided not to get a mammogram.
 - C. Jane feels healthy and normal and does not have any symptoms of any kind. As a result, she has decided not to get a mammogram.

5. Which of the following scenarios indicate *Sociocultural Deterrents*?
- A. Jane does not like hospitals. As a result, she has decided not to get a mammogram.
 - B. Jane does not have a way to get to the clinic. She also has difficulties using the automated system to schedule her appointment. As a result, Jane has decided not to get a mammogram.
 - C. Although Jane has never had a mammogram, she believes that they are extremely painful. As a result, she has decided not to get a mammogram.

Answer Key

- 1. A
- 2. B
- 3. A
- 4. C
- 5. B

Appendix D

Sample Training Intervention with Healthcare Professionals involved in Breast and Cervical Cancer Screening

Scenario 1

Cancer Screening Fatalism

Jane believes that if she is destined to get cancer, she will get cancer and there is nothing she can do about it. She believes that *life events are inevitable thus cancer screening is unnecessary*. This has prevented her from scheduling a mammogram.

As the healthcare professional in charge of Jane's care, it could be beneficial to: -

- Discuss rates of prevention and effects of early detection.
- Inquire and discuss the screening tools "God has given us" to help detect and treat cancer.
- Emphasize the idea that taking these steps will increase the chances that she lives a long healthy life with her family.

Scenario 2

Negative Beliefs about Health Professionals

Jane has a very negative perception of healthcare professionals. She believes that they are *rude and lack compassion*. This has prevented her from scheduling a mammogram.

As the healthcare professional in charge of Jane's care, it could be beneficial to: -

- Discuss the patient's prior experiences with HCPs.
- Acknowledge the patient's negative experiences while educating her that HCPs are different.
- Discuss your openness to providing options to see other providers that she may feel more comfortable with.
- Discuss the steps involved in seeing a doctor in the U.S i.e. scheduling an appointment, making a follow up call, time limits beyond the physicians control etc.

Scenario 3

Catastrophic Disease Expectation

Jane is terribly afraid of getting breast cancer. She believes that *breast cancer is the worst thing that can happen to a woman*. This has prevented her from scheduling a mammogram.

As the healthcare professional in charge of Jane's care it could be beneficial to: -

- Discuss survival rates especially as it relates to early detection.
- Explore the possibility of involving her family members with her permission.
- With permission, discuss another patient who was saved by early detection and explore the opportunity of this patient meeting with Jane
- Consider referring the patient to a culturally appropriate breast cancer awareness group.

Scenario 4

Symptomatic Deterrents

Jane believes that she *does not need to screen for breast or cervical cancer because she does not have any symptoms*. This has prevented her from scheduling a mammogram.

As the healthcare professional in charge of Jane's care it could be beneficial to: -

- Ask direct questions to identify how much Jane knows about breast and cervical cancer.
- Along those lines, educate her about risks, symptoms and survival rates making sure to use culturally appropriate language.
- Identify and discuss any misconceptions that the patient has about symptoms.
- Discuss the importance of screening linking it to the fact that early detection increases the chances that the patient will be around for memorable events such as birthdays, and is therefore an investment in her children's future.
- Provide culturally appropriate printed materials to the patient as needed.

Scenario 5

Sociocultural Deterrents

Jane has expressed difficulty in *making an appointment as well as difficulty getting transportation to the clinic*. This has prevented her from scheduling a mammogram.

As the healthcare professional in charge of Jane's care it could be beneficial to: -

- Provide culturally appropriate referrals to low/no cost locations e.g. for mammograms
- With the Patient's consent, discuss the possibility of recruiting family members to help transport the patient to her appointments.

Appendix E

Sample Of Open Ended Semi Structured Interview Questions for Healthcare Professionals Involved in Cancer screening.

1. What are your beliefs about women who have breast cancer?
2. What are your beliefs about breast and cervical cancer screening and treatment in general?
3. What are your thoughts about Latino women diagnosed with breast or cervical cancer?
4. What are your beliefs about Anglo patients diagnosed with breast or cervical cancer?
5. What are your beliefs about non- English speaking Latino patients.
6. What are your beliefs about the above population as it relates to access to information about breast and cervical cancer screening, treatment etc?
7. What are your beliefs about this population particularly as it relates to time needed to provide care?
8. What are your beliefs about this population as it relates to adherence to appointments etc?
9. What are your beliefs about your Anglo patients as it relates to adherence to appointments etc?
10. What are your beliefs about the current costs, efficacy, process etc of breast and cervical cancer screenings and treatment?