Guidelines for Culturally Informed Interventions: Culture, Attributions and Continuity of Care

Chung Mu Seo

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Guidelines for Culturally Informed Interventions:
Culture, Attributions and Continuity of Care

by

Chung Mu Seo, M.A.

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

September 2011
Each person whose signature appears below certifies that this project in his/her opinion is adequate, in scope and quality, as a project for the degree Doctor of Psychology.

Hector M. Betancourt, Professor of Psychology

Patricia M. Flynn, Postdoctoral Fellow
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ABBREVIATIONS

CCSS  Cultural Cancer Screening Scale
COC  Continuity of Care
HCP  Healthcare Professionals
NCB  Negative Cultural Beliefs about Health Professionals
SES  Socioeconomic Status
ABSTRACT

Guidelines for Culturally Informed Interventions: Culture, Attributions and Continuity of Care

by

Chung Mu Seo

Doctor of Psychology, Graduate Program in Psychology
Loma Linda University, September 2011
Dr. Hector Betancourt, Chairperson

Although early detection can improve survival of breast and cervical cancer, U.S. Latinas are more likely to be diagnosed at later stages of cancer and have poorer survival rates compared to Anglo women. Poorer continuity of care and adherence to recommended screening are seen as contributing factors to this disparity. Existing interventions have tried to reduce human, system, and culture barriers. However, they lacked a systemic guidance in the process of identifying cultural factors and the pathways in which they affect the specific behavior of interest through psychological processes in a minority population. Guided by Betancourt’s integrative model of culture, psychology, and behavior, the current project proposes guidelines to facilitate studies that are theoretically and methodologically sound in making unbiased discoveries and scientific assessment. A further purpose of these guidelines is to design well-informed interventions that can be evaluated and improved. An illustrative process is also presented in which a specific cultural factor (negative beliefs about healthcare professionals) and psychological processes (attribution of negative healthcare interaction and related emotions) are identified as determinants of emotion and behavior. This process leads to a more focused intervention strategy using patient education and attribution retraining components.
Chapter 1

Introduction

Latino women in the U.S. are more likely to be diagnosed at later stages of breast and cervical cancer than non-Latino White (Anglo) women and therefore face less favorable health outcomes that could be prevented (American Cancer Society, 2009; Howe, Delfino, Taylor, & Anton-Culver, 1998; Hunter, 2000; Smigal et al., 2006). Furthermore, Latino women are less likely to adhere to timely screening for breast and cervical cancer as well as follow-up treatment when recommended (American Cancer Society, 2009; K. Blanchard et al., 2004; Fernandez-Esquer, Espinoza, Ramirez, & McAlister, 2003; Hunt, Voogd, Soucy, & Longworth, 2002; Press, Carrasquillo, Sciacca, & Giardina, 2008; Reynolds, 2004). Improving continuity of care (COC) can help establish an on-going and persistent pattern of care with a healthcare professional (HCP) or clinic relevant to the early detection of cancer. While the trusting, relational aspect of COC has been found to likely influence future health outcomes (Saultz & Lochner, 2005), patients’ negative perceptions of healthcare interactions can rupture the trusting relationship.

According to attribution theory, patients may perceive HCPs as having control and intention over negative clinical interactions. These perceptions can influence the subsequent emotion and health behaviors. Betancourt’s integrative model for the study of culture, psychological processes and behavior (Betancourt & Flynn, 2009; Betancourt & Lopez, 1993) provides a broader contextual framework in which the role of culture is postulated to influence behaviors through psychological processes such as attributions. In
this framework, interventions to improve COC in Latino populations need to take into account the role of culture and psychological processes. A bottom-up methodological approach to the study of culture has been proposed and implemented (Betancourt, Flynn, Riggs, & Garberoglio, 2010) to guide development of interventions to improve COC.

Using the above model and approach, the goals of the present project are to: 1) provide a set of methodological guidelines for developing culturally informed interventions for diverse populations and 2) illustrate how these guidelines can be implemented to develop interventions for improving cancer screening among culturally diverse women.

**Breast Cancer and Cervical Cancer Disparities**

In the U.S., breast cancer is the most frequent form of cancer among women and is the second most frequent cause of death due to cancer (Jemal et al., 2009). For Latino women in the U.S., breast cancer accounts for more deaths than any other type of cancer (American Cancer Society, 2009). Latino women have higher mortality rates from breast cancer despite lower prevalence rate compared to mainstream Anglo women (Clegg, Li, Hankey, Chu, & Edwards, 2002). Latinas are also more likely to be diagnosed at later stages of breast cancer and have poorer survival rates than Anglo women (American Cancer Society, 2009; Hunter, 2000; Smigal, et al., 2006). Among the factors that may be relevant to Latino women’s later-stage diagnosis are less frequent mammography and delayed follow-up for diagnostic clarification and treatment after abnormal mammography (American Cancer Society, 2009; K. Blanchard, et al., 2004; Press, et al., 2008).
Similar observations can be made with regards to cervical cancer and cervical cancer screening. Compared to other ethnic groups, Latino women in the U.S. report a higher prevalence of cervical cancer (Carozza & Howe, 2006; Jemal, et al., 2009), higher rates of invasive cancer at diagnosis (Howe, et al., 1998), and higher rates of death caused by cervical cancer (American Cancer Society, 2009). Detection at the precancerous stage and early treatment are necessary for improved survival (Ell et al., 2002). However, past studies indicate that Latinas are less likely to have Pap exams, less likely to obtain repeated Pap testing, and less likely to receive follow-up treatment. This behavior contributes to higher mortality due to cervical cancer (Fernandez-Esquer, et al., 2003; Hunt, et al., 2002; Reynolds, 2004). It is possible that poorer adherence to cancer screening and follow-up care may be related to the higher percentage of preventable cancer deaths among Latino women. It is expected that this mortality rate could be improved by increasing return visits to their healthcare professionals at recommended times (routine or per abnormal findings) and establishing an on-going and persistent pattern of care among Latino women. It has been estimated that 80% of cervical cancer deaths are preventable with improved continuity of care (IARC, 2005).

**Continuity of Care and Patient-Professional Relationship**

Sustained COC is associated with patient satisfaction, decreased hospitalizations and emergency department visits and improved receipt of preventive services (Cabana & Jee, 2004). COC with a regular site, especially with the same primary care professional, is linked to greater cancer screening (Bazargan, Bazargan, Farooq, & Baker, 2004; O'Malley, Forrest, & Maldelblatt, 2002). In spite of the benefits associated with better
COC, Latinos are less likely to have a usual source of care, which is associated with fewer received preventive services (Corbie-Smith, Flagg, Doyle, & O'Brien, 2002). Spanish-speaking Latinos, in particular, lack a regular site of care (Doescher, Saver, Fiscella, & Franks, 2001). Positive interaction between patients and professionals, such as satisfaction and trust, is related to better COC, improvements in health outcomes, cancer screening, and early cancer detection (J. A. Hall, Horgan, Stein, & Roter, 2002; Mainou et al., 2004; Saultz & Albedaiwi, 2004; Saultz & Lochner, 2005; Sheppard et al., 2008).

The trusting relationship between patients and physicians, as well as interpersonal COC, can be ruptured when patients have negative perceptions of their interactions with healthcare professionals. In fact, Latinos were more likely than Anglos (56% vs. 27%) to report that Latinos receive lower-quality healthcare than Anglos (Lillie-Blanton, Brodie, Rowland, Altman, & McIntosh, 2000). Latino women are also more likely (19.4% vs. 9.4%) to perceive medical staff as disrespectful and feel looked down on by physicians compared to Anglo women (J. Blanchard & Lurie, 2004). Latino women also reported being treated in a cold or harsh manner by Anglo physicians performing mammograms (Moy, Park, Feibelmann, Chiang, & Weissman, 2006). Since the perception of negative healthcare interaction has been associated with lower breast cancer screening (Crawley, Ahn, & Winkleby, 2008), these findings have implications for Latino women’s vulnerability to cancer.
Current Studies and Interventions

There are two dimensions of interventions that are related to the present study: cancer screening interventions and patient-professional relational interventions. Cancer screening interventions aim to increase the rate of cancer screening in non- or less-compliant women, and most interventions in this area seem to play a role in reducing barriers to receiving preventive care. Interventions for reducing system barriers include improving access by means of mammography vans or free/low-cost vouchers. Interventions for reducing human barriers include telephone counseling and tailored print materials on an individual-level implementation or on some form of community-level implementation (King, Rimer, Seay, Balshem, & Engstrom, 1994; Masi, Blackman, & Peak, 2007; Rimer et al., 1992; Skinner, Strecher, & Hospers, 1994).

These interventions provide improved access to care by lowering the practical and psychological burdens experienced by patients. And they seem to increase primarily the short-term likelihood of cancer screening but do not aim to maintain continuity of care. Although psychoeducation and improved health-consciousness may provide some lasting effect, they do not warrant patient satisfaction at the site of the screening, particularly through good personal relations with the health professional. A negative personal interaction with the health professional could undermine COC and offset the benefits of the reduced barriers. This may be an important area of consideration for many Latino women, who may be influenced by their traditional cultural emphasis on interpersonal relationships (personalismo) and their expected way of relating to professionals (respeto) compared to Anglo women (National Alliance for Hispanic Health, 2001). The
effectiveness of these interventions can benefit from improved quality of medical interaction with health professionals.

In primary care settings, training physicians in communication skills has been found to be associated with greater patient satisfaction (Haskard et al., 2008). On the patient side, some studies have discussed the importance of patient activation and empowerment (Thiel de Bocanegra, 2004). Also, leaflets designed for patient empowerment have been found to be effective (Little et al., 2004). These studies provide a good foundational approach for improving the general effectiveness of patient-professional interaction, but the interventions discussed above neither identify nor target the factors that are disparate in Latino women.

Other studies and interventions have tried to address this disparity by adding cultural sensitivity to their approaches. Interventions that have sought to lower the cultural barriers to screening have effectively increased screening by using culturally sensitive and linguistically appropriate multimedia material, psychoeducation and community lay helpers from the same linguistic and cultural background (Eng, Parker, & Harlan, 1997; C. Hall, Hall, Pfriemer, Wimberley, & Jones, 2007; Masi, et al., 2007).

The effectiveness of culturally sensitive interventions highlights the important role of culture in breaking down human and interpersonal barriers to receiving preventive healthcare. However, it is also noted that the current cultural interventions often involve using cultural familiarity to reach out to non-mainstream populations rather than applying more operationalized cultural factors. Here, something seems to remain unclear in the process of identification, definition, or application of cultural factors in relating to the desired behavioral outcome in the corresponding culturally-diverse populations.
Furthermore, the quality and satisfaction in patient-professional relationships are still not addressed.

In a study of patient-physician relationships, higher self-report of professionals' cultural competence was associated with better patient satisfaction and interaction (Paez, Allen, Beach, Carson, & Cooper, 2009). Physicians' cultural competence is an important area of concern for improving the interpersonal COC. “Cultural competency”, however, is a very broad concept. It also may emphasize cultural familiarity without clearly defined cultural factors that are specifically related to the health behavior of interest for the corresponding population or community.

**Sensitivity to Cultural Factors**

Cultural differences between health care professionals and patients may contribute to health disparities seen between mainstream and minority groups (Betancourt & Flynn, 2009; Betancourt & Fuentes, 2001). Yet, current prevention research has not fully embraced the need for progressively diversifying non-mainstream cultural groups who may not benefit from the dominant prevention strategies designed for the mainstream (Roosa, Dumka, Gonzales, & Knight, 2002). Efforts to provide more sensitive treatment for Latinos have included describing Latino traditional cultural characteristics relevant to health behaviors. These include emphasis on family involvement (*la familia*), appropriately respectful behavior based on social relations (*respeto*), personal rather than institutional relationships (*personalismo*), trust (*confianza*), and body-mind-spirit integration (*espiritu*) (National Alliance for Hispanic Health, 2001).
Clinicians who are familiar with these traditional values would no doubt be able to be more accommodating to the implicit needs of Latino patients. On the other hand, a clinician who blindly assumes these values in all Latino patients may find himself or herself misinformed while interacting with many patients who do not follow these traditional and stereotypical characteristics. Such discrepancies may become progressively more common as the Latino population grows more diverse with regard to place of origin, generation status, socioeconomic status, acculturation and contact with other cultures (Betancourt, et al., 2010).

We should continue to infer from previously recognized cultural factors and use them as general considerations in broad situations. Meanwhile, we should also seek a more accurate understanding of how cultural factors fit with specific target groups and behaviors and be more critical in evaluating our understanding. If researchers and clinicians increased the availability and awareness of a more systematic approach for identifying cultural factors related to health behaviors, one that can accommodate changing trends over time and across culture, minority patients would greatly benefit. A systematic approach with clear guidelines can also allow us to be more scientific and specific with factors that are central to the intervention. Interventions will be more effective when designed with improved understanding of the psychological processes underlying the cultural influence on behavior.

**Attribution of Negative Healthcare Interaction**

According to attribution theory, when an individual is faced with an event, such as the perception of negative healthcare interaction, an attribution process takes place in
which the individual searches for an understanding of why that event occurred (Betancourt & Blair, 1992; Weiner, 1985, 2006). This attribution process involves a perception of conflict with someone, appraisal of controllability and intentionality on the part of that person, resulting emotion, and the reactive violence that plays an important role in the behavioral outcome (Betancourt & Blair, 1992). For example, a patient may perceive a negative interaction with an HCP and believe that the HCP has the ability to control the situation and the intention to cause a negative interaction. As a result, the patient may feel angry and decide not to return for follow-up. Interventions that have involved targeted attribution change have been found to be instrumental in changing behavior in areas such as reducing school aggression, promoting walking in sedentary older adults, and preventing child abuse by mothers (Bugental et al., 2002; Hudley, Graham, & Taylor, 2007; Sarkisian, Prohaska, Davis, & Weiner, 2007).

One of the aims of the current project is to contribute to the development of interventions designed to improve COC by affecting the attribution process of patients. By intervening at the level of patients’ attribution processes stemming from their cultural beliefs, it is expected that cancer screening COC will be improved, ultimately leading to increased cancer screening and early detection. Another important aim of the current project is to provide guidelines for developing culturally informed interventions based on scientific data with an illustration of that process. To that end, the current project will focus on targeting patients using research data collected from patients.

That is not to suggest or imply that negative healthcare interactions exist only in the perception of the patients. The perception may very well be based directly or indirectly on socially shared experiences with the healthcare system. They may have been
treated poorly by mean hospital staff, heard about someone else’s bad experience, or may have been influenced by culturally shared beliefs that may have resulted from a collective accumulation of such experiences. Ultimately, there needs to be a more comprehensive effort to promote breast and cervical cancer screening by improving the actual services provided. Such interventions may eventually lead to improved cultural and personal beliefs concerning health professionals and may reduce perceptions of mistreatment.

However, patient-centered interventions are still important because a perception of mistreatment can exist in Latino women regardless of any improvements in reality. Hostile attribution bias can elicit a hostile response in a perceiver in ambiguous situations whether or not a hostile intention really exists (Dodge, 1980). Moreover, if a cultural discrepancy between Latino women and health professionals plays a role separately from any ill-practice by professionals or misperception by patients, it would behoove us not to leave out either party in promoting a change in this transactional phenomenon.
Chapter 2
Guidelines

The following guidelines, based on a systematic approach, list important steps for gathering scientific knowledge and implementing interventions based on an appropriate understanding of culture, psychology and behavior.

Guideline #1: Research that is conducted in the population or community of interest must be based on theory and must take into account the roles of culture, psychological processes and the corresponding health behavior.

It is becoming increasingly evident that social and behavioral science theories help public health interventions to be more effective (Glanz & Bishop, 2010). Theory gives meaning to facts (Strong, 1991). It offers encouragement to “investigate ‘why,’ ‘what,’ and ‘how’ health problems should be addressed” and to understand behavior. In addition, theory provides a road map and tools for designing and evaluating interventions (National Cancer Institute, 2005).

However, theories developed in one setting (usually the mainstream culture) may fail to capture the complex social and cultural contextual influences over behavior in a minority setting (Pasick et al., 2009). This appears especially true for theories that are based on specific constructs rather than on more abstract, higher-order concepts (Pasick, Burke, & Joseph, 2009). Transcending cultural and social contexts may interact with individual psychological processes and behaviors differently across communities. It is important that a theoretical framework be broad enough and flexible enough to capture
these differences. Clinicians designing interventions for minority populations need to understand and evaluate the theoretical basis of interventions carefully.

**Illustration: Step 1.**

![Diagram illustrating the steps from distal to more proximal determinants of behavior](image)

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**Figure 1.** Betancourt's Model of Culture, Psychology and Behavior as Adapted for the Study of Health Behavior

Betancourt's Integrative Model for the Study of Culture, Psychological Processes and Behavior is an example of a broad theoretical framework that is not construct-specific but rather describes the relationship between levels of constructs such as social factors, cultural factors and psychological processes as related to behavior (Betancourt, Hardin, & Manzi, 1992; Betancourt & Lopez, 1993). The current project will use an
adaptation of Betancourt’s model for the study of health behavior (Betancourt & Flynn, 2009) for its illustrative process of intervention development (Figure 1, page 12).

In this model, health behaviors of patients (Column D), such as their clinic visits and compliance with recommended regular cancer screening, are not directly explained by their population categories (Column A) such as race, ethnicity, gender, SES or religion. Rather, population categories facilitate variations in cultural factors (Column B) such as shared values, beliefs, and expectations related to interaction with healthcare professionals. These cultural factors influence their health behaviors. They also affect patients’ individual psychological processes (Column C), including attribution, motivation and emotions resulting from healthcare interactions. These psychological processes, in turn, also influence the health behaviors.

Individuals may not be aware of the effect of culture on their behavior, directly or through a psychological process. They may simply partake in behaviors that “feel normal” to them. An important job of researchers and clinicians using this model is to methodologically make explicit these implicit pathways, in a lab or in a clinic. Patients can be better served with better-understood antecedents of their behavior.

**Guideline #2: Research needs to utilize culturally appropriate methodological approaches to identify the cultural factors relevant to health behaviors of interest in the corresponding population.**

In designing an intervention based on evidence, clinicians gather knowledge from research studies which are often based on a top-down approach. However, in a top-down approach, experts test the validity of their own preconceived ideas. Such ideas may not
always be relevant for a new population. For example, research by Stewart, Rakowski, & Pasick found that stated intention was a predictor of mammography for Anglo women, consistent with the theory of reasoned action/planned behavior. Stated intention was not a significant predictor in four other ethnicities, however (2009). Effective interventions for a minority population should be based on research focused on native cultural factors specific to the target population and behavior. They should not be based on constructs that are developed from assumptions relevant to the mainstream population.

Alternatively, a bottom-up approach that begins with qualitative research ensures that new factors and insights can be integrated into theory based on a process of observation and hypothesis testing (Betancourt & Lopez, 1993). A qualitative approach recognizes that health behaviors may be influenced by complex contexts that might not be expected by a researcher. This approach benefits populations that have not been studied well in the past and have poor health behavior (Hay & Craddock Lee, 2009). Clinicians should be aware of the possible misalignment between the mainstream ideas and a minority population. Consequently, this awareness should lead them to adopt a careful stance in interacting with minority patients and evaluating available research. More direct, open-ended communication with the population of interest can help researchers and clinicians get a sense of more truly salient cultural factors rather than being limited by transferred expert biases. From this direct insight, new concepts and ideas can be generalized and formulated into a new, more appropriate instrument for these cultural factors.
Illustration: Step 2. In order to illustrate the development of culturally appropriate interventions, research based on the bottom-up approach that has identified cultural factors among Latino and Anglo women related to breast and cervical cancer screening will be used (Betancourt, et al., 2010). In this study, Latino and Anglo women were interviewed with open-ended questions to identify relevant cultural factors. Cultural elements were content coded and their frequency distributions were calculated to identify ethnic-specific (e.g. unique to Latino and/or Anglo culture) and ethnic-general cultural beliefs (e.g. shared by both groups). Then a Spanish/English instrument was developed to assess these cultural factors. The resulting Cultural Cancer Screening Scale (CCSS) was psychometrically validated with Latino and Anglo women. CCSS, as well as other instruments that have been developed based on culturally appropriate methodology, can help clinicians assess their patients. They can also help to guide their culturally informed intervention strategies.

Guideline #3: Within-group differences need to be recognized.

Although a between-group difference informs the need of a targeted intervention, it does not specify how to intervene. Here’s an example of what this means. The fact that “being Latino” is associated with poor screening behaviors compared to Anglos represents a symptomatic status. It does not represent the underlying cultural and individual processes on which we can intervene. Focusing on a between-group difference also carries a seemingly inherent risk of ignoring within-group differences. There is a common misconception of Latinos as a homogeneous cultural group. In reality, there is a great diversity within the Latino community across country of origin, immigration status,
generation status, socioeconomic status, acculturation, and contact with other cultures (Betancourt, et al., 2010; Betancourt & Fuentes, 2001). Age, income, education, and socioeconomic status (SES) can create variations in cultural beliefs and values even within the same ethnicity (Argueta, 2008; Powe, 2001). This is consistent with Betancourt’s model (Figure 1).

In directly assessing patients and evaluating literature, clinicians need to remember that there may be more accurate determinants of behavior than ethnicity. Each patient’s behavior can be attributed to a wide possible range of population categories that may be influencing cultural beliefs and psychological processes. Instruments like CCSS can be helpful in measuring varying individual or group levels of cultural elements and their relationship to subgroup categories. Subsequent targeted or tailored interventions can then be based on more accurate evidence.

**Illustration: Step 3.** In the cancer screening study (Betancourt, et al., 2010), given that the Latino community is vastly heterogeneous, multistate-stratified sampling was used to include various demographic characteristics in the sample. These characteristics included age, education, income, and religion. This inclusion made it possible for factors to be identified that may be more prevalent in some subgroups than in others. It also guarded the study from missing relevant factors of behavior based on an assumption that the target population is homogeneous. Furthermore, more specific determinants of behavior than ethnicity (i.e. social, cultural, and psychological variables) could be considered.
Guideline #4: Interventions could utilize the developed cultural instrument to assess the extent to which the cultural factors are present in a population and test their relationships.

A validated instrument can be used to measure the extent to which the relevant cultural factors are salient in a target population. It can help clinicians further understand the population of interest before designing intervention plans.

Illustration: Step 4. Using the Cultural Cancer Screening Scale (CCSS) with a sample of Latino and Anglo women revealed a number of distinct cultural factors including Negative Cultural Beliefs about Health Professionals (NCB). NCB reflected the extent of their beliefs such as a lack of concern for patients, compassion, and trustworthiness on the part of physicians. Among women who responded to CCSS regarding their negative cervical cancer screening experiences, those who scored higher on NCB also scored higher on controllability (believing that HCPs had control over the negative situation) and intentionality (believing that HCPs were intentional). They also scored higher on anger and poorer continuity of care (COC) (Tucker, 2008).

CCSS was developed for Latino and Anglo women in Southern California. Therefore, clinicians working in similar communities may design an intervention based on the above findings about NCB and poor COC. They may also utilize CCSS to find more relationships between cultural factors and other health behaviors. In other populations, CCSS can be used similarly after validation. New instruments also may be developed and other existing instruments may be used that were developed from a culturally-appropriate methodology. More broadly, by being aware that some patients are
influenced by cultural factors such as NCB, clinicians can enrich patient interactions with more cultural sensitivity.

Guideline #5: Interventions should focus on cultural factors that are relevant to the behavior and psychological processes of interest.

In general, cultural familiarity may improve intervention effectiveness in a target population, patient satisfaction, and interpersonal COC. However, when there is knowledge available on specific cultural factors and psychological processes associated with the target behavior, interventions can be designed with more specific focus on these cultural factors. Interventions can be more efficient or emphasize more direct influence on behavior through a known mechanism in addition to general cultural familiarity.

Illustration: Step 5. Further analysis (Figure 2, page 19) found that NCB predicted poorer continuity of care through an attribution process (Tucker, 2008), consistent with Betancourt’s Model. NCB predicted both intentionality and controllability, both of which predicted anger toward HCPs. Patients’ perception of intentionality on the part of the HCP was the strongest predictor of women’s COC, mediating the effect of NCB. Based on this knowledge, in addition to more general ways of improving cancer-screening COC, more specific interventions can be designed. They can affect 1) the cultural notions of NCB that may be the sources of the attribution and 2) the attribution process of intentionality appraisal.
Because a causal relationship was observed between negative cultural beliefs on healthcare professionals (NCB) and attribution of intentionality, it can be beneficial to address those negative beliefs as sources of the attribution and poor COC. Patient education can be offered to alleviate some of the possible negative beliefs by explaining how the Anglo American healthcare culture may deviate from some Latino expectations. For example, limits in healthcare set by the funding structure may be explained:
In many cases, doctors and other health professionals work within a healthcare system that limits how they can shape their interaction with patients. Some may be employed by hospitals and may have poor control over how many patients they schedule per day and how much time they can spend with each patient. Some doctors may be in contract with third party payers that pay within a range that limit the amount and quality of services provided per visit. As a result, there may be many doctors who would like to spend more time with patients who cannot do so due to such external constraints.

Similar explanation can be provided in other topics including a culture of preventive (rather than curative) treatment, the diversifying trend of medical specialties, and general cultural/linguistic discrepancies. In addition to intervening at the preceding level of cultural factors, the attribution process can be directly addressed. Patient education can be offered to increase their awareness of how attribution may be implicitly influencing their screening behavior:

Some patients believe that health professionals are not compassionate toward patients, in a hurry to move through patients, or look inappropriately during cancer screening. When patients are not satisfied with medical interactions such as in cancer screening, such beliefs can cause patients to think that the negative interaction was caused by the professional’s deliberate intention. Then the patient may feel angry and is less likely to return for more services, which increases the patient’s health risk.
In addition, attribution retraining can be used to encourage patients to examine their natural way of making attributions. The key aspect of this training is to invite patients to consider a hypothetical situation involving a patient who was dissatisfied with an HCP whose intention is left unclear or ambiguous. Reflecting on such a hypothetical situation and reporting their attribution can reveal their style of attribution, and alternate attributions can be suggested. In a more formal training session, a vignette can be presented, followed by questions:

Did you think that the professional had an intention to provide service in a way that the patient would feel unsatisfied? (Some examples would be: “The professional did not like the patient and treated her poorly,” “she deliberately made the patient uncomfortable,” or “the professional decided to do a substandard job with the patient.”). Or did you think that there was no deliberate intention on the part of the professional? (Examples are: “The professional had no idea that the patient was uncomfortable” or “she was probably doing her job in a standard way that she treats everyone.”).

Because controllability is a prerequisite for intentionality (i.e. an HCP can be intentional only if he or she has causal control over the situation), similar exercises can be done on controllability to ultimately influence intentionality:

Did you think that the professional had control over the patient feeling unsatisfied with the service? (Some examples would be: “The professional could have easily
comforted the patient,” “this is something she can change and improve with relative ease,” or “it was within her ability to do a better job.”). Or did you think that she did not have control? (Examples are: “The professional was probably being overworked and has a lot of paperwork between patients,” or “she did not have a control because she really didn’t have a way of knowing how the patient felt.”).

Other aspects of attribution (Weiner, 1985, 2006) can be considered for auxiliary training. These can include the locus of causality (i.e., Was the negative interaction due to HCP’s internal factors or external factors?), stability (i.e., Is healthcare interaction always negative?), and globality (i.e. Do all HCPs cause negative interactions?). The goal of these exercises is not to convince participants that generally HCPs in unpleasant healthcare situations are intentional or have control over the situation. Rather, goals are to encourage participants to study their own reactions, to empower them in their ability to critically assess each situation experienced and to help them consider more possibilities than “the usual one” guided by the cultural context or attributional style.

These interventions can take various forms: pamphlets for mass dispersal, a part of a personalized packet, a community outreach meeting topic for group discussion, or counseling by a health worker. An intervention strategy targeting a population can be based on validated study results that report average salient factors in that population. On the other hand, a more tailored approach can benefit from an administration of instruments for measuring individual pre-intervention levels of cultural, psychological, and behavioral elements. A goal of such an administration of instruments is accurate
identification of intervention needs. In addition to any broad intervention efforts to encourage changes in patients, professionals can ultimately use the knowledge to improve their actual interaction with patients.

Although the current project involves primarily intervening at the level of patients' cultural beliefs and attribution processes, these should be seen not as problematic occurrences but rather as natural human factors. In light of this, HCPs are also under the influence of their own cultural beliefs and psychological processes including attribution (see Figure 1, page 12), which may constitute "the other half" of a clinical misalignment. An intervention will be more therapeutic when HCPs are more aware of the cultural influences and attributional processes of both patients and professionals.

**Guideline #6: Interventions should include ways to evaluate their effectiveness.**

Evaluating the effectiveness of interventions is important for maintaining evidence-based practices. Using resources for these interventions is ultimately justified by observed changes in behavior. In addition, post-intervention assessment should look for appropriate changes in cultural factors and psychological processes related to the behavior.

**Illustration: Step 6.** The instrument can be administered again during or after the intervention. Along with changes in the actual screening behavior or some other positive indicators, the post- or mid-treatment measurement can tell us whether the interventions made the desired changes in cultural factors and attribution processes and whether these changes have led to the desired changes in behavior. This insight can provide appropriate directions for the subsequent steps. On a more micro level, alternate strategies can be
recommended to individuals. On a more macro level, the general intervention material or protocol may be modified or improved. Other possible means of evaluation can include gathering direct patient feedback on various aspects of the intervention and conducting a randomized, controlled experiment.

Guideline #7: Based on the evaluation, appropriate changes can be made to the intervention.

Based on the results of the evaluation, it can be assessed whether the intervention was effective in making changes in the behavior and/or the underlying cultural factors and psychological processes. If goals are not met, alternate or additional approaches can be considered to replace or augment the previous efforts.

Illustration: Step 7. If there has been no desired change in the screening behavior or in other positive indicators of behavior change, an alternate approach may be necessary. Likewise, if there has been no change in attribution processes after the intervention, the design or fidelity of the intervention may need to be revisited. If there has been a significant change in the attribution processes but no indication of a positive behavior change, it is possible that the poor adherence to recommended screening was also a function of additional factors. These factors can include other cultural, human, or system barriers. In such cases, other intervention strategies can be considered. Even if the intervention was not effective in the behavior change, the results of the evaluation can help in identifying or prioritizing focal areas in subsequent intervention strategies.
Chapter 3

Discussion

The intervention approach proposed in this article is aimed specifically at changing attribution processes that may be keeping patients from adhering to regular cancer screening and follow-up recommendations, thereby facilitating a positive change in screening behavior. It is expected that such an approach can complement other cancer screening interventions designed to improve early cancer detection and reduce overall harm caused by cancer. However, the mechanism involves a deeper process of improving interpersonal COC and patient-HCP relationship, benefits of which may extend beyond cancer screening.

It is important to note that the attribution process is not taken as an isolated phenomenon but as a part of a theoretical model that describes behavior through cultural factors and psychological processes. While the role of theory is important in research and intervention, theories used in existing interventions targeting cancer screening disparities have lacked sensitivity to the complexity of social context and the culture underlying behavior (Pasick, Burke, Barker, et al., 2009). Betancourt’s integrative model of culture, psychology, and behavior is an abstract, higher-order theoretical framework that is not limited by constructs that have been developed within a certain cultural group. As such, it allows and requires detection of salient constructs that influence behavior in particular target populations.

Direct observation of the target population is a key element of culturally informed interventions. By being attentive to cultural factors that may vary according to multiple
social categories and influence psychological processes and behavior, clinicians can be more sensitive to within-group differences among a minority population. Appropriate investigation leads to the formulation of measurable cultural factors and instruments. This can be used to find more specific causal factors of behavior. Clinicians may adopt the principles of these guidelines at any phase in order to implement and improve interventions that are based on unbiased salient factors and appropriately measured data.

Using the proposed intervention as an illustrative example, an important goal of this project has been to present a set of guidelines as a framework that describes orderly phases spanning from theory to research, to intervention, and finally to evaluation. Although cancer screening among Latino women has been presented as a specific example, these guidelines can be applied to many other populations and behavioral domains. One such combination of population and behavioral domain would be school dropouts in a regional student population. Adaptation of these guidelines is also not limited by the scope set by the illustrative example. And more creative strategies may be followed, such as interviewing community experts and families in addition to individuals meeting the targeting criteria (Pasick, Burke, Barker, et al., 2009).

It would be very costly to carry out the entire span of the guidelines before developing an intervention strategy for a local clinic. However, each principle component can be independently applied for varying needs and it is hoped that the guidelines and illustrative process would be useful on multiple levels. The proposed intervention approach may be adapted for use with a population with similar cultural beliefs and/or attributional processes that prevent cancer a screening COC. The Cultural Cancer Screening Scale may be used as a preliminary study for a population. Or it may be used
to find causal relationships with other psychological factors and behaviors. In addition, entirely new instruments may be developed using the bottom-up methodology described.

Most importantly, it is emphasized that interventions need to be based on theory but with a humble recognition of the complexity of overlaying cultural contexts that direct psychological processes and behaviors. Ultimately, the guidelines are useful for ensuring that we allow a population to reflect its own salient elements, scientifically study the salience of these elements, and intervene in ways that are theoretically and scientifically sound.
Reference


National Cancer Institute. (2005). *Theory at a glance (NIH Publication No. 05-3896)*.


Appendices
Appendix A
Psychoeducation Material

Cancer Screening and Continuity of Care

Regular cancer screening is crucial in preventing serious health and social costs that result from breast and cervical cancer. One factor that has been found to negatively impact regular cancer screening is negative beliefs held by patients on healthcare professionals, which makes it less likely for patients to return for the next regular screening or follow-up of abnormal findings when they perceive negative interactions with healthcare professionals.

Some patients believe that health professionals are not compassionate for patients, in a hurry to move through patients, or look inappropriately during cancer screening. When patients are not satisfied with medical procedures such as cancer screening, such beliefs can cause patients to think that the negative interaction was caused by the professional’s deliberate intention and feel angry. Then the patient is less likely to return for more services, which increases the patient’s health risk.

While there actually may be cases where health professionals provide services in problematic ways, there also may be times when patients prematurely conclude that the professionals intentionally provided inadequate services. Certainly we encourage all health professionals to remain mindful of the level of patient satisfaction and strive to improve patients’ experience. At the same time, we also would invite you to study your beliefs on health professionals and consider if you have any mismatched beliefs that may be keeping you from receiving optimal preventive care.

First, we want you to consider some of the following points on the current American medical system and see if they match your expectations on office visits.

1. Doctors are often NOT in charge.
   a. In most cases, doctors and other health professionals work within a healthcare system that limit how they can shape their interaction with patients. Some may be employed by hospitals and may have poor control over how many patients they schedule per day and how much time they can spend with each patient. Some doctors may be in contract with third party payers that pay within a range that limit the amount and quality of services provided per visit. As a result, there may be many doctors who would like to spend more time with patients who cannot do so due to such external constraints.
2. Move from curative services to preventive services
   a. With advancements in science and medical technologies, there has been a shift in medical services that also changed the nature of the professional-patient interactions. Historically doctors struggled to help patients get cured and recover from diseases and illness, providing close attention in long term attachment to patients through difficult battles. More recently, however, many of the deadly diseases that required close medical care are prevented with advancements in medical technology and public health policies.
   b. Focus in contemporary American medical service has, in turn, shifted to preventive care, in which patients visit doctor's office more regularly for briefer consultations to prevent illness rather than fighting it after onset. Someone who does not make regular doctor visits or see a doctor only when feeling very sick may be disappointed by lack of attention, while the doctor may be treating a session as the patient's one of many medical sessions.
   c. Patients have also changed, transitioning from passive recipients of services to educated consumers of medical services. They began to view doctors and healthcare professionals as sources of information and consultants rather than decision makers.
3. Generalists vs. specialists
   a. With advancements in the medical science and increasingly more sophisticated procedures for diagnosis and treatment, the medical field is growing to include more specialists who focus on a medical subsystem. In the past it may have been possible and beneficial to see a single compassionate doctor who considered all the patient variables and made his best clinical judgment in prescribing treatment. Currently, however, the medical field is diversifying and advancing at a pace too fast for any single doctor to keep up with. Inevitably, patient care is spread across many professionals who share information and responsibility and medical interaction may seem less personally attached compared to the compassionate doctor in the historical healthcare.
4. Cultural differences between patients and professionals
   a. In American medical culture, the role of an authoritative doctor has become less emphasized as patients began to participate more in the medical decision-making. One benefit of this movement is that patients have more freedom to consider possible outcomes and decide what would be the best choice for them. In conjunction to this movement, healthcare professionals have become less directive and more cooperative. Rather than making decisions and instructing patients, they try to educate patients and let patients make educated decisions.
   b. While dissatisfaction in a healthcare interaction may be based on the actual ill-practice by healthcare professionals, sometimes it can exist in the patients' perception regardless of the professionals' intention. Lacking a common cultural basis may lead to misinterpretation of intention, which is associated with
negative emotions such as anger, which further disconnects the patient-provider relationship and limits their chance of reaching a mutual understanding.

c. Often this results from a language barrier and differences in cultural expectations and customs. For example, *personalismo, confianza, and respeto* are some of traditional Latino characteristics that may lead Latino patients to expect respectful patient roles and personally involving attitude in professionals. When these expectations are not met, patients may believe that the professionals are intentionally uncaring, because in their culture only uncaring professionals behave so distantly. However, the professional may simply be unaware of such expectations.

Did you find that perhaps you have some expectations or beliefs on doctors and medical services that are not well aligned with the medical system we have today? If so, then you have felt confused, disappointed, or angry by some of your office visits. Now we encourage you to consider how you can benefit the most within this environment.
Appendix B

Attribution Retraining Material

How we perceive and understand a situation affect how we feel and act. For example, depending on how we perceive and understand our relational interaction with a dog, we would feel and act differently. Some of us perceive dogs as friendly animals and may feel pleased and smile at the dog. Some of us, however, may recognize dogs as unfriendly animals, feeling uncomfortable and frowning at the dog. Note that such perception is not entirely based on the encounter with the current dog, because we may not yet have had an opportunity to study the dog. Rather, what influences this attribution process is our memory of past experiences with dogs and what we have heard about dogs. Individual and cultural factors influence our perception and attribution.

Similar process exists when we encounter unpleasant situations with healthcare professionals. How we understand our interaction influences how we feel and whether we come back for more services. First, consider the following recollection of Jessica on her visit to a clinic for cancer screening. As you read her story, try to place yourself in her place.

I arrived 10 minutes prior to my scheduled appointment time, but I was not seen by a healthcare professional until 30 minutes past my appointment. She gave me a routine greeting and explanations for the procedure. She was using a professional language that I was not familiar with and did not slow down for me. I felt a bit uncomfortable during the procedure but she didn’t seem to notice. The procedure was relatively quick, and when it was done I wondered why I had to wait 30 minutes for this screening. The professional told me that I will receive a letter with the lab results. I sensed that it was my cue to leave, and I left feeling unclear. Overall I was not satisfied with the visit.

How did you perceive and understand this situation? Take a moment to write down your thoughts on the way the professional provided service to Jessica.

(If in group format, have a discussion and share some responses.)

Now, let’s try to analyze your response along a few dimensions. The purpose of this exercise is to examine your way of understanding a negative healthcare interaction. This process, which might be occurring without your awareness, may have a big impact on your access to healthcare and health risk.

1. Intentionality

Did you think that the professional had an intention to provide service in a way that Jessica would feel unsatisfied? Some examples would be: The professional did not like Jessica and treated her poorly, she deliberately made Jessica uncomfortable, or the professional decided to do a substandard job with Jessica.
Or did you think that the professional had no intention to dissatisfy Jessica? Examples are: *The professional had no idea that Jessica was uncomfortable or she was probably doing her job in a standard way that she treats everyone.*

When we perceive negative interaction with healthcare professionals, how we perceive the *intentionality* of the professionals is important. The more intentional we think the professionals were in that negative interaction, the less likely we are to return for services, which increases our health risk.

2. **Controllability**

Did you think that the professional had control over Jessica feeling unsatisfied with the service? Some examples would be: *The professional could have easily comforted Jessica, this is something she can change and improve with relative ease, or it was within her ability to do a better job.*

Or did you think that she did not have control? Examples are: *The professional was probably being overworked and has a lot of paperwork between patients, or she did not have a control because she really didn't have a way of knowing how Jessica felt.*

Perception of the professional’s control over negative interactions does not affect their decision to return for future service as intentionality. However, it is relevant to consider it because when we perceive that someone has an intention to cause something, we are assuming that he or she has the control to cause it. Inversely, if the professional had no control, then her interaction that caused Jessica’s dissatisfaction could not have been intentional.

3. **Internal vs. External locus of causality**

Did you think that the quality of the service was determined by the professional’s internal factors or external factors? That is, was it influenced more by her thoughts, feelings, or character than some external, situational or contextual factors? Some of previous examples can also be categorized in these terms. Examples of internal attribution are: *The professional is just a lazy worker, she is just too inconsiderate for a clinician, or obviously she wasn’t enjoying her job that day.* Attributing an unsatisfactory service to a professional’s ill intention is an internal attribution.

Examples of external attribution can be: *maybe the clinic is assigning too many cases to the professional, the clinic should reorganize and emphasize patient satisfaction, or it seems like Jessica and the professional’s style weren’t well matched.*

4. **Stability**

When we perceive a negative interaction and try to understand it, we can recognize a source of cause that is stable over time or unstable. Examples of stable attribution would be: *This*
professional has a mean personality and this is how she treats everyone, the healthcare system doesn’t allow doctors to be passionate, or cancer screening is always uncomfortable.

Examples of unstable attribution include: The professional was just very busy that day, she may be having some temporary personal problems that are distracting her from work, or a clinic staff could have called in sick and they were understaffed today.

Some of us may be more naturally inclined to make stable attributions. However, it may be beneficial to explore other explanations before making premature conclusions with stable causes. Such explanations are inherently enduring and may take extra effort to reverse later on, meanwhile creating undue concerns and unnecessary negative feelings. It can be beneficial to consider unstable attributions first and challenge yourself from making stable attributions too soon.

5. Globality

When we determine the cause of a negative experience, the cause can be specific to the immediate context or generalized (global) beyond that particular experience. All doctors are lazy and mean (as opposed to this doctor) is a global attribution, while this doctor is not able to focus on me today is a specific attribution.

Once global attributions are made and shared among a group of people, they can become stable cultural beliefs. While some of these may be accurate, they also affect how we approach new events in new situations and function as inaccurate biases. Such may be the case in new doctor visits. Even though we may have never seen a particular professional in the past, we may still be biased to think in certain ways based on our past experiences and what we’ve heard about doctors and healthcare professionals.

6. Combination

The attribution dimensions discussed so far are not mutually exclusive. This doctor is not able to focus on me today, for example, is an internal, specific, and unstable attribution. The healthcare system doesn’t allow doctors to be passionate is an external, global, and stable attribution.

Did you find that you tend to make certain types of attribution over others? People often get used to making certain types of attributions, where they do so habitually without realizing that there are other ways of taking a perspective. See if you have a bias and if you can re-create an explanation that is not typical to your bias.
Caveat

As you analyze your response to the vignette and how you attributed the Jessica’s dissatisfaction, you should remember that this exercise was intended to encourage you to be more flexible and fluid in your ability to seek explanation. We do not mean to teach you that certain way of thinking is better than another. There may be times when negative attributions are actually accurate when healthcare professionals are now providing high quality services. On the other hand, we encourage you not to jump to such conclusions too quickly.

[Repeat with another vignette. Having only one vignette has the risk of “teaching” the patients rigid points on attribution styles rather than encouraging them to be more fluid.]
Appendix C

Cost-Benefit Analysis I

Are you against receiving cancer screening or other preventive health services because you are unsatisfied with healthcare services caused by seemingly intentional behaviors of healthcare professionals? If so, would it be beneficial to study the advantages and disadvantages of your choice?

Often we are stuck in old beliefs or behaviors and unable to make a change because we don’t fully consider the outcomes. With any choice we make, there are costs and benefits associated with that choice. 1) Below, make a list of costs and benefits for challenging the view that healthcare professionals intentionally provide poor quality service to you.

<table>
<thead>
<tr>
<th>Benefits of challenging the view</th>
<th>Score</th>
<th>Benefits of keeping the view</th>
<th>Score</th>
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</table>

2) For each of the benefits/costs, put a score next to it, 0 being no benefit beneficial at all and 10 being the most beneficial imaginable.

3) Add each column of scores for total benefit scores of receiving PHC and avoiding PHC.
Sample items

Benefits of keeping the view that healthcare professionals intentionally treat you poorly:

- Save time and effort needed to think and change thoughts.
- No need to change behavior – keep things the same.
- You may have others who share the same view with you.
- If you felt angry at them, your view validates the anger.
- If you were really treated poorly, such view helps you stay away from bad services.

Benefits of challenging the view that healthcare professionals intentionally treat you poorly:

- You may be able to develop other thoughts that help you understand the healthcare system.
- You may build a better relationship with healthcare professionals.
- Your thoughts won’t get in the way of you getting the care you need.
- You may feel less angry.
- Improved health and lowered health risk
Appendix D

Cost-Benefit Analysis II

Are you against receiving cancer screening or other preventive health services because you are unsatisfied with healthcare services caused by seemingly intentional behaviors of healthcare professionals? If so, would it be beneficial to study the advantages and disadvantages of your choice?

Often we are stuck in old beliefs or behaviors and unable to make a change because we don’t fully consider the outcomes. With any choice we make, there are costs and benefits associated with that choice. 1) Below, make a list of costs and benefits for not receiving preventive health care (PHC), such as breast/cervical cancer screening.

<table>
<thead>
<tr>
<th>Benefits of receiving PHC Score</th>
<th></th>
<th>Benefits of avoiding PHC</th>
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</table>

2) For each of the benefits/costs, put a score next to it, 0 being no bet beneficial at all and 10 being the most beneficial imaginable.

3) Add each column of scores for total benefit scores of receiving PHC and avoiding PHC.
Sample Items

Benefits of avoiding preventive healthcare, such as breast/cervical cancer screening

- Avoiding uncomfortable office visits.
- Saves time, effort, and cost right now.
- Reduces anticipatory anxiety.
- Don’t have to learn or study unfamiliar medical concepts.

Benefits of receiving preventive healthcare, such as breast/cervical cancer screening

- Lowers serious health risks and improves overall health.
- Early detection saves the potential cost of care for later stage diseases.
- Prevents emotional pain for self, family and friends.
- Making better use of the current healthcare system and resources.
- Developing better relationship with healthcare professionals.
- Building safer habits and health practices.