A LITERATURE REVIEW OF HISPANIC WOMEN WITH DEPRESSION AND PROVIDER/PATIENT COMMUNICATION ISSUES THAT IMPACT THE THERAPEUTIC RELATIONSHIP

by

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A Masters Report Submitted to the Faculty of the COLLEGE OF NURSING

In Partial Fulfillment of the Requirements for the Degree of

MASTER OF SCIENCE

WITH A MAJOR IN NURSING

In the Graduate College

University of Arizona

2005
STATEMENT BY AUTHOR

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Abstract

This literature review is a qualitative examination of the therapeutic communication between depressed Hispanic women and their Health care providers. Literature is sought that examines the outcomes of the clinic visit for depressed Hispanic women. Understanding the relationship between ethnicity, communication, cultural competency and guideline concordant diagnosis and treatment of depression is the purpose of this literature review. Five studies were found that address this specific concern. Studies chosen for review address the issue of diagnosis of depression and medication management and adherence as observed after a visit in a primary care setting. Review of these studies explores the body of evidence that the problem of disparity in care of the depressed Hispanic female does occur; however, there is little information about cause of communication mismatch and its relevance to cultural competence.
Chapter One

The purpose of this project is to review literature pertaining to the communication between healthcare providers (HCPs) and depressed Hispanic women. This project seeks to identify the degree to which the literature reports on culturally competent communication with this population and outcomes in treatment. Anecdotal observations by this author have been adapted into a scenario that is the catalyst for exploration of mental healthcare provision for Hispanic women with depression. In researching Hispanic women with depression, the subject of disparity in care arises. Hispanics, women, and depression care are all subject to disparity. Researching disparity leads to the awareness of bias in healthcare and its part in disparity. Is the therapeutic communication impacted by bias? The author seeks to understand the nature of communication problems as they relate to disparity. Cultural competency theory is reviewed as a tool to improving communication and studies are reviewed within a frame of cultural competency.
Introduction

This chapter will discuss disparity in the health care of Hispanic women who have depression. A scenario depicting communication related to the diagnosis and management of depression in Hispanic women will be given. A discussion of the scenario will lead to the topic of health care disparity in the provision of evidence based diagnostic and disease management of depression care in Hispanic women in the United States. Relevance of the topic will be justified by describing the scope of the problem of health care disparity for Hispanics, depression in the United States and specifically in the diagnosis and treatment of depression in Hispanic women. Causes of disparate health care when described in the literature will be reported.

Definitions

Definitions of terms that will commonly be used in this review will serve as a guide to understanding.

Hispanic refers to those persons whose ancestors are from any country where Spanish is the primary language. Hispanic participants in the US census could declare themselves Hispanic of Mexican, Puerto Rican, Cuban, or other origin. Other includes those persons whose origins or
ancestors are from Central America, South America, Spain, or the Dominican Republic. This is a broad definition which allows for many cultural differences within the Hispanic group. Studies that informed about Hispanics of Mexican origin were sought for this literature review.

Disparity in health care is defined as a difference in treatment provided to members of different racial or ethnic groups not justified by the underlying health conditions or preferences about treatment of the patient.

Depression is defined loosely for the purpose of this study. Meeting the DSM-IV criteria for Major Depressive Disorder (MDD) is included; however studies also used tools such as the CES-D to measure depressive symptoms which may include dysthymia and emotional distress. Each study set their own criteria for the labeling of sample participants as having a high probability of depressive disorder based on the tools they employed to measure depressive mood.

Cultural competency has been defined in many ways. For the purposes of this literature review we will look at cultural competency in health care as the ability of systems (HCPs included) to provide care to patients of diverse values beliefs and behaviors, including tailoring
delivery to meet patient’s social, cultural and linguistic needs (Betancourt, Green and Carillo, 2002. p2).

Bias is defined in The American Heritage Dictionary as preference or inclination that inhibits impartial judgment: prejudice. For the purpose of this report, Snowden (2003) discusses an enlarged definition of bias that notes two types of distortion. Overpathologizing bias may occur when an HCP is unfamiliar with certain behaviors of an ethnic group and interprets the behavior as manifestation of mental illness. Minimization bias occurs when HCP’s ignore genuine manifestations of mental illness.

Ethnicity refers to a common heritage shared by a particular group. It includes similar language, rituals and preferences for music and foods. Persons of same ethnicity are often linked by race, nationality and language.

Clinic scenario

M.G. sits hunched over in the hard chair in the sterile exam room. The briskly efficient primary care provider (PCP) enters the room with her student. She sees a 38 year old Mexican-American female with a complaint of a headache. The woman’s shoulders are slumped forward and her arms are folded across her chest; she appears worn and tired. The
PCP’s initial questions explore the patient complaint. ‘Si’, her headache has been off and on for the last two weeks, her neck is stiff, she can’t seem to sleep at night and she is feeling very bad, very tired and very nervous. Health history and physical exam reveal no red flags for physical problems. The PCP asks about stress; the patient eyes well up with tears. She has been missing some work with these headaches and she is the sole provider for her three children. Finances are tight and her son has been rebellious lately. Her parents and siblings are in Mexico and she feels terribly alone with her burdens. The PCP offers the patient a tissue; a sympathetic touch. She then suggests medication for the headache and some sleeping pills on a short term basis. The patient is grateful for the sympathy and the medications; they will provide an immediate alleviation of her symptoms. Lab work is ordered which will require the patient to travel to the main clinic five miles away. The PCP then suggests that perhaps the patient would like to be referred to the mental health clinic for further support. The patient reports that her car is unreliable and she has already missed too much work. The provider rises and clutches the door knob; she fervently urges the patient to try and make the time to be
seen at the mental health clinic. The provider also instructs the patient to return in two weeks if the headache is not improved. This appointment is over. The allotted time has passed and other patients are waiting. After the provider leaves the room she turns to the student and notes with a sigh, “You’ll have to deal with lots of tears from some of these women.” They move on, the next patient is waiting.

Discussion of Scenario

The above situation is a composite rendering representative of several experiences seen by this nurse practitioner student. When the patient cried and discussed her life stressors and her inability to sleep, her fatigue, nervousness and her multiple vague symptoms, it would seem appropriate to screen for MDD and dysthymia. In this scenario, the HCP failed to investigate an apparent case of clinical depression. Her demeanor is one of efficiency and she takes time to consider possible physical options and mentions mental health care in passing but seems reluctant to investigate the possibility of depression in a deeper and more meaningful way. She seemed disapproving of the patient’s tears and impatient about her reasons for not seeking assistance at the mental health clinic. Both
provider and patient seem relieved that the provider can prescribe something for headache. The provider’s comments to the student seem to indicate bias on the part of the health care provider. The idea of bias in therapeutic encounters aroused the curiosity of the author to explore the nature of culturally mismatched communication in a therapeutic setting when dealing with Hispanic women presenting with symptoms of depression. The scenario may be representative of circumstances that might typically be found in geographical areas where high concentrations of Hispanics reside. In this particular scenario, the Mexican woman received her care at a clinic setting devoted to care of marginalized members of the community; her PCP is a white non Hispanic white Nurse Practitioner grounded in nursing theory and philosophy. The provider has chosen this practice setting and has become medically conversant in Spanish because she is committed to the population that frequents this clinic.

Despite the aforementioned favorable attributes, the therapeutic intervention does not approach standard of care. The somatic complaints and the patient affect indicate the possibility of depression; the provider alludes to the patient’s distress and a possible need for
some form of mental health intervention but the interaction that occurs does not approach standard of care for diagnosis of depression (Ferrini, R. and Clark, B., 2003; allpsych.com, 2005). There is no screening tool used to ascertain if the patient meets the criteria for depression and no probative questioning to follow the thought of the existence of depression. Relevant issues that impact the patient’s life stress and her ability to comply with a provider’s suggestions seem beyond the scope of a 20 minute office visit. The physical complaint has been addressed and serious physical illness has been ruled out.

The personal experience of the author, as well as the author’s discussion with fellow students and healthcare providers, indicate the above scenario is not atypical in health care settings and may be quite common. Numerous reports document the existence of health disparities that negatively impact minorities (Agency for Healthcare Quality (AHRQ, 2004; AHRQ, 2005; Institute Of Medicine March, 2002; The Kaiser Family Foundation, 2005; Leigh & Jimenez, 2002). Race and ethnicity have been examined to determine the significance of the problem of disparity in a cultural context.
Scope of the Problem

Disparity in Health Care.

In 1998 President Clinton launched The National Disparities Initiative. With the advent of this initiative the problem of disparities in health care became a focal point in the Healthy People 2010 campaign. The inclusion of disparities as a targeted health problem created a sense of urgent need to delineate the extent of disparities and suggest avenues for improvement within the health care system (McDonough et al., 2004; Healthy People 2010, 2000). The Kaiser Women’s Health Survey (2004) reported ethnic disparities related to quality of health care, access to health care and differences in health status. In 2002 the Institute of Medicine, with support from the DHHS Office of Minority Health published the report Unequal Treatment: Understanding Racial and Ethnic Disparities in Health Care. (Institute Of Medicine, 2002) This report was undertaken to assess the extent of racial and ethnic disparity in healthcare. Extensive review of the scientific literature provided information about health care outcomes for minority groups. Barriers to care were assessed. Financial barriers, transportation barriers, and language barriers were identified as access problems within our health care
system. These were expected findings. However the report caused controversy and increased dialogue within the healthcare and minority communities when it reported that “Although myriad sources contribute to these disparities, some evidence suggests that bias, prejudice and stereotyping on the part of the healthcare providers may contribute to differences in care” (Institute Of Medicine, 2002, health care provider section,¶ 2))

Hispanics.

Findings of the United States 2000 census indicate that Hispanics, with a population of 35 million people, are the fastest growing minority within the United States (United States Census Bureau, 2001). In the Latina’s Bible, Guzman (2002) states that the Hispanic population increased by 12.9 million people between 1990 and 2000, which is a 58% growth rate. She further notes that it is projected that the Hispanic population will nearly triple by the year 2050.

The United States 2000 Census provides information about the Hispanic subgroup populations. Fifty eight percent of Hispanics are of Mexican descent. Other groups who are identified by the Census Bureau as Hispanic are Cubans and Puerto Ricans. A section called “other ancestry”
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includes people from other Spanish speaking nations such as Central America, South America, The Dominican Republic and Spain. (Figure 1)

Hispanics account for 23 percent of people who live in western states. In the southwest the largest sub-group of Hispanics is of Mexican descent (55%). In Arizona the official population of Hispanics is 1,295,617, which is 25.3 percent of the total Arizona population. Of the total number of Hispanics in Arizona 1,065,578 or 84% are of Mexican descent.

Figure 1. Representation of Hispanic groups by percentage within the United States
Within the Hispanic groups living in the United States 14 million are women. Currently that is 11 percent of the total US population; by the year 2050 nearly one in four women in the US will be of Hispanic descent (The National Women's Health Information Center, 2003). Hispanic women suffer disproportionately from economic and health care disparities. In 1999 a quarter of a million Hispanic women had incomes below the poverty level and often were head of household. While non Hispanic women who were head of household in homes with income below the poverty level equaled 26%, the corresponding percentage of Hispanic women who were head of household below poverty level was 38%. Hispanic women who are employed tend to have low pay, low status jobs. Often the employers of Hispanic women do not provide insurance benefits and thus Hispanic women are less likely to have insurance than any other group of women. They are often found working in labor intensive or dangerous jobs (Leigh & Jimenez, 2002).

Besides evidence of disparity in financial situations, there is also evidence of disparity in health and healthcare practices among Hispanic women. The AHRQ fact sheet published in February 2000 notes that follow up screening for abnormal mammograms takes twice as long for
Hispanics and other minority women than for white women (AHRQ, 2000). Additionally, in a report from the Kaiser foundation in their 2001 Kaiser Women’s Health Survey, twenty-nine percent of Latina women assess their health status as fair to poor; Hispanic women have a higher rate of diabetes and diabetic complications when compared to white women; and over one half of Hispanic women do not have dental coverage or vision coverage (Kaiser Foundation, 2004). Numerous reports can be found delineating further evidence of disparities for Hispanic women (Office of Women's Health, 2005; Guzman, 2002; Kaiser Foundation, 2004; Leigh & Jimenez, 2002).

Among Hispanics, thirty percent lack a usual source of health care (Phillips, Mayer, & Aday, 2000; Weinick, 2000; Center for Disease Control, 2004). Usual source of health care is defined as one primary care provider that sees his patients on a regular basis and is thus better able to provide historically knowledgeable and consistent care. Hispanics are the largest group of uninsured and they report more difficulty in obtaining care as well as going without care due to lack of financial resources. (Lewis-Fernandez, Das, Alfonso, Weiss, & Olfson, 2005). Weinick (2000) notes, “Hispanics also report that their
providers failed to listen to them and provide them with needed information.” Phillips et al. (2000), note that even when admitted to the hospital for the same condition, Hispanic Americans were often significantly less likely to receive major therapeutic procedures than white Americans.

Acculturation of Hispanic women into the majority culture might be considered desirable. Economic stability is used to measure acculturation. Hispanic women who are better acculturated generally have better paying jobs, are more conversant in the English language and have higher level of education. However, while some aspects of healthcare may improve in the process, there also appear to be drawbacks for Hispanic women as they become more acculturated. Acculturation leads to decline in health in some areas. Acculturated Hispanic females tend to drink and smoke more than non acculturated Hispanic females. They are also more prone to a number of illnesses. Among acculturate Hispanic females the rates of low birth rate, cancer, cardiac disease, hypertension and depression increase. (National Alliance For Hispanic Health, 2001; Lewis-Fernandez, Das, Alfonso, Weissman, and Olfson, 2005).
Depression.

Listed as one of the twenty-eight objectives for improvement by Healthy People 2010, mental health issues provide enormous challenge. Major Depressive Disorder is the most common problem in primary care and yet it remains under diagnosed and under treated (Solnek & Seiter, 2002). PCPs see approximately seventy-five percent of patients who present with depression. Hispanics are twice as likely to seek mental health intervention from PCPs as from mental health providers (Lewis-Fernandez, Das, Alfonso, & Weiss, 2005). Despite the prevalence of this problem in primary care, the PCP fails to recognize up to fifty percent of depression cases (Solnek et al., 2002; Williams et al. 1999; Preboth, 2000). Depression impacts functional and economic status of those so afflicted. People with depression generally are not able to operate at their normal physical levels of function. The World Health Organization has concluded that major depression is the leading cause of disability in the world (Preboth, 2000). The financial burden of depression is staggering. The estimated cost in the United States is 43 billion dollars per year; 30 percent from direct medical care and the remainder from premature death and impaired productivity in
the work place (Preboth, 2000). It is estimated that depression contributes to “50-100 percent higher medical costs in medical patients in all facets of medical care, including emergency room visits, primary care visits, prescriptions, laboratory tests, hospital days and mental health visits” (Bachman, Pincus, & Unutzer, 2004, introductory remarks, ¶ 1).

Recognition of depression when physical symptoms are presented often complicates the diagnosis of depression. Symptoms of fatigue, sleep disturbance and appetite disturbances have been correlated with depression; however pain is not listed as a possible physical symptom in DSM-IV (Physicians Postgraduate Press, 2004). In a teleconference on physical symptoms of depression, Dr. Maurice Ohayon reported on study results that link pain with MDD. Some of the study findings of significance were that patients who reported even one depressive symptom had a higher rate of report of physical pain symptoms. And more painful symptoms correlated with higher depressive symptoms.

Of the subjects who participated in the interview, 4% had a diagnosis of MDD. At least 1 chronic painful physical condition was mentioned by 43.4% of these subjects. Subjects with MDD were 5 times more likely
to report backache, 4 times more likely to report headache, 3 times more likely to report limb pain, 2 times more likely to report gastrointestinal problems or joint/articular diseases that the rest of the sample (Physicians Postgraduate Press, 2004).

Beyond these obstacles to making a depression diagnosis and providing depression care, is the stigma surrounding the diagnosis of depression. Many people believe that depression is not an illness but a problem of mood which therefore can be cured with time and with support from family and friends. Lozano-Vranich (2003) notes that Hispanics seeking help for emotional issues are often considered crazy and that this designation of “loco” can be one of the worst fates possible. She further notes that in a cultural context, emotional weakness and problems related to the mind are often considered taboo for discussion outside the family. Often primary care physicians are uncomfortable making the diagnosis of depression and initiating medication or a course of therapy. One study found that even when patients hinted at symptoms physicians did not initiate a conversation about depression and if there was discussion of depression it was minimal (Sleath & Rubin, 2002). In the office setting where time allotments
to see patients are generally 15 minutes increments, a discussion of depressive symptoms was found to take an average time of 22 minutes (Sleath & Rubin, 2002).

Many factors then conspire to confound the depression of diagnosis in all groups of people. In situations where cultural factors may further hinder communication on a difficult subject, it seems that disparity may be increased.

*Depression among Hispanics.*

Hispanic students report suicide attempts at a rate of 12.6 percent compared to 6.7 percent of white students and among Hispanic students female report rate is 18.9% compared to 6.6 percent in males (United States Department of Health And Human Services, 2003; National Youth Violence Prevention Resource Center, 2005). Among adults, Hispanic women have a lower incidence of depression than white women. Acculturation increases the incidence of depression in Hispanic women so that rates between white and Hispanic women are similar. However, as Hispanic women are less likely to seek treatment for depression (Heilemann, 2005), and less likely to receive adequate care when treatment is sought (Sleath & Rubin, 2002), their burden of depression is greater than that of non-Hispanic whites. *The Women of*
Color Data Book notes that Hispanic women were more likely to suffer moderate to severe depression than either non-Hispanic blacks or whites and that Hispanic women were most likely to report that they were currently psychologically distressed (Leigh & Jimenez).

Importance of the Problem

Beyond the problems of access and financial constraints, is the troubling notion that bias in health care is a major contributor to disparity. In attempting to understand the nature of bias several articles were reviewed. The American Psychologist, in November 2004, printed a copy of a speech made by Derald Sue at an annual APA convention in 2004. The discourse on bias was highly illuminating. Dr. Sue’s introductory remarks begin,

Whiteness and ethnocentric monoculturalism are powerful and entrenched determinants of worldview. Because they are invisible and operate outside the level of conscious awareness, they can be detrimental to people of color, women, and other marginalized groups in society. Both define a reality that gives advantages to White Euro American males while disadvantaging others. Although most Americans believe in equality and fairness, the inability to
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deconstruct these 2 concepts allows society to continue unjust actions and arrangements toward minority groups. Making the “invisible” visible is a major challenge to liberating individuals and society from the continued oppression of others (Sue 2004 address, reprinted in American Psychologist, 2004, p.761).

In his speech Sue (2004) continues to hammer away at the status quo way of thinking. He notes that attempting to produce a color blind society, while possibly good intentioned is quite dangerous. He states that color blindness is a denial of differences, which is really a denial of the unfair power imbalance that exists in society. He further notes, “color blindness allows Whites to deny the experiential reality of minorities by minimizing the effects of racism and discrimination in their day-to-day lives” (Sue 2004 address reprinted in American Psychologist, p.763).

Sue’s address implies that the majority white culture chooses to ignore their culpability in the design of racism and bias. He challenges the profession of psychology to become aware of their ethnocentric reality. Although his speech was directed to the American Psychological
Association members, it cuts across all areas of health care. In his conclusion he states:

A psychology that does not recognize and practice diversity is a psychology that is truly bankrupt in understanding the totality of the human condition. It will forever perpetuate a false reality that provides advantages for certain groups while disadvantaging and oppressing others. As long as the invisible is not visible, the profession of psychology may continue to operate from monocultural theories and practices that deny the rights and privileges due to all individuals and groups (Sue, 2004 reprinted in American Psychologist, 2004 p.768).

Summary

This chapter explored health care disparities. The scenario presented may typify subtle communication flaws that contribute to disparities. Hispanics are at higher risk for disparate health care in many areas, including mental health care. The scope of the problem was outlined in this chapter with examinations of Hispanics, and disparities for Hispanics, specifically women, in health care. This chapter reviewed the subject of depression as related to disparate healthcare for Hispanic women. In
review of the nature of disparity, the Surgeon General report asserted the influence and contribution of bias as it relates to disparate health care. Ethnic disparity of Hispanics is reviewed in this chapter as is the problems of depression in general and in the specific context of Hispanic women. Also reviewed is the inherent nature of bias in the health care system.
Chapter 2
Theoretical Models

Introduction

This chapter explored theoretical models of cultural diversity and cultural competence from Leininger, Campinha Bacote, Purnell and Warren. A theoretical model allows us to use interrelated concepts in a systematic way. Its purpose is in explaining and making predictions about certain phenomena. This author posits that cultural competency on the part of the HCP could improve outcomes of care by improving communication.

“Cultural competence in health care describes the ability of systems to provide care to patients with diverse values, beliefs, and behaviors including tailoring delivery to meet patients social, cultural and linguistic needs” (Betancourt, Green, & Carillo, 2002).

Warren’s model of the Interlocking Paradigm was chosen as a framework for exploring the issue of cultural competence in provider-patient communication.

Leininger

In the early 1960’s, Leininger introduced the concept of cultural competence. In 1978 she published Transcultural Nursing: Concepts, Theories, Research and Practice. She
felt that nursing lacked in-depth knowledge about different cultures and a value of caring. “Care was not fully known and valued in nursing” and “the medical mind-body treatments and symptoms held nurses’ interests and practice” (Leininger, 2002). Leininger’s Sunrise Model was designed to explicate cultural care meanings and practices. She is a leader and innovator in the area of cultural competence and her work has raised the awareness within the profession of nursing about culturally competent care. Leininger’s model is highly complex. The level of complexity is unsuitable for comparing to the literature to be reviewed in Chapter 4.

Purnell

During the 1990’s both Campinha-Bacote and Purnell built on the Leininger model. The Purnell Model for Cultural Competence is applicable to all health care providers. Dr. Purnell established the idea of biocultural ecology which “includes variations in specific ethnic and racial origins such as skin coloration and physical differences in body stature; genetic, hereditary, endemic, and topographical diseases; and the difference in the way drugs are metabolized by the body” (Purnell, 2000). The model is logical and complete with good generality. It
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displays consilience. Consilience as defined by Wilson, is linking of knowledge across disciplines to develop a common explanation. Consilience envisions a weaving together of science and humanities to develop a deeper understanding of human welfare (Glittenberg, 2004). Purnell defends his model’s lack of simplicity by noting the complexity of the subject matter (Purnell, 2000). The Purnell model has many fine characteristics. It is complete and directed towards a wide variety of HCPs. The idea of biocultural ecology has been shown to have merit in application of medications. One example of this is hypertension in African Americans and poorer response rates to medication. This model however did not emphasize caring as a primary factor in the model and the author will be looking for caring as a necessary component to cultural competency.

Campinha-Bacote

Dr. Campinha-Bacote’s model views cultural competence as “an ongoing process in which the health care provider continuously strives to achieve the ability to effectively work with the cultural context of the client” (Campinha-Bacote, 2002, p. 181). The model requires health care providers to see themselves as becoming culturally competent and not already being culturally competent. In
the development of her ASKED model, she adds the need for cultural desire to the constructs of cultural awareness, cultural skills, cultural knowledge, and cultural encounters. Her model states that without a genuine desire on the part of the health care provider to be open and flexible, to adopt an attitude of cultural humility, cultural competence is not possible. Her model depicts the interrelatedness of the constructs, is simple to understand, and can be adopted for HCPs in all areas of practice. She further developed a tool to measure cultural competence in health care providers. The Inventory for Assessing the Process of Cultural Competence (IAPCC) is a twenty item instrument and is used to measure the competency of providers in all constructs except cultural desire. This tool could be utilized in a study to measure self perception of cultural competency in a provider sampling. This model provides ideas of continuous process and her ASKED model adds the construct of desire. The question on which this study is built is the question of why HCPs are not providing competent care for Hispanic women with depression. One of the areas of inquiry that will be sought in the literature is attitude of HCP’s about the provision of culturally competent care. A model that
explicates caring through the term desire would be advantageous. However, her method did not seem to as thoroughly contain a thorough domain of attributes such as those developed by Purnell.

Interlocking Paradigm of Cultural Competence

The Interlocking Paradigm of Cultural Competence (IPCC) draws on the strengths of each of the theorists reviewed above. It was developed by Barbara Warren in 1999 and refined over the next three years as a model of cultural competency that could be utilized in psychiatric nursing and will allow exploration of the literature about cultural competency issues that impact therapeutic communication for depressed Hispanic women.

Warren (2002) defines culture as the psychological, physiological and spiritual expression of an individual, group or community’s beliefs, values and norms. She draws on qualitative knowledge from several sources (Lutz & Warren, 2001; Meleis, Isenberg, Koerner, Lacey & Stern, 1995; Purnell & Paulanka, 1998; Spector, 2000) in defining cultural competence as a circular process that flows from nurses respect and understanding of the importance of culture in persons’ lives; the importance of the use of culturally specific knowledge, and approaches of culturally
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competent therapeutic interactions that are grounded in client needs. Her article notes that this model answers the need for a best practice full service approach. A full service approach is defined as a holistic approach that is inclusive and meets the psychological, physical, and spiritual needs of PMH clients (Bedell, Cohen & Sullivan, 2000). It is said to increase client adherence, quality and satisfaction of life, everyday functioning and appropriate use of community services as well as reduce hospital use, recidivism and symptoms (Bedell et al., 2000; Herrera, Lawson, McClellan & Sramek, 1999). Figure 2 below is the model as developed by Warren (2002). This depiction of the model was published in her article and is recreated here to provide a visual guide for further examination of the Interlocking Paradigm.
Figure 2. The Interlocking Paradigm of Cultural Competency (Warren, 2002).

Therapeutic Factor.

The pivotal focus of the paradigm is the Therapeutic Factor. It is grounded in Peplau’s theory about interpersonal relationships. As cited by Warren, Peplau (1988) states the nurse’s ability to interact and relate to the client is key to the nurse’s development and achievement of successful psychiatric-mental health interventions and strategies. Peplau further states there is no cultural competence without good therapeutic communication. Warren has placed this idea as central in her model. She believes that all therapeutic relationships are grounded in an ability to relate to the client.
Value Factor.

The Value Factor is derived from Leininger. Her theoretical perspective is that all nurses need to value and incorporate cultural knowledge into their personal nursing milieu.

World View Factor.

Another factor in the IPCC is the World View Factor. Warren cites Nichols (1987) who contends that persons from diverse racial and ethnic groups have different world views to exist and function within their lives. Warren reframes this to allow for blended world views that may occur for individuals as they are exposed to other’s world views. She uses descriptors such as relational, analytic, transcendence and ecological, to provide some sense of different world views. Relational is used to mean that value is placed on relationships and community service. The word analytic is used to describe a world view that values individualism and status. A transcendent world view indicates that value is placed on elevation of the spiritual self and community needs. The last descriptor is ecological; value is placed on one’s interaction with the earth maintaining its integrity. Racial groups may be thought to be described by these words; however Warren
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contends that world views may be blurred from group to group by the process of enculturation in a blended world. It is stressed that world views of others need to be respected and valued in order to engage successfully in the therapeutic factor.

*Process Factor.*

Another factor in the IPCC is the Process Factor. This is adapted from Campinha-Bacote’s cultural competence model. As mentioned previously, Campinha-Bacote develops the acronym ASKED to outline her constructs for cultural competency. Her original work of adding Desire to Awareness, Skills, Knowledge and Encounter (ASKED) allows us to more thoroughly examine the question of communication problems between provider and patient.

Warren acknowledges that the development of cultural awareness, skill, knowledge, encounters and desire are necessary for excellent cultural competence. The IPCC uses the same definitions for the aforementioned constructs as does Campinha Bacote. Warren agrees with Campinha-Bacote’s idea that cultural competence is a process as opposed to a concept. In the IPCC model the process is circular and fluid and involves constant learning on the part of the health care provider as they establish relationships and
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interact with clients. The process depends on the interaction between two people, therefore the patient becomes part of this model of fluidity and constant learning.

The Orientation Factor.

The Orientation Factor evolves from Purnell’s model as explicated in his article, *A Description of the Purnell Model for Cultural Competency* (Purnell, 2001). Purnell has delineated twelve domains that healthcare workers need to use to obtain a complete client assessment. The domains are heritage, communication, family roles, workforce issues, biocultural ecology, high risk behaviors, nutrition, pregnancy practices, death rituals, spirituality, health care practices and health care practitioners (Purnell & Paulanka, 1998). Although Warren contends that these domains are best assessed by psychiatric mental health nurses, an argument can be made that they are the basis of a complete history and physical and can best be examined by a primary care provider who has continuity, sometimes over years of the lifespan, with her clients (Sleath & Rubin, 2002). Warren further borrows from Purnell’s descriptions of clinician competence levels. Purnell sees these levels as ranging from unconscious incompetence to unconscious
competence and Warren calls for assessment reviews for each practitioner about their own levels of culture competence. This awareness is also outlined in the ASKED model of Campinha-Bacote and can be tied to the address by Sue mentioned in Chapter one (Sue, 2004). Warren further proposes that the twelve domains outlined in the Purnell theory can be used as an assessment tool when peer review is done.

Warren notes that a provider may have an enculturated negative view about some characteristic of a client he is caring for. She states that under these circumstances the provider may exhibit a condescending or disrespectful attitude toward this particular client. Without respect there will generally not be good therapeutic communication. The outcome might be that the client feels a sense of non-acceptance and may be less likely to follow a treatment plan. The client will then be labeled as noncompliant and the vicious cycle of disrespect and discontent will permeate the therapeutic relationship (Warren, 2002).

Warren (2002) states, “The IPCC is a paradigm that acknowledges and incorporates therapeutic interaction and the interconnectedness of the psychological, physical, cultural, and spiritual aspects of care within the PMH
client and nurse.” For the purpose of this study the IPCC is used as a framework of cultural competency for all HCPs and their clients.

ASKED Process as a Tool

Warren’s use of Campinha-Bacote’s ASKED model is applied as a tool in screening the literature. The constructs are further defined:

A is for awareness which is the self examination and in-depth exploration of one’s own cultural and professional background. It involves recognition of one’s biases, prejudices and assumptions about individuals who are different. Without being aware of our own values, cultural imposition may occur.

S is for skill which is learning how to conduct a history and physical that accounts for cultural differences. One must be adept at explaining an issue from another’s perspective reducing resistance and defensiveness and acknowledging interactive mistakes that hinder the desire to communicate.

K is for knowledge which is the process of seeking and obtaining a sound educational foundation about diverse culture and ethnic groups. The knowledge base requires integration of three issues by the health care provider.
These are health related beliefs and cultural values, disease incidence and prevalence, and treatment efficacy.

E is for encounter which is meeting and working with clients from culturally diverse backgrounds in large enough groups to truly be conversant with the group culture. This will help refine or modify the HCPs’ existing beliefs about cultural groups and may reduce stereotyping. Cultural encounters involve assessment of the linguistic needs of the client and proper use of translators.

D is for desire which is motivation of the healthcare provider to want to, rather than have to, engage in the process of becoming culturally aware, knowledgeable, and skilled in encounters. This involves the concept of caring. It also involves respecting other values and beliefs and requires a genuine desire be open and flexible with others and to be willing to learn from others as cultural informants. This is a lifelong process and has been termed “cultural humility”.

Summary

This chapter explored the development of the IPCC theory. Mention was made of Peplau, Leininger, Nichols, Campinha-Bacote, and Purnell, whose works influence and contribute to the IPCC model. Particular attention was paid
to the process factor of Warren’s theoretical model which utilizes Campinha-Bacote’s ASKED constructs model and will be used to screen studies in this literature review.
Introduction

This chapter will outline the methodology utilized to search for research reports related to depression care and provider communication for Hispanic women. Data bases will be identified. Key words will be delineated as well as modifier words which were used to expand the search. Inclusion and exclusion criteria will be presented. The number of studies that were examined for further inclusion will be tallied.

Data Bases

Medline, Cinahl, and PsychInfo are the data bases that were utilized for this report. Suitable appearing historical references, e.g. citations mentioned in journal articles, were also included. Citations from articles that were mentioned in these data bases were also examined.

Key Words

Key words used were Hispanic, depression, patient-provider relationship, patient perception, provider perception, communication, cultural competency and bias. Initial searches done utilizing the key words together yielded one study. In order to increase the chances of
obtaining acceptable studies, key word combinations were then tried using only two key words in different combinations; Mexican American was changed to Hispanic/Mexican American, and gender was not utilized except to exclude studies of men only.

Inclusion Criteria

Inclusion criteria were broad. Abstracts and titles promising articles on Mexican American or Hispanic women, depression in adults, and provider/patient relationship were examined. With key words and inclusion criteria searches yielded 488 studies to examine against the exclusion criteria.

Exclusion Criteria

Articles were excluded from this report if they were about children, adolescents, postpartum, elderly over 65, physical health problems, physical health problems with depression components, other mental health problems such as schizophrenia or bipolar disorder, sexual orientation, African Americans, Asians, study groups who were predominantly any other Hispanic group besides Mexican American and men. If the study was directed toward men exclusively or predominantly, it was excluded. However if the study stated Mexican American or Hispanic without
identifying the gender it was considered for inclusion. Studies had to be in English and published between 2000 and August 2005. Applying the exclusion criteria to titles and abstracts narrowed the selection to 70 trials or articles. These were selected for final analysis. A table listing these studies is provided at the end of this chapter.

Process of Final Analysis

Analysis of the aforementioned material included reexamination of the studies against the original inclusion criteria. Subject matter in the 70 articles proved quite broad. It was difficult to find appropriate studies that included Hispanic women only, so studies that included men but were predominantly women were accepted. Obtaining studies that specifically narrowed to Hispanics of Mexican descent also proved difficult. While Hispanic females of Mexican descent remained a preference, studies that noted Hispanic females were included. Final criteria for choosing studies for this literature review included Hispanic women, preferably of Mexican descent, who manifested signs of depression and were involved in some form of communication with their providers and that communication was observed and described in the studies. The studies were also examined for number of ASKED
construct factors that were utilized. Studies that explicated three of the five ASKED criteria were to be kept. The process of expansion of terms and then tighter reframing of terms yielded five studies.

Attempts to apply three out of five of the ASKED constructs to the 5 research reports proved difficult. It would be reaching to say that these studies spoke to the construct of awareness. Each study did have physician subjects who volunteered to participate in the study. This may speak to their awareness of communication difficulties, however their reasons for volunteering are not explicated and therefore citing physician awareness of their role in culturally biased care is not possible. It seems obvious that there is an awareness of the researchers about the subject of disparity, but again as awareness is said to indicate self knowledge, and as none is discussed, the construct of awareness cannot be noted as part of these studies.

Skills in communication are considered in a round about sense. Each of the studies explicates disparity, which may speak to a lack of good communication, or to a lack of skill in the provision of culturally competent communication exchanges; therefore we will include Skill or
its inverse relationship to be a factor in each of the studies.

Knowledge as a process of seeking information about other people’s cultural beliefs is not found in these studies. The knowledge that is obtained in the studies furthers the evidence that communication mismatch exists but does not explicate how to improve this situation.

The studies chosen in this project for critique contain the element of Encounter that is described in the ASKED model. Each of the studies measures outcomes and variables based on actual patient provider encounters. Encounter as defined by Campinha-Bacote as multiple meetings with members of different groups. It is thought that by frequent encounter with members of different ethnic groups, awareness and knowledge levels will rise and skill level will follow.

Studies chosen for review contain the following elements: 1) depression or depressive symptoms, 2) Hispanic females are included as a majority group of the populations chosen for the studies, 3) providers engage in clinical visits with the patients and their observations and communications about depression are examined. Although Skills, Knowledge and Encounter were seen in varying
degrees in the studies, no studies contained Awareness or Desire.
Figure 3. Flow chart

Potentially relevant trials by key words in multiple combinations (n= 488)

Trials excluded against broad inclusion criteria
- Hispanic/Mexican women
- Depression in adults
- Provider-patient communication
- Cultural competence in health care (n=326)

Trials excluded against exclusion criteria
- Children
- Adolescents
- Elderly over 65
- Postpartum
- Physical health problems causing depression
- Other racial or ethnic groups
- Men only
- Sexual orientation
- Other psychiatric disorders ie bipolar
- Studies prior to 2000
- Studies after 8/2005
- Written in other languages
  - (n=256)

Trials retrieved for more detailed information (n=70)

Trials included applying criteria of three out of five ASKED constructs (n=0)

70 trials examined and excluded against tighter inclusion criteria reframed after initial examination of material
- Greater percentage Hispanic women than men
- Depressive symptoms present
- Patient provider communication as variables in studies
  - (n=65)

Trials included in final review (n=5)
Figure 4. Table of Studies Chosen for Final Analysis

<table>
<thead>
<tr>
<th>Authors</th>
<th>Publication date</th>
<th>Title</th>
</tr>
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<tr>
<td>Borowsky, S.</td>
<td>2000</td>
<td>Who is at risk for Nondetection of Mental Health Problems in Primary Care</td>
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<td>Rubenstein, L</td>
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<td>Meredith, L</td>
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<td>Sleath, B.</td>
<td>2002</td>
<td>Gender, Ethnicity, and Physician-Patient Communication about Depression and Anxiety in Primary Care</td>
</tr>
<tr>
<td>Rubin, R.</td>
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<td></td>
</tr>
<tr>
<td>Huston, S.</td>
<td>2003</td>
<td>Hispanic Ethnicity, Physician-Patient Communication and Anti-Depressant Adherence</td>
</tr>
<tr>
<td>Author(s)</td>
<td>Year</td>
<td>Title</td>
</tr>
<tr>
<td>------------------</td>
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<td>----------------------------------------------------------------------</td>
</tr>
<tr>
<td>Sleath, B</td>
<td>2003</td>
<td>The Influence of Hispanic Ethnicity on Patients’ Expression of Complaints about and Problems with Adherence to Antidepressant Therapy</td>
</tr>
<tr>
<td>Rubin, R.</td>
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<td>Wurst, M.</td>
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<td>Chung, H.</td>
<td>2003</td>
<td>Depressive Symptoms and Psychiatric Distress in Low Income Asian and Latino Primary Care Patients: Prevalence and Recognition</td>
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<td>Teresi, J.</td>
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<td>Guarnaccia, P.</td>
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Chapter Four

Results

Introduction

Chapter four will describe the results of the literature searches. It will summarize and evaluate the surviving five articles about patient-provider communication of Hispanics with depression. The intent of this literature review was to determine the state of knowledge regarding Hispanic/Mexican women with depression and communication with them by health care providers.

Hispanic Patient-Provider Communication

Five research reports will be examined. The articles all contained sample groups of patients as well as physicians to correlate results of actual clinical visits an outcomes. All included women of Hispanic descent; none explicated Mexican nationality. Four did not inform about Hispanic subgroup identity and the one that did name the subgroup identity did not include Hispanics women of Mexican descent. Variables examined ranged from recognition of mental health problems by the physicians (Chung et al., 2003; Borowsky et al., 2000), to actual communication about emotional distress (Sleath & Rubin, 2002), to antidepressant medication adherence related to the
communication that occurred during the visit (Sleath, Rubin, & Wurst, 2003; Sleath, Rubin, & Huston, 2003). All five contained variables that measured patient-provider communication. It should be noted that the major contributors to our knowledge about depressed Hispanics’ patient-provider communication are from a single group of researchers at the University of New Mexico Health Sciences Center (Sleath & Rubin, 2002; Sleath, Rubin, & Huston, 2003; Sleath, Rubin & Wurst, 2003).

Sleath Studies

Three of the studies examined in this literature review are led by Dr. B. Sleath. Each report is drawn from the same study sample. Different variables are examined in each study.

Sleath and Rubin.

Sleath & Rubin (2002) described the influence of patient and physician gender and ethnicity on physician-patient communication about depression and anxiety. A sample of 383 English or Spanish-speaking patients’ primary care visits was analyzed and 25% of these visits included a mention of depression. All interviews as well as patient visits were conducted in English or Spanish. It should be noted the sample included both Hispanic and non-Hispanic
males and females. The design of this research study was qualitative analysis of open-ended questions posited by physicians about depression, although there were quantitative measurements of demographic variables. The Generalized Estimation Equation (GEE) was utilized to determine potential relationships between patient gender, ethnicity, age, educational level, rating of emotional health and many other patient and provider variables. Results were discussed on a number of combined variables of both patient and provider. The topic of depression was addressed most often by providers if the patient rated their emotional health as poor. More often than not, it was the patient who initiated the subject of depression. Higher educated patients were more likely to bring up the topic of depression. Female patients were 3.5 times more likely to bring up the subject of depression than male patients during visit. Providers (67%) were more likely to bring up the topic of depression when the patient was male. In general, those physicians who asked open-ended questions limited it to one only. Of interest, gender and ethnicity of the provider did not appear to affect any aspect of the physician-patient communication about depression. This finding is congruent with the work of Verbrugge (1984) and
Borowsky (2000). Even when patients brought up the topic of depression, only 58% of physicians asked questions about it and only 21% asked one or more open-ended questions. These findings suggest that physicians may not be picking up cues provided by their patients (Sleath & Rubin, 2002).

Sleath Rubin and Huston.

Sleath, Rubin, and Huston (2003) studied the impact of physician-patient communication on adherence to medications for depression. Their focus was on the physician communication about antidepressant medications. The sample was a mixed group with 56% being Hispanic and 71.4% female. Age range was 23 to 83 with mean of 48 years. The purpose of the study was to examine how Hispanic ethnicity influenced the physician-patient communication about antidepressants and patient adherence.

The study design was identified as qualitative analysis of patient visits. Quantitative analysis was conducted of demographic variables. Patients were interviewed in either English or Spanish. The sample demographics include information about both patient and physician variables. Source of data were audiotaped visits of ninety eight patients to assess the communication that occurred, patient interviews conducted at the time of visit.
to obtain demographic information, and access to medical record and prescription data to assess use and adherence of medications post visit. Analysis of the data included only those patients who were provided an initial or refill prescription during a visit. The sample analyzed was 98 people and contained both genders as well as both Hispanics and non Hispanic whites. Quantitative data were analyzed using GEE to determine possible relationships of demographic characteristics to medication adherence. Patient provider communication as impacted by variables of ethnicity was scrutinized. The important questions of this study were;

- What type and how much information does the physician provide about antidepressant medication to the patient during the visit?
- Are there differences in that communication pattern when correlated with ethnicity?
- If there are differences are they correlated with adherence to the antidepressant medication?

Outcomes were that Hispanic patients were significantly less likely to adhere to their antidepressant medicine regimen than their non Hispanic white counterparts. The
authors of the study hypothesize that since little is known about side effects or Hispanic response to antidepressants, Hispanics in the study may have experienced more side effects therefore finding antidepressants unacceptable (Sleath, Rubin & Huston, 2003). Physicians were “significantly more likely to give non-Hispanic whites more information about depression medication than Hispanic patients” (Sleath, Rubin, & Huston, 2003). It was also found that Hispanic patients offered less information about their medication than did non Hispanic White patients.

Sleath, Rubin and Wurst.

Utilizing the same sample data that was utilized in the first two studies by Sleath (2002, 2003), Sleath, Rubin and Wurst (2003) studied the influence of Hispanic ethnicity on patient expression of complaints and problems. This study objective was to “examine the influence of Hispanic ethnicity on patient’ expression of complaints about and problems to adherence with antidepressant medications and physicians’ reactions to these complaints and adherence problems (Sleath, Rubin & Wurst, 2003). A sample of 98 patients was identified who received a new or refill prescription for an antidepressant at the time of the audiotaped visit. Only 28.6% patients expressed a
complaint about their antidepressant and, of these, younger patients and non-Hispanic white patients were more likely to express such a complaint than were older patients and Hispanic patients (Sleath, Rubin, & Wurst, 2003). Patients who rated their physical health as better were more likely to express adherence problems with antidepressant therapy than were patients who rated their physical health as worse. Moreover, physicians were generally responsive to patients’ expression of complaints and adherence problems. Study methods and analyses were the same as the study by Sleath, Rubin and Huston (2003).

Summary of Sleath Studies

All three of the studies in which Sleath is the primary investigator were conducted from the same data collected on the same study sample. All three are cross-sectional studies of physician-patient communication conducted in 1995 in general medicine and family practice clinics at the University of New Mexico. All three studies were conducted in either fluent English or Spanish.

Borowsky

In the earliest study included in this paper, Borowsky et al. (2000) examined nondetection of mental health problems in primary care. Their objective was to determine
patient and provider characteristics associated with increased risk of non detection of mental health problems by primary care physicians. Study design is a cross sectional analysis of patient and provider surveys. The sample utilized was obtained from the Medical Outcomes Study (MOS) conducted in three large U.S cities in 1986. The Borowsky group examined this data to find information about patients in three nested samples. Initially participants were screened for inclusion in the MOS, and one half of those patients were randomized to a group who also had data collection about general health status (HSE group). The last nested group was delineated by those patient who fit criteria for inclusion in the Diagnostic Interview Schedule (DIS). The DIS sample had positive screening for depression. In the final analysis, 661 patients were included in the Borowsky study. The demographic characteristics of the patients included information about gender, age and race or ethnicity. Physicians were from a variety of practice types and sizes. Variable information about the physicians included age, gender, ethnicity/race and self reported preference for personally providing patients with counseling for depression (Borowsky et al. 2000). Correlates between
patient information, visit diagnosis and physician variables were examined during a quantitative analysis using univariate and bivariate approaches. Results were multifaceted and included information about both physician and patient variables that were associated with non-detection of mental health. The information collected about females and Hispanics will be explored. The DIS subgroup, that is those persons with diagnosis of depression, were likely to be female (73.5%) and likely to be African American or Hispanic (Borowsky et al., 2000). Physicians detected mental health problems most often in persons with high numbers of indicators of mental health dysfunction. They were more aware of the possibility of problems among patients who were older, female, white, non-married, less educated or poorer. Also of note is that there were no significant findings based on physician gender or race/ethnicity. Younger physicians were slightly better at detection of mental health in the healthier population. Physicians who self reported interest in mental health counseling were associated with significant detection in both the less depressed groups (HSE and screening group) and the more depressed group (DIS). The authors note, “A disturbing finding, however, was that
patient race/ethnicity and gender influenced physician recognition of mental health problems” (Borowsky et al. 2000).

This study furthers the evidenced based knowledge that disparity exists. There remain few clues as to why the disparity exists. One interesting correlation was observed by the researchers. On comparing variables it was noted that minority patients are seen more often by physicians who do not report interest in providing mental health counseling. Despite the sample generality of this study, the findings speak to the issue of decreased incidence of detecting mental health in minority women. Sample subjects had to be able to speak English, which excludes a large population of Spanish speaking Hispanics. As the MOS gathered study subjects in two east coast cities and one west coast city and variation of Hispanic origin is not noted there is no clear evidence of which subgroup of Hispanics is prevalent in this study.

Chung

The last study to be examined was conducted by Chung et al., (2003). The objective of this study was to assess the degree to which primary care physicians recognize psychiatric distress among ethnically diverse patients. The
The study was conducted in internal medicine clinics of a large medical facility in an ethnically diverse neighborhood in the lower east side of New York City. The facility provides care for many people from lower socioeconomic strata. The study sample size was 11 physicians and 252 patients and consisted of both men and women of Asian and Hispanic groups. Hispanics accounted for 133 of the sample participants and of that number 72.9% were female. None of the participating Hispanic women were of Mexican descent. The Hispanic population of the eastern seaboard is of different Hispanic background, primarily Puerto Rican and the sample includes both Puerto Rican and Dominican Hispanics predominantly. Language fluency by physicians in both Chinese and Spanish mitigated the variable of language barrier. Study instruments used for both Asians and Hispanics were the Kahn-Goldfarb Mental Status Questionnaire (MSQ), which screened out patients with cognitive dysfunction, the Center for Epidemiologic Studies-Depression (CES-D) scale for detection of depressive symptoms. The Marin Acculturation Scale designed for use with Hispanics was used on the Hispanic group to measure acculturation level. The question posed to the
physicians’ post visit was “Do you believe this patient has an emotional/psychiatric problem” (Chung et al., 2003)?

Results of the study demonstrated that there is a high prevalence of psychiatric disorder in the sample. Depressive symptoms were high for both the Asian and Hispanic cohorts. Chung et al., posits this as possibly related to low socioeconomic status. Result also demonstrate low physician match of depression diagnosis with CES-D findings. For the Hispanic group match was 30.3%. It was lower in Asians. For Hispanics, the match between high CES-D scores and provider diagnosis was better if the patient was more highly acculturated. Physicians were more likely to report emotional distress in Hispanics than in Asians. This may be related to presentation of symptoms and is a subject for a different study. Of note is that physicians were aware of the purpose of the study and so were perhaps more attuned to consideration of depression than would normally be the case. Even given this factor there is evidence of low detection levels of emotional distress by physicians in a study group with high prevalence of psychiatric distress. The authors note that awareness of depression is very poor for the Asian cohort and average for the Hispanic cohort.
The authors further recommend that a lower threshold of physician suspicion of mental health disorders as regards these populations is needed.

Summary

The results of the literature research were reported in this chapter. Five research reports were described and evaluated for their design and findings, as well as their contributions to knowledge about Hispanic individuals with depressive symptoms and their patient-provider communication. The next chapter will discuss this literature review in relation to the Cultural Competency model as well as pertinence to the project purpose. Finally, significance of this project will be discussed.
Chapter 5
Discussion

Introduction

This chapter will synthesize the information presented, as well as the studies reviewed. It will explore the use of a cultural competency framework for research study and analysis.

Literature Evaluation

There were no studies that totally matched original inclusion/exclusion criteria. Too little information was uncovered about Hispanic women of Mexican Descent or even about Hispanic women only. In order to obtain information on the subject of physician interaction and communication with Hispanic women who have symptoms of depression, the author was forced to broaden criteria for inclusion. All studies include Hispanics and report findings based on ethnicity. All studies include a predominance of women as subjects despite the inclusion of men. All studies examine encounter between patients and providers.

Of the five studies identified, three are from a single sample at the University of New Mexico (Sleath & Rubin, 2002; Sleath, Rubin & Huston, 2003; Sleath, Rubin & Wurst, 2003). The three reports of this single sample focused on
different aspects of the study. For example, one focused on
gender and ethnicity and its effect on communication with
the health care provider. Two others focused on
antidepressant adherence based on communication with
providers. Study design, methods, and analyses protocols
were similar for all three of these studies. Therefore,
findings must be evaluated carefully. These were not three
separate studies but, in fact, three separate reports of
the same study.

Strengths of these three research reports include that
both qualitative and quantitative analyses were conducted.
This is commonly referred to as triangulation and allows
for a better description of findings. Another strength was
that both English and Spanish language for data collection
was utilized. This allows the inclusion of both
acculturated and less acculturated participants which is an
important factor in research of ethnic minorities. It also
lessens the possibility that communication difficulties are
due to language barriers.

Use of GEE statistical methods was a strength of the
three research reports. GEE allows the use of multiple
variables in a single model, and this is a good exploratory
 technique. GEE allowed the researchers to determine
potential relationships among demographic variables of patients and of providers.

Limitations to these three research reports (Sleath & Rubin, 2002; Sleath, Rubin Huston, 2003; Sleath, Rubin & Wurst, 2003) is anchored in the fact this was a single study. Since the sample was obtained in New Mexico, which is known to have a large Hispanic community with deep historical roots, it seems less likely that less acculturated Mexican Americans were included. A better designed study might deliberately sample by acculturation measures, such as primary language use, number of years living in the U.S., and generation since immigration.

The work by Borowsky et al. (2000) is a secondary analysis of study material collected in the MOS study. It is representative of a large sampling of both physicians and patients from urban areas across the United States. A strength of this study was use of an existing data set. Secondary analysis has many positive aspects including, but not limited to, greater utilization of data contributed by participants, less cost to participants, less cost in money to the researchers, and potential increases to sample sizes from several different existing data sets. The study does not clearly delineate subgroup Hispanic populations and
there appears to be no inclusion of less acculturated subjects as all participants spoke English.

The Chung et al study (2003 scrutinizes recognition of depression by physicians in two minority groups. It again is qualitative in nature with quantitative analyses of the data sets. Strengths include the bilingual ability of the HCPs and the study instruments used. A weakness may be the best case scenario whereby HCPs were aware that depression detection was the focus of the study. For the purposes of the present literature review, the population while Hispanic and primarily female, did not represent the subgroup of Hispanics of Mexican descent.

Strengths and Weaknesses

The five studies reviewed contain information based on a single encounter. None of them elucidate the longevity or consistency of the patient provider relationship. None of them sample women only and none of them sample Hispanics of Mexican descent only. Only one even bothers to delineate the subgroup of the Hispanic population. Four of the five provide for communication in either English or Spanish. All are examining depression as a variable. All the studies denote inconsistencies in diagnosis and management of depression in Hispanic women. All use measurable variables.
to further the knowledge that indeed disparity in depression care of Hispanic women and other minority groups exists. There are few conclusions drawn as to the cause of the disparity or what actions or behavior changes might elicit positive changes in therapeutic encounters. This leads this author to believe that while the subject of whether disparity occurs has been fairly well studied, there is a dearth of research on communication deficits that may be responsible.

Searches for literature specific to depression care of Hispanic women of Mexican descent reveal a paucity in the literature for this group. Despite a body of knowledge that indicates that Hispanic ethnicity includes many subgroups with similar yet different characteristics, studies specific to the Mexican woman are difficult to find.

Little research centers on how HCPs perceive themselves and their role with regards to disparity. Little attention has been directed to how the newly enacted laws and regulations regarding cultural competence have impacted practice settings or whether these regulations are viewed with reservations or resentments. Personal observations by this student attending mandatory workshops on cultural
competency are that there is some resentment among some students about mandatory classes to “learn” cultural competency. There also appears to be some defensiveness when the subject of cultural competency is mentioned in health care circles. Little research is found addressing these issues.

Studies that observe the outcomes of the provision of culturally competent care are few. This author is in agreement with Brach (2000), “the literature on cultural competency has by and large, not linked cultural competency activities with the outcomes that could be expected to follow from them” and “We also found the literature on racial and ethnic disparities weak on identifying the sources of disparities, and almost no attention has been paid to techniques for reducing them” (Brach, 2000, p.184). Despite the bleak statements expressed by Brach in 2000, some articles that denote progress in technique for reducing disparities in reference to Hispanics with depression have been published in the last year (Anez, Paris, Bedregal, Davidson, & Carlos, 2005; Cardemil, Kim, Pinedo, & Miller, 2005; Lewis-Fernandez et al., 2005).
Summary and Future Recommendations

Strengths and weakness that appear in the researched body of knowledge have been mentioned above. In conducting this literature examination it has become clear that there is little knowledge in the area of Mexican woman suffering from depression; how they relate to their providers; and how this relationship impacts their care. Anecdotal reports suggest that Hispanics are treated differently, that communications are less clear in the area of emotional health needs. The studies examined in Chapter 4 corroborate these observations. The lack of information about the nature of the communication between health providers and depressed Mexican women may lead to serious deficiencies in treatment outcomes for these women. The number of Hispanics that inhabit the United States is rising. Over half of these Hispanics are of Mexican origin. As the number of Hispanic/Mexican women rises it becomes even more important that health care researchers focus on this group.

Nursing has historically been a leader in the area of culturally competent care. The importance of this review is that it clarifies the paucity of information about a specific group of women with a specific health problem. Armed with this awareness, nurse researchers could
design qualitative studies that speak to this area. As evidenced based practice becomes the standard for nursing care it becomes even more important that we continue to seek knowledge and understanding of individual groups and their health problems. Nurse educators are charged with the responsibility of creating awareness in students; awareness of ethnocentrism, awareness of the insidious nature of bias, awareness of cultural impact on communication and on the awareness of the need for more scientific knowledge. The Interlocking Paradigm of Cultural Competence expounds on cultural competence as a process of becoming. It is a continuous process of learning and a continuous process of growing. Nurses in all fields of endeavor can apply the information obtained in this study to improve health care outcomes for depressed Hispanic women.
References

(an * next to reference denotes inclusion in final analysis)


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