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Addressing Cultural Considerations of African Americans in Interdisciplinary Care

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ADDRESSING CULTURAL CONSIDERATIONS OF AFRICAN AMERICANS IN INTERDISCIPLINARY CARE

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DISSERTATION APPROVAL

This is to certify that the thesis presented to us by Ashley Smith

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requirements for the degree of Doctor of Psychology, has been examined and is

acceptable in both scholarship and literary quality.

COMMITTEE MEMBERS' SIGNATURES

DEDICATION

When 10 were healed, only one returned to say thank you. Similarly, a buried talent is taken away. This dissertation is the work of my hands, my heart, and my mind, symbolizing a collection of gifts and sacrifices made along my journey leading to this work. I humbly dedicate this dissertation, all that led to it, and all that comes of it back to He who ultimately enables me to use my gifts in service. Giving back to God that which is His, I love you and I thank you! I also dedicate this dissertation to my parents and family, who continue to lead with love, setting examples that inspire and motivate me daily. Words are insufficient to describe the love and gratitude I have for the family God hand-picked for me. Your support, encouragement, and sacrifice give me the courage and faith to pursue my dreams. You have been the best role models and professors I could ask for, and I thank and love you all!

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Abstract

Communication and appreciation for culturally significant factors are essential to the helping relationship between the patient and the interdisciplinary team members in the health care setting. Historically, the relationship between African Americans and health care professionals in the American health care system has been one of mistrust based on unequal treatment, stereotypes, and other factors negatively affecting rapport. The main purpose of this study was to identify the cultural considerations within the Black and African American communities and their impact on the relationship between interdisciplinary care team members and their African American patients. This study used a qualitative grounded theory design and included 12 individuals aged 19 years and older recruited from the southeastern Pennsylvania, metro Philadelphia area. Semistructured interviews were conducted to gather information regarding cultural considerations African Americans deemed to be important in their interactions with interdisciplinary team members. Results identified 11 themes across five contexts that suggest relevant cultural factors for African Americans working with physical and mental health providers. Themes included Patient-Provider Collaboration, Personal Values and Sharing, Physical Environment, Empathy, Provider Reviews, Cultural Awareness and Competency, Racial Connections, Health Care Teams, Follow-up Referrals, Provider Mistrust, and Stereotypes and Stigma. Overlap in themes suggested the importance of the role of values and trust in rapport building during health care interactions. Future research may benefit from studies discussing and acknowledging the impact of providers eliciting the individual values relevant to African American patients during these patients' health care visits on patients' perceptions of trust and health outcomes.

CHAPTER 1: INTRODUCTION

Statement of the Problem

Traditional approaches to health care and mental health care singularly emphasize the medical model. This model aims to examine a patient's physical symptoms and use medical intervention to address and ameliorate the ailment. More recent approaches seek to incorporate a broad and holistic assessment of the patient that embraces a biopsychosocial model. Using this model, a patient's physical, mental, and environmental factors are considered in one unified conceptualization. This multidimensional model has been a cornerstone of integrated care settings in which a patient can access comprehensive treatment at one site. One of the benefits of integrated care is a decreased stigma related to mental health treatment. However, this benefit alone fails to address other barriers that may prevent people from accessing treatment.

Recent research has focused on the propensity of those in minority populations to more frequently use the health care system for emergent-care issues than for preventive care. Preventive care is used to promote wellness and detect illnesses and other health problems by means of early screenings, check-ups, and patient counseling services (Centers for Disease Control [CDC], 2015). However, the preferred method of care for many racial minority group members with physical and mental illness symptoms involves complementary and alternative medical treatments (Gallant et al., 2010). Impediments to access can be a significant barrier that prevents many racial minority groups from obtaining medical care. Disparities in health and health status include differences in availability of services and the variation of disease rates and disabilities among certain socioeconomic or geographically defined groups (National Institutes of Health [NIH], 2017). These disparities most often are related to health care providers' beliefs, expectations, biases, and perceptions, such as racial, ethnic, and socioeconomic biases; age

biases; and assumptions about quality of care from physician and patient adherence (Sims, 2010). African Americans and Black individuals have long suffered from health care disparities, such as access and quality of care, that contribute to treatment barriers, such as attitudes toward medicine and related beliefs. African American and Black adults, in particular, are most likely not to have a consistent source for routine health care, which can impact the probability of seeking care when needed, lead to overuse of emergent care as a source of primary health care, and result in not having continuity of care (Kosoko-Lasaki et al., 2009). Historically, African Americans have been less likely to have adequate health insurance to cover the cost of medical care, and therefore, they may often postpone seeking medical treatment (Cheatham et al., 2008). This lack of primary care use and follow-up may be linked to past and current segregation or to perceptions of stereotypes that are significantly correlated with persistence and existence of health disparities (Kosoko-Lasaki et al., 2009).

African Americans' and Blacks' historic distrust of the medical system may be a significant factor that continues to interfere with their willingness to trust the medical establishment at present. Some in these populations may resort to using home remedies and alternative medicines as the preferred treatment interventions (Carr, 2001). Actions rooted in racism and discrimination, such as the Tuskegee Study of Untreated Syphilis in the Negro Male (The Tuskegee Study), have contributed to breaking the bonds of trust between the African American community and health care providers (Cheatham et al., 2008). The Tuskegee Study also illustrates the creation of significant and costly gaps between the African American or Black community and medical research. This distrust might extend to psychological practice within the interdisciplinary health care team and in research. Many of the barriers that contributed to health disparities continue to affect the direct experience of African American and Black populations

within the American health care and mental health care systems. These medical barriers, coupled with the stigma of mental health treatment in these populations, highlight the need for cultural competency by helping professionals within the integrated care field. Providing care to members of these populations that is customized to each person but considers the rich cultural history of being Black or African American is paramount to the competency of interdisciplinary team members and the delivery of effective health outcomes. Each patient/client-helping professional relationship builds from the foundational alliance that is established during initial meetings. Engaging members of this population to identify what is of cultural importance to incorporate in health care encounters may help to bridge the gap created by health care disparities, mental health stigma, and other barriers to optimal care.

CHAPTER 2: REVIEW OF THE LITERATURE

Examining the ways in which cultural components relevant to African Americans can be addressed in interdisciplinary care is aided by the discussion of significant factors related to integrated care models and salient cultural factors for African Americans. Although the care models are referred to as *integrated* to reflect the consolidation of care across professional disciplines, this word holds strong connotations of racial unification to those outside the medical and behavioral sciences. As such, to reduce misunderstanding of the use of the word *integration, interdisciplinary* will be used to indicate the collaboration of primary-care and mental health professionals in a centralized health care setting. Against the backdrop of medicine's and psychology's separate developmental histories, the concept of these team members working in tandem is relatively new. Consequently, these histories may still influence expectations and attitudes of patients, making a fundamental knowledge of early medical and psychological directive approaches essential to understanding some of the challenges that may arise within the collaborative interdisciplinary health care setting.

Similarly, investigation of the significance of African American identity and the history of interaction with mental and primary health care professionals may provide some insight into motivating factors that may facilitate or impede health care use and treatment adherence. Health care disparities and other barriers illuminate macrolevel challenges faced by African American community members. Therefore, discussion of the values held by many within this community could inform themes of cultural significance that further impact motivation to seek and maintain health care services. The consideration of these factors may potentially shape the conversations and interactions between health care professionals and African American clients. The identification of salient themes in African American culture within the interdisciplinary setting

may serve as a bridge across the historical gap between these entities and inform future systems of care health professional and patient interactions.

Medical Model

Directive Approaches in Primary Care

Early medicine sought to identify the source of illness and eradicate it. The theoretical and traditional medical model holds that health is the state of absence from disease and regards the physician as the expert (Robinson & Reiter, 2016). Regarding the physician as the expert is a directive approach that encourages the physician to provide diagnosis and solutions, as opposed to encouraging the physician to elicit collaboration from the patient. Traditionally, medical training programs focused on producing allopathic (MD) physicians until 1892, when Andrew Taylor opened the first osteopathic college (Gevitz, 2009). These osteopathic (DO) training programs continue to grow, and projections indicated that by 2019, greater than 25% of medical programs will produce DO physicians (Gevitz, 2009). Although still directive in nature, DO training programs take a holistic approach to treating patients, particularly in primary-care and family medicine.

Primary Care/Family Medicine

Graduates of osteopathic medical school programs are trained in manipulative medicine, receive a Doctor of Osteopathic Medicine (DO) degree, and, subsequently, pursue primary-care or family medicine in underserved areas at a significantly more frequent rate than do their MD counterparts (Gevitz, 2009). Osteopathic approaches expanded the medical model beyond the definition of health as solely the absence of disease by addressing each patient holistically. The biopsychosocial approach is a strength-based model that focuses on improving functioning by examining and intervening in consideration of biological, psychological, and social factors that

impact well-being (Robinson & Reiter, 2016). Although this expansion of the medical model embraces holistic care, it still regards the physician as the expert. As such, patients consider the physician as the authority for all health-related care. The majority of people in the United States reportedly seek care for mental health, substance use, and behavioral health care in primary health care offices as the first point of contact, increasing the need to incorporate psychology-based consultation as a part of an interdisciplinary team (McDaniel & DeGruy, 2014).

Psychological Approaches

Psychology's roots arose from medical education and in many ways resemble the directive nature of the medical model. Sigmund Freud was trained and educated in the medical field but had a passion for psychopathology and psychiatry. His training in medicine and interest in human nature led to his development of psychoanalysis (Woody & Viney, 2017). Psychoanalysis tends to be directive, as it attempts to address and interpret the unconscious in line with Freud's theory (Corey, 2012). Although psychoanalysis is regarded as the foundational beginning of psychological therapy, it is now one of many psychological approaches that extend beyond reliance on clinician interpretation. Overall, psychology now seeks to involve the patient in care by using a collaborative approach that views patients as the experts in their lives and the psychologist as the expert in providing care. Specifically, research indicates that at increasing rates, psychologists most often collaborating with primary-care physicians are those trained in cognitive-behavioral therapy (Blane et al., 2013).

Interdisciplinary Primary Care

Incorporation of a psychological framework within primary care is a pillar of interdisciplinary care. The biopsychosocial model is relatively new compared to the medical model, and as such, patients still anticipate a directive response from health care professionals.

Holistic Approaches

George Engel originally proposed a biopsychosocial model in 1977; however, health care professionals continued to favor the more directive biomedical model for several years thereafter (McDaniel et al., 2014). However, when tobacco use, poor diet, and sedentary behavior were ranked in recent years as leading causes of death, the value of behavioral interventions was considered by the medical community, and Engel's biopsychosocial model was reevaluated (McDaniel et al., 2014). Now, primary care and incorporation of mental health are a part of one of the national health care priorities called the Triple Aim, focused on improving patient experience, improving health of the overall population, and reducing cost (Miller et al., 2014). Integrated health care centers use interdisciplinary approaches to address patient concerns with a holistic perspective, aiming to provide treatment collaboratively with the patient. National Provider Identification data indicate more primary-care physicians colocating with mental health practitioners, with most locations in the northern states of the United States as compared to southern states (Miller et al., 2014). This northern preference may be a result of the historical tendency of members of the interdisciplinary team to independently practice in more affluent areas, where better health care insurance coverage is available (Miller et al., 2014). As of 2010, 55% of people who identified as African American or Black resided in southern states; only 18% of this population lived in the Midwest, and 17% of Black or African American persons lived in northern states (Hoeffel et al., 2014). Thus, most Black and African American communities are in many southern states, whereas primary-care and mental health practitioner colocations are more limited.

Recently, the U.S. government has begun to recognize the value of interdisciplinary care. In 2017, the 4-year Comprehensive Primary Care (CPC) initiative was expanded, leading to a

new model, the Comprehensive Primary Care Plus (CPC+) initiative (Centers for Medicare & Medicaid Services [CMS], 2019; TMF Health Quality Institute, 2017). This initiative incentivizes primary care practices that incorporate one of three care management strategies as a part of the risk-stratified care management core function; one of these strategies is behavioral health services (CMS, 2019). Under this initiative, the participating 2,912 practices across 18 regions are evaluated and incentivized, and providers are paid based on a performance system in which better patient outcomes, as opposed to number of visits, lead to financial gain. In the year since the CPC+ unrolled, 98% more practices addressed behavioral health needs in 2018 than in the previous year (CMS, 2019). As such, in Fall 2018, most of the CPC+ practices retained a portion of their performance-based incentive (CMS, 2019). Although the final results on patient care will be released at the conclusion of both phases of this initiative in 2022, an increase in use of behavioral health by practices and the subsequent financial gain based on patient outcomes suggest interdisciplinary care is vital in the treatment of patients.

Identity

Understanding identity is paramount, as this concept encompasses the combination of a person's inner values, rules, and experience of the social world, which influence behaviors (Heshmat, 2014). Examination of the African American identity includes theories proposed by researchers and group identity theories.

Racial Identity Approaches

Mainstream. Early theories of Black identity emerged in the early 1970s, with one of the most notable conceptualizations being the nigrescence model (Constantine et al., 1998; Cross, 1971). The nigrescence model examined the process of identity development, received the most empirical attention, and served for many researchers as the foundational model to understanding

Black identity (Cokley & Chapman, 2009). The nigrescence and other similar identity models developed at that time proposed distinct stages of Black identity realization, with emphasis on negative race experiences as central to overall identity (Cokley & Chapman, 2009; Constantine et al., 1998). Within this model, the principal focus is placed on the stigma of having African features in a non-African majority society. The research tradition of defining African American identity through the lens of the history of oppression and stigmatization has been categorized as a mainstream approach (Constantine et al., 1998; Sellers et al., 1998). Another defining characteristic of mainstream approach theories is the consideration of biases and cognitive-processing errors to explain the experience of prejudice (Sellers et al., 1998). Some of the limitations of mainstream conceptualizations lie in the linearity of identity stages, negligence of other world views as alternatives to White idealization, and group generalizability (Constantine et al., 1998).

Underground. Another set of theories that emerged was categorized as the underground approach and was heavily influenced by W.E.B. DuBois' Afrocentric perspective, in which he described *double consciousness* as the tension African Americans suffer when attempting to balance their American (White) and African (Black) souls (Cokley & Chapman, 2009; DuBois, 1903; Sellers et al., 1998). The underground approach describes the Black and African American personality as African self-extension orientation and African self-consciousness (Constantine et al., 1998; Sellers et al., 1998). In contrast to mainstream approach identity theories, the underground approach views racial prejudice as a by-product of American slavery and exploitation in which prejudice is more than cognitive errors or bias (Sellers et al., 1998). One of the major criticisms of the underground approach is the lack of discussion about the

possible impact of racism on the perspective and experiences of Black individuals (Constantine et al., 1998).

Multidimensional Model of Racial Identity. Considering the various facets of several identity theories of African American and Black identity, a multidimensional model of racial identity (MMRI) was created as a fusion of existing mainstream and underground theories, with consideration given to history and cultural experiences (Sellers et al., 1998). This model also sought to address inconsistencies in other theories, specifically in the nigrescence model (Cokley & Chapman, 2009), and limitations of the mainstream and underground approaches (Constantine et al., 1998). The MMRI defines racial identity for African Americans as the qualitative meaning and importance individuals attribute to Black racial group membership and self-concept (Sellers et al., 1998). This model assumes race is a part of several hierarchically ordered social identities (Cokley & Chapman, 2009).

The MMRI has four major dimensions: salience, centrality, ideology, and regard. Each dimension houses specific assumptions (Sellers et al., 1998). Racial salience refers to the importance of race as it relates to identity and self-concept in a situational context (Cokley & Chapman, 2009; Sellers et al., 1998). In this dimension, individual situations are considered as sensitive to the evaluation of racial prominence; thus, salience can vary between individual African Americans in the same situation. Identity centrality is defined in the model as the extent of normative stability and dominance of racial identity in a person's self-concept across situations (Cokley & Chapman, 2009; Sellers et al., 1998). Centrality is also considered implicit in the hierarchical ranking process of different identities (Sellers et al., 1998). Salience and centrality are not mutually exclusive; as such, salience is variable within a person's racial centrality. Racial ideology encompasses the beliefs, attitudes, rules, and opinions regarding the

behaviors of racial group members (Cokley & Chapman, 2009). Racial ideology delineates four prevalent philosophies: a nationalist philosophy, which specifies the experience of African Americans as different from that of any other group; an oppressed minority philosophy, which emphasizes similarity between oppression of African Americans and other groups; an assimilationist philosophy, which is characterized by drawing similarities between African Americans and American society; and, lastly, the humanist philosophy, which does not consider race, gender, class, or specific characteristics and is most concerned with the human race overall (Sellers et al., 1998). The fourth dimension, racial regard, indicates a personal evaluation of positive or negative feelings toward one's racial group and as a group member in public and private (Cokley & Chapman, 2009). More specifically, African Americans may experience different feelings toward other African Americans and about being African American within a positive-negative valence.

The MMRI aims to reflect the complexity of racial identity and self-concept for African Americans but does not consider any one dimension to be all-encompassing of identity. The model serves as a guide to conceptualizing African American racial identity, with more flexibility that allows for intragroup differences.

Defining African Americans and Black Americans

Current literature regarding African American and Black identity is largely dichotomous. Several articles, chapters, and books delineate Black identity or African American identity separately. As such, little within research suggests which factors influence members' identification with one identity over the other. This absence from the literature may reflect the subjective nature of self-identifying as African American or Black, possibly based on racially charged experiences living in America, a desire to connect with African heritage, double

consciousness (DuBois, 1903), immigration or migration factors, or intracultural comparisons and classifications. Additionally, some individuals may identify as either and both with no preference, depending on the context. As a result, African American will be used as an overarching term to include those who identify as Black and both African American and Black unless otherwise specified.

Racial Identity and Health Care

Evaluation of the models of identity and identity development is especially important to consider when exploring a possible relationship between African American identity and use of and attitudes toward health care. Closer examination of identity development posits that a youth's racial identity, colorism, and racial preference formulation blossom from societal and parental cues (Bentley et al., 2009). This assertion of racial socialization is closely aligned with tenets of Bandura's social learning theory, in that learning occurs through observations or direct instruction and in the absence of direct reinforcement (Bandura & Walters, 1977). For African Americans, rules and values that further define racial identity may be strongly influenced by older generations and reinforced by in-group community members.

Within the health care context, one of the characteristic messages passed intergenerationally and that has been reinforced is mistrust of the majority (i.e., European American) population, a population that is strongly represented in the health care field (Terrell et al., 2009). This racially socialized message may be used to protect youth from and combat harmful stereotypes, to avoid negative racial experiences, and to promote safety (Bentley et al., 2009). This cultural mistrust is seen as a normative and adaptive reaction to historical inequities against African Americans (Burkett, 2017). As such, part of the rules for African American identity are to discourage sharing information with European Americans and to use caution when

interacting with this population (Terrell et al., 2009). For example, a recent study surveying 220 African American adults on the centrality of racial identity found that participants with self-reported higher racial centrality indicated lower trust in health care institutions (Cuevas & O'Brien, 2017). Although another study of 117 adults across five minority groups, including 26 African Americans, identified overall satisfaction with health care treatment. The same study indicated high levels of cultural strength and identity along with a preference for cultural matching among providers and patients (Shepherd et al., 2018). This preference for cultural matching might suggest that when the provider is seemingly African American, African American patients might have greater trust that they will receive culturally sensitive treatment.

History of African American Participation in Medicine and Psychology

Throughout history, the experiences of African Americans in health care settings dominated by European Americans have fostered cultural mistrust toward health care professionals in practice and research. As such, for many African Americans, cultural perception views health care delivery as prominently controlled by and tailored for European American majority populations (Murray, 2015).

Medical Research

The relationship between African Americans and the health care system is one of mistrust rooted in unequal treatment, as their ancestors were categorized as inferior to European Americans (Murray, 2015). Systematic power and mistrust continued after emancipation, with one of the most notable studies, The Tuskegee Study of Untreated Syphilis in the Negro Male (The Tuskegee Study), showcasing discriminatory treatment of African Americans within a medical research context.

Beginning in 1932, the US. Public Health Service (USPHS) conducted the 40-year Tuskegee syphilis experiment. Six-hundred African American men were offered free meals, medical check-ups, and treatment for *bad blood*, a common term for various rudimentary ailments, such as anemia and fatigue (Centers for Disease Control and Prevention [CDC], 2016). Under the guise of providing free health care, the USPHS was actually monitoring the progression of untreated syphilis in 399 of the men. The remaining men, who did not have syphilis, were used as a control group (Heintzelman, 2003). The subjects were given spinal taps without anesthesia to study the neurological effects of syphilis.

The deception of this experiment gained notoriety in 1972 after the results were published and new articles criticized the methods used. At that time, the government ended the study, but only 74 men were still alive. The study was deemed unethical because of the participants' lack of informed consent and of the physicians' failure to preserve life by leaving the men untreated even after penicillin was approved as the appropriate syphilis treatment (CDC, 2015). Additionally, this study is cited by many as one that has impacted the attitudes toward medical care among members of this population. Recent research indicated that African Americans' awareness of this study reinforced their distrust of medical systems decades later (Murray, 2015).

Psychology

As psychology's origin lies within early medicine, those credited as contributing to its foundation are not African Americans. Research supports that the mistrust of the medical profession by African Americans was transferred to the psychological field largely because of the perception that mental health and psychology are also controlled by the European American majority (Terrell et al., 2009). Consequently, one of the major challenges faced by mental health

practitioners is engaging and motivating African Americans to seek and maintain mental health care (Terrell et al., 2009). When services are used, research has found that African Americans overuse inpatient services and underuse outpatient mental health care (Thompson et al., 2004). This pattern closely mirrors the report of African American patients' higher use of medical emergent care as opposed to maintaining preventive and routine care follow-up appointments (CDC, 2015).

While no identifying psychology study parallels the Tuskegee study, the use of racially targeted deception as a research methodology in that study may contribute to the view of psychology among African Americans within a health science framework. Other challenges that contribute to the alienation of African Americans from mental health and psychology services may include vulnerability factors, such as racism and perceived discrimination and health care disparities, as well as resiliency factors, such as family, cultural and racial identity, and spirituality and religion (Earl & Williams, 2009).

Health Care Disparities

Health care disparities refer to preventable differences in the burden of illness or the opportunities to achieve and maintain optimal health experienced by socially disadvantaged populations (CDC, 2018). Health disparities are directly related to current and historical misdistribution of resources (CDC, 2018). The examination of health care disparities among minority populations dates back to the mid1980s, when U.S. Department of Health and Human Services (HHS) Secretary Margaret Heckler indicated in her annual report that although overall health and life expectancy for Americans were improving, significant disparities existed among non-Hispanic White individuals and racial and ethnic minority groups, resulting in higher instances of death and illness in the latter group (CMS, 2017; U.S. Department of Health and

Human Services [HHS], 1983). Subsequently, the Task Force for Black and Minority Health convened to further investigate the extent and prevalence of these disparities, eventually producing the Heckler Report in 1985 (CMS, 2017). This report highlighted factors contributing to and provided recommendations for alleviating the strain contributing to the reported health disparities for Black individuals and other minorities (HHS, 1985). Although more attention has been given to addressing these factors and recommendations in the 30 years since the Heckler Report, health care disparities for African American individuals continue to be an area of critical concern and need for exploration. These inequities are still closely tied to racial disparities and impact access to quality care, specifically access to health education and information, location, and affordability (Crossley, 2016).

Education and Information

Lack of education regarding physical and mental health is cited as one of the prominent barriers adding to the disparities in health care faced by African Americans (Minority Nurse Staff, 2013). The Heckler Report identified African Americans as less knowledgeable about prevalence of and symptoms related to cancer and heart disease, which are the more salient health problems in this community, and in its recommendations called for more educational outreach (HHS, 1985). Similarly, although the National Comorbidity Study indicated African Americans were initially at a slightly lower risk than European Americans for persistence of anxiety, depression, and mood disorders, African Americans with mental health challenges were at a much higher risk of suffering prolonged debilitating and severe symptom presentation over their lifespans (Earl & Williams, 2009). This risk may indicate lack of education on symptom and illness management and overall absence of care resources for African Americans. As a follow-up to the Heckler Report, Congress created the Office of Research on Mental Health. Its

research led to the passing of the Minority Health and Health Disparities Research and Education Act of 2010 ("Patient Protection and Affordable Care Act," 2010). This act promotes further research on and education regarding health disparities and resources for African Americans and other minority groups, recognizing that access to health information is a vital step in addressing the gap between this population and health care practices (Maddox, 2015).

Recent survey research of 82 adults noted that when provided with health information, African Americans' awareness prompted them to report changes in diet and behavior (Austin & Harris, 2011). However, the same study found that African Americans between the ages of 25 to 40 years who indicated fewer health concerns were less likely to read the health literature provided (Austin & Harris, 2011). These findings may suggest that providing health literature as an adjunct to personal interaction could have greater impact in providing education on preventive health care, symptom management, and accessing additional resources. Similarly, the African American Health Engagement Study found African Americans reported higher motivation for healthy life changes and more favorable individual interactions with health care providers when health information was provided in community settings, such as health fairs, social gatherings, and other related events (Pfizer, National Medication Association, & National Black Nurses Association, 2017). Additionally, African Americans reported that they were more trusting of the source and validity of health information when it was provided by medical organizations with a specific focus on African American health (Pfizer et al., 2017). Taken together, these findings suggest that while providing access to health information is essential in addressing the health disparities among African Americans, the method of and setting for delivery of such information are important.

Location

As noted in the Heckler Report and supported by more recent literature, location of providers continues to be an important factor in use of physical and mental health care among African Americans, and it is directly related to continuity of care (HHS, 1985). A review of specific disparities indicated inaccessibility of health care locations was predictive of poor health outcomes (Crossley, 2016). Essentially, African Americans are less likely to seek out or continue health care when accessing the location is more challenging, thereby impacting health status. Although historical challenges have encouraged African Americans to use primary-care services, they are more likely to present with mental health concerns in general medical settings in lieu of specialty mental health offices (Earl & Williams, 2009). Recent initiatives in transformative health care seek to address cultural barriers by identifying, monitoring, and remedying location as a barrier by promoting colocations and interdisciplinary approaches (Evans, 2011). The advent of interdisciplinary teams and colocation seeks to make access less burdensome for African Americans by offering multiple treatment professionals in a centralized setting; however, many locations are out of reach for those living in urban and less affluent areas (Miller et al., 2014)

Affordability

Providing education through information and increasing accessibility are two important steps identified in addressing disparities. However, if African Americans cannot afford the care they are motivated to seek, they are not benefiting from the health care centers and resources. The Heckler Report identified that most minority populations rely on charity care or Medicaid for health care. At the time of the report, twice as many African Americans as other groups had no medical coverage (HHS, 1985). In the years leading up to 2010, more than 8 million African

Americans lacked health coverage (Center for American Progress, 2017), and by 2009, fewer than 30% of African Americans were eligible for Medicaid coverage (Henry J. Kaiser Family Foundation, 2018).

The passage of the Affordable Care Act (ACA) in 2010 expanded rights and protections to make health coverage more financially accessible to those within 400% of the poverty level by offering additional funding to states extending Medicare eligibility and enacting financial penalties against employers and insurance companies providing inadequate coverage (Patient Protection and Affordable Care Act, 2010). This expansion of Medicaid included free preventive health care, young-adult coverage under parents' plans until age 26 years, and protection for choice of physician and against employer retaliation and insurance company cancellation because of illness (Patient Protection and Affordable Care Act, 2010). For African Americans, the ACA lowered the rate of uninsured individuals by more than one third and increased rates of follow-up appointments, medication access, and continuity of care (Bailey et al., 2017).

Although the ACA offered financial health care access benefitting African Americans, by 2017, 19 states had not adopted the Medicaid expansion, resulting in more than 800,000 African Americans remaining ineligible (Bailey et al., 2017). Additionally, the threatened partial repeal of the ACA was projected to dramatically increase the number of uninsured African Americans significantly by 2019, causing many to lose their physical and mental health coverage (Center for American Progress, 2017). Thus, affordability of care continues to be a major issue for African Americans and other minority groups in accessing health care.

Additional Barriers

Along with education and information, location, and affordability, additional barriers to health care use exist for African Americans. Stigma, defined as discrimination or a mark against a person based on perceived social characteristics or circumstance, and stereotype threat, which is the risk of confirming negative stereotypes that perpetuate inferiority, are important factors to consider as barriers for African Americans (Aronson, 2011; Davis & Simmons, 2009).

Stereotype Threat

Stereotype threat for African Americans was studied most extensively in an academic context, in which African Americans are stereotyped as unintelligent and poor performers (Davis & Simmons, 2009; Steele & Aronson, 1995). However, stereotype threat remains relevant for African Americans in health care settings because the rate of communication with providers, help-seeking behaviors, and treatment adherence are lower in the African American population than in other groups, possibly as the result of beliefs held by African Americans regarding interactions (Aronson et al., 2013). Specifically, if African Americans find interactions with health care providers to be unpleasant because of the fear of perpetuating the stereotype of unintelligence, health care may be avoided, questions regarding care compliance may be unasked, and disclosure may not be full or truthful (Aronson et al., 2013). Among a study involving 162 women, researchers found stereotype threat to be a social determinant of health-related decisions for the 94 African American participants (Abdou & Fingerhut, 2014). This study found that when women, who identified as Black or White, were assigned to stereotype threat or control conditions, the women who most strongly identified as Black within the stereotype threat condition reported significantly higher instances of anxiety in health care settings than those reported by other women across groups (Abdou & Fingerhut, 2014). Also,

women who held higher levels of ethnic self-identification were more affected by stereotype threat than those who did not endorse strong ethnic identity. The nature of stereotype threat to decrease performance (Davis & Simmons, 2009) and engender mistrust (Aronson et al., 2013) continues to contribute to health care use and treatment outcomes among African Americans.

Stigma

The stigma related to mental health has been cited as a barrier for all people and for African Americans in particular. Common mental health stigma beliefs posit that individuals suffering from a mental illness are violent, are at fault for their illness, and will remain ill (DeFreitas et al., 2018). Mental health is also misunderstood within the African American community, and stigmatic beliefs contribute to the lack of conversation and sharing of education among group members (National Alliance on Mental Illness [NAMI], 2018). African Americans may view psychological pathology as the presence of in-group dysfunction (Alang, 2016). Similarly, an exploratory cross-sectional study investigating attitudes of 272 African American men and women toward and perception of stigma related to mental health found that participants were not open in acknowledging personal mental health concerns as a function of stigma related to mental illness (Ward et al., 2013). African American parents were more likely to have more stigmatic beliefs than parents of other ethnic groups, thus impacting the likelihood of seeking mental health services for their children (Turner et al., 2015). As with identity characteristics, misinformation regarding mental health and the perpetuation of stigmatic beliefs are passed through generations of African American families (DeFreitas et al., 2018).

Values

The consideration of values held within the African American community is paramount in crafting a positive alliance with health care professionals. Throughout the literature, common

values include, but are not limited to, religion and spirituality; family, relationships, and community; and acculturation and language.

Religion and Spirituality

Although the words are used interchangeably in conversation and throughout the literature, *religion* typically refers to traditional practices associated with a belief and value system, whereas *spirituality* is a less collective practice and focuses more on personal connection beyond behavioral components (Dowd & Neilson, 2006; Magaldi-Dopman & Park-Taylor, 2010). For African American adults, religiosity and spirituality are cited as significant coping tools for routine and extraordinarily stressful circumstances and, for many, are considered important pillars of identity (Mattis & Watson, 2009). More specifically, spirituality was cited as the most prominently used coping mechanism among African Americans (Gallant et al., 2010). As many African American parents use prayer and other spiritual practices to cope with their children's illnesses, one may deduce that through modeling, African American children experiencing this parental response may also rely on religion and spirituality to cope with adversity (Denby et al., 2015). The ideology represented in most religions and spiritual beliefs practiced by African Americans serves as a protective factor by decreasing engagement in high-risk behaviors (Mattis & Watson, 2009).

Considering the many disparities and barriers, coupled with the coherence of religiosity and African American identity (Mattis & Watson, 2009), valuing the church community as a place for guidance and dissemination of health care and mental health care services is logical (Brown & McCreary, 2014; NAMI, 2018). The African American church has been a center for community members to obtain spiritual guidance and has more recently become a resource for health care services through fairs and free clinics (Thomas et al., 1994). As the church is a

primary resource for African Americans, the role and views of church leaders are vital to consider when parishioners present with mental health concerns. A qualitative study investigating the beliefs of Pentecostal African American clergy members regarding mental health and the influence of those views on referral practices within the community notes that the gap between religious providers and mental health providers may be bridged by incorporating the spiritual supports of African American patients in treatment (Harris, 2018). In a study of 39 southern pastors regarding practices and perceptions of mental health, the pastors expressed a neutral attitude toward mental health, and pastors with more positive perceptions counseled members more often (Brown & McCreary, 2014). However, the same study participants indicated a desire for further training in many of the mental health issues presented (Brown & McCreary, 2014). As pastoral counseling and health fair resource provision are recognized as different from outpatient therapy and primary care, the importance of incorporation of spirituality and religious values into interdisciplinary treatment plans is emphasized throughout the research.

Family, Relationships, and Community

The social influence of family members, community, and peers to participate in health care practices can shape attitudes toward health care. African American men are less likely than African American women to seek preventive care but are more likely to make an appointment if encouraged by a female family member (Cheatham et al., 2008). Similarly, African Americans are more likely to go to a clinic for health screenings and testing in peer groups than independently (Grande et al., 2013). Research also found that incorporation of family and friends in exercise routines increased motivation for African American and Latinx groups (Orzech et al., 2013). Among young adults, a recent study of 180 participants indicated a

correlation between behavioral health and strong peer and community influence (Ford et al., 2017). These findings suggest strong family and community ties impact African American health care decision making. Community-based programs create awareness and can increase interdisciplinary treatment seeking and adherence (Williams et al., 2014), but family members and peers also can discourage health care visits and perpetuate mental health stigma. Thus, family and friends serve as moderators of health care treatment within the African American community.

Acculturation and Language

Acculturation, the process by which a person adopts characteristics and traditions of a different culture (Walker & Hunter, 2009), for African Americans is relative to the amount of shared language, cognitive styles, and values of the community in which deviations are considered an adoption of European American values (Anglin & Kwate, 2009). Previous research has shown correlations between acculturation status and aspects of health care access and use (Hasnain et al., 2013). Conceptualization of African American acculturation as it relates to mental health indicates that those with low levels of acculturation are ill equipped to recognize pathological signs and are more resistant to psychological intervention (Walker & Hunter, 2009). Contrastingly, this view holds that African American individuals who are more acculturated are more susceptible to manifesting psychological pathologies, making African American identity a protective factor against mental illness (Walker & Hunter, 2009).

Language, dialect, or vernacular is unique within African American communities and may suggest level of acculturation and identity with other community members (Harper & Hudley, 2009). The use of African American English can be traced to times of slavery, during which cultural mistrust and safety created coded language to hide messages in spoken word and

song (Terrell et al., 2009). Additionally, African Americans historically received lower quality education, even after emancipation, thereby furthering differences in dialect. Within the African American community, "sounding White" is associated with desire for high achievement but also with distancing from African American cultural language (Harper & Hudley, 2009). As such, many African American individuals have developed code-switching skills to communicate successfully between groups, most notably, the first president of African American descent, Barack Obama (Young, 2009). While code- switching is a subject of debate within the African American community, little research exists examining its influence on behavior. This lack of research may be because of its origins in cultural mistrust. With regard to health care, team members typically use jargon that can mimic a different language and discourage communication (Shepherd et al., 2018). Identifying the role of language between patient and provider and, more specifically, the impact of code switching or lack thereof would be helpful in in-group patient-provider interactions.

Current Research

Purpose of the Study

Understanding the factors that are of cultural significance to each client is vital in building and maintaining the helping relationship with members of the interdisciplinary team. Considering that African Americans and Blacks are among underserved populations, identifying the cultural factors they want their helping professionals to consider may help to decrease the stigma and distrust that has plagued this relationship. The main purpose of this study is to identify salient cultural considerations within the Black and African American communities that impact the relationship between physicians, nurses, mental health therapists, psychologists, and

all other allied professionals on the interdisciplinary care team and their Black or African American patients.

CHAPTER 3: METHOD

Study Design

This study used a qualitative grounded theory design. Qualitative grounded theory was selected to gain more information about the relevant cultural factors African American adults would like to be considered in their interdisciplinary health care settings. Current research on the African American population identifies its common cultural values, but little investigation has been done into the cultural factors that are important to African Americans within their interactions with helping professionals.

Using a grounded theory design allows for open discovery of theory led by the data collection and analysis process (Corbin & Strauss, 2008; Glaser & Strauss, 1967; Marshall & Rossman, 2011). Grounded theory in qualitative design is not driven by preexisting theory or hypotheses, thus allowing for flexibility in data collection in service of the research aim (Glaser & Strauss, 1967). The grounded-theory method emphasizes questioning over measuring and the development of a hypothesis using theoretical coding (Auerbach & Silverstein, 2003). As such, this approach is considered hypothesis-generating research (Auerbach & Silverstein, 2003). Some defining hallmarks in this qualitative method are the simultaneous collection and analysis of data, the development of codes and categories from the data, and theoretical sampling in which the sampling process is in service of theory construction (Corbin & Strauss, 2008; Glaser & Strauss, 1967). Additionally, research using grounded theory involves taking cues from the participants and encourages following new leads generated in the interviews (Smith, 2003). The use of open-ended questions in the interview allows for the gathering of data that is richer than the data that might be provided on a quantitative instrument (Smith, 2003). This methodology was chosen as the most helpful method in the attempts to uncover the cultural values that are

most relevant in the interactions between African Americans and their interdisciplinary health care team members.

Data Analysis and Plan

Within the qualitative framework, data analysis and collection are connected to build interpretation (Marshall & Rossman, 2011). Using grounded theory methodology, this study used relevant literature as a guideline for investigation and analysis. Data analysis employed coding, which is an analytic tool that conceptualizes raw data (Corbin & Strauss, 2008). Coding is a fluid and dynamic process that allows for organization according to dimensions and properties (Corbin & Strauss, 2008; Corbin & Strauss, 2014). The application of grounded theory and coding allows the researcher to generate and organize themes that emerge from the data. Memoing, in grounded theory, consists of breaking categories apart for closer examination (Smith, 2003). This form of note-taking allows the information to be highlighted for patterns, clusters, or themes (Marshall & Rossman, 2011). Coding was conducted in three stages: open, axial, and selective coding.

Open Coding

Open coding is the analytic process in which the concepts are extracted from the raw data and the data dimensions and properties are identified (Corbin & Strauss, 2014). Additionally, open coding provides anchors or blocks that further delineate and qualify the derived concepts (Corbin & Strauss, 2008). During open coding, the data are broken down and compared for differences and similarities within the data through close examination (Corbin & Strauss, 2014). During the early stages of coding, memoing also occurs. The data gathered from the participants is openly coded throughout the data collection process to identify properties and underlying assumptions and as a way to monitor when categories develop and shift.

Axial Coding

Axial coding was the next step in the coding process in which the derived concepts are related to one another (Corbin & Strauss, 2008). The codes are grouped according to the conceptual categories that reflect similarities around points of intersections called axes (Marshall & Rossman, 2011). The researcher used axial coding and higher order connections between repeating ideas to derive themes from the data.

Selective Coding

The next step consisted of selective or focused coding. Selective coding involves focusing and extracting the most significant or frequent codes from the initial codes created (Marshall & Rossman, 2011). Sometimes, themes are combined to develop and further reflect the research construct (Marshall & Rossman, 2011). The researcher used selective coding to evaluate the relationships between the categories for further clarification until saturation was achieved and all of the identified concepts were well defined and explained by the coded data.

Participants

The convenience sample included 12 African American, English-fluent adults older than the age of 18 years. The Metro Philadelphia area in southeast Pennsylvania was the target recruiting location. Additionally, all participants received health care services in the target area. More specifically, participation in the study required inclusion of adults who had received care from an interdisciplinary care member (i.e., physician, nurse practitioner, mental health therapist, psychologist, or psychiatrist) within the previous 2 years (24 months) from participation selection date.

Once the sample was selected, any participants whose ability to communicate was hindered as a result of impaired cognitive functioning or significant auditory limitations were

excluded from the study. An additional exclusion criterion was lack of access to a telephone to complete the interview in a private area. All participants meeting the appropriate criteria were included in the study.

Sampling

Within a theoretical sampling framework, a combination of convenience and snowball sampling was used to generate the final sample. Participants were recruited beginning in December 2019 and ended once saturation was reached in March 2020. Saturation occurs when new data start to reinforce themes or categories analyzed from data already gathered during the study (Auerbach & Silverstein, 2003) by offering depth and variation in development (Corbin & Strauss, 2008).

Recruitment

In order to conduct the study, an informed consent form and recruitment advertisement were developed for approval from the Institutional Review Board (IRB) of the researcher's institution. Once approved, the researcher used the electronic and paper recruitment advertisements (Appendix A) and requested permission from local businesses servicing African American clients, such as community centers, salons, academic institutions, churches, and health care centers, to post the advertisement. As potential participants responded, the researcher screened for inclusion and exclusion criteria.

Measures

Demographic Questionnaire

A demographic questionnaire (Appendix B) was created to gather background information, including but not limited to occupation, education, insurance source (private or other), age, racial identity, and gender identification. The demographic questionnaire was

developed and used in expanding data analysis. The demographic information was collected after each interview.

Semistructured Interview

A semistructured interview was developed by the researcher using open-ended questions to gather data regarding cultural factors important to African Americans in their health care experiences (Appendix C). Questions focused on qualities and characteristics participants look for in choosing providers, factors different providers should consider relative to individual cultural identity when providing treatment, any barriers specific to their identity, perception of health care providers with same or different racial characteristics, and other needs and desires salient to investigating the cultural components that are important for an interdisciplinary team to consider.

Procedure

Once potential participants contacted the researcher regarding interest in the study, the researcher screened each individual to determine eligibility. The researcher then used an Eligibility Screener (Appendix D) to determine if criteria were met. Once eligibility was determined, the study's purpose, potential benefits and risks, and informed consent were reviewed and sent to each participant through email. The researcher then scheduled a phone interview date and time. Each participant was asked to reserve 1 hour to complete the interview in a quiet setting free from interruption. Participants were also asked to electronically sign informed consent before the interview.

On the scheduled interview date, the participants were reminded of participant rights, and signed copies of the informed consent were collected. Consent included permission to audio record the interview. All participant interviews were given a code to deidentify their participation

and allow for data analysis. The researcher then collected demographic information from the participant. After the interview, the researcher thanked each participant and transcribed the interviews and deidentified participant responses. At the conclusion of data collection, the participants were entered into a raffle for one of three $50 Visa gift cards as compensation for their time and participation.

A communication request was produced and sent to a pool of advanced graduate students in the Philadelphia College of Osteopathic Medicine's doctoral Clinical Psychology Program to recruit a data analysis and coding team of two doctoral students who had completed the Ethics and Research Methods course. Once recruited, team members were provided with educational materials on the study and coding procedures. The researcher met with the team and reviewed interviews to be coded independently as the researcher coded interviews simultaneously. The researcher met with the team regularly to address progress and answer any questions regarding the data. More specifically, once initial open coding of each interview was completed individually, the researcher met with the research team to provide education on axial coding. Team members and the researcher then completed the second stage of axial coding independently. Once completed, the researcher and team met to review interviews, compare codes, and discuss and resolve any differences in coding for final agreement in selective coding.

CHAPTER 4: RESULTS

The current study explored culturally significant factors among African Americans when seeking health care services from members of an interdisciplinary health care team. Participants were recruited and interviewed to identify salient considerations regarding health care experiences, desires, and values. A total of 17 people responded to the recruitment flyer; however, two potential participants did not respond to additional outreach attempts. Furthermore, another three potential participants did not meet eligibility criteria per the Eligibility Screener. As such, the final sample consisted of 12 eligible participants.

Demographic Characteristics

Each participant who completed the interview was given the Demographic Questionnaire. Participants ranged in age from 19 to 70 years old, with a mean of 36.41 years old. The sample consisted of three people who identified as male and nine who identified as female. Most participants identified as Black (n =7) while others identified as African American (n = 4), or both African American and Black (n = 1). Participants' highest education level ranged from high-school graduate/GED to bachelor's degree. Ten of the participants were employed, and of the remaining two, one was retired, and the other was a student. All participants reported using public (n = 1) or private (n = 11) insurance for health care services. Furthermore, participants reported having attended one or more health care visits with a primary care physician, specialist physician, nurse practitioner, physician assistant, psychiatrist, psychologist, licensed mental health counselor, master's-level therapist, or a professional within the mental health field whose title was unknown. Most participants stated traveling 2 to 5 miles to reach their health care locations (n = 7), while the remaining traveled fewer than 2 miles (n = 3) or 5 to 10 miles (n = 2). The following Table provides demographic information collected for each participant.

Table

Participant Demographic Characteristics Summary

Participant ID	Gender identity	Ethnic/racial identity	Age (Yrs)	Highest education	Occupation	Health visit(s)[a]	Health location	Insurance
VJ	Male	Black	19	Some college	Student	PCP, PA, Psychologist	< 2 miles	Private
LA	Female	African American	19	Some College	Student, Cashier	PCP, PA, NP	2-5 miles	Private
CE	Female	Black	23	Bachelor's degree	Case manager	PCP, LMHC	< 2 miles	Private
BP	Female	Black	21	Bachelor's degree	Legal aid	PCP, SP, NP, Psychologist, MLT	5-10 miles	Private
TY	Female	African American	24	Some college	Salon worker	PCP, SP	2-5 miles	Private
LZ	Male	Black	28	High school/GED	Roofer	PCP, Psychiatrist, Psychologist	2-5 miles	Private
NH	Female	Black/African American	37	Bachelor's degree	Social worker	PCP	2-5 miles	Private
ZS	Male	Black	40	Bachelor's degree	Construction superintendent	PCP, SP	5-10 miles	Private
XN	Female	African American	47	Bachelor's degree	Retail, Home caregiver	PCP, PA, NP, unsure within mental health	2-5 miles	Public
IY	Female	African American	48	Bachelor's degree	Correctional sergeant	PCP, SP	2-5 miles	Private
QN	Female	Black	61	Associate degree	Administrative coordinator	PCP, SP, NP	2-5 miles	Private
JL	Female	Black	70	Some college	Retired	PCP, SP	< 2 miles	Private

Note. PCP = primary care physician; SP = Specialist physician/surgeon; NP = Nurse practitioner; PA = Physician assistant; LMHC = Licensed mental health counselor; MLT = Master's level therapist[a]

Analysis of the participant interview response data yielded themes across each interview and question within overarching contexts: Communication, Rapport, African American/Black Culture in Health Care, Health Care Teams and Follow-up Referrals, and Barriers to Care. Within each context, consistent themes were endorsed within each interview to account for mental and physical health care experiences and desired interactions.

Communication

Participants discussed the importance of effective communication and its impact on their individual health care visits and treatment adherence. An emphasis throughout many of the responses focused on fostering a collaborative partnership. Additionally, participants illustrated salient values and the process of sharing those values with their health care providers.

Patient-Provider Collaboration

Participants explained the importance of expressing their expectations of the provider and, in turn, gaining an understanding of the provider's expectations. For instance, IY shared, "Some doctors just go straight in with what they expect, but what do I expect as the patient?" She further expressed clarifying expectations: "Kind of like, how my past experiences were with other doctors. Were they good or bad, or did I have a doctor that I think could do more? You know, get some background on me." Assessing for expectations from the provider was also endorsed, as QN reflected, "...and from the very beginning, he told me what kind of doctor he was, things that he takes care of...." Participants expressed a desire for a stronger sense of autonomy with the presentation of education in the formulation of partnership with health care providers. BP stated, "…there needs to be an independence and choice relationship there. And I don't care how small it is." She continued, "I would also need my doctor to educate me at the same time and not cover an opinion by education." Specific to mental health providers, participants illustrated collaboration by

noting the importance of staying out of an advice-giving role. While sharing her thoughts on mental health providers giving advice, QN stated, "It was too much in your face, whereas I thought you were supposed to listen." Participants consistently advocated for being provided with choices in decision making. Many expressed wanting to be asked for input from the provider, for example, VJ responded as follows:

> …asking me what the best situations and scenarios and ways for me would be to get through certain situations. Even if I said something crazy and they said, "Oh, no. We can't do that." Just knowing that they're *asking* me, and I was assured that this wasn't a possibility, would make me feel better. (VJ)

Personal Values and Sharing

All of the participants detailed the values most important to them and the degree to which they would communicate these values to their providers. Every participant stated *family* as a prominent personal value, and *health* was explicitly endorsed among the majority of responses. Many responses were articulated similar to NH's expression of family and health: "Well, I make sure my family is my number 1 priority....I make sure we're all healthy." Other values that were frequently discussed throughout the interviews were *openness*, *equality*, *communication*, *religion*, and *honesty*. Regarding incorporation of values into family interactions, all participants described either using an overt method of teaching values to family members or engaging in modeling behaviors consistent with values. Teaching methods were described as intentional conversations, such as JL described: "I always try to instill in my children to be honest. Honesty is a big thing with me. Not to tell lies. Religion is a big part of my life." Similarly, in describing the importance of *communication, family*, and *honesty*, XN shared the following:

> So, with my child, I really teach him to tell the truth and to be honest because it's your character. If you don't do those things, then nobody will think that you're a good person. And you want people to think that you're a good person. And, like, to communicate. We don't always have to agree on things, but we can communicate. Maybe we can understand and know where the other person came from and why they did whatever they did. (XN)

Modeling behaviors aligned with personal values were often noted, as NH shared, "I make sure that we all, friends and family, I make sure we're all healthy. I make sure everyone goes to the doctor." Additionally, other participants described the acts inherent in taking care of their families as a modeling of values, such as ZS's description of his behaviors related to expressing love and creating stability:

> …making sure I have a good job, making sure the kids are taken care of.… Taking care, and being taken care of, by my family.… Part of being stable is being healthy. If my health, mental health, physical health isn't where it's at, I can't be good for my family. (ZS)

Although all participants indicated being comfortable with communicating their personal values with health care providers, differences emerged among some participant responses that reflected shifts in communication between provider types. For instance, TY stated, "I feel like with the mental health, your family has a little bit more importance." Similarly, in sharing her value of work-life balance and discussing the vulnerability and required strength related to valuing equality, BP shared the following:

> Definitely equality. I have a dual mindset where you can be vulnerable but also strong like a woman. I know that's really hard to do, especially like a Black

> woman…I would emphasize more of the vulnerability and having to be strong more to my mental healthcare provider. And then my physical health provider, I would more so talk about that work drive because that plays into wearing down my body (BP)

Similar differences were expressed among other participants who endorsed changes in the expression of values between providers.

Rapport

Participants discussed the salient considerations in building a positive relationship with the health care provider. One of the key factors endorsed in creating positive rapport hinged on the *alignment of values*. As participants discussed the types of interactions desired with their health care professionals, an overlap emerged between the characteristics of the provider and previously stated personal values. For example, BP directly stated, "…a doctor that I would value or a health care professional that I would value is one that is family oriented, because *I'm* family oriented." Similar overlaps were noticed among many participant responses. More specifically, participants who emphasized honesty described wanting a provider who they felt behaved honestly. Additionally, participants who valued communication and collaboration or autonomy described wanting a provider who makes them feel "listened to" and included in physical and mental health decisions. Other factors that were identified to impact the rapport with the health care professional were the physical environment, empathy, and other patient reviews of the provider.

Physical Environment

All participants indicated the importance of positive rapport, and within responses, participants specifically identified that rapport with the health care provider starts in the reception

area. Front-desk staff, waiting time and communication, and the physical presentation of the office or suite impact the initial impression and interaction with the provider. QN shared the following:

> …and just have the front people be courteous. That's really important because if they don't come off as being courteous from the very beginning, that even sort of turns me off from the doctor and he might be nice as pie, but that already makes me have an attitude. (QN)

The level of warmth during the first interactions with staff and the amount of time before being seen colored the initial experience of the health care provider, as NH stated the following:

> …because sometimes when you come into the doctor's office, the receptionist, the front desk is not always welcoming. Then when you get to the doctor—you know—so by the time you get to the doctor, you already have an attitude. And then the wait time as well. (NH)

Waiting time and communication presented as themes affecting rapport. Participants reported frustration with making appointments that did not start at the appointment time. ZS expressed, "And going to the doctor, you set the appointment for 1 o'clock…you go there at 1 o'clock and you still wait there for like a half hour. It's like the appointment doesn't matter." Other participants emphasized a desire for an increase in communication as wait time increases. For instance, QN elaborated the following:

> …if you're in the waiting room, it would be nice of someone to come out and let you know if they're behind or whatever than to just let you sit there and wait for hours and hours on—well, not hours, but you know what I mean. That's really frustrating. (QN)

There was also a relationship noted between the cleanliness of the environment across health care providers and the level of comfort experienced. As XN described why she feels comfortable at her health care provider's office, she said it was "always clean." Other participants drew connections between the presentation of the office and sense of comfort before seeing the provider as she further elaborated the following:

> It's just the environment itself is a very comfortable environment vs. going somewhere that don't make you feel comfortable so for them to be able to talk to you about your personal business would be kind of awkward if you already not comfortable walking into the office. (XN)

Empathy

Another common theme that emerged within responses reflected participants' perceptions of empathy from the provider. CE shared, "...if I feel like the professional is not really, not a warm person, not empathic, then I'm not going to open up to them." She also added, "Set the ground where we can trust and the mental health professional actually listens and is empathic to their client." Although professionalism was a preferred provider characteristic, a described balance was desired between efficiency and warmth, as TY noted, "…just be a little more compassionate…some professionals are too much about the business, like it's no compassion, no empathy sometimes." Similarly, participants reported wanting to be seen as a human in the eyes of the provider, as LZ shared in his description of what he looks for across health care providers: "Professionalism, being grounded, treating the patient as if they are a human being instead of a number or something to get through the day." Getting through the day was a notion expressed specifically by another participant as a barrier to feeling empathy from the provider. In talking about what she wants in any health care provider, BP stated the following

> Also just feeling like they actually care about you, they have your best interest…one of the things that make me want to go back to that is the way they treat me in the beginning. So how they approach me, how they greet me. Almost like customer service…who cares about me as a patient and not just getting through the next hump/workload of their day. (BP)

Participants further expressed wanting to feel understood, cared for, and valued in the interaction. These expressions humanized the provider and made participants feel they were being treated more holistically. All participants described feeling comfortable with providers who were "personable," as VJ shared, "…being personable, being able to hold a conversation aside from what's wrong with me. Just to show that you care." Other participants specifically indicated that the types of questions asked by providers illustrated their investment in care and demonstrating empathy. NH expressed feeling valued when her provider asks questions that reflect her values: "...my doctor, she asks me about my family, she know I have kids, she knows I'm married. She knows stuff. So, I feel like if you know personal stuff, not too personal, just the basic stuff, that mean that you care!"

Provider Reviews

Four of the participants stated that they use online reviews from other patients to help them determine if they are choosing a provider with the characteristics reflective of empathy and professionalism. QN stated, "I look on the website to see what other people have said…" Others shared the impact of an online review in their making an initial appointment. XN stated, "Because if all your reviews are bad, then nobody has positive things to say. I probably wouldn't go there." Similarly, the remaining participants expressed that less formalized reviews, such as observed

behaviors and shared opinions of those who interact with the provider impact their view of the provider. TY expressed,

> …like what their coworkers have to say about them. And how patients that have been seeing them for a while, how they react to them. How long they've had the same patients, because I think that speaks volumes about the person. You've had patients for years, you're doing something right, you're a nice doctor, you're very caring for your patients. (TY)

African American/Black Culture in Health Care

The importance of having a provider across health care fields that demonstrates cultural awareness and competence was a prominent theme throughout participant responses. Specifically, participants expressed the requirement of understanding African American culture and history, biologic predisposition, and views of health care.

Cultural Awareness and Competency

Awareness was often referred to as a specific understanding of the intersectionality of culture and mental and physical health concerns, as QN stated, "They should know that different backgrounds might suffer more than other backgrounds." Similarly, awareness was noted as an understanding of characteristics of African Americans and of their expression in health care settings. In talking about provider awareness when working with African Americans, TY shared the following:

> I think African Americans are probably like a more sensitive culture. And that even though we come off like you know the 'no questions,' still like try to at that time if we don't have any questions, be open to still give information. (TY)

Competency reflected the way the provider exercised awareness in treatment provision. Participants noted providers need to understand treatment beyond the presence of cultural differences to include relevant background. IY indicated, "...they should know a little more background on them as far as where they came from and different health needs that African Americans might have." Participants also expanded that the need for cultural awareness and competence should include African American and other cultures. CE shared the following:

> I would hope that they are a little culturally competent in dealing with people of different ethnicities. So, I would hope that the professional is a little bit culturally competent in understanding what I'm going through and how it affects me and my race.... (CE)

All of the participants noted culturally specific conditions, and seven participants talked about specific health issues, such as heart disease and diabetes, and their cultural prevalence. QN stated the following:

> ...you know how they say African Americans - it's more like we have heart problems, or what else ...like diabetes and stuff like that. I think they should take a closer look to see what's going on with us, especially since we're more prone to having those kinds of diseases. (QN)

Another emerging theme within cultural awareness and competency was cultural obesity and weight, as participants advocated for a reevaluation of diagnostic criteria, as reflected in statements similar to that of XN: "Some of things that they consider in regards to, you know, being overweight and obesity that the weight size that they have for us today isn't realistic." Participants further suggested gathering more information related to weight, history, and family. ZS stated the following:

> For instance, let's say I'm 230 lbs. I'm not, but let's say I'm 230 lbs. If they, I would appreciate if they ask, "Oh, OK. What size were your family members?" And if I say, "Oh, my dad was 250, but he played college football," from that they can have a greater understanding of my genetic history, but that they don't automatically put me in the obese category or something like that. (ZS)

Family history was also extended to include a more historical cultural competency and awareness in the relationship between family and weight, indicated in IY's response:

> I know, like, as far as some doctors and nurses, they think that we're like obesity because of our size. And I know in our culture, down south our parents feed us healthy. And it might not be an obesity thing; it just might be the type of culture/upbringing that we eat certain type of food. Something if you study on that. I don't think that everyone is obese according to their charts. (IY)

Racial Connection

Discussion of culture within the interviews identified a level of importance for a sense of racial or cultural connection with providers. Participants indicated the significance of having a provider with a similar racial background.

A stronger ability to relate to African American providers was commonly endorsed, specifically by 11 participants, as expressed by LA, who stated, "...because we have the same skin complexion and we somewhat come from the same background, we're able to relate." Several participants added to this notion by expressing this ability to relate was the result of a shared racial experience. IY postulated, "Maybe they had went through some things maybe that I had went through being an African American." Other participants shared that this relatability and shared

experience would be accompanied by the cultural competency and awareness desired. BP elaborated the following:

> I would rather have a Black doctor than a doctor that's not Black just because I feel like I can relate to them more and they'll give me the best advice, medical advice or things like that…I feel very strongly about having if not all my health care personnel Black. However, I don't mind other cultures. I just feel as though if I'm going to the therapist, they may be more culturally competent than a White female from wherever that can't really relate to what I'm going through. So, it's really important to me to have an African American or a Black doctor just for the cultural competency part. (BP)

Availability was also outlined in the scarcity of and preference for Black or African American providers. Some participants like ZS shared never having seen a culturally similar provider: "Truth be told, I've never encountered a Black general practitioner. I've never seen a Black specialist, but I know they exist more so." Other participants highlighted the difficulty related to searching for one. JL stated, "That would be great, but the thing is, I am not able to find a whole lot of doctors within my race." Participants also indicated believing African American providers would see a higher percentage of African American patients compared to other providers, thus fostering the relationship between competency and relatability:

> I think that's really important because it's like some things that's more prevalent or comes up more in the African American culture, and it'll be an African American doctor that'll be able to tell you more because maybe they not - they might have not been personally affected by it or seen it, but I'm pretty sure they've had more

> patients that can attest to the things they're telling me because they're the same culture as me and they have the same doctor. (TY)

Speaking specifically of mental health, ZS stated, "...there's a whole set of different rules for being Black in America than being anything else in America. And that's an important context to have when talking about mental health," further emphasizing the role of racial connection across health care fields.

Health Care Teams and Follow-up Referrals

Health Care Teams

Regarding interdisciplinary teams in health care, responses reflected positive outcomes related to multiple providers working together. Participants noted benefits related to the promotion of holistic care, such as in TY's statement: "I think that's a good idea, actually. That would have them have a more understanding both my physically and mentally about what's going on." Location was another theme prevalent in the rationale provided, noting efficiency. LZ shared, "I feel as though it would be more efficient." Within responses, the limitations within the African American community associated with transportation were expressed, such as in BP's statement: "Also transportation—accessibility would be helpful to have that in one space." Another participant specifically noted the characteristic limitations that would be addressed in a team approach. For example, QN shared the following:

> I think it would be helpful because, you know, we don't like going from place to place to place. I mean you know you might leave your primary and then they'll tell you, "Well, you got to go to so-and-so," and he's maybe two blocks away, and then it's like, "Oh, I'm going home!" [laughs] (QN)

This cultural characteristic was also delineated by two other participants.

Financial benefits were also discussed in relation to insurance. LA remarked, "I think it would be an asset, especially for those who don't have insurance and have to pay extra money." Another participant, CE, more overtly stated the impact of accessibility to mental health care during a primary-care visit for African Americans in her statement, "I think it would be better honestly just because I feel like a lot of Black people don't check out on their mental health. So, I think it would be better because they're right there."

Follow-Up Referrals

The degree to which participants follow up on mental health referrals from the primary-care office identified response patterns. A relationship between the perceived competency of the referring physician and following up on the referral was identified in statements similar to IY's remark: "I would follow up on it because if my doctor feels that I need it, I think it's something…" XN noted the authority of the physician as a defining feature:

> I would follow up just because it was referred to me because that's just the type of person that I am whether I agree with it or not. If somebody referred that to me, evidently they felt that I needed. And I'm not a doctor, so I don't know. (XN)

For others, collaboration and communication continued to be defining factors. For instance, QN said, "I think maybe if they gave like a questionnaire in the beginning…then after I fill it out, then we can go over it and then I think he would have a better picture if I needed anything."

Relatedly, the relevance of the referral to the participant impacted follow-up practices. NH stated, "…it all depends on what it's for. If it's something serious that me and my doctor talked about, then I would follow up," highlighting collaboration and relevancy. Education was also embedded in collaboration and relevancy, as illustrated in TY's comment:

> I would probably be more likely to follow up on a mental or something like that if the doctor that I'm talking to brings more information - brings A LOT of information.... you got to bring everything to the table and not just try to diagnosis me with something because I had two symptoms. No, tell me 10 of the symptoms that I have. (TY)

The other pattern reflected individual attitudes toward follow-up referrals overall, such as in LA's comment, "I mean, it's always good to follow up in general," and toward mental health, specifically observed in responses like CE's, "I would definitely follow up only because I think mental health is important."

Barriers to Care

Provider Mistrust

One of the barriers to care that was discussed by the participants was specifically related to the impact of trust in the medical provider and interdisciplinary system of care. Although all participants stated their belief in care teams to be beneficial to African Americans, four participants expressed a hesitancy for mental health providers to collaborate with a physical health provider. For example, XN was of the opinion that this collaboration represented a potential "conflict of interest." Similarly, LA shared, "...some people don't want the other physician to know what they're going through." However, another theme among these responses emphasized the need to regulate information related back to the physical health provider, noticed in the following comment expressed by QN: "If you ask them maybe not to relay this information to my primary doctor, I think they should do that."

The notion of trust was prevalent throughout participant comments. BP shared the impact of a history of mistrust in medicine on her and her family members. She continued to explain the

importance of the physical health care provider recognizing this impact for all African American individuals. She stated the following:

> I know a lot of people in my family do not like to go to the doctor's and do not really trust doctors and nurses that are not of African American descent due to things like the Syphilis Experiment, and things like that, the Henrietta Lacks story…They would need to know the background of how African Americans' bodies were used against their will for testing and things like that, so the trust that African Americans have going to the doctor and hospital and having the relationship and trust in doctors and nurses is very low. (BP)

Other participants, such as JL, expressed a mistrust related to diagnosis and medication: "I really don't have a whole lot of confidence in them to be truthful…There are some medications that I don't think, we as Blacks, they should be prescribing for us."

Stereotypes and Stigma

Another emergent theme in barriers to care related to stereotypes of African Americans and the perception's effect on health care interactions. Participants shared the role of stereotype in appropriate prescribing practices. For instance, VJ stated the following:

> …they're skeptical to give us the correct medication because they assume that we're going to try to take the medication and sell it or flip it…Just listen to what we say, and if we tell you that we're feeling badly, do your job as a doctor to investigate, and see if there's some truth to what we say. (VJ)

Other participants made connections between the role of stereotypes on diagnosing practices and interactions. While discussing the appropriateness of an obesity diagnosis and of stereotypes, ZS remarked, "…whether it be us being physically more dominant or even feeling as though we're lazy,

or the types of foods we would eat, you know things of that nature that probably would not come up with our White counterparts. (ZS)

Stigma was a theme specific to mental health care among the participants. Themes included Black community perception and access to educational resources. NH illustrated the impact of the lack of resources and community perception of mental health. She also spoke of racial connection:

> …mental health in the Black community it needs to be more advertisement. Because in the Black community, mental health, people don't think mental health is real, but it's real…It would be a positive thing if they were the same, same race. Because a lot of times in the Black culture, you know, they'll say, "Oh, they don't understand that." So, if we had more psychiatrist, therapist, and more advertisement, I think the Black community would be open to mental health. They don't have the knowledge, the information. (NH)

Among participants who echoed the theme of negative mental health stigma within the African American community, VJ suggested the remedy to address stigma and provide education to the community, calling for Black and African American mental health providers to educate fellow mental health providers. He suggested competency in outreach to the community, stating stigma might be addressed if "someone of our culture was inside letting them know of what was expected or what was normal in our culture." Here, he implies a responsibility for Black and African American providers to build a bridge between their provider colleagues and the Black and African American community by teaching appropriate and effective interactions within the community.

CHAPTER 5: DISCUSSION

This qualitative study aimed to investigate the cultural factors most salient to members of the African Americans in their interactions with health care providers who practice as a part of an interdisciplinary team, including mental and physical health providers. This study attempted to add to the literature by identifying and evaluating the most important aspects in the development of a trusting patient-provider relationship in the health care treatment of African Americans. Overall, results identified 11 main themes across five contexts that emerged from participant responses. These contexts included Communication, Rapport, African American/Black Culture in Health Care, Health Care Teams and Follow-Up Referrals, and Barriers to Care.

Summary Overview

The *Communication* context housed two themes: *Patient-Provider Collaboration* and *Personal Values and Sharing*. A sense of autonomy within teamwork was prevalent, indicating participants desired and believed that African Americans would benefit from interactions with providers in which more involvement in treatment decisions was encouraged. All participants stated their willingness to share their values with providers. A distinction was noted between participant sharing behaviors between provider categories. Among the values shared, *family* and *health* were the most frequently reported values, with all 12 participants specifically stating that *family* was the most important, with 11 participants listing *health*.

Within *Rapport*, the three themes were *Physical Environment*, *Empathy*, and *Provider Reviews*. The data indicated that the front reception areas of the provider's office, including administrative staff behavior, created an initial impression of the provider and informed the subsequent provider interaction. Empathic engagement was found to enhance the perception of the participant's value to the provider. Additionally, online reviews from other patients or clients and

informal verbal or observational reviews were determinants of seeking services from certain providers. Participants noted that the way other providers, patients, and staff interacted with their provider informed the decision to initiate or continue health care services with that provider.

Two themes, *Cultural Awareness and Competency* and *Racial Connection*, were identified relating to African American/Black culture in health care. Having an awareness of and ability to demonstrate knowledge of the ways in which culture interacts with mental and physical health care was another prominent data feature. Furthermore, a shared experience based on racial similarity was assumed to increase the likelihood of the cultural competency and sensitivity of the provider. However, the scarcity of African American and Black mental and physical health care providers was also noted.

Health Care Teams and *Follow-Up Referrals* were the two themes that comprised Health Care Teams and Follow Up. Interdisciplinary teams were described to be helpful, given strict adherence to patient consent regarding information relayed back to the medical provider from the mental health provider. Health care teams were identified to have geographic, financial, and holistic benefits. Referrals from primary-care providers for mental health providers were followed up if the patient felt the referral was relevant, if the primary-care provider was considered competent by the patient, or if following up aligned naturally with individual patient characteristics.

The last context, Barriers to Care, also included two themes, *Provider Mistrust* and *Stereotypes and Stigma*. Historical and systematic mistrust of the medical provider was supported by the data, with specific emphasis on diagnosing and prescribing practices. Negative stereotypes of African Americans were found to be a barrier to effective interactions with medical providers. Similarly, negative mental health stigma operated as a barrier for African Americans seeking treatment.

Integrative Theme Conceptualization

While patterns were noted among the data to develop themes, the themes also contained overlapping features, reinforcing one another. Generally, themes reflected the importance of individual and collective values and the degree of trust between patient and provider.

Values

Further examination of the data indicated a relationship between expressed values of *openness, honesty, collaboration,* and *equality* as they pertained to health care interactions. Perceptions of equal treatment in diagnosing and prescribing practices were described as a characteristic of honesty and openness. Equality shared some common features associated with collaboration, which requires effective communication. Similarly, themes within the Rapport context reflected honesty and openness in the demonstration of empathy. Additional overlap was noted in the manner in which participants described the characteristics and values desired in a provider and their described personal values. Alignment of values seemed to strengthen the rapport and may be related to the sense of connection assumed to be inherent when patients and providers are racially similar. Another theme, *racial similarity,* was used as a rationale for cultural competency and awareness. Taken together, this connection asserts that African Americans have similar experiences of culture that shape and reflect perceptions of similar values and that this similarity of values enhances empathy and, by extension, rapport among individuals. When those individuals are patients and mental or physical health providers, the patient-provider interaction feels open, honest, and equal.

Trust

While some participants specifically detailed the lack of trust in medical health care providers, similarities between trust and other identified themes, as well as an overlap on the importance of values, were prevalent. The overlapping values of *openness, honesty, collaboration, empathy,* and *equality* imply a degree of trust between patient and provider that impacts rapport. Additionally, the most salient values of *family* and *health* suggest a required baseline relationship of trust for the establishment of a trusting working alliance. Furthermore, the connection between racial similarity, values, and cultural competency fosters the relationship of trust, with specific focus on accurate diagnosing and prescribing, collaboration in treatment, and provision of mental health referrals. Given that interdisciplinary teams were found to be favorable in addressing barriers to care, trust was outlined as a necessity in the patient's comfort with collaboration between primary-care and mental health providers. The themes of stereotypes and stigma may also be barriers that are addressed when trust is increased. Altogether, an overarching bidirectionality may exist between trust and values, in which trust is a fundamental necessity for a patient to share personal values with a provider. Likewise, patients may also need to value the components of a trusting relationship to facilitate effective and meaningful interactions that positively enhance the health care experience.

Theoretical Application

Theories of social behavior provide insight into the interaction of the individual and the environment. Specifically, social learning theory (SLT) and social identity theory (SIT) might offer specific rationale for themes identified within the data.

Social Learning Theory

SLT supports the influence of family and peers on attitudes within the African American community by explaining the interaction between the environment, personal factors, and individual behavior (Corey, 2012). Learning through SLT is facilitated by direct experiences with rewards and punishments and observing the behavior of others, known as modeling (Bandura & Walters, 1977). Modeling replication becomes long-term behavioral change when intrinsically reinforced and motivated (Bandura & Walters, 1977). SLT assumes persons are their own agents of behavioral change through the personal belief in performance to bring about change known as self-efficacy (Corey, 2012).

Mistrust in the medical system and mental health stigmatic beliefs may be reflections of social learning. For example, all participants indicated their personal values were taught through instruction of, or modeling to, family members and friends. Values mirroring mistrust of medical provider or negative views of mental health may be adopted by family members. Similarly, watching parents model avoidance, disengagement, or condemnation of physical or mental health care maintenance may also teach family members to acquire similar behaviors and subsequently develop similar values through implicit observation. Contrastingly, positive values and pro-social-modeling behaviors related to health care may be socially learned.

Social Identity Theory

SIT posits that self-concept is derived from the groups in which a person belongs (Tajfel & Turner, 1979). Individuals' categorizations impact the ways in which they see themselves and engage in their environments. SIT further states that the perception of belonging to a group creates an in-group. Individuals may develop a bias or preference to their in-group, known as in-group bias (Tajfel & Turner, 1979). Furthermore, as social identity is connected with personal identity,

individuals strive for a positive in-group social identity by way of in-group bias (Tajfel & Turner, 1979).

Themes in the data reflecting a preference for or positive assertion regarding the care received by African American providers may be a function of SIT and in-group bias that is grounded in theories of racial identity. Cultural matching may communicate, as noted in the data, a shared experience, similar goals and values, and favorable intergroup treatment on the basis of physical and mental health care. Promotion of positive experiences when seeing an African American provider may also be a type of in-group bias working to enhance positive social group identity.

Clinical Application in Research

Since the initial development of SLT and SIT, subsequent studies have evaluated these theories in the population. Similarly, studies have also supported the evidence of mistrust of health care providers, mental health stigma, and identified values.

Historical context and histories taught actively through instruction and implicitly through behavioral modeling can support the legacy of mistrust of health care professionals among African Americans and certain other minority groups. Keeping with SLT, decades following the Tuskegee study, African Americans scored higher than other groups on distrust scales, indicating they expected their provider to be dishonest or withholding from them (Corbie-Smith et al., 2002). Additional research shows racial and ethnic minority groups are more likely than White individuals to report poor interactions during their medical visits (Elder et al., 2015). Considering the data suggesting a belief of positive outcomes relative to interdisciplinary care teams and follow-up practices, lack of trust can be a barrier for physical and mental health care when such care is delivered collaboratively through interdisciplinary teams. Here, mistrust of one provider of mental or physical health care may carry over to the entire health care team. Aligning with SIT, the health care

team might become an outgroup in this case, further bolstering the barrier to care. Another example of this transfer of attribution was evident in the data that discussed the impact of the physical environment and the administrative personnel interactions within a provider's office, creating an assumption about or coloring the interaction with the provider. An in-group-outgroup categorization of patients and providers could develop. Multiple identities, such as African American and patient, can emerge, or a more detailed identity can develop as African American patients.

The data also showed that trust in one referring provider impacted the degree to which the referral was followed up. Regarding the interaction of stigma with health, SIT, values, and SLT, the sharing of values through social learning within an identified in-group, such as African Americans, may impact attitudes toward mental health treatment. More specifically, if African Americans perceive themselves as a stigmatized racial group, a rejection of mental health engagement may result, as mental health stigma would not positively support the in-group racial identity. Research has found that when racially stigmatized groups, such as the African American community, perceive discrimination as more pervasive, the commitment to their in-group is greater (Jetten et al., 2018). However, the data suggested that patient values aligned with those of health care providers produced better health experiences and outcomes, and this alignment could support the extension of the in-group to include the provider and health care team if the interaction is favorable. More specifically, the alignment of values and establishment of trust may allow African American patients to add a detail to an existing in-group identity that includes the interdisciplinary health care team members or to add a new in-group identity altogether.

Strengths

One of the main strengths of the study is its addition to the literature, as there is a wealth of research on African American cultural values, but not on the value of the importance of interactions

between interdisciplinary care team members and their African American patients. Considering SIT, the researcher's self-identifying as a Black American in recruitment materials may have enhanced participants' levels of comfort and openness in participation and responses. Conducting a qualitative study allowed for a richer collection of data by allowing the participants to respond freely and flexibly, providing them with the opportunity for open responses, including a more in-depth account of which values were important in their interactions with interdisciplinary-care team members. Although participant responses provided overlapping themes regarding values and trust, the variance in the display or definition of trust and the variability of values among the participants captured the presence of individual differences within a collective racial identity. This variance emphasized the importance of customization of care within cultural competence. Additionally, the nature of the qualitative approach yielded strong content and face validity (Barker et al., 2016).

Limitations

Although the researcher's racial self-disclosure to participants during recruitment served as a strength in this study, it could also be a limitation. The intracultural understanding assumed within an in-group matched on racial identity may have prompted less detailed responses. Information could have been omitted, as participants assumed the researcher understood the nuances and subtext of certain statements. Furthermore, to maintain the integrity of the data-gathering process, prompts for additional information remained conservative to protect against bias and encourage free response.

This study also had limitations inherent in the design. Qualitative-study sample sizes challenge generalizability and are not constructed to describe all in the population investigated. The sample size of 12 is much smaller than that of most quantitative studies, thereby impacting effect size. This study also accessed participants who self-selected as volunteers, perhaps reflecting a

common characteristic or bias among this group. Volunteers may offer views that saturate the data, further impacting external validity (Morling, 2018). Similarly, the study criteria required participants to have access to receive electronic dissemination of materials. This stipulation excluded individuals without electronic resources. Within the design, the data collection was limited to the southeastern Pennsylvania area and, as such, reflects views of only those who responded and who resided within the metro Philadelphia recruiting locations. In addition, the research team members individually completed both open and axial coding procedures, a deviation from more traditional models of coding but does not impact the validity of the data.

Study Implications

The goal of this study was to identify factors most important to African Americans in their interactions with different health professionals that may be a part of an interdisciplinary team. Given the documented historical strain between African Americans and health care professionals, addressing the values identified may serve as a balm that encourages this relationship to mend. Increasing trust within the provider-patient relationship may lead to better physical and mental health outcomes through adherence to health recommendations that are in the patient's best interests. Additionally, as trust builds, future generations within the African American community can benefit through social learning as parents and other significant family members model beneficial interactions and partnerships with heath care professionals for younger family members. As a health care provider, understanding the values important to this community can serve as a guide for treatment. Customizing treatment for each patient takes patient values into account, builds rapport, and can lead to longer treatment adherence, possibly translating to positive treatment outcomes. Recognition of these values also enhances the cultural competence of the health care provider, furthering ethical standards of practice. Findings from this study have implications for health care

providers and student health care providers treating African Americans and working on an interdisciplinary health care team regarding health care education and professional practice that support future research directions.

Implications for Future Research

Interdisciplinary Education

Interdisciplinary education, or interprofessional education (IPE), is the holistic training of providers across health care departments. IPE aims to provide health care professionals and students with skills to work in a collaborative manner to improve patient care (Buring et al., 2009). For interdisciplinary health care teams to benefit patients, competency training through the transmission of knowledge, skills, and attitudes is necessary. Students in IPE experience learning with students of partner health care professions with an emphasis on reflective interactions among students receive instruction from faculty focused on highlighting professional interactions in a team approach and share in the decision making or responsibility in patient care (Buring et al., 2009). Research supports the positive impact of increasing the diversity of health care professions in which students participate in IPE courses, resulting in reports of higher satisfaction with education by medical students (Association of American Medical Colleges, 2014). Medical schools in which IPE is inclusive of students across physical and mental health care have also produced similar outcome data. A recent study with IPE students also evaluated the perception of contribution between physical and mental health disciplines. Students were able to state ways in which fellow health care disciplines can contribute to patient care across six categories: medication management, behavioral interventions, treatment, counseling, prevention, and referral (Poole, 2020). Furthermore, contribution ratings ranged from moderate to significant (Poole, 2020). These findings illustrate the positive impact of IPE on health care student education.

Given the empirical support for the benefits of interdisciplinary care, the growth of IPE programs, and production of professionals who are equipped with the requisite knowledge, skills, and attitudes to work on health care teams will facilitate increased accessibility of this resource for African Americans. Additionally, the graduation of IPE students will continue to promote the holistic conceptualization of patient care gained in learning from, with, and about other health care professions. For students who graduate but are not working in interdisciplinary care, IPE will still provide the knowledge, skills, and attitudes that will inform treatment, interventions, and appropriate referrals. Integrating IPE into continuing-education requirements for health care service providers has been discussed in the research; if found effective, it may impact related professional educational policy (Minniti et al., 2019;Owen & Schmitt, 2013).

Patient Satisfaction and Health Outcomes

The health care literature provides various definitions for patient satisfaction, including the feelings and emotions of the patient, congruency between patient expectations for ideal and perception of real care, and attitudes of care (Al-Abri & Al-Balushi, 2014); however, all of these operational definitions reflect the patient's subjective experience. Satisfaction is distinguished from treatment and health outcomes in the literature. Outcome is the actual result of health, reflecting treatment as a true measure of quality of care (Pantaleon, 2019). Although patient satisfaction and patient health outcomes are different, a meaningful interaction is noted in research that influences patient health.

The working alliance is a concept within the psychological literature representing the rapport or relationship between the health care provider and the patient. Working alliance has also been studied within physician-patient relationships. Research involving 101 patients investigated the connection between patient satisfaction and patient treatment adherence as defined by ability to

follow treatment regimen. Results indicated the working alliance could predict patient treatment adherence through patient satisfaction showing moderate effect (Fuertes et al., 2015). Similar research supports the relationship between patient satisfaction and care within large hospital systems with specific focus on surgical care. Higher rates of patient satisfaction were correlated with lower perioperative mortality and readmission rates (Tsai et al., 2015). Within primary care, another significant correlation was found between satisfaction and outcomes in a study in Ghana, in which higher patient-rated satisfaction was associated with better health outcomes (Ofei-Dodoo, 2019). Moreover, patient satisfaction was operationalized in measurement to include wait times, respectfulness, communication, decision making, privacy, choice, and cleanliness, all of which were shown to be significant predictors of satisfaction (Ofei-Dodoo, 2019). More research that investigated mental and physical health outcomes and association with patient satisfaction found that poor mental and physical health outcomes were correlated with lower ratings of satisfaction (Chen, 2019). Additionally, an inverse relationship was noted between lower rates of satisfaction and increased rates of emergency department visits among patients (Chen, 2019). Taken together, the relationship between patient satisfaction for physical and mental health care is seen in the research to influence and predict health outcomes. Patients with a positive rapport and working alliance with their providers show better health outcomes. The positive relationship, which might be a function of increased trust or collaboration, may encourage the patient to maintain treatment recommendation, thereby enhancing health outcomes.

Future research may benefit from studies on patient satisfaction among African Americans who seek interdisciplinary team treatment as well. Similar studies might investigate this relationship among providers who practice independently but have received IPE-related training. A focus might be placed on any variance in satisfaction based on the level of exposure to IPE in graduate or

medical programs among team members. Other studies may consider the impact of any differences in IPE delivered during different points in training (e.g., graduate school or career training) on African American patient satisfaction. Additionally, implications promote future research into the impact of interprofessionally educated team members on health outcomes of African Americans compared to outcomes of members of other groups. Such research may be informative.

Values Integration in Practice

Given the themes within the data, African Americans may benefit from providers' assessments of patient values. Motivational interviewing (MI) is a counseling approach designed to facilitate change through focus on natural language about change based on personal values and interests (Miller & Rollnick, 2013). The specific focus on the elicitation of personal values customizes the interaction, thus leading to more tailored treatment interventions. MI has been shown to be effective in mental health settings and adapted for health care settings. Within health care settings, MI encourages the delivery of strategies already employed by physicians, such as asking, listening, and informing, using a guiding and collaborative style as opposed to a directive style of communication (Rollnick et al., 2014). Recent studies examined the impact of MI training for medical providers. Twenty pediatric health care professionals from an academic pediatric hospital completed an advanced 20-hour MI training, and results indicated that advanced training evidenced significant growth in using MI skills and self-reported confidence in skill use (Victor et al., 2019). Furthermore, the study concluded that advanced MI training allowed providers to develop skills to deliver MI effectively (Victor et al., 2019).

The skills inherent in the spirit of MI not only reflect the eliciting of values in a meaningful way, but also reflect characteristic traits mentioned in the data. Feeling valued and listened to and being provided with a sense of autonomy communicate a desire for collaboration with African

American patients. Moreover, the elicitation and use of personal values in health care interactions and treatment may enhance rapport and trust. Research examining the specific use of MI in referral outcomes might provide insight on this technique in health care. Similarly, studies might evaluate African American patients' sense of rapport with and trust in various members of interdisciplinary health care teams that practice MI. Another study might seek to investigate MI training outcomes as a part of IPE for medical students working within African American communities.

Additional Directions

Although some of the values highlighted may generalize to other populations, future investigations may seek to identify salient cultural values among other minority populations, including different ethnicities and gender identities. Similarly, within the African American community, future research can be expanded geographically and compared across locations to identify similarities and differences among regions. The data for this study were collected via phone interviews; however, in-person interviews may add a personal component that could expand themes or generate additional themes.

A more in-depth analysis might identify the origin of mistrust and learned stigma related to health care. Additionally, a qualitative study on the perception of cultural connection among African American providers with African American patients could support rapport building and provide insight into communication and collaboration. Keeping with the implied assumption in the data that African American providers are underrepresented and, as such, in higher demand among African Americans, no research supports this assertion. Similarly, if a treatment manual or competency program were developed to support providers working with the African American population, results might add to the body of literature and inform treatment practices. Given the established inverse relationship between emergency visits and preventative care visits among African Americans,

investigating a comparison of emergency visits between African American patients who have an interdisciplinary care team, an African American provider, or a self-reported positive relationship with their providers could also inform treatment interactions and education.

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Appendix A

Recruitment Statement

Greetings,

My name is Ashley M. Smith and I am an African American/Black doctoral candidate in the APA-accredited Clinical Psychology program at Philadelphia College of Osteopathic Medicine. As a part of my program, I am conducting a research study and writing a dissertation. I am under the supervision of Dr. Bruce Zahn, Ed.D., ABPP, and interviewing African American adults regarding their experiences and values around health care interactions.

If you are an African American adult who receives health care services in the metro-Philadelphia area and have attended an appointment in the last 2 years, you may qualify as a participant in my study. Participants must be willing to complete a phone interview that will last30-60 minutes. Health care professionals are defined as physicians, psychiatrists, physician assistants, nurse practitioners, psychologists, licensed mental health counselors, and masters-level therapists.

Your participation is voluntary and at no cost or penalty. Additionally, no identifying information will be released as I will be assigning you a coded identification name to protect your personal identity. Participating in this study anonymously will give you an opportunity to share your views and responses freely regarding your health care experiences, values, and recommendations. All information gathered could be used to improve the cultural competency of health care professionals and begin to address any barriers that African Americans may face when interacting with their doctors, clinicians, and therapists.

The study will require you to complete an interview with me over the phone and answer a short screener and demographic questionnaire. I would greatly appreciate your participation and contribution to my research as I aim to provide a platform for African Americans to share their experiences. Participants will also be entered in a raffle for one of three $50 Visa gift cards.

Those interested in participating in my study can contact me at ashleysmit@pcom.edu

Thank you!

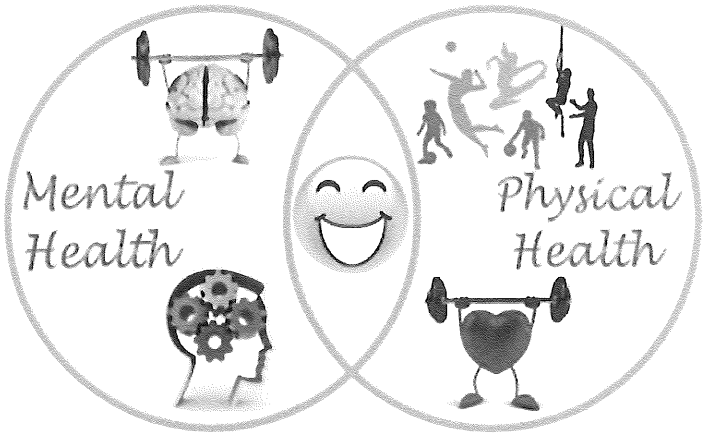
Ashley M. Smith

Recruitment Flyer

Participants Needed!!!

Participants Must

- **18 years of age or older**
- **Identify as African American/Black**
- **Attended a health care appointment within the last 2 years**



Participants who complete the study will be entered to WIN one of THREE $50 VISA GIFT CARDS

Study Consists of:

-2 Brief Verbal Questionnaires

-1 Phone Interview (30-60 minutes)

Cultural Considerations: African Americans and Health Care

My name is Ashley M. Smith and I am an African American/Black 4th year doctoral candidate at Philadelphia College of Osteopathic Medicine. I am currently collecting data for my dissertation on the values and experiences of African Americans when interacting with health care professionals.

If interested in participating, please contact me and provide your initials as reference:

Ashley M. Smith
267-332-4611
ashleysmit@pcom.edu

Appendix B

Demographic Questionnaire

Participant Id: _____

Instructions: Please provide answers to each question below.

1. Gender identity: _____
2. Age in years: _____
3. Racial identity: _____
4. Highest grade/degree completed:

☐ Less than 12th grade ☐ High school diploma/GED ☐ Trade school certificate

☐ Some college ☐ Associate degree ☐ Bachelor's Degree ☐ Master's Degree

☐ Doctoral Degree ☐ Post-Doc ☐ Other/Multiple: _____

5. Occupation(s): _____
6. Health care professional visit(s) within the last 2 years (select all that apply):

☐ Primary Care Physician (MD/DO) ☐ Specialist Physician or Surgeon ☐ Physician Assistant

☐ Nurse Practitioner ☐ Psychiatrist ☐ Psychologist (PsyD/PhD)

☐ Licensed Mental Health Counselor (LPC/LCSW) ☐ Master's Level Therapist (MS/MA)

☐ Unsure w/in medical field ☐ Unsure w/in mental health field ☐ Other:_____

7. Health care location:

☐>2miles ☐2-5 miles ☐5-10 miles ☐<10 miles

8. Insurance type:

☐ Private ☐ Public ☐ Not used-out of pocket ☐None-out of pocket

Appendix C

Semi-Structured Interview Questions

1. Aside from your health, what could make a doctor's visit or health care experience good for you?
2. What would make you more or less likely to follow up on a referral for mental health or behavioral health services?
    a. F/u- What if the professional worked in the same office or as a part of the same team as your physician?
3. Other than health education and expertise, what *characteristics* or *values* are important to you when choosing a health care professional?
4. If you were starting to see a new health care professional, what would be the most important questions they could ask about *you* to build a trusting and good relationship?
5. Could you please share with me some of the values that mean the most to you?
    a. F/u-How do you incorporate these values in your family interactions?
6. If you were to share your values with your providers, are there differences in the *importance* of values you'd like addressed?
    a. F/u-What are the values that are most important for your mental health professional vs your physician?
7. In your experience, what would be helpful for health care professionals to know about working with African American patients, from *your* perspective?
8. How could a health care provider best add your (cultural) values to treatment?
9. Please explain how important it is to you to have someone of the same cultural or racial background on your health care team.
10. How is cultural or racial connection or understanding important to you in your relationship with your health care professional?
11. Is there anything else I didn't ask you that you would like me to know, or others in the professional community to know, related to cultural considerations of African Americans in interdisciplinary care?

Appendix D

Eligibility Screener

	Yes/No
1. Are you African American or Black?	☐ ☐
2. Are you 18 years or older?	☐ ☐
3. Do you reside in the southeast Pennsylvania/Metro Philadelphia area?	☐ ☐
4. Have you attended an appointment with a local health care professional (psych, physician) within the last 2 years?	☐ ☐
5. Are you able to complete a phone interview for 30-60 minutes?	☐ ☐

*Any questions answered "No" excludes participant from study

Eligible Participant ID: _____