5-2007

Literature Review; Culturally Competent Care for Native Americans with Mental Illness

Pamela V. Merrifield

Literature Review; Culturally Competent Care for Native Americans with Mental Illness

By

Pamela Vallie Merrifield

Bachelor of Science Nursing, University of North Dakota, 2005

A Non-Thesis Project

Submitted to the Nursing Faculty

Of the

University of North Dakota

In partial fulfillment of the requirements

For the degree of

Master of Science Nursing

Grand Forks, North Dakota

May

2007

This non-thesis project, submitted by Pamela Vallie Merrifield in partial fulfillment of the requirements for the Master of Science in Nursing from the University of North Dakota, has been read by the Faculty Advisor under whom the work has been done and is hereby approved.

_____

Chairperson

Permission

Title: Providing Culturally Competent Care to Native Americans With Mental Illness: A Literature Review

Department: Nursing

Degree: Master of Science in Nursing

In presenting this non-thesis project in partial fulfillment of the requirements for a graduate degree from the University of North Dakota, I agree that the library of this University shall make it freely available for inspection. I further agree that permission for extensive copying for scholarly purposes may be granted by the professor who supervised my non-thesis project, or in her absence, by the chairperson of the department or the dean of the graduate school. It is understood that any copying or publication or other use of this non-thesis project or part thereof for financial gain shall not be allowed without my written consent. It is also understood that due recognition shall be given to me and to the University of North Dakota in any scholarly use which may be made of any material in my non-thesis project.

Signature_____

Date_____

Table of Contents

Acknowledgements..... vi

Abstract..... vii

Chapter

I. Introduction..... 1

Background..... 1

Significance and Purpose..... 2

Definitions..... 2

Theoretical Framework..... 3

II. Literature Review..... 5

Cultural Diversity in Health Perceptions..... 5

Introduction..... 5

Rural Culture and Health..... 5

Health Care for Native Americans..... 6

Black American Health-seeking Issues..... 7

African Americans Compared to Native Americans..... 9

Chinese Elders Health Issues..... 11

Korean Health-seeking Behaviors..... 15

Native Americans Health Related Behaviors..... 15

Summary..... 16

Mental Illness Care..... 16

General Population..... 16

Adolescents..... 17

Women With Mental Illness..... 20
Men With Mental Illness..... 22
Barriers to Mental Health..... 24
Introduction..... 24
Stigma as a Barrier to Mental Health Care..... 24
Comorbidity as a Result of Barriers..... 25
III. Implications and Recommendations..... 27
Introduction..... 27
Primary Care Practitioner Practice..... 27
Education..... 30
Research..... 30
Recommendations..... 31
Conclusions..... 33
References..... 34

Acknowledgement

To Dr. Eleanor Yurkovich, I am truly grateful for your patience and your support through my educational endeavor.

Abstract

There is a great need for culturally competent nurse practitioners within the health care system. However, the literature is lacking regarding the utilization of services or the health-seeking behaviors of Native Americans with mental illness. There is increased morbidity and mortality afflicting racial and ethnic populations. Poor health of these populations may be attributed to poverty, lack of health care access, and cultural competence of health care providers (Geiger, 2001). As diversity increases within the general population, health care providers have a greater responsibility to become culturally competent to provide better diagnoses, treatment and outcomes of minorities as they seek health care. A review of literature including articles from the past nine years was performed. Madeline Leininger's Sunrise Model served as a framework for this project. This literature review examined the literature addressing health-seeking behaviors of various minority cultures to assist health care providers with knowledge that supports the provision of culturally competent care for Native Americans with MI. The review of literature examined the comparison of health-seeking behaviors of Native American people with MI to rural, Black, Chinese, and Korean Americans as well as people with MI from the general population. This comparison expanded the ability of a culturally competent provider to be responsive to their clients' unique cultural needs. This information will assist health care providers in being more effective in their utilization of cultural preservation, accommodation, or restructuring.

Chapter 1

Introduction

The literature is expanding with information regarding prevalence of mental illness (MI) within the Native American population. However, very little is written regarding the utilization of services or the health-seeking behaviors of the Native American people with MI. This information is important in supporting culturally competent care to Native American people with mental illness. This paper presents the connection between providing competent cultural care as a primary health care provider and the needs of Native American people with MI, which are compared to rural, Black, Chinese, and Korean Americans.

Background

There is increased morbidity and mortality afflicting racial and ethnic minority populations. Poor health of these populations may be attributed to poverty and related environmental factors (such as social, physical, biological, economic and political), lack of health care access and cultural competence of health care providers (Geiger, 2001). These factors may affect the diagnosis, treatment, and outcomes of minorities when they seek health care. The need for culturally competent care in the Native American population is pronounced when comparing several other minority cultures to them, more specifically, focused on people with mental illness. As diversity increases in the population, cultural competence becomes a major responsibility of our primary health care providers.

Significance and Purpose

African Americans, Hispanic, and American Indians are less likely to receive coronary artery angioplasty or bypass surgery, advanced cancer treatment, renal transplantation or surgery for lung cancer as compared with white patients having health care insurance status, income, or education, severity of disease, comorbidity, and age (Geiger, 2001). This pronounced difference in care extends to the availability/accessibility of common physical examinations, history taking and laboratory tests.

However, there is a growing interest in understanding how to provide culturally competent care in educational settings, in undergraduate and graduate curriculums. Moreover, there is an increasing effort to develop educational and research resources to assist the health care professionals already in practice. The purpose of this project is to examine the literature addressing health-seeking behaviors of various minority cultures to assist health care providers with knowledge that supports the provision of culturally competent care for Native American people with MI.

Definitions

Mental illness is impairment of cognitive, emotional, behavioral, and interpersonal relationships leading to a dysfunctional lifestyle.

Mental Health is a state of cognitive, emotional, behavioral, and interpersonal relationships leading to positive associations and contributions to the community and promotion of a healthy lifestyle.

Cultural competence is understanding the needs of others and applying congruent behaviors, attitudes, and policies to facilitate effective care in cross-cultural situations.

Health-seeking behavior is actively seeking health care to promote/create a healthier lifestyle.

Barrier is the obstruction of actively seeking and/or obtaining health care services.

Theoretical Framework

The Sunrise Model by Madeline Lieninger is the theoretical framework for this project. This model is depicted as a rising sun, in which the upper half of the circle presents social components and worldview factors that impact the health care process, including health seeking behaviors. This social structure includes factors such as technology, religion, family, cultural values, political and legal factors, economic conditions, and education factors. All of these factors impact health care professionals and how they care for people of a particular culture (Tomey & Alligood, 2002, 512).

Professional decisions regarding health care can be influenced by the determination to use one of three approaches: 1. support, preserve, and maintain culture, 2. work for cultural accommodation, or 3. need to recognize and begin restructure or repattern the cultural response with the clients (Tomey & Alligood, 2002, 512).

Nurses provide the conduit between profession and generic or folk systems with which we base our cultural practices of health care. The first

approach uses support, preservation, and maintenance of culture to guide the nursing decision-making process. Within this approach, the focus is on maintaining care values of a culture that enables professionals to assist people in the healing process of illness and/or death (Tomey & Alligood, 2002, 509).

The next approach to taking nursing care action is to accommodate or negotiate cultural care. Within this process, people of a certain culture may use compromise of cultural aspects to advance through the health care process toward better health care outcomes. This type of change is designed and implemented by both the nurse and people of a certain culture (Tomey & Alligood, 2002, 509).

Lastly, cultural care repatterning or restructuring may be used to change or modify a culture to achieve better health care outcomes. These changes are important to a culture to prevent further illness and promote wellness by integrating new ideas or concepts into their value system (Tomey & Alligood, 2002, 509).

Chapter 2

Literature Review

Cultural Diversity in Health Perceptions

Introduction

The purpose of this project is to examine the literature addressing health-seeking behaviors of various minority cultures to assist health care providers with knowledge that supports the provision of culturally competent care for Native American people with MI. This chapter discusses the health-seeking behaviors of rural, Black, Chinese, and Korean Americans and how these behaviors compare to Native Americans with MI.

Rural Culture And Health

There are approximately 15 million rural residents experiencing MI and substance abuse with limited resources to address their health care. Ethical problems such as compromised confidentiality and cultural issues related to health care exist, which can greatly influence the health seeking behaviors of its rural residents (Roberts, Battaglia, & Epstein, 1999).

Rural subpopulations such as rural women and Native Americans exhibit more alcohol abuse and related complications such as spousal abuse and drug use than urban areas (Roberts, et al, 1999). Other mental illnesses relevant in rural areas are mood, anxiety, trauma, and psychotic disorders. Rural residents may experience seasonal disorders related to harvests, natural disasters or economic conditions, all of which increase rural suicides compared to those of urban origin (Roberts, et al, 1999).

In general, barriers for Rural Americans seeking health care include lack of health care or limited services; overlap of relationships may pose ethical problems; compromised confidentiality; cultural issues; and inaccessibility to consultational resources (Roberts, et al, 1999).

The Southern rural population struggles with racial barriers to health care, leading to mistrust and dissatisfaction with medical care. Rural populations, both poor Caucasian Americans and African Americans, find that discriminatory practices in health care discourage health-seeking behaviors even when health care services are needed (Fowler-Brown, Ashkin, Corbie-Smith, Thaker, & Pathman, 2006).

African Americans who professed racial barriers to health care were less satisfied, consequently, less likely to have confidence in their health care provider. This perception may be due to previous experiences with racial disparities in the health care setting (Fowler-Brown, et al, 2006). Racial disparities in the health care system may be due to lack of training and inaccessability to clinical resources/consultants who provide routine culturally competent care to African Americans in rural areas.

Health Care for Native Americans

Native American health seeking behaviors are similar to those of the rural population. They exhibit behavioral health problems such as substance abuse, mood, anxiety, trauma, and psychotic disorders. Suicide rates among young

Indian men are the highest of any demographic group in American (Benson, 2003). This may not be surprising since the Native American population may be considered a part of the rural population in most parts of the country.

The Native American population suffers from limited mental health care services. There is a severe deficit of Native American psychologists and other mental health professionals considered necessary to meet the mental health care for Native Americans with MI (Benson, 2003).

Finally, Native Americans experience prejudice or discrimination just as both White and African Americans do in the South. This has led to unfavorable mortality and morbidity precedents for the Native American people. Because Native Americans may practice health behaviors that are not congruent with western medicine such as seeking natural or homeopathic treatments for disease processes, there is a level of discord between Native American people and western medicine, leading to poorer health for Native American people (Gary, Baker, & Grandbois, 2005).

Black American Health Seeking Issues

African Americans are less likely to utilize a consistent source of health care and are likely to seek lay consultation from an informal health care system such as asking family and friends, before seeking medical services (Hewins-Maroney, Schumaker, Williams, 2005). Hewins-Maroney, et al. (2006) found that lack of money or limitations of insurance coverage contributed to delaying treatment for health care problems and/or prescriptions.

Language differences presented barriers between African Americans and their health care providers, impacting their ability to provide culturally competent care. Physicians of different cultures may misinterpret nonverbal signals, which can have an impact on the diagnosis and quality of care given. When negative sociocultural and psychosocial variables were removed, including racism and mistrust toward health care providers, the health seeking behaviors of African Americans are similar to those of the White majority population (Hewins-Maroney, et al, 2005).

Health-seeking behavior is a dynamic process and highly influenced by responses from health care professionals. African Americans and Latinos were more likely than whites to perceive racism within the health care system due to inability to pay for care and/or racial background, indicating that race and ethnicity have a considerable impact on health behaviors (Hewins-Maroney, et al, 2005). Consequently, these perceptions may lead to minor discomforts such as backaches, upset stomachs, or headaches and eventually, more severe medical conditions and poorer health status (Hewins-Maroney, et al, 2005).

The patient and health care provider relationship is crucial in determining health seeking behaviors of an individual or population. Trust must be present to accept recommended care, satisfaction with care, continual care with one provider, period of health convalescence, and acceptance of the health care provider as the consultant or expert (Jacobs, Rolle, Ferrans, Whitaker, & Warnecke, 2005).

African Americans exhibit less trust toward health care providers, regardless of ability to pay, than the Caucasian population (Jacobs, et al, 2005). Furthermore, Jacobs, et al., (2005) believed the distrust of African Americans related to experiences and perceptions with racism and financial discrimination by health care providers. This distrust affected African Americans' willingness to adhere to treatments prescribed by health care providers and contributed to their receding from seeking care completely.

The inability to acquire health care services, for whatever reason, may further impair an individual or population's ability to access preventative services. This inaccessibility is related to participation in risk-taking behaviors and acquisition of chronic diseases. African Americans exhibit a significantly higher prevalence of cigarette smoking and alcohol consumption when they experienced obstacles in attaining health care than those that did not have similar experiences (Shavers, Shankar, Alberg, 2002).

Furthermore, African Americans are less likely to maintain a consistent source of health care, leading to less continuity in their health care. They tend to utilize emergency rooms and hospital outpatient departments as a source for routine health care needs (Shavers, et al, 2002). These health-seeking behaviors may often delay the health care process because of their costs.

African Americans Compared to Native Americans

Native American populations experience much of the same culturally-related obstacles as African Americans. As far as lack of money or limitations of

insurance coverage, Tom Daschle (2004) summed up the limitations of health care when he told a story regarding this topic:

> "Several years ago, a stillborn baby was delivered in Eagle Butte, SD. A simple ultrasound would have prevented the death of this full-term healthy baby since it died because the umbilical cord was wrapped around his neck. No ultrasound was performed, even though the baby's heart rate was dangerously low, because the Indian Health Service, due to budget constraints, allows only one ultrasound per pregnancy, and the baby's mother already had hers." (Office of General Counsel, 2004).

Barriers may exist due to a family's inability to pay, affecting their health care options and services they can access.

Native Americans face health care barriers due to language, differences in beliefs about the person's spirit being, and traditional healing practices or traditional medicine. Culture and language insensitivities contribute to ineffective health care treatments and health seeking behaviors of the Native American population. Furthermore, these ineffective methods find deliberation of eliminating racial health care disparities within the health care system for Native Americans (Office of General Counsel, 2004).

Like African Americans, the Native American population experience mistrust and racial disparities within the health care system. Segregation has led to inequalities in housing, education, and physical environment. At the hands of the government and society, Native Americans have experienced "extermination of tradition, language, and land rights; broken treaties; sterilization of Native

American women; placement of Indian children in boarding schools; and other oppressive experiences leading to mistrust of the government that exists today" (Office of General Counsel, 2004). This ongoing oppression has negatively contributed to the health seeking behaviors of Native Americans and their lack of trust in Western medicine.

Because of the lack of adequate health services and limited health promotion activities, health problems and risk behaviors are significantly present in Native American daily lifestyles. Native Americans are more likely to be current smokers than Caucasian, African, or Asian Americans and more likely than African and Asian men to be current moderate or heavier drinkers (Barnes, Adams, & Powell-Griner, 2005). Like African Americans, Native Americans face the challenge of many chronic diseases such as chronic liver disease and cirrhosis, diabetes, and heart disease associated with these risk-taking behaviors.

Chinese Elders Health Issues

Pang, Jordan-Marsh, Silverstein, & Cody, (2003) determined shifts in health seeking behaviors for Chinese elders that can be attributed to changes in their family structure. Younger generations of Chinese immigrants do not live with or even close to their elders, leaving the elders to provide their own daily cares for themselves or to rely on neighbors rather than family. These Chinese elders have become more autonomous by living in apartments and relying on spousal support for daily care (Pang, et al, 2003).

However, this change in lifestyle for these Chinese elders may promote delayed intervention for needed medical services. Some of the barriers to health-seeking of services for Chinese elders include lack of trust in Western doctors, insurance, language interpretations, and transportation. Often, adult children provided assistance in surmounting these challenges. However, with many adult children living great distances from their parents, these challenges become barriers to health-seeking behaviors. Friends and neighbors might not provide adequate health care advice, even though Chinese Elders turn to these people for advice in making health care decisions (Pang, et al, 2003).

Pang, et al. (2003) found that the Chinese elders used a combination of health resources such as home remedies, traditional Chinese medicine, and Western medicine, which is considered the "alternative" medicine by the Chinese Elders. The use of these other resources impedes the utilization of Western health care services earlier in the stages of disease progression by Chinese Elders (Pang, et al, 2003).

Since many Chinese were not born in the United States, cultural values, beliefs, and traditional health practices affect health seeking behaviors. Ma (1999) found that unfamiliarity with Western concepts and terminology of illness and diseases negatively affected health seeking behaviors. This lack of knowledge illustrates a distrust in Western health care providers that leads to many Chinese and other Asian Americans suppressing information regarding their cultural practices. This lack of trust or cultural competence delays Chinese

immigrants to seek health care, even when medical services are needed (Ma, 1999).

Ma (1999) found that Chinese immigrants lack of health insurance and transportation, health care costs, cultural dissimilarity, language barriers, issues with immigration status, and lack of knowledge regarding the health care system are barriers for Chinese immigrants when seeking health care. These barriers delayed health-seeking behaviors and encouraged use of home remedies and self treatment of diseases as their main form of health care. Few Chinese immigrants utilize Western and traditional clinics and hospitals in the United States due to health care barriers (Ma, 1999).

Ma discussed one very interesting aspect of Chinese health seeking behaviors. Chinese immigrants preferred to consult Chinese physicians because they were more readily available for consult and did not pose the language barriers experienced with the Western physicians. Traditional Western health care providers may not identify with the Chinese health beliefs and this may deter Chinese immigrants from seeking Western health care services (Ma, 1999).

Native Americans have experienced changes in their family structure similar to those of Chinese immigrants, not so much in the nature of the changes but in the effects. During the 1900s, many Native American children were sent to boarding schools, long distances from home in isolated rural locations in the country, for assimilation into another culture. These experiences had a major impact on the family structure of the Native American people. Children moved to other geographical locations, sometimes, permanently, away from their parents.

Like the Chinese, this left the Native American Elders relying on friends, traditional healers, and neighbors for health care advice.

The negative affects of boarding school along with dishonored agreements between Native Americans and the United States government affects health-seeking behaviors of Native American people by supporting distrust of Western health care providers and delays in seeking health care services. When seeking health care, a sick tribal member may be sent away from their culturally based environment to receive treatment. This visual impression may often times be associated with the negative experiences and emotions from the boarding school experiences leading to lack of cultural information and enhancing distrust for Western doctors (Gary, et al, 2005).

Furthermore, culturally incompetent attempts at health care are supported by violating historical governmental policies/treaties which negatively impact the civil rights of Native Americans by not providing services and programs which are available to the general populace (Office of General Counsel, 2005). Like the Chinese immigrants, the Native American people experience lower health status than other Americans. Health care financial appropriations for Native Americans are excessively insufficient compared to other Americans, having 50 percent less than prisoners have appropriated for health care by the government (Office of General Counsel, 2005). This lack of governmental support is a barrier to health seeking behaviors of Native Americans with MI.

Korean Health-Seeking Behaviors

Korean American elderly retain cultural values, beliefs, and traditional health practices for health care needs. Kim, Hau, Kim, & Duong (2002) found that health seeking behaviors among the Korean American elderly are diverse and include the use of Western health care services, traditional Korean medicine, and/or both Western and traditional clinics. It is likely for elders to discuss Western biomedical experiences with traditional healers. However, it is very unlikely for elders to discuss traditional healing with Western physicians for fear of ridicule. This is a barrier to positive health seeking behaviors. Results from this study showed that the traditional medicine may be used as a supplement to Western medicine. Korean American elderly will seek health care if the Western doctor speaks Korean (Kim, et al., 2002).

Native Americans Health Related Behaviors

Native Americans are more likely to engage in risky behaviors, have poor health and economic conditions, and seek health care services less than other populations (Barnes, et al, 2005). This report states that American Indian/Alaska Native (AI/AN) were more likely to consider a clinic or health center as their usual place of care than Caucasian, Black, or Asian adults. AI/AN were more likely than Black adults, twice as likely as White adults, and three times as likely as Asian adults to not receive needed medical care due to cost of care. AI/ANs were as likely as Black adults and more likely than Caucasian and Asian adults to have seen a dentist more than 5 years ago. AI/ANs were more likely than

Caucasian and Asian men and less likely than Black men to have ever been tested for the acquired immunodeficiency syndrome virus (Barnes, et al, 2005).

Summary

The literature review supports the idea that factors related to culture influence the health-seeking behaviors of those populations. The literature identified five common problems with reference to health-seeking behaviors regardless of culture: 1) Limited services; 2) Racial discrimination; 3) Mistrust of western medicine and providers; 4) Financial limitations or insurance coverage limitations; and 5) language differences.

Mental Illness Care

General Population

Alternative medicine has become a popular form of treatment for a wide range of physical and mental illnesses and has become an important factor in the health care delivery system. Kersnik (2000) found that more people from the midlife age groups, those with chronic conditions, had lower life qualities, and higher incidence of anxiety and depression. These people appear to have a more active role in their personal health care and utilize both mainstream medicine and alternative medicine for satisfaction of disease treatment (Kersnik, 2002).

The concept of utilization of alternative medicine is a common practice within the Native American population regardless of the disease process. For example, some Native Americans have utilized traditional healing practices in the treatment of alcohol abuse along with Western medicine approaches to

alcoholism (Abbott, 1998). The use of both approaches helped Native Americans with substance abuse problems increase health-seeking behaviors more than utilizing one or the other alone (Beals, Novins, Spicer, Whitesell, Mitchell, & Manson, 2006). Integrative medicine may prove to be a viable course of treatment for Native Americans with MI.

Adolescents

Historically, information regarding the health-seeking behaviors of adolescents has been limited to whether they have sought help or not. However, in regards to rural adolescents, age, sex, perceptions of help attained, emotional and behavioral adjustments, and the type of MI or problem influence the way a teenager seeks help (Sears, 2004). In this study, Sears (2004) found that girls were more likely to talk to someone about their problems than boys. For problems with family or friends, school, depression, or alcohol/drug use, adolescents were more likely to approach family members for advice. However, adolescents did not seek help from others if they considered their problem or MI to be serious. Emotional adjustments within the adolescent population showed an increase in health seeking behaviors when dealing with depression or significant problems. Behavioral adjustments showed that adolescents with serious problems exhibited more substance use, school misconduct, and antisocial behavior than adolescents without problems. Older adolescents were reported to seek professional help more often than younger adolescents (Sears, 2004). Basically, these older youths were more inclined to seek professional help only in the later stages of their emotional or behavioral problems.

Adolescent depression affects many aspects of the community such as families, schools, and primary health care providers. African American adolescents experience high rates of depression along with abuse, academic failure, and high incarceration rates. Often, the mental health needs of this population continue without proper treatment or adequate care. Family members and friends were an important source for help and support when African American adolescent boys sought help for symptoms of mental illness or depression from them but most families would not support seeking professional help for mental illness (Lindsay, Korr, Roitman, Bone, Green, Leaf, 2006). In this study, Lindsay et al (2006) found that religion or prayer did not play a part in coping with mental illness. African American adolescent boys would attempt to handle their illness alone because of perceived embarrassment surrounding mental illness. They did not want to share their feelings as this exhibits signs of weakness (Lindsay, et al, 2006).

Health seeking behaviors of adolescents with depression are developed or influenced by family and friends. For example, Wisdom and Agnor (2006) found that if family support is positive regarding MI, the more likely the adolescents will seek and receive mental health care. If the family exhibits a negative attitude toward MI or unwillingness to recognize depressive symptoms, the less likely the adolescent will receive care for MI. Positive peer support have been shown to lower levels of depression, just as adolescents who are influenced by their peer support to engage in high risk behavior are more likely to engage in those behaviors (Wisdom, et al, 2006).

Research is beginning to illustrate statistics involving Native Americans with MI. However, health seeking behaviors of Native Americans with MI are not well documented. Like the other adolescent populations, Native American adolescents seek informal help from friends, family, and nonprofessional people before actually seeking help from professionals (Hodge, Pasqua, Marquez, & Geishirt-Cantrell, 2002). Hodge, et al. (2002) found that Native American female adolescents were less likely than Hispanic or European American female adolescents to seek help from their informal circle. However, they were more likely to seek help from adult family members. Native American adolescents were more likely to accept help from culturally trained professionals than professionals who did not emphasize respect and awareness of cultural beliefs and practices (Hodge, et al, 2002).

Like African American adolescent males, Native American adolescent males experience high rates of mental illness including substance abuse, anxiety, and depression along with lower income and educational levels (Office of General Counsel, 2004). Native Americans have the highest poverty rate of any ethnic group and the highest risk for mental health disorders (Office of General Counsel, 2004). Treatment involves an immense amount of western values and remains fragmented. Schools, boarding schools, mental health clinics, emergency care, hospitals, and Human and material resources provide care without integration of cultural beliefs and practices, making health care much less appealing to Native American children with mental illness to seek health care (Gary, et al, 2005).

Just as positive support impacts adolescents in the general population with mental illness to seek health care, Native American adolescents rely on their families, tribal leaders, and communities for positive support in deterring depression or suicide. Gary, Baker, and Grandbois (2004) found family attention and positive support showed encouragement for adolescent girls as a protective factor in deterring mental illness. Adolescent boys found that positive experiences at school, participation in traditional activities, affirmative academic performance, and caring attitudes were a deterring factor for them (Gary,et al, 2004). Consequently, both of the male and female Native American adolescent sought positive support from their families and communities to avoid mental illness.

Women with Mental Illness

Persons with severe mental illness have significantly higher rates of substance abuse (RachBeisel, Scott, & Dixon, 1999). RachBeisel, et al (1999) found that patients with mental illness and substance abuse may experience more symptomology, increased hospitalization, medication noncompliance, disruptive behaviors, and decreased social functioning. It places the women at greater risk for sex activity including sex for drugs and general prostitution placing them at greater risk for sexual violence. Women with greater levels of burden had lower levels of staying in a treatment program (RachBeisel, et al, 1999).

Depression is difficult to diagnose in women with depression who use a general medical clinic as their source of mental health care. Van Hook (1999)

conducted a study including Black, Hispanic, and White women, primarily from low-income families. He found that all of these women were more likely to depend on family, friends, and medical clinics for diagnosis and treatment of their depression. However, they were less likely to be diagnosed or treated appropriately (Van Hook, 1999). This is similar to the general health seeking behaviors of the Native American population.

Lack of appropriate mental health care poses a complex dilemma among Latinos in the United States. Heilemann and Copeland (2005) found that Latino women who have insurance and speak English receive less mental health care than Caucasian women and that Latino women who were battered did not utilize informal or professional health care as frequently as compared to white women. From their study, they concluded that Latino women did not seek help from a professional health care provider but from familial or other sources (Heilemann, & Copeland, 2005).

Alcohol abuse is common in most Native American communities, accounting for greater mortality rates than that of the general population (Office of General Counsel, 2005). Health-seeking behaviors regarding the treatment of alcohol abuse for Native women is lacking. However, Peterson, Berkowitz, Cart, and Brindis (2002) found that most Native American women have made multiple attempts to recover from their addictions, often times, for their children. This is a key concept in designing successful treatment programs for Native American women with children.

Violence against women poses a health risk for public health. Native American women did not share similar health seeking behaviors as the Latino women who have experienced some type of physical abuse. According to Evans-Campbell, Taryn, Bu, and Walters (2006), Native American women were likely to seek out help from either a Western-centered professional or by utilizing a traditional Native intervention after experiencing interpersonal violence unlike the Latino women who did not seek help.

Men With Mental Illness

It is difficult to grasp the health seeking behaviors of men based on research comparing men to women. Most research illustrates the fact that men do not seek treatment for MI as often as women but do not emphasize the rationale regarding the behavior. There has been very little research pertaining to men, specifically, and how their health seeking behaviors impact their MI. Health seeking patterns and consultation rates of men may be influenced by traditional masculine perspectives that impede expression of MI symptoms, especially depression and substance abuse (Moller-Leimkuhler, 2002). Men may be disinclined to seek treatment for MI because they may be viewed as weak or their masculinity may be threatened (Galdas, Cheater, & Marshall, 2005). Further research is needed to be able to implement successful interventions intended for men with MI.

Men who may delay treatment for their MI may be susceptible to accidental death, including car accidents and suicide. Stanistreet, Gabbay, Jeffrey, and Taylor (2004) found that men were more likely to have seen a

mental health professional before death from accidental death or suicide. However, these men did not consult a professional in the crucial time of one month prior to death when emotional distress or problems related to mental health were prominent. This may indicate a need for further intervention beyond the risk assessment or initial therapy.

Health-seeking behaviors of men in regards to alcohol vary greatly from that of their counterparts, women. Moos, Moos, and Timko (2006) found that men were less likely to seek out treatment or participate in Alcoholics Annonymous. Within the male population that did seek treatment, men were less likely to achieve success and did not participate in treatment for as long as time as women (Moos, et al, 2006). The health-seeking behaviors of men in this study coincide to the overall health-seeking behaviors of men in regards to MI.

Like men in the general population, little research is available regarding the health seeking behaviors of Native American men. However, Rhoades (2003) found that the top five leading causes of deaths for Native American men are heart disease, accidents, cancer, chronic lever disease, and suicide. Accidents, suicide, and homicide are epidemic among Native American males. And, like other men, Native American males do not utilize the health care system or seek health care as often as female counterparts until the elderly stages of life (Rhoades, 2003). The reasons for lack of seeking health care have not been well studied for this population.

BARRIERS TO MENTAL HEALTH

Introduction

Wrigley, Jackson, Judd, and Komiti (2005) discussed negative attitudes toward MI related to lack of knowledge regarding the MI. For example, weakness of character causes depression. This lack of knowledge only provided for embarrassing or frightening experiences for the people with MI seeking health care services. Furthermore, the fear of being committed to some type of hospital or institution impacts failure to seek health care by people with MI (Wrigley, et al, 2005).

This stigma rings true for Native Americans. For many Native Americans, thoughts of being placed in a hospital far from home when sick brings back horrific memories of boarding schools and can impede health-seeking behaviors for MI.

Stigma as a Barrier to Mental Health Care

People are hesitant to seek professional help for depression. Barney, Griffiths, Jorm, and Christensen (2006) found that self stigma affected people seeking help from a mental health professional. These people felt greater embarrassment associated with the experience, especially if the professional was a psychiatrist. People with depression also perceived others, including the health care professionals, to view them as disturbed or neurotic. The greater the self stigma and perceived stigma, the less likely for these people with depression to seek health care (Barney, et al, 2006).

Native Americans view MI as a disparity involving the use of spiritual medicine or a lack of harmony with nature, whereas, Western medicine focuses on the cause of MI as genetic or biological factors (Gary, et al, 2005). This internal-external difference in views can facilitate hesitancy for Native Americans seeking health care for MI.

Comorbidity as a Result of Barriers

Hahm and Segal (2005) found that those who failed to seek mental health care were more likely to suffer from other diseases such as tuberculosis, AIDS, cancer, or diabetes (Hahm & Segal, 2005). DeCoux (2005) found that nine out of ten study participants perceived health care facilities as questioning the veracity of complaints from people with mental illness (DeCoux, 2005). People with mental illness do not seek medical services until their objective symptoms become so severe or obvious that their subjective information can be corroborated or validated (DeCoux, 2005). Therefore, these patterns of behavior by health care professionals support the apparent overuse of emergency services by people with severe MI.

Access to health care presents one of the principal barriers for Native Americans seeking health care for MI. Health-seeking behaviors of Native Americans include fewer office visits and outpatient facilities and more emergency room visits than any other population (Office of General Counsel, 2003). Since most Native Americans rely on Indian Health Service for their health care needs, their needs are directly affected by the cuts in budget.

Emergency visits are much more easily accessed through this system than office visits and outpatient facilities.

Chapter 3

Introduction

The literature addressing health seeking behaviors of various minority cultures assist health care providers with knowledge that supports the provision of culturally competent care for Native American people with MI. The purpose of this project is to examine the literature addressing health-seeking behaviors of various minority cultures to assist health care providers with knowledge that supports the provision of culturally competent care for Native American people with MI. This chapter addresses the implications and recommendations derived from the literature for the primary care practitioner practice, education, and research.

Implications/Recommendations

Primary Care Practitioner Practice

Nurse Practitioners and other primary health care professionals who are comfortable with their own culture and aware that diversity exists between and among cultures may provide more culturally competent care to other people of different cultures other than their own. A Nurse Practitioner that is culturally competent or possesses confidence in accepting and assessing cultural needs of others will provide better holistic care for those individuals. When patients are able to build a trusting relationship with their primary care providers, they will have better outcomes in preventing disease and morbidity.

The literature identified compromised confidentiality as a problem for rural Americans, including the Native American population (Roberts, et al, 1999). This

could interfere with provision of health care services to those who fear the stigma placed on physical and mental illnesses due to lack of confidentiality. Nurse practitioners need to lobby for stronger policies, better education, and implement and enforce existing guidelines regarding confidentiality within their own facilities.

Limited services pose a problem for rural America (Roberts, et al, 1999). This is especially true for Native Americans with MI. With dependence on the Indian Health Service for all of their health care needs, services are limited. Every year the Indian Health Service experiences budget cuts limiting the services to the Native American people. Primary health care providers can lobby political representatives to provide more funds to rural health care, mental health, and Native American programs.

Racial barriers and mistrust associated with the health care system lead to decreased use of this system (Fowler-Brown, et al, 2006; Gary, et al, 2005; Hewins-Maroney, et al, 2005; Jacobs, et al, 2005; Pang, et al, 2003; Ma, 1999). Discriminatory practices may instill fear into people who seek health care. They may not seek medical attention even if their disease process requires treatment. Cultural desire that motivates education is key in developing cultural awareness. Nurse educators can place greater emphasis on cultural awareness by requiring students to participate in cultural classes such as American Indian Studies during preparation of nurse practitioners. Nurse practitioners who are already in practice can encourage cultural competence by researching historical events, culture, and language pertinent to the clients they serve and teaching this material to other care providers.

Economic barriers and lack of insurance coverage limit use of the health care system (Hewins-Maroney, et al, 2006). Employment is the main provider of health care insurance for most people. With such a high unemployment rate on the reservations, most Native American people do not have health care insurance or the finances to afford health care and are forced to rely on the Indian Health Service for all of their health care needs, which are in adequately funded by the federal government. The answer can be found in pressuring the federal government for more appropriations for Native American health care programs. Nurse practitioners can advocate for these changes by contacting their political representatives and expressing their concerns for these issues. In addition, nurse practitioners can lobby for changes by expressing their concerns through professional organizations such as the American Nurses' Association or the Academy of Nurse Practitioners.

Language differences are implicated as the major barrier in providing culturally competent care in the health care setting (Hewins-Maroney, et al, 2005; Pang, et al, 2003; Ma, 1999). Nurse practitioners have a responsibility to patients to provide the best health care possible. Providers need to take the time to learn communication techniques or assure translators are available for the population they serve. Providers can learn through formal educational courses and/or organized informal classes utilizing people from the community to learn culturally appropriate communication techniques.

Education

Education must meet the demands of the healthcare system. If the demand is to increase culturally competent healthcare providers, then school curriculums need to incorporate cultural aspects. To provide culturally competent healthcare providers, educators would need to encourage enrollment of a diverse population of students. The curriculum would need to incorporate cultural aspects into each class, by providing lectures, speakers, and devoting clinical time for a culturally diverse population. The schools need to embrace the idea of cultural competence before the students or future healthcare professionals will accept this idea. Faculty may need education about cultural approaches to education and practice as well as assistance in recognizing their routine discriminatory practices.

Research

The literature is limited in the health-seeking behaviors of Native Americans with MI. However, the literature identified stigmatization of mental illness as a deterent to seeking treatment for MI in the early stages of the illness. If the family of adolescents with MI exhibit negative attitudes toward MI, the adolescent is less likely to receive proper treatment for MI (Wisdom et al, 2006). This stigmatization coupled with the discrimination felt by Native Americans seeking health care may have a devastating effect on those who are Native American with MI. With Native Americans having the highest suicide rate in the country, more research is needed to determine the effects of stigmatization coupled with ethnic discrimination of Native Americans with MI.

There has been little research regarding men's health-seeking behaviors as it pertains to seeking treatment for MI. There is higher comorbidity and mortality in Native American people with MI, especially Native American men (Rhoades, 2003). Men who do not seek adequate care for MI in the early stages of the illness, are more likely to experience car accidents, homicide, and suicide (Stanistreet et al, 2004). More research is needed to understand the reasons that men from both the general population and the Native American population do not seek appropriate health care in a timely manner. This would assist health care professionals in designing gender appropriate interventions for men with MI and limiting gender related stereotypes that may interfere with seeking health care. The following recommendations were derived from guidelines for cultural competence in the American Academy of Critical Care Nurses' Association.

Recommendations

Cultural competence begins with teaching awareness of one's own culture and values. Nurse practitioners may seek answers to questions regarding their own behaviors or the behaviors of their patients that are not fully understood in the history or culture of the population in question. These practitioners can begin learning about themselves and other cultures by taking classes during their preparatory nursing education and continue with research of other cultures during practice. This will allow nurse practitioners to obtain complete information regarding culture, its effects on disease progression, and choice of treatment. Nurse practitioners may utilize this information to implement effective treatments

that are acceptable to both the practitioner and the patient, which may reflect an integration of two cultures or cultural accommodation.

Nurse practitioners can learn from the community leaders and people they serve or learn more by spending time in that community or environment. For example, nurse practitioners can learn more about Native Americans by visiting neighboring reservations with an internal contact to gain more knowledge regarding health care delivery, spiritual beliefs, social practices, and economic conditions to better understand their health-seeking behaviors, thus supporting cultural preservation.

Communication is a major part of being a health care provider, without it, how can we talk to our patients? Most health care providers have learned communication techniques for a small percentage of their patients. However, education should expand on these techniques to include different cultural approaches that would expand the effectiveness of their interactions. Diverse communication skills should be viewed as a necessary step in providing health care to all populations. Communication skills support preservation of cultural remedies and accommodation or restructuring of cultural health practices.

Cultural competence can be learned through leadership classes. Leadership can provide information regarding contact information to political figures and the latest laws and politics relating to populations that are being served by primary care providers. Leadership knowledge is key in advocating for patients and their interests in the health care system. Health care providers can spend some time with pertinent political figures and groups that influence the

population served. They can also learn more about community groups that can be accessed through the health care system.

Nurse practitioners need to take responsibility for their own learning process and not place the responsibility on the patient. Nurse practitioners can resolve cultural differences by: 1) having a desire to learn about ethnic diversity, 2) becoming aware of and accepting diversity, and 3) exploring cultural diversity with each client encounter, thus providing effective culturally responsive health care services.

Conclusion

This literature review examined the literature addressing health-seeking behaviors of various minority cultures to assist health care providers with knowledge that supports the provision of culturally competent care for Native Americans with MI. The review of literature examined the comparison of health-seeking behaviors of Native American people with MI to rural, Black, Chinese, and Korean Americans as well as people with MI from the general population. The comparison of several different ethnic groups to the Native American culture expanded the ability of a culturally competent provider to be responsive to their clients' unique cultural needs. This information will assist health care providers in being more effective in their utilization of cultural preservation, accommodation, or restructuring.

References

Abbott, P. (1998). Traditional and western healing practices for alcoholism in American Indians and Alaska Natives. *Substance Use Misus, 33(13), 2605-2646.*

American Academy of Critical Care Nurses' Association. Retrived on February 27, 2007 from http://www.aaccn.org

Barnes, P., Adams, P., & Powell-Griner, E. (2005). Health characteristics of the American Indian and Alaskan Native adult population: United States, 1999-2003. *Advance Data,* 356. Retrieved on December 12, 2006 from http://origin.cdc.gov/nchs/data/ad/ad356.pdf

Barney, L., Griffiths, K., Jorm, A., & Christensen, H. (2005). Stigma about depression and its impact on help-seeking intentions. *Australian and New Zealand Journal of Psychiatry, 40(1), 51-58*. Retrieved on July 24, 2006 from http://www.blackwell-synergy.com.exproxy.undmedlibrary.org /doi/full/10.1111/j.1440-1614.2006.01741.x

Beals, J., Novins, D., Spicer, P., Whitesell, N., Mitchell, C., & Manson, S., American Indian Service Unitilization, Psychiatric Epidemiology, Risk, and Protective Factors Project Team. (2006). Help seeking for substance use problems in two American Indian reservation populations. *Psychiatric Services, 57(4), 512-520.*

Benson, E. (2003). Psychology in Indian country. *American Psychiatric Association Online.* Retrieved on December 12, 2006 from http://www.apa.org/monitor/jun03/indian.html

DeCoux, M. (2005). Acute versus primary care: The health care decision making process for individuals with severe mental illness. *Issues in Mental Health Nursing, 26, 935-951.*

Evans-Campbell, T., Lindhorst, T., Huang, B., & Walters, K. (2006) Interpersonal violence in the lives of urban American Indian and Alaska Native women: implications for health, mental health, and help-seeking. *American Journal of Public Health, 96(8), 1416-1422.*

Fowler-Brown, A., Ashkin, E., Corbie-Smith, G., Thaker, S., & Pathman, D. (2006). Perception of racial barriers to health care in the rural south. *Journal of Health Care for the Poor and Underserved, 17(1), 86-99.*

Galdas, P., Cheater, F., & Marshall, P. (2005) Men and health help-seeking behaviour: literature review. *Journal of Advanced Nursing, 49(6):616-623.*

Gary, F., Baker, M., & Grandbois, D. (2005). Perspectives on suicide prevention among American Indian and Alaska Native children and adolescents: a call for help. *Nursing World.* Retrieved on December 12, 2006 from http://www.nursingworld.org/ojjn/hirsh/topic4/tpc4_3.htm

Geiger, J. (2001). Racial stereotyping and medicine: the need for cultural competence. *Canadian Medical Association Journal, 164(12), 1699-1700.*

Hahm, H. & Segal, S. (2005) Failure to seek health care among the mentally ill. *American Journal of Orthopsychiatry, 75(1), 54-62.*

Heilemann, M., & Copeland, D. (2005). Sources of emotional help sought by low income women of Mexican descent. *Issues in Mental Health Nursing, 26, 185-204.*

Hewins-Maroney, B., Schumaker, A., & Williams, E. (2005). Health seeking behaviors of African Americans: implications for health. *JHHSA, 68-95.*

Hodge, F., Pasqua, A., Marquez, C., & Geishirt-Cantrell, B. (2002). Utilizing traditional storytelling to promote wellness in American Indian communities. *Journal of Transcultural Nursing, 13(1), 6-11.*

Jacobs, E., Rolle, I., Ferrans, C., Whitaker, E., & Warnecke, R. (2006). Understanding African Americans' views of the trustworthiness of physicians. *Journal of General Internal Medicine*, 21, 642-647.

Kersnik, J. (2000). Predictive characteristics of users of alternative medicine. *Schweizerische medizinische Wochenschrif, 130(11), 390-394.*

Kim, M., Han, H., Kim, K., & Duong, D. (2002). The use of traditional and western medicine among Korean American elderly. *Journal of Community Health, 27(2), 109-120.*

Lindsey, M., Korr, W., Roitman, M., Bone, L., Green, A., & Leaf, P. (2006). Help-seeking behaviors and depression among African American adolescent boys. *Social Work, 51(1), 49-58.*

Ma, G. (1999). Between two worlds: the use of traditional and western health services by Chinese immigrants. *Journal of Community Health, 24(6), 421-437.*

Moller-Leimkuhler, A. (2002). Barriers to help-seeking by men: a review of sociocultural and clinical literature with particular reference to depression. *Journal of Affective Disorders, 71(1-3), 1-9.*

Moos, R., Moos, B., & Timko. (2006). Gender, treatment and self-help in remission from alcohol use disorders. *Clinical Medical Research, 4(3), 163-174.*

Office of General Counsel. (2004). Broken Promises: evaluating the Native American health care system.

Pang, E., Jordan-Marsh, M., Silverstein, M., & Cody, M. (2003) Health-seeking behaviors of elderly Chinese Americans: shifts in expectations. *The Gerontologist, 43(6), 864-874.*

Peterson, S., Berkowitz, G., Cart, C., & Brindis, C. (2002). Native American women in alcohol and substance abuse treatment. *Journal of Health Care Poor Underserved, 13(3), 360-378.*

RachBeisel, J., Scott, J., & Dixon, L. (1999). Co-Occurring severe mental illness and substance use disorders: a review of recent research. *Psychiatric Services, 50, 1427-1434.* Retrieved on February 10, 2007 from http://www.psychservices.psychiaryonline.org/cgi/content/full/50/11/1427

Rhodes, E. (2003). The health status of American Indian and Alaska native males. *American Journal of Public Health, 93(5), 774-778.*

Roberts, L., Battaglia, J., & Epstein, R. (1999). Frontier ethics: mental health care needs and ethical dilemmas in rural communities. *Psychiatric Services, 50(4), 497-503.*

Sears, H. (2004). Adolescents in rural communities seeking help: who reports roblems and who sees professionals. *Journal of Child Psychology and Psychiatry, 45(2), 396-409.*

Shavers, V., Shankar, S., & Alberg, A. (2002). Perceived access to health care and its influence on the prevalence of behavioral risks among urban African Americans. *Journal of the National Medical Association; 97(11), 952-961.*

Stanistreet D., *Gabbey, M., Jeffrey, V., & Taylor, S. (2004).* The role of primary care in the prevention of suicide and accidental deaths among young men: an epidemiological study. *British Journal of General Practice, 54(501), 254-258.*

Tomey, A. & Alligood, M. (2002). *Nursing Theorists and Their Work.* St. Louis, MO:Mosby.

Van Hook, M. (1999). Women's help-seeking patterns for depression. *Social Work Health Care, 29(1), 15-34.*

Wisdom, J., *& Agnor, C. (2006).* Family heritage and depression guides: family and peer views influence adolescent attitudes about depression. *Journal of Adolescence.* Retrieved on January 26, 2007 from http://www.sciencedirect.com.ezproxy.undmedlibrary.org/science?_ob=ArticleURL&_udi

Wrigley, S., Jackson, H., Judd, F., & Komiti, A. (2005). Role of stigma and attitudes toward help-seeking from a general practitioner for mental health problems in a rural town. *Australian and New Zealand Journal of Psychiatry, 39(6), 514-523.* Retrieved on July 25, 2006 from http://www.blackwell-synergy.com.exproxy.undmedlibrary.org/doi/full/10.1111/j.1440-1614.2005.01612.x