CLINICAL PRACTICE GUIDELINE FOR THE EARLY DIAGNOSIS OF DEPRESSION IN AFRICAN AMERICAN WOMEN

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CLINICAL PRACTICE GUIDELINE FOR THE EARLY DIAGNOSIS OF DEPRESSION IN AFRICAN AMERICAN WOMEN

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Table of Contents

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LIST OF FIGURES

FIGURES PAGE

Abstract

Depression is among the most prevalent psychiatric disorders that primary care clients experience. It has a major effect on the quality of life of any client experiencing the disorder. African American women are at a high risk for depression but may not be able to define their feelings as depression. This Culturally Competent Clinical Practice Guideline will provide an assessment tool for primary health care providers to utilize in the early diagnosis of depression in African American women. The Guideline is based on a review of the literature and is supported by Campinha-Bacote's Culturally Competent Model of Care (1994). The Clinical Practice Guideline consists of several identified steps the primary health care provider should follow when evaluating African American women for depression. The steps include culturally relevant symptoms of depression for African American women, risk factors for depression in African American women, diagnostic tests to consider, and suggestions for culturally relevant assessment tools for making a diagnosis of depression. The Guideline concludes with a flowchart to utilize when making the diagnosis of depression in African American women. The goals of the Clinical Practice Guideline are to bring attention to the uniqueness of depression in African American women, provide another educational tool for health care providers, decrease the cost delayed diagnosis or misdiagnosis may cause, and improve the quality of life for African American women.

Introduction

Depression is among the most prevalent disorders that primary care clients experience (Haber, Krainovich-Miller, McMahon & Price-Hoskins, 1997). It disrupts family, vocational and social functioning and its disabling consequences equal or surpass those of many physical disorders. In the general population, one out of eight persons may experience depression requiring treatment during their lifetime (The American Medical Directors Association {AMDA}, 1996).

Major depression is the most common psychiatric disorder among women. In 1993, the U.S. Department of Health and Human Services (DHHS) reported that during a lifetime, men are at a depression prevalence risk of 7 to 12% while women are at a lifetime prevalence risk of 20 to 25%. Furthermore, race and lower socio-economic status increases the depression rates in women and the rate of misdiagnosis and delayed diagnosis has a tendency to be race related (Barbee, 1992; Kizilay, 1992; Warren, 1995). For example, only four to six percent of all African Americans are diagnosed with clinical depression (Brown, 1990; Fellin, 1989; Warren, 1994). Moreover, the reported incidence of depression in African American women is unclear due to controversy regarding misdiagnosis and the lack of clinical research using African American women (Barbee, 1992; Warren, 1994, 1995). This is unfortunate, because when identified, depression can almost always be treated successfully, either with medication, psychotherapy or a combination of both (DHHS, 1993). An early and accurate diagnosis of depression in African American women, followed by appropriate interventions and treatment for this diagnosis, is a challenge for primary health care providers.

Purpose

The purpose of this project was to develop a Culturally Competent Practice Guideline to be utilized in primary care for the early diagnosis of depression in African American women. The Guideline is based on review of the literature, guidelines developed by the Agency for Health Care Policy and Research (AHCPR), and supported by Campinha-Bacote's Culturally Competent Model of Care (1994). The Guideline consists of a step by step culturally relevant assessment guide. The Culturally Competent Guideline for Diagnosing Depression in African American Women would provide a guide for primary health care providers. The goals of the guideline would be to decrease the social, economic and personal costs delayed diagnosis and treatment of

depression place on African American women. The Guideline could also be a solid foundation for creating a positive relationship with the primary health care provider. These improvements could lead to increased use of the health care system for health promotion, treatment for acute episodes of depression and improvement in the quality of life for African American women who suffer with depression.

Literature Review

Depression is a mood disorder characterized by disturbances in emotional, cognitive, behavioral, and somatic regulations (AMDA, 1996). It affects an individual's functional ability and capacity for pleasure and enjoyment. Annually, over 60% of suicides can be attributed to depression. As many as one in eight individuals may require treatment for depression during their lifetime (DHHS, 1993). Depression can manifest itself as a single episode or recurrent episode and varies according to gender, race and age (American Psychiatric Association {APA}, 1994). It is estimated that seven million women in the U.S. are affected by depression (DHHS, 1992). The onset of depression is highest in women between the ages of 18 to 44 (Kizilay, 1992; Warren, 1995), with a mean onset of 27 years of age (Jefferson & Greist, 1994).

Women are at a greater risk for depression than men because, as a group, they experience multiple minority statuses related to gender and lower economical and political status. There are biological, social, economic, cultural, and psychological events that are unique to women's lives that may contribute to depression (Beeber, 1987, 1995; Warren, 1995). Multiple roles and stressors (Smith, 1981; Warren, 1995) combined with society's socialization of women are possible explanations for higher depression rates in women. Traditional socialization of women may result in their using maladaptive coping strategies when stressful events occur. This encourages passive behavior, decreases women's self esteem and their perception of control over their lives, and may result in an increased risk for depression (McGrath, Keita, Strickland & Russo, 1992; Warren, 1995).

African American women may be more at risk for depression because of their triple minority status-ethnicity, gender and in many cases they are positioned at a lower level politically and economically (Cannon, Higginbotham & Guy, 1989; Carrington, 1980; Fellin, 1989; Jones, 1992; Taylor, 1992; Warren, 1995). Problems related to triple minority status are exacerbated by the multiple roles and stressors that affect their social support systems, self esteem and health care actions. For example, physiological and psychological damage may result when material and

emotional resources are few or are believed to be few. African American women may not be able to describe what they feel as "depression" because often they are unaware of its presence (Jones, 1992; Warren, 1995). Culturally, they have placed the needs and goals of their spouses, children, and community as a greater priority than personal goals and aspirations (Jones, 1992). Hence, feelings of being overwhelmed and feelings of frustration that could lead to depression may be denied or misconstrued as being normal.

Two additional possibilities exist for this lack of accurately diagnosing depression in African American women. First, African American women may be reluctant to access health care for their symptoms because they fear being labeled with a mental or emotional illness (Iram & Redd, 1985). Secondly, it may be difficult for African American women to find culturally competent health care providers (American Nurses Association {ANA}, 1997; Barbee, 1992; Campinha-Bacote, 1994; Iram & Redd, 1985; Jones, 1992; Sue & Zane, 1987; Warren, 1994, 1995). A further discussion of this information follows.

Reluctance Due to Fear of Labeling

Many adults may perceive depression as a sign of personal or emotional weakness rather than a health problem and may be hesitant to cooperate when the health care professional solicits symptoms (Schulberg, Madonia, Block, Coulehan, Scott, Rodriguez & Black, 1995). In the African American community, generally there may be some stigma attached to seeking help for mental disorders or illnesses. Perceptions surrounding the etiology and treatment of mental illnesses, especially among minorities with lower educational levels, may explain the stigma attached to mental illness in African Americans (Campinha-Bacote, 1995). Further, there are a disproportionate number of African Americans diagnosed with schizophrenia and other serious mental/behavioral disorders (Abebimpe, 1981; ANA, 1997; Barbee, 1992; Campinha-Bacote, 1994; Carrington, 1992; Davis, 1995; Loring & Powell, 1988; Neighbors, Jackson, Campbell & Williams, 1989; Neighbors, 1990; Smith, 1981;Warren, 1995; Worthington, 1992). Fifty-six percent of African Americans admitted to state hospitals received a diagnosis of schizophrenia while overall only 33 percent of all clients received this diagnosis (Mandershied, 1990). The high rates persist when private, general and veterans hospitals are considered (ANA, 1997). African American females are more likely to be diagnosed as schizophrenic while European Americans are more likely to be diagnosed as depressive. Generally, depression is considered an acute rather than chronic illness, and has a better prognosis than schizophrenia (Smith, 1981).

Difficulty in Finding Culturally Competent Health Care Providers

Historically, Thomas and Sillen (1972) noted two basic themes which may have influenced American psychiatry in regards to African Americans: 1) African Americans are born with inferior brains and have a limited capacity for mental growth, and 2) African Americans personalities tend to be abnormal. Although the themes are myths, they may have delayed accurate diagnosis, and subsequent adequate treatment of mental disorders in African Americans. For many years, African Americans were thought to be too light-hearted to experience depression and lacked the intelligence to experience object losses (Jones & Gray, 1986). The myth that African Americans are generally happy people may make it difficult to consider mild or moderate depression as a diagnosis. Likewise, hyperactive behavior, which could be a cover-up for depression, may also be considered normal behavior (Jones & Gray, 1986), and the diagnosis of depression could be missed.

The theme that African Americans tend to have abnormal personalities could be because African Americans and European Americans show psycho pathology in different ways. Health care providers may be unaware of, or may lack sensitivity, to the cultural differences (Neighbors et al, 1989). For instance, depressed African Americans may present with symptoms of delusions or hallucinations (Adebimpe, Klein & Fried, 1981; Campinha-Bacote, 1995; Jones & Gray, 1986; Neighbors et al, 1989). Campinha-Bacote (1995), offers two explanations for these symptomatologies. One explanation may be the spiritual manifestations of African Americans in some churches. Spiritual manifestations such as visions can be considered hallucinatory in Western culture, and hallucinations are generally considered irrational and a sign of some major psychiatric problem, usually psychosis. Primary care providers, not familiar with such expressions of spirituality, may misdiagnose the vision as a hallucination if assessment of spiritual expressions is omitted (Campinha-Bacote, 1995).

The second possible explanation is that minorities such as African Americans have what is called "healthy paranoia" (Campinha-Bacote,1995; Grier & Cobbs, 1971; Jones & Gray, 1986; Underwood, 1994). Because of racism and past history of discrimination and abuse of African Americans in research and in institutions, some may mistrust their health care provider. They may believe their providers do not value their lives (Campinha-Bacote,1995; Underwood, 1994) and may compromise their well being. Reluctance to answer questions and cooperate, or withdrawing from the health care provider who may be ethnically different, is not uncommon (Griffith &

Gonzalez, 1994). Unfortunately, these behaviors are signs of paranoia which is a symptom of schizophrenia. Culturally incompetent health care providers may misdiagnose this "healthy" paranoia as pathology without considering the reason behind such manifestation (Campinha-Bacote, 1995). Assessment for depression may be completely omitted.

Other writers have offered similar culturally related explanations for misdiagnosing depression. Some suggest differences in communicating stress, vocabulary, styles of interaction and body language (Campinha-Bacote, 1995; Cross, Bazron, Dennis & Isaacs, 1989; Fellin, 1989; Griffith & Gonzalez, 1994; Jones & Gray, 1986). Also, some African Americans may see the health care providers as "outsiders" and may resent "outsiders" telling them about their problems or suggesting solutions to them (Underwood, 1994). Historically, African American women have relied on family, religion or the church for support, rather than health care providers.

A final factor that may explain the tendency of misdiagnosis of depression in African American women is the instruments used by health care providers to make diagnoses. Several tools are available for measuring depression. They include the Beck Depression Inventory (BDI), the Zung Self-Rating Depression Scale (ZSRDS), the Center for Epidemiolgical Studies-Depression Scale (CES-D), the General Health Questionnaire (GHQ), the Hamilton Rating Scale for Depression (HRS-D), the Inventory for Depressive Symptomatology-Clinician Rated (IDS-C), and the Bech-Rafaelsen Depression Scale (BRDS) (DHHS, 1993). These tools were compiled by clinicians working predominantly with European American subjects as their samples; none are culturally specific for African American clients.

When depression is appropriately diagnosed, treatment strategies can reduce the symptoms of depression within three to four months in 80% to 90% of cases (DHHS, 1993). Early appropriate treatment is dependent on accurate assessment and diagnosis. The Depression Guideline Panel (1996), has recommended that primary care providers determine risk factors for depression in diverse ethnic/racial/cultural groups. Within the Clinical Practice Guideline on Depression in Primary Care (1993), no risk factors for diverse ethnic/racial/cultural groups are found.

Risk Factors for Depression in African American Women

The DHHS, 1993, has identified ten primary risk factors for depression. They are: 1) prior episodes of depression, 2) family history of depressive episode, 3) prior suicide attempts, 4) female gender, 5) age onset under 40, 6) postpartum period, 7) medical co-morbidity, 8) lack of

social support, 9) stressful life events, and 10) current alcohol or substance abuse. (p.73)

As previously stated, it is believed that African American women are at risk for depression because of their triple minority status: gender, ethnicity and lower economical and political status. Others have identified more specific factors that increase African American women's high risk for depression. The risk factors include being poor, between the ages of 18 and 45 years, being unemployed, not having completed high school, the presence of minor children in the household, and being divorced or separated (Barbee, 1992, 1994; Brown, 1990). Divorced and widowed African American women report the highest incidence of depression symptomatology (Brown, 1990; Warren, 1995).

Being poor could be a risk factor for depression in women of other ethnic groups such as Hispanic Americans, Native American Indians, Alaskan and Asian/Pacific Islanders (ANA, 1997). Hence, some may question if being poor should be addressed as a risk factor for depression just for African American women. Kessler and Neighbors (1986) analyzed eight epidemiology surveys and indicated that the stresses of racial discrimination, compounded by poverty, leads to symptoms of depression among African Americans. Forty-eight percent of all African American female-headed families had incomes below the poverty level in 1990, and 75 percent of the two million African American families in poverty were maintained by women with absent husbands (Bureau of the Census, 1992). The stresses of constantly struggling to make ends meet may directly relate to the conclusion that African Americans below the poverty level have the highest rate of depression for any group (Liu & Yu, 1985). Race, combined with poverty, increases the risk for exposure to drug and alcohol use, poor academic achievement, high unemployment and a lack of parenting skills which could produce a cyclic effect (Gross & McCaul, 1991). That is, one generation of women's decreased mental health patterns may affect the next generation's psychological health (Taylor, 1992).

The effect on African American children's development if their mothers have a history of depression is not clear (Warren, 1995). Further, some educators and researchers allude to African American women being at risk for destructive lifestyle behaviors such as smoking, alcohol and other drug abuse to decrease symptoms of depression (Brown, 1990; Taylor, 1992; Warren, 1995). Taylor (1992) states that the "health of one's mother begins with her mother's mother" and that destructive health patterns of African American mothers may compromise their children's physical as well as psychological health (p.39). For example, children living in homes with

mothers suffering undiagnosed or misdiagnosed depression, may see the behaviors as normal and learn similar behaviors through observation.

A final risk factor for depression in African American women that needs consideration is violence. Adult victims of violence are more likely to suffer from major depression than nonvictims (Koss, 1990). Criminal violence such as aggravated assault, forcible rape, and homicide, is disproportionately higher in African American women than in European American women (Barbee, 1992). Homicide is one of the ten leading causes of death for African American women. The aggravated assault rate is three times more than that of European American women. The reported rate of rape of African American women is almost three times that of European American women (U.S. Department of Justice, 1991). Therefore, criminal and intimate violence should be considered risk factors for depression in African American women.

In conclusion, recognition and diagnosis of depression hinges on an awareness of the risk factors for depression along with, the ability to elicit key signs, symptoms and history of illness (DHHS, 1993). However, the culturally competent health care provider must be aware of culturally specific risk factors when caring for African American women who may be at risk and presents with symptomatology, different than Western medicine criteria for depression.

Symptoms of Depression in African American Women

Depression can occur as a primary mood disorder or with non-mood disorders such as with physical illnesses, as a reaction to grief, and during drug or other substance misuse (Warren, 1995; Weissman ; 1993). The Diagnostic and Statistical Manual of Mental Disorders-IV (DSM-IV), describes depression as a syndrome of symptoms that persists over a minimum two week period (APA, 1994). The clinical manifestations of depression reflected in the DSM-IV criteria fall into four broad categories: mood, cognition, behavior and somatic (physical). The client must have a depressed mood, significant loss of interest in activities and a minimum of four out of nine symptoms.

> The nine symptoms are: 1) depressed mood throughout the day (often every day), 2) lack of pleasure in life activities, 3) significant (more than 5%) weight loss or gain over a month, 4) sleep disruptions (generally every day), 5) unusual, increased, agitated, or decreased physical activity (generally every day), 6) daily fatigue or lack of energy, 7) daily feelings of worthlessness or guilt, 8) inability to concentrate or make decisions, and 9) recurring death or suicidal thoughts. (p.195)

Most research on depression in women has involved predominately European American women (Barbee, 1994; Beeber, 1989, McGrath et al, 1992; Warren, 1995). In the few studies using African American women, five additional characteristics of depressive symptoms have been described: 1) poor self esteem, 2) preoccupation with failure, 3) dependence on others good opinions, 4) sensitivity to criticism or rejection by others, and 5) decreased drive in pursuing gratification (Carrington, 1980; Dressler, 1985; Dressler & Badger, 1985; Warren, 1994).

Based on these symptoms alone, the Advanced Practice Nurse (APN) who lacks cultural knowledge about the African American woman may misdiagnose the African American woman presenting with these symptoms. To avoid misdiagnosis, the APN should recognize that cultural assessment of the African American woman is needed. For example, factors such as perceptions, beliefs and spirituality are needed to make an accurate diagnosis (Campinha-Bacote, 1995).

Conceptual Framework

Definition of Concepts

Culture is an abstract concept that describes the entire way of living for a particular society (Leighton & Murphy, 1965). It is an ever-changing learned concept taught by one generation to the next and is an integral component of all societies. Further, the concept of culture includes shared patterns of belief, feeling, and knowledge that ultimately guide everyone's conduct and definition of reality. The elements of culture defines human life and refers to things such as social relationships, religion, technology and economics (Griffith & Gonzales, 1994).

Cultural competence is defined by Orlandi (1992) as a "set of academic and interpersonal skills that allow individuals to increase their understanding and appreciation of cultural differences and similarities within, among and between groups" (p.3). The author further states that a willingness and ability to include community-based values, traditions and customs and to develop a partnership with knowledgeable persons of and from the community is required for cultural competence.

Conceptually then, cultural competence is the awareness and informed ability of an individual or organization to value and respect differences of individuals in regard to racial, ethnic, religious or social preferences. The culturally competent health care provider assesses oneself and avoids posing personal beliefs, values, or judgments on other cultures because their beliefs and values differ. There must be internalization of the awareness and therefore operationalization of respect for each individual's uniqueness which incorporates all aspects of the individual including

racial, ethnic, religious, and social preferences. Operationalization refers to *doing*--or the ability to act on this awareness of cultural differences.

Campinha-Bacote (1994) has developed a conceptual model, "The Process of Cultural Competence: A Culturally Competent Model of Care" to be used in the process of becoming culturally competent in a multi-cultural society. Campinha-Bacote's Culturally Competent Model of Care is used as a framework to support the proposed practice guideline to be utilized in primary care for the early diagnosis of depression in African American women. Campinha-Bacote's model represents the four constructs of cultural competence APNs must obtain in becoming culturally competent providers. Figure 1 depicts the constructs and concepts including: 1) cultural awareness, 2) cultural knowledge, 3) cultural skill, and 4) cultural encounters.

Cultural awareness is the phase where the health care provider explores his/her own cultural background and then goes through a process of self-examination of bias toward cultures different from one's own. Within this process, the health care provider develops sensitivity and respect for the client's cultural beliefs, values, lifeways, practices and problem solving strategies. A positive outcome in this construct is the client is able to maintain and retain cultural identity. Without this cultural awareness, the health care provider may be prone to impose one's own cultural beliefs, values and patterns of behavior upon clients of a different culture.

Cultural knowledge is "a process in which the health care professional seeks and obtains a sound educational foundation concerning the various world view of different cultures" (Campinha-Bacote, 1994, p.9). The beliefs, values, lifeways, practices and problem solving strategies of different cultures are learned in this phase. Cultural, physiological, social, spiritual, environmental and psychological dimensions of clients of different ethnicity and cultures must be valued in the process to becoming culturally competent. A positive outcome of this construct is the client will receive a diagnosis and treatment based on educational facts that are culturally relevant, not myths or stereotypes.

Cultural skill refers to the healthcare provider's ability to conduct a cultural assessment on each client realizing that each *individual* client is different. Just because the client is from a certain cultural group, the health care provider cannot assume that the *individual* client thinks the same way as their cultural group. A positive outcome of possessing cultural skill in conducting a cultural assessment is that other factors other than ethnicity are considered (i.e. gender, religious affiliation, geographical location, occupation and socioeconomic status).

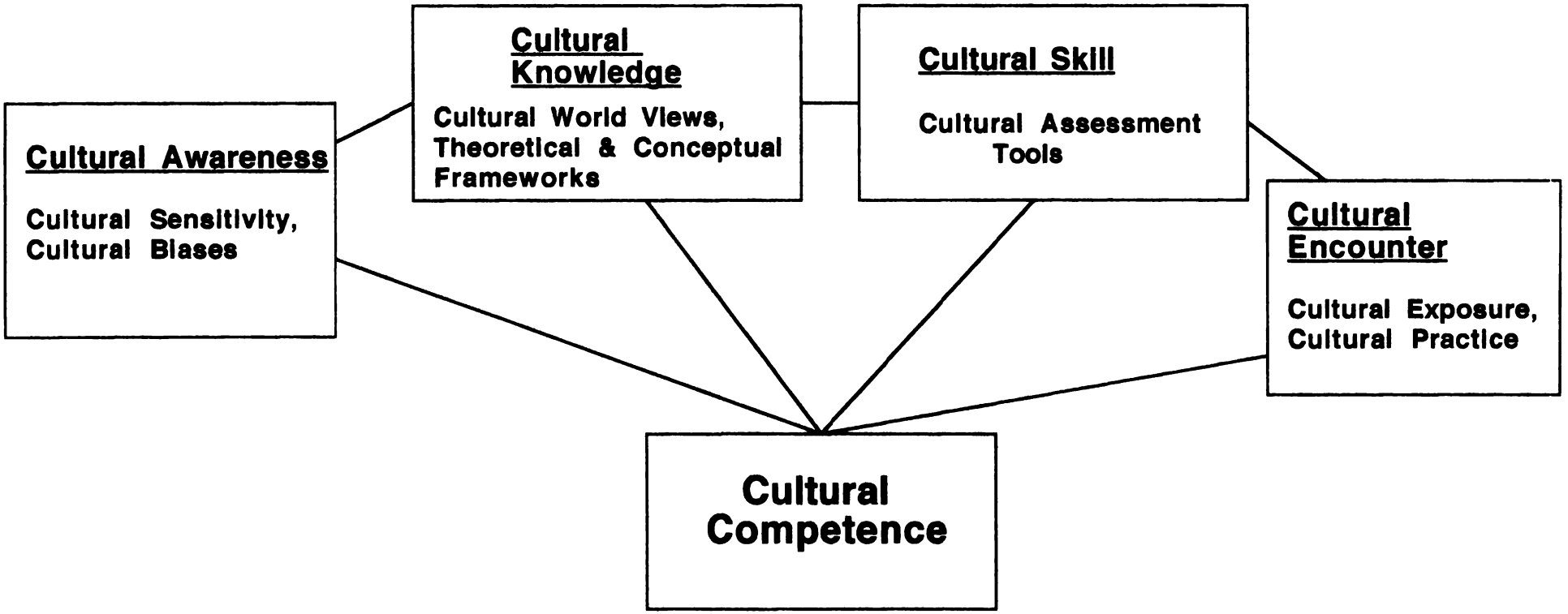

Figure 1 Culturally Competent Model of Care (Campinha-Bacote, 1994)

In the **cultural encounters** phase, the health care provider has continual direct cross-cultural involvement with clients from culturally diverse backgrounds (Campinha-Bacote, 1994). This continual cultural encounter enables the health care provider to stay current with the trends and issues about a specific cultural group while maintaining respect for the variation that exists within groups. Without cultural encounters, stereotyping based on previously learned academic knowledge about certain groups may occur.

J. Campinha-Bacote (personal communication, May 23, 1997) explains that her model is a process of *becoming* culturally competent and not an event of *being* culturally competent. One never really completes the process, rather, it is ongoing. Campinha-Bacote purports that some people do not even know the components of cultural competence, so her model informs readers that there are four components the health care provider must address when interacting with individuals. J. Campinha-Bacote (personal communication, April 22,1997) further explains "my model represents the four constructs of cultural competence. It is not developmental in nature but rather cyclic. This means no matter where you start in my model, you must attain the other components. You do not have to begin by being culturally aware, but you must attain that construct. For example, if you began by having an 'encounter' you then need to assess your biases (cultural awareness) your knowedge about that ethnic group (cultural knowledge) and assess that culture's values, beliefs, practices (cultural skill). The most important part is that you address each component in the model, evaluate it, then address them again and re-evaluate. That is the cyclic nature of the model."

Depression Clinical Guideline Within the Theoretical Framework

The model (Figure 2) for diagnosing depression in African American women is based on Campinha-Bacote's Culturally Competent Model of Care (1994). It is used as a framework for incorporating the phases of the model into the development of a Clinical Guideline for Diagnosing Depression in African American Women. To apply the "Culturally Competent Model for Primary Care Providers Diagnosing Depression in African American Women", Campinha-Bacote's model was modified to reflect the evolving process of becoming culturally competent. The model was designed to reflect that there is a core within each construct in becoming culturally competent. The larger divided circle surrounding each core includes tasks the health care provider must master within each construct. The circles are symbolic of the continuous process and though they could

be overlapping, must be mastered separately.

An analogy of the terms within the cores; awareness, knowledge, skill, and encounter, not only apply to the process the health care provider goes through in becoming culturally competent to deal with the African American woman, but they can apply to African American women with depression. Just as there is a core within each construct in becoming culturally competent, so there is within each African American woman presenting with depression. The client simply may be unable to describe it as depression or the client may be describing it with vague complaints, denying it or thinking that the feelings are normal. Being able to get to that core, and helping the African American woman be aware of her feelings, would require the health care provider to explore her/his own cultural background, personal values, beliefs and practices. Also, if bias and prejudice toward African American women exist, the health care provider must resolve them to the extent that an unbiased diagnosis is possible.

Lara (1997) suggests self-assessment and self-awareness questions the health care provider may answer about her/himself to answer the question "Where are you?" The questions are:

> What ethnic group, socio-economic class, religion, age and community group do you belong to? What experiences have you had with people from ethnic groups, socio-economic classes, religions, age groups, or communities different from your own? What are those experiences like? How did you feel about them? When you were growing up, what did your parents and significant others say about people who were different from your family? What about your ethnic group, socio-economic class, religion, age or community do you find embarrassing or wish you could change? Why? What socio-economic factors in your background might contribute to being rejected by members of other cultures? What personal qualities do you have that will help you establish interpersonal relationships with persons from other cultural groups? What personal qualities may be detrimental?

The health care provider would first examine personal bias and prejudice towards African American women in general, then examine personal bias and prejudice toward African American women suffering from depression. Questions such as what do **I** believe are the most positive and negative physical characteristics of African American women? What do **I** think of African American women in poverty? What do **I** think of African American women at different socio-economic levels? What do **I** think of African American women based on their obtained

educational level ? What do **I** think of African American women suffering with depression or other mental, emotional, and physical disorders? After each question, the health care provider would ask, "What is the extent of prejudice in what **I** believe?"

Now that the core of awareness has been opened within the depressed African American woman, and the health care provider is in a state of continually acquiring cultural knowledge concerning African American women's beliefs, perceptions, practices, lifestyles and problem solving strategies, the health care provider can use skill to get to the client's feelings, beliefs, and symptomatology. The culturally competent health care provider may be able to conduct a cultural assessment and assess for depression in such a mannner that the African American woman gains knowlege about herself and feelings, and shares those feelings with the health care provider.

Kleinman, Eisenburg and Good (1978) suggested using open-ended questions to conduct a culturally sensitive assessment. In each question the emphasis would be on the African American woman and leaves little room for making judgments about her problem simply on the basis of how the client looks or behaves. Campinha-Bacote (1994) explains that these questions should be asked for any client regardless of race or ethnicity. However, conducting culturally relevant assessments will help the APN to step back from his/her own cultural beliefs and assumptions and focus on the perceptions, beliefs, values, interpretations and practices of the client. The open-ended questions include:

> What do **you** think has caused **your** problem? Why do **you** think it started when it did? What do **you** think **your** sickness does to **you**? How severe is **your** sickness? What kind of treatment do **you** think **you** should receive? What are the most important results **you** hope to achieve from these treatments? What are the chief problems **your** sickness has caused? What do **you** fear the most about **your** sickness? (Kleinman, Eisenburg & Good, 1978, p.256).

Cultural knowledge of the concept of spirituality within African American women could be beneficial for the APN. African American women may have limited trust in the health care system but most have spiritual convictions. For example, prayer empowers African Americans (especially women, poor and elderly African Americans) to deal with personal stressors that may lead to depression. In a study by Neighbors, Jackson, Bowman, and Gurin (1983), prayer was found to be the most important coping mechanism among African American women. Moreover, the reliance on prayer increased as the seriousness of the problem increased.

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Cultural knowledge and exposure to spirituality beliefs also includes current thinking on voodoo illness, a culture bound illness seen in some African Americans. The client suffering with a voodoo illness believes that sickness or death may come from supernatural forces, i.e. spirits. Voodoo illness is believed to be a result of not having a close relationship with God (Campinha-Bacote, 1995; Green, 1995). Health care providers should have current knowledge about cultural practices important for establishing trusting relationships with African American women. Cultural encounters is a way of staying current.

Cultural encounters in Campinha-Bacote's model (1994) include continuous cultural exposure and cultural practice through-face to-face encounters and interactions. In the cyclic process of becoming culturally competent, face-to-face encounters and interactions with African American women have the potential to stimulate the health care provider to reassess personal biases (cultural awareness), obtain current cultural knowledge, and sharpen cultural skills. As it relates to depression in African American women, face-to-face exposure could assist health care providers to obtain factual information regarding identity preference, economy, and health belief practices of the African American woman.

It is important to know how the African American client prefers to be identified, i.e. African American, Black, Negro, Colored and be respectful of that preference (Campinha-Bacote, 1995). Factors such as age, education, social class, gender, racism, and multi-racial status may affect the client's preference. Assuming one preference over another, based on prior encounters with African American women, could interfere with establishing effective relationships and this may delay accurately diagnosing the client. Cultural exposure would serve as a reminder to the health care provider that racial/ethnic identity may be important to the client. The responsible cultural practice would be to ask the client's preference.

Face-to-face encounters with African American women may also aid the health care provider in determining the effect of current economical status of African American women. This could be beneficial in practice since poverty may present as a risk factor for depression. African American women experience higher degrees of poverty and stress which could lead to depression (Davis et al, 1992). Further, unemployment, and incarceration of African American men may be directly related to the economy. This decreases the potential for strong male/female relationships and may further exacerbate stress and depression in the African American woman (Jackson & Sears, 1992).

Health care providers can get face-to-face cultural encounters with African American women by attending predominantly African American churches. This interaction could increase understanding of the concept and the significance of spirituality for many African American women. It could further provide opportunities for the health care provider to seek out personal experiences and relationships with African American women.

Other face to face cultural encounters for health care providers with African American women could be attending the Black Nurses Association meetings or conferences where the health care provider could interact with African American women from the same discipline. Health care providers could also attend conferences with topics focused on issues affecting "Women of Color", where African American women are likely to attend. Such conferences may provide open discussion on health issues of African American women (e.g., the stigma attached to having an emotional disorder, the difficulty the African American may have in describing depression , and the culturally relevant risk factors and symptoms of depression in African American women).

Clinical Practice Guideline for Diagnosing Depression in African American Women

This Clinical Practice Guideline was developed for two main reasons. The first was to bring attention to depression in African American women in primary care. The second was to provide a simplified concise guideline for primary care providers to utilize in diagnosing depression accurately. The Guideline is based on Campinha-Bacote's Model of Cultural Competence (1994) and a review of the literature. The purpose of this Clinical Practice Guideline is to improve the quality of care for African American women in primary care. The format of the guideline is similar to the format developed by the American Medical Directors Association (AMDA) panel in 1996 in developing Clinical Practice Guidelines for the Elderly. The Guideline is divided into two phases, six steps and a detailed flowchart. Phase one is the recognition phase which comprises the first three steps and phase two is the diagnostic phase which includes the remaining three steps. Following is an explanation of how to use and implement the Clinical Guideline.

PHASE 1: Recognition

Step 1:

Look for entries in the African American woman's medical record that may suggest a history of depression. Talking with the client and the family may help identify a history or problem with depression.

Step 2

Observe for current signs and symptoms of depression. Depression is a syndrome of symptoms that occur over a two week period. The client must have four out of the nine symptoms present. Symptoms of depression from DSM-IV (1994) include:

-depressed mood throughout the day, often every day

-lack of pleasure in life activities

-significant weight loss or gain (usually more that 5%) over a month

-sleep disruptions (generally every day)

-unusual, increased, agitated, or decreased physical activity

-daily fatigue or lack of energy

-daily feelings of worthlessness or guilt

-inability to concentrate or make decisions

-recurrent thoughts of death or suicide

In addition to the above symptoms African American women may have five other characteristic depressive symptoms. They are:

-poor self-esteem

-preoccupation with failure

-dependence on others good opinions

-sensitivity to criticism or rejection by others

-decreased drive in pursuing gratification

Conducting a cultural assesment is appropriate within steps two or three. The African American woman may not be aware that what she's feeling is depression, or she may be reluctant to describe her feelings. Using a cultural assessment tool, such as the one developed by Flynn (1984) (Appendix A) or the Cultural Assessment Worksheet (Appendix B) developed by Campinha-Bacote (1994), based on Fong's CONHFER Assessment Tool

(Communication/Orientation/ Nutrition/Family Relationships/Health Beliefs/Education/Religion) (Fong, 1985), could provide explanations of the African American woman's behavior, alert the health care provider to potential barriers for the woman to participate in psychological interventions and serve as a cue to the health care provider to potential value conflicts between the health care provider and the African American woman. A culturally sensitive assessment can be conducted using open-ended questions such as those suggested by Kleinman, Eisenburg and Good (1978) (previously listed on page 15). Although none of the scales used for diagnosing depression are culturally specific, the panel on the project for Diagnosing Depression in the Elderly has recommended the CES-D for African American elderly (Appendix C). Any signs and symptoms of depression should be documented in the client's medical record.

Step 3

If the African American woman does not present with current signs or symptoms of depression, the client should be evaluated for risk factors of depression. Any findings should be documented in the medical record. If the client is at risk, a plan with follow-up should be developed for addressing each risk factor. Observation for signs of depression should continue at all follow-up visits. If no risk factors are detected, then monitoring the client for development of risk factors and for signs of depression should continue during future visits. The primary risk factors for depression identified by the DHHS (1993) are:

-prior episodes of depression
-family history of depressive episode
-prior suicide attempts
-female gender
-age onset under 40
-postpartum period
-medical co-morbidity
-lack of social support
-stressful life events
-current alcohol or substance abuse

Additional risk factors specific for African American women are:

-being poor
-between the ages of 18 and 45 years

-unemployed

-high school dropout

-divorced or separated

-becoming a mother before age 18

-having minor children in the household

-criminal and intimate violence

PHASE 2: Diagnosis

Step 4

Determine if a workup is indicated for making a diagnosis. The African American woman may need a physical examination, including pelvic and pap smear, and/or diagnostic tests to determine if symptoms are from physical rather than emotional issues. Consideration should be given to the client's desires, health insurance coverage or client's ability to pay. The work-up should be done in a manner that causes the least amount of physical, emotional or financial stress. The following laboratory tests should be considered, but depend on other medical symptoms, pre-existing medical conditions, history and client's age:

-complete blood count (CBC)

-chemistry profile (electrolytes, BUN, creatinine, uric acid, glucose)

-T3, T4, TSH

-estradiol level (depending on age and pre-menopausal symptoms)

-mammogram (depending on age and family history)

-urinalysis

-stool for occult blood

-flexible sigmoidoscopy (depending on age)

-HIV testing

-electrocardiogram

-chest x-ray

-Vitamin B12, folate levels

Step 5

The African American woman should be assessed for physical and culturally relevant conditions that may mimmick depression. Physical conditions to consider are organic brain

diseases, endocrine diseases, diabetes mellitus, liver failure, renal failure, chronic fatigue syndrome, vitamin deficiency, medication side effects/overdose/abuse/withdrawal, alcohol or substance abuse, and withdrawal from abused substances (Dambro, 1996). The health care provider should be alerted to spiritual manifestations and issues surrounding spirituality that may mimmick a mental disorder or hinder the African American woman from trusting conventional medicine. For example, can the client's symptoms be explained by a belief in voodoo illness?

Step 6

At this step, the health care provider should have sufficient information to make or rule out a diagnosis of depression. The diagnosis of depression would be made if the signs/symptoms of depression are not explained by cultural assessment and if a diagnosis of depression is supported by culturally relevant assessement tools. A summary of the Clinical Practice Guideline, in the form of a flow chart, can be seen in Figure 3.

Pertinent questions that need to be addressed with each client are listed in the diamond shaped boxes. Depending on a response of Yes or No, arrows are pointed in the direction of the appropriate sequence of questions or actions. Rectangle shaped boxes represent what action the primary care provider should take. Cue boxes in the upper right side at the beginning of the flow chart provide a quick checklist of DSM-IV symptoms of depression along with culturally relevant risk factors and symptoms the APN can check off while assessing for depression in the African American woman. The cue box on the flow chart under diagnosis provide a checklist of laboratory tests the APN may check off and order to assist in making an accurate diagnosis.

Evaluation of the depression clinical practice guideline

Evaluation of the Clinical Practice Guideline could be done by giving the Guideline to several APN's in practices that treat African American women. This author would do inservice explaining how to use the Guideline. APN's would then use the Guideline for six months and record their ideas and concerns in a journal. After six months, this author would meet with the APN's to share ideas, concerns, and sucesses. Changes could be made to the tool to enhance use and to make a culturally accurate diagnosis.

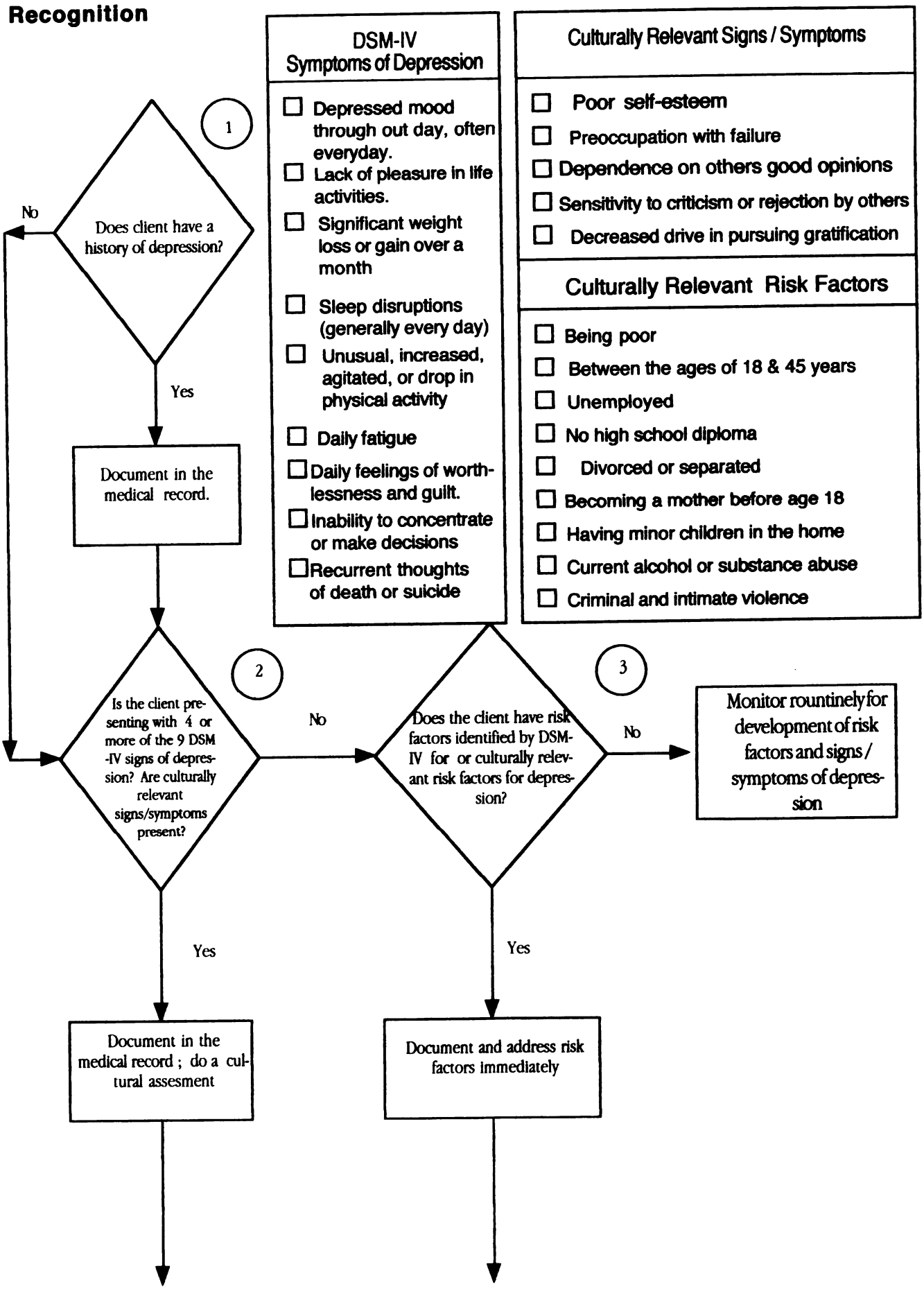
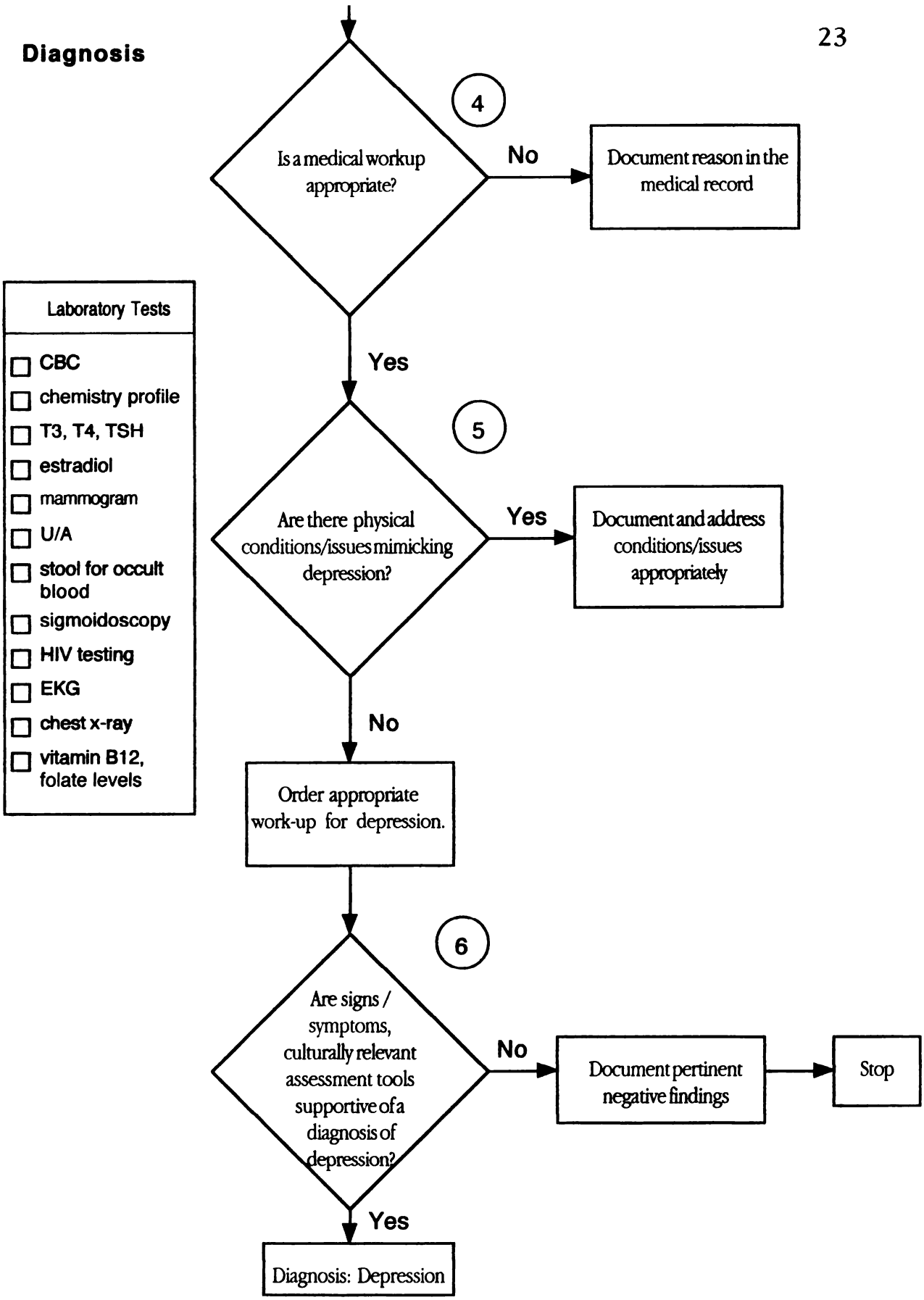


Figure 3: Flowchart of Clinical Practice Guideline for Diagnosing Depression in African American Women

Diagnosis


4
Is a medical workup appropriate?
No
Document reason in the medical record
Yes
5
Are there physical conditions/issues mimicking depression?
Yes
Document and address conditions/issues appropriately
No
Order appropriate work-up for depression.
6
Are signs / symptoms, culturally relevant assessment tools supportive of a diagnosis of depression?
No
Document pertinent negative findings
Stop
Yes
Diagnosis: Depression
Laboratory Tests
CBC
chemistry profile
T3, T4, TSH
estradiol
mammogram
U/A
stool for occult blood
sigmoidoscopy
HIV testing
EKG
chest x-ray
vitamin B12, folate levels

Implications for Advanced Practice Nursing in Primary Care

The restructuring of the health care delivery system is creating multiple challenges for primary health care providers. Delivering quality health care at a lower cost is in high demand. APN'S are qualified to deliver high quality, cost effective care within the primary health care setting. However, APN's must give added attention to education, research and program development. Rising to the challenges in these areas will increase the effect APN's have on restructuring health care. This Clinical Practice Guideline has several implications for the APN in primary care including education, research, and practice.

Education

Advanced nursing education should incorporate changes in curriculum that emphasize developing and utilizing clinical practice guidelines and pathways that are culturally relevant (e.g., the Clinical Practice Guideline for Diagnosing Depression in African American Women). The assessment of depression in African American women should be based on sound knowledge however, much of the knowledge is based on perception and beliefs (Barbee, 1992). In 1974, it was concluded that European American middle-class clinicians' lack of knowledge about African American culture made it difficult for them to make valid judgments about either the presence of or severity of depression (Carter, 1974; Faberga, 1974; Hanson & Klerman, 1974). In the 1990's, the ability of the health care providers to be objective in diagnosing clients in cross-cultural situations, and to be objective about the ways clients from various cultures express mental illness were issues of controversy in diagnosing depression (Campinha-Bacote, 1994). APN's can impact nursing education by providing sound information needed to further restructure nursing curriculum and include guidelines for diverse populations.

It is difficult to obtain cultural knowledge relating to depression in African American women from the literature. Educators should emphasize the uniqueness in how African American women may view, define and acknowlege depression. This should be done in such a way that the meaning and significance of the differences are understood. Differences should not be assumed to be bad or warrant harsh diagnoses sometimes imposed on African Americans with emotional and mental disorders. Individualized culturally relevant assessment should be taught as a standard for practice. This could decrease stereotyping and generalization based on ethnicity.

Research

Theorists and advocates have continued to convey that health care for culturally diverse individuals is often inadequate because it is based on the norms, values, and mores of European American middle class culture (Barbee, 1992). Despite these claims, little research has been conducted to verify these claims and some researchers and practitioners would argue that much of the existing research on this topic has been conducted in a culturally insensitive manner (Jones & Gray, 1986). For example, diagnostic criteria for making a diagnosis of depression may be made using structured instruments such as the Center for Epidemiological Studies-Depression Scale (CES-D) and the Diagnostic and Statistical Manual of Mental Disorders, Third Edition, Revised (DSM-III-R) that were compiled by clinicians working predominantly with European American clients (Barbee, 1992; Neighbors, et al 1990; Warren, 1995).

It has been suggested that culturally sensitive research should follow several guidelines to enhance the validity of its findings. Researchers have recommended that sociocultural variables (e.g., beliefs, values) be assessed directly in cross-cultural studies to provide texture to the differences detected among ethnic groups in the targeted outcome variables (Moscou, 1996). Moscou (1996) states:

> Race or ethnicity for many practitioners has become a shorthand explanation for client behavior, economic status, and social history--a metaphor for class and social conditions assumed by practitioners but rarely confirmed directly. Identifying a client's race or ethnicity without a critical analysis of racism and socioeconomic factors encourages health care professionals to routinely confuse race or ethnicity as the risk factor in place of the social conditions that contribute to illness and disease. (p. 8)

Further, research studies on depression in African American women should include the race/ethnicity of the researcher, larger sample sizes, the procedures for selecting the samples, age, socio-economic status, educational level, geographic location of the client and tools and strategies to diagnose depression. This would contribute to greater generalizability and replication. Also, such documentation could result in the development of a common language and understanding about cultural relevance and it's influence on diagnosing depression in African American women.

Research on depression in African American women should focus on increasing understanding of what African American women think about mental illness and depression. Qualitative studies determining how they define depression and further exploration of the stigma

attached to mental illness and depression should be considered in research. The influence of the stigma attached to mental illness and depression on health seeking practices could be a crucial factor influencing early diagnosis and treatment of depression in African American women.

By conducting culturally relevant research and documenting outcomes, APN's can have a positive impact on the delivery of primary health care. This could also lead to utilizing more clinical practice guidelines that include the cultural component. If cultural considerations are believed to be valued, this could lead to increased trust in health care which should lead to increased use of the health care system. More research is needed to document if using the clinical practice guidelines would increase quality of life and decrease health care costs.

Practice

APN students should have the opportunity to work with culturally and ethnically diverse populations in primary care. Time should be spent utilizing various clinical guidelines and research tools that are culturally relevant. Practice should be integrally related to both education and research. With the enmeshing of these major concepts, APN's would be better prepared to deliver the highest quality care in primary care for all populations. Additionally, guidelines and research tools can be refined, made easier to use and become a part of standard operating procedure in primary care.

For example, the Clinical Practice Guideline for Diagnosing Depression in African American Women could be evaluated by doing a six month study with primary health care providers at two different locations. At one location, the health care providers would have an eight hour inservice on cultural competence, followed by an explanation of the Clinical Practice Guideline. Health care providers at the second location would not attend the inservice on cultural competence. Both groups would receive the Clinical Practice Guideline with instructions on how to follow the Guideline when assessing all African American women presenting at the clinic for health care. It is this author's belief that inservice would increase cultural awareness and sensitivity and the clients would report greater patient satisfaction. Further, there would be increased documentation of factors that may indicate the client is at risk for depression or have symptoms of depression.

At the end of each month, records of all African American female clients at both locations would be pulled. A tally, noting documentation of information recommended in all steps of the Clinical Practice Guideline would be accomplished. The tally would also include the number of

follow-up visits and visits to emergency rooms or other health care facilities for depression related incidents. At the end of the six month period, a short questionnaire would be sent to health care providers at both locations, seeking reactions to the study. A satisfaction survey would be sent to African American women who presented to the clinics during the six month time frame.

The final evaluation would include noting how many African American female clients were diagnosed with depression, how often risk factors for depression were documented in the medical records, how frequently these risk factors were addressed, and the clients and the health care providers evaluation of care. Changes in the Guideline could be made based on input from health care providers and clients.

To reach a wide range of health care professionals and African American women, this information could be disseminated and discussed at seminars where depression and issues affecting "Women of Color" are discussed. It could be presented at nurse organization meetings and sorority gatherings where women are likely to attend. Getting information to the general African American women population could be done by inserting leaflets in the Sunday morning church bulletin describing depression, risk factors, and symptoms. Non-threatening directions for seeking help would be included. Community leaders in housing units where African American women at risk for depression live could arrange to have information passed out in the housing unit and arrange for health care professionals to visit and circulate among the women.

Conclusion

It has been said that by the year 2010, ethnic minorities in the United States will increase from 25 to 40 percent of the total population (Pacquiao, 1995). APN's are a viable provider of health care and have the ability to continually assess, evaluate, and reassess cultural competencies to deal with diverse populations. Approximately 74% of Americans seeking help for depression, or symptoms of depression, will present to a primary care provider rather than a mental health provider. When correctly diagnosed, depression can usually be successfully treated with medication, psychotherapy or a combination of both. African American women experience high levels of stress, and are at a greater risk for depression, with limited access to culturally relevant assessment. Health care providers have a responsibility to use tools such as the Clinical Practice Guideline which considers cultural influence in the assessment for depression. This Culturally Competent Clinical Practice Guideline for Diagnosing Depression in African American Women

could not only be used as a model for developing cultural sensitive protocol for diagnosing and treating depression in African American women, but for diagnosis and treatment of other disorders in other populations.

It is imperative that APNs make the effort and take the lead in incorporating a cultural assessment component into every client visit. Furthermore, the APN needs to increase sensitivity to symptoms of depression by creating an atmosphere of trust and rapport so that African American women feel comfortable and supported in sharing their thoughts and feelings. It is only when APNs make an effort to reach out to the African American community of women that there will be appropriate research carried out, leading to factual articles appearing in the literature and new and appropriate clinical guidelines mandated as basic standards of practice. Then the harsh statistics and stigmas documented in this paper will decrease and we will no longer have to pursue depression as a scholarly endeavor - everyone will be aware.

APPENDIX A

FLYNN'S CULTURAL ASSESSMENT TOOL

Nursing: From Concept to Practice

Name _____ Age _____ Sex ____ Marital Status _____
Address _____ Phone _____
Religion (specify denomination) _____ Clergyman _____
Educational level _____ Occupation _____

Communication
Language spoken at home _____ Does patient speak English? Yes ___ No ____
If yes, how much? Few words _____ Basic Vocabulary _____ Speaks fluently _____
Does patient understand English? Yes ___ No ___ If so, how much? _____
Can a family member (or friend) speak English? Yes ____ No _____
Can that person stay with the patient to interpret? Yes ____ No _____
If yes, when? (hours) Sun ____ M ____T ____ W ____ Th ____ F ____ S ____
Can another person act as translator? Yes ____ No ____ Who _____ Phone _____
Does patient reach out to touch? Yes ____ No ____
Do family members touch each other? Yes ____ No ____
Would any common gestures assist in understanding the patient? _____
Does the patient pull away when touched? Yes ____ No ____
Does the patient touch health care givers? Yes ____ No ____

Religious Beliefs
Is Baptism permitted? Yes ____ No ____ If so, by whom? _____
Under what circumstances? _____
Will the patient permit blood transfusion? Yes ____ No ____
Will the patient accept medications? Yes ____ No ____
If only specific types, which types? _____
Do religious leaders have a role in prevention or treatment? _____
What rituals are necessary? _____ Circumcision? Yes ____ No ____
How are religious artifacts disposed of? _____

Health Perception
Prevention-Related to religion? Yes ____ No ____
Do any beliefs contradict those of health care agency? Yes____ No ____
If yes, what? _____
Do any beliefs coincide with health care agency? Yes ____ No ____ If yes, what? _____
How is health care system perceived? _____
Illness-Will of God? Yes ____ No ____ Predestined? Yes ____ No ____
Evil spirits? Yes ____ No ____
What rituals or practices are necessary to restore health? _____

Health-Illness Practices
What medications and folk medicine treatments, regimens, etc., is patient using? _____
_____
Where are these purchased? _____
Who prepares them? _____ Who administers them? _____
Is the patient permitted by his physician to continue taking these preparations?
Yes ____ Not ____
Who treats the sick in the patient's family? Grandmother _____ Faith healer _____
Medicine Man _____
Does patient ask for pain medicine or exhibit stoicism? _____
What are cultural beliefs about the experience of pain? _____
Belief as to what caused the disease process the patient is exhibiting? _____
What is the patient's outlook for the future? _____

Disposal of amputated limbs _____
Physical care and comfort-Skin care _____ Hair care _____ Bathing _____
What are practices concerning prevention of illness? _____

Nutrition
Ethnic preference _____ Cultural/Religious taboos _____
Holiday and festive occasions _____ Who prepares food at home? _____
If necessary can someone bring special foods? Yes ____ No ____ Who _____ Phone ___
Has diet been modified by illness? Yes ____ No ____
Likes _____ Dislikes _____

Time Orientation
Does patient need to be reminded of appointments? Yes ____ No ____

Territoriality
Does patient stand close to others? Yes ____ No ____ Far away? Yes ____ No ____
Does patient retreat to room ____ bed ____ for privacy?
Does patient pull covers over face ____ turn away ____ draw curtains ____?

Privacy
Will patient allow physical examination? Yes ____ No ____
By person of opposite sex? Yes ____ No ____
Will patient remove his/her clothes? Yes ____ No ____
Does another family member have to be present? Yes ____ No ____
Any special considerations of personal belongings? _____

Family
Who makes decisions? _____ Relationship _____
Who makes health decisions? _____ Relationship _____
Can patient make own health decisions? Yes ____ No ____
Does patient have to consult with the decisionmakers? Yes ____ No ____
Do family health beliefs or practices conflict with hospital/clinic heath teaching and practices?
Yes ____ No ____ If yes, describe _____
_____
Effects of illness or hospitalization on other members of household _____
_____
What hours are best for various family members to visit? _____

Death (optional)
What are dominant practices? _____
Deathbed confession? Yes ____ No ____ Last rites? Yes ____ No ____
Who is to be called? Family ____ Clergy ____
Will bedside ritual be required? Yes ____ No ____
Are there measures to ward off death? Yes ____ No ____
Where does patient/family want the patient to die? Home ____ Hospital ____ Other ____
Who should be with patient at the time of death?
What is the role of the family members in the death of patient? _____
What are preparations for burial? _____
Who performs these? _____
Additional comments, observations, and assessments _____
_____

APPENDIX B

CAMPINHA-BACOTE'S CULTURAL ASSESSMENT WORKSHEET

CULTURAL ASSESSMENT WORKSHEET

I. *COMMUNICATION:*
1. Do you speak any other languages? If yes continue, if no, go directly to question 5.
2. Is English your first language? Which is your language of choice?
3. Does the client speak English fluently?
4. Does the client prefer a translator or to have questions stated in simple terms?
5. How much physical touch is appropriate?
6. Are there ethnic behaviors or styles that the client uses?

II. *ORIENTATION:*
1. How long have you lived in the town/city you are live in?
2. Where were you born?
3. What cultural or ethnic group do you identify yourself with?
4. How closely do you adhere to the traditional values, beliefs and/or practices of this cultural/ethnic group?
5. What are your thoughts on the following:
   A. In terms of human nature; do you believe that people are basically good, evil, or both good and evil?
   B. What are your thoughts on gaining knowledge/wisdom? Do people learn more from the past; the present moment; or should one plan a set goals for the future?
   C. In terms of activity, is it enough to "just be"; is our purpose for being to gain inner growth; or do you believe that if people just work hard and apply themselves their efforts will be rewarded?
   D. Do you believe that some people are born to lead, while others to follow?
   E. What are your thoughts on your relationship with nature? Is life determined by external forces, such as fate, God, genetics; or can one control and conquer life?

III. *NUTRITION:*
1. Do you prefer certain kinds of ethnic/cultural foods?
2. Are there foods that you eat, or your family encourages you to eat, when you get sick?
3. Are there foods you don't eat because of your cultural/ethnic origin, or health status?

IV. *FAMILY RELATIONSHIPS:*
1. Who do you consider your family?
2. Is there anyone you would like us to contact or you would like to see while your in the hospital?
3. How are decisions made in your family?
4. In your family, what are the roles of women, men,

children, and elderly?
5. What are some of the social customs or practices that your family engages in.
6. Tell me three of your family values.

V. *HEALTH BELIEFS:*
1. How would you describe the problem that brought you here?
2. What do you think will help you clear up your problem?
3. List some examples of the kinds of treatment and care that you find helpful to you now.
4. What types of treatments are not acceptable to you or your family?
5. What do you think will get you better?
6. Other than doctors, nurses, social workers and other healthcare workers, who do you go to for help when you are sick?
7. What is the best way for healthcare workers, like myself, to care for you?
8. What are your beliefs about what causes emotional problems?

VI. *EDUCATION:*
1. How did you get your education; formally in a school or by life experiences?
2. What is the best way for you to learn about something new --- reading, watching a program, actually experiencing it or by talking about it?
3. Tell me about your work experience; past and present.
4. Do you have any form of medical or dental insurance coverage?

VII. *SPIRITUAL/RELIGIOUS:*
1. Do you consider yourself a spiritual or religious person? Tell me about it.
2. Do you have a religious preference?
3. Are there spiritual/religious beliefs or practices that are important to you?
4. Are there specific people that are involved in your spiritual/religious well-being and recovery?

VIII. *BIOLOGICAL/PHYSIOLOGICAL*
1. Are there any health problems or diseases that are specific to your family? For example, is there a history of high blood pressure, or sickle cell anemia?
2. Are there certain medications that you or your family members avoid because of a negative side effect?
3. Are there any types of specific skin care, hair care, or other grooming needs that you prefer?

* (Tool is based on Fong's CONHFER Model, 1985)

APPENDIX C

CENTER FOR EPIDEMIOLOGICAL STUDIES-DEPRESSION SCALE (CES-D)

CES-D

Instructions: Below is a list of the ways you might have felt or behaved. Please tell how often you have felt this way during the past week.

1. Rarely or None of the Time (Less than 1 Day)
2. Some or a Little of the Time (1-2 Days)
3. Occasionally or a Moderate Amount of Time (3-4 Days)
4. Most or All of the Time (5-7 Days)

During the past week:	Less than 1 day	1-2 days	3-4 days	5-7 days
1. I was bothered by things that usually don't bother me.	1	2	3	4
2. I did not feel like eating; my appetite was poor.	1	2	3	4
3. I felt that I could not shake off the blues even with help from my family or friends.	1	2	3	4
4. I felt that I was just as good as other people.	1	2	3	4
5. I had trouble keeping my mind on what I was doing.	1	2	3	4
6. I felt depressed.	1	2	3	4
7. I felt that everything I did was an effort.	1	2	3	4
8. I felt hopeful about the future.	1	2	3	4
9. I thought my life had been a failure.	1	2	3	4
10. I felt fearful.	1	2	3	4
11. My sleep was restless.	1	2	3	4
12. I was happy.	1	2	3	4
13. I talked less than usual.	1	2	3	4
14. I felt lonely.	1	2	3	4
15. People were unfriendly.	1	2	3	4
16. I enjoyed life.	1	2	3	4
17. I had crying spells.	1	2	3	4
18. I felt sad.	1	2	3	4
19. I felt that people dislike me.	1	2	3	4

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