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Cover Page Footnote

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A closer look at the association between African American men's perceptions of healthcare providers' cultural sensitivity and hypertension

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Abstract

African Americans, specifically African American men, continue to have a substantially higher rate of hypertension and lower life expectancy than other racial and ethnic groups. This has been linked to poor interactions with health care providers. The purpose of this study was to examine the association between African American men's perceptions of health care providers' cultural sensitivity and a diagnosis of hypertension. A cross-sectional quantitative study was conducted with a specific focus on the association between the perceptions of provider cultural sensitivity and hypertension controlling for age, socioeconomic status, insurance status, and anxiety. Quantitative data were collected from 330 African American men using a modified NHIS (National Health Interview Survey) questionnaire consisting of an 18-question multiple-choice and Likert-scale survey. A logistic regression analysis was conducted to predict hypertension from age, socioeconomic status, insurance status, anxiety, and perception of provider cultural sensitivity. The overall model was significant and explained 11.7% of the variance in hypertension. Age and anxiety were unique significant predictors of hypertension in African American men. Based on the findings from this study, it is essential healthcare professionals accurately diagnose and treat African American men based on risk factors such as age and anxiety, which may be related to perceived racism and experiences of racism over time.

Keywords

Hypertension, African American men, patient experience, patient-centered care, healthcare, communication, perceived racial discrimination, patient engagement

Introduction

Studies of health disparities have increased over the years, but there are still areas remaining unexplored.^{1,2} Social determinants of health are considered an essential aspect of health care contributing to forming and continuing health disparities.^{1,2} Population-level health disparities such as gender, age, ethnicity, language, education, insurance status (insured versus uninsured), perceived health status, and socioeconomic status must be researched to determine factors contributing to differences in care and unequal access.^{2,3} Life expectancies and increased health conditions related to health disparities for African Americans have been an issue for many years but were not always documented until the 1980s.⁴ African Americans have higher rates of hypertension, diabetes, and stroke compared to White Americans.

African Americans, specifically African American men, still have a substantially higher rate of hypertension than other racial and ethnic groups.⁵ Poor patient and clinician interactions are connected to hypertension for African American men due to decreased communication, insufficient discussions of treatment options provided, and disengagement.^{1,2} Another contributing factor for African American men is perceived racial discrimination, a life stressor that contributes to physical and mental health.⁶

Research is still needed to examine the association between perceived racial discrimination, anxiety, and hypertension for African-American men.^{4,5} The Purnell model for cultural competence (PMCC) has been described as the most appropriate clinical assessment tool but evolved to study cultural competence between cultural interactions of patients and healthcare providers.⁷ Experts recommend that when discussing health disparities and conducting a cultural assessment of patients' needs, providers should look beyond race and ethnicity to focus on the PMCC's 12 domains of cultural attributes.⁷ This study explored if African American men's perceptions of healthcare providers' cultural sensitivity predicted hypertension, while controlling for age, socioeconomic status, insurance status, and anxiety.

Methods

Study Design

A cross-sectional quantitative study design was used and data were collected using a web-based 18-question multiple-choice and Likert-scale survey. Items were extracted from the National Center of Health Statistics Department of the Centers for Disease Control and Prevention's 2017 National Health Interview Survey (NHIS). This survey tool is standardized and has been identified as a reliable and valid survey instrument.^{8,9} The

validity of the specific NHIS items used in this study were analyzed during a pilot study preceding this study. Reliability as well as validity of composite variables constructed from NHIS items were assessed during this study. Items included age, socioeconomic status (as measured by education), insurance status (as measured by having insurance in the past 12 months), anxiety (as measured by having feelings of anxiety in the past 30 days), perceived racial discrimination of healthcare providers, and hypertension (as measured by a diagnosis of hypertension).

Participants and Data Collection

A convenience sample of 357 African American men was recruited by email and Facebook posts from across the United States through churches, universities, businesses, fraternities, veterans, and other social organizations. Organizations such as from Benedict College, a Historically Black Colleges and Universities (HBCU) institution, National Pan-Hellenic Council, consisting of five African American men fraternities, Black Man Day organization, and United AME Zion Church endorsed the study. The web-based survey was emailed to identified participants through a Survey Monkey link. The data were collected through a web-based survey application, Survey Monkey.

The data were collected and analyzed by SPSS version 26.0. Descriptive analyses were conducted to describe the study sample and each survey items. Binary logistic regression models were used to address the research questions. Statistical assumptions for the logistic regression analyses were assessed to ensure data were appropriate for analysis.

Results

A total of 357 participants consented to participate in the survey. Among these individuals, 27 participants did not meet the inclusion criteria for male sex and African American race. Participants were excluded if they selected sex as female, ethnicity as Hispanic, or considered themselves any other race besides Black/African American. The final sample consisted of 330 participants. Most of the participants had an associate’s degree (24.5%) or a bachelor’s degree (28.8%). An equal number of participants had insurance coverage and did not have insurance coverage (both *n* = 165, 50%). Most participants indicated they had very good perceived health (37.0%) or good perceived health (31.5%). A total of 148 participants (44.8%) indicated they had hypertension. Table 1 presents the frequencies and percentages of the nominal-level variables.

Table 1. Sample Demographic Characteristics

Variable	<i>n</i>	%
Education level		
Some high school	8	2.4
GED or equivalent	6	1.8
High school	55	16.7
Some college, no degree	45	13.6
Associates	81	24.5
Bachelors	95	28.8
Masters	26	7.9
Professional school degree	6	1.8
Doctorate	8	2.4
Insurance coverage		
Yes	165	50.0
No	165	50.0
Perceived Health Status		
Poor	3	0.9
Fair	22	6.7
Good	104	31.5
Very Good	122	37.0
Excellent	79	23.9
Hypertension		
Yes	148	44.8
No	182	55.2

Data Analysis

Composite variables for cultural sensitivity and anxiety were constructed. The survey items used to construct these variables are reported in Table 2. Composite scores were developed for anxiety and cultural sensitivity by taking an average of the series of survey items comprising the two scales.

Descriptive statistics were examined for the continuous variables of age, income, anxiety, and cultural sensitivity. Participants were all males (100%), middle aged ($M = 38.97$, $SD = 16.31$) and middle class ($M = \$75,136.03$, $SD = \$30,570.38$). Anxiety level of the sample was low ($M = 2.67$, $SD = 0.79$) and the perception of health care providers' cultural sensitivity was moderate ($M = 2.51$, $SD = 0.49$). Table 3 presents the descriptive statistics for the interval-level variables

Reliability

The strength of the alpha values was assessed using the guidelines suggested by George and Mallery (2016), in which $\alpha \geq .9$ Excellent, $\alpha \geq .8$ Good, $\alpha \geq .7$ Acceptable, $\alpha \geq .6$ Questionable, $\alpha \geq .5$ Poor, and $\alpha < .5$ Unacceptable. Anxiety met the acceptable threshold for internal consistency ($\alpha = .83$). Cultural sensitivity did not meet the acceptable threshold for internal consistency ($\alpha = .59$), therefore, the results for this scale will be interpreted with a level of caution. Prior to inferential analysis, the assumptions of a logistic regression were assessed and verified.

A binary logistic regression was conducted to examine whether perceptions of cultural sensitivity predict hypertension. The results of the overall model were not significant suggesting the cultural sensitivity composite score did not predict hypertension. The Nagelkerke R-squared was 0.003, indicating 0.3% of the variance in

hypertension could be explained by the cultural sensitivity composite score. Due to the non-significance of the overall model, the individual predictor was not examined further.

A second binary logistic regression was conducted to examine whether perceptions of cultural sensitivity predict hypertension, while controlling for age, socioeconomic status, insurance status, and anxiety. Using a hierarchical regression method, the control variables of age, socioeconomic status, insurance status, and anxiety were entered into the first block of the model. The predictor, cultural sensitivity, was entered into the second block of the model.

The results of the first block of the regression model were collectively significant, suggesting that age, socioeconomic status, insurance status, and anxiety do predict hypertension. The results of the second block of the regression model were collectively significant, suggesting that age, socioeconomic status, insurance status, anxiety, and cultural sensitivity do predict hypertension. The

Table 2. Survey Items Combined to Construct Cultural Sensitivity and Anxiety Composite Scores

Anxiety	
Item 10:	During the past 30 days how often did you feel nervous?
Item 11:	During the past 30 days how often did you feel restless or fidgety?
Item 12:	During the past 30 days how often did you feel that everything was an effort?
Cultural Sensitivity	
Item 16:	How often were you able to see health care providers who were similar to you in any of these ways?
Item 17:	How often were you treated with respect by your health care providers?
Item 18:	How often did your health care providers ask for your opinions or beliefs about your medical care or treatment?
Item 19:	How often did your health care providers tell or give you information about your health and health care that was easy to understand?

Table 3. Descriptive Statistics for Age, Income, Anxiety, and Cultural Sensitivity

Variable	<i>n</i>	Minimum	Maximum	<i>M</i>	<i>SD</i>
Age	330	18	78	38.97	16.31
Income	330	\$0.00	\$300,000	\$75,136.03	\$30,570.38
Anxiety	330	1.00	5.00	2.67	0.79
Cultural sensitivity	330	1.00	4.00	2.51	0.49

Note. *M* = mean; *SD* = standard deviation.

Table 4. Binary Logistic Regression Results with Age, Socioeconomic Status, Insurance Status, Anxiety, and Cultural Sensitivity Predicting Hypertension

Predictor	<i>B</i>	<i>SE</i>	<i>Wald</i>	<i>p</i>	<i>OR</i>
Block #1:					
Age	0.03	0.01	15.73	<.001	1.03
Socioeconomic status	0.00	0.00	0.54	.461	1.00
Insurance status (reference: no insurance)					
Had insurance coverage	-0.35	0.26	1.86	.172	0.71
Anxiety	0.40	0.16	6.51	.011	1.49
Block #2:					
Age	0.03	0.01	16.18	<.001	1.03
Socioeconomic status	0.00	0.00	0.28	.600	1.00
Insurance status (reference: no insurance)					
Had insurance coverage	-0.37	0.26	2.04	.153	0.69
Anxiety	0.39	0.16	5.99	.014	1.48
Cultural sensitivity	0.19	0.25	0.60	.438	1.21

Note. Step 1: $\chi^2(4) = 29.48, p < .001$, Nagelkerke $R^2 = .114$; Step 2: $\chi^2(5) = 30.08, p < .001$, Nagelkerke $R^2 = .117$.

Nagelkerke R -squared increased by approximately 0.3% (11.4% to 11.7%) between the blocks.

Age was a significant predictor in the model, indicating that with every one-year increase in age, the odds of hypertension increased by approximately 3%. Anxiety was a significant predictor in the model, indicating that with every one-unit increase in anxiety, the odds of hypertension increased by approximately 48%. Cultural sensitivity remained a nonsignificant predictor in the regression model. Table 4 summarizes the results of the binary logistic regression model.

Discussion

This study aimed to examine if African American men diagnosed with hypertension experience a perceived lack of cultural sensitivity in their interactions with healthcare providers. The participants for the study consisted of 330 African American men, of which 148 participants (44.8%) indicated they were told by a doctor or other health professional they have hypertension. This is consistent with previous research findings that determined 40% of African Americans have high blood pressure.^{10, 11} Interestingly, while African Americans account for approximately 13% of the population, they are 50% more likely to be diagnosed with high blood pressure than White Americans.^{12, 13}

The hierarchical logistic regression results from this study were collectively significant, indicating age, socioeconomic status, insurance status, anxiety, and cultural sensitivity do predict hypertension. Age and anxiety were significant unique predictors of hypertension in African American

males. The results of racial discrimination have been reported to lead to anxiety and depression symptoms, which can contribute to mental health outcomes.^{6, 14} Anxiety is known to cause an increase in high blood pressure and may be associated with “white coat syndrome” in the presence of a healthcare provider.¹⁵ Together, prior experiences of racism along with increased anxiety, may affect African American men during office visits with healthcare professionals.^{16, 17} In addition to other risk factors, some researchers suggest white coat hypertension is a predecessor to African American men diagnosed with hypertension.¹⁸ According to Forde,¹⁷ previous research determined the differential effects of discrimination by age for African American men with hypertension. Those African American men experiencing more racism over their lifespan were more likely to be hypertensive.

Most participants in this study (90%) reported experiencing some level of anxiety some of the time. The odds of hypertension increased by approximately 48% with each unit increase in anxiety. This aligns with previous data showing African Americans are 20% more likely to report psychological distress, but just 30% of all African American men receive treatment mental health services compared to the average of 43% for all ethnic and racial groups.^{19, 20} On average, one out of three men experiences daily feelings of anxiety. An estimated 29% of the population in the United States experience some form of anxiety disorder throughout their lifetime.^{18, 21} Reported anxiety from participants may be related to distress over past and future experiences of racial discrimination. Having anxiety can create a higher risk of hypertension for African Americans.²¹ Previous research found a

relationship between perceived discrimination experienced by African American men and their hypertension status.²⁰ Living with hypertension due to disease burden and white coat hypertension can enhance or create stress; however, it is unknown if additional stressors contributed to the anxiety scores for this study.

Age was a significant predictor in the model, indicating that with every 1-year increase in age, the odds of hypertension increased by approximately 3%. This aligns with previous research that found as age increased, there was a considerable amount of progression for hypertension in African Americans compared to White Americans.^{22, 23} Research has determined that African Americans are typically diagnosed at an earlier age when compared to other ethnic and racial groups.^{10, 11} The median age for participants in this study was 38.97 years. The study results show that as age increased, risk factors increased for participants, leading to increased odds of hypertension for participants. Perceived discrimination due to the occurrence and frequency of everyday and lifetime discrimination as age increased can increase the risk of hypertension in participants. Previously, it has been shown that compared to White Americans, regardless of the blood pressure level throughout young adulthood, African Americans had a higher risk for hypertension through the age of 55 and were 1.5 to 2 times higher to be diagnosed with hypertension.^{22, 23}

The overall model results for prediction of hypertension from perceived cultural sensitivity of health care providers were not significant, suggesting the cultural sensitivity composite score used in this study may not have been an optimal indicator. Very little variance (< 1%) of the hypertension diagnosis in the sample was explained by the perception of cultural sensitivity in health care providers. Despite these nonsignificant results, on average, participants' responses indicated perception of health care providers' cultural sensitivity was moderate. Current evidence shows an association between patients' dissatisfaction with doctor visits and the patient-provider relationship.^{24, 25} Patients have reported an uncomfortable feeling when speaking with providers they perceive to lack cultural competence.^{24, 25} The perceived racial discrimination experienced in the healthcare system by African Americans can increase blood pressure, contributing to the disparity in hypertension between African American men and White American men.¹⁸ Based on previous literature, using an instrument designed specifically to measure the cultural sensitivity of patients may have yielded a different outcome in this study.

The life expectancy for African American men is 71.8 years, compared to 76.7 years in White men.²⁶ There are several physiological and social determinants of health risk factors related to the cause of hypertension for African American men. This study confirms associations between

age and anxiety with hypertension in African American men. While other variables examined were not significant, this study does not preclude effects of socioeconomic status, insurance status, and cultural sensitivity as each contributed some explanation of hypertension variance in the full regression model.

Many risk factors contribute to African American men developing hypertension.²⁰ Results from this research support the use of the Purnell model for cultural competence consisting of 12 cultural domains, specifically the health care practices and health care provider domains. Purnell²⁷ explained the domains are not intended to stand alone as individual topics; instead, they affect one another when addressing cultures to improve health outcomes such as hypertension. This model, through its emphasis on the interconnectedness of the 12 ethnographic domains, provides a framework for interpreting how health disparities such as hypertension may be exacerbated or diffused by forces operating in each domain. It suggests how experiences of racism, including health care provider lack of cultural competency, can promote mental health disorders like anxiety which increase the risk for chronic diseases such as hypertension.

Limitations

While recruitment included a Historically Black Colleges and Universities (HBCU) institution, the National Pan-Hellenic Council (consisting of five African American men fraternities), Black Man Day organization, and the United AME Zion Church, the geographical location of the participants was not assessed. Therefore, the results are broad and do not have a specific targeted area such as a state, region, hospital, or practice; therefore, it is unknown if the sample is representative of all African Americans in the United States.

Omitted variable bias is a limitation related to the study design. Although a thorough literature review was made to select salient variables, it is possible variables with higher associations to perceived cultural competence and hypertension were omitted from the analysis. This may have led to bias and inconsistency in the coefficient estimates. Lastly, the composite variables for cultural sensitivity and anxiety were constructed during the pilot data analysis. These composite variables were not evaluated for validity and reliability prior to the instrument being deployed. The validity and reliability of the questions related to cultural sensitivity and the formulation of the composite scores could have affected the outcomes and contributed to the lack of significance for cultural sensitivity as a predictor of hypertension. Therefore, these variabilities may lack specificity of measurement.

Recommendations for Future Research

Future research of the relationship between providers' cultural sensitivity and hypertension in African American men is warranted.¹⁷ Life experiences, such as racism and discrimination contribute to increased morbidity and mortality rates in African American men.²⁸ This study should be repeated using more specific valid and reliable instruments to measure the perception of provider cultural sensitivity and participants' anxiety. Additionally, targeting participants in a specific geographical location or healthcare system can assist with detecting problem clusters where intervention may be efficiently targeted.

Conclusion

Despite research and known factors related to hypertension in African American men, they continue to be diagnosed with hypertension at disproportionately higher rates than other racial groups. Based on the findings from this study, it is essential that healthcare professionals accurately diagnose and treat African American men based on risk factors such as age and anxiety which may be related to perceived racism and experiences of racism over time. Health care providers can benefit from being familiar with culture-related characteristics to promote and facilitate sensitive and competent health care for African American men of various ages. Health care professionals should recognize health effects due to discrimination experienced by African American men as an important public health problem. Health care professionals should be mindful of the effects of perceived discrimination on hypertensive risk factors and not limit assessments to standard high-risk factors such as exercise and diet when treating hypertension. Critical factors tailored for African American men's health will help create strategies for reducing health disparities among racial groups such as hypertension through public health programs targeting behavioural risks and environmental exposure, social determinants of health, and health care access.

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