

Health Professional Cultural Competence Reduces the Psychological and Behavioral Impact of Negative Healthcare Encounters

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Objectives: Negative health care encounters have psychological and behavioral consequences for patients, particularly for minority and low socioeconomic populations. Guided by an integrative model of culture, psychological processes, and health behavior, this study examined whether provider cultural competence reduces the emotional and behavioral consequences of negative health care encounters among Latina and non-Latino White American women in the United States. **Method:** A total of 335 women participated in the study, of which 236 (Latina = 112; non-Latino White = 124) reported at least one negative health care encounter during a preventive medical screening exam. Structural equation causal modeling was used to examine whether provider cultural competence, as perceived by the patient, influenced emotions associated with negative health care encounters and subsequent medical avoidance. **Results:** When both Latina and non-Latino White American patients perceived their provider to be higher in cultural competence, they experienced less shame and embarrassment related to the negative encounter. Lower levels of shame and embarrassment in turn, predicted less medical avoidance for Latina, but not non-Latino White American women. **Conclusions:** Findings revealed that provider cultural competence reduces some of the consequences of negative health care encounters that are relevant to health behavior. These findings shed light on the complexity of how providers' cultural competence impacts patient behavior, highlighting the importance of including psychological variables when investigating the role of cultural competence in health behavior and outcome.

Public Significance Statement

This study revealed that when Latina and non-Latina White American patients believe their health care provider is culturally competent (possesses the knowledge, awareness, and skills relevant to their cultural background), they are less likely to feel ashamed and embarrassed in response to a negative health care encounter. This is particularly important for Latina patients considering that feeling less shame and embarrassment resulted in less avoidance of future medical care. Our findings suggest that training health care providers in cultural competence could have beneficial effects on patients' feelings towards their providers and on the likelihood that they will seek timely medical care.

Keywords: cultural competence, patient-provider interactions, emotions, medical avoidance, Latinas

Research conducted with culturally diverse populations in the United States indicates that negative health care experiences have psychological and behavioral consequences that significantly impact subsequent care. For instance, Latin American (Latino) patients who experience negative health care encounters, such as those marked by long waiting times and poor communication,

report increased anger and dissatisfaction with their health care, and are less likely to return for care (Abraído-Lanza, Céspedes, Daya, Flórez, & White, 2011; Betancourt, Flynn, & Ormseth, 2011). Other studies report that negative health care encounters are associated with emotional consequences, such as feelings of shame (Lynøe et al., 2013). According to one national study, unfavorable

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evaluations of medical care and affective concerns represented critical reasons for avoidance of subsequent care (Taber, Leyva, & Persoskie, 2015). In addition, qualitative research with Latinos points to past negative experiences in health care and emotional avoidance as obstacles to medical care (Larkey, Hecht, Miller, & Alatorre, 2001).

Considering the multiple structural, linguistic, and cultural barriers that minority and low socioeconomic status (SES) patients can encounter when accessing a health care system (Ruiz, Campos, & Garcia, 2016; Strzelczyk & Dignan, 2002), reducing negative encounters may be difficult. In addition, in countries like the United States, the cultural divide between patients and the health care system may increase the potential for misunderstandings and the perception of unfair treatment. Hence, cultural competence on the part of medical providers could play an important role in reducing such negative experiences or ameliorating the consequences for patients and for the health care system.

Despite receiving considerable attention in the health care literature, empirical evidence that demonstrates a clear link between provider cultural competence and patient outcomes is less forthcoming (Lucas, Michalopoulou, Falzarano, Menon, & Cunningham, 2008; Renzaho, Romios, Crock, & Sönderlund, 2013). For example, a Cochrane review of cultural competence education for health professionals (search dates 1946–2012) identified only five studies investigating the impact of cultural competence on patient outcomes and all of the identified studies had some limitations (Horvat, Horey, Romios, & Kis-Rigo, 2014). Critics have argued that a lack of conceptual and theoretical clarity regarding cultural competence in health care may explain some of the inconsistencies that make it difficult to reach clear conclusions concerning the role of cultural competence on patient outcomes (Perloff, Bonder, Ray, & Siminoff, 2006).

Conceptualization of Cultural Competence

The extensive literature on cultural competence in multicultural psychology has produced a multitude of definitions and operationalizations (Gamst, Liang, & Der-Karabetian, 2011). One of the most influential of these conceptualizations (Sue, Ivey, & Pedersen, 1996), points to various competencies based on the three cultural domains of beliefs/attitudes, knowledge, and skills. This conceptualization served as the foundation for the Multicultural Guidelines adopted by the American Psychological Association (American Psychological Association, 2003, 2017). The *cultural beliefs/attitudes* competency domain reflects the counselor's awareness of his or her own values and biases, which may influence perceptions of their client and the counseling relationship (Sue, 2006). The *cultural knowledge* domain reflects the counselor's knowledge of the clients' beliefs, values, and worldviews while the *cultural skills* domain refers to the counselor's ability to communicate and provide care in a culturally sensitive and relevant manner. This conceptualization of cultural competence in multicultural psychology has been important in guiding the development of models for cultural competence in counseling and clinical psychology (see Gamst et al., 2011 for a review). The study of cultural competence in health care services could certainly benefit from conceptual models that can shed light on the role of cultural competence in health care interactions, behaviors, and outcomes.

Betancourt's integrative model of culture, adapted for the study of health behavior and outcome (Figure 1; Betancourt & Flynn, 2009; Betancourt, Flynn, Riggs, & Garberoglio, 2010; Flynn, Betancourt, & Ormseth, 2011) provides a framework that has contributed to understanding the role of culture in health care and can be used to investigate the multiple factors associated with cultural competence in this area. The model is based on a clear conceptualization of culture, which is defined as the socially shared beliefs, values, norms, and practices considered most relevant to psychological and behavioral phenomena (Betancourt, Hardin, & Manzi, 1992; Betancourt & López, 1993). Moreover, the model specifies the structure of relations among socio-structural, cultural, and psychological factors relevant to the behaviors of both health care providers as well as their culturally diverse patients. Specifically, it describes not only the ways in which culture relates to psychological factors and behavior, but also the socio-structural sources of cultural diversity such as ethnicity, race, SES, gender, age, and religion. Both direct and indirect (i.e., through psychological processes) effects of culture on health behavior and outcome are represented in the model.

In line with the integrative model and conceptualization of culture described above, as well as the conceptualization of cultural competence in counseling and clinical psychology described earlier, health professional cultural competence should be operationalized to reflect providers' cultural awareness, knowledge, and skills relevant to the health care they provide. Specifically, it should reflect providers' knowledge and awareness of the role of culture (e.g., socially shared values, beliefs, and norms) in the health behavior of their patients, as well as an awareness and understanding of how their own culture impacts how they relate to their patients. This conceptualization should also reflect the culturally sensitive skills providers employ to provide effective health care.

Methodological Aspects of Cultural Competence Research

In addition to the noted conceptual limitations regarding the study of cultural competence in health care, critics of research in this area have also identified a number of methodological concerns. For example, it has been argued that health professional cultural competence should be assessed from the lens of the patient (Perloff et al., 2006; Pope-Davis, Liu, Toporek, & Brittan-Powell, 2001), yet most research focuses on the perspective of the health care professional (Lucas et al., 2008). Furthermore, only 13% of health professional cultural competence measures have demonstrated psychometric reliability and validity (Gozu et al., 2007). In addition, research reveals no significant correlation between provider's perceptions of their own cultural competence and the perceptions of their patients (Ohana & Mash, 2015). In fact, results from that study showed that the greater the discrepancy between physician self-perceptions of cultural competence and patient perceptions of their providers' cultural competence, the less likely the patient was to adhere to medical treatment ($r = -.50$).

The limited studies that have examined health professionals' cultural competence from the lens of the patient are promising. This is particularly true in the case of research that examines the impact of cultural competence on psychological factors relevant to health care. For instance, research suggests that when patients with

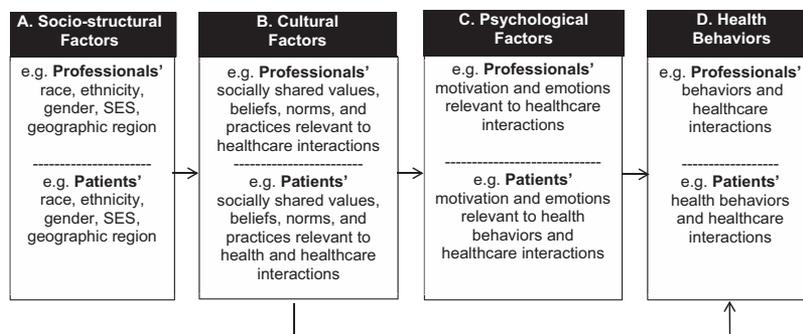


Figure 1. Graphic representation of Betancourt's Integrative Model of Culture, Psychological Processes and Behavior adapted for Health Behavior and Health Care Interactions.

diabetes perceived their health professionals to be high in cultural competence, they experienced lower emotional burden associated with the disease (Slean, Jacobs, Lahiff, Fisher, & Fernandez, 2012). Others have documented significant associations between patient perceived cultural competence and patient satisfaction and trust (Lucas et al., 2008; Michalopoulou, Falzarano, Arfken, & Rosenberg, 2009). One of the more comprehensive empirical studies in this area (Nielsen, Wall, & Tucker, 2016) revealed that although there was no direct effect of Latino-patient perceived cultural sensitivity on treatment adherence, there were significant indirect effects through perceived trust and satisfaction. Collectively, these studies highlight the complexity of cultural competence research and the importance of examining mediating psychological factors when investigating the impact of cultural competence on patient outcomes.

Emotions and Medical Avoidance

A number of psychological factors such as shame, distress, and a lack of trust in one's provider have been identified as predictors of medical avoidance (Lazare, 1987; Leyva, Taber, & Trivedi, 2017; Moore, Sickel, Malat, Williams, Jackson, & Adler, 2004). Moreover, research indicates that when Latina patients experience negative health care encounters, the associated negative interpersonal emotions (e.g., anger toward the health care professional) predict their decision to discontinue health care with that provider (Flynn et al., 2015). According to social psychological research on motivation and emotion, shame and embarrassment may be particularly salient emotions that elicit avoidance tendencies in the context of being wronged or threatened (Dickerson, Gruenewald, & Kemeny, 2004; Schmader & Lickel, 2006). However, when providers are culturally competent in their health care interactions, this could effectively reduce the experience of shame and embarrassment associated with negative experiences in health care.

The Present Study

The present study addresses some of the conceptual and methodological limitations of previous work concerning cultural competence in health care by investigating the role of patient-perceived health provider cultural competence as a potential mechanism for reducing the emotional as well as behavioral consequences of negative health care encounters. According to the structure of

relations specified in the integrative model (see Figure 1), culturally diverse patients' (A in Figure 1) perceptions regarding the cultural competence of providers is expected to influence patients' emotional reactions following a negative health care encounter (C in Figure 1) and their subsequent health care seeking behaviors (D in Figure 1). Specifically, we hypothesized that when patients perceive their provider (of White American or ethnic minority background) to be higher in cultural competence, they would report lower shame and embarrassment related to the negative encounter, which would in turn predict less medical avoidance. For the purpose of this study, a patient's perception of the cultural competence of a provider is conceptualized as a psychological factor (C in Figure 1) rather than a cultural factor per se, since it is assessed based on the patient's *perception* of the provider's behavior.

Method

Participants and Procedures

This study was part of a larger research program examining the role of culture in breast and cervical cancer screening. Multistage stratified sampling was conducted to obtain nearly equal proportions of self-identified Mexican-origin Latina and White¹ American women of varying demographic backgrounds. Based on U.S. Census tract data, demographic projections for ethnicity, education, income, and age were anticipated for a number of recruitment settings including churches, markets, universities, mobile home parks, and community settings in Southern California. Once permission was obtained from the sites, a Spanish and/or English language recruitment flyer was posted describing the study, eligibility criteria, and the time and on-site location for participation.

Approval for the study was obtained from the Institutional Review Board at Loma Linda University prior to data collection. Bilingual Spanish-English research assistants greeted the interested women at each research location, described the purpose of the study, and restated the eligibility criteria (self-identified Mexican-origin Latina or White American women, ≥ 20 years old,

¹ For the purpose of this article, participants from this study who self-identified as "Anglo American/Non-Latino White", as an ethnic category, are referred to as "White Americans".

able to read English or Spanish). After participants provided written informed consent, they were administered an English or Spanish version of the instrument, which took approximately 30 to 45 minutes to complete. Participants received \$15 as compensation for the time involved in participation.

As a result of multistage stratified sampling, the sample was well balanced between Latina ($n = 164$) and White ($n = 171$) American women. Of the 335 participants, 236 women (Latina = 112; White = 124) reported at least one negative health care encounter during a preventive medical exam (breast or cervical cancer-screening).

Measures

Negative health care encounters. Participants responded to a validated instrument designed to assess exposure to negative health care encounters, which was developed based on the mixed methods research approach to instrument development (see Betancourt et al., 2010). The scale reflects specific instances of negative health care encounters during a routine breast or cervical cancer-screening exam (e.g., poor communication, long waiting times, rushed care). Participants were presented with the 24 items and asked to indicate if they ever experienced the negative health care encounter during a breast or cervical cancer screening exam. A sample item includes, “The health professional rushed or hurried when they treated me.” Reliability for this scale was good (Latina $\alpha = .95$; White $\alpha = .95$). A “cumulative exposure to negative healthcare encounters” score was derived by summing the total instances endorsed by participants.

Patient-perceived health professional cultural competence. The nine-item Health Care Provider Cultural Competency Scale (Lucas et al., 2008) was employed to assess health professionals’ cultural knowledge, awareness, and skill. This particular scale was selected because it measures patients’ perceptions of their providers’ cultural competence and because items were developed in a manner consistent with the conceptualization of cultural competence recognized in multicultural psychology. The scale was previously validated with minority patients in the United States demonstrating good internal consistency for each of the three factors (knowledge $\alpha = .88$; awareness $\alpha = .81$; skill $\alpha = .89$) as well as discriminant and convergent validity (Lucas et al., 2008).

In the present study, participants were asked to think about the health professional involved in the negative encounter that occurred during a breast or cervical cancer screening exam and respond to the nine items based on a 7-point Likert scale from 1 (*not at all*) to 7 (*very much*). A sample item includes, “In my opinion, the professional made an effort to understand cultural differences.” Exploratory factor analyses of the 9-item scale produced a one-factor solution. Three items were dropped due to multicollinearity resulting in a 6-item scale, which demonstrated good internal reliability (Latina $\alpha = .90$; White $\alpha = .88$). For the purpose of testing the study hypothesis with structural equation modeling, three parcels of two items each were constructed using a balancing approach (Little, 2013). Items with higher item-scale correlations were paired with items that had lower item-scale correlations.

Negative interpersonal emotions. To assess the degree to which participants experienced negative emotions as a result of the incident, they were presented with the question, “As a result of the

negative healthcare encounter, how much did you feel the following emotions?” They were then asked to rate the degree to which they experienced shame and embarrassment based on a 7-point Likert scale anchored at the extremes from 1 (*not at all*) to 7 (*very much*). The emotions scale demonstrated good reliability for each ethnic group (Latina, $\alpha = .80$; White, $\alpha = .77$).

Medical care avoidance. Participants were asked if as a result of the negative health care encounter, they took longer to return for their next cancer screening exam. Response options were “no” or “yes.” Participants who responded “yes” were then asked to indicate the length of time they delayed their cancer screening exam from, “1 year” to “4 or more years” in increments of six months (e.g., 1-year delay; one to one and a half-year delay; one and a half to 2-year delay, and so on). An additional response option was “I have not had a screening exam since the incident.” Responses from these two questions were then recoded from 0 (no delay) to 9 (haven’t screened since the incident), with higher values indicating longer avoidance of medical care following the negative health care incident.

Demographic and health care information. Participants also responded to items designed to assess age, income, education, and self-reported ethnicity. Ethnic categories included “Latino American/Hispanic American” and “Anglo American/non-Latino White American”. Information concerning the ethnicity and gender of the provider involved in the negative encounter was also obtained and used to create gender-match and ethnic-match variables.

Statistical Analyses

Structural equation modeling with Maximum Likelihood (ML) estimation was used to test the study hypothesis via EQS 6.3 (Bentler, 1995, 2017). Twenty-three participants were removed from the original sample due to missing data that exceeded 25%, resulting in a total sample of 213 participants (Latina $n = 100$, White $n = 113$; see Table 1). The data were assessed for Missing Completely at Random (MCAR) via Little’s χ^2 test of MCAR (Little, 1988), which suggested that the data for both Latina and non-Latino White American participants were MCAR (Latina $\chi^2[68] = 80.16$, White $\chi^2[105] = 91.38$, $ps > .05$). Full Information Maximum Likelihood (FIML) estimation techniques were

Table 1
Sample Demographics by Ethnicity

Demographics	Latino American ($n = 100$)	White American ($n = 113$)
Age M (SD)	46.43 (13.36)	47.85 (16.54)
Education M (SD)	11.30 (4.00)	14.09 (2.64)
Ethnic match (%)	19.1	59.5
Gender match (%)	51.6	40.0
Income (%)		
\leq \$14,999	27.7	26.6
\$15–24,999	18.1	19.3
\$25–39,999	17.0	14.7
\$40–59,999	14.9	14.7
\$60–79,999	8.5	12.8
\$80–100,000	7.4	2.8
$>$ \$100,000	6.4	9.2

Note. The percentages reported above do not account for instances of missing data.

Table 2
Correlations and Descriptive Statistics of Measured Variables by Ethnicity

Variable	1	2	3	4
1. Cumulative negative healthcare encounters	—			
2. Perceived professional cultural competence	-.17 (-.32**)	—		
3. Negative interpersonal emotions (shame & embarrassment)	.25* (.33**)	-.23* (-.30**)	—	
4. Medical avoidance	.28** (.32**)	-.17 (-.09)	.32** (.12)	—
Mean	8.58 (9.18)	4.14 (4.67)	3.04 (2.47)	1.69 (1.96)
SD	7.01 (7.14)	1.72 (1.63)	2.19 (2.02)	2.95 (2.94)

Note. Values for Latina American participants are reported in the left portion of the cell. Values for White American participants are reported in parentheses.

* $p < .05$. ** $p < .01$.

used to handle additional cases of missing data in both groups (total missing $n = 28$). Although the data were multivariate non-normal, prior studies have shown that FIML is quite robust to non-normality (Enders, 2010).

A two-step structural equation model building procedure was used to first test the measurement model and then the full structural model. The robust ML estimation techniques available in EQS 6.3 for Windows (Bentler, 2017) were used to mitigate bias due to non-normal data, by providing adjusted standard errors and indices of model fit. Adequacy of model fit was evaluated using both robust and nonrobust fit indices, including: a nonsignificant Yuan-Bentler scaled χ^2 , a χ^2/df ratio less than 2.0 (Tabachnick & Fidell, 2007), a nonrobust Comparative Fit Index (CFI) of .95 or greater (Kline, 2015), and a robust Root Mean Square Error of Approximation (RMSEA) of less than .05, with the upper limit of the 90% confidence interval less than .10 (Kline, 2015). In conjunction with theoretical and conceptual reasoning, the Wald and LaGrange test statistics were reviewed to determine if eliminating or adding paths would improve model fit and if so they were implemented in a stepwise manner.

A test of measurement invariance was also conducted to ensure there were no differences in the factor structures for the cultural competence and negative interpersonal emotions scales for the White and Latino American samples. Invariance was evaluated according to the process discussed by Little (2013), such that the data were first assessed for invariance in the configuration of the factor structures of both scales between groups. Configural invariance was supported, $\chi^2[8] = 10.53, p > .05$. A subsequent test of measurement invariance was then conducted by placing equality constraints on each factor loading across groups. The constrained model also demonstrated adequate fit (Yuan-Bentler Scaled $\chi^2[12] = 15.29, p > .05$). Furthermore, the chi-square difference test revealed no significant difference in model fit between the constrained and unconstrained models ($\Delta\chi^2[4] = 4.76, p > .05$), suggesting that both the cultural competence and negative interpersonal emotions measures are invariant between the non-Latino White and Latino American groups.

Results

Preliminary Analyses

Table 2 includes the means, standard deviations, and correlations among the study variables. A review of the correlations revealed a stronger association between negative interpersonal

emotions and medical avoidance for Latinas as compared to White American women suggesting that the study hypothesis should be tested for each ethnic group separately.

Test of Study Hypothesis

A structural equation model including the hypothesized theory-based relations among cumulative negative health care encounters, perceived professional cultural competence, negative interpersonal emotions, and medical care avoidance was tested for Latina and White American participants, respectively. Age, income, education, patient-provider ethnic match, and patient-provider gender match were included as covariates in the tested model. A review of the Wald test statistic for the Latina structural equation model suggested eliminating paths from income and education to the

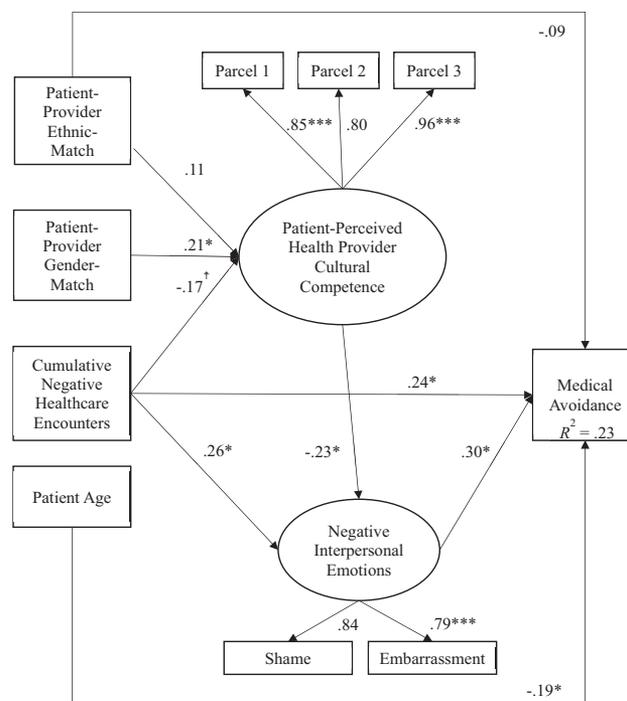


Figure 2. Structural equation model with standardized coefficients of factors contributing to medical avoidance among Latina American participants. Indicators that were used to set the metric of their associated latent factor appear without an asterisk. * $p < .05$. ** $p < .01$. *** $p < .001$.

study variables. Hence, these covariates were eliminated from the model all together. The Wald statistics for the White American structural model suggested dropping income, education, and ethnic-match. In addition, the Wald test statistics suggested eliminating the direct path from cultural competence to medical avoidance for both ethnic groups.

After eliminating the noted covariates and path from cultural competence to medical avoidance, the model including the hypothesized relations fit the data well for both, Latina (robust model fit: Yuan-Bentler scaled $\chi^2[30] = 34.10, p = .28; \chi^2/df = 1.02; RMSEA = .04, 90\% CI [.00, .09];$ nonrobust CFI = .98; see Figure 2), and White (robust model fit: Yuan-Bentler scaled $\chi^2[31] = 36.21, p = .24; \chi^2/df = 1.17; RMSEA = .04, 90\% CI [.00, .08];$ nonrobust CFI = .98; see Figure 3) American participants. The study variables accounted for approximately 23% of the variance in medical avoidance for Latina American and 19% of the variance for White American participants ($R^2 = .23, \text{ and } .19$, respectively).

Consistent with the study hypothesis, both Latina and White American women who perceived their health professional to be high in cultural competence reported experiencing lower levels of shame and embarrassment related to the negative health care encounter (Latina $\beta = -.23, p = .03;$ White $\beta = -.28, p = .02$). Lower levels of shame and embarrassment were in turn associated with less medical avoidance for Latina ($\beta = .30, p = .03$) but not White ($\beta = .04, p = .76$) American women. As mentioned earlier, the direct effect of perceived provider cultural competence on medical avoidance was not significant for either ethnic group and, hence, this direct path was eliminated from both models.

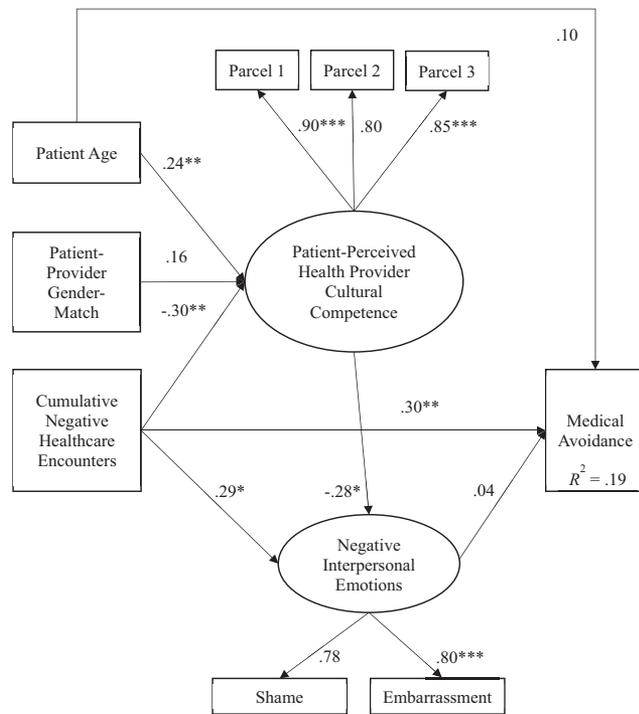


Figure 3. Structural equation model with standardized coefficients of factors contributing to medical avoidance among White American women. Indicators that were used to set the metric of their associated latent factor appear without an asterisk. * $p < .05$. ** $p < .01$. *** $p < .001$.

Although not central to the study hypothesis, there were additional findings that are worthy of discussion. For Latinas, patient-provider gender-match predicted greater perceived provider cultural competence ($\beta = .21, p = .05$). In addition, Latina American patients who received their care from a Latino provider (i.e., ethnic-match) perceived higher levels of cultural competence ($\beta = .11, p = .24$). For White Americans, older age ($\beta = .24, p = .02$) and patient-provider gender-match ($\beta = .16, p = .09$) were predictive of greater perceived provider cultural competence. Although some of the noted paths were not statistically significant at $p < .05$, there was a significant decrement in model fit when these variables were omitted from the model.

Discussion

Findings from this research suggest that cultural competence plays an important role in reducing the consequences of negative health care encounters for both Latina and non-Latino White American women from diverse socioeconomic backgrounds. Results revealed that greater exposure to negative health care encounters resulted in increased levels of shame and embarrassment, as well as a greater likelihood of medical avoidance. However, when Latina and White American patients perceived their health professional to be higher in cultural competence, they experienced less shame and embarrassment. Moreover, the reduced level of negative interpersonal emotions (e.g., shame and embarrassment) associated with perceiving the health professional to be higher in cultural competence resulted in less medical avoidance for Latinas. These findings provide greater clarity concerning the means by which provider cultural competence can impact health behavior and improve patient outcomes.

Guided by an integrative model that specifies the structure of relations among culture, psychological processes, and health behavior (Betancourt & Flynn, 2009; Betancourt et al., 2010; Flynn et al., 2011), this study revealed that cultural competence did not influence patient outcomes directly. Instead, these results suggest that the way in which provider cultural competence impacts Latina patient outcomes is largely through psychological processes, namely by reducing negative interpersonal emotions. Our findings are consistent with other studies that revealed significant associations between physician cultural competence and psychological variables such as disease related distress (Slean et al., 2012), patient satisfaction, and trust (Lucas et al., 2008; Michalopoulou et al., 2009; Nielsen et al., 2016). Still, other studies report inconsistent findings, particularly those examining the direct effect of cultural competence training programs on patient outcomes (see Lie, Lee-Rey, Gomez, Bereknyei, & Braddock, 2011; Renzaho et al., 2013). Our results suggest that when psychological factors are not included as potential mediators, the lack of a direct effect may lead one to wrongly conclude that cultural competence (or the impact of cultural competence training) is not an effective means for impacting health behavior and outcome. These results are consistent with the view that culture predicts behavior directly and/or indirectly through its effect on psychological processes (Amador, Flynn, & Betancourt, 2015) and suggest that the role of provider cultural competence functions similarly.

Although the literature in this area has largely emphasized the importance of cultural competence for patients from diverse ethnic and racial backgrounds, findings from this study suggest a similar benefit for White American patients, particularly when it comes to reducing the experience of shame and embarrassment associated with a negative health care encounter. At the same time, our results revealed that younger White American women and those who did not share the same gender as their health professional were less likely to perceive the provider to be culturally competent as compared to older White American women and those who received their care from a female provider. Cultural diversity is a function of a broad spectrum of social structural factors such as age and gender in addition to ethnicity, education, income, religion, and sexual orientation. In the case of White Americans from this study, the cultural divide with providers may have had more to do with age and gender-mismatch. Since outcomes associated with matching clients and counselors on social structural factors has produced mixed results in the counseling literature, adding cultural competence training may be a more effective strategy (Cabral & Smith, 2011).

Despite the finding that perceived provider cultural competence reduced the emotional consequences of negative health care encounters for both Latina and White American women, the reduced experience of shame and embarrassment was only found to be predictive of medical avoidance for Latinas. Cross-cultural research on emotions suggests that this finding may have to do with the cultural construction of emotion (Boiger & Mesquita, 2012). In a qualitative study identifying cultural self-constructs among college students in the United States and Mexico, Ramirez-Esparza and associates (Ramírez-Esparza, Chung, Sierra-Otero, & Pennebaker, 2012) identified the cultural construct of warm, positive relationships (e.g., *simpatía*) as central to students' self-construct in Mexico, but not in the United States. It may be that the experience of these negative interpersonal emotions (i.e., shame, embarrassment) among our sample of Mexican-origin Latinas is particularly impactful on medical avoidance, because it implies that the patient-provider encounter may have violated expectations associated with their primary self-construct (e.g., warm, positive relationships).

Despite the significance of the study findings, some limitations should be noted. For instance, because items from the cultural competence scale were worded broadly, it is not clear what specific aspects of culture participants were thinking of when indicating the cultural competence of their provider. Moreover, since participants reported their perceptions regarding the cultural competence of a health care provider involved in a negative encounter during breast or cervical cancer screening, our findings may or may not be generalizable to other health care professionals or medical interactions of a different nature. Furthermore, the Latinas included in this study reflected the demographic reality of Southern California, which is predominantly of Mexican cultural background. Therefore, it is unclear whether the results would be the same with Latina populations from other regions of the United States that represent different Latin American origins. At the same time, the generalizability of the study findings to White American women from other regions of the United States should also be viewed with caution. Finally, while the tested propositions are

solidly grounded in theory, the cross-sectional design of this study limits the test of temporal relations. The sample size used for the separate analysis of each ethnic group may have also resulted in the inability to detect additional significant paths. Still, this study has several strengths including the use of an integrative model of culture and advanced statistical procedures for addressing the complex nature of relations among cultural competence, psychological factors, and medical avoidance.

Results from this study suggest the need for additional research aimed at demonstrating a clear link between provider cultural competence and patient outcomes. Namely, this study highlights the importance of future research that can test the role of psychological factors as potential mechanisms through which cultural competence impacts patient outcomes. In addition, research on cultural competence in health care could benefit from methodological approaches that are longitudinal in nature in order to test this effect in a more definitive manner. Finally, additional work is needed to examine the role of cultural competence on health outcomes among other minority groups as well as other intersectional facets of diversity and culture such as ethnic identity, sexual orientation, and body size in order to advance research in this field.

The present study findings provide promising evidence for the importance of training health care providers in the area of cultural competence. Research suggests that cultural biases on the part of professionals may contribute to biased behaviors when interacting with racial and ethnic minorities (Madeira, Pereira, Gama, & Dias, 2018; Penner et al., 2016). Our study suggests that this may also be the case for patients who do not share the same background with their health providers in terms of ethnicity and gender. Since one component of cultural competence reflects the necessary skills and behaviors for working with diverse patients, cultural competence programs should also include training in evidence-based strategies for reducing the implications of bias in interpersonal relations (Stone & Moskowitz, 2011). In addition to addressing their own biases, when professionals are culturally responsive to their patients' expectations about patient-provider relationships, they are likely to provide higher quality care resulting in improved patient outcomes (Campos & Kim, 2017).

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