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Patient–Provider Communication: Understanding the Role of Patient Activation for Latinos in Mental Health Treatment

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Abstract

This article highlights results from the Right Question Project–Mental Health (RQP-MH), an intervention designed to teach skills in question formulation and to increase patients' participation in decisions about mental health treatment. Of participants in the RQP-MH intervention, 83% were from a Latino background, and 75% of the interviews were conducted in Spanish. The authors present the steps participants undertook in the process of becoming "activated" to formulate effective questions and develop decision-making skills in relation to their care. Findings suggest that patient activation and empowerment are interdependent because many of the skills (i.e., question formulation, direct patient–provider communication) required to become an "activated patient" are essential to achieve empowerment. Also, findings suggest that cultural and contextual factors can influence the experience of Latinos regarding participation in health care interactions. The authors provide recommendations for continued research on the patient activation process and further application of this strategy in the mental health field, especially with Latinos.

Keywords

Latino; mental health; patient activation; patient communication; patient–provider communication

Patient participation in treatment decisions is an important component of health care that has been related to higher levels of patient satisfaction, adherence to treatment (Hall, Roter, & Katz, 1988; Ley, 1988), and improved health outcomes specifically related to chronic conditions such as asthma, diabetes, and hypertension (Greenfield, Kaplan, Ware, Yano, & Frank, 1988; Kaplan, Greenfield, & Ware, 1989; Rost, Flavin, Cole, & McGill, 1991).

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Patient’s level of participation in treatment decisions is influenced by intrapersonal (e.g., patient characteristics such as race and education), interpersonal (e.g., communication style between provider and patient), and contextual factors, such as clinical setting (Kaplan, Gandek, Greenfield, Rogers, & Ware, 1995; Street, Gordon, Ward, Krupat, & Kravitz, 2005). According to these authors, a patient’s confidence and communication style are among the most fundamental of the intrapersonal factors. At the interpersonal level, the provider plays an important role modulating the extent to which a patient “actively” participates in health care decisions. For example, the level to which a patient participates in treatment decisions is usually a byproduct of a relational style encouraged by the provider that welcomes questions from a patient or elicits the patient’s opinions or narratives related to the condition under scrutiny. Contextual factors such as the longevity of the patient–provider relationship and time constraints during a medical encounter may also affect the extent to which a patient plays a more or less active role during a medical encounter.

Although the extent to which patients participate in health care decisions is influenced by multiple factors (e.g., patient’s confidence, provider’s role, time constraints, clinical setting, etc.), there are specific skills that patients need to develop to be able to make informed decisions along with their providers. Two of the most basic skills are question formulation and decision making. Through these two skills, patients can ask and assess information needed to make an informed decision and thus “take charge” of their health and their interactions with health care providers. Although these skills seem very simple at face value, many patients either lack these skills or are unable to effectively implement them.

This study presents findings from a project—called the Right Question Project–Mental Health (RQP-MH)—designed to teach mental health patients skills aimed at increasing their participation in their mental health treatment and involvement in decisions related to their mental health treatment. RQP-MH was based on a community-based social action intervention—Right Question Project (RQP)—that was designed to both activate and empower participants in multiple contexts that require making decisions. True to the spirit of RQP, the original goal of this study was to increase patient empower-ment, defined as the capacity for individuals to increasingly believe that they play a role in their heath care and have control over their lives and destinies (Staples, 1990), and to increase patient activation (i.e., acquisition of knowledge, skills, and beliefs by individuals to take action and participate in questions and decisions about their treatment). According to the philosophical tenets of RQP-MH, patient activation and empowerment are not mutually exclusive processes but rather are interdependent. As noted by Alegría et al. (2008), patient activation refers to the process through which patients develop skills related to question formulation and collection of health-related information that leads to more patient–provider collaboration. Empowerment refers to a capacity-building process that leads patients to experience an attitudinal shift through which they feel that they are taking action, are capable of and feel confident about making decisions, and are able to have better control of their health and health care process (Alegría et al., 2008). To be empowered, individuals need skills and tools (e.g., question formulation) that will lead them to make informed decisions about their treatment.

Evaluation outcomes from the original study (Alegría et al., (2008) indicated that RQP-MH was effective at increasing patient activation. In this article, we use the qualitative data collected through open-ended questions as part of the original study to describe the processes that participants went through as they were learning “patient activation” and empowerment skills and the changes their role as patient underwent over a brief period of time. In addition, we organize our findings under a theoretical model previously developed by Finfgeld (2004) that illustrates the relationship between the processes of patient activation and patient empowerment. By examining the factors or ingredients involved in the

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process of learning the RQP-MH skills, we show how the patient-activation process achieved through RQP-MH coalesced with certain ingredients or elements previously identified as essential to achieving empowerment (Finfgeld, 2004). We also use this information to formulate recommendations for continued research on the activation process for patients and further application of this strategy in the mental health field.

Patient Activation and Empowerment

The literature on patient participation in mental health treatment decisions has very seldom referred to the concept of “patient activation” but rather has focused on patient empowerment. For the most part, empowerment has been defined as a complex, multidimensional concept that describes a *process* rather than an event (Chamberlin & Schene, 1997). The common thread among the many definitions of empowerment is that empowerment encompasses *active participation* in making decisions related to important areas of an individual’s life (Linhorst & Eckert, 2003). Among these “important areas of an individual’s life,” health is paramount, yet the medical model—with a physician as the final authority in the treatment of illness—does not necessarily foster high levels of patient participation (Anderson, 1995). Nevertheless, empowerment, with its focus on redistributing power so that individuals gain more say and control over their lives (Croft & Beresford, 1992), has had a long-standing presence in the health and mental health spheres, primarily in the nursing and consumer empowerment arenas.

In this exploratory analysis, our aim was to better understand the processes through which mental health patients become active participants in their treatment. To organize our results, we used the empowerment model offered by Finfgeld (2004), which is based on concept analyses and qualitative research findings. The model focuses on individuals with enduring mental health illnesses, similar to our study participants, and views empowerment as a process composed of antecedents, barriers, attributes, and outcomes. For the purposes of this exploratory study, we focus on three of the four components of the model (i.e., antecedents, barriers, and attributes). Antecedents refers to the contextual, intrapersonal, and interpersonal precursors that may cause an individual with mental health problems to have less than optimal power to be an active player in his or her treatment. Barriers are factors that interfere with the process of empowerment. They include personal characteristics such as cognitive impairment, lack of institutional support of patient empowerment–related activities, and the role of providers in the process of patient empowerment.

The attributes of empowerment are described as a staged but iterative process, with individuals moving through four consecutive levels of increasing personal efficacy: participating, choosing, supporting, and negotiating. The first two levels loosely correspond to the concept of activation as defined above in the RQP-MH evaluation, whereas the last two levels more closely correspond to our definition of empowerment. The levels of attributes presented by this model allowed us to organize the many variables involved in the process of training mental health consumers to become more active players in their treatment. Although presented in a linear fashion, Finfgeld (2004) emphasizes that the process of moving through these stages is nonlinear and iterative; there may be delays in the process of moving through the stages, and it is likely that some individuals will not have the potential or desire to experience all four levels.

Cultural Components of the Activation Process

A majority of the respondents who participated in the RQP-MH intervention were from a Latino background (83%), and 75% of the interviews were conducted in Spanish. One of the objectives of the study was to develop an intervention that could be successful with this ethnic population. The literature has suggested that there may be cultural and contextual

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components that could influence the experience of those from racial and ethnic minority groups who try to take a more active role in health care decision making (Cooper et al., 2003; Surbone, 2006). For example, differences in patterns of communication have been identified across groups, with African Americans rating their interactions with their physicians as less participatory than Whites (Cooper-Patrick et al., 1999). Although cultural nuances may vary across Latinos from different countries of origin, sociodemographic characteristics and individual experiences, Latina women have been found to be less likely to experience patient-centered prenatal care compared to non-Latinas, leading to difficulty in understanding information, ability to ask questions, and intent to return for subsequent visits (Tandon, Parillo, & Keefer, 2005). Few studies have specifically looked at communication patterns in mental health care for Latinos. However, contextual factors such as immigration history have been found to influence the degree to which respondents become engaged in mental health treatment; for first-generation immigrants in general (i.e., Spanish-speaking Latinos), attitudes toward mental health care in their country of origin may be a stronger influence on their patterns of care than other contextual variables in the United States (Portes, Kyle, & Eaton, 1992). Understanding the cultural components (i.e., relational patterns, disease-related beliefs) that may influence communication patterns provides important information for providers and may help mitigate potential racial and ethnic disparities in health services (Armstrong, Highs-Halbert, & Asch, 2006).

Description of the Intervention

To achieve patient activation, participants in this study were taught specific skills: (a) identification of important decisions and issues about their mental health care, (b) question formulation around these decisions and issues, and (c) revision and refinement of questions to lead to more informed decision making about their mental health care and to facilitate communication with the provider so that the communication highlights their needs. This was accomplished through a methodology (RQP) initially developed by the Right Question Project, Inc. and further developed and standardized (RQP-MH) by the Center for Multicultural Mental Health Research at the Cambridge Health Alliance. This methodology focuses on providing individuals with strategies—through training—to participate in developing solutions to their mental health issues instead of simply offering solutions to their problems. There are three steps involved in the training process: (a) establishing a set of beliefs, principles, and values about client involvement with which clients identify and thus “own”; (b) teaching a skill-building technique that helps clients to think critically and ask the “right” questions to lead them to the answers they need; and (c) giving clients a framework to create action plans and use their question-formulation skills. The RQP method is designed to build a permanent skill set that clients can apply in health care and in other contexts that involve self-advocacy.

METHOD

To evaluate an activation and empowerment intervention for mental health outpa-tients, we conducted a study from October 2004 to January 2006 (for a complete description of the project, see Alegría et al., 2008). Respondents were recruited from two outpatient mental health clinics that provided services to primarily Latino and low-income patients, one of which served as an intervention clinic and one as the comparison. For this qualitative study, we analyze data collected only at the intervention clinic, where 83% of the patients were Spanish speakers and 65% were either uninsured or insured through Medicaid. Almost 76% of the participants were born outside of the United States, with almost half of them born in El Salvador, Puerto Rico, and the Dominican Republic. The eligibility criteria for participation were age within the 18 to 65 years range and not currently experiencing a psychiatric crisis or active psychosis. Participants were actively recruited by clinicians and

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administrative staff at the clinic, by care managers trained to implement RQP-MH, and through the use of fliers (see Table 1 for a description of the sample). At the intervention site, respondents were interviewed before receiving the training and then received three half-hour training sessions over an average of 74 days. Post assessments were administered a few weeks after each training session to give the respondents time to integrate and use the information from the trainings. All Spanish-speaking respondents were trained and interviewed in Spanish if this was their preferred language. The assessments included a combination of quantitative and qualitative measures to assess the impact of RQP-MH on the respondents' processes of decision making and their experiences in mental health care. All interviews were transcribed in the language in which they were conducted (English or Spanish), and the transcriptions were organized in a question-by-question format from the original interview used in the study.

For this analysis, only the qualitative data collected at the intervention site were analyzed. The qualitative questions were open ended and designed to elicit the patients' experiences with the RQP-MH intervention and to provide more information about changes in the quality of their relationships with their provider. The questions asked whether the respondent experienced changes in confidence, decision making, and quality of relationship and other characteristics across a range of mental health and health care providers: therapists, psychiatrists, general practitioners, and specialists. In addition, the qualitative questions asked what the patient learned from the RQP-MH intervention. As noted earlier, the same questions were asked in each follow-up interview, providing us with responses to these same questions during three points in time, a few weeks after the RQP-MH training sessions. Interviewers were trained to briefly probe with each question to clarify and expand on the initial responses when necessary.

Four coders—two English speakers and two Spanish speakers—coded the qualitative questions from these interviews and developed codes to answer two questions: "What are the qualitative indicators of change [because of RQP-MH]?" and "What do people say about what helps them [regarding RQP-MH]?" Interviews were analyzed in the language in which they were conducted. Although below we present all participants' quotes in English, we note which ones were translated from Spanish. All questions were coded into themes, and each language coding dyad met to compare emerging themes and generate a list of responses that demonstrated the greatest degree of variability across the codes. Once the initial list of codes was developed, the four coders met and compared the coded passages from the English and Spanish transcripts. This allowed the identification of themes that ran across English and Spanish interviews and "unique" themes that did not run across cultural and language lines. The lead author sorted the codes according to the two research questions and also generated a second level of codes that more appropriately described a more encompassing category—contextual factors that influence the processes through which mental health patients become active participants in their treatment. Finally, using these sets of codes, each coder continued coding the rest of the data.

Based on the themes that were generated, the coders met as a team over several months, discussing the findings and organizing the results into categories. Category development was an iterative process. The categories were created and then reviewed by the team who developed the RQP-MH project originally and the researchers who designed the study to check the face validity of the results that were generated.

RESULTS

Through the coding process, qualitative differences began to emerge across what appeared to be different levels of change in the degree to which respondents were actively involved in

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asking questions and making decisions with their providers and contextual factors that influenced this process. As a result, we chose to represent these findings using a broader model for description than the framework provided by the original research questions. Following Finfgeld's (2004) model, we organize the study's results related to indicators of change under three of the four components of the empowerment model (i.e., antecedents, barriers, and attributes). We focused on these three components because the process of patient activation did not occur in a vacuum and all three components appeared to be important influences on each other. Changes were observed at various levels: contextual, intrapersonal, and interpersonal precursors that rendered a mental health patient with less than optimal power to actively participate in treatment decisions (i.e., antecedents); levels of empowerment (e.g., participating, choosing, supporting, and negotiating) demonstrated by the experiences expressed by participants; and factors that interfered with the process of empowerment (i.e., barriers and personal characteristics).

Antecedents

In analyzing the systemic and individual prerequisites considered under important antecedents (e.g., contextual factors that respondents discussed during the RQP-MH intervention), several areas emerged as significant regarding receptivity to or "readiness" for the RQP-MH intervention. The RQP-MH intervention was designed to initiate question formulation and confidence development, and as such the necessary prerequisites for engaging in the process were considered to be minimal. Nevertheless, both systemic and individual prerequisites appeared to be important for the effective assimilation of the strategy. At the systemic level, institutional support for and commitment to the intervention were critical. Multiple meetings were conducted with the providers over the course of the study to explain the intervention and respond to providers' concerns. During the study's preparation stages, mental health providers were supportive of the RQP-MH intervention, as the intervention was consumer focused. Over the course of the study, engagement with the clinic was necessary to foster the success of the intervention implementation and encourage positive provider attitudes toward changes in their patients.

At the individual level, several critical variables emerged from the qualitative data collected in this sample of Latino mental health outpatients. During the training sessions, most participants appeared to grasp and embrace the basic tenets of the RQP-MH intervention across varying levels of impairment and social circumstances. However, analyses of the interviews revealed that a small subset of patients did not remember the content of the RQP-MH trainings between sessions. For example, after the third training session, when asked what the RQP-MH training was about, one respondent said, "My memory may not serve me well…. I forgot. I forget a lot."

Another individual-level antecedent that emerged was patients' attitude toward the provider as an all-knowing authority figure. Respondents spoke of how they learned to actively ask more questions while also maintaining respect for the provider's expertise and authority: "I learned how to better question him without offending his professional abilities to get the answers that I needed for my care." Another participant said (in Spanish), "I am still a little afraid about talking to my doctor, but the training taught me a little bit about how to talk to the doctor." However, other respondents appeared unable or unwilling to let go of their view of their provider as an all-knowing authority. For example, in her final session, one respondent expressed (in Spanish) unwavering commitment to the provider's professional opinion: "She is a psychiatrist, she went to school, she knows more than me. She is a professional." This hesitance for questioning authority appeared most frequently in the Spanish transcripts, suggesting a tendency toward not questioning authority or avoiding confrontation among these participants. A strong identification with the provider as an

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authority figure seemed to affect respondents' ability to take more of a role in the decision-making process:

> I'm really comfortable about my doctor, it's easy to communicate with her so there's no need for me to make any extra decision about anything she does cause I'm really comfortable with her…. I'm really comfortable about the way we make decisions about my mental health. I have no problems with her at all so there would be no need for me to make any other decisions.
>
> There hasn't been a single moment when I haven't agreed with her. I always agree with what she says to me. She explains. (Translated from Spanish)
>
> I asked her questions and she explains [things] to me. I am always in agreement with her. I can't have a single complaint about her. (Translated from Spanish)
>
> Of course she is the one who knows and the one who can guide you. (Translated from Spanish)

Alternately, some Spanish-speaking participants were apprehensive about asking questions and becoming more assertive with their provider because of the fear that they would threaten the nature of the relationship. However, RQP-MH provided them with skills to resolve such conflict. This is what two participants experienced:

> [I learned] how to communicate better with my therapist and to ask her questions that don't make her feel bad about the therapy, how to ask questions so that my therapist doesn't feel bad, like [when] the therapy is not working. (Translated from Spanish)
>
> How to express myself with my doctor. How I can ask questions to the doctor. [The trainer] taught me how to ask questions to the doctor, because sometimes you are afraid, don't know how to ask, then she taught me how to ask questions to the doctor. (Translated from Spanish)

For these respondents, there was a tendency to view the mental health provider as a family member or a friend, which falls within the realm of *personalismo*, or the importance ascribed to personal relations within Latino culture (Kennedy, 2004). However, as noted in the section below, becoming an active player in the patient–provider relationship did not always mean severing the personal bond with the provider. In fact, for some participants the RQP-MH training resulted in an internal shift in which viewing the provider as a "friend" facilitated the process of actively participating in their own treatment. In these cases, implementation of the RQP-MH training encouraged mutual trust, closeness, caring, and support, and participants reported being able to open up to their providers. A participant described this process in detail:

> To communicate better with my doctor, to see that he is not a person different from me, that I can talk with him the way I talk with a friend. To get rid of that fear, to remove that block that sometimes is between patient and doctor that sometimes makes you afraid to ask or because one thinks that they know everything, that one is not limited to say "yes" and to listen what they have to say and not having a lot of participation. That is gone. Now I ask. The way I feel with them is like if they were friends I wanted to talk with about any particular topic. (Translated from Spanish)

Attributes

The data we analyzed provided a window of understanding into the components of activation and participation in care for this population of mental health patients. By analyzing what the respondents described about this process, identifying the qualitative

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indicators of change and the components of the process that appeared to help with activation, we were able to better understand what stages of the empowerment process—as outlined by Finfgeld (2004)—this intervention was able to tap into. We were also able to examine to what extent future applications of the RQP-MH methodology needed refinement for this population.

Participating—Participants' responses that we coded as "what was learned from RQP-MH" were grouped under the first level of empowerment outlined in Finfgeld's model (i.e., participating). These responses described how participants embarked on the process of asking questions to their providers, trying different types of question formulation (e.g., open-ended vs. close-ended questions), asking more targeted questions (e.g., being direct, probing for clarification, asking more meaningful questions), and exploring different strategies for getting information (e.g., writing questions down before the appointment). Two respondents described how they now ask questions differently of their provider in the following ways:

> I think going through the first part of the training I was able to rephrase my questions, I was able to not only ask the question, but also rephrase it and learn two different ways to get answers, to get some really good answers to what's going on with my physical health.
>
> Just more direct, processing what I want to get out of the visit before going, setting goals, having questions I want to ask when I'm there. Making better use of my time, having a plan…. Direct, meaning knowing what questions I want to have answered and just asking them rather than just talking.

A corresponding theme at this level of participation is a growing awareness of the patient's ability to be persistent, asking and rephrasing until the meaning is clear:

> That when she gives me an answer I don't like, I don't let it slide. I re-ask or explain why I don't like the answer she gave me or if there are other alternatives.
>
> I'm able to phrase the question to find out exactly what I want to know and if she gives me answers I don't understand I'm able to ask her to explain so I understand them.

Becoming persistent about getting information in this way leads some patients toward what they see as more effective decision making. At the beginning of the study, one respondent described the way she makes decisions about her psychiatric medication as follows: "I just don't have enough information about what my condition is, and so I just trust my psychiatrist now to make decisions even though I didn't feel confident/ comfortable with that. I just don't know what questions to ask." After the first session of the training, her experience with these strategies resulted in a very different description of this issue: The "medication I was on had some horrible side effects and so I conveyed that to my psychiatrist; we both came to a decision about changing the type of medication I should be on." At this first level, respondents described asking questions and making decisions in a more conscious and determined way.

Choosing—Some participants in the study explicitly described how asking questions more directly and using this information to inform decisions about their care had affected their feelings of confidence about themselves. These data corresponded most closely to our research question of identifying "qualitative indicators of change." This internal shift appears to also be linked to a level of self-efficacy by which respondents now see themselves not just understanding the provider's choices or contributing information to help the provider make choices but instead describing their own role in making choices. For

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many, this component includes not allowing the provider to tell them what they feel but instead having the confidence to express their feelings themselves:

> The survey [training] helped me a lot explaining myself and getting my point across to let him know how I feel instead of letting him tell me how I feel…. I would say I'm a confident person, but the training opened me up even more to be able to talk to him and don't let him give his opinion when I should be giving him mine.
>
> I feel like I pull all the stops now. I tell him how I feel now; I don't let him tell me how I feel. After the survey [training], I said this is my mind, my body, and I could ask the questions.

At this level of activation, we also observed a significant shift in the role of the provider (as reported by the patient) and the patient from simply having the courage to contribute information to the provider's decision-making process to a much more participatory process. In the data collected from patients, this element often emerges as a shifting back and forth in perspective between patients and providers in describing the decision-making process:

> [Before] usually she made the decision. Now we talk and elaborate on treatment. She asks about my progress, we focus on substance abuse. The decision making as to medication is up to her.
>
> Before, I wasn't comfortable making decisions. I went to see her again and I'd wanted to switch doctors. Between the two visits, something had changed with her and she was better, more open, had a new approach. I can talk more openly and be more honest now and I didn't feel that way before.
>
> We talk more in depth about what changes she wants to make, how she wants to make them and how I feel about the changes, whether I agree or disagree.
>
> Before, it was hard for me to make decisions along with her, but not now. I suggest something, we take a look at it together, she gives me her point of view, and we reach an agreement. (Translated from Spanish)
>
> Now, if something happens to me, we decide together. (Translated from Spanish)

Finally, at this stage, and consistent with Finfgeld (2004), the combination of increased confidence and more effective participatory decision making is indicative of an increase in assertiveness on the part of the patient. In some of the transcripts, this shift was expressed by some individuals as a greater sense of personal responsibility: "Because health care is involving specialists, more focused on that right hand doesn't know what left is doing, I have to be the one to connect the dots." Here, however, there emerged another theme that appeared to be more common to the Spanish speakers: These respondents tended to describe this level of empowerment more in terms of standing up for "their" rights. In this regard, one Spanish-speaking patient said, "What I have learned is that one asks for an opinion, you are not given one, you make it…you have the right. One has the right to have an opinion, regarding one's health or safety" (Translated from Spanish). Another participant said (in Spanish), "[I learned] what my rights are and how I have to act regarding my rights so that my rights as a patient are heard."

Supporting—According to Finfgeld (2004), at this level of empowerment individuals develop a sense of responsibility regarding their process of empowerment and may support and even coach others who are less empowered. Patients in this study described not coaching others but rather being in a place where they were beginning to generalize and implement the principles of RQP into the rest of their life and with other relationships:

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> Confidence is the biggest thing because participating in the survey [training] has given me a lift of self-esteem, participating in something, and it's carried over into everything…. It also was a boost at home to relate the information I learned in the training session with my family.

However, the awareness of this level of impact was not as salient as were the other categories. For the most part, the RQP-MH intervention appeared to affect the first two levels (i.e., participating and choosing) of the model, and respondents did not explicitly report applications of these strategies beyond the clinical encounter. However, a number of Spanish-speaking participants did report applying these strategies elsewhere:

> I learned how to handle the questions, how to get more information, not only with the doctor but sometimes in one's private life, at work. (Translated from Spanish)

> At the end I learned that these questions can help me resolve a situation between a friend and I and to make my own decision and to decide what I am going to do and say next time. (Translated from Spanish)

> [I learned] what role to play in my decisions, I can choose and have an option, the role and function I can have in court. (Translated from Spanish)

> At least to ask more questions, not only at the clinic, but in other places too. (Translated from Spanish)

Several interesting observations may be made regarding these narratives. First, in this study, Spanish speakers were more likely to report transferring the skills into other life contexts. It is possible that Spanish speakers have experienced higher levels of dis-empowerment in contexts other than health care, and the RQP-MH training easily became a useful tool to address power imbalances elsewhere. These findings signal the potential generalizability of this strategy to broader contexts, which is one of the goals the developers of RQP wanted to achieve.

Negotiation—Similarly, the respondents in this study reported few examples of true negotiation in which there was an overt difference of opinion and the two parties (patient and provider) negotiated to understand and resolve the difference. Unlike the choosing stage in which respondents learn to identify their own position, explore their feelings, and share this information in the process of choosing their care, negotiation implies that the positions of patient and provider differ and that there is a process whereby they negotiate a compromise. This patient's narrative (originally in Spanish) illustrates a negotiation between patient and provider:

> Sometimes I describe something, like a problem, but then she comes and gives me some advice that I might not be a hundred percent in agreement with. For example, I wanted to go back to school to get some training because I was going to get help to pay for it, but then she tells me, "Why going to school? You already went to school, get a job because why are you going to do something that is practically the same thing you already did." But then I say no, that I want to go to take advantage that they are going to pay for school.

Barriers

Respondents volunteered a number of barriers, mainly those that got in the way of developing a relationship with their provider. Some referred to the relationship as being too short to really have trust and be able to ask the difficult questions: "I would feel more confident if we had a longer relationship. We have only seen each other six times. I think as we form a longer relationship I will feel more confident." Others described the fact that their provider did not share their ethnic, racial, cultural, or social background as a barrier to

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confidently asking questions or sharing the decision-making process. A common theme was a lack of time in the sessions to actually ask questions and explore new patterns of an empowered relationship with the provider. These findings further confirm that contextual factors related to clinical settings and practice affect the extent to which a patient plays an active role during a medical encounter.

DISCUSSION

This study provided a unique opportunity to document and examine the steps mental health patients undertook in the process of becoming “activated” by learning how to formulate questions and develop decision-making skills in relation to their mental health treatment. Findings from the study suggest that patient activation and empowerment are interdependent. Using Finfgeld’s (2004) empowerment model as a guiding tool to identify and analyze these qualitative processes involved in patient activation, we were able to document ways in which patient activation—through RQP-MH—involved the four elements of empowerment (i.e., participating, choosing, supporting, and negotiating). However, the short duration of the study and lack of postintervention follow-up data prevent us from determining whether patient activation transcended the intervention to become more than just a rote skill practiced during a short period or indeed evolved to be a more overarching occurrence involving a pervasive attitudinal shift in the lives of the patients. In other words, we do not know whether participants continued applying the lessons learned through RQP-MH beyond the study’s limited duration. Participatory learning strategies such as RQP-MH that treat people as active participants of their own learning can have the effect of changing patterns of dependence and passivity by providing and reinforcing engaged and empowering experiences (Roter, Stashefsky-Margalit, & Rudd, 2001). Empowering experiences foster the competence and confidence necessary for personal transformation and the realization of critical consciousness, and they further support the use of learned skills over time (Roter et al., 2001). Psychosocial intervention research has similarly found that individuals continue to make gains in using new skills when measured months or years after an intervention and after an opportunity for further integration into regular practice (McGurk & Mueser, 2006). Our study did not provide an opportunity to further measure these “delayed” but potential ongoing outcomes and stages (Bowles, 2006) related to empowerment. However, a future longitudinal research design with longer postintervention follow-up could be helpful in assessing the impact that patient activation may have on psychological outcomes. More important, such a research design would allow us to further examine whether long-lasting and sustainable patient activation is comparable to empowerment. If so, then patient activation could become a patient–provider communication paradigm that is more germane, tangible, and accessible for mental health patients than is empowerment.

The study design also did not provide extensive opportunities to document the role of antecedents in patient activation. However, a few lessons were learned during the process. For example, when thinking about the antecedents of empowerment in the clinical encounter with Latino patients, we need to consider the influence of culture on the interpersonal context. Although patient activation is an opportunity for growth and enrichment, it can also cause discomfort, as shown through some of the participants’ concerns about hurting the providers’ feelings or offending them by using the RQP-MH skills with their providers. It was demonstrated that tension can arise when different health belief systems confront one another and common responses to the unknown or unfamiliar (i.e., anxiety, wariness, and fear) emerged.

As shown through the Spanish interviews, findings also highlighted that linguistic and culturally distinctive patients may be at risk of difficult or negative communication interactions within health care systems even after exposing them to training purposely

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designed to change or improve patient–provider relations. This was evident among some patients who reported that asking questions to health care providers is not acceptable for them, considering their views of providers as figures of authority and repositories of specialized knowledge that participants are unable to question. Cultural studies have identified differences in interactive patterns across cultures that could potentially affect the mental health care encounter. Although a thorough discussion of this literature is beyond the scope of this article, theorists point to cultural factors that influence communication patterns, such as differences between low- or high-context cultures, collectivist versus individualistic approaches, differences in perceptions of social position and authority (e.g., *respeto* among Latinos), and varying attitudes toward personal space and physical contact (Beaulieu, 2004; Castro & Hernández Alarcón, 2002; Zhu, Nel, & Bhat, 2006). Shifting the patterns of communication within the therapeutic encounter may require closer attention to such cultural differences in patterns of interaction for some patients, and further research is needed to understand how these differences may manifest themselves within the structure of a therapeutic encounter.

Furthermore, although the sources of a relational pattern in which patients are reluctant to ask questions may be culturally normative, the pattern could also be a by-product of contextual or systemic factors. For example, the degree of familiarity with the U.S. health care system, which generally presents formidable navigational obstacles among historically underserved populations such as Latinos, could also influence relational patterns between patients and providers. That is, these systems may be perceived as intimidating or perpetuate power differentials between patients and providers.

Although cultural factors might play a role in the way individuals interact with their providers, other factors might influence such interactions. For example, a patient who has navigated the health care system for an extensive period and who has come into contact with numerous providers might feel more comfortable asking questions to his or her provider than someone who has had limited access to services. In addition, there might be instances in which an individual’s beliefs about treatment decisions may run counter to treatment guidelines. In those instances, interventions such as RQP-MH could provide the necessary tools for patients to recognize if and when the provider’s input and expertise are necessary to make an informed treatment decision.

In addition, providers themselves appeared to play important roles during the early stages of the project (i.e., supporting the initiative) and throughout the implementation process. As evidenced by participants’ reports related to confidence building processes, providers generally supported patients as they were shifting their relational paradigm. Although we do not have additional data from providers to document the role they played in the process of patient activation, the current study underscores the importance of the interaction between providers and patients in the process of patient activation and increasing patient participation in decision making. The participants’ narratives illustrate that as communication patterns shift, patients’ perceptions of their relationship with their provider also appear to undergo change. The role of the provider in understanding and facilitating this process is an area for continued research.

This qualitative study provides important information to consider in future adaptations of the RQP-MH intervention strategy. Given that the study found limited impact on the levels of empowerment illustrated by the two higher levels of Finfgeld’s (2004) model, adaptation in future research may be necessary. It may be that extended trainings, a modified curriculum, or additional sessions are necessary for certain individuals, particularly those with memory or other cognitive problems. Future examination of the RQP-MH strategy should more explicitly test for the influence of these factors and the effectiveness of RQP-MH across

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different diagnoses. Including a screening tool to assess cognitive functioning in future trials could facilitate this investigation.

Furthermore, there may be measurement issues to consider, including expanding both our qualitative and quantitative measures of empowerment in future studies. Given that the intervention evaluation for this analysis specifically focused on assessing the applications of the RQP-MH in the provider encounter, it may have limited potential for discussion of applications in other areas of the respondents' lives, thus failing to pick up more nuanced application of the process in the areas of supporting and negotiating. Furthermore, even though the study included three measurement points, an important limitation of this study is that we did not measure outcomes longitudinally beyond the original study period itself. We thus have no way of knowing whether the qualitative successes reported regarding involvement in the patient–provider relationship persisted beyond the period of the study or whether patients eventually returned to prior patterns of communication with their providers.

Based on these findings, it may be useful to consider adding a provider component for the RQP-MH, given that, for some respondents, explicit encouragement from the provider may be necessary to counteract cultural attitudes such as treating the provider as an all-knowing authority. It may also be important to address issues of belief regarding authority and *personalismo* with the provider, who may expect such attitudes from certain groups and unknowingly further discourage activation within the patient–provider relationship as a result. Within the health care setting, *personalismo*-oriented patients may be more likely to expect providers to be friendly and to demonstrate interest in the patient as a person (Kennedy, 2004). Thus, in this relational context, it is important to teach how to ask questions in a way that does not jeopardize the "personal" relationship with the provider. Furthermore, an educational component regarding the mental health system as a whole (a "new patient orientation"), including information about what types of providers conduct what types of treatment and the nature of a person's mental illness and psychiatric medication, may provide didactic information that could particularly help first-generation immigrants who may carry attitudes and beliefs regarding the health care system in their country of origin into their experiences with their providers here in the United States.

In many respects, the RQP-MH strategy runs counter to stereotypical models of Latino relational patterns documented in health and mental health research, which emphasize at times a high degree of respect or power distance (Benavides, Bonazzo, & Torres, 2006; Castro & Hernández Alarcón, 2002) for authority as a determining factor in patient–provider relationships for this population (Lagomasino et al., 2005) and fatalism (Benavides et al., 2006), thus rendering many Latinos as passive actors in relation to figures of authority, their health, and surrounding environment. As documented in this study, RQP-MH challenged widely accepted and documented cultural values that have characterized Latinos as having a culturally determined preference for more directive approaches on the part of providers (Pomales & Williams, 1989; Ponce & Atkinson, 1989) and feeling uncomfortable responding to open-ended questions (Folensbee, Draguns, & Danish, 1986).

Moreover, RQP-MH questions culturally driven assumptions about how Latinos interact with service providers. Given that many of the participants in this study embraced RQP-MH, we see these findings as challenging an approach wherein cultural patterns are readily accepted as a given in mainstream health practices instead of potentially modifiable with easily adapted strategies for change (Armstrong et al., 2006) such as the process of asking questions to obtain information that is crucial to make decisions about one's own health (Wiltshire, Cronin, Sarto, & Brown, 2006). We further suggest that the enthusiastic integration by some participants of these strategies could be in part because of a strong and

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yet potentially transformative reaction to a previous lack of agency in many other areas of these participants' lives.

IMPLICATIONS FOR CLINICAL PRACTICE

Improving patient–provider communication is an essential component of addressing potential disparities in health care quality. Mental health providers may want to explore communication strategies that facilitate patients becoming more actively involved in their care. Immigrants and individuals with limited English proficiency may benefit from increased education about the health care system as a whole and more didactic information about mental health providers, mental health disorders, and psychiatric medications. It is important for mental health providers to consider our findings that cultural patterns of communication with clinicians, although evident, may not be as firmly engrained as some may have previously thought. RQP-MH demonstrated that patient–provider communication can be improved with consideration for cultural frameworks that affect interpersonal exchange. Future work may be able to further distill the components of RQP-MH that most actively support this process of empower-ment over the long term in the mental health setting and especially for ethnic minorities.

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Table 1

Description of Sample

	n	%
Gender		
Male	30	21.3
Female	111	78.7
Age		
18 to 34	36	25.5
35 to 49	63	44.7
50 or older	42	29.8
Ethnicity/race		
White	5	3.6
Latino	117	83.0
African American	10	7.1
Other	9	6.2
Language of interview		
English	35	24.8
Spanish	106	75.2
Nativity		
U.S. born	34	24.1
Non–U.S. born	107	75.9
El Salvador	35	26.2
Puerto Rico	24	17.9
Dominican Republic	15	11.2
Other	33	44.7
Diagnosis category		
Depressive	87	62.14
Bipolar	11	7.86
Anxiety	26	18.57
Psychotic	6	4.29
Other	10	7.14
Missing	1	

NOTE: *N* 141.