UC San Diego
UC San Diego Previously Published Works

Title

MULTIGROUP CONFIRMATORY FACTOR ANALYSIS OF THE CULTURAL HEALTH ATTRIBUTIONS QUESTIONNAIRE-REVISED

Permalink

Authors

Fox, Rina S
Mills, Sarah D
Roesch, Scott C
et al.

Publication Date

2015

Peer reviewed

10:15 AM-11:15 AM   D054

MULTIGROUP CONFIRMATORY FACTOR ANALYSIS OF THE CULTURAL HEALTH ATTRIBUTIONS QUESTIONNAIRE-REVISED

Rina S. Fox, M.S., MPH[1], Sarah D. Mills, M.S.[1], Scott C. Roesch, PhD[2], Georgia Robins Sadler, PhD, M.B.A., B.S.N.[3], Vanessa L. Malcarne, PhD[4]

[1]SDSU/UC San Diego Joint Doctoral Program in Clinical Psychology; UC San Diego Moores Cancer Center, San Diego, CA; [2]SDSU/UC San Diego Joint Doctoral Program in Clinical Psychology; San Diego State University, San Diego, CA; [3]SDSU/UC San Diego Joint Doctoral Program in Clinical Psychology; UC San Diego Moores Cancer Center, La Jolla, CA; [4]SDSU/UC San Diego Joint Doctoral Program in Clinical Psychology; UC San Diego Moores Cancer Center; San Diego State University, San Diego, CA

The Cultural Health Attributions Questionnaire (CHAQ) was developed to assess health attributions that affect health behaviors among Latinos/Hispanics. The CHAQ – Revised (CHAQ-R) is a 10-item short-form that was derived from the 24-item original measure. Both the CHAQ and CHAQ-R are comprised of two subscales measuring Equity health attributions (e.g., health outcomes caused by punishment from God/others) and Behavioral-Environmental health attributions (e.g., health outcomes caused by diet). The CHAQ-R was derived with a sample of English- and Spanish-speaking Latinos/Hispanics. However, the dimensionality of the measure has never been explored outside of its development sample. Thus, the present study aimed to confirm the structural validity and reliability of the two-factor CHAQ-R across a novel sample of English- and Spanish-speaking Latinos/Hispanics. Latinos/Hispanics with an English ($n = 115$) or Spanish ($n = 140$) language preference completed the CHAQ-R. Multigroup confirmatory factor analysis evaluated the goodness of fit of the two-factor structure across language-preference groups. Both statistical (Satorra-Bentler Chi Squared/SB-χ^2) and practical (Root Mean Square Error of Approximation/RMSEA, Comparative Fit Index/CFI, Standardized Root Mean Square Residual/SRMR) indicators of model fit were considered. Internal consistency reliability of each factor was evaluated using Cronbach's alpha. Results indicated a similar two-factor structure with equivalent response patterns and variances across language-preference groups when the factor loading for one item on the Behavioral/Environmental subscale was unconstrained across groups (SB-χ^2 = 142.79, $p < .01$; RMSEA = .07; CFI = .91; SRMR = .22). Internal consistency was good for both the Equity attributions subscale ($\alpha s > .83$) and the Behavioral-Environmental subscale ($\alpha s > .74$) for the full sample, as well as for the English- and Spanish-speaking subsamples. Results indicate that the CHAQ-R can be confidently used to evaluate culturally based health attributions among Latinos/Hispanics with either an English- or a Spanish-language preference. The measure may be a good choice for medical professionals who wish to learn about health attributions among Latinos/Hispanics.

CORRESPONDING AUTHOR: Rina S. Fox, M.S., MPH, SDSU/UC San Diego Joint Doctoral Program in Clinical Psychology; UC San Diego Moores Cancer Center, San Diego, CA, 92120; rsfox@ucsd.edu

10:15 AM-11:15 AM   D055

PTSD META-ANALYSIS METHODS COMPARISON: PHARMACOLOGY, COGNITIVE-BEHAVIOR AND NON-TRADITIONAL THERAPY

Haley M. Cook, B.A., Harvey Ginsburg, PhD

Texas State University, San Marcos, TX

The need for research-based PTSD treatment for military veterans is reflected in growing numbers of empirical studies examining treatment outcomes. These can be categorized as pharmacological or behavioral. The latter may be sub-categorized as traditional Cognitive-Behavioral Therapy (CBT), Exposure Therapy (ET), or non-traditional approaches, e.g., exercise, yoga, and meditation/mindfulness. Previous meta-analyses focused exclusively upon outcomes of PTSD treatment for military veterans. Although treatment efficacy is confirmed among all three approaches, the validity of outcomes depends upon fundamentally sound research design and methods. Minimum criteria for sound research methods include having an appropriate relative comparison condition and controlling for pre-existing between-subject differences and/or within subject order effects. The rationale behind this study was to compare the methodological quality of the three broad treatment categories for military PTSD: pharmacological, traditional cognitive-behavioral and non-traditional, e.g., exercise, yoga, and meditation/mindfulness. From 1985 -2014, over 700 published articles were accessed via EBSCO online databases for Post-Traumatic Stress Disorder in veterans; of these, 131 were empirical studies. We predicted a significant difference for the frequencies of well-designed and conducted empirical research studies among the treatment categories, comparing methods quality of 42 pharmacological, 59 traditional and 30 non-traditional cognitive-behavioral empirical studies. Chi-square analysis of methods quality (strong versus weak) for military PTSD treatment categories confirmed a statistically significant difference (p=0008). However, post-hoc paired-comparisons (2x2 Fisher tests) showed that the proportion of sound methods for pharmacological and non-traditional approaches both differed from the traditional cognitive-behavioral treatment for military PTSD (p<001). Clients seeking traditional cognitive-behavioral therapy for military PTSD should have the expectation that their treatment will be based on rigorous research methods on par with pharmacological and non-traditional treatments.

CORRESPONDING AUTHOR: Haley M. Cook, B.A., Texas State University, San Marcos, TX, 78666; hc1138@txstate.edu

---

CITATION POSTER
10:15 AM-11:15 AM   D056

SYMTRAK: MONITORING PATIENT AND CAREGIVER REPORTS OF SYMPTOMS IN PRIMARY CARE

Patrick O. Monahan, PhD[1], Christopher M. Callahan[2], Kurt Kroenke, MD[1], Tamilyn Bakas, PhD, RN, FAHA, FAAN[3], Amanda Harrawood, BS[4], Philip Lofton, B.A.[5], Debra Saliba, MD, MPH[6], James E. Galvin, MD, MPH[7], Timothy Stump, MA[8], Amanda L. Keegan, BA[9], Mary Guerriero. Austrom, PhD[8], Malaz Boustani, MD, MPH[1], Danielle Frye, BS[10]

[1]Indiana University, Indianapolis, IN; [2]Indiana University Center for Aging Research, Regenstrief Institute, Indianapolis, IN; [3]Indiana University School of Nursing, Indianapolis, IN; [4]Regenstrief Institute, Inc., Indianapolis, IN; [5]Indiana University Center for Aging Research, Indianapolis, IN; [6]UCLA Borun Center/Veterans Administration, Los Angeles, CA; [7]NYU Langone Medical Center, New York, NY; [8]Indiana University School of Medicine, Indianapolis, IN; [9]Regenstrief Institute/Indiana University Center for Aging Research, Indianapolis, IN; [10]Regenstrief Institute, Seattle, WA

Background: Health care systems routinely collect physical vital signs such as blood pressure but not patient-reported symptoms. The aim was to develop a new clinically practical, multi-domain assessment tool for measuring and monitoring symptoms of older patients. Existing tools are either too lengthy, disease specific, or cover a single domain. SymTrak was developed to be clinically actionable, sensitive to change, broadly applicable to multiple chronic conditions, culturally sensitive, and easily understood. Methods: Expert panels, existing data, extant instruments, and focus groups were used. Both Self-Report and Caregiver-Report versions were developed. Multidisciplinary experts prioritized the following 7 symptom domains: cognitive, functional, psychological, pain, sleep, fatigue, and other physical symptoms. Potential items were drawn from extant tools. Results: Physician and nurse practitioner focus groups valued instrument performance characteristics: use in practice (administrable within 5 minutes, easily retrievable from electronic medical record systems, graphically reportable, and viewable at item, domain or total score level); purpose (more useful for tracking than screening); and preference for a single brief (10 not 17 items) physical symptom domain instead of multi-item pain, sleep, and fatigue domains. There was no preference for item response format of frequency vs. severity. Preference for number of item response options ranged from 3 to 5 for clinicians, nurses, patients and caregivers. We chose 4 options (never, sometimes, often, always) to balance clinical brevity with sensitivity to change. Patient and caregiver focus groups valued item wording (simple language, and applicability regardless of roles), and were enthusiastic about using SymTrak as a communication aid with providers. "Think aloud" interviewing, held subsequent to focus group sessions for patients and caregivers, was helpful for revising items. SymTrak was rated as highly useful on an 8-item usability scale administered during think aloud interviewing. Version 1.0 (25 items) was finalized and is currently being psychometrically tested. Conclusions: SymTrak has been shown by focus groups of clinicians, patients, and caregivers, to be potentially useful for tracking symptoms in primary care.

CORRESPONDING AUTHOR: Patrick O. Monahan, PhD, Indiana University, Indianapolis, IN, 46202-3002; pmonahan@iu.edu

---

10:15 AM-11:15 AM   D057

THE ACCURACY OF A BRIEF STRESS DAIAGNOSTIC TOOL IN PREDICTING ILLNESS: THE SOS-S

James H. Amirkhan, PhD

California State University Long Beach, Long Beach, CA

The Stress Overload Scale (SOS) is a self-report stress measure that was empirically derived to be (1) consistent with stress theories, (2) psychometrically sound, and (3) appropriate for use in demographically variegated community samples. Unlike other stress measures, it offers options for both continuous and categorical scoring (which groups respondents according to risk for stress-related pathology). The success of these scores in predicting physiological (cortisol) and symptomatic responses to stressors has been well documented. However, at 30 items, the SOS is cumbersome for use in survey research or emergency clinical applications. The present study examined the accuracy of a 10-item short SOS-S as an alternative to the full SOS in predicting markers of illness (symptoms and behaviors). Using a general population sample, 408 participants were recruited from community sites specifically selected to insure a wide range of stress levels. At either a courthouse or an aquarium, volunteers completed either the full SOS or the short SOS-S, along with measures of somatic symptoms and illness-related behaviors (Wave 1). At home, one week later, they all completed the SOS-S and he symptoms and behaviors (Wave 2). Results showed continuous scores from the SOS and the SOS-S to significantly correlate with both illness symptoms and behaviors, both at Wave 1 and Wave 2. Moreover, for those who completed both forms ($n = 72$), significant covariation was found between SOS and SOS-S scores ($r = .80$). Categorical scores from the two forms divided the sample into comparable proportions, with 41% and 46% classified at Low Risk and 23% and 20% classified at High Risk by the SOS and SOS-S, respectively. Comparing mean symptoms and behaviors across risk categories showed significantly more pathology in the High Risk than in the Low Risk group, both for the SOS and the SOS-S, both at Wave 1 and Wave 2. By several metrics, then, current results indicate the SOS-S is a viable substitute for the SOS in assessing stress level and risk for stress-related pathology. Applications of the SOS-S to health research and practice, as well as potential limitations, are discussed.

CORRESPONDING AUTHOR: James H. Amirkhan, PhD, California State University Long Beach, Long Beach, CA, 90840; james.amirkhan@csulb.edu