TITLE: Cultural beliefs and treatment preferences of ethnically diverse older adult consumers in primary care.

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ABSTRACT

**Background:** Beliefs concerning the causes of mental illness may help explain why there are significant disparities in the rates of formal mental health service use among ethnic minority elderly as compared with their Caucasian counterparts. This study applies the Cultural Influences on Mental Health framework to identify the relationship between ethnicity and differences in: (1) beliefs on the cause of mental illness; (2) preferences for type of treatment; and (3) provider characteristics.

**Method:** Analyses were conducted using baseline data collected from participants who completed the Cultural Attitudes toward Healthcare and Mental Illness Questionnaire, developed for the PRISM-E (Primary Care Research in Substance Abuse and Mental Health for the Elderly) study, a multi-site randomized trial for older adults (65+) with depression, anxiety, or at-risk alcohol consumption. The final sample consisted of 1257 non-Latino Whites, 536 African-Americans, 112 Asian-Americans, and 303 Latinos.

**Results:** Older African-Americans, Asian-Americans, and Latinos were more likely to use folk models in the explanation of the causes of mental illness. Ethnicity was also associated with determining who makes healthcare decisions, treatment preferences, and preferred characteristics of healthcare providers.

**Conclusions:** This study highlights the association between ethnicity and health beliefs, treatment preferences, healthcare decisions, and consumers’ preferred characteristics of healthcare providers. The results suggest potential directions for tailoring clinical services and educational materials to the specific needs of an increasingly diverse and growing population.
Ethnic minorities constitute the fastest growing segment of the elderly population. Population projections for the year 2050 predict that approximately 40% of the elderly population will belong to a racial or ethnic minority (U.S. Census Bureau, 2002). Ethnic minorities, older and younger alike, display disproportionate rates of mental disorders as compared to Caucasians (Hwang, Myers, Abe-Kim, & Ting, 2008) and receive a lower quality of care (Nelson, 2003). As a result, ethnic minorities experience a greater burden of unmet mental health needs (U.S. Department of Health and Human Services, 2001), due, in part, to patient, provider, and health care system barriers (Borowsky, Rubenstein, Meredith, Camp, Jackson-Triche, & Wells, 2000; Cooper-Patrick, Gallo, Powe, Steinwachs, Eaton, & Ford, 1999; Diala, Muntaner, Walrath, Nickerson, LaVeist, & Leaf, 2001; Hines-Martin, Malone, Kim, & Brown-Piper, 2003; U.S. Department of Health and Human Services, 2001). Effective mental health services have been developed to overcome some of these barriers (Unützer et al., 2003; Bartels et al., 2002); yet ethnic minorities seek mental health care less and drop out at a greater rate (Vega, 2005). Culturally associated health beliefs may provide insight as to why these disparities exist as well as provide information on how to provide culturally appropriate services to ethnic minorities older adults. Different cultural beliefs about mental illness may influence the type of treatment that is sought and how mental illness is addressed and managed. The purpose of this study is to identify cultural beliefs about the causes of mental illness and treatment preferences, among four different ethnic groups.

The Cultural Influences on Mental Health (CIMH) framework is a useful approach to characterizing cultural factors in the relationship that develops between the patient and the mental health care system (Hwang, et al., 2008). This model suggests that
various cultural influences contribute to the etiology and development of mental illness and affect how one personally defines his symptoms and illness. For example, cultural differences may contribute to the prevalence of mental disorders, influence beliefs about the causes of mental illness and subsequently impacts treatments and interventions. Even prior to engaging in mental health care, preferences are developed regarding the type and role of the health care clinician or alternative provider addressing mental health issues. Ethnic minorities may have treatment preferences that shape the manner in which they seek help.

The current study applies the CIMH model to identify cultural attitudes toward healthcare and mental illness among various ethnic minority older adults with common mental health problems including depression, anxiety disorders, or at-risk alcohol use. Specifically, this study examines to what extent ethnicity is associated with differences in: (1) beliefs on the cause of mental illness; (2) preferences for type of treatment; and (3) provider characteristics.

METHODS

The Primary Care Research in Substance Abuse and Mental Health for the Elderly (PRISM-E) was a multisite randomized trial that compared two specific interventions; an integrated care model and enhanced referral model (Gallo, et al., 2004; Krahn, et al., 2006) for older persons with depression, anxiety, or at-risk alcohol consumption. In the PRISM-E study, all patients aged 65 years and older were initially seen by or referred to the study by their primary care clinician, and those eligible for the study were subsequently randomized to treatment into either the integrated care model or the enhanced referral model. The integrated model provided mental health/substance abuse
services in the primary care clinic by a mental health provider. The enhanced referral model provided mental health/substance abuse services in a specialty setting that was physically separate and designated as a mental health/substance abuse clinic. A total of 24,930 older adults aged 65 and above were screened at primary care clinics or practices across the United States. Participants who were excluded failed to meet criteria for a target diagnosis, were ineligible for the study because of incomplete data, and were ineligible because they had hypomania or psychosis. The final study sample consisted of 2,244 participants who completed the baseline diagnostic interviews, agreed to participate, and were enrolled in the study. Sixty-eight percent of the participants (1,531) met criteria on the Mini-International Neuropsychiatric Interview (MINI) for depressive disorders of interest, with or without comorbid anxiety.

Patients were recruited from six Veterans Administration (VA) Medical Centers, three community health centers and two hospital networks, thus representing a diversity of clinical settings and patient demographics. A detailed description of the study methods is provided elsewhere (Levkoff, et al., 2004). Data from a variety of psychological instruments were collected at pre-determined intervals. Because the current study seeks to identify cultural attitudes toward healthcare and mental illness as well as cultural sensitivity desired from the healthcare system from a cross-sectional perspective, only baseline data are presented.

Participants

The baseline sample of the PRISM-E was used in this study. Due to the multisite nature of the study and the recruitment of participants in a variety of settings (i.e., community settings and primary care clinics), a diverse sample participated in the
study. Of those who screened eligible for the PRISM-E study, only those participants who completed the Cultural Attitudes toward Healthcare and Mental Illness measure at baseline (prior to participation in any of the interventions being evaluated) were included in these analyses (N = 2208). The final sample consisted of 1257 non-Latino Whites, 536 African-Americans, 112 Asian-Americans, and 303 Latinos were included in the analyses.

Measures

Of the various caregiver measures collected in the projects, two from the baseline assessment were used in the current analysis.

Sociodemographic Characteristics

The following sociodemographic data pertinent to the current study were gathered: age; country of birth (United States or outside the United States); years in the United States; primary language spoken (English or Spanish); years of formal education; country received most of formal education (United States or outside the United States); annual household income; and marital status (married or unmarried).

Cultural Attitudes toward Healthcare and Mental Illness Questionnaire

In order to measure cultural attitudes toward healthcare and mental illness as well as to assess cultural sensitivity desired from the healthcare system, a measure was specifically developed for PRISM-E. This questionnaire asks four questions: (1) “Nobody knows for sure what causes mental health problems such as depression, but people have many different ideas about what the causes might be. What do you think causes depression?” (2) “If you had a mental health problem, what do you think would help you get better?” (3) “Who would you talk to if you had a mental health problem?” (4) “Who makes most of the decisions about your health care?” Answers to these
questions are categorical in nature (see tables 2-6), and the respondents were allowed to choose more than one response for each question. The questionnaire also asked respondents to rate the importance of their health care provider having certain characteristics (e.g. speaking the same language; being of the same racial/ethnic group; being the same gender; being the same age; being open to different treatment options; and understanding the respondent’s culture). Answers for this set of questions were scored on a 5-point Likert scale ranging from 0 (Not important at all) to 4 (Very Important).

*Statistical Analyses*

Ethnic group differences on sociodemographic variables were tested using a one-way analysis of variance (ANOVA) for continuous variables and chi-square analyses for categorical variables.

For the main outcomes, chi-square analyses were used. Once the main effects were determined, logistic regressions were used to determine which groups were different from each other in their response patterns. Non-Latino Whites were used as the reference group with comparisons made by every other ethnic group. Due to the multiple comparisons, only those results with a p value less than or equal to .01 were interpreted.

**RESULTS**

*Sociodemographic and Immigration Characteristics*

Table 1 examines sociodemographic and immigration characteristics among non-Latino white, African-American, Asian-American, and Latino elderly participants in PRISM-E. A greater proportion of Latinos and Asian-Americans reported lower income less than 12 years of education as compared to the non-Latino whites. The majority of Latinos and Asian-Americans reported living in the U.S. 10 years or longer.
Cultural Attitudes toward Healthcare and Mental Illness

“Nobody knows for sure what causes mental health problems such as depression, but people have different ideas about what the causes might be. What do you think causes depression?” Pairwise comparisons revealed significant differences in the way each ethnic group viewed the etiology of mental illness. African-Americans tended to view mental illness as caused by stress and loss. They viewed the loss of family friends, stress over money, and stress or worry, in general, as causes of mental illness more than non-Latino Whites. A greater proportion of Asian-Americans than non-Latino Whites believed that family issues, medical illness and cultural differences caused mental illness. In comparison to non-Latino Whites, Latinos stated that mental illness was caused by the loss of family and friends, family issues, and moving to a different place. Details are presented in Table 2.

“If you had a mental health problem, what do you think would help you get better?” As shown in Table 3, compared to non-Latino Whites, a greater proportion of African-Americans said they would seek spiritual advice to help them with a mental health problem. There was no single treatment modality that the Asian-Americans preferred more than the non-Latino Whites. However, Latinos were more likely to endorse a preference for medications.

“Who would you talk to if you had a mental health problem?” Table 4 shows that African-Americans were more likely to speak to a family member living with them (non-spouse) but were unwilling to speak to psychiatrists or psychologists when compared to non-Latino Whites. Asian-Americans were unwilling to speak to anyone when
compared to non-Latino Whites. Latinos were more likely to speak to a psychologist and less likely to speak to a medical doctor than the non-Latino Whites.

“Who makes most of your health care decisions?” As shown in Table 5, the majority of participants in all ethnic groups stated that it was they (on their own as individuals), who make most health care decisions. Since, the respondents were allowed to choose more than one response; the majority of African-Americans also stated that their doctors also were most likely to make healthcare decisions. Asian-Americans and Latinos were less likely than the non-Latino Whites to report that their doctors made health care decisions for them.

Preferred characteristics of health care provider. Table 6 shows ANOVA comparisons of group means for each item on preferred characteristics of health care provider (as the dependent variable) and ethnic group affiliation as the independent variable. Significant overall group differences were found for ethnicity. Subsequent pairwise comparisons between non-Latino Whites and each ethnicity were conducted. African-Americans expressed a greater degree of preference for their health care providers to understand their culture compared to non-Latino Whites. Asian-Americans indicated a greater preference for their health care providers be of the same ethnic/racial group compared to non-Latino Whites.

DISCUSSION

The results of this study confirm that there are ethnic differences among older adults with mental illness and their treatment preferences, roles of health care providers in decision-making, and preferred characteristics of providers. We found that African-
Americans, Asian-Americans, and Latinos had differing beliefs regarding the causes of mental illness. Furthermore, ethnicity was associated with differences in preferences for type of treatment and preferred provider characteristics. The response patterns of the African-Americans, Asian-Americans, and Latinos indicate that cultural values influence beliefs on the cause of mental illness, preferences for type of treatment, and provider characteristics.

In this study, African-Americans viewed the loss of family and friends, stress over money, and general stress or worry as causes of mental illness. These health beliefs are tied to the sociocultural context in which these African-Americans live. Insight into how social support, poverty, and constant stress affect the African-American community may provide understanding as to why these individuals endorsed these items. Intergenerational family support and support from the extended family has been reported as a common element contributing to health care in the African American community (Beach, Kogan, Brody, Chen, Lei, Murry, 2008). African-Americans appear to be more likely to attribute disruptions in social support to developing a mental illness. Poverty is likely to affect a disproportionately greater number of African-Americans than non-Latino Whites (Thomas & Quinn, 2008). Denavas-Walt, Proctor and Smith (2007) showed that 24% of those who lived below the poverty line were African-Americans compared to 8% who were non-Latino White. In a study by Turner and Wallace (2003) and replicated by Ford and colleagues (2007), researchers found that African-American respondents with lower incomes were significantly more likely to have been diagnosed with a substance abuse disorder in their lifetimes than those with higher incomes. Discrimination, which can be viewed as a constant stressor, has been found to be causally
associated with poor mental health outcomes (Borrell, Kiefe, Williams, Diez-Roux, Gordon-Larsen, 2006).

African-Americans in this study were willing to see and speak with family and medical doctor, but expressed a distrust of conventional mental health professionals. Knowledge of the Tuskegee Experiment is prevalent in the elderly African-American community (Thomas & Quinn, 1991). This memory, in addition to the widespread discrimination most have faced in their lifetimes, may provide the basis for African-American elders to be suspicious of health care providers (Brangman, 1995). Another reason African-Americans do not utilize mental health services may be because of cultural differences with mental health specialists. These cultural differences may go unaddressed which can lead to African-American patients feeling underappreciated, misunderstood, and less engaged in treatment (Atdjian and Vega, 2005). This also helps explain the importance African-Americans placed on their health care providers understanding their culture.

In this study, Asian-Americans, believed that mental illness is caused by medical illness, cultural differences and family issues. This is consistent with reports that Asian-Americans respondents are more reluctant to report psychological distress (Kleinman, 1986) and are more likely to somaticize (Kleinman, 1986; Parker, Cheah, & Roy, 2001). The expression of psychiatric problems through physiological symptoms may be more congruent with their cultural beliefs and values. Asian-Americans have been described as being reserved and unwilling to speak to anyone about mental illness, perhaps due to a strong cultural stigma and the need to preserve a sense of dignity (Sue, Sue, Sue, & Takeuchi, 1995). This guarded approach to seeking treatment may help in understanding
why Asian-Americans stated that they were unwilling to speak to anyone regarding mental health concerns and why they tended to place more importance on their healthcare providers being of the same race/ethnicity. The belief that mental illness is borne out of a disruption in the family is a theme that cuts across ethnic lines for the three ethnic minority groups in this study. For the Asian-Americans and the Latinos, however, the narrative of family disruption or loss of family may have its roots in migration.

Latinos stated that mental illness was caused by the loss of family and friends, family issues, and moving to a different place. Migration and relocation involve a series of stressful experiences, and these experiences of migration can shape individuals’ perceptions of reality (Comas-Diaz & Grenier, 1998). While the act of migration may only take a relatively short amount of time, its effects can be profound and long lasting. The experience of migration transcends the actual physical move. Relocation is a transitional experience that affects the individuals’ behaviors, feelings, values, and cognitions, and it is a pervasive condition that influences the family system and generations after (Sluzki, 1979). Migration can play a critical role in the culture and influences health beliefs. For example, a subgroup of Latinos believes that dementia is a result of migrating to a new country (Hinton & Levkoff, 1999). The effect of the scattering of family members on family structure and relationships is believed to be traumatic and can lead to poor health (Ortiz, Simmons, & Hinton, 1999).

Our finding that Latinos were willing to speak to psychologist and to use medications was surprising, as it is contrary to research which has found that Latinos have a mistrust of health care professionals and are concerned about the effects of
psychotropic medications (Cooper, Gonzales, Gallo, Rost, Meredith, Rubenstein, Wang, & Ford, 2003). This inconsistency may be explained by the fact that the study participants were drawn from primary care. Latinos who are seeking treatment may be more willing to use other forms of treatment. Furthermore, the study participants consist of older primary care patients who were willing to be randomized to integrated mental health treatment in primary care or to specialty mental health care. Hence, participants may not be representative of older adults who are reluctant or unwilling to accept mental health services.

Caution is warranted in interpreting the results of this report due to several limitations associated with the sample, study methods, and design. First, the participants who took part in this study were patients with a diagnosis of substance abuse or other psychiatric illness who were seeking help for their diagnosis. Furthermore, participants in the study were willing to be randomized to two different models of mental health treatment, including integrated and specialty referral substance abuse or mental health services. Hence, this was not an epidemiological sample and conclusions drawn cannot be generalized to the population at large. Second, the Latinos and Asian-Americans in this study were treated as homogeneous groups, when they actually comprise different subgroups of varying nationalities. For example, Latinos comprise those individuals of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race. The Asian population consists of over 43 ethnic groups (including Chinese, Japanese, Filipino, Thai, Korean, Vietnamese, Hmong, Laotian, Asian Indian, Pakistani, etc.) speaking over 100 languages and dialects. Combining these individuals into broad categories (i.e., Latino or Asian) may make comparisons easier and
elicit meaningful results, it is important to note that the participants who make up these groups come from vastly different cultures. Third, multiple comparisons were conducted, introducing the potential for Type II error. However, interpreting results with a p value less than or equal to .01 reduces the potential of committing a Type II error. In sum, the present study had limitations that may potentially reduce the generalizability of the findings.

While these results should be viewed with some caution, they suggest potential directions for further inquiry. A potential next step would be an epidemiological study measuring health beliefs and patient preferences in a non-patient population to see if health beliefs or preferences are affected by disease severity or treatment engagement. In addition, further research is indicated that addresses differences that may be present in health beliefs and treatment preferences among the various sub-ethnic groups within the Latino and Asian-American population. As Alegria and colleagues (2008) have demonstrated, valuable information may be gained by disaggregating these populations. Researchers may be able to acquire useful knowledge about the elderly from the various Latino and Asian ethnic groups by comparing health beliefs and preferences between these subgroups.

This study provides preliminary findings that may help to inform how patients with a psychiatric illness or substance abuse from different cultures view mental illness. By understanding patients’ health beliefs, clinicians may be in a position to educate their patients in a culturally sensitive manner. Addressing preferences may also help to support culturally associated preferences of patients. Accommodating the values and preferences of individuals facilitates shared health care decision-making and ongoing
participation in treatment. This can be especially helpful in engaging minority patients that have historically underutilized mental health services. Our results underscore the importance of addressing patient’s health beliefs and preferences. By not taking into account these cultural values, the healthcare system are likely to perpetuate pre-existing health disparities, among ethnic minority older adults comprising the fastest growing segment of the elderly population.
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