Addressing mental healthcare disparities in the U.S.: The importance of culture and context

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Overview

- Statement of problem
  - Mental disorders are highly prevalent
  - Healthcare disparities in access to mental health services remain significant
- Current understanding of the field
- Next generation of research
  - Development of models that incorporate culturally-relevant psychological variables
- Present preliminary findings from our research on Latino men

Prevalence of mental disorders

- Recent estimates place lifetime prevalence of mental disorders at 46% (Kessler et al., 2005).
  - Most common disorders:
    - Major Depressive Disorder (~17%)
    - Alcohol abuse (~13%)
    - Social and specific phobias (~12.5%)
  - Significant numbers of individuals will experience subthreshold levels of symptoms that warrant clinical attention (e.g., Lewinsohn et al., 2000).

- The consequences of mental disorders are considerable, producing substantial human suffering and loss of productivity (e.g., Greenberg et al., 2003).

Depression treatment and utilization

- Good news
  - There exist a number of efficacious pharmacological and psychosocial treatments for most disorders (DeRubeis & Crits-Cristoph, 1998)

- Bad news
  - Utilization rates are low, particularly for individuals from low-income and cultural minority backgrounds (U.S. DHHS, 2001; Kessler et al., 2007).
    - Some recent data suggests that disparities may be increasing (Blanco et al., 2007)

What might explain these disparities?

- Researchers have divided reasons for these disparities into a variety of categories, including:
  - Community-level reasons
    - Number of mental health centers/clinics in a community
  - Systems-level reasons
    - Insurance, fragmented provision of care
  - Provider-level reasons
    - Training, expectations for treatment, attitudes towards difference
  - Client-level reasons
    - Instrumental reasons: difficulties with transportation, child care, scheduling
    - Attitudes and beliefs: Conceptions about mental health/illness, concerns about stigma, uncertainties re: utility of mental health treatment
  - Provider-client interactions
    - Working alliance, cultural competence

Current models of treatment-seeking

- Considerable research has been conducted over the years trying to understand disparities at these different levels.
- And, yet, significant disparities in mental health care continue to exist for cultural minorities (U.S. DHHS, 2001; 2005).
- Why might this be?
  - Community- & systems-level changes difficult to implement
    - Example: Takes time to produce bilingual health providers

Why do healthcare disparities persist?

- Perhaps there exist limitations to current research
  - Overrepresentation of between-group research
  - Conceptualize treatment-seeking behavior separately from psychopathology
  - Lack of theoretically-guided attention to relevant psychological variables

Overrepresentation of between-groups research

- Research that conceptualizes race/ethnicity as moderator variable has yielded important findings regarding:
  - Prevalence rates of disorders
    - NCS-R: African Americans and Latinos have lower lifetime risk for mood and anxiety disorders than European Americans, although last longer (persistence)
    - NLAAS: Latinos had lower rates of almost all disorders than European Americans
  - Intervention engagement, retention, and outcomes
    - NCS-R: African Americans and Latinos are less likely than European Americans to make initial treatment contact and delay onset of treatment
    - Worse retention/dropout of mental health treatment among African Americans and Latinos
    - Mixed evidence re: outcomes

Overrepresentation of between-groups research

- However, this design has important weaknesses
  - Study must be sufficiently powered to examine differences
    - Few studies meet this high bar (Mak et al., 2007)
  - Risks missing important within-group variability
    - Immigrants from different countries of origin
  - Cannot adequately consider context
    - e.g., Immigration status (paradox), racial/ethnic identity, acculturation
  - Offers very little information regarding underlying reasons for between-group differences
    - Provides little guidance for adaptation efforts (Lau, 2006)

Why do healthcare disparities persist?

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Conceptualize treatment-seeking behavior separately from psychopathology

- Most of the models target health behavior and not as much time on underlying pathology
  - Makes sense for physical health conditions
  - Example: toothache → dentist visit
- May not work as well with mental health, particularly if the experience/manifestation of disorders is influenced by sociocultural factors
- Any evidence for this?

Conceptualize treatment-seeking behavior separately from psychopathology

- In fact, cultural effects have been found in disorders
- Focusing on depression:
  - Racial/ethnic differences in prevalence rates of disorders
  - Developmental trajectories of disorders
  - Correlates and predictors of disorders
    - Standard cognitive predictors work less well than expected
    - Culturally-salient predictors (e.g., discrimination, acculturative stress, neighborhood disadvantage)

Conceptualize treatment-seeking behavior separately from psychopathology

- How might understanding these differences in depression help us understand and address healthcare disparities?

- Or: What might underlie these racial/ethnic differences?
  - Traditional predictors (e.g., differential distribution of negative life experiences)?
  - Differential willingness to report symptoms?
  - Differential experience of affect/emotion?
  - Differential protective factors?

Why do healthcare disparities persist?

- Perhaps there exist limitations to current research
  - Overrepresentation of between-group research
  - Conceptualize treatment-seeking behavior separately from psychopathology
  - Dearth of theoretically-guided attention to relevant psychological variables

Individual differences framework

- Incorporating an individual differences framework:
  - Focuses on role of psychological variables
  - Could help explain why many individuals do seek mental health services despite presence of obvious barriers
  - Could help explain why some individuals do not seek services despite the absence of obvious barriers
  - Allow us to move beyond patient/subject self-appraisal

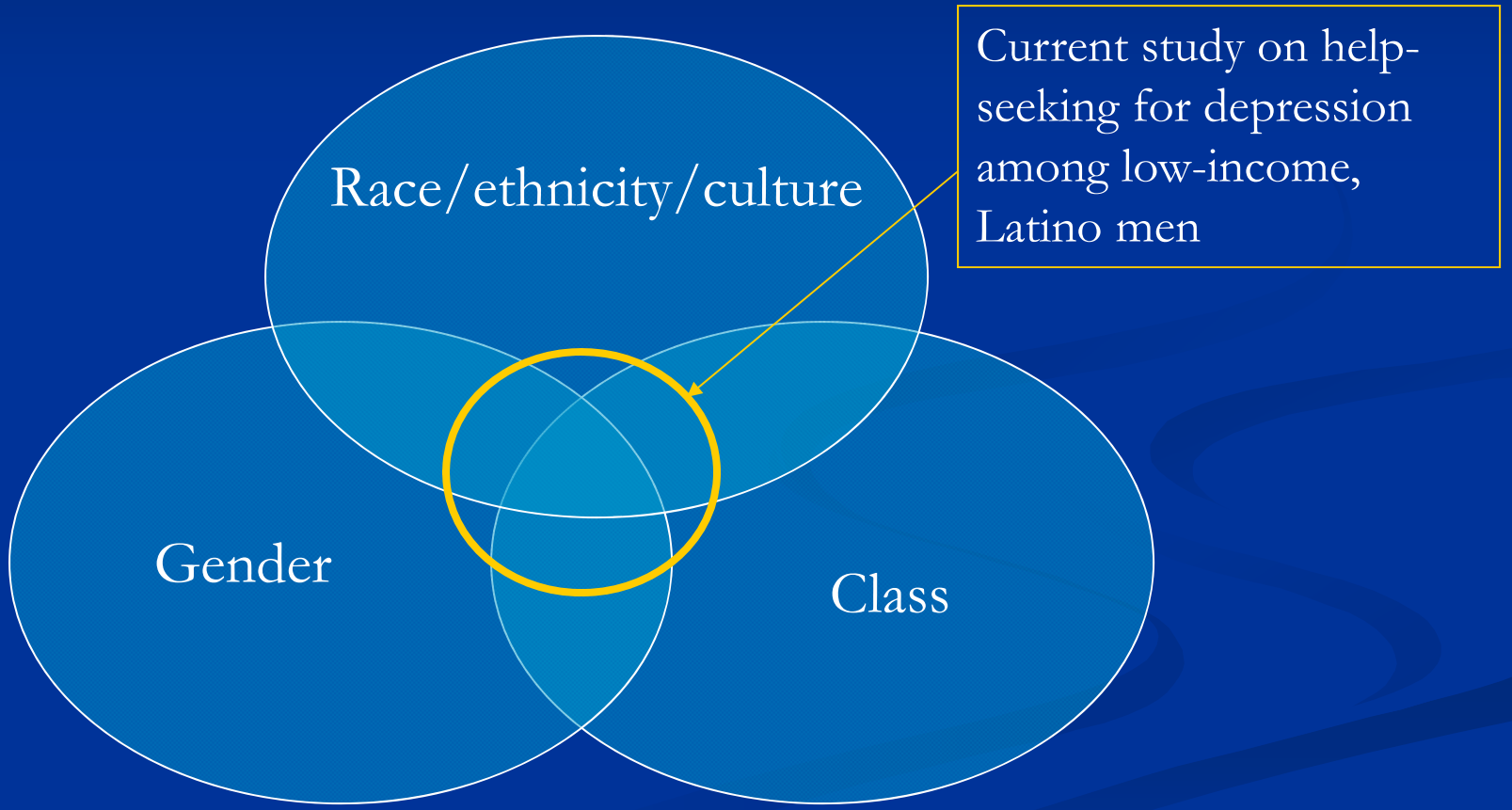
- Some support for this approach:
  - In a study of help-seeking among Puerto Ricans, Ortega & Alegría (2002, 2005) found that *self-reliance* and *denial of a mental health problem* interfered with use of formal mental health services

Individual differences framework

- And yet, it is unclear how these variables might explain why *Latinos* generally, or *Puerto Ricans* specifically, might underutilize mental health services relative to non-Latinos.

- It is critical to identify individual differences variables that are:
  - Psychological in nature
  - Theoretically related to treatment-seeking
  - Offer explanations relevant to healthcare disparities

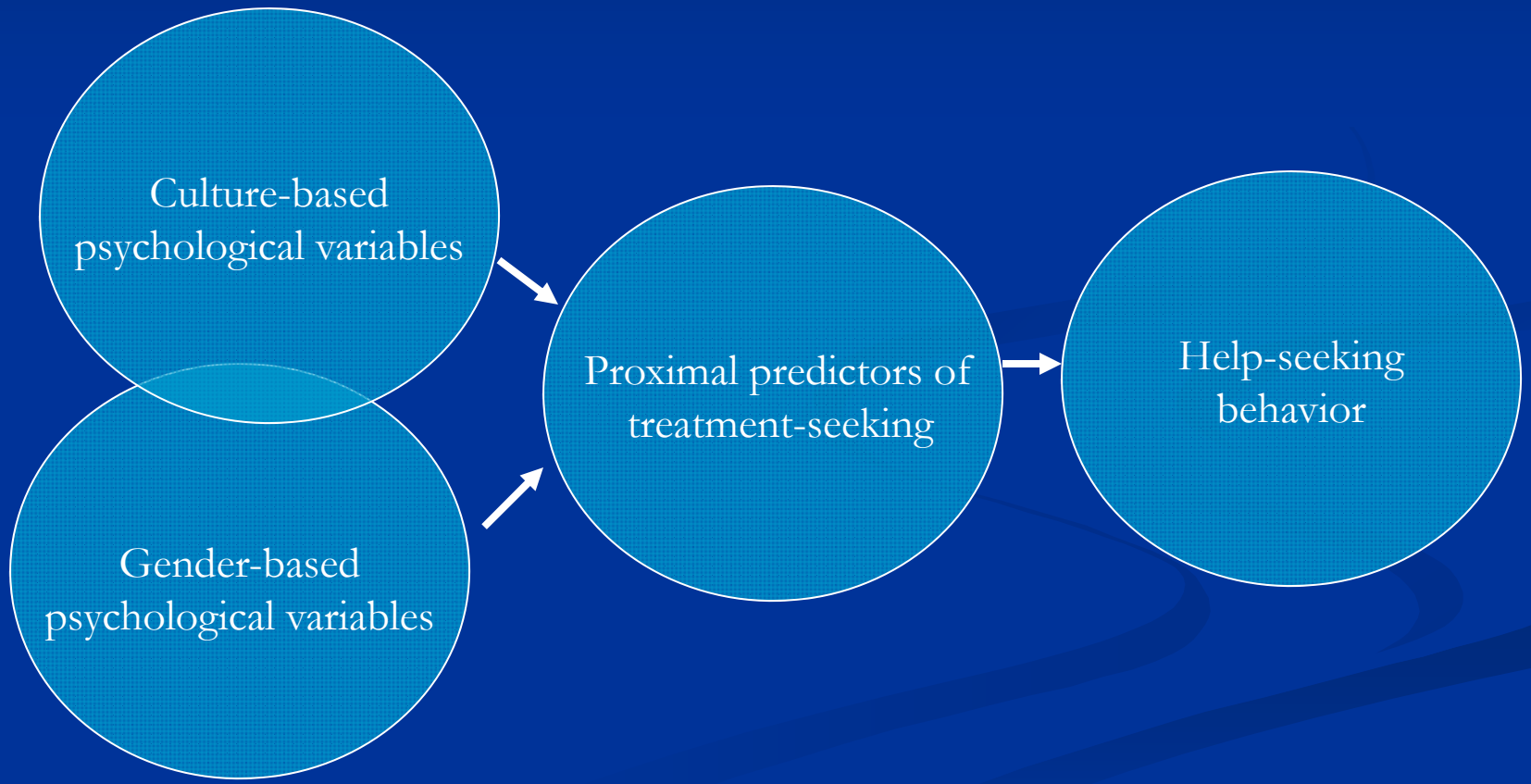
Where should we start to look for relevant psychological variables?



How might these variables function?

- Culture-based variables
  - Culturally-specific experiences of distress, cultural values, culturally salient life experiences
- Gender-based variables
  - Considerable research has found that men underutilize mental health services relative to women
  - Masculine gender socialization (e.g., Addis & Mahalik, 2003)
    - Values at odds with help-seeking:
      - physical strength, toughness, restricted emotionality, power, competition, and self-reliance
- Class-based variables
  - SES is negatively associated with use of mental health services
  - Many barriers to treatment-seeking are financially related

Culture- and gender-based model of treatment-seeking



What proximal variables?

- Proximal variables would likely include traditionally studied predictors of treatment-seeking
  - Attitudes toward seeking professional help
  - Stigma about mental health and mental health treatment
  - Self-reliance
  - Social network and support

Help-seeking for depression among low-income Latino men: Preliminary Findings

Help-seeking for depression among low-income Latino men

- Goal of this research:
  - To investigate the possibility that Latino men face unique obstacles to receiving care
  - Might a model that incorporates culture, gender, and class help explain healthcare disparities that affect low-income Latino men?

- Mixed methods approach
  - Qualitative phase: open-ended interview
  - Quantitative phase: self-report & interviewer measures

Qualitative Phase: Recruitment Process

- Participants were recruited from:
  - Waiting rooms of community health centers, local supermarkets, Latino-owned eateries, community centers, street corners, provider referrals, and word of mouth.
  - Paid $75 for participation (if eligible)
- Qualitative recruitment and enrollment:
  - 73 men completed initial screener (scores >=10 on PHQ-9)
  - 65 eligible to attend second screener
  - 44 completed the second screener (scores >=12 on Ham-17)
  - 36 eligible and enrolled in the project

Qualitative Phase: Procedures

- Self-report and interview-based measures
  - Acculturation (BAS)
  - Depression (PHQ-9, BDI; HRSD)
  - Anxiety (BAI)
  - Alcohol use/abuse (AUDIT)

- Men's Coping Interview – Latino Version
  - Open-ended / semi-structured interview
  - Focuses on range of topics including:
    - Experience of distress and depression
    - Coping with distress
    - Attitudes towards and experiences with formal and alternative services
    - Barriers to help-seeking

Qualitative Phase: Analysis

- Thematic Analysis (Braun & Clarke, 2006)
  - Method for identifying, analyzing, & reporting themes in data.
  - Particularly useful for working within a contextualist framework

- Analysis of transcribed interviews is ongoing
  - Team meetings created list of tentative themes
  - Two coders jointly coded first three interviews
    - Subsequent interviews coded independently and then met to compare coding and establish consensus.
    - Every 5 transcripts were coded jointly
  - Periodic review of codes for refinement and reanalysis of transcripts

Demographic Information

Country of Origin	*N*	*%*
Puerto Rico	25	70
Central America	5	14
Other	6	16

Mean Acculturation Scores (BAS)	*Mean (SD)*
Hispanic Domain	3.22 (0.47)
Non Hispanic Domain	2.30 (0.82)

Acculturation Categories	*N*	*%*
Separated (Enculturated)	19	53
Assimilated (Acculturated)	2	6
Bicultural	9	25

Demographic Information

Mean Age	40.43 (SD=11.10)	
Marital status	*N*	%
Married/Committed	18	50
Divorced/Separated	7	19
Single	11	31
Income	*N*	%
Under $10,000	21	58
$10,000-$25,000	11	31
No information	3	8

Other Information

Depression severity	*Mean (SD)*
PHQ-9	16.03 (3.99)
Hamilton 17-item	17.70 (5.67)
Beck Depression Inventory (BDI)	25.39 (10.81)
Other psychiatric symptoms	
Anxiety (BAI)	25.31 (12.73)
Alcohol Use (AUDIT)	6.59 (7.31)
Current Treatment Status	*N* *%*
Receiving mental health treatment	18 50
Not receiving mental health treatment	18 50

Some Preliminary Themes

Some relevant cultural variables

- Culture-specific conceptions and experiences of mental health and illness.
  - *Idioms of distress* (e.g., Malgady, Cortés, & Rogler, 1996)
    - Nostalgia, anger, & disillusionment:

I: De que forma le afecto (inmigrar a los Estados Unidos)?

P: Mira, yo he dejado atras todo -- toda mi familia, toda mi cultura, puede decir. Para gastarme a comer hotdogs y cosas asi. Que tu… te me entiendes? Pues eso es sufrir. Lo deje atras.

I: In what way did it affect you (immigrating to the United States)?

P: Look, I left behind everything, my whole family, my whole culture, you could say. To spend my life eating hotdogs and things like that. Do you understand me? That is what it is to suffer. I left it behind.

Some relevant cultural variables

- Culturally-specific values: How might they be related to treatment-seeking?
  - *Respeto*

I: Cuando decidio usted que seria beneficioso tomar medicamentos?

P: Bueno cuando ellos …me dieron la medicacion. Ellos fueron los que me dieron la medicacion. Yo les explique el problema y ellos me dieron la medicacion.

I: When did you decide that it would be helpful to take medication?

P: Well, when they gave me the medicine. They were the ones who gave me the medicine. I explained to them the problem, and they gave me the medicine.

Some relevant cultural variables

- Culturally-specific values, ctd.
  - *Personalismo*

I: And uh, um, do you feel like he understands what it means to be you and your cultural background?

P: Yeah, he, he feels like-- The way I feel about him is that he shows that he cares.

I: Okay he shows that he cares.

P: About, about with me yeah…You know he just don't, "ok, ok, ok." And "Next!" y'know. I actually feel like I'm a patient or like a somebody when I'm with him. And he hears me.

Some relevant cultural variables

- Culturally-salient life experiences: familial separation, immigration stress, prejudice and discrimination

I: Okay, was there anything difficult about working with her?

P: Eh I hate to say it was you know she was, she was white but … I don't know, I just felt that she just looked at me that she was, like, maybe even though it wasn't the case, but that's the way I felt you know?

I: Yeah.

P: That she just looked to me ah he's just some sp- you know a spic or whatever… He's never gonna get his stuff together or whatever so—

Some relevant gender variables

- Masculinity and *machismo* can make some negative life events particularly difficult to endure

  P: O claro. Yo estoy buscando todos los días a dos pesos para una caja de cigarrillos. Tú crees que, que, que eso no me va a deprimir? ... Tu sabes, cómo es que un hombre no puede tener dos pesos en su en su cartera. Tengo una cartera vacía.

  P: Oh sure. I am looking every day for two dollars for a box of cigarettes. You think that won't make me depressed? You know, how can it be that a man doesn't have two dollars in his wallet. I have an empty wallet.

Some relevant gender variables

- *Machismo* can make therapy seem uncomfortable

  I: When you think about being a man speaking with a professional about depression and about your drug use, is there anything about it that makes you uncomfortable?

  P: Ya it does. Cuz like it does, ya, cuz, even myself I, I have a problem with like opening up to anybody or whateva but um—…you don't talk about your feelings and stuff like that you know that's- feelings, that's for girls (laughs).

Quantitative Phase

- Recruitment process was identical to that in qualitative
- Eligible participants completed a battery of questionnaires

- Symptom measures
  - Depression: PHQ-9, BDI, HRSD-17
  - Anxiety: BAI
  - Hostility: SCL-90-R

Quantitative Phase

- Cultural variables
  - Latino values: Familismo, Fatalismo, Personalismo (MACC)
  - Machismo and Caballerismo Scale (MCS)
- Gender variables
  - Conformity to Masculinity Norms Inventory (CMNI)
- Proximal predictors of help-seeking
  - Attitudes towards seeking prof. psychological help (ATSPPH)
    - Psychotherapy and medication
- Intention to seek treatment (HSBS)
  - Formal and informal

Demographic Information

Country of Origin	*N*	*%*
Puerto Rico	67	84.8
Caribbean	5	6.3
Central and South America	7	8.9

Mean Acculturation Scores (BAS)	*Mean (SD)*
Hispanic Domain	3.11 (0.65)
Non Hispanic Domain	2.52 (0.86)

Acculturation Categories	*N*	*%*
Separated (Enculturated)	36	46
Assimilated (Acculturated)	11	14
Bicultural	32	41

Demographic Information

Mean Age	40.43 (SD=11.10)	
Marital status	*N*	%
Married/Committed	27	34
Divorced/Separated	16	20
Single	35	44
Income	*N*	%
Under $10,000	60	64
$10,000-$25,000	12	15
$25,000-$50,000	5	6
No information	4	5

Other Information

Depression severity	*Mean (SD)*
PHQ-9	18.99 (4.60)
Hamilton 17-item	19.87 (5.77)
Beck Depression Inventory (BDI)	30.40 (10.30)

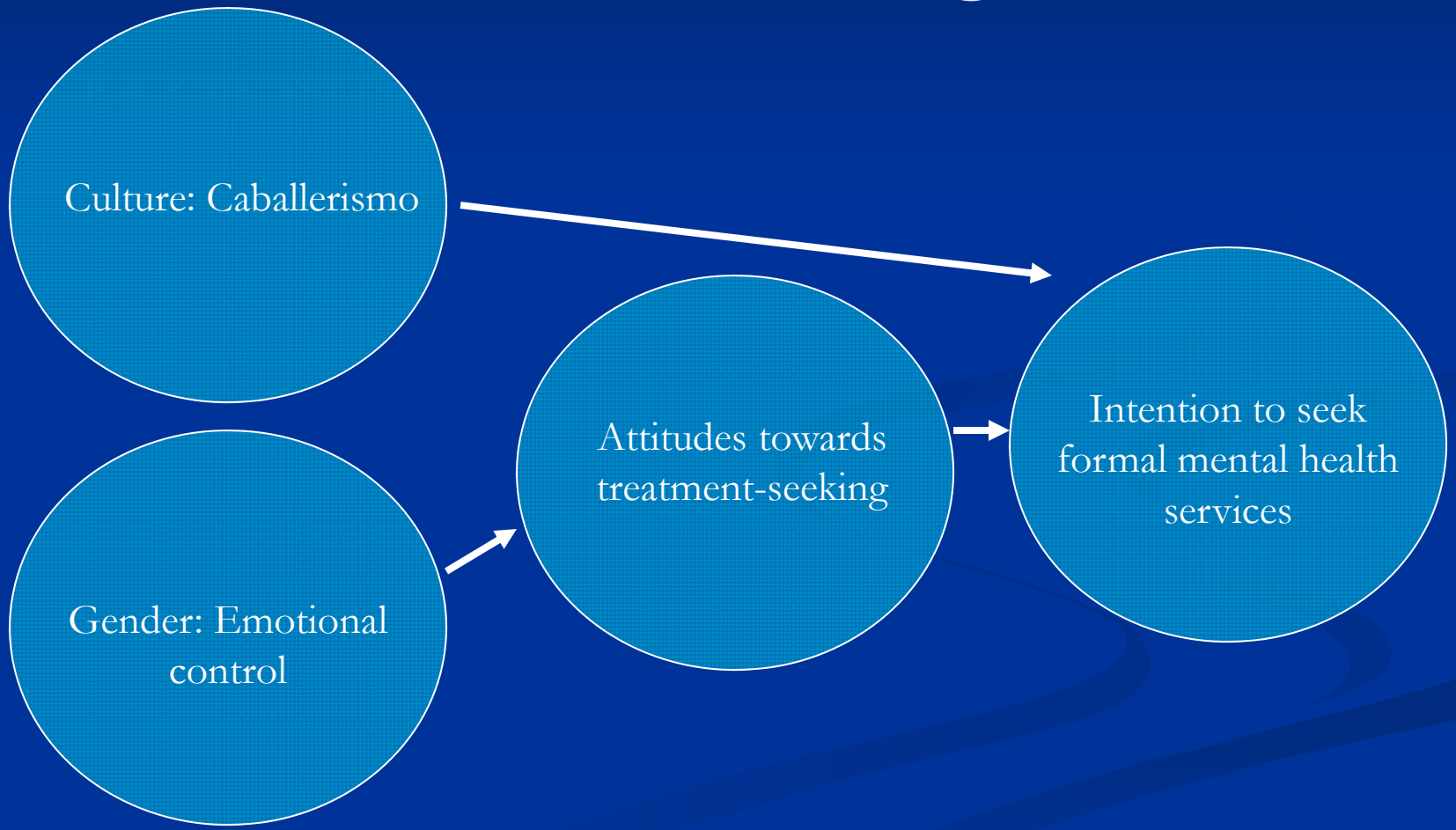
Other psychiatric symptoms	
Anxiety (BAI)	27.61 (13.41)
Alcohol use (AUDIT)	6.76 (7.97)

Current Treatment Status	*N*	*%*
Receiving mental health treatment	41	50
Not receiving mental health treatment	38	50

Univariate Correlations

- Gender-based variables
  - Emotional control ←→ intention to seek informal ($r = -0.34$, $p < 0.01$)
  - Emotional control ←→ intention to seek formal ($r = -0.28$, $p < 0.05$)
- Culture-based variables
  - Caballerismo ←→ intention to seek informal ($r = -0.31$, $p < 0.01$)
  - Caballerismo ←→ intention to seek formal ($r = -0.21$, $p < 0.10$)
- Proximal variables
  - Attitudes ←→ intention to seek formal ($r = 0.37$, $p < 0.001$)

Culture- and gender-based model of treatment-seeking



What else are we seeing?

- Theories of depression
  - Stress from childhood problems, family, finances, immigration
  - Negative outlook on life, shame, isolation
  - Chemical imbalance
- Coping with depression
  - Coping through religion/spirituality
  - Coping by helping others
  - Culturally salient coping (e.g., *desahogando; aguantando*)
- Cultural strengths
  - Family
  - Pride and ethnic pride
- Influence of social class

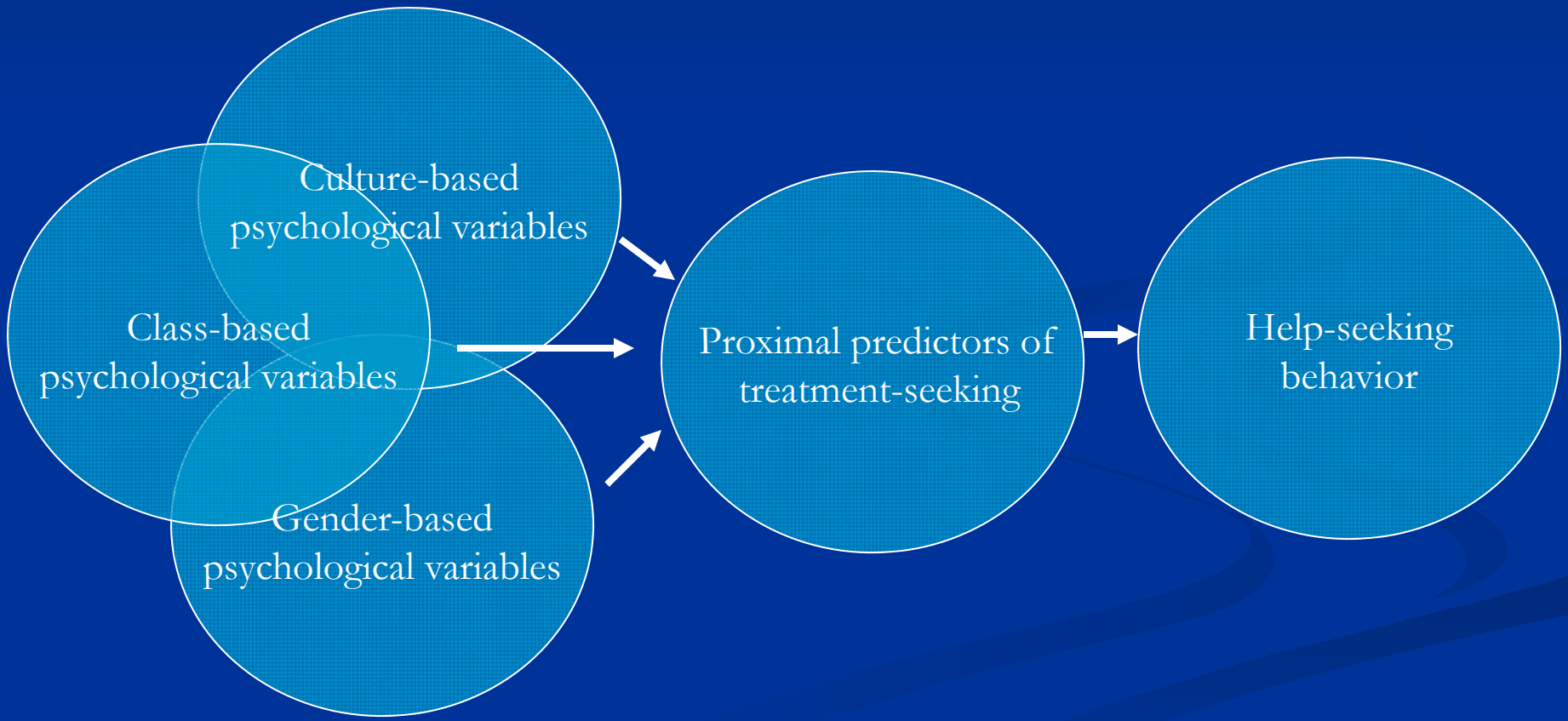
What about social class?

- Financial stress can be conceptualized as a direct cause of depression, making treatment of questionable utility

  I: Could a psychologist help you when you're feeling down about ….[your] economic situation…?

  P: Unless he's gonna lend me some money [chuckle] a penny, you know that's that's the way I see it….[chuckles] This this is what he says. Oh um let me see uh you could do better if you had twenty dollars more…. thirty. I know that. … if he's not gonna give me any money, he's not gonna help, cause my situation economically can only be resolved me getting… making more money.

Culture-, gender-, and class-based model of treatment-seeking



Summary

- Although preliminary, we are seeing support for our culture- and gender-based model of help-seeking
  - Culture-based variables include idioms of distress, cultural values, culturally-salient life experiences
  - Gender affects the meaning of life experiences (e.g., shame) and the subsequent help-seeking (or lack thereof)
  - Social class also matters, beyond financial distress
  - These concepts are highly intertwined and entangled
- Next steps:
  - Complete coding and analysis of all 30 interviews
  - Conclude quantitative analyses

Implications for psychology

- What are the implications of this framework?
  - Clinical work
    - We typically only see the proximal variables in action, which can lead to assumptions abut client motivation
    - May have implications for provider factors (e.g., attitudes) and provider-client factors (e.g., cultural competence and working alliance)
    - May even have implications for systems-level factors
      - Role of primary care
      - Role of religious figures
      - Assumption about treatment course (continuous vs episodic)
  - Research
    - Basic research
      - Questioning existing models of psychopathology
    - Intervention research
      - Most of the extant adaptations are relatively superficial and not directly connected to theoretically relevant variables

Concluding thoughts

- In order to address continuing healthcare disparities, we need to build on existing research
  - Next generation of research should explicitly consider the role of culture-, gender-, and class-based variables
  - Improving our understanding of the person-level contributors to these disparities can lead to real-world changes and possibly impact these disparities

Thank you