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Attitudes of Older Korean Americans Toward Mental Health Services

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Abstract

Given the increasing evidence that older ethnic minorities underuse mental health services, the present study assessed determinants of attitudes toward mental health services with a sample of older Korean Americans (N = 472). Adapting Andersen's behavioral health model, predisposing factors (age, sex, marital status, education, length of residence in the United States), mental health needs (anxiety, suicidal ideation, depressive symptoms), and enabling factors (personal experiences and beliefs) were considered as potential predictors. Shorter residence in the United States and higher levels of depressive symptoms were associated with more-negative attitudes toward mental health services. Culture-influenced personal beliefs (knowledge about mental illness and stigmatism) were found to play a substantial role in shaping individuals' attitudes toward mental health services. Findings call attention to the need to investigate how culture influences the response to mental health needs and to develop community education and outreach programs to close the gaps between mental health needs and service utilization in older ethnic minority populations.

Keywords

mental health; service utilization; Korean American; older adults

Asian Americans are one of the fastest growing minority groups in the United States. Currently constituting nearly 4% of the total U.S. population, they are projected to reach 10% by 2050,[1] but little is known about this population, especially in the mental health arena.[2,3] Given the heterogeneity of Asian Americans, the present study focuses on one group: older Korean Americans. Korean Americans have been identified as one of the most understudied populations[4] despite the fact that they constitute one of the largest and fastest-growing segments of Asian Americans.[1] Their reportedly high risk for mental health problems also indicates the need for more research on Korean Americans.[4]

Although service underutilization of Asian Americans is well documented,[3–5] there is little research on their attitude toward mental health services and its correlated factors. Exploring variables associated with the perceptions of mental health service use will help identify facilitators and barriers to service utilization. Because attitudes have been shown to be a critical determinant of help-seeking behaviors,[6,7] this line of research may inform about how to design and implement effective interventions to reduce disparities in mental health services.

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An adequate assessment of factors influencing attitudes toward mental health services needs to cast a broad net. For this reason, Andersen's[8] behavioral model of healthcare utilization, with its inclusion of multiple explanatory factors, was chosen to serve as a conceptual guideline. In this model, predisposing factors consist of demographic characteristics and other background variables. Previous research has found that older adults are less likely to use mental health services than younger adults.[9,10] Findings on the role of sex are not consistent, with some studies finding that women hold more-positive attitudes toward professional help-seeking than men[11] but others finding small or no sex differences.[7,12] A positive connection between education and willingness to use mental health services has also been observed.[13] In research on immigrant populations, acculturated individuals with a longer residence in the United States and greater English proficiency were shown to have more-positive perceptions of mental health service use.[14,15]

Need constitutes the second explanatory factor. Just as physical health problems such as illness and chronic conditions represent needs for medical service, mental health problems represent needs for mental health services. In a prospective study based on medical records, level of depression was found to be the most significant predictor of service use.[16] Nevertheless, despite the fact that psychological morbidity and severity of conditions indicate a need for service, there seems to be a wide gap between mental health needs and care.

Enabling factors encompass a variety of resources that facilitate access to services. Personal experiences and beliefs were of particular interest. The literature has shown that individuals who have had prior contacts with mental health professionals tend to have more favorable attitudes toward service use[7] and that subjective perceptions of or beliefs about mental illness play a substantial role in shaping attitudes toward mental health service use.[17] Lack of knowledge and negative stereotypes of mental illness are widespread in the community, serving as a critical barrier to service utilization.[10] Older individuals who attribute depression to aging[18] and who perceive depression as a sign of personal weakness[19,20] tend to have negative attitudes toward professional help seeking. It is also known that Asians, in particular, tend not to accept the medical model of depression, which views depression as a disease requiring professional treatments.[17]

Other culturally relevant variables may include shame and stigma. In Asian societies, in which culture places a strong emphasis on saving face and bringing honor to the family, a great deal of stigmatization has been attached to mental illness.[21,22] Stigmatization linked to shame has been suggested as a major cultural barrier to the use of mental health services.[21,22]

Using the above-mentioned variables, the present investigation explored determinants of attitudes toward mental health services in older Korean Americans. Obtaining an understanding of cultural mechanisms of perceptions and behaviors associated with mental health issues may help identify areas that can enhance intervention strategies.

METHODS

Participants

A survey of older Korean Americans (aged ≥60) was conducted during October 2005 to May 2006 in Tampa and Orlando, Florida. Because of the underrepresentation of ethnic minorities in public databases (e.g., census data), standard sampling methods may miss a substantial proportion of potential subjects. Indeed, only 612 and 437 Korean residents were counted in Tampa and Orlando, respectively, in the 2000 U.S. Census. Because immigrant populations are often hard to identify using any single approach, and a single-source sampling frame may lead to bias, a variety of sources were used for recruitment. In the beginning phase of sample recruitment, local Korean churches, other religious groups, senior centers, and elder

associations were contacted. When contacts were made, the research team visited the sites and arranged for surveys to be conducted. The survey instrument consisted of a standardized questionnaire in Korean. Although the survey was designed to be self-administered, trained interviewers were available for anyone who needed assistance. To reach out to individuals who were not affiliated with those groups or organizations, referrals were asked for.

The convenience sampling procedure was supplemented with a systematic approach based on a telephone directory of Korean residents provided by the Florida Korean American Association. A total of 2,000 Korean residents in Tampa and Orlando were listed in the directory. After excluding those who had already been recruited through the convenience sampling efforts, all remaining individuals were called to ask whether there were age-eligible members in their household. Up to five phone calls were made. When there was an eligible person in the household, mail surveys were conducted. A packet including a questionnaire and prestamped return envelope was mailed to the potential participants. This step aimed to improve comprehensiveness of the sample by including individuals who were not recruited using the convenience sampling efforts.

In the final sample, 472 participants were included. About 60% of the sample lived in Tampa and 40% in Orlando. Forty-seven percent of the sample was recruited through site visits, and approximately 53 percent through mail surveys. Results from the comparative analyses showed no difference in major demographic characteristics between the residing cities, although participants recruited using site visits were less likely to be married (chi-square = 16.5, $P<.001$) and were less educated (chi-square = 9.97, $P<.01$) than the individuals whose data were collected using mail surveys. This finding suggests that reliance on the directory-based mail survey might have excluded individuals with more-vulnerable characteristics. All respondents were paid $10 for their participation. Detailed information on sampling procedures and validation of the use of combined sampling methods is available elsewhere.[23]

Measures—A Korean-language questionnaire was developed specifically for this project. Several of the measures had been translated into Korean and evaluated for psychometric qualities in previous work.[23,24] For additional scales, back-translation was used to confirm the appropriateness of initial translations into Korean. The structured questionnaire was pilot tested with 20 Korean older adults who were representative of the anticipated sample in this study.

Attitudes Toward Mental Health Services—An abbreviated 10-item version[6] of the 29-item Attitudes toward Seeking Professional Psychological Help Scale[11] was used to assess individuals' propensity to use mental health services. The revised scale includes five positive statements (e.g., "If I believed I was having a mental breakdown, my first inclination would be to get professional attention") and five negative statements (e.g., "The idea of talking about problems with a psychologist strikes me as a poor way to get rid of emotional conflicts"). Individuals were asked to rate each statement using a 3-point scale ranging from 0 (disagree) to 2 (agree). Responses to the negative statements were reverse-coded, and all responses were summed for total scores. Total scores could range from 0 to 20, with higher scores indicating more-positive attitudes toward mental health services. Internal consistency for the scale was satisfactory ($\alpha = 0.78$).

Predisposing Factors—Demographic variables included age, sex (1 = male, 2 = female), marital status (1 = not married, 2 = married), and educational attainment (1 = <high school, 2 = ≥high school). Length of residence in the United States was also asked about.

Need Factors—Anxiety, suicidal ideation, and depressive symptoms were used as indices of mental health status. Anxiety was measured using the three items from the survey of the

Aging, Status, and Sense of Control project.[25] The items ask on how many of the previous 7 days the respondents worried a lot about little things, felt tense or anxious, and felt restless. Individual responses were summed for total scores. The scores could range from 0 to 21, higher scores indicating greater levels of anxiety. Internal consistency of the scale in the present sample was good ($\alpha = 0.92$).

Suicidal ideation was assessed by asking a single question, "Have you ever thought of killing yourself?" A simple yes/no response format was used.

A short form of the Center for Epidemiologic Studies Depression Scale (CES-D)[26] was included to assess depressive symptoms. The 10 items rate on a 4-point scale how often symptoms such as loneliness, feelings of fearfulness, and restless sleep were experienced during the previous week. The CES-D has been translated into Korean, and its psychometric properties have been validated in previous studies.[27] Internal consistency in the present sample was good ($\alpha = 0.80$).

Enabling Factors (Personal Experiences and Beliefs)—A series of questions was asked about individuals' prior contacts with mental health professionals and personal beliefs about mental illness. The items, selected from the National Mental Health Association Survey,[19] questioned whether participants had previously received psychological counseling or treatment, thought that depression was a normal part of aging, thought that depression was a sign of personal weakness, thought that depression was a medical condition that needed a treatment, and thought that having a mentally ill family member brings a shame to the whole family. Responses were coded as 1 (yes) or 0 (no).

Analytical Strategy

A hierarchical regression analysis was conducted to assess the predictive model of attitudes toward mental health services. Sets of predictors were entered in an order appropriate to the Andersen model: predisposing factors (age, sex, marital status, education, length of residence in the United States), mental health needs (anxiety, suicidal ideation, depressive symptoms), and enabling factors (personal experiences and beliefs). Analyses were performed using SPSS version 13 (SPSS Inc., Chicago, IL).

RESULTS

Descriptive Information of Sample and Study Variables

The sample consisted of 472 Korean Americans ranging in age from 60 to 94 with an average age ± standard deviation of 69.9 ± 7.0. As shown in Table 1, 57.9% were female, and 75.2% were married. Approximately 64% of the sample had received more than a high school education. All participants were born in Korea. The number of years lived in the United States ranged from 2 months to 51 years, with a mean of 24.9 ± 10.8 years. The average scores for anxiety and depressive symptoms were 3.7 ± 4.8 and 7.6 ± 4.9, respectively. Approximately 8.5% of the sample reported that they had ever thought about committing suicide. When applying the cutoff score (10) for the short form of the CES-D, approximately 34% of the sample fell under the category of probable depression.

Despite their high levels of depressive symptoms, only 6.5% of the sample reported that they had previously contacted mental health professionals. The overall sample's perception of depression generally reflected a dismissive or negative stereotype. More than half (51%) thought that becoming depressed was a normal part of aging, approximately 71% perceived that depression was a sign of personal weakness, and approximately 14% reported that having a mentally ill family member brought shame to the whole family. On the item concerning

personal beliefs about the medical model of depression, 67% reported that they perceived depression to be a medical condition. The total scores of the attitudes toward mental health services averaged 13.0 ± 4.4 (range 0–20).

Predictors of Attitudes Toward Mental Health Services

After assuring the absence of multicollinearity by examining bivariate correlations (<0.47) and variance inflation factor scores (<1.54), the predictive model of attitudes toward mental health services was estimated. Hierarchical regression models were tested, and the results are summarized in Table 2.

At the first step, the predisposing set of variables explained a small portion of variance, and only the length of time having lived in the United States was significant. Those who had lived longer in the United States had more-positive attitudes.

Of need factors that were entered after controlling for the predisposing variables, depressive symptoms were found to be significant. In contrast to what is typically found with a need factor, individuals with higher levels of depressive symptoms (i.e., a presumably higher need) exhibited more-negative attitudes toward mental health services. The overall need factors accounted for an additional 4% of the variance.

In the final model, personal belief variables made a considerable contribution to the model by adding 13% of variance and resulting in the total explained variance of 17%. A personal belief that depression was a medical condition was associated with more-positive attitudes toward mental health services, whereas believing that depression was a sign of personal weakness and that having a mentally ill family member brought shame to the whole family was associated with more-negative attitudes.

DISCUSSION

The high rates of mental health problems and the under-utilization of mental health services often found in older populations[9,10] and ethnic minorities[3] prompted the present study with its focus on attitudes toward mental health services of older Korean Americans. Adapting Andersen's behavioral health model, various influential factors were explored.

Among the array of demographic and background variables included, a significant role was found only in the length of residence in the United States. Individuals with longer stays in the United States were more likely to have favorable perceptions of mental health services. This finding is in accordance with previous studies that showed positive associations between acculturation and service utilization.[14,15] The length of time having lived in the United States can be considered to be a proxy for the overall level of adaptation to the host culture, which in turn is generally associated with greater knowledge and acceptance of available resources and services. Contrary to the studies with younger populations and the native born,[11,12] no significant effects of sex or education were observed in the present study.

One of the striking findings of the present study was that greater levels of depressive symptoms, here conceptualized as need, were associated with more-negative attitudes toward mental health services. The original conceptualization was based on the fact that mental health services are generally accessed by individuals with intense symptoms of distress and psychological morbidity.[16] In the present study, in which subjective attitude rather than actual utilization was an outcome criterion, depressive symptoms were found to function as a barrier rather than a need. This finding calls attention to the problem of self-recognition of mental health needs in Asian Americans, including Koreans. Given that tolerance or suppression of personal emotions is often respected as a virtue in Asian culture,[21,22] psychological mechanisms of

self-recognition of the severity of conditions and need for care may be different from those of other racial/ethnic groups. Their distinctive culture may hinder older Korean Americans from recognizing or admitting that their symptoms reflect a need for care. Because self-recognition is an initial step toward help-seeking behavior, cultural responses to mental health needs deserve further attention.

Despite the fact that the levels of depressive symptoms in the present sample were higher than those found in studies of other racial/ethnic groups of older adults,[28] only a small portion (6.5%) had previous experience with contacting mental health professionals. An informal review of service agencies by study investigators revealed no Korean-speaking mental health professionals in the areas where the survey was conducted. Findings suggest a general lack of information and limited access to services in this population and call attention to the need for community education and outreach programs to promote knowledge and usage of mental health services.

The results generally highlighted the role of personal experiences and beliefs in shaping individuals' attitudes toward mental health services. Culturally distinctive beliefs about mental illness were found to play a critical role in predicting individuals' attitudes. Those who associated mental illness with personal weakness or shame tended to have more-negative attitudes toward mental health services. Alternatively, beliefs that depression is a medical condition predicted positive attitudes toward mental health services. The findings support the notion that culturally constructed beliefs function as a prism in perceiving mental health issues and shaping pathways for help-seeking.[21,22]

Some limitations of the present study should be noted. Because the study was based on a cross-sectional design, caution must be exercised in drawing causal inferences. Also, because of the geographically defined and nonrepresentative nature of the sample, the findings are only suggestive and invite further investigation. The fact that participants' cognitive abilities were not systematically screened may add to the limitations. In the present study, the assessment of predictive variables was limited to the individual level of barriers, and future studies may need to consider a broader spectrum of barriers, including environmental and system level variables. Also, research interests should be extended to an assessment of access and quality problems in mental health services to increase cultural competence and effectiveness of services for minority populations.

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Table 1

Descriptive Characteristics of Sample and Study Variables (N = 472)

[[Characteristic|]]	[[Value|]]
Age, mean ± SD (range)	69.9 ± 7.04 (60–94)
[[Female, n (%)|]]	[[272 (57.9)|]]
[[Married, n (%)|]]	[[352 (75.2)|]]
Education ≥high school, n (%)	[[292 (63.6)|]]
Years of residence in the United States, mean ± SD (range)	24.9 ± 10.8 (0.17–51)
Anxiety, mean ± SD (range)	3.70 ± 4.83 (0–21)
Suicidal ideation, n (%)	[[39 (8.5)|]]
Depressive symptoms, mean ± SD (range)	7.58 ± 4.85 (0–26)
Prior contact, n (%)	[[30 (6.5)|]]
Normal part of aging, n (%)	[[234 (51.0)|]]
Sign of personal weakness, n (%)	[[323 (70.7)|]]
Medical condition, n (%)	[[309 (67.2)|]]
[[Shame, n (%)|]]	[[63 (13.7)|]]
Attitudes toward mental health services, mean ± SD (range)	13.0 ± 4.42 (0–20)

SD = standard deviation.

Table 2

Hierarchical Regression Model of Attitudes Toward Mental Health Services

[[Step|]]	[[Predictor|]]	[[β|]]	[[t|]]	R^2	ΔR^2
[[1|]]	[[Age|]]	[[0.03|]]	[[0.66|]]	[[0.02|]]	[[0.02|]]
[[|]]	[[Female|]]	[[0.04|]]	[[0.75|]]	[[|]]	[[|]]
[[|]]	[[Married|]]	[[0.04|]]	[[0.69|]]	[[|]]	[[|]]
[[|]]	[[Education ≥high school|]]	[[0.04|]]	[[0.63|]]	[[|]]	[[|]]
[[|]]	Years of residence in the United States	[[0.11|]]	[[2.06|]] *	[[|]]	[[|]]
[[2|]]	[[Anxiety|]]	[[0.05|]]	[[0.99|]]	[[0.04|]] *	[[0.02|]] *
[[|]]	[[Suicidal ideation|]]	[[−.09 3|]]	[[−1.73|]]	[[|]]	[[|]]
[[|]]	[[Depressive symptoms|]]	[[−.12 3|]]	[[−2.03|]] *	[[|]]	[[|]]
[[3|]]	[[Prior contact|]]	[[0.05|]]	[[1.12|]]	[[0.17|]] ‡	[[0.13|]] ‡
[[|]]	Normal part of aging	[[0.04|]]	[[0.78|]]	[[|]]	[[|]]
[[|]]	Sign of personal weakness	[[−.10 3|]]	[[−2.01|]] *	[[|]]	[[|]]
[[|]]	[[Medical condition|]]	[[0.30|]]	[[6.10|]] ‡	[[|]]	[[|]]
[[|]]	[[Shame|]]	[[−.16 3|]]	[[−.18|]] †	[[|]]	[[|]]

Note: βs represent standardized regression coefficients in each step after controlling for the previous variables.

* $P < .05$,

† .01,

‡ .001.

R^2 = coefficient of determination.