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Stigmatizing Attitudes towards Mental Illness among Racial/ Ethnic Older Adults in Primary Care

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Abstract

Objective—The current study applies the perceived stigma framework to identify differences in attitudes toward mental health and mental health treatment among various racial/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 race/ethnicity is associated with differences in: (1) perceived stigma of mental illness; and (2) perceived stigma for different mental health treatment options.

Methods—Analyses were conducted using baseline data collected from participants who completed the SAMHSA Mental Health and Alcohol Abuse Stigma Assessment, 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 1247 non-Latino Whites, 536 African-Americans, 112 Asian-Americans, and 303 Latinos.

Results—African-Americans and Latinos expressed greater comfort in speaking to primary care physicians or mental health professionals concerning mental illness compared to non-Latino Whites. Asian-Americans and Latinos expressed greater shame and embarrassment about having a mental illness than non-Latino Whites. Asian-Americans expressed greater difficulty in seeking or engaging in mental health treatment.

Conclusions—Racial/ethnic differences exist among older adults with mental illness with respect to stigmatizing attitudes towards mental illness and mental health treatment. Results of this study could help researchers and clinicians educate racial/ethnic minority older adults about mental illness and engage them in much needed mental health services.

Keywords

race/ethnicity; stigma; older adults

Population projections predict that the number of older adults with mental illness will climb in the next 20 years. It is estimated that by 2030, 1 in 5 older adults – over 15 million persons – will have a mood, anxiety, or psychiatric disorder.[1,2] Despite this demographic

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trend, the stigma of having a mental illness appears to be getting worse, not better.[3] In particular older adults are more likely than younger adults to experience mental illness as stigmatizing, presenting an important barrier to accessing care.[4,5] Older adult mental health consumers from racial/ethnic minorities have reported experiencing a "triple stigma" consisting of being old, mentally ill, and from an ethnic minority.[5] However, little is known about racial/ethnic differences in stigma associated with mental illness among older adults. Since attitudes have shown to be a critical determinant of actual help-seeking behaviors,[6,7] research on stigmatizing attitudes may provide valuable information concerning how to design and implement effective interventions to reduce disparities in mental health care.

Most of the previous research regarding racial/ethnic minority adults' attitudes towards mental illness has focused on young adults with no history of mental illness, and the results have been inconsistent. Some studies suggest that African-Americans, Latinos and Asian-Americans tend to hold more stigmatizing perceptions of mentally ill individuals than non-Latino Whites.[8–11] Other studies have found no differences or more positive attitudes.[8,12–15] Ethnic/racial group sampling differences (i.e., foreign versus U.S. born, college students vs. U.S. population) may account for these inconsistencies.

Recent work by Conner et al.[16] has sought to compare stigmatizing attitudes held by older African-Americans with depression with those of depressed non-Latino White older adults. In this study, the authors found that older African-Americans were more likely to experience stigma about mental illness than their White counterparts.[16] To our knowledge, no similar studies have been conducted that include older mentally ill Asians or older mentally ill Latinos. The purpose of this study is to compare stigmatizing beliefs about mental illness among non-Latino Whites, African-Americans, Asian-Americans, and Latinos who are seeking treatment for a mental illness.

Theoretical Framework

Link and colleagues[17] posit that conceptions of mental illness are developed from family lore, personal experience, and peer relations. Racial/ethnic differences exist regarding the causes of mental illness.[18] Belief that mental illness is caused by the loss of family and friends, stress over money, cultural differences, family issues, and migration are quite common among older racial/ethnic minority adults.[18] Such misconceptions are likely to lead to negative attitudes towards mental illness and mental health services.[15,19]

The current study seeks to identify differences in attitudes toward mental health and mental health treatment among various racial/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 race/ethnicity is associated with differences in: (1) perceived stigma of mental illness; and (2) perceived stigma for different mental health treatment options. Although the present study is exploratory in nature, we hypothesize that African-Americans, Asian-Americans, and Latinos will endorse greater stigmatizing attitudes towards mental health and mental health treatment compared to Non-Latino Whites.

METHODS

The Primary Care Research in Substance Abuse and Mental Health for the Elderly (PRISM-E) is a multisite randomized trial that compared two specific interventions; an integrated care model and enhanced referral model[20,21] 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 an 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 were excluded if they failed to meet criteria for a target diagnosis, had incomplete data, or had hypomania or psychosis.

Six thousand, four hundred thirty patients screened positive for one of the three target conditions (depression, anxiety, or at-risk alcohol use). Of these, 3,225 refused to participate in the baseline assessment interview. There were minor differences between those accepting and refusing participation. Those who chose not to participate were more likely to be Caucasian males with lower mean General Health Questionnaire score (indicating less severe distress); and more reported drinks per week.[22] 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.[23] 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. Of those who screened eligible for the PRISM-E study, only those participants who completed the SAMHSA Mental Health and Alcohol Abuse Stigma Assessment measure at baseline (prior to participation in any of the interventions being evaluated) were included in these analyses (N = 2198). The final sample consisted of 1247 Whites, 536 African-Americans, 112 Asian-Americans, and 303 Latinos were included in the analyses. Interviews were conducted in Spanish and Chinese (Mandarin and Cantonese) to accommodate those participants that did not speak English.

Measures

Of the various 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).

SAMHSA Mental Health and Alcohol Abuse Stigma Assessment—In order to measure stigmatizing attitudes towards mental illness and mental health treatment, a measure was developed by a workgroup consisting of investigators in the PRISM-E study with expertise in mental health services for racial/ethnic minorities. Each item was developed and reviewed using a consensus process. The final questionnaire consisted of the following questions rated on a 5-point Likert scale ranging from 1 (Not at all) to 5

(Extremely): (1) “Would you be embarrassed or ashamed if you had a mental health problem?” (2) “Would you be embarrassed or ashamed if you had an alcohol abuse problem?” (3) “Do you think people around you would think differently of you if received mental health or alcohol abuse treatment?” (4) “Would it be difficult for you to start mental health or alcohol abuse treatment if other people knew that you were going to be in treatment?” (5) How comfortable would you be talking about your mental health or alcohol abuse problems with your primary care doctor?” (6) How comfortable would you be talking about your mental health or alcohol abuse problems with a counselor or mental health professional?” (7) “Would it be difficult for you to obtain treatment for a mental health or alcohol abuse problem in a setting that was clearly identified as a mental health clinic or alcohol treatment center?”

No psychometric information for this questionnaire is available. However, it has been used in a previous study. Chen and colleagues[24] used the first item in a regression predicting satisfaction with mental health services provided as part of the PRISM-E study. The item was found to be associated with satisfaction, with those participants indicating higher levels of stigma feeling less satisfied with the mental health services that were provided to them. The measure was translated into Spanish and Chinese. The authors went through a translation and back translation process to ensure the linguistic validity.

Statistical Analyses

Racial/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. Racial/ethnic group differences on sociodemographic variables were tested using a one-way analysis of variance (ANOVA) for continuous variables and χ^2 analyses for categorical variables. For the “Years in the US” variable, a Fisher’s exact test was used since there were too many cells with expected frequencies less than 5 to make a χ^2 feasible.

For the main outcomes, χ^2 comparisons were used to answer each of the seven questions in the Mental Health and Alcohol Abuse Stigma Assessment questionnaire. Responses on the 5-point Likert scale were dichotomized in order to illustrate strong feelings of perceived stigma. The first variable contained all the responses ranging from “1=Not at all” to “3=Somewhat”. The second variable contained all the responses ranging from “4=Very” to “5=Extremely.” Since the Whites were the referent group, their responses were compared with those of each racial/ethnic minority group. Missing data were imputed using mean estimates.

RESULTS

Sociodemographic and Immigration Characteristics

Table 1 shows the sociodemographic and immigration characteristics among White, African-American, Asian-American, and Latino 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 Whites. The majority of Asian-Americans and Latinos reported living in the U.S. 10 years or longer. African-Americans, Asians, and Latinos had significantly greater rates of depression than Whites. Rates of anxiety did not differ by ethnicity. Whites exhibited greater rates of at-risk drinking compared to the other ethnic groups. African-Americans had significantly greater rates of dual diagnosis than Whites.

Perceived Stigma

No significant differences in shame or embarrassment in having a mental illness were observed between African-Americans and non-Latino Whites. A significantly greater proportion of African-Americans expressed comfort in discussing mental health problems with their primary care physicians (PCPs; 85.3%) and mental health professionals (83.2 %) than non-Latino Whites (73.1% and 66.1%, respectively). A significantly greater proportion of Asian-Americans felt shame or embarrassment with regard to having a mental illness (25.9%) compared to non-Latino Whites (15.3%). They also stated having greater difficulty engaging in mental health treatment if others knew (16.9% vs. 8.3%), less comfort in speaking with their PCPs (50% vs. 73.1%) about mental health issues, and greater difficulty seeking mental health treatment in specialty mental health settings (23.2% vs. 12.9%). Latinos expressed greater shame or embarrassment of having a mental illness (40.3% vs. 15.3%) or alcohol abuse problem (47.5% vs. 34.8%) than non-Latino Whites. A greater proportion of Latinos (38.6%) than non-Latino Whites (13.7%) felt that people would think differently of them if they sought mental health treatment. Latinos expressed a greater amount of comfort in discussing mental health problems with their PCPS (85.1%) and mental health professionals (87.8%) than non-Latino Whites (73.1% and 66.1%, respectively). Details are presented in Table 2.

DISCUSSION

The results of this study confirm that there are racial/ethnic differences among older adults with mental illness with respect to stigmatizing attitudes towards mental illness and mental health treatment. We found that African-Americans, Asian-Americans, and Latinos had differing levels of perceived stigma when compared to Whites. This study adds to the small, yet growing literature of racial/ethnic differences in stigmatizing attitudes in older adulthood.

Contrary to our hypothesis, we found no significant difference in feeling shame or embarrassment over having a mental illness between African-Americans and non-Latino Whites. This is in contrast to a prior study that found that older African-Americans were more likely to experience stigma about mental illness than their White counterparts.[16] The reason for this difference may be due to contrasting sampling methods. Conner and colleagues[16] administered a telephone-based survey to a representative sample of older, depressed African-Americans and non-Latino Whites. Less than 16% of this sample was in treatment at the time of the survey.[14] In contrast, the African-Americans in this study were older primary care patients who consented to be in a research study in which they were randomized to integrated mental health treatment or referral to specialty mental health care. Hence, these participants may not be representative of older African-American adults who are reluctant or unwilling to accept mental health services.

Consistent with previous studies was our finding that African-Americans expressed a significantly greater amount of comfort in discussing mental health problems with their mental health professionals than non-Latino Whites. Prior research has shown that compared to non-Latino Whites, African-Americans are more likely to believe that antidepressants are addictive and not an effective treatment for mental illness.[15,16] As a result, African-Americans have shown a preference for counseling over medications.[15,25] In addition, older African-Americans, who accessed mental health services were more likely than their non-Latino White counterparts to seek outpatient care that did not include psychotropic medications.[26]

Supporting our hypothesis were the results that Asian-Americans compared to non-Latino whites expressed greater shame or embarrassment with regard to having a mental illness or

alcohol abuse problem, greater difficulty engaging in mental health treatment if others knew, more discomfort in speaking with their PCPs about mental health issues, and greater difficulty seeking mental health treatment in specialty mental health settings. These findings reflect cultural norms and attitudes related to family expectations and mental illness.[27] In many Asian societies, a strong emphasis is placed on saving face and bringing honor to the family. Thus, a great deal of stigmatization has been attached to mental illness.[28–31] Mental illness is not perceived as a personal matter but as a threat to the harmony of the family, and having a family member with a mental illness brings shame, embarrassment, and disappointment to the family.[28,29,31]

As predicted, Latinos expressed greater shame or embarrassment of having a mental illness or alcohol abuse problem. These findings may also be reflective of cultural norms and attitudes towards mental illness. This is consistent with previous research that has shown that older Latinos see depression as a sign of personal weakness and are concerned about family disappointment.[19] The shame and embarrassment Latinos expressed in this study may be related to the sense of obligation and responsibility they feel towards their families.[19] They may fear that acknowledging that they have a mental illness would disappoint the family and place undue burden upon them.

Despite endorsing high levels of negative attitudes towards having a mental illness, Latinos expressed a greater amount of comfort in discussing their mental health problems with their PCPs and mental health professionals. Previous studies regarding Latinos' attitudes towards mental health treatment are inconsistent. Some studies suggest that Latino adults tend to be averse to taking antidepressant medications when compared to Whites.[15,25] However, a recent study focusing on older Latinos found that older Latinos were accepting of modern medical practices[30] and held positive perceptions of mental health treatment.[15,25,32] Given that this was a treatment seeking sample, these results are consistent with a recent study that found that once older Latinos accessed mental health care, they were more likely to receive outpatient mental health care plus medications.[26]

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 older primary care patients with a diagnosis of depression, anxiety disorder, or at-risk alcohol use. As such, the results do not necessarily apply to community residing older adults with other mental health disorders of varying severity levels (e.g. schizophrenia), or individuals who do not have primary health care providers.

Second, participants had all consented to be in a study in which they were willing to be randomized to two different models of mental health treatment, consisting of either integrated or referral substance abuse or mental health services. These participants may differ with respect to perceived stigma related to engaging in mental health treatment compared to those individuals who declined to participate. As such, it is possible that results based on this study sample may not generalize to the population at large. It is important to note that the sample primary PRISM-E study (2,244 participants) had relatively minor differences when compared to the larger primary care population represented by 24,930 outpatients screened. Those who chose not to participate were more likely to be non-Latino White, male, had less severe psychological distress, (a lower mean General Health Questionnaire score); and more reported drinks per week.[22] Since the measure was translated into Spanish and Chinese, it is likely that our results are representative of older Latino and Chinese primary care patients. However, the results are less likely to apply to older, non English speaking primary care patients from other Asian ethnicities.

Third, the Latinos and Asian-Americans in this study were treated as homogeneous groups, when they actually comprise different subgroups of varying nationalities. 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.

Fourth, levels of formal education vary by ethnicity in this sample and could be a potential confounder since education level has been shown to influence attitudes towards mental health services in ethnic minority adults.[33] Finally, the stigma assessment measure used in this study was developed by the investigators and has not been validated. The measurement of perceived stigma is a complex task, thereby making it difficult to establish the validity of any assessment that attempts to capture this construct.[34]

While these results should be viewed with some caution, they suggest potential directions for further inquiry. Cross ethnic comparisons of stigmatizing attitudes may help to identify culturally tailored and culturally appropriate approaches to overcoming barriers for engaging older adults in treatment for mental health disorders and help inform efforts such as “anti-stigma campaigns” designed to provide information, education and referrals. These analyses could help determine to what extent stigmatizing attitudes have on mental health service use disparities. Moreover, examining to what extent acculturation level mediates stigmatizing beliefs is another potential direction for future research. As racial/ethnic minority groups become more acculturated to the mainstream, would the effect of cultural norms and attitudes towards mental illness more or less pronounced?

In summary, results from this racial/ethnic comparison of stigmatizing attitudes towards mental illness in older adults could help researchers to provide culturally specific content for psychoeducational materials. Our findings also suggest that interventions designed to reduce stigma towards mental illness and mental health services should potentially address misconceptions and cultural beliefs. By addressing the specific concerns of each racial/ethnic group highlighted in this study, researchers may be able to better identify and implement culturally appropriate interventions aimed at engaging and maintaining older racial/ethnic minority adults in mental health care.

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Table 1

Sociodemographic Characteristics

Sociodemographic Variables	Ethnicity								Significant Difference	
	Non-Latino White (n = 1247)		African-American (n = 536)		Asian-American (n = 112)		Latino (n = 303)			
	M	SD	M	SD	M	SD	M	SD	F	p
Age	74.1	6.2	72.9	6.0	70.5*	5.0	72.7	5.8	17.2	<.01
	N	%	N	%	N	%	N	%	χ^2	p
Years of Education[a]									777.3	<.01
Less than 8th grade	73	5.9%	111	20.7%*	60	53.6%*	204	67.3%*		
Less than 12th grade	262	21.0%	183	34.1%*	14	12.5%*	30	9.9%*		
High School Graduate/GED	339	27.2%	119	22.2%	13	11.6%*	32	10.5%*		
Some College	300	24.1%	94	17.5%*	2	1.8%*	24	7.9%*		
College Graduate	144	11.5%	17	3.2%*	21	18.8%	8	2.6%*		
Graduate School	120	9.6%	11	2.1%*	2	1.8%*	4	1.3%*		
Marital Status									177.8	<.01
Married	732	58.7%	190	35.4%*	75	67%*	108	35.6%*		
Separated	22	1.8%	53	9.9%*	2	1.8%	36	11.9%*		
Divorced	168	13.5%	104	19.4%	4	3.6%*	52	17.2%		
Widowed	262	21.0%	149	27.8%	29	25.9%	84	27.7%		
Never Married	61	4.9%	39	7.3%	2	1.8%	21	6.9%		
Place of Birth[b]									1673.3	<.01
US	1188	95.3%	533	99.4%	3	2.7%*	29	9.6%*		
Outside US	52	4.2%	3	0.6%	106	94.6%*	274	90.4%*		
Years in the US									81.7	<.01
Less than 1 year	0	0%	0	0%	0	0%	3	.01%		
1–5 years	0	0%	0	0%	18	16.1%*	7	2.3%*		

Sociodemographic Variables	Ethnicity								Significant Difference	
	Non-Latino White (n = 1247)		African-American (n = 536)		Asian-American (n = 112)		Latino (n = 303)			
	M	SD	M	SD	M	SD	M	SD	F	p
6–9 years	2	.16%	0	0%	26	23.2%*	8	2.6%*		
10+ years	48	3.8%	3	.56%	63	56.3%*	235	77.6%*		
Psychiatric Illness[c]										
Depression	825	66.2%	433	80.8%*	105	93.8%*	286	94.4%*	143.5	<.01
Anxiety Disorder	325	26.1%	132	24.6%	29	25.9%	64	21.1%	3.5	.48
At-risk Drinking	458	36.7%	142	26.5%*	4	3.6%*	20	6.6%*	148.7	<.01
Dual Diagnosis[d]	88	7.1%	49	9.1%*	3	2.7%	7	2.3%*	19.1	<.01

Notes: Differences in age (df = 3, 2194) were calculated using ANOVA. Differences in years of education (df = 15), marital status (df = 12), place of birth (df = 3), and rates of psychiatric illness (df = 9) were calculated using χ^2 test. Differences in years in the United States (df = 9) were calculated using Fisher's exact test. SD: standard deviation; US: United States; GED: General Education Development

[a] 11 participants (9 Whites, 1 African-American, 1 Latino) did not report their years of formal education.

[b] 10 participants (7 Whites, 3 Asian-Americans) did not report their birth country.

[c] Totals may not add up to 100% since diagnostic categories were not mutually exclusive.

[d] Dual Diagnosis is defined as diagnosis of at risk drinking + diagnosis of depression and/or anxiety.

* Signifies difference with Non-Latino Whites

Table 2

Perceived Stigma by Race/Ethnicity

Item		Percentage endorsing very or extremely				Significant Difference	
		White (N = 1247)	African-American (N = 536)	Asian-American (N = 112)	Latino (N = 303)		
		% (n)	% (n)	% (n)	% (n)	χ^2	p
Perceived Stigma							
	Q.1 Shame or embarrassment if you had mental illness	15.3% (191)	12.9% (69)	25.9% (29) *	40.3% (122) *	117.9	<.01
	Q.2 Shame or embarrassment if you had alcohol abuse	34.8% (434)	33.2% (178)	19.6% (22) *	47.5% (144) *	33.0	<.01
	Q.3 People think differently of you if you sought m.h. treatment	13.7% (171)	15.1% (81)	18.8% (21)	38.6% (117) *	106.9	<.01
	Q.4 Difficulty starting m.h. treatment if others knew	8.3% (103)	8.6% (46)	16.9% (19) *	9.9% (30)	9.9	.02
	Q.5 Comfort talking about m.h. problems with PCP	73.1% (911)	85.3% (457) *	50% (56) *	85.1% (258) *	87.5	<.01
	Q.6 Comfort talking about m.h. problems with m.h. professional	66.1% (824)	83.2% (446) *	70.5% (79)	87.8% (266) *	93.4	<.01
	Q.7 Difficulty seeking treatment in specialty m.h. setting	12.9% (161)	10.5% (56)	23.2% (26) *	10.6% (32)	15.0	<.01

χ^2 test was used to detect differences in response patterns. df = 3.

* Signifies difference with Non-Latino Whites