Chapter

ETHNIC DIFFERENCES IN ATTITUDES TOWARDS SEEKING HELP FOR MENTAL HEALTH PROBLEMS


Submitted as a brief report
ABSTRACT

Insight into culturally specific barriers to mental health care use is important to improve accessibility. This population-based survey among non-western (i.e. Turkish and Moroccan) migrants and ethnic Dutch respondents (N = 613) focused on attitudinal differences towards self-reliance and (in)formal help in relation to common mental disorders. Overall, patterns in attitudes towards informal help for mental health care were similar as those found in collectivistic groups in the U.S., in that Moroccan and Turkish respondents were more positive about self-reliance, and displayed more positive attitudes regarding help from family than ethnic Dutch. However, attitudes towards formal types of care were similar across all groups. What is more, there were differences between Moroccan and Turkish respondents (e.g. Moroccan ethnicity was associated with a more negative attitude against sharing problems with friends compared with Turkish). Strikingly, in none of the analyses were attitudes related with actual mental health care utilization.
**INTRODUCTION**

Ethnic minority groups tend to have different help seeking patterns for anxiety and depression compared to members of the ethnic majority population [1]. Given the burden of disease of these common mental disorders (CMD) in the general population, it is important to study factors that may help explain such disparities.

Among possible explaining factors are insufficient trust in formal mental health services, and greater reliance on informal social support (e.g. family). These characteristics are often attributed to the individualistic-collectivistic backgrounds of ethnic groups, which refers to the subjective priority given to individuals’ preferences versus the preference for collective needs and norms [2]. Collectivistic groups preferably avoid contact or interaction with members outside their group, guided by the fear that communication of sensitive information may bring shame to family or community members [2].

Support for such attitudes acting as barriers to mental health care is provided by various studies from the U.S. among groups with collectivistic orientations [3,4]. Yet, these studies have limited generalisability to health care settings in Western Europe, where most immigrant groups have different ethnic and cultural backgrounds. What is more, some studies have indicated that there are differences between collectivistic groups in the extent to which (in)formal mental health services are relied upon [5,6]. This study investigated attitudes towards self-reliance and (in)formal help seeking for mental health problems as possible barriers to mental health care among Turkish, Moroccan and ethnic Dutch respondents in the Netherlands.

**METHODS**

Subjects were sampled in two stages. The first stage consisted of the Amsterdam Health Monitor (AHM) of 2004. This general health survey among the population of Amsterdam was based on a representative sample (N = 4000) from the population register, stratified for age (18-34 years, 35-44 years, 45-54 years, 55-64 years and 65 years and older) and ethnicity. The overall response rate was 45%. The AHM 2004 was followed-up by a second phase, conducted in 2005, specifically
aimed at mental health. For the present study, data were available from 613 ethnic Dutch, Turkish and Moroccan respondents. Elaborate information about both data collection stages and the study sample can be found elsewhere [7].

**Measures**

A short list of five items was used to measure attitude towards mental health care. The items were previously applied in the Netherlands Study of Depression and Anxiety (NESDA) [8]. The items, rated on 5 point scales (with extremes labeled as ‘totally disagree’ and ‘totally agree’), are depicted in **table 1**. Since the items do not form a scale they were taken into analysis separately.

Demographics included ethnic background, age and gender. Ethnic background was defined on the basis of country of birth. Respondents had an ethnic Dutch background if they and both their parents were born in the Netherlands. For this study we selected only first-generation migrants, meaning that all ethnic Turkish and Moroccan respondents were born in Turkey or Morocco themselves (equaling >90% of the migrant population in our sample). Two indicators of SES were applied, i.e. level of education (no education or only primary school vs. higher than primary school) and type of health insurance (public vs. private). Until January 2006 people with an income below a certain level had public health insurances. Moreover, everybody in the Netherlands is legally obliged to be medically insured.

Presence of an anxiety disorder and/or depressive disorder in the past six months was established with the CIDI version 2.1, which has been translated into Dutch, Turkish and Arabic [9]. For the interview with Moroccan participants, the Dutch questionnaire was used in combination with core themes from the Arabic version. Additionally, psychological distress was measured with the Kessler psychological distress scale (K10) [10,11]. Mental health care utilization was measured with the Trimbos/iMTA questionnaire for Costs associated with Psychiatric Illness [12]. Mental health care utilization was defined as at least one contact with primary care services for mental health problems, or at least one visit to specialised mental health services during six months preceding the interview.

**Analyses**

Multivariate linear regression analyses were conducted, with the items measuring attitudes towards mental health care serving as outcome measures. Beta’s were reported with standard errors, and subsequently corrected for age, gender, SES, prevalence of
anxiety and/or depressive disorder, current psychological distress, and recent uptake of formal services for mental health problems. Differences between Turkish and Moroccan respondents were reported as well. All analyses were done in SPSS version 17.

RESULTS

Among Moroccan respondents there were significantly more male subjects than in the Turkish and ethnic Dutch subgroups (Chi2 = 7.871, df. = 2, p = 0.020). Turkish and Moroccan migrants were significantly younger than ethnic Dutch subjects (F = 17.338, df. = 2, p < 0.001), had lower educational levels (Chi2 = 75.633, df. = 2, p < 0.001), and more often had public insurances (Chi2 = 47.775, df. = 2, p < 0.001), which is an indicator of lower income levels. Turkish respondents more often met the criteria for a DSM-IV mood and/or anxiety disorder (Chi2 = 27.096, df. = 2, p < 0.001). Both migrant groups reported higher levels of psychological distress (F = 30.881, df. = 2, p < 0.001). Concordantly, there was higher uptake of health services among migrants (Chi2 = 75.633, df. = 2, p < 0.001).

Migrant respondents held more positive attitudes towards keeping mental health problems to themselves (table 1, item 1, model 1), and Turkish respondents held more positive attitudes towards self-reliance than Moroccans (Beta = 0.729, SE = 0.120). Differences between Turkish and Moroccan respondents were partially explained by SES; a higher education was associated with a more positive attitude (Beta = 0.272, SE = 0.099). More distress was associated with a more positive opinion as well (Beta = 0.026, SE = 0.007). Migrant respondents were more likely to agree that it is better to discuss mental problems with family first (table 1, item 2, model 1). Differences remained after inclusion of the confounding variables. Moroccan respondents held more negative views with respect to the statement that it is better to discuss mental problems with friends first (table 1, item 3, model 1). In that respect they also differed from Turkish respondents, since Moroccans had more negative attitudes than Turkish as well (Beta = -0.427, SE = 0.135). Although differences between Moroccans and ethnic Dutch decreased after inclusion of the confounding variables, they did not disappear. There were no significant ethnic differences regarding item 4 or item 5, which were focused at professional help for mental health problems. Attitudes in items 4 and 5 were unrelated to the confounding variables. In none of the analyses presented here was there a relation between attitudes and recent uptake of mental health care services.
Table 1. Ethnic differences in attitudes towards mental health care, based on linear regression

<table>
<thead>
<tr>
<th>Model</th>
<th>Morocco (N=143)</th>
<th>Turkey (N = 167)</th>
<th>F-change (df.1,df.2)</th>
<th>sign. F-change</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Beta (SE)</td>
<td>Beta (SE)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. “It is better to keep mental health problems to yourself”</td>
<td>0.280 (0.108)</td>
<td>1.010 (0.103)</td>
<td>30.04 (4, 608)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Model 1</td>
<td>0.051 (0.117)</td>
<td>0.742 (0.114)</td>
<td>6.20 (5, 603)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Model 2</td>
<td>0.753 (0.110)</td>
<td>0.887 (0.104)</td>
<td>24.913 (4, 608)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>2. “It is better to discuss mental health problems with family first”</td>
<td>0.720 (0.121)</td>
<td>0.889 (0.117)</td>
<td>1.173 (5, 603)</td>
<td>0.321</td>
</tr>
<tr>
<td>Model 1</td>
<td>-0.434 (0.122)</td>
<td>-0.007 (0.117)</td>
<td>3.949 (4, 608)</td>
<td>0.004</td>
</tr>
<tr>
<td>Model 2</td>
<td>-0.357 (0.135)</td>
<td>-0.085 (0.131)</td>
<td>1.480 (5, 603)</td>
<td>0.194</td>
</tr>
<tr>
<td>3. “It is better to discuss mental health problems with friends first”</td>
<td>0.022 (0.098)</td>
<td>0.133 (0.093)</td>
<td>1.244 (4, 608)</td>
<td>0.291</td>
</tr>
<tr>
<td>Model 1</td>
<td>-0.010 (0.108)</td>
<td>0.157 (0.105)</td>
<td>1.062 (5, 603)</td>
<td>0.381</td>
</tr>
<tr>
<td>Model 2</td>
<td>-0.076 (0.110)</td>
<td>-0.065 (0.110)</td>
<td>1.071 (4, 608)</td>
<td>0.370</td>
</tr>
<tr>
<td>5. “People are better capable of addressing problems if supported by a psychologist/ psychiatrist”</td>
<td>-0.023 (0.120)</td>
<td>0.005 (0.120)</td>
<td>0.944 (5, 603)</td>
<td>0.452</td>
</tr>
</tbody>
</table>

1 positive associations indicate more positive attitudes
2 ethnic Dutch are the reference group
Model 1 = corrected for gender, age
Model 2 = additionally corrected for SES, presence of depressive and/or anxiety disorder, psychological distress, and recent uptake of mental health services
Although the preference to keep mental health problems to oneself is not exactly the same as that person being self-reliant, these results support the idea that self-reliance may be an important barrier for subjects with collectivistic backgrounds than for those with individualistic backgrounds. This is similar to previous studies from the U.S. Yet, attitudes towards formal types of care were similar across all ethnic groups, including ethnic Dutch. Moreover, attitudes were not associated with actual uptake of mental health care.

Judging from this, differences in attitudes may be less important in explaining ethnic differences in mental health care utilization, but may still be important in other aspects of health care utilization. For example, a negative attitude towards formal services (‘thought it was not helping’) has been found to be among the most important reasons for dropping out of care [13]. Alternatively, it should be acknowledged that what people report to be their attitude does not necessarily reflect what their actual behavior will be. Concepts like ‘subjective norm’ and ‘self-efficacy’, are important as well [14]. Moreover, in the setting of health services utilization by migrants there are numerous other barriers imaginable than attitude alone [15].

The results also indicated differences between the non-western groups, in that Turkish respondents held more positive attitudes towards self-reliance than Moroccans, while Moroccan respondents were more disapproving of sharing mental health problems with friends than Turkish respondents. An explanation for this finding is not readily available, but may be found in cultural differences between both non-western groups. For example, first-generation Moroccan migrants are mainly Berbers, an ethnic population from rural Morocco. In Berber communities, the boundary of the collective is typically defined by the extended family, and outsiders are those who do not (or no longer) belong to the family or tribe. Conversely, stronger social cohesion of the Turkish community in the Netherlands is reflected in the high membership of Turkish inhabitants in cultural, religious and sports organizations. As a consequence, the Turkish collective may be defined differently than the Moroccan collective, as a result of which people are considered to be outsiders or friends on different conditions. Other explanations, such as differences in acculturation, should be explored as well.
A limitation of the present study is the cross-sectional design of the study, so that the direction of the associations remains largely unclear. In addition, there is a lack of information about cross-cultural validity of the instrument measuring attitude towards mental health services. For example, acquiescent responding (‘a tendency to agree with questions regardless of item content’) has been positively associated with collectivism [16].

In summary, this study among non-western ethnic minority groups and an ethnic Dutch population in the Netherlands revealed patterns in attitudes towards informal help for mental health problems that were similar as those found in the U.S. However, attitudes towards formal types of care were similar across all groups. What is more, there were differences between Moroccan and Turkish respondents. Strikingly, in none of the analyses were attitudes related with actual mental health care utilization.
REFERENCES


