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Ethnic differences in the perception of barriers to help-seeking

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Summary. This paper explores differences among ethnic groups in their perception of barriers to help-seeking. Data for this analysis were drawn from a Hawaii statewide survey conducted in 1984. A total of 2503 adult residents were interviewed. Four ethnic groups were selected for study in this particular analysis: Caucasian, Filipino, Japanese and Native Hawaiian. The major dependent variable was the perception of barriers for two distinct types of problems: alcoholism and severe emotional problems. Caucasians perceived less barriers for both types of problems than the three minority ethnic groups. A logistic regression analysis found that this ethnic difference held when controlled for other demographic variables. Additional analyses were conducted to determine the types of barriers perceived for each problem by the ethnic groups.

Mental health services planners are increasingly turning their attention to the development of services for geographic catchment areas like counties and cities. These efforts are motivated to a large extent by an interest in developing continuums of care, increasing linkages among service providers, and minimizing costs (Mechanic 1980). A by-product of these efforts is frequently the development of a uniform set of procedures for all organizations and individuals providing services. Given the heterogeneity of many of our communities, this strategy may cause organizations and providers to ignore cultural and social factors that affect both the presentation of problems and the acceptability of alternative treatment strategies (Higginbotham 1984; Kleinman and Good 1985; Leighton and Murphy 1959; Marsella 1982, 1985, 1987; Marsella et al. 1985; Rogler et al. 1987; Triandis and Draguns 1980). Since continued Asian and Hispanic immigration to the United States is likely to result in continued diversity, more attention needs to be paid to the plans for delivering services to minority populations.

Cultural and social factors affecting service use warrant continued study because ethnic minorities make less use of mental health services than others and are less likely to stay in treatment when contact is initiated (Hough et al. 1987; Liu and Yu 1985; Special Populations Task Force of the President's Commission on Mental Health 1978; Sue 1977). Perceptions of barriers to the use of mental health care are important inhibiting factors which may disproportionately deter or delay certain ethnic minorities from seeking professional help (Leaf et al. 1986). Little is actually known about which minorities perceive more barriers or different barriers than whites. This is due in part to the small numbers of minorities, especially Asians and Pacific Islanders, included in most previous studies (Liu and Yu 1985).

In this paper we identify differences between ethnic groups in their propensity to seek professional help for two types of problems (alcoholism and severe emotional problems) controlled for age, gender, income, marital status, and education. Past studies have typically focused on overall attitudes towards service use assuming that attitudes towards mental health services were consistent across types of services (Broman 1987). However, differences in the perception of barriers may depend upon the type of problem for which services are sought.

Methods

Data for this analysis were drawn from a Hawaii statewide survey conducted in 1984. The survey sample consists of adult residents from each of the major islands in Hawaii. A two-stage cluster sam-

pling design was implemented within each of the state's eight mental health catchment areas. The first stage involved the random selection of 60 primary sampling units which were census blocks or census enumeration districts. The second sampling stage involved the selection of clusters of five households within the primary sampling unit. A minimum of 300 households were selected per catchment area and one individual per household was interviewed. Individuals within the household who were 18 years old and over were randomly selected for inclusion in the sample. A total of 2503 interviews were completed using this procedure. The survey interview focused on alcohol and drug usage, mental health problems, well-being, and other psychosocial variables (e.g., critical life events, life satisfaction, perceptions of family and work environments, social support).

This data set encompasses a relatively small geographic area with a diverse number of ethnic groups making it useful to study ethnic differences in mental health status and service utilization. This data set also includes relatively large samples of Asian Americans and Native Hawaiians. The ethnicity of respondents was determined by a self-report measure based on parental ethnic background. Four ethnic groups were selected for study in this analysis: Caucasian, Filipino, Japanese and Native Hawaiian. Other ethnic groups such as the Chinese and Koreans had sample sizes too small to conduct some of the analyses for this paper.

Caucasians are the largest ethnic group in Hawaii (25%), but they do not constitute a majority population in Hawaii. By most standards, however, they are considered the dominant group because of their social, historical, and political influence in Hawaii's history (Kent 1983). Their general orientation reflects Western values and customs.

The Japanese are the second largest ethnic group in the state comprising approximately 23% of the state population. The Japanese were first brought to Hawaii to work on the sugar plantations in 1868. Despite a history of discrimination, the Japanese have achieved a high level of political and economic power in Hawaii. They have a high median annual income and exceed the average percent in executive and professional occupations.

The Native Hawaiians are the indigenous group in the state and comprise about 19% of the state's population. Historically, the Native Hawaiians have experienced many of the social, economic, and political hardships that other Native Americans have faced. They are among the lowest in income, educational attainment, and occupational status.

The Filipinos were the last group of plantation laborers to arrive in Hawaii and are the largest ethnic group still migrating to Hawaii. Currently, the Filipinos comprise the fourth largest ethnic group in the state (12%). The Filipinos are well below the average in income and percent in professional occupations.

Table 1. Sociodemographic variables of the Hawaii epidemiological survey, 1984

Variable	Unweighted No.	Weighted %
Sex		
Male	1078	45
Female	1412	55
Age		
18-24	330	14
25-44	1076	44
45-64	693	29
65+	308	13
Ethnic background		
Caucasian	713	29
Filipino	285	10
Japanese	540	24
Native Hawaiian	472	17
Other	499	21
Household income		
$5,000 or less	201	8
5,001-10,000	338	13
10,001-20,000	570	23
20,001-35,000	721	30
35,001-50,000	289	13
50,001+	259	12
Education		
0-8th grade	304	12
9-11th grade	253	10
12th grade	936	37
13-15th grade	482	18
16th+	527	24
Marital status		
Married	1632	64
Not married	861	36

The major dependent variable in this study is the perception of barriers for two distinct types of problems: alcoholism and severe emotional problem. The respondents were asked if they perceived barriers for a personal alcohol problem/alcoholism or severe emotional problem which would prevent them from seeking professional help.

Results

The data were weighted to reflect the original sampling strategy and to provide appropriate estimates for geographic areas included in this study. Table 1 displays the unweighted sample totals and the weighted percentages for selected demographic

variables in our sample. In this study, (a) women outnumbered men, (b) the modal age category was 25-44, (c) Caucasians, Filipinos, Japanese and Native Hawaiians comprised 80% of the weighted sample, (d) a majority of the sample had a household income over $20,000 and (e) over 75% of the sample completed at least 12 years of schooling.

Table 2 displays the percentage of each ethnic group perceiving a barrier to help-seeking for an alcohol or emotional problem. The analysis will concentrate on the four major ethnic groups; other ethnic groups were excluded from the remainder of the analyses. The percentage of respondents reporting a barrier for alcohol treatment ranged from 33% for Caucasians to 56% for Filipinos (chi square = 51.903, $P < 0.001$). Paired comparisons in proportions between ethnic groups (not reported here) revealed differences between Caucasians and non-Caucasians. Caucasians were significantly less likely to perceive a barrier to help-seeking for a personal alcohol problem than other ethnic groups. Among ethnic minorities, Filipinos had a statistically higher percentage who perceived a barrier for alcohol use than the Japanese and Native Hawaiians.

While statistically significant ethnic group differences also existed with regard to a personal emotional problem (chi square = 32.651, $P < 0.001$), the differences between ethnic groups were less pronounced. Again, paired comparisons revealed that statistically significant differences existed between Caucasians and non-Caucasians. Caucasians still had the lowest percent who perceived barriers to help-seeking, but the difference between Caucasians and Native Hawaiians and Japanese for an emotional problem were not as large compared to an alcohol problem. Filipinos had the highest percent who perceived a barrier for an emotional problem (54%). This percentage was statistically higher than the percentages for the other three ethnic groups.

We also examined whether the proportion anticipating a barrier for an emotional and alcohol related problem differed within ethnic groups. Caucasians and Filipinos had the same proportion who perceived a barrier for an emotional and alcohol problem. Significantly more Japanese and Native Hawaiians perceived barriers for an alcohol problem than for an emotional problem.

A related analysis was conducted to determine whether the ethnic groups perceived alcohol and emotional barriers as the same phenomenon. Table 3 displays Goodman and Kruskal's lambda with alcohol and emotional barriers as dependent variables. Lambda is a measure of association based on the proportional reduction in error when the value of the independent variable is used to predict values of the dependent variable (Goodman and Kruskal 1954).

Table 2. Perceptions of barriers by ethnic group

Type of problem	% Perceiving a barrier to seeking help:			
	Caucasian	Filipino	Japanese	Native Hawaiian
Personal alcohol problem	33.25	55.51	46.78	48.42[b]
Personal emotional problem	32.07	54.04	39.87	41.44[a]

[a] chi square = 51.903, df = 3, $P < 0.001$
[b] chi square = 32.651, df = 3, $P < 0.001$

Table 3. Measure of association (lambda) between the perception alcohol barriers and the perception of emotional barriers

Type of problem	Caucasian	Filipino	Japanese	Native Hawaiian
With emotional barriers as dependent	0.47	0.72	0.55	0.52
With alcohol barriers as dependent	0.49	0.70	0.61	0.59

Filipinos had the highest association between variables regardless of which variable is used as the dependent variable, Caucasians had the lowest associations, and Japanese and Native Hawaiians were in between. We interpret these data to indicate Filipinos tend to have a greater liklihood of perceiving barriers to both types of problems as similar than the other ethnic groups.

Before moving to determine whether the ethnic group differences can be explained by demographic differences among groups, the bivariate relationship between the control variables and perceived barriers is presented in Table 4. Neither gender nor marital status was related to perceived barriers for either problem. Significant differences in perceived barriers vary by income, education, and age. Lower income people generally perceived more barriers for both types of problems; people with lower educational backgrounds tended to perceive less barriers; young people (18-24) and the elderly (over 65) anticipated more barriers for both types of problems. These bivariate relationships were generally consistent with studies on the utilization of health and mental health services (Anderson and Aday 1978; Berki and Kobashigawa 1978; Greenley and Mechanic 1976; Huffine and Craig 1974; Kessler et al. 1981; Leaf and Bruce 1987; Mechanic 1975; Wells et al. 1986).

To determine if ethnic groups differed in the an-

Table 4. Bivariate relationship between perceived barriers and the control variables

Control variable	% Perceiving the barrier:	
	Alcohol problem	Emotional problem
Sex		
Male	44	41
Female	44	38
Household income		
$5,000 or less	60*	53*
5,001-10,000	43	41
10,001-20,000	48	43
20,001-35,000	45	41
35,001-50,000	38	31
50,001+	34	29
Education		
0-8th grade	51*	49*
9-11th grade	50	44
12th grade	46	41
13-15th grade	42	38
16th+	37	32
Marital status		
Married	45	42
Not married	44	38
Age		
18-24	54*	51*
25-44	43	39
45-64	39	33
65+	47	45

*$P<0.001$

Table 5. Perceived barriers: Logistic regression summary

Ethnic group	Beta	Adjusted odds ratio	95% Confidence interval	
			Upper limit	Lower limit
Alcohol problem				
Filipino	0.8486	2.336	3.237	1.686
Native Hawaiian	0.5945	1.812	2.373	1.384
Japanese	0.5977	1.818	2.383	1.419
Emotional problem				
Filipino	0.7533	2.124	2.948	1.531
Native Hawaiian	0.2749	1.316	1.731	1.001
Japanese	0.3147	1.370	1.762	1.065

Note: Caucasians are the comparison group. The logistic regression analysis controlled for age (18-24, 65 and older, others), income, education, marital status (married and unmarried), and gender

ticipation of barriers controlled for other variables, we conducted a logistic regression analysis. Logistic regression estimates the independent effects of different variables on a dichotomous variable. The dependent variable was the perception of barriers for a personal alcohol problem or a severe personal emotional problem (coded as: 0 = no barrier, 1 = anticipation of barriers). The ethnic variable was transformed into three dummy variables: Filipino, Japanese, and Native Hawaiian (coded as: 1 = yes, 0 = no). All of the control variables were entered into the logistic regression model even though there was no bivariate relationship between perceived barrier and marital status and gender.

Table 6. Perceived barriers by ethnic group among individuals perceiving at least one barrier

Barriers	% perceiving the barrier:			
	Caucasian	Filipino	Japanese	Native Hawaiian
Alcohol problem				
n	(238)	(137)	(274)	(207)
Awareness	15.88	33.15	24.26	23.48**
Inaccessible	5.50	4.01	3.06	2.22
Cost	9.08	7.60	4.81	12.27**
Shame (self)	48.75	42.74	53.32	48.93
Shame (others)	37.66	21.88	32.67	43.30*
Inappropriate problem	16.72	11.12	5.22	11.26*
Ethnic match	2.68	5.93	0.00	1.96*
Emotional problem				
n	(230)	(133)	(234)	(177)
Awareness	24.28	35.32	31.61	31.71
Inaccessible	3.22	1.53	2.88	3.96
Cost	20.49	11.52	8.77	16.94**
Shame (self)	35.05	32.35	32.54	37.37
Shame (others)	21.62	19.19	29.98	29.86**
Inappropriate problem	18.34	13.14	7.28	11.11**
Ethnic match	1.77	7.32	3.33	5.10

* $P<0.001$
** $P<0.05$

Table 5 presents the results of the logistic regression. All three ethnic dummy variables (Filipino, Japanese, and Native Hawaiian) showed an independent effect on the anticipation of a barrier for an alcohol problem; that is, they were different from Caucasians, the comparison group, controlling for education, income, gender, marital status, and age. Filipinos had the highest odds ratio (2.3:1): They are the ethnic group which is most different from Caucasians in terms of perceived barriers. The Native Hawaiians (1.8:1) and Japanese (1.8:1) were similar in their levels of perceived barriers vis-a-vis Caucasians.

Ethnic groups also differed in their perception of barriers to treatment for an emotional problem. All three ethnic groups were significantly different from Caucasians in the perception of barriers for an emotional problem controlled for the other demographic variables.

For the most part, then, we conclude that ethnic variations in the perceptions of barriers for an alcohol or emotional problem persisted even when controlled for education, income, age, gender, and martial status.

We now turn our attention to the types of barriers anticipated for each type of problem. Four major barriers have been identified as inhibiting service utilization: cost, availability, accessibility, and stigma (Cleary 1987). This paper explores these and other barriers which may inhibit help-seeking for alcohol and emotional problems among different ethnic groups. Respondents were asked to identify the barriers which would prevent them from seeking help for an alcohol or emotional problem. The barriers are categorized as structural or psychosocial. Structural barriers refer to perceived problems in the delivery of mental health services and include: (a) Awareness - "I don't know where to go," (b) Accessible - "Agency is too far away," (c) Cost - "Agency is too expensive," (d) Ethnic match - "Professionals from my own cultural or ethnic group not available." Psychosocial barriers refer to the perception of mental illness or alcoholism as a problem and include: (a) Personal shame - "I would be ashamed or embarrassed," (b) Group shame - "I would be ashamed or embarrassed if my family or friends knew," and (c) Inappropriate - "I don't think this problem can be helped by a professional." For the purposes of this analysis, we define "personal shame" as an experience of discomfort generally associated with the violation of an individual's sense of self and "group shame" as an experience of discomfort associated with the violation of social norms or expectations. These definitions are modified from Marsella et al. (1974).

Table 6 displays the perceived barriers to help-seeking for each ethnic group. This analysis is limited to people who reported a barrier to utilization. The barriers of awareness, cost, group shame, inappropriate problem, and ethnic match were statistically significant between ethnic groups in seeking help for an alcohol problem. No significant ethnic difference was found in personal shame, but the percentages of each ethnic group who considered it a barrier were quite high: Filipinos, with 43% considering personal shame a barrier, had the lowest percentage of the four ethnic groups. Ethnic groups did not differ in their perception of accessibility as a barrier, nor did many respondents think of it as inhibiting help-seeking.

While significant ethnic differences were found in five of the barriers for alcohol problems, only three of the barriers for emotional problems showed significant differences: cost, group shame, and inappropriate problem. Ethnic differences were not found in the awareness and personal shame, but the percentages in each ethnic group perceiving awareness and personal shame as barriers were quite high. Accessibility and ethnic match did not differentiate the ethnic groups nor was there a high percent in each ethnic group who considered it a problem.

Table 7. Perceived barriers among individuals perceiving at least one barrier arranged by percentages

	Personal alcohol problem		Personal emotional problem	
	barrier	Pct.	barrier	Pct.
Caucasian		(238)		(230)
	Shame (self)	48.75	Shame (self)	35.05
	Shame (others)	37.66	Awareness	24.18
	Inappropriate	16.72	Shame (others)	21.62
	Awareness	15.88	Cost	20.49
	Cost	9.08	Inappropriate	18.34
	Inaccessible	5.50	Inaccessible	3.22
	Ethnic match	2.68	Ethnic match	1.77
Filipino		(137)		(133)
	Shame (self)	42.74	Awareness	35.32
	Awareness	33.15	Shame (self)	32.35
	Shame (others)	21.88	Shame (others)	19.19
	Inappropriate	11.12	Inappropriate	13.14
	Cost	7.60	Cost	11.52
	Ethnic match	5.93	Ethnic match	7.32
	Inaccessible	4.01	Inaccessible	1.53
Japanese		(274)		(234)
	Shame (self)	53.32	Shame (self)	32.54
	Shame (others)	32.67	Awareness	31.61
	Awareness	24.26	Shame (others)	29.98
	Inappropriate	5.22	Cost	8.77
	Cost	4.81	Inappropriate	7.28
	Inaccessible	3.06	Ethnic match	3.33
	Ethnic match	0.00	Inaccessible	2.88
Native Hawaiian		(207)		(177)
	Shame (self)	48.93	Shame (self)	37.37
	Shame (others)	43.30	Awareness	31.71
	Awareness	23.48	Shame (others)	29.86
	Cost	12.27	Cost	16.94
	Inappropriate	11.26	Inappropriate	11.11
	Inaccessible	2.22	Ethnic match	5.10
	Ethnic match	1.96	Inaccessible	3.96

Table 7 displays the pattern of responses for the four ethnic group arranged by percentages. In describing this table, we have set an arbitrary cutoff point of 10% to indicate a "major" barrier to help-seeking. Caucasians perceived both types of shame, inappropriateness, and awareness as major barriers to help-seeking for an alcohol problem. The psychosocial barriers of both types of shame had much higher percentages than the structural barriers of inappropriateness and awareness. When emotional problems were considered, five of the seven barriers had percentages over 10%. Second, the percentage of people who considered the psychosocial dimension a barrier diminished for an emotional disorder. An overall shift can be seen in the importance of structural barriers for an emotional problem. The percentage for each structural barrier increased for an emotional problem. Awareness had the second largest

percentage of all the barriers (24%). The percentage who considered cost a barrier more than doubled.

Filipinos presented a different pattern of responses from Caucasians. Four of the barriers for an alcohol problem had percentages over 10%: personal shame, awareness, group shame, and inappropriateness. Awareness ranked as the second most common barrier for an alcohol problem. The importance of perceived structural barriers was evident for an emotional problem. Five of the barriers had percentages over 10%, with cost added as a major barrier for an emotional problem. Awareness had the highest percent of Filipinos who considered it a barrier to help-seeking for an emotional problem. Overall, Filipinos were the only ethnic group to consider awareness as such an important barrier.

Japanese adults had much agreement over the barriers which impede help-seeking. The psychosocial barriers of shame and the structural barrier of awareness were all important for an alcohol and emotional problem. No other barrier had percentages over 10%. The major difference between the perceptions of barriers for an alcohol and emotional problem were the reduction in the percentages who considered personal shame a barrier for an emotional problem and the increase in percent who considered awareness a barrier. In fact, the percentages who considered both types of shame and awareness were quite similar for an emotional problem, all were between 30% and 33%.

Native Hawaiians perceived five major barriers for both an alcohol and emotional problem. All three psychosocial barriers and two structural barriers of awareness and cost had percentages of over 10%. Native Hawaiians had a unique pattern of perceived barriers for an alcohol problem, but had a pattern similar to Caucasians of perceived barriers for an emotional problem.

The psychosocial dimensions of shame were major barriers for all ethnic groups for both types of problems. In most instances, personal shame was the major barrier for an alcohol and emotional problem. External shame or shame to others was also a major but not as dominant a barrier as personal shame. Awareness was the most important structural barrier. The only exception was Caucasians who considered appropriateness slightly more important than awareness for an alcohol problem.

Discussion

This paper began with one primary objective: to identify differences between ethnic groups in their perceptions of barriers to help-seeking for two types of problems (alcoholism, severe emotional problems) controlled for age, gender, income, marital status, and education. Findings from this study indicate that service planners and providers must take into account ethnic differences in the perceptions of barriers to help-seeking. We found differences among ethnic groups in their perception of barriers for both alcohol and severe emotional problems. Caucasians anticipated fewer barriers to seeking professional care than the other three ethnic groups. The relationship generally held with the addition of the control variables.

Ethnic differences were also found in the type of perceived barriers for an alcohol and emotional problem. Several conclusions can be drawn from this finding. First, shame was a major barrier for all ethnic groups for both types of problems. The stigma associated with alcoholism and mental illness is important in explaining barriers to utilization, a finding supported by previous research. For example, in a study of patients with mental illness and their spouses, Clausen et al. (1982) found that spouses who feared stigmatization were less likely to interpret the patient's disorder as a mental illness. While there was no time difference in seeking professional care between those who expressed a fear of stigmatization and those who did not, there was a definite qualitative difference in the decision making process. Spouses who expressed fear of the stigma were more likely to rely upon professionals to decide on hospitalization for the patient. Lin et al. (1978) confirm these findings for the Chinese. In studying referrals to a community mental health team, the researchers found Chinese families attended to the patient for a prolonged period. A sense of obligation and loyalty to the patient and the stigma associated with mental illness are possible reasons for the extended period before contacting a professional. A family physician was contacted only when psychiatric episodes manifested into disruptive or violent behavior.

Differences were apparent within each ethnic group in the perception of barriers for an alcohol and emotional problem. Few Caucasians anticipated barriers for an alcohol and emotional problem. Filipinos perceived similar levels of barriers for both problems and perceived greater barriers than the other three ethnic groups. The greater perception of barriers may reflect the greater concentration of immigrants in the Filipino sample. Immigrants may be most affected by structural barriers such as awareness and cost and, indeed, these factors are prominent barriers for the Filipinos. Unfortunately, the data set does not allow us to test whether immigrant status can account for the high

levels of perceived barriers among the Filipinos. Native Hawaiians and Japanese were alike in their anticipation of barriers. No significant differences were found between Native Hawaiians and Japanese. However, significant differences were found within each group: a higher percentage anticipated barriers for an alcohol problem than an emotional problem.

Certain barriers were more important in impeding help-seeking than others. Generally, perceived psychosocial barriers were more evident for an alcohol problem than an emotional problem and perceived structural barriers increased in importance for an emotional problem. Differences were found in the pattern of barriers anticipated for each problem between ethnic groups.

Both types of shame were generally more important for an alcohol problem than for an emotional problem. The stigma associated with alcohol use may be attributed to the familiarity with alcohol usage and the personal responsibility associated with alcoholism (Murakami 1985). Whitney (1986) suggests that the "local" drinking culture in Hawaii allows individuals to consume alcohol and to establish social ties where they can feel at ease with each other and "talk story." This local culture provides a social context for drinking large quantities of alcohol. Within this context, alcohol consumption is an individual responsibility - shame is associated with a person who cannot control drinking behavior. Although shame is still important as a barrier for an emotional disorder, it is not as important as it was for an alcohol problem. Ethnic groups may be less inhibited because emotional disorders are less prevalent and they may not be able to attribute responsibility for the disorder. The unfamiliarity with emotional problems is evidenced by the importance of structural factors in inhibiting usage.

This research did not have an adequate measure of actual service utilization. We were unable to test whether experience within treatment settings can help to explain ethnic differences in perceived barriers. Future research will need to consider how actual utilization influences perceived barriers. However, this paper has demonstrated the importance of ethnic factors in understanding perceived barriers to help-seeking for two kinds of problems. We have shown that simply removing structural barriers to utilization may not sufficiently reduce the perceived barriers to help-seeking among ethnic minorities.

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