Illness attributions among ethnic minorities: assessment and clinical relevance
Ghane, S.

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Introduction
Ethnic minorities form a considerable segment of populations in many Western countries (United Nations, 2006; US Census Bureau, 2001). In the Dutch urban areas, some 24 to 38 percent of the total population (CBS, 2009), and nearly half of the youth population (CBS, 2006) are from a non-Western ethnic background. While there has been an upward trend in the utilization of mental health care by members of ethnic minority groups, they do not seem to equally profit from conventional services as the majority population (Department of Health and Human Services, 2001; Struijs & Wennink, 2000). In the context of psychotherapy for instance, minority patients have been shown to have higher drop-out rates (Organista, Munoz, & Gonzalez, 1994), and worse treatment outcome (B. S. Brown, Joe, & Thompson, 1985; Zane, Enomoto, & Chun, 1994).

The relatively poor mental health care outcome among ethnic minorities has often been ascribed to patients’ cultural background and “cultural differences” with their therapists (Van Dijk, 1989). However, “culture”, and by extension the notion of cultural differences, are too broad and vague concepts to constitute an adequate unit of analysis (Kuper, 2000). Indeed, culture refers to many conceptual entities, such as traditions, beliefs, norms and values, and it is often unclear which specific differences between therapists and patients may be responsible for the poor outcome. A specific cultural element, which is thought to be of direct relevance for clinical outcome, is patients’ beliefs regarding the nature and etiology of their illness (Kleinman, 1980). It has been suggested that discrepancies between patients and therapist in illness beliefs and attributions may be one of the reasons, underlying the poor intercultural therapy outcomes (Kleinman, 1980) (see box 1).

**Illness beliefs and explanatory models of illness**

During the past decades, two theoretical models have been proposed, linking patients’ illness beliefs to health behavior and treatment outcome.

*The Explanatory Model Framework*

The first model, the so-called Explanatory Model Framework (Kleinman, 1980, 1988), assumes that individuals (e.g., patients, their family or practitioners) tend to construct *explanatory models* (*EMs*), when facing a specific episode of illness. These models are informed by broader cultural beliefs about health and illness, and are held by patients and practitioners in all cultures and societies. Theoretically,
Case 1.

Mr. A is a 20-year-old refugee from Sierra Leone who has been living in the Netherlands for the past three years. Since his arrival, Mr. A has been suffering from depression and anxiety symptoms, as well as severe pain in his eyes and forehead. When different medical tests did not point to an organic pathology, his GP concluded that the pain in his eyes and head could have a psychological origin. Mr. A did not agree with this explanation, since he does not “intend or direct his mind to hurt his eyes”. He believes that his pain symptoms are either caused by an unknown allergy or “invisible computer rays”, which may have affected his eyes, when he was spending a lot of times in front of a computer screen. Mr. A is frustrated that medical tests have “failed” to discover the true nature of his symptoms, and accused his GP of being incompetent. He followed the GP’s advice to consult a psychologist, but discontinued treatment after the initial session.

Case 2.

Mrs. B is a 36-year-old married woman of Moroccan origin. One year ago, she lost her father in a car accident. Since then, Mrs. B has been suffering from depression and low self-esteem. In the past six months, she has increasingly felt inadequate and anxious in social situations. On a number of occasions, she has experienced sudden anxiety attacks, which forced her to minimize her social contacts to a great extent. Mrs. B has been referred to a psychotherapist for the treatment of her depression and anxiety symptoms. When the therapist asked what could be causing her problems, she mentioned witchcraft as her main explanation. Mrs. B and her husband have been happily married, and she suspects that her jealous sister-in-law may have bewitched her. The therapist, in contrast, believes that Mrs. B’s “panic symptoms” stem from her low self-esteem and social anxiety. In his view, the witchcraft explanation forms a barrier to change, which should be removed to engage the patient in psychotherapy. Hence, the therapist attempted to challenge the validity of the witchcraft theory, using cognitive restructuring. Although she did not discuss her reservations openly, Mrs. B viewed the therapist’s attitude as dismissive, and had the impression that he could not understand her situation adequately. Besides, she could not see how her low self-esteem could account for sudden bodily changes, which were accompanied by severe anxiety. On her initiative, the treatment was terminated after four sessions.

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1 Both cases are fictional, although each consists of elements, adapted from real cases.
EMs may consist of different cognitive components, each pertaining to a different aspect of illness, i.e., (1) etiology, (2) time and mode of onset, (3) pathophysiology (physiological mechanisms underlying the illness), (4) course of illness (severity and degree of chronicity), and (5) treatment. Although in practice often limited to one or more tentative explanations, EMs are believed to serve a number of key functions for patients and therapists alike. They project personal and social meaning on the experience of illness, guide and evaluate treatment choices, and provide an idiom through which the experience of illness is communicated to others.

The Self-regulation Model
The second theoretical approach is the Self-regulation Model (Leventhal, Diefenbach, & Leventhal, 1992; Leventhal, Nerenz, & Steele, 1984). This model assumes individuals to be rational actors, who purposefully select coping strategies in order to improve their current health towards a desirable health state. When confronted with a symptom or health threat, individuals develop cognitive representations of illness. Similar to the EM Framework, these illness representations are thought to consist of beliefs regarding five different domains of illness: (1) antecedent causes, (2) identity (the disease label and its symptom indicator), (3) physical, social, and economic consequences, (4) time-line (acute, chronic or cyclic), and (5) potential for cure and/or control. Based on an initial representation of illness, individuals apply and subsequently evaluate particular coping or help-seeking strategies. If these strategies fail to generate the desired outcome, the initial illness representations may be adjusted, leading in turn to new coping strategies.

Despite the apparent value of the Self-Regulation Model, the present thesis is more substantially based on Kleinman’s EM Framework. This has to do with the relatively elaborated nature of Kleinman’s hypotheses, linking EMs to treatment process and outcome. On the other hand, the Self-regulation Model, while acknowledging the relevance of illness representations for treatment success, is more explicitly focused on their association with coping strategies and health outcome. The present thesis addresses two important issues, derived from the EM Framework (see further), while focusing exclusively on a single component of EMs, namely the ideas on illness etiology, i.e., illness attributions. On a theoretical level, illness attributions are perhaps the most salient component of EMs. In fact,
personal ideas on the course and severity of symptoms, as well as their pathophysiology and adequate treatment may not be established without some indication of antecedent causes. Indeed, a recent study found illness attributions to be significantly associated with patients’ preferred coping/treatment, as well as ideas on the course and severity of illness (C. Brown et al., 2007).

**Aim and focus of this thesis**

The two important issues, which are addressed in this thesis, pertain to the assessment and clinical relevance of illness attributions. In this section, each subject is briefly outlined, followed by an overview of empirical evidence, and a description of the present work’s contribution to this literature.

**Assessment of illness attributions**

Although not presented as a formal hypothesis, Kleinman (1980) referred to the problematic assessment of EMs, using face-to-face interviews. Specifically, patients may have the occasional tendency to conceal their EMs in interactions with clinicians, as their ideas may appear mistaken or primitive from a Western medical perspective. However, the EM Framework does not further elaborate on specific factors, which may be associated with misreports of EMs.

There is a keen lack of direct evidence concerning the misreports of illness attributions in interview situations. Although the concealment and misreports of beliefs is well documented in anthropological literature (Fabian, 1990; Pool, 1994), not much is known regarding the factors, which may be associated with their occurrence. In social psychological literature, misreports of beliefs and attitudes have been found to be related to a number of factors, such as respondent’s tendency towards social desirability (McCann & Hancock, 1983), high levels of uncertainty towards one’s beliefs (Finkel, Guterbock, & Borg, 1991), poor rapport with the interviewer (Cannell, Miller, & Oksenberg, 1981), and disparities between the interviewer and the respondent in social demographic characteristics (e.g., ethnicity) (Davis, 1997). It seems plausible to assume that the same factors may underlie the presumed misreport of illness attributions in interview situations.

Misreports of illness attributions may be reduced by employing *indirect* measures, which have been widely used in the field of social psychology (Fazio, Williams, & Powell, 2000; Greenwald, McGhee, & Schwartz, 1998; Nosek & Banaji, 2001). Indirect measures are computer administered association tasks,
which in contrast to interviews, tend to assess a given belief or attitude, independently of respondents’ self-report. For this reason such measures are generally believed to be less sensitive to response manipulations.

This thesis aimed to identify factors, which may affect the self-reports of illness attributions, using face-to-face interviews, and to introduce an alternative (indirect) instrument, which is less sensitive to these factors. Based on previous evidence in social psychological literature, it was examined whether ethnic minority patients report different illness attributions to ethnically similar and dissimilar interviewers, and whether this differential report is associated with patients’ social desirability, degree of certainty towards their beliefs, and the quality of rapport with the interviewer. Moreover, it was investigated whether an indirect measure of illness attributions is less sensitive to ethnic (dis)similarity with the interviewer than face-to-face interview.

**Clinical relevance of illness attributions**

*a. Treatment-induced changes in illness attributions*

The EM framework assumes patients’ EMs to be inherently dynamic. Often, they are constructed based on specific information to cope with specific symptoms. As the information evolves, for example through changes in symptom severity or processing of new information from social network, EMs are prone to change accordingly. This is particularly likely to occur in the context of treatment, in which patients may be exposed to professional EMs of therapists. Kleinman (1980) hypothesized that patients may subsequently reject, assimilate, or integrate the professional EMs in their existing views, or even develop new EMs as a result. The clinical communication is, however, effective to the extent that it reduces the initial EM discrepancies between patients and their therapists.

Thus far, only a limited number of studies have focused on attributional changes in the context of treatment. Among European patients with somatoform disorders, physical attributions appear to decrease as a result of psychological interventions (Avia et al., 1996; Sharpe et al., 1996). With regard to ethnic minorities, however, the current evidence for the effect of treatment on illness attributions is equivocal (Bäärnhielm, 2004; Bäärnhielm & Ekblad, 2000; Jacob, Bhugra, & Mann, 2002). Furthermore, the hypothesis that therapist and patient attributions become more similar in the course of treatment has not been rigorously
examined, as none of the previous studies has included an explicit assessment of therapist attributions.

The present thesis contributes to the literature by examining the effect of psychotherapy on minority patients’ illness attribution. Moreover, by assessing both patient and therapist attributions, it investigated whether therapist-patient discrepancies in illness attribution will decrease in the course of treatment.

b. The impact of therapist-patient attributional discrepancy on treatment process and outcome

Perhaps the most significant contribution of the EM framework pertains to its hypothesis, linking illness attributions with treatment process and outcome. Kleinman (1980) hypothesized that treatment effect will be greater, when patients and therapists hold similar understandings of illness. When discrepancy occurs in the way patients and therapists explain the symptoms, treatment strategies will make no sense to patients, resulting in non-adherence, treatment disengagement, and poor treatment outcome.

Research into the association between patients’ illness attributions, treatment process and outcome has produced mixed findings. While a number of studies seem to suggest that patient attributions, which are compatible with the treatment rationale, may enhance the therapeutic bond (McCabe & Priebe, 2004), treatment attendance (Foulks, Persons, & Merkel, 1986) and outcome (Chalder, Godfrey, Ridsdale, King, & Wessely, 2003; Kennedy et al., 2006), others have failed to do so (Deale, Chalder, & Wessely, 1998; Sullivan et al., 2003). The current literature is problematic in two ways. First, the studies have exclusively focused on illness attributions of patients, regardless of their (in)congruence with therapists’ attributions, which may explain some of the inconsistencies in the research findings. Second, there is virtually no evidence for the presumed clinical relevance of illness attributions among ethnic minority patients.

The present thesis aimed to fill this gap by investigating the association between therapist-patient discrepancies in illness attributions and psychotherapy outcome among ethnic minorities. Furthermore, it was examined whether the presumed negative effect of attributional discrepancy on outcome is due to poorer process of treatment, as indicated by lower treatment attendance rates.
Thesis outline

This thesis is divided into two sections, dealing respectively with the assessment and clinical relevance of illness attributions among ethnic minority patients. Chapter 2 examines whether Turkish and Moroccan patients in the Netherlands report different illness attributions to ethnically similar and dissimilar interviewers, and whether this differential report is associated with patients’ social desirability, degree of certainty towards their beliefs, and the quality of rapport with the interviewer.

Chapter 3 reports on two studies, in which an indirect measure of illness attributions is introduced and compared with face-to-face interviews. In the first study, the convergent and discriminant validity of this indirect measure was assessed among Dutch university students. The second study examined whether the indirect measure is less sensitive to ethnic (dis)similarity with the interviewer than face-to-face interview among patients from Turkish and Moroccan origins.

The second section of this thesis is concerned with the clinical relevance of illness attributions. This section opens with a comprehensive overview of evidence on the clinical relevance of illness attributions in a broad sense of the term. Thus, chapter 4 goes beyond the narrow focus of the remaining of the thesis by providing a systematic review of the literature on the presumed effect of illness attributions on coping, help-seeking behavior, alliance, satisfaction, drop-out, as well as treatment adherence and outcome.

Chapter 5 describes a study, which examined the effect of psychotherapy on minority patients’ illness attributions. Also, the study assessed whether therapist-patient discrepancies in illness attribution will decrease in the course of treatment.

Chapter 6 reports on a study, which focused on the association between therapist-patient discrepancies in illness attributions, treatment attendance and outcome. Finally, in the closing chapter the findings are summarized and discussed, alongside a number of implications for research and practice.
References


