Illness attributions among ethnic minorities: assessment and clinical relevance
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General Discussion
The main objective of the present thesis was to investigate a number of important issues concerning the assessment and clinical relevance of illness attributions among ethnic minority patients. This chapter provides a brief overview of the main findings, describes strengths and limitation of the studies, and concludes with a number of implications for research and practice.

Assessment of illness attributions

To date, issues with regard to the assessment of illness beliefs have been mainly studied, using anthropological methods (e.g., Kleinman, 1980; Pool, 1994; Van der Geest, 1991; Van Dongen & Fainzang, 2005). While anthropological studies are suitable to explore a number of extraneous factors, which may distort self-reports of illness beliefs during interviews, they are also problematic in two ways. First, anthropological studies are not generally adequate for estimating the relative and cumulative effect of different extraneous factors, nor do they establish causal effects in the strict sense. Second, the main body of the literature on misreports of illness beliefs is based on secondary and ad hoc findings, and there has been virtually no systematic line of research, aimed at inducing formal theory. In the first study of this thesis (chapter 2), insights from social psychology were used to formulate a number of hypotheses regarding the impact of specific factors on self-reports of illness attributions. A quantitative, experimental method was chosen to examine whether self-report of illness attributions was affected by patients’ ethnic similarity or dissimilarity with interviewers, quality of rapport with the interviewer, social desirability, and attributional uncertainty. Results indicated that patients, indeed, reported different illness attributions to ethnically similar (ethnic match) and dissimilar interviewers (ethnic mismatch). Furthermore, social desirability seemed to affect patients’ self-reports of interpersonal and victimization causes, whereas attributional uncertainty enhanced the (mis)match effect on self-reports of medical and religious/mystical attributions.

Chapter 3 described two studies, in which an indirect measure of illness attributions was introduced and evaluated. This measure was adapted from an existing latency measure (Fazio, Williams, & Powell, 2000), and was designed to be less sensitive to extraneous factors than conventional interviews. The first study provided evidence for the convergent validity of the indirect measure among a sample of Dutch university students. Moreover, social desirability and attributional uncertainty seemed to affect the correspondence between direct and indirect
measures on interpersonal and medical attributions, respectively. These results were partly consistent with those of the previous study, in which social desirability and attributional uncertainty seemed to affect self-reports of the same attributions. This consistency in research findings suggests that these associations are not specific to ethnic minority patients, and may also emerge among entirely different populations (e.g., Western university students). In the second study, the indirect measure appeared, as expected, less sensitive to ethnic (mis)match with the interviewer. In contrast, self-reports of illness attributions on the direct measure varied significantly, as a result of ethnic (mis)match with the interviewer, which provided partial support for findings in chapter 2. Thus, the indirect measure appears to be a valid measure of illness attributions, and is at the same time less sensitive to extraneous factors than the direct measure. However, the indirect measure has also a number of limitations. First, it is not clear which mechanisms account for the relative insensitivity of this measure to extraneous factors. As discussed in chapter 3, the indirect measure does not prevent strategic manipulation of responses, nor is it likely to tap into unconscious associations. The relative insensitivity of this measure can be best explained by a sense of anonymity that it may create among respondents. This may be due to the fact that the process of response generation does not require interpersonal interaction, and responses are stored in a computer, rather than registered by an interviewer. The second limitation of the indirect measure concerns its strong reliance on cognitive capacities of respondents. Although the indirect measure was designed as a simple measure as possible, respondents are still required to maintain high levels of concentration for several minutes. This may lead to cognitive exhaustion and error, especially among patients with anxiety and mood disorders whose concentration is inherently affected. Finally, the indirect measure is reductionistic, in the sense that it reduces complex thoughts to simple latency scores. Such scores do not reveal why and how patients arrive at certain attributions, and what these attributions mean to them. Therefore, the indirect measure should not be viewed as a replacement for interviews, and especially not in clinical practice.

**Illness attributions in the context of treatment**

The second part of this thesis was concerned with treatment-induced changes in illness attributions, and with potential effect of attributions on treatment process and outcome. In chapter 4 the existing empirical evidence was systematically
reviewed. In the most reviewed studies, patients’ attributions changed significantly during (Nolan & Badger, 2005; Schreiber & Hartrick, 2002) and as a result of treatment (Sharpe et al., 1996). However, these findings were almost entirely based on Western populations, and may not necessarily apply to ethnic minority patients. Further, based on an integration of theoretical models and empirical findings a dual mechanism was proposed, which could explain the presumed effect of illness attributions on treatment process and outcome. According to the first mechanism, patients’ illness attributions affect coping behavior, which in turn determines the quality of outcome. This mechanism had been previously studied in and outside the context of treatment (Brown et al., 2007; Rutter & Rutter, 2002). The second mechanism assumes patients’ attribution to affect outcome in interaction with those of their therapists. In this view, discrepancy in illness attributions of patients and therapists distorts the treatment process (e.g., attendance and working alliance), which in turn leads to poor outcome. This mechanism had not been evaluated in any of the previous studies.

Chapter 5 described a randomized controlled trial, in which the effect of psychotherapy on minority patients’ illness attributions was examined. Findings indicated that psychotherapy led to a reduction in a number of externalizing attributions, and in therapist-patient discrepancies in those attributions. Turning to treatment process and outcome (chapter 6), it was found that higher baseline therapist-patient discrepancy in psychological attributions was associated with poorer psychotherapy attendance, and worse outcome. However, low attendance could not explain the association between discrepancy in psychological attributions and outcome. These findings underscore the idea that agreement on psychological causes of symptoms, and patients’ endorsement of the psychotherapy rationale foster better treatment outcome. However, the precise mechanism for this effect remains largely unknown, and may be found among a number of process variables, such as working alliance, treatment credibility, patients’ responsiveness, and other forms of compliance than treatment attendance.

Integrating the results of the two intervention studies, one may conclude that psychotherapy do not reduce therapist-patient discrepancy in psychological attributions, while this discrepancy is most strongly associated with outcome. This may point to either ineffectiveness of psycho-educational elements in the studied treatments, or to difficulties in enhancing psychological attributions among patients who already endorse these attributions to a large extent. Furthermore, the studies indicated that therapist-patient discrepancies in medical and magical
attributions did not change in the course of psychotherapy, nor were they associated with poorer outcome. These results are in sharp contrast with stereotyped beliefs, which view minority patients’ medical and magical attributions as obstacles to recovery. This apparent inconsistency may be explained by the complex and ‘layered’ nature of illness attributions. Past studies (Kleinman, 1980; Williams & Healy, 2001) have indicated that patients may hold different at times even inconsistent attributions simultaneously. For instance, a patient who mainly attributes his symptoms to evil spirits, may also recognize psychological factors, which may have contributed to his illness. In such cases, patients are likely to benefit from psychotherapy, despite their predominantly non-psychological attributions. Perhaps, medical and magical attributions pose a threat to treatment outcome, only when they exclude psychological attributions and interventions.

Strengths and limitations of the studies

The conclusions of the present thesis may be viewed in the context of a number of strengths and limitations. First, the studies have a strong interdisciplinary orientation. The fields of intercultural psychology and cultural psychiatry are situated on the border between health and social sciences. For this reason, research on culture and health should entail an interdisciplinary approach to theory construction and research methodology (De Jong & Van Ommeren, 2002; Weiss, 1997). While the hypotheses in this thesis were mainly derived from medical anthropology and cultural psychiatry literature, the studies have benefited from methods and insight in different fields of social, clinical, experimental, and health psychology. Second, the present thesis presented the first series of studies, in which different factors, affecting self-reports of illness attributions were explicitly examined, using an experimental design and instrument. Finally, this thesis is unique in its attempt to investigate the association between attributional discrepancy and outcome.

The main limitation of this thesis concerns the absence of the indirect measure in the two intervention studies. Indeed, given the problems with the direct measure in the first two studies, the validity of the assessments in the later studies may be questioned. The omission of the indirect measure in the intervention studies had to do with its exhausting nature, which was considered a threat to the sample integrity halfway through the data collection. More specifically, a considerable number of patients found the measure tiring and tedious, and some
even explicitly refused to complete the task during the next assessment. However, prior to start of the study, measures were taken to reduce bias in interviews, using insights from the first two studies. As noted in chapters 5 and 6, patients were encouraged to provide genuine accounts of their attributions, and interviewers were trained to establish a good rapport with respondents prior to the interview, and to demonstrate a non-judgmental attitude towards patients’ utterances. Furthermore, the ethnicity of the interviewer at pre- and post-assessment did not vary within participants. Thus, the observed attributional change cannot be explained by possible (mis)match effects. It should also be noted that the inclusion of the indirect measure could only assist the analyses regarding attributional changes. Using the indirect measure to estimate attributional discrepancy would require therapists to complete this measure as well, which would have affected the swiftness of their responses, given the target stimuli lacked personal relevance for them. A second limitation of the studies has to do with the external validity of the findings. Relatively low response rates, high attrition, and medium to small sample sizes may have posed a threat to the generalizability of the results. However, except for one instance, participants were not different than refusers on any of the known variables. Further, given the main data are exclusively based on research among Turkish and Moroccan patients, caution is required when generalizing the conclusion to other ethnic groups. Also, the majority of the participants were foreign born immigrants. Findings need to be replicated among the so-called second and third generations of immigrants who will be increasingly represented in mental health care during the years to come.

Future directions

Future endeavors may focus on mechanisms of (mis)match effect on self-report of illness attributions. Also, in future studies a shortened version of the indirect measure may be developed and tested, which can serve as a viable addition to interviews with greater utility for research and practice. In this respect, reducing the number of distractor items is an adequate starting point.

In the present thesis, attributional discrepancy was examined in relation to early outcome. Further studies are required to establish the association between therapist-patient discrepancy and long-term outcome. Also, the mechanisms through which attributional discrepancy may affect outcome need to be more explicitly addressed. Findings need to be reproduced among other ethnic groups,
including Western populations, and across different treatment modalities (e.g., pharmacotherapy and group therapy). Finally, explicit treatment protocols may be developed and examined to reduce attributional discrepancy between therapists and patients.

Clinical implications

The present thesis has a number of significant implications for clinical practice. First, given the importance of attributional discrepancy for early outcome, clinicians are encouraged to elicit patients’ attributions prior to the development of a treatment plan. However, patients are most likely not to spontaneously volunteer their attributions during their clinical encounters (Kleinman, 1980). Moreover, social desirability, uncertainty towards one’s attributions and ethnic match or mismatch with clinicians may impact the validity of patients’ accounts. Therefore, a proactive, inviting and non-judgmental attitude on the part of the clinician is essential to facilitate a genuine disclosure of illness attributions. Clinicians are further advised to routinely assess their attributional discrepancy with patients, and to initiate a process of negotiation on the origins of symptoms and the nature of intervention to be carried out. In cases where discrepancies exist between the dyads, it may often not be necessary for patients to completely revise their illness attributions. In fact, such departures from previous beliefs may be an extremely confusing experience (Bäärnhielm, 2004). The process of negotiation is perhaps most successful when psychological attributions are integrated within the patients’ pre-existing beliefs. In doing so, the patients are likely to accept the treatment rationale, without having their “system of meanings” challenged or devalued in the context of treatment. Finally, a collaborating process can be initiated, in which decisions are made regarding the tasks and goals of treatment, based on common attributions of symptoms.
References


