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Cross Generational Immigrant Attitudes toward Mental Health Services

Liudmila Shapoval and Elizabeth L. Jeglic

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Depression is a major mental health problem both in the United States and globally, and thus, increasing research has focused on how to treat it. The major treatments include medication and psychotherapy; however, it appears that most depressed individuals are selecting pharmacological treatment as opposed to psychological treatment despite treatments similar outcomes. This is in contrast to survey data which suggests that individuals overall prefer psychological types of treatment (Givens et al., 2007; Olfson & Marcus, 2009). As the population of the United States increases to become more ethnically and culturally diverse, little is known about how racial and cultural factors impact treatment selection. Therefore, this study assessed the role of acculturation in treatment preference for depression. Specifically, the study sought to determine the acceptability of pharmacological treatments and assess whether this differs across immigration and generational status. The sample was comprised of 580 racially and ethnically diverse undergraduate students who completed a series of questionnaires to assess their level of acculturation and treatment preference. Overall, we did not find a significant difference in preference for medication across generations suggesting acculturation level may not contribute to depression treatment selection. However, we did find that higher levels of immersion in American culture play role in the selecting psychological treatments which may suggest the level of psychological literacy and overall knowledge of mental health related issues is higher in the U.S. in comparison to other cultures. Further, we found that those who reported higher levels of depressive symptoms also reported a preference for pharmacological types of treatment. These findings point to the fact that the more people suffer from depressive symptoms, the more likely they would choose treatment that provide faster relief.

Introduction

Major Depressive Disorder is considered to be the most prevalent mental disorder in the United States (Kessler et al., 2003). Consequently a great deal of attention has focused on the treatment of this disorder (Rush et al., 2009; Blais et al., 2013; Cuijpers et al., 2008; Gaynes et al., 2008). However, among the general population there appears to be a difference in the stated treatment preference and what is actually done. Specifically, while most people express a preference for psychotherapy as the primary treatment for depression, however in practice, antidepressant medications are the most often used (Olfson & Marcus, 2009; Hanlon et al., 2011; Delate et al., 2004). As the population of the United States becomes increasingly racially and ethnically diverse (U.S. Census Bureau, 2012), it is unclear how, if at all, factors related to race and culture are influencing the election of treatment for depression. It has been noted that in recent years the trend has been for patients to select pharmacological rather than psychological treatment for depression (Olfson & Marcus, 2009); however, it is unclear if this trend varies by immigration and generational status. In addition, research points on the fact that other countries have significantly lower percentage of people who accept or receive any type of treatment for depression in comparison to the U.S. varying from 0% in St. Petersburg (Russia) and 4% in Be er Sheva (Israel) to 38% in Seattle (USA) and 21% in Barcelona (Spain) (Simon et al., 2004). The current study will investigate treatment decision-making among an immigrant population by examining their level of acculturation. Further, we will investigate whether generation status impacts treatment choice. It is postulated that as individuals become acculturated to the host
country, they are more likely to adopt the native attitudes and behaviors with time (Gordon, 1964). Based on that, we may assume that newly arrived immigrants may not have established beliefs of the host country and carry the ones of their own culture. Therefore, we anticipate that the first generations of immigrants will be more likely to choose psychological interventions while subsequent generations will be more likely to choose pharmacological interventions as those have become more accepted in the U.S. (Lim, Jung, & Shi, 2013; Paulose-Ram et al., 2007).

Depression

Depression is considered to be the most prevalent mental disease in Western countries (Kessler et al., 2003). In the United States, the lifetime prevalence of MDD is 17%, and it occurs twice as often among women as compared to men (Kessler, Chiu, Demler, & Walters, 2003). Depression has an onset in late adolescence and early adulthood (Fergusson et al., 2005) and places a significant burden on the economy and society since it is characterized by significant impairment in functioning, reduced quality of life, and has a strong relationship with suicide attempts (Moscicki, 2001; Zisook et al., 2009). Thus, it is vital to understand the etiology and course of depression in order to develop better prevention and intervention efforts.

Treatment. There are two main types of treatments for depression: psychotherapy and pharmacotherapy (antidepressants). Both psychotherapy and medications have been found to be effective in decreasing symptoms of depression (Blais et al., 2013; Cuijpers et al., 2008; Gaynes et al., 2008; Rush et al., 2009). However, some studies have found that those who attended therapy were less likely to have a subsequent depressive episode as opposed to those who took medication alone (Evans et al., 1992; Hollon et al., 2005; Paykel, 2001; Vittengl et al., 2007).

There are several advantages and disadvantages to both forms of treatment. For example, time to remission is quicker using antidepressant medications; thus, they are preferred as a major treatment of depression (Gaynes et al., 2009). Further, medications are widely available, and treatment requires minimum time and effort; thus, this form of treatment is more accessible (Rush, 2011). However, there is a concern regarding misuse and over prescription of antidepressants (Jureidini & Tonkin, 2006; Kirsch et al., 2008; Pigott et al., 2010). Many general medical practitioners prescribe antidepressants without consulting with mental health specialists, and consequently individuals may not be prescribed the proper dosage for the correct time intervals (Jureidini & Tonkin, 2006; Olsson & Marcus, 2009). Further, there is a black box warning on antidepressants as they have been found to increase suicide risk, particularly when prescribed to children and adolescents (The U.S. National Library of Medicine, 2014).

Psychotherapy has been found to be as effective as medication in the treatment of depression but it takes longer to reduce symptoms – 55 days vs. 40 days with medications on average (Rush et al., 2009). Results showed that Cognitive Behavioral Therapy (CBT), Cognitive Therapy (CT) and Interpersonal Therapy (IPT) are all effective in the treatment of depression among adults (Cuijpers et al., 2013; Gibbons et al., 2010; Jakobsen et al., 2012; Lampe, Coulston, & Berk, 2013). In addition, psychotherapy demonstrates lower relapse rates in comparison to antidepressants (Rush et al., 2009) as those who receive therapy learn skills and coping strategies, and thus they are able to apply these new strategies every time they experience negative ruminations and cognitions (DeRubeis, Siegle, & Hollon, 2008). However, it should be noted that therapy is
more costly than medications. According to Consumer Reports, the monthly cost of Fluoxetine (Prozac) is about $257 on average (Consumer Reports, n.d.) while the average psychotherapy monthly expenses are about $600 on average plus co-payments for every visit (assuming that a patient attends six session per month) (Bullock, n.d.).

Despite the relatively similar outcomes for both psychotherapy and medication, over a 10 year period (1996-2005) there was a twofold increase in antidepressant use among people diagnosed with MDD (from 13.3 to 27.0 million people; Olsson & Marcus, 2009), with antidepressants currently being the most commonly prescribed medication in clinical settings (Cherry, Woodwell, & Rechtsteiner, 2007). It is plausible that this increase could have resulted from the development of more effective antidepressants such as SSRI’s that are less addictive, have fewer side effects and less chance of overdose in comparison to previous types of medications used for treatment of depression (Montgomery & Roberts, 1994; Nelson, 1994).

Preferences. While pharmacological and psychological treatments have similar outcomes in the treatment of depression (Gaynes et al., 2008; Rush et al., 2009), more people still take medications than attend psychotherapy (Olsson & Marcus, 2009). In addition, there are relatively small numbers of patients attending psychotherapy in the U.S. suggesting that psychological treatments are not the treatment of choice for depression (Gibson et al., 2014; Olsson & Marcus, 2009). While a significantly greater proportion of individuals report a preference for psychotherapy as opposed to medication as a treatment (Givens et al., 2007; Houle et al., 2013), this preference does not translate into behavior when seeking treatment for depression (McHugh, 2013).

Further, there appear to be racial and ethnic differences in treatment preferences. Whites and Native-Americans, for example, have been found to prefer medication over psychological treatment. On the other hand, Asians/Pacific Islanders were most likely to report no strong preference for either medication or psychotherapy, while Hispanics and African-Americans were less likely to attribute depression to biological causes, and thus had stronger beliefs that psychotherapy and prayer were more effective in the treatment of depression (Cooper et al., 2003; Givens et al., 2007).

In general it has been found that ethnic minorities are less likely to access mental health services such as psychotherapy (Lasser et al., 2002). Several reasons for this have been put forth including clinicians’ misunderstanding of the cultural context of patients (Taylor & Lurie, 2004), which may impact the therapeutic relationship, and hence, therapy engagement (Cooper-Patrick et al., 1994; Saha, Arbelaez, & Cooper, 2003). Thus, it is crucial to understand how cultural differences impact treatment choice.

Acculturation

There is research suggesting that acculturation or generational status may contribute to treatment preference and selection. Acculturation is defined as a process that takes place as a result of contact with a different social group (Gibson, 2001). There is some debate as to whether acculturation is a unidimensional or multidimensional process. A unidimensional explanation of acculturation postulates that once immigrants get exposed to a new culture, they are expected to discard the beliefs and attitudes of their own culture (Gordon, 1964). However, people who were born and raised within a specific environment will learn and adopt norms and values from that environment and will value those traditions even residing in a completely alien culture. On the other hand, a
multidimensional explanation postulates that exposure to a new culture does not make one discard values of his or her own culture (Berry, 1980). In this model, people carry their values into the new environment as well. Researchers debate whether acculturation scales should include only items that measure beliefs of the host country or whether they should also include items that measure levels of immersion in the host country and country of origin (Park & Rubin, 2012).

Acculturation has been identified as a risk factor for depression in cases where the process has been difficult or stressful. For example, new Hispanic immigrants who did not speak English were at greater risk for depression as it hindered them from gaining access to appropriate treatment services (Coffman, 2010). Also, Korean immigrants had higher levels of depression compared to the U.S. community samples, and the major predictor of depression among Korean immigrants was acculturative stress caused by language barriers, social isolation, and family relations (Park & Rubin, 2012).

Coupled with the process acculturation, it is important to pay attention to the differences between generations of immigrants. The literature highlights the clear differences in overall behavior and physical and mental health between immigrant generations (Bui, 2012; Padilla & Duran, 1995; Vaughn et al., 2013). For example, the immigrant paradox refers to the fact that the first generations of immigrants have better motivation in terms of academic achievement, overall behavior, and physical and mental health compared to their native-born counterparts (Coll & Marks, 2011). Further, non-citizens and recent immigrants tend to have a lower prevalence of mental health disorders upon arrival in the U.S. as compared to citizens of the same background. The more years immigrants have spent in the U.S., the greater the likelihood that they will suffer from a diagnosable mental disorder (Alderete et al., 2000). In addition, the lifetime prevalence of any psychiatric disorder for a native-born sample is significantly higher than an immigrant sample from Mexico (Vega et al., 1998). This trend was also observed among Filipino immigrants such that new immigrants had fewer depressive symptoms compared to their US-born counterparts (Mossakowski, 2007).

Rational and Hypothesis

Based on the acculturation literature, it appears that the acculturation process may be associated with depressive symptoms, and the immigrant paradox suggests that there may be a difference between generations of immigrants and between immigrants in general and their native-born counterparts. Further, we know that people who live in the U.S. tend to receive pharmacological types of treatments for depression even though they claim to prefer psychotherapy.

Therefore, based upon the research to date, it is hypothesized that there is a relationship between the level of acculturation, generational status, and preferences for treatments and general attitude towards mental health services. Further, we hypothesize that the longer individuals have been in the U.S., the more their treatment choices and preferences will mirror those of the host country due to acculturation process. Finally, we hypothesize that, due to the immigrant paradox, people of the first generations will be less accepting of pharmacological treatments, while the subsequent generations will be more accepting of pharmacological types of treatments.

Methods

Design

This was a mixed methods cross-sectional study, including correlational analysis of scaled data and qualitative analysis of open-ended
survey questions. Treatment preferences were assessed using both close and open-ended questions asking participants to explain the reasons for their decision-making. Generational status was determined by the number of years spent in the U.S. or number of generations of the family living in the U.S.

Participants

Six hundred and forty four undergraduate students from an urban college in New York City participated in the study. Students enrolled in undergraduate psychology classes had the opportunity to participate in research studies in exchange for a course credit. Each student who participated in this study received one credit toward the fulfillment of their research requirement. All students 18 years and older were eligible to participate in the study.

Out of 580 responses in total, there were 450 females (78.0%, N = 577) and 127 males (22.0%, N = 577). The age range was from 18 to 46 (M = 20.5, SD = 3.33). The majority of participants identified their race/ethnicity as Hispanic (46%), followed by White (19.8%), African-American (15.3%), Asian (12.2%), Native American (1.0%), and other (5.7%). Generational status of immigration was reported as follows: 1st generation - 8.7%, 1.5 generation - 16.2%, 2nd generation - 48.5%, and 3rd and above generations - 26.6% (Table 1).

Procedures

All students that participated in the Research Experience Program (REP) were invited via the SONA website to participate in an on-line study of the relationship between acculturation level and emotional well-being. Those students who elected to participate were directed to an on-line survey hosted by www.surveymonkey.com.

The Principal Investigator was in charge of monitoring the sign up list for participation in the study and awarded credits to participants who completed the survey. Participants had to indicate their names to receive research credits. Once the participation credit was awarded, the Principal Investigator removed the participant’s name from the questionnaire, thus removing any identifiable information and ensuring confidentiality.

Prior to viewing the survey, participants had to indicate whether they were 18 years of age or older, and then electronically signed the informed consent page leading the survey. Only after participants signed the consent, could they proceed to the questionnaire. At the end of the questionnaire, there was a debriefing form stated the purpose of the study and provided the contact information of the Principal Investigator.

Measures

Participants completed a series of self-report questionnaires described below:

**Beck Depression Inventory—II.** The BDI-II is a 21-item self-report questionnaire assessing the somatic, cognitive, and motivational symptoms of depression during the preceding two week period (Beck, Steer, & Brown, 1996). Scores can range from 0 to 63 with higher scores representing more severe depressive symptoms. Psychometric properties of the scale have shown high reliability among a multi-ethnic college sample (Carmody, 2005). The Cronbach coefficient (α = 0.92) in this study showed high internal consistency.

**Depression history.** Participants were asked to answer 11 items pertaining to their lifetime history of depressive symptoms (Whether they have ever experienced depressive symptoms, How many times for the past 12 months and throughout their lifetimes), family history of depression, their preferred choice of treatment (psychologist, psychiatrist, family member,
friend, religious association, alternative healer), and how satisfied they and their family members were with the treatment (if applicable). All answers were ranked on 4-point Likert scales ranging from 1 - Not satisfied at all to 4 - Very satisfied.

Preferences in treatment. This measure includes several options for treatment including psychotherapy, medications, no preferences, natural, or other. Participants were asked to explain the option they selected in an open-ended question. This scale was designed specifically for the purpose of this study using some elements from Bradley et al. (2009).

Acculturation. The Stephenson Multigroup Acculturation Scale (SMAS; Stephenson, 2000) is a 32-item self-report scale that measures the extent to which participants are immersed in non-dominant and dominant cultures. The scale assesses domains such as language use, TV and media preferences, food preferences, and the social relations of participants. Participants had to report to what extent they either agree or disagree with each statement on a 4-point Likert scale ranging from 1 - False to 4 - True. The SMAS was found to have high reliability and validity among an ethnically diverse population. Coefficient $\alpha$ was .86 for the entire scale, .97 for the nondominant subscale, and .90 for the dominant subscale (Stephenson, 2000).

Demographics. Participants were asked to provide demographic information including age, gender, ethnicity, religious affiliation, employment status, income, and number of people in household. Participants were also asked to identify their immigration and generational status, and four response options were given which included: 1st generation (foreign-born who moved to the U.S. with their parents before adolescence (13 years old); Rumbaut & Ima, (1988)); 2nd generation (U.S. born from earlier immigrated parents); and 3rd generation and above (U.S. born from the previous generations of the U.S. origins).

Results

After the data were collected and transferred into SPSS, those respondents who had more than 20% missing data were eliminated leaving 580 complete surveys out of an initial 644. Quantitative data were analyzed by using SPSS Version 21.

Depression

Out of 580 respondents, 62.3% reported minimal (less than 10 in total) depressive symptoms, 25% showed mild depressive symptoms, 8.4% experienced moderate symptoms, and 4.1% reported severe symptoms of depression.

Approximately half of the respondents (50.3%, N = 578) reported that they experienced depressive symptoms at least once in their lives, 30.8% (N = 578) claimed that they did not at all, and 18.9% (N = 578) reported that they were not sure. For the past 12 months, 33.6% (N = 578) responded that they experienced depressive symptoms, 49.3% (N = 578) answered that they did not, and 17.1% (N = 578) indicated that they were not sure. About one third of the participants 33.8% (N = 532) sought any treatment to reduce they depressive symptoms, in comparison to those who did not - 66.2% (N = 532). Out of those who indicated that they sought help for their depressive symptoms, 20.4% (N = 201) answered that they went to a psychologist, 9% (N = 201) - to a psychiatrist, 8% (N = 201) - to a family member, 33.3% (N = 201) - to a friend, 14.4% (N = 201) indicated self-monitoring, 8% (N = 201) - to a school counselor, .5% (N = 201) turned to an
alternative healer, and 6.5% (N = 201) sought help at a religious association. Out of those who answered that their family member had a history of depression (22%, N = 574), 43% (N = 121) answered that they were treated with medications while only 25.6% (N = 121) attended psychotherapy, and 31.4% (N = 201) had combined therapy of antidepressants and psychotherapy.

Preferences for treatment

The majority of participants reported a preference for psychotherapy (56.1%, N = 540), and only 6.5% (N = 540) preferred medications, while 16.5% (N = 540) of respondents chose homeopathic treatment, and 20.9% (N = 540) had no preference.

Open-ended responses were coded into specific themes and the frequency of responses in each was reported. For Psychotherapy responses the following themes were identified: “Revealing” – “It is better to talk thing out and share your problems”, “Efficacy” – “Psychotherapists are trained professionals, and they know how to help”, “Medication stigma” – “I do not want to rely on drugs and become dependent on them”, “The cost” – “Psychotherapy is expensive”. Responses in Medication group were coded into themes such as “Efficacy” – “Drugs are meant to work”, “Easiness” – “Medications are easy to use”, “Stigma of mental illness” – “I would rather take medications than tell anyone that I have such problems”, “Privacy” – “I prefer not to share my thoughts and experiences with a stranger”, “Quick results” – “Medications work fast”. Coding was performed using the created coding book, and inter-rater reliability was 92%.

Out of 279 open-ended responses from those who preferred psychotherapy as their primary choice for treatment of depression, the majority of people (68.5%, N = 279) indicated that psychotherapy is helpful because it helps by revealing problems, 22.6% agreed that counseling specialists are professionals, and, therefore, psychotherapy should be effective, 13.3% of respondents showed their stigma towards medications and their unwillingness to rely on them, and only .4% mentioned the cost of psychotherapy. In the group preferring medications, out of 33 answers, the majority (48.5%) indicated their belief in the results of medications, 21% indicated that they would choose medications to avoid talking to another person about their problems, 18.2% agreed that medications are easier for treatment, 12% responded that results are faster on antidepressants, and 3% demonstrated general stigma towards mental illness.

Chi square tests were performed to determine whether there were statistically significant differences between generation status and treatment selection. Originally, we planned to compare across 4 groups of generations (1st, 1.5, 2nd, and 3rd and above). However, since the sample sizes for the two first generations groups (1st and 1.5) were significantly smaller in comparison to the two subsequent generations groups (2nd and 3rd and above), we combined first generations into one leaving all sample sizes large enough to compare (Table 2). While not significant ($\chi^2(6) = 9.008, p = .173$), we found that a higher proportion of respondents in the 1st generations group (61.2%, N = 129) reported the highest preference for psychotherapy as compared to those in the subsequent generations (2nd - 53.8%, N = 253, 3rd - 57.3%, N = 143). Interestingly, the lowest percentage of those with the preference of medications was in the 2nd generation group (4.7%, N = 253) in comparison to the 1st generations (7.0%, N = 129) and 3rd and above generations group (9.8%, N = 143).

Chi square tests were performed to determine whether there was a relationship between each category of BDI-II (no
depression, mild, moderate, and severe) and a type of the preferred treatment. The results were significant, $\chi^2(9) = 27.536^a, p < .01, N = 540$. Post-hoc measures for each event category revealed significant residuals in medication preference group for those with the lowest and the highest scores on BDI-II.

**Acculturation**

A one-way ANOVA test did not reveal any significant differences between preference for treatment and levels of acculturation on the nondominant culture subscale ($F(3,536) = 1.083, p = .356$). There was a significant mean difference in the acculturation scale for the dominant subscale score among different types of treatments ($F(3, 536) = 6.756, p < .001$). Specifically, post-hoc comparisons (Bonferroni-adjusted) revealed that those who had higher scores on the scale were more likely to prefer psychotherapy ($M = 46.2$, $SD = 5.5, p < .01$) and natural/homeopathic treatment ($M = 45.5$, $SD = 6.5, p = .031$) compared to those who have no preference ($M = 42.9$, $SD = 8.6$). This suggests that the choice of treatment has an impact on the levels of immersion into the dominant (U.S.) culture. Moreover, those who scored high on the dominant subscale with the preference for psychotherapy and natural/homeopathic treatment differ significantly from those who have no preference (Figure 1).

**Discussion**

This study investigated the preferences for treatment of depression across generations of immigrants. Overall, we found that people state that they prefer psychological types of treatment in comparison to pharmacological. However, there were no statistically significant differences in treatment choice across generations of immigrants. Also, acculturation level did not seem to play a significant role in the selection of treatment. However, those who had higher scores on the scale that measured level of immersion into the U.S. culture were more likely to choose psychotherapy and homeopathic types of treatments.

As we anticipated and consistent with the previous research, people in general prefer psychological types of treatments (Givens et al., 2007; Houle et al., 2013). However, the majority of the participants indicated that their family members who were diagnosed with depression by a doctor received antidepressants as their treatment. This suggests that regardless of their stated preference, people in general tend to receive pharmacological treatments over psychological. Perhaps, regardless of the preference, people are not given a choice of the treatment, and may rely on the doctor’s suggestion or opinion. In addition, other factors may contribute to this decision making process such as the cost of medication versus therapy or the time involved.

Previous studies suggest that patients get depression treatment primarily from a primary care physician (Petterson et al., 2014; Wang et al., 2006). In addition, primary care practitioners tend to be less likely to provide referrals for their patients for mental health services due to financial barriers to obtain those and their concern that mental health specialists do not seem to be interested in implementing an integrative and collaborative system of health practices (Beacham et al., 2012). Consequently patients will have low rates mental health service utilization, and thus, medications are the only other option available.

Since research has suggested that there are some racial/ethnic differences in treatment preferences, and the immigrant paradox posits that there are clear differences between generations of immigrants, we hypothesized that acculturation may play role in the selection of the treatment for depression. However, contrary to our hypothesis, we did not find any
differences in treatment preference for depression across generations. Based on our results, it seems that regardless of whether an individual was born in the U.S. or immigrated here later in life, he or she would have the similar treatment preferences.

We also examined whether treatment selection was related to acculturation level; however, once again we did not find a significant relationship between treatment selection and acculturation level. We did find that people who scored higher on the acculturation scale of the immersion to the dominant (U.S.) culture were more likely to prefer psychotherapy as their primary choice of treatment. These findings have some relevance to previous research which suggests that people who identify themselves as belonging to a minority group are less likely to seek help for depression and appear to have lower rates of mental disorders. Such behavior may be either due to their limited knowledge of mental disorders, and, therefore, failure to identify them, or it may be due to limited resources (Kim et al., 2011; Coffman & Norton, 2010; Park & Rubin, 2012). Results comparing the levels of immersion into the U.S. culture and the likelihood of choosing psychotherapy suggest that the more people become acculturated to the U.S. culture, the more knowledgeable they become about the existence of treatments for mental disorders, specifically, psychotherapy.

Based on our analysis of open-ended questions, we found that respondents acknowledged the fact that psychotherapy was useful but difficult to access since it was expensive and required more time. Results showed that those who expressed a preference for psychotherapy as the primary treatment for depression indicated that psychotherapy seemed to be more helpful since it allowed for revealing one’s problems to someone who has appropriate training. Participants acknowledged the experience and training of mental health professionals, and were willing to trust them as a primary choice of treatment. In comparison, participants that expressed their preference for medications believed that antidepressants assured quick remission, were easy to obtain, and did not disrupt one’s daily schedule. Participants also showed an unwillingness to share their feelings and expressed a higher belief in the results of medical interventions. Since this study assessed people’s reasoning behind their treatment choice qualitatively, these findings contribute to the existing debate of treatment preference. Based upon these findings, we may conclude that the general preference for psychological treatments is based on people’s trust in psychological interventions and the nature of talking therapy while the final choice of medications is based on the idea that medications are there to help and meant to solve medical issues, and it seems to be the most convenient for majority of people.

The significant relationship between the severity of depressive symptoms and treatment preference suggests that the level of the severity of the depressive symptoms can contribute to the treatment choice. Those who scored highest on the BDI-II were significantly more likely to choose pharmacological types of treatments for depression. This finding may suggest that quick results and convenience in the utilization of antidepressants were more valuable and preferable when the overall affective well-being was more impaired. This is consistent with the previous research suggesting that higher levels of symptoms severity were associated with the higher antidepressant adherence (Aikens et al., 2008). Since the majority of participants who had chosen antidepressants as their primary treatment preference indicated that medications were effective in resolving medical issues, it may suggest that people who have increased depression levels view it more as a
medical illness and thus rely more heavily on pharmacological interventions.

This study has several limitations. First of all, we used a convenient sample of college students. While there was large number of first and second generation students in the sample, they were generally young, and it is unclear how well they represent the general immigrant population of the U.S. Second, the study was designed so participants had to fill out self-reports. Even though self-reports are the most convenient way for collecting data, we had no way of verifying the accuracy and quality of the data. Third, we examined race and ethnicity as a whole, and there are likely more within race/ethnic groups differences than between racial/ethnic group differences in terms of their beliefs and views. And finally, results for treatment choice explanations may have been influenced by the fact that participants were students taking courses generally in a psychology major; therefore, they may have more basic knowledge of mental illness and types of treatments and cannot represent general population.

This study has important implications for health care providers who prescribe antidepressants in the primary care settings. Since a large body of research suggests that people have significantly greater preference for psychological treatments of depression, this should be taken into serious consideration when making treatment recommendations. Since we cannot be sure what exactly causes the inconsistency between treatment preference and the type of treatment received, primary care doctors may certainly impact the decision making of their patients. This may especially true for those who are new to the country and who have limited knowledge about the different forms of treatment. Since pharmacological treatments are not the primary stated choice for treatment of depression, medical care providers should take more time to explore and provide a range of choices to their patients. Such considerations should be taken into account in treatment of immigrant populations who may not have knowledge of existing options or may not have direct access to many services.

Given the potential long lasting effects of psychotherapy, further research should be done to investigate the discrepancy between people choice and actual behavior in regards to the treatment choice for depression. Possible factors that contribute to selection of a particular type of treatment should be assessed. Since there were some statistically not significant differences between generations of immigrants and treatment preferences, further research should be conducted on the general population to see whether immigration status predicts treatment selection.

References


ATTITUDES ACROSS GENERATIONS OF IMMIGRANTS | SHAPOVAL & JEGLIC


**Appendix**

### Table 1 – Demographics

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### Table 2 – Preferences of treatment across generations

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</tr>
<tr>
<td></td>
<td>N</td>
</tr>
<tr>
<td>Psychotherapy</td>
<td>79</td>
</tr>
<tr>
<td>Medications</td>
<td>9</td>
</tr>
<tr>
<td>Natural/Homeopathic</td>
<td>18</td>
</tr>
<tr>
<td>No preference</td>
<td>23</td>
</tr>
<tr>
<td>Total</td>
<td>129</td>
</tr>
</tbody>
</table>
Figure 1.
Main Effect of Treatment Preference in Dominant Subscale of Acculturation Scale

What type of depression treatment would you prefer?
- Psychotherapy
- Medications
- Natural/Homeopathic treatment
- No preference

Error Bars: 95% CI