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A Study of Psychiatric Inpatient Satisfaction on an Asian-Focus Unit

by

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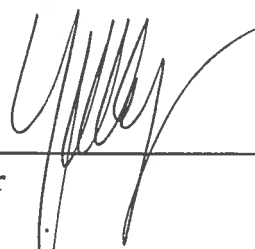
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Chapter One: Culture, Psychiatry, and Addressing the Mental Health Needs of the Asian American Population

This study assesses patient satisfaction on a psychiatric inpatient unit that was designed to give care to Asian Americans. The establishment of the Asian-focus unit was intended to break down barriers to mental health services for a population greatly underserved in this arena, by offering culturally accessible and acceptable mental health services to the Asian American population.

Our study set out to answer three questions: 1) Are the patients satisfied with this specialized unit?; 2) Do patients of different ethnicities differ in their levels of satisfaction?; and 3) What aspects of the hospital stay on this unit contribute to overall satisfaction?

By addressing these questions, we hoped to see to what extent the unit has met the needs of a population usually excluded from adequate mental health care.

From 1980 to 1990, the Asian American population increased by 107.8%, comprising 2.9% of the United States population in 1990. The city of San Francisco's current population is 29% Asian. This ethnic group is expected to grow by 68.7% by the year 2000.¹ Thus, implications for the provisions of mental health service in this San Francisco community are vast.

Several community outpatient centers with a focus toward Asian American immigrants and refugees exist in San Francisco and the country at large. However, inpatient psychiatric units for Asian American care are

¹Center for the Continuing Study of the California Economy, 1988.

extremely scarce.

At present, there are only two Asian-focus inpatient psychiatric units in the country. The first was opened in 1980, in San Francisco General Hospital's (SFGH) Department of Psychiatry. This 21-bed Asian American/Pacific Islander-focus unit was created to address the needs of the 210,000 Asian American inhabitants of the city of San Francisco. (Please note that I will use the term "Asian American" to refer to both Asian Americans and Pacific Islanders.) The unit (Unit 7C) was designed to accept Asian Americans from a diverse community, from well-aculturated naturalized citizens to recently arrived Southeast Asian refugees.

During the program's first four years, the highest priority was to hire bilingual, bicultural staff. Currently, two-thirds of the staff members and trainees are Asian American. In addition to English, the staff speak a variety of languages including Cantonese, Mandarin, Toishanese, Tagalog, and Vietnamese. A majority of the staff were born, raised, and educated in China, the Philippines, or Vietnam; many of the staff are themselves immigrants or refugees. The personal experiences of these staff members have helped them and other staff members to understand the psychological plight of many patients that this unit serves. Studies have demonstrated that ethnic, linguistic, and cultural similarities between client and therapist decrease the dropout rate and improve effectiveness of care (Lee, 1985; Sue et al., 1991).

Many of the unit activities reflect this dedication to cultural diversity. For example, the staff conducts small group and community meetings in various languages. Magazines and newspapers are available in many languages, and Asian art decorates the walls. Furthermore, ethnic holidays, such as Chinese New Year, are routinely celebrated. Rice and tea are served at every meal, and

families are encouraged to bring in home-cooked meals.

Diagnosis and treatment is not based on a solely biomedical approach, as is often used in other inpatient psychiatric hospitals; rather, Unit 7C attempts to incorporate the "ethnomedical model" (Lee, 1985) into diagnosis and treatment. This is based on having an understanding of the cultural expression of mental illness, knowledge of the historical and cultural background of patients, and an awareness of cultural beliefs and health practices. The unit uses some unique assessment tools to identify cultural expression of mental disorders, such as the Vietnamese Language Depression Rating Scale developed by Kinzie et al. (1982)². Physical examinations are routinely performed, and add a lot of information to the assessment, since most refugees are admitted with physical complaints.

Family assessment, intervention, and education are highly emphasized in the program. As the family unit is particularly important in Asian culture, an attempt is made to keep families involved in the process of treating the mentally ill family member.

Many studies have shown that antidepressant and psychotropic medication dosages for Caucasians may not be appropriate (i.e. are too high) for many Asians (Lin, 1985). This fact is recognized on Unit 7C, and patients are treated accordingly. Furthermore, many patients are more accustomed to Chinese herbal medicine and are unfamiliar with the concepts of western medicine dosages or their side effects. Unit 7C attempts to reconcile any misunderstandings with full histories of past medication used by the patient, and education to families and patients about the western drugs.

²Kinzie JD, Manson SM, Nguyen TT, Bui A, Pho NP: Development and Validation of a Vietnamese Language Depression Rating Scale. *American Journal of Psychiatry* 1982, 139: 1276-1281.

Activities are geared to make patients feel more comfortable on the ward. Some are designed for all patients, while others are especially for monolingual patients. Small discussion groups are conducted, which discuss a wide range of issues, such as past life experiences in the country of origin, joys and disappointments about being an immigrant, attitudes toward western versus herbal medicine, and questions about diagnosis. Refugees tend to become more expressive, open, and verbal when discussions are conducted in their own language. There is an attempt to make activities culturally familiar, including table tennis, cooking, meditation, physical exercise, and English tutoring.

Lastly, the program has developed extensive contacts with posthospital care agencies, such as community mental health centers, day treatment outpatient programs, and residential care facilities. Unit 7C works with these agencies to facilitate patient transition from the hospital to the community, with continued follow-up care.

In short, Unit 7C has specific goals that it is trying to address:

1. Provide culturally relevant clinical inpatient services for the Asian American residents of San Francisco
2. Provide multidisciplinary training opportunities for students and clinicians interested in inpatient services to Asian American patients
3. Provide consultation services to other departments and agencies
4. Conduct mental health clinical research on the Asian American population³

Why, however, is there a need for Unit 7C? The unit was founded to try

³Lee: Inpatient Psychiatric Services for Southeast Asian Refugees. In TC Owen (ed.) *Southeast Asian Mental Health: Treatment, Prevention, Services, Training, and Research* 1985, 309.

to solve some of the mental health service challenges in providing care to Asian Americans. For example, several studies have shown that Asian Americans use mental health services at a much lower rate than do other ethnic groups. This is not likely due to lower rates of mental illness among Asian Americans; rather, it has also been shown that when they do use inpatient psychiatric services, Asian Americans tend to stay longer than other ethnic groups, indicating more severe psychopathology (Snowden and Cheung, 1990; Sue and McKinney, 1975; Sue and Sue, 1987; Flaskerud and Hu, 1992; Shon and Ja, 1982).

In addition, Asian Americans have a high dropout rate from mental health services. Sue and McKinney (1975) studied nearly 14,000 clients in 17 community mental health clinics in the Seattle area. Their results showed that, relative to their proportions in the general population, African Americans and Native Americans were overrepresented in the mental health centers, while Asian Americans and Latino Americans were underrepresented. However, they also found that regardless of the differences in utilization rates, all of the ethnic-minority groups had a significantly higher drop-out rate after one session than did the Whites. For example, while Whites had a 30% dropout rate, Asian Americans had a dropout rate of 52%.

In analyzing these statistics, Sue and Zane (1987) concluded that "there is ample evidence that minorities are not faring well in our mental health system." They agreed with past researchers on some of the possible reasons for the inadequacies in mental health services, such as the lack of bilingual therapists, stereotypes therapists have of ethnic clients, and discrimination. However, they emphasized that "the single most important explanation for

the problems in service delivery involves the inability of therapists to provide culturally responsive forms of treatment."⁴

In fact, Sue and McKinney (1975) reported that during the last year of their three-year study, an Asian American Counseling and Referral Service was founded in Seattle, and that in one year, this agency saw the same number of Asian American clients as did all seventeen community mental health clinics over a period of three years! The authors attributed the greater responsiveness of Asian Americans to this clinic to widespread publicity, the use of bilingual therapists, and perhaps most importantly, "the ability of the therapist to understand the needs and lifestyle of Asians in the community."⁵ Subsequently, Sue et al. (1991) found in a similar study in Los Angeles County that dropout rate amongst Asian Americans, Mexican Americans, and Whites was lower when patients and therapists were matched for ethnicity and/or language. Among such patient-therapist matches with Asian and Mexican American clients, the drop-out rate was significantly lower when the patient's primary language was not English (a category which includes many less acculturated immigrants); furthermore, for this subgroup of patients, ethnic match was significantly associated with better outcome.

This chapter will address some of the sociocultural explanations as to why the underutilization and high dropout rates occur. In addition, this chapter will elucidate some of the ways in which Unit 7C has tried to address these sociocultural barriers; our study assesses whether patients are satisfied with

⁴Sue & Zane: The Role of Culture and Cultural Techniques in Psychotherapy: A Critique and Reformulation. *American Psychologist* 1987, 42:37.

⁵Sue & McKinney: Asian Americans in the Community Mental Health Care System. *American Journal of Orthopsychiatry* 1975, 45:117.

the unit's attempts.

Before continuing, however, it should be noted that the following discussion about "Asian Americans" makes several generalizations about an ethnic group comprised of several distinct populations. Each specific Asian ethnic group has its own history, social issues, cultural traditions, and belief systems about illness that cannot be adequately addressed in this format. What is presented here are some common themes that are seen in most Asian populations. In addition, the information presented must be considered only as a backdrop in the treatment of any individual patient; a health care practitioner must be aware of *potential* ethnocultural issues relevant to the treatment process, without assuming that these issues will be relevant to the individual patient.

Beliefs Regarding Mental Illness, and How These Affect Help-Seeking, Service Utilization and Symptom Manifestation

One of the reasons for underutilization and high dropout rates by Asian Americans is that these clients are not satisfied with mental health services. Satisfaction includes having the client's expectations met; expectations are culturally based, and include not only ideas about what treatment should be, but also how illness is defined.

Two components exist to that which both psychiatric professionals and lay people label as *mental illness*. The first is *disease*, which refers to physiological abnormalities in the structure and function of body organs or systems. ("Mental disease" can also refer to a psychological abnormality.) Fabrega (1982) describes psychiatric disease as "underlying organic processes in the central nervous system that are universal among *homo sapiens*."⁶ The

⁶Fabrega: Culture and Psychiatric Illness: Biomedical and Ethnomedical Aspects. In Marsella

second component is *illness*, which is the human experience of sickness, or what a patient suffers. Illness includes "experiences of disvalued changes in states of being and in social function,"⁷ or the "domain of personal experience (e.g., self definition, attitudes toward others, emotions, role functioning)"⁸ that accompanies the state of being sick.

As illness is what a mentally ill person feels (e.g., a person does not feel schizophrenia; rather, the person feels the impact of having schizophrenia -- not only the thought disorders, but perhaps also a loss in function, unemployment, a disruption in family and social relations, a sense of ostracism, and the carrying of a highly stigmatic label of "schizophrenic"), to truly heal the mentally ill person, it is the illness that must be dealt with, and not merely the physiological or psychological disease category.

How, then, can an illness be treated? This depends foremost on how the illness is defined for a given individual, or in other words, how the disease affects an individual's life. Fabrega (1982) posits that:

... an individual's theory of illness and of self, which impact on one another and are complementary, strongly influence how an underlying psychiatric disease condition expresses itself psychosocially or in psychiatric illness generally. This means that (1) an individual's representation or attributions about illness, illness causes, mental functioning, body functioning, symptoms, etc. together with (2) an individual's representation or attributions regarding personhood (e.g., volition, self-control, boundaries of the self, social responsibility, etc.) play a critical role in how the underlying psychiatric disease process is expressed in behavior, how it unfolds, how it is handled, how long it lasts, and indeed how it is shunted about in the social

& White (eds.) *Cultural Conceptions of Mental Health and Therapy* 1982, 51.

⁷Kleinman et al.: Culture, Illness and Care: Clinical Lessons from Anthropologic and Cross-Cultural Research. *Annals of Internal Medicine* 1978, 88:251.

⁸Fabrega (1982), 39.

system. The person who is psychiatrically ill is thus held to behave and function in ways which reflect his or her theory of illness-self. (p. 39)

The aspects contributing to the experience of mental illness that Fabrega outlines above are clearly influenced by cultural conceptions. For example, Westerners typically view the human being as an individual entity, while including the notion of a mind-body dichotomy. Many Asians, however, perceive the mind and body to be more unified in function; furthermore, a human being's functions (of both mind and body) depend on an internal balance that can be influenced by external factors, such as the movement of the planets, or supernatural spirits. A different conception exists of boundaries of the self, as well as of mental and bodily functions.

Therefore, the *meaning* given to having a mental illness is defined by cultural explanations of the reasons for and the implications of having such an illness. Kleinman et al. (1978) summarize:

Illness is culturally shaped in the sense that how we perceive, experience, and cope with disease is based on our explanations of sickness, explanations specific to the social positions we occupy and systems of meaning we employ. These have been shown to influence our expectations and perceptions of symptoms, the way we attach particular sickness labels to them, and the valuations and responses that flow from those labels. How we communicate about our health problems, the manner in which we present our symptoms, when and to whom we go for care, how long we remain in care, and how we evaluate that care are all affected by cultural beliefs. Illness behavior is a normative experience governed by cultural rules: we learn 'approved' ways of being ill. It is not surprising then, that there can be marked cross-cultural and historical variation in how disorders are defined and coped with. (p. 252)

The problem is that in order to heal a patient's illness, the practitioner must first understand what the illness is that needs to be healed. Cultural barriers may preclude the practitioner from truly understanding all the significant components of the illness for the patient. The practitioner also needs to give explanations and recommendations for treatment. However, practitioners, like their patients, carry their own culture-specific explanations and models of illness, and therefore patients may not fully understand or agree with proposed treatments. Culturally dystonic "explanatory models of illness" (Kleinman, 1980) can thus hinder communication and establishment of the therapeutic rapport between practitioner and patient that is necessary for effective treatment.

An individual's conceptualization, or "explanatory model," of an illness includes theories about the illness' etiology, what parts of the body are affected, and what should be done to treat it. An example of how an Asian American's explanatory model of illness may differ from that of the western practitioner involves the issue of somatization, a well-acknowledged "phenomenon" that has been observed when Asian Americans with psychological problems (particularly refugees and immigrants, and most notably Chinese) seek professional care. Somatization is defined as a patient's presenting with bodily complaints, though little or no physiological evidence for the patient's complaint is discovered with examination or laboratory tests; the phenomenon of somatization is usually due to an underlying psychosocial problem. It would appear evident that if one were to somatize, or have a physical conceptualization with physical symptoms for a psychological problem, then one would seek professional help that would deal with physical disorders (i.e. that of a medical doctor or a traditional

healer).

However, is somatization the true reason why Asian Americans underutilize mental health services? While several researchers have argued that somatization of psychological problems directs patients to seek more physical-oriented care, more recent work suggests that it is the type of care that patients seek that directs them to present their symptoms in a certain way.

Some reasons for the somatic complaints seen among this population of patients have been proposed. One is a general reluctance to openly display emotion, based on the ethics of Confucianism. Confucianism teaches that expressing one's feelings overtly is a sign of weakness, as well as a disruption of social harmony. It also teaches that one should suppress one's true feelings towards people of higher status (Kawanishi, 1992); this could feasibly apply to the suppression of emotion in front of a professional health care provider.

A second reason is due to the stigma associated with mental illness; this stigma is especially strong in many Asian cultures. Presenting the disorder to a healer as a physical problem keeps outsiders from knowing about the mental illness, while providing the patient with a legitimized sick role with which to seek care (Kawanishi, 1992; Lin et al., 1985; Kleinman, 1980). In this case, somatization can be seen as a coping mechanism. As Lin et al. (1985) explain, "[Somatization] mobilizes social support from the family and the community and provides relief from routine responsibilities."⁹

A third reason attributed to the somatization is that there may be lack of vocabulary in a patient's Asian language that specifically refers to feelings of depression (Kawanishi, 1992; Kleinman, 1980). As a result, patients may try to

⁹Lin et al.: An Exploration of Somatization among Asian Refugees and Immigrants in Primary Care. *American Journal of Public Health* 1985, 75:1080.

convey their distress in physiological terms, such as gastric complaints, insomnia, or sensations of weakness. Patients may also use more "metaphorical" descriptions; for example, Kleinman (1980) reported that depressed Chinese patients sometimes complain that they feel something "pressing down" on their chests or on their heads. They said that they felt that their hearts were "locked in," or "suffocating behind a door," pointing to their chests to locate the feeling. Kleinman said that these patients did have a word meaning "depressed," which is *mên*, whose written character is the heart radical enclosed within the doorway radical. Thus the basis for the somatic expression can be seen.¹⁰

However, Kleinman argued that to the Chinese patients he spoke with, *mên* indicated a physiological rather than a psychological state. This is where the controversy arises. He concluded, "The metaphors communicate how they feel in physical imagery in which the affect is inferred. The physical imagery rather than the affect is most real. The idiom makes the experience primarily somatic."¹¹ In fact, Kleinman (1982) states that among Chinese patients, "Most cases of depression and many other psychiatric disorders are *perceived, experienced, and labeled as physical problems*"¹² (emphasis added). The controversy about Kleinman's (and others') conclusions is the idea that Chinese (or other Asian) patients do not *conceptualize* psychological problems psychologically. What Kleinman failed to note is that there may be a difference between a patient's conceptualization of illness and what he or she presents to a health care practitioner as complaints.

¹⁰Kleinman: *Patients and Healers in the Context of Culture*, Berkeley, University of California Press, 1980, 140.

¹¹*Ibid*, 141.

¹²Kleinman: Selected Issues in Treating the Chinese Patient. *Hospital Physician* 1982, 18:59.

A vivid example of the problem of Kleinman's analysis is given by Kawanishi (1992). He quotes Kleinman's (1980) description of a depressed Chinese woman who expressed her feelings by saying, "Suppose you were climbing a very steep mountain, to the right and left people are falling off the mountainside ..." Kawanishi argues that although this woman did not use the language that western psychotherapists are accustomed to, her words can certainly not be described as lacking expression of affect. Rather, her description can be seen as an articulate metaphor indicating her emotional distress. Likewise, he argues, patients who use somatic idioms should not necessarily be regarded as unable to articulate their psychological difficulties.¹³

Several studies have shown that Asian patients can conceptualize mental illness with psychological models, and that use of somatic idioms is contextually based. For example, in many Asian countries, the practice of psychiatry has not been well established. Therefore, when patients go to see a doctor, they *expect* medical (physically-based) care. Likewise, when such patients migrate to the United States, they expect any doctor they see to be more concerned with physical problems than with emotional. They will therefore present to the doctor what they believe the doctor will find relevant to their care. Consistent with the concept of a unified body and mind, when such a patient is feeling psychological distress, the patient will present the somatic equivalent of the emotional problem to the doctor, believing that physical symptoms are what the doctor wants to know. Many researchers and clinicians accustomed to working with Asian psychiatric patients report, however, that when given enough time (i.e. to establish trust in the therapist

¹³Kawanishi: Somatization of Asians: An Artifact of Western Medicalization? *Transcultural Psychiatric Research Review* 1992, 29:19.

and an understanding of the therapy process) and when directly asked about emotional distress, the patients will frequently cite underlying psychological difficulties as their major problem (Kawanishi, 1992; Westermeyer, 1989; Cheung, 1987; American Psychiatric Association Committee of Asian-American Psychiatrists, Forum at 1993 APA Conference).

Furthermore, several studies have determined that when Asians/Asian Americans do have psychological conceptualizations, the coping mechanisms for psychological problems involve dealing with the problem on one's own or consulting close friends or family. Only if the psychological problem were quite serious would an individual seek professional help, most likely from a general practitioner (Ying, 1990; Cheung and Lau, 1982; Cheung et al., 1983; Cheung et al., 1984; Cheung, 1987).

The studies cited above elucidate some of the problems in Kleinman's and others' conclusions. If researchers were only to look at presenting symptoms among Chinese patients in a health care facility, they would likely only notice somatic symptom presentation, even if an underlying psychiatric problem could be diagnosed. This is because (1) patients who conceptualize their problem in purely psychological terms tend to avoid professional treatment, and (2) once patients do seek out professional help, they may only tell the doctor about somatic symptoms, based on their beliefs about the doctor's concerns.

Although the studies cited above concern Chinese patients, a generalization can be made in terms of Asians and Asian Americans of any ethnicity: While somatization is seen among many Asian patients, it cannot be assumed that the somatization is purely due to an intrinsic trait of the patient. In other words, while symptom presentation may be purely the

result of an individual's cultural or personal conceptualization of his or her illness, this is not necessarily the case, and may equally likely be the result of the processes of the doctor-patient interaction.

Nevertheless, the expression of mental illness in physical symptoms *in front of a health care provider* is commonly seen in work with Asian American patients. This is something that more medical and mental health professionals need to be aware of, as it becomes a barrier to mentally ill Asian American patients receiving proper psychiatric care. These patients may spend months to years in the medical system, getting shifted from physician to physician, and undergoing many expensive (and ultimately useless) tests, until finally reaching a mental health professional.

Unit 7C has tried to play a role here. Part of their provision of "culturally relevant" mental health services involves a thorough physical exam. (This not only addresses the issue of somatization, but also the fact that many refugees present with manifestations of physical trauma.) Furthermore, staff are educated on the possible physical presentations of psychological illness. Unit 7C is also part of a teaching hospital, and teaches medical students and clinicians about treating Asian American patients. Finally, the unit consults with other hospital departments. These efforts are present to make practitioners more aware of "somatization" among Asian Americans, and to help get psychiatric care to these patients in a more timely matter.

In our study, we asked patients if they felt that their needs were met; this allowed patients who may have presented with physical complaints to think about whether or not the staff on Unit 7C were able to effectively treat the patients' underlying difficulties.

• Cultural Beliefs and Their Effects on Mental Illness Conceptualization and Treatment Expectations

Among many Asian Americans, conceptualizations of mental illness have their roots in fundamental cultural beliefs. For example, Confucianism, Taoism, and Buddhism are the three major philosophical and religious teachings at the foundation of ethics and morality in many Asian cultures; as will be explained later, these doctrines also have significant impact on the interpretations of mental illness. Likewise, they have similar implications for the delivery of effective mental health services.

Confucianism has been described as traditionally having "the most pervasive influence on Chinese behavior."¹⁴ Confucianism sets the rules for properly conducting one's social interactions. Its teachings stress reciprocity; loyalty, especially to one's superiors and elders; benevolence; character building, which emphasizes demonstrating self-respect and self-reliance by exerting restraint over one's emotions and avoiding extremes; and face-saving, or keeping an honorable family name. Confucianism deals with issues such as the family hierarchy and filial piety. It also emphasizes that an individual's actions can reflect well or poorly on the family name, and that each individual should model his or her actions accordingly (Lee, 1986; KM Lin, 1980).

Taoism is an integral component in the explanatory models of health in many Asian societies (Tseng, 1973; KM Lin, 1980; TY Lin, 1980; Lee, 1986; Pham, 1986; Muecke, 1983). Under Taoism, people search for *tao*, or "the way" to live one's life harmoniously in relation to the cosmological, social,

¹⁴Lee: The Chinese Perception of Mental Illness in the Canadian Mosaic. *Canada's Mental Health* 1986, 2.

and natural environments. Such harmony includes microcosm and macrocosm relationships. The microcosm involves an individual's inner organs and *ch'i*, or the circulating "vital essence" that keeps the organ systems and the body itself functioning in a balanced manner, including emotional balance. Macrocosm refers to the surrounding universe, including astronomical movement, the seasons, the weather, and geomancy. A link exists between every individual's inner organs and emotions and the surrounding universe; to be healthy, an individual must exist in proper balance, both within his or her body and in relation to his or her environment.

Yin-yang, another component of Taoism that is particularly significant for health, refers to contrasting but complementary elements of the body and of the universe. *Yang*, for example, signifies the active, excited, external, forward, aggressive, volatile, hard, bright, and hot elements, as well as the abstract and functional. *Yin* refers to the passive, inhibited, inward, unaggressive, cold, dark, and soft, as well as the material and concrete (KM Lin, 1980). For the body to be in balance and therefore functioning properly, the *yin* and *yang* elements must also be in balance. For example, a common fear among Chinese men is that excessive sexual activity will lead to loss of *yang*, causing weakness and sickness. Therapy, involving dietary modification and use of herbs, would be aimed at restoring *yang* to its proper levels. As *yang* represents the hot in one's body, for instance, therapy for a man who had lost some *yang* could involve eating foods that are designated as "hot" (Kleinman, 1982).

The Five Natural Elements (wood, fire, earth, metal, and water) also affect one's well-being. These inorganic elements interplay via facilitation and

inhibition; for example, water helps wood grow and wood facilitates fires, while water inhibits fire and fire melts metal. These five elements also correspond to internal organs, emotions, and climate, and just as they interact to maintain balance in the external world, they also represent internal balance within a person. The five main organs (liver, heart, spleen, lungs, and kidney), the five main emotions (anger, joy, worry, sorrow, and fear), and five climatic factors (wind, heat, humidity, dryness, and cold) correspond respectively to each other and to wood, fire, earth, metal, and water (Tseng, 1973). For instance, too much wind can make someone angry; worrying too much may be attributed to a dysfunction in the spleen. *Ch'i*, the vital essence that circulates from organ to organ, can affect the corresponding emotions and vice versa. When *ch'i* is concentrated on the heart, for example, joy is created. Conversely, joy improves circulation of *ch'i*, while sorrow disturbs its circulation. Thus, to maintain healthy circulation of *ch'i*, it is believed that one must avoid excessive expression of emotions (Tseng, 1973). Furthermore, since *ch'i* is considered vital to the maintenance of all organ functions and is virtually irreplaceable, any loss of *ch'i* or obstruction of its circulation is believed to have serious consequences for one's health and well-being (KM Lin, 1980).

All of the elements described above may go through changes, even temporarily falling out of balance; such is the nature of the dynamic universe we live in. However, if balance cannot be restored, dysfunction, either physical or psychological, may ensue. Therefore therapy, even for psychological problems, tends to be somatic or medical, aimed at restoring the balances within the body. This would seem rational, since, according to this explanatory model, the anatomical-physiological functions of the body are

integrally linked to the psychological. (In terms of preventative medicine, the martial art *tai-chi* is practiced to train the body and mind together in achieving a state of internal balance [TY Lin, 1983].)

Lastly, Buddhism, which originated in India but has widespread influences in Asian cultures, plays a role in daily living and health practices (Lee, 1986; Mollica et al., 1987; KM Lin, 1980; Tseng, 1973; Muecke, 1983). Buddhism teaches that one's life here on Earth is temporary, but that reincarnation will occur after one's death. Therefore, the effects of one's actions can have important consequences in subsequent lives. Buddhism stresses that one must accumulate good deeds in order to achieve a higher state of being in the next life (Lee, 1986).

In many Asian cultures, the supernatural has an important effect on one's well-being (KM Lin, 1980; Lee, 1986; Mollica et al., 1987; Muecke, 1983; TY Lin et al., 1980; Westermeyer and Wintrob, 1979; Ganesan et al., 1989; Kleinman, 1980). Dealing with the supernatural is generally considered to be the realm of folk medicine, and involves concepts including divination, sorcery, spirit loss, and spirit possession by gods, ghosts, or ancestors (KM Lin, 1980; Kleinman, 1982). Both Taoism and Buddhism have incorporated beliefs about the supernatural, and thus many people with illnesses attributed to supernatural influences seek help from Taoist or Buddhist priests or shamans (Kleinman, 1980; KM Lin, 1980; Ganesan et al., 1989; Tseng, 1973).

What, then, are the general explanations for mental illness, based on the beliefs described above? Granted, the exact explanations for any specific mental illness episode will vary from culture to culture as well as from individual to individual, but overall generalizations can be made. Lee (1986) and Lin and Lin (1980) describe the perception of mental illness as being

multifactorial, including moral, religious or cosmological, physiological, psychosocial, and genetic components.

The moral view holds that mental illness is caused by misconduct or deviation from socially correct behavior, especially in neglecting the proper respect due to ancestors. Such misconduct is considered a violation of Confucian norms and can therefore bring great shame upon a family. (An individual's misconduct can cause the family to "lose face.") Mental illness is regarded as punishment for the poor behavior. Consequently, "treatment" is usually in the form of a lecture from the male head of the family, to teach the mentally ill person about the virtues of good conduct, with the hope of correcting the misbehavior. Such a lecture, however, can be more of an admonishing exhortation, the intensity of which depends on the amount of shame held by the family for their failure in controlling the behavior of an individual member. As Lin and Lin (1980) point out, such preaching can make the mentally ill person feel guilty about his or her conduct, potentially complicating the problem.

The religious or cosmological etiologies also hold a punitive explanation. Drawing on the Buddhist belief of reincarnation and the Buddhist/Taoist beliefs in the supernatural, mental illness is regarded as the wrath of gods or ancestors, incurred by the mentally ill person or his or her family members in either present or former lives. In such a case, treatment may involve prayers and offerings at temples, or consulting priests or shamans, who engage in healing through expulsion of evil spirits and by divination (Lin and Lin, 1980; Kleinman, 1980).

Physiological etiologies have largely been outlined above. These may include such disturbances as *yin-yang* or hot/cold imbalances, or loss of *ch'i*.

For example, the *yin-yang* balance can be offset by excess or deficiency of physiological functions such as breathing, eating, bowel movement, sexual activity (including masturbation), and physical exercise. Such a physiological imbalance can either directly cause mental illness, or make a person more susceptible to other causes of mental illness (Kleinman, 1982; Lin and Lin, 1980). The influence of western medicine has added the popular beliefs of hormonal imbalances, vitamin deficiencies, and brain dysfunction as possible explanations for mental illness (Lee, 1986; Lin and Lin, 1980). The physiological linking of body and mind functioning has been cited by several researchers as a reason for somatization of psychological problems (especially among the Chinese). (See below for a discussion of somatization.) In general, the physiological explanation can bring more psychological relief to the family; the physiological causes of mental illness tend to be less punitive, and the mentally ill individual (as well as his or her family) does not carry as much blame for the disorder. Therefore, less shame is brought to the family name.

When the cause of the mental illness is described as physiological, remedies are aimed at restoring balance in the mentally ill individual. The family, sometimes with the consultation of traditional doctors or herbalists, may seek out special therapies including diet, herbs, tonics, and acupuncture.

Psychosocial explanations are fairly similar to some western conceptualizations of mental illness etiology. Such explanations include the occurrence of crisis situations and extreme psychological stressors, such as failure in love affairs, career and finance problems, death and mourning, or public humiliation. However, Lin and Lin (1980) argue that in Asian cultures, the breakdown of family relations is given a much greater role in

causing mental illness than it is in western cultures. This would be consistent with the importance of a strong family structure, inherent in many Asian cultures (especially with the influence of Confucianism). In discussing the Chinese, Lee (1986) nonetheless emphasizes the belief that "if one follows Confucian teachings closely, and avoids excessive and incongruent emotions, mental disturbances [due to psychosocial causes] should not occur."¹⁵

For mental illnesses believed to have a psychological cause, the initial coping mechanisms do not generally involve professional consultation (Cheung et al., 1984; Ying, 1990). In studies regarding help-seeking among the Chinese, Cheung (1987) and Cheung et al. (1983) noted that people with purely psychological conceptualizations about the etiology of mental illness tended to use self-directed psychological means to cope initially. Such coping mechanisms may include using self-control or self-resignation (i.e., the idea that nothing can be done for the psychological problem other than to accept the reality of it through self-control) (Cheung et al., 1984). Mentally ill persons have also been found to rely on their family network for social support. A few mentally ill people consult close friends, but other than that, psychiatric problems are kept within the family.

Lastly, mental illness may be attributed to genetic causes. There are two components to this: one is the idea of genetic transmission (i.e., through the genes), while the second involves concepts related to reincarnation or ancestral misconduct. For example, the misconduct of parents or ancestors can affect the mental health of descendents. For this reason, before an arranged marriage, potential parents-in-law often search back three generations into the family history of a potential son or daughter-in-law, to be assured of no traces of mental illness within the family. Likewise, it is very

¹⁵*Ibid*, 3.

difficult for parents to arrange the marriage of a mentally ill son or daughter; marriage arrangements of the siblings of a mentally ill child can also be adversely affected (Lee, 1986; Lin and Lin, 1980).

- **Stigma, Shame, and Help-Seeking Behavior**

Several consequences result from the above conceptualizations of mental illness. One major part of mental illness is the stigma associated with it, and the resulting shame that having a mental illness brings to an individual and his or her family. For most of the explanations above, mental illness is caused by wrong-doing, either on the part of the afflicted individual or by ancestors. (Physiological causes, as explained above, are less likely due to faulty behavior. An exception to this, however, is excessive sexual activity or abstinence, considered to be a main cause of *yin-yang* imbalance [Lin and Lin, 1980].) The idea of wrong-doing, as well as the problem of marrying off a mentally ill child to carry on the family name, contribute to the stigma associated with mental illness.

As a result, families with a mentally ill member try to avoid letting anyone outside the immediate family know of the mental illness. However, this method of coping is not always entirely effective, and often delays the seeking of needed professional help. Lin and Lin (1980) distinguish five phases of coping with mental illness, from the onset of the psychological problem to the utilization of a mental health institution. All phases involve the family. Since in many Asian families, the family is male- and age-dominated, the head of the family weighs the pros and cons of the views expressed in dealing with the mental illness, and takes responsibility for making decisions. When decisions are arrived at, all family members

participate in the implementation.

The first phase is exclusively intrafamilial coping. Keeping the mental illness secret within family boundaries "saves face" for the family name. In this phase, family members mobilize to provide the mentally ill member with loving care and whatever intrafamilial resources they can muster, including relying on the extended family network when necessary. The atmosphere in the family is supportive and warm, one of caring for the sick.

In the second phase, the family may find that it needs more assistance in dealing with its problem. At this point, the family may turn to close, trusted friends and some community leaders, herbalists, or religious figures, depending on the exact etiology that the family assigns to the illness. If methods such as these fail, the family may opt to turn to professional medical care.

In phase three, the family decides to consult external agencies, physicians, and ultimately a psychiatrist or other mental health worker, to seek assistance in restoring the patient's mental condition. This stage is one of consultation; the family is still very active in trying to cope with and heal the mental illness.

Phase four is one of diagnosis by the mental health professional. At this point the patient is labeled as "mentally ill." This labeling has profound effects on the family's attitude toward the afflicted individual. Such a label given to a blood relative delivers a sense of "shock" to the family. As a result, the family may attempt to resist the label, existing in a state of denial, and may therefore continue previously ineffective interventions. Thus, professional psychiatric care is avoided and delayed, perhaps while the patient's symptoms are worsening.

Eventually, the family may grow to accept the diagnosis, but as this occurs, the family also becomes less tolerant of the ill individual. This is due to both the stresses of coping with mental illness as well as the constant stigma that the "mentally ill" label brings to the family, incessantly reminding them of their guilt and shame. As a result, the family may start to feel resentment toward the ill family member. This ill individual may be thought of less as a family member and more as a "crazy" person. The family's feelings of frustration, anger, and fear are directed at the patient, adding to the ill individual's own feelings of shame and guilt. This only contributes to the mental illness.

Consultation continues with the outside agencies, physicians, and psychiatrists, and may eventually lead to occasional hospitalizations, often with the help of the police. Hospitalization removes the patient from the home, bringing some sense of relief, like a temporary vacation, to the family. Frustration tends to subside, as feelings of hope for a "cure" develop. Eventually, the patient recovers, at least temporarily, and is brought back to the home, where once again the atmosphere is one of loving care and familial warmth. However, on relapse, the entire cycle (phases one through four) repeats itself.

This sequence of intrafamilial coping/extrafamilial coping/hospitalization may continue over and over, until the period of intrafamilial coping shortens more and more and the length of hospitalization grows longer and longer. The family's tolerance decreases, they visit the patient less often in the hospital, and eventually all contacts cease between the family and the ill member. Often, hospitals will find that there is no family willing to accept the patient when he or she is ready to return home. This rejection constitutes phase five.

This is where Unit 7C attempts to step in. Nearly all of the patients on the unit are involuntarily hospitalized, often by the police, consistent with the model above. However, once a patient is hospitalized, Unit 7C attempts to keep the family closely involved with the treatment process. This includes meetings with the doctor, family, patient, and social worker, as well as family assessment and education. Furthermore, Unit 7C tries to slow down the "revolving-door" phenomenon of repeated hospitalizations by working with post-hospitalization community agencies (e.g. day treatment centers). Such liaisons allow patients a smoother discharge to their community, as well as a chance for outpatient treatment, giving them the opportunity to stay close to their families.

In our study, we asked patients how they felt about meetings they had had with their family and social worker; this question addressed the level of involvement the family had with the treatment process. In addition, we asked how patients felt about their discussions with their social worker regarding discharge plans.

•Attitudes Toward Western Treatment Regimens

Once a patient does get to mental health services, the interaction between the psychiatrist (or other therapist) and the patient becomes crucial. One barrier to engaging clients and their families in the therapy process is a difference in expectations about what meeting with a mental health professional entails. Asian American patients (particularly those who are less acculturated) may not be familiar with the mental health system and the type of doctor-patient interaction that is expected by the doctor (i.e. talk therapy). Likewise, the doctor may become frustrated with a patient that is seeking

psychiatric help, yet is unwilling to "open up" and talk about personal feelings.

Several researchers have suggested that, following the biomedical model of what a medical doctor should be, many (less acculturated) Asian Americans enter a psychiatrist's office expecting the doctor to be an authority figure who will tell them explicitly what they must do to get rid of their symptoms (Tsui, 1985; Sue and Zane, 1987; Pham, 1986; Root, 1985; Kleinman, 1982; Shon and Ja, 1982). Consistent with perceiving the therapist as an authority figure, the client and family may assume a more passive attitude, as a sign of respect. This may include not speaking unless spoken to, as well as not verbally revealing too many emotions to this superior and stranger. White and Marsella (1982) mention "the importance of indirect and nonverbal expressions of emotion in Chinese social interaction where open or strong verbal displays of emotion are contrary to cultural ideals of harmony and equanimity."¹⁶ Furthermore, Kawanishi (1992) emphasizes, "Understanding beyond what is said or overtly expressed is deeply rooted in Japanese social interactions."¹⁷

Traditional psychotherapists, on the other hand, are accustomed to assuming a less directive role, where sessions are less structured. The therapist relies on the patient to verbally express his or her feelings; it is the therapist's role to help the patient mobilize his or her own resources to develop "insight" into his or her problem.

Thus, just based on structure alone, the psychotherapeutic process breaks

¹⁶White & Marsella: Introduction: Cultural Conceptions in Mental Health Research and Practice. In Marsella & White (eds.) *Cultural Conceptions of Mental Health and Therapy* 1982, 29-30.

¹⁷Kawanishi, 20.

down. The client and family may not understand why the doctor is being so passive and not directing the meeting. The doctor becomes frustrated because the patient will not freely discuss any thoughts or emotions; meanwhile, the doctor may be unable to read the patient's nonverbal expressions of emotion.

Furthermore, the therapist may not only become dissatisfied with the session, but may also misinterpret the patient's behavior. Kawanishi (1992) states, "If a therapist holds on to a set of terms or vocabularies which can be translated into English, there is danger of losing much real meaning."¹⁸ For example, by failing to read the nonverbal signs of facial expression or other body language, the therapist may perceive the patient to have lack of affect and perhaps misdiagnose the patient as being depressed (Tsui, 1985).

Aside from the format of the psychotherapy session is the issue of whether the patient or family find it necessary. The views of many Asian Americans toward psychotherapy and the treatment process are consistent with the belief of a unified body and mind. Therefore, patients often wonder how merely talking about problems can alleviate emotional distress; rather, they may feel that medical intervention (e.g. medication or other somatic therapy) is required. Pham (1986) describes the expectations of Vietnamese refugees using mental health services in Canada: "Mental illness is perceived to be simply another disease than can be cured by medication within a specified time frame. As a result, the Vietnamese client may not wish to comply with long-term medication since, if it is effective, it should no longer be needed."¹⁹

We addressed the issue of psychotherapy by asking patients how they felt

¹⁸ *Ibid.*

¹⁹ Pham: The Mental Health Problems of the Vietnamese in Calgary: Major Aspects and Implications for Service. *Canada's Mental Health* 1986, 8.

about their therapy sessions with psychiatrists, nurses, and psychologists. In addition, we asked how they felt about their meetings with their families and social workers (though doctors were often present at these meetings as well). Such questions were to see if therapists were able to act flexibly amongst patients and families, while dealing with different levels of familiarity with therapy.

Furthermore, we asked patients how they felt about their medications. Unit 7C makes an effort to educate patients about the uses of western medication, with a focus on the regimens and side effects of psychotropic medications, as well as how western medicines differ from traditional herbal medicines.

In summary, there are several barriers to Asians getting adequate psychiatric care in the United States. First, are the inherent beliefs about illness conceptualization and how these affect the decision-making, coping, and help-seeking processes. Second are concrete problems related to access to care, such as knowledge about available services and outreach to the Asian American communities, and language barriers between the family, patient, and providers. Third, once medical or psychiatric help is sought, there are again conceptualization barriers. To the extent that somatization of psychological problems does exist, physicians may not recognize somatic complaints as representing serious underlying psychological disorders. When psychiatric care is sought, the psychiatrist may not recognize the manifestations of mental illness or be aware of specific mental illnesses (e.g. post-traumatic stress disorder) in the Asian American patient. In addition, the provider and the patient or family may have different beliefs about mental illness and the appropriate treatment. Aside from pure language

barriers, conceptual barriers may exist whereby the psychiatrist and the patient (or family) cannot comprehend each other's explanatory models. Such barriers to conceptual communication may keep the family and patient from returning to the psychiatrist. Likewise, if a patient is involuntarily hospitalized, these cultural and communication barriers may keep the family isolated from the hospital, and thus will contribute to the breaking of patient-family ties.

Our Study of Patient Satisfaction on Unit 7C

Since the opening of the Asian-focus unit in 1980, the admission of Asian American patients on Unit 7C has risen from approximately 5% to 50% of all admissions to the unit; in 1993, Asian Americans represented 48% of admissions.²⁰ (Unit 7C cares for patients of all ethnicities, not just those of Asian descent.) This is ostensibly an argument for the efficacy of the program, at least in terms of improving accessibility to mental health care for Asian Americans.

However, while more Asian Americans are represented on the unit, does this mean that quality of care is indeed better? Perhaps the best way to answer this question is to elicit patients' evaluations of their stay on the unit.

In this study, we sought to assess patient satisfaction, to see if ethnicity affected satisfaction, and to determine what specific aspects about their stay contributed to patients' overall satisfaction. We also wanted to hear patients' open-ended comments regarding what disturbed them, what they enjoyed, and what they found important about their hospitalization. Our hypothesis was that Asian American patients would have positive feelings about their

²⁰Dr. Kenneth Gee, personal contact.

stay.

Ultimately, the results of this study will be used as a quality control measure on Unit 7C. In addition, the entire study will be considered an elaborate pilot study, for the purpose of developing effective instruments for assessing satisfaction among Asian American psychiatric inpatients. (Thus, another question to be answered is how well our instruments fare with this population.) The patients that we interviewed were divided into two groups: Asian American and non-Asian American; the non-Asian American group served as a control population with which to compare responses to the interviews and questionnaires, as well as to compare patients' ease and understanding with participation in the study. Furthermore, interviewing non-Asian American patients allowed us to assess whether non-Asian American patients are satisfied with their care on an Asian American-focus unit.

Another implication of this study involves budgetary matters and health policy. Every year, San Francisco General Hospital's Department of Psychiatry is threatened with budget cuts, to the point that any further loss of funding will mean loss of beds. While the department fought intensely this year and was just able to hold off bed losses, the threat of budget cuts grows stronger each year. Thus, the results of a patient satisfaction study could demonstrate to the Mayor of San Francisco the importance (or potentially lack thereof) that a given community attributes to psychiatric services. Such implications are particularly significant with the new national changes in health policy and managed care. California will be independently initiating a managed health care program for Medi-Cal patients using inpatient mental health services; this program will begin as soon as July 1994.

Chapter Two: Satisfaction Studies

Given the previously identified barriers to mental health care for Asian Americans, when a service is established to provide this population with care, it is important to assess whether or not the target population is indeed satisfied with the specialized service. Hence, a study of satisfaction on Unit 7C could assess the utility and effectiveness of the unit.

Why Assess Psychiatric Patient Satisfaction?

The number of studies evaluating psychiatric patient satisfaction has been greatly increasing over the past fifteen years. There are several important reasons why this is so. First of all, legislative mandates were passed, such as the Community Mental Health Centers Amendments of 1975 (Title III of Public Law 94-63), requiring human service fields to include clients and/or citizens in the evaluative process (Zastowny and Lehman, 1988; Larsen et al., 1979).

Second, in this era of cost containment, where there is increased financing of treatment services by government and third-party payers, mental health facilities need to be held accountable for their services. Patient evaluations can be used to demonstrate to the community and to funding sources the value of services. With such a function, patient evaluations of satisfaction can protect clients in the face of service cuts (Lebow, 1982; Elbeck and Fecteau, 1990; Greenley et al., 1985).

Third, we are living in a period of increased "social movements toward more aggressive and concerned consumerism."²¹ The importance of consumer rights is being emphasized in many facets of health and human

²¹Zastowny & Lehman: Patient Satisfaction with Mental Health Services. *QRB* 1988, 285.

services. El-Guebaly et al. (1983) point out that many consumer advocates are concerned about the lack of effective bargaining power that psychiatric patients have in their treatment. Patients' evaluations of care can therefore generate patient-defined needs and preferences. Several studies have shown that patients and therapists rarely agree on the amount of progress made in treatment (Larsen et al., 1979), nor do mental health professionals accurately predict what patients' expectations and levels of satisfaction are. (For example, Kalman (1983) argues that satisfaction studies have demonstrated that patients are more pleased with treatment and less bothered by research, teaching, and commitment than mental health professionals expect them to be.) Therefore, it can be argued that clients' and therapists' opinions represent two different perspectives of the services; not taking the clients' opinions into account gives at best a one-sided, incomplete evaluation, skewed to the evaluator's or provider's perspective (Larsen et al., 1979).

Fourth, in a publicly-funded mental health service, the "free enterprise model of health care" does not exist for all patients. This model assumes that "patients' and providers' views of the objectives of treatment are likely to be similar and should there be a divergence of views, patients would merely seek treatment elsewhere."²² Unfortunately, such alternatives are not available to many disadvantaged citizens (e.g. the poor, the nonmobile, and immigrants with low levels of acculturation and/or English skills). This is particularly true for Asian Americans, for whom culturally relevant alternatives to Unit 7C are rare. These consumers are unable to go elsewhere, even if dissatisfied (el-Guebaly et al., 1983; Larsen et al., 1979). Furthermore, as Larsen et al. (1979) illustrate:

²²el-Guebaly et al.: On Evaluating Patient Satisfaction: Methodological Issues. *Canadian Journal of Psychiatry* 1983, 28:24.

... publicly funded organizations seldom have a profit motive and have virtually no financial incentive to satisfy the client or to involve the client in the evaluative process: If the client leaves the program, monetary penalty is rarely incurred. Thus, without explicit client evaluation of services received, the determination of service quality, adequacy, and appropriateness is left in the hands of service providers and managers ... This situation may lead to a phenomenon of "underdoctoring," that is, the provision of too little service, or service of poor quality. (p. 198)

Hence, not only the provision of services, but specifically the quality and quantity of services, are entirely supplier dominated (el-Guebaly et al., 1983; Larsen et al., 1979).

Finally, several studies have shown that satisfaction affects course of treatment, treatment outcome, utilization of services, and compliance with therapeutic recommendations (Hansson et al., 1985; Kalman, 1983; Elbeck and Fecteau, 1990). For example, assessing patients' subjective reactions to treatment, in terms of their expectations and fears regarding medication, has revealed that these subjective reactions are important therapeutic variables (el-Guebaly et al., 1983). Lebow (1982) argues:

Because minimal satisfaction is requisite in effectiveness, satisfaction retains importance as a mediating goal of treatment, even if it not accepted as an ultimate goal. A strong argument for the importance of satisfaction as an ultimate goal of treatment can also be made. Consumer satisfaction is widely regarded by clients as an important goal of treatment ... In part, treatments must be judged by whether consumers obtained what they wanted and were satisfied with their experience, just as evaluation of other services is determined by such considerations. (p. 255)

All of the reasons given for conducting a patient satisfaction study are

especially relevant to the Asian American population. Aside from having few options for culturally and linguistically appropriate mental health care, Asian Americans have not been the subject of patient satisfaction studies in western research. Therefore, it is not known how they feel about their treatment, what they find important in their treatment, and if their needs are being met. These factors make a satisfaction study on Unit 7C particularly important.

Our Study's Responses to The Typical Problems with Patient Satisfaction Studies

- **Are the opinions of psychiatric patients valid?**

Psychiatrists and other mental health professionals caring for inpatients have argued that patient assessments are of little value, i.e. that patients are too mentally impaired to give valid responses. Other arguments that challenge the consumer view state that consumer evaluations will be distorted because of the client's intensity of involvement in treatment, and because the client is regarded as lacking the experience required to assess treatment adequately (Greenley et al., 1985; Lebow, 1982; Corrigan, 1990).

Nonetheless, many argue that a total dismissal of patients' views is unwarranted and that a proper quality-of-care assessment should integrate views from providers and patients. Lebow (1982) states that although distortion may occur, it should not be presumed that the client will give inaccurate information; on the contrary, Lebow argues, in most cases the client can be expected to make reasonable assessments. Furthermore, differences between clients' and therapists' judgments of quality may be due to different perspectives of the treatment process, or even to distortion on the therapist's part. "[Even] when the client's view does represent a distortion of

the treatment experience, client satisfaction continues to influence the treatment process. Utilization and premature termination are at least partly the product of client satisfaction."²³ Furthermore, in a literature review, Corrigan (1990) cites research showing that patients' views regarding the quality of inpatient care are not discordant with "reality," in that their views correlate significantly with those of treatment staff.

In deciding which psychiatric patients to include in our study, we chose to interview only patients who were deemed clinically stable and ready for discharge, according to the Unit 7C Chief Psychiatrist. There are several reasons for this decision. First, we felt that all patients' perspectives were important. Second, we did not believe that all patients would be "too mentally impaired" to give valid responses; we tried to eliminate the impaired patients by only including those that were considered "clinically stable." Third, although some studies have excluded patients belonging to certain diagnostic categories, finding a specific "black or white" diagnosis as a basis of exclusion is not always possible; diagnostic gray areas often exist, especially in cross-cultural settings. (Diagnostic tools, such as the DSM-III-R, are lacking in information for cross-cultural assessment.)

Greenley et al. (1985), for example, did a study to determine whether including the opinions of "cognitively incapacitated" patients affects the overall outcome of the study. "Cognitive incapacity" refers to the inability to report about the environment; cognitively incapacitated patients are those who show evidence of delusions, hallucinations, and disorientation (such as patients with schizophrenia or organic brain syndromes). Greenley and his

²³Lebow: Client Satisfaction with Mental Health Treatment: Methodological Considerations in Assessment. *Evaluation Review* 1983, 7:743.

colleagues noted that most psychiatric inpatient satisfaction studies fail to show statistically significant differences between inpatient units, when different wards are compared. They hypothesized that if satisfaction responses of cognitively incapacitated patients are not related to conditions on a unit, then their responses would be insensitive to differences between units. In a study comparing several units, Greenley et al. contrasted their results when they included the responses of cognitively incapacitated patients with their results when they omitted these responses. They found that omitting the responses of these patients substantially improved their ability to delineate differences in satisfaction between units. The responses that were omitted were from patients with the following diagnoses: schizophrenia, all organic brain syndromes, manic depressive disorder, and personality disorders. Unfortunately, these patients represent a major proportion of patients on most psychiatric units, including Unit 7C; therefore, a study sample excluding these patients would be highly non-representative of most psychiatric unit populations.

- **Involuntary hospitalization and satisfaction levels**

Another important issue to consider when evaluating psychiatric patients' satisfaction is that mental illness is the only health condition for which people can be hospitalized against their will. Thus, the situation of involuntary hospitalization could potentially play a large role in patient satisfaction. In our study, we felt that interviewing all inpatients (voluntary or involuntary) was warranted; we wanted the opinions of all types of patients on the unit. Furthermore, almost every patient on Unit 7C was involuntarily hospitalized, so by necessity involuntary patients had to be included in the study. The research on this issue, however, is conflicting as to

whether or not involuntary hospitalization affects satisfaction.

Bradford et al. (1986) interviewed involuntarily committed inpatients who were "lucid and coherent." They found that 58 percent of the patients considered that involuntary hospitalization was appropriate for them; fifty-four percent expressed a definite willingness to return to the hospital if care was needed in the future; and 81 percent indicated that they had been "helped" by their treatment. Adams and Hafner (1990) showed similar results.

Spence et al. (1988) compared a group of involuntarily admitted patients to voluntary patients, to determine if there were differences in attitudes toward hospitalization. While involuntarily admitted patients had much more negative attitudes than voluntary patients initially (i.e. at admission), approximately 2 weeks later there was virtually no difference between patient groups.

Spence et al. believed that these results probably occurred because the involuntarily admitted patients had developed "insight" into their condition, acknowledging the presence of a psychiatric illness. They cited the work of Szmukler et al.²⁴, as well as their own clinical experience, that many of the originally involuntary patients later chose to remain in the hospital as voluntary patients after their detention order had expired. Spence et al. also noted research by Kane et al.²⁵, who showed that a high proportion of involuntarily hospitalized patients later continue with outpatient therapy, and in relapse cases, present voluntarily to the hospital.

²⁴Szmukler GI, Bird AS, Button EJ: Compulsory Admissions in a London Borough I. *Psychology and Medicine* 1981, 11: 617-636.

²⁵Kane JM, Quitkin F, Rifkin A, et al.: Attitudinal Changes of Involuntarily Committed Patients Following Treatment. *Archives of General Psychiatry* 1983, 40: 374-377.

Hansson (1989) showed contrasting results. He mailed surveys asking former voluntary and involuntary psychiatric patients to evaluate six areas of treatment: physical environment, information/influence, staff-patient relationship, treatment design, treatment program, and general satisfaction. He found that involuntarily hospitalized patients were significantly less satisfied in all areas except treatment design. It should be noted, however, that these patients were surveyed 3 to 15 months after their treatment; Weinstein (1979) reports that patients interviewed prior to discharge and then again 3-18 months later changed their attitudes in a negative direction. This could have been a factor in the difference in Hansson's results.

- **The positive skew of patient satisfaction studies**

Several problems are inherent in patient satisfaction studies. First of all, patient satisfaction studies notoriously show a high level of patient satisfaction, regardless of the method used or the medical or psychiatric population sampled. There are several possible explanations for this. For example, patients' ratings may be an expression of gratitude for receiving care, or they may be relieved at the reality of patient life compared to their preconceptions (Greenley et al., 1985).

More likely, however, since this effect happens in nearly every patient satisfaction study, is that "acquiescence" or "yea-saying" is occurring (Kalman, 1983; Lebow 1982; Flaherty et al., 1988); that is to say, patients are for some reason feeling pressured to say that they are satisfied. Patients may, for example, feel pressured to give high ratings to an agency that may likely be treating them in the future. They may be concerned that a low rating will affect their future care (Kalman, 1983; Lebow, 1982). In addition, staff

administering the surveys and lack of anonymity can cause biased results (Lebow, 1982). Finally, social desirability may cause ratings to be inflated. This includes a patient's need for social approval, as well as trait desirability (e.g. being content and accepting, rather than discontent and complaining) (Lebow, 1982; Flaherty et al., 1988).

In terms of our study, the issues of acquiescence and social desirability are particularly important when surveying an Asian American population. As many of these patients are raised in the Confucian tradition of respecting persons of authority (e.g. members of the medical profession), they may easily acquiesce and give positive ratings on satisfaction surveys. Furthermore, many patients who are trying to acculturate may give overly-high ratings so that they will appear more socially acceptable to the interviewers, as well as to the staff who may potentially see their responses.

In order to minimize bias due to these reasons in our study, staff were not present during administration of the interviews and questionnaires. We emphasized to patients that their responses would be confidential and that no members of the staff would know what individual patients had said. Furthermore, we stressed to patients that the purpose of the assessment was to evaluate services and not the patients themselves. We also explicitly stated that the patients' answers would never affect their care on Unit 7C or anywhere else, during their present stay or in the future. Lastly, we encouraged patients that their most honest responses would be greatly appreciated, keeping in mind the issues of confidentiality outlined to them. (It is not possible to assess how much bias was eliminated by these measures. Of particular concern is that despite these recommendations to patients, Asian American patients were still responding to white interviewers. Thus the problem of social acceptability potentially continued to exert a strong

effect.)

Certainly, a problem with uniformly high ratings, or lack of variability, is that results become less useful to researchers, staff, and administrators trying to adequately assess or compare services. We attempted to avoid this problem by using two scales, one that rates global satisfaction (the Client Satisfaction Questionnaire, or CSQ-8 [Larsen et al, 1979]) and a second that rates satisfaction with Specific Aspects of the Ward Stay (SAWS Questionnaire, or SAWS-Q). We also included the opportunity for patients to provide oral, open-ended comments (using the SAWS Interview, or SAWS-I), to obtain more detailed and useful information and suggestions, as well as to clarify and validate patients' scores on the questionnaires. (Refer to Appendix A for these instruments.)

However, despite the problems with biased, inflated ratings, Lebow (1983) counteracts: "Biases are likely to inflate estimates of satisfaction, but the biasing can be known. If a program cannot achieve a high degree of approval on a measure that has a high likelihood of positive bias, this is particularly telling."²⁶

- **The bias from non-responders**

Another problem with satisfaction studies is the issue of non-responders, and whether their self-exclusion is in fact biasing the data. Lebow (1982), in reviewing satisfaction studies of outpatient therapy, found that respondents are more likely than non-respondents to have mutual agreements (between therapist and client) for termination of therapy, longer treatments, and treatments judged successful by therapists -- all conditions that imply that

²⁶Lebow (1983), 742.

respondents would be more satisfied with treatment. In addition, when respondents and non-respondents were given a follow-up survey after discharge, the original non-respondents reported lower levels of satisfaction.

To maximize our response rate, we decided to survey patients while they were still hospitalized (rather than mailing out surveys). In addition, when possible, we re-asked patients to participate if they had previously refused (with the second request being from one hour to one day later). Finally, we offered patients a financial incentive of \$5.00 for their participation. (Weltzien et al. (1986) performed study assessing how to improve response rate. They found that, when administering a mailed-out patient satisfaction survey, offering ex-clients a token financial incentive of only two cents significantly increased the response rate over that of ex-clients not offered any financial incentive.)

Regarding *non-response*, however, Rubin (1990) argues:

Nonresponse matters more for certain purposes than for others. To find out which components of care predict who will return and recommend the hospital or which components are most highly related to patients' ratings of quality of care, we might worry less about nonresponders. However, if we wish to use patient ratings as quality assessment measures to compare hospitals or treatments, we may need supplementary information about the patients the survey did not reach. (p. 293)

The current uses of our study are to assess whether or not patients are satisfied with the services provided by Unit 7C, as well as to delineate components of care that contribute to general satisfaction on the unit. Thus, with the first aim, non-respondents may reduce the validity of our results; with the second, the issue of non-respondents is not as problematic. However, another potential use of this study is to pilot our instruments, in

order to develop instruments for comparing satisfaction of Asian American psychiatric patients in different inpatient settings (i.e. Asian-focused vs. non-Asian-focused). In such a comparison study, the potential bias due to non-respondents would need to be addressed.

An additional problem in our study is not only the non-respondents who refused to participate, but also the non-respondents whom we intentionally excluded. Most notably, this includes patients who did not speak English. The opinions of these less acculturated patients is important for both sides of Rubin's argument: for measuring general satisfaction with Unit 7C, and for discovering what components of care are important in patients' ratings of quality. Thus their exclusion does reduce the validity of our results.

- **Question format**

Question format (i.e. open-ended versus closed-ended questions) also has consequences for study validity. Rubin (1990) in her literature review found that responses to closed-ended questions tend to show higher satisfaction than responses to open-ended questions. Greenley et al. (1985) argue that this may be due to the fact that closed-ended questions call for summary responses, which may lead to reports of greater satisfaction. However, in their study, Greenley et al. also noted that patients who made more negative comments on open-ended questions had more negative mean responses on the closed-ended questionnaires than patients who had had more positive answers on the open-ended questions. Rubin (1990) concluded from Greenley et al.'s study that closed-ended questions are valid for finding out which of two or more groups rate hospital care as better in quality.

We chose to use two closed-ended questionnaires (the SAWS-Q and the

CSQ-8) because they permit quantitative, "exact" measures of satisfaction, allowing for analysis of scores and comparison of results between Asian American and non-Asian American patients on the unit (as well as between Asian Americans on Unit 7C and on a non-Asian-focus unit, for future studies). However, because of the tendency for inflated ratings on closed-ended questions, we administered a series of open-ended questions (the SAWS-I) prior to the SAWS-Q and the CSQ-8, to allow patients to discuss the details of their satisfaction/dissatisfaction with each item, before having to make a summary judgement; the open-ended questions also elucidated to us the components that were important in each summary rating, not otherwise revealed in a closed-ended format.

Further, the open-ended questions allowed us to clarify the *meaning* of individual patients' ratings of "satisfaction," by encouraging patients to explain *why* they felt a certain way, rather than accepting simple "yes/no" answers about satisfaction. One problem affecting the validity of satisfaction studies is the lack of precise meaning for the terminology used, such as *satisfied*, *very satisfied*, and *helped*. As Lebow (1982) illustrates, "To some, *satisfaction* means a minimum state of acceptability of services, whereas for others it means near perfection."²⁷

- **Cross-cultural equivalence**

Several problems with validity arise when designing instruments for cross-cultural research. Instruments that are valid in one ethnic group may not be "cross-culturally equivalent" (Flaherty et al., 1988). Flaherty et al. proposed five major components of cross-cultural equivalence. Content

²⁷Lebow: Consumer Satisfaction with Mental Health Treatment. *Psychological Bulletin* 1982, 91:247.

equivalence refers to the content of each item of the instrument being relevant to the members of each culture being studied. For example, in a study by Flaherty assessing antisocial behavior of migrants from an Andean village, asking a question like "Have you had at least four traffic tickets in your life for speeding or running a red light?" had no relevance to the migrants, since none of them drove cars. In our study, all questions were about Unit 7C, an environment common to all patients regardless of ethnicity, so content equivalence was present.

Semantic equivalence assures that the meaning of each item of the instrument is the same after translation into the language of each culture. Semantic equivalence was theoretically not an issue for our study, since we did not include patients who could not speak English. However, as many of the patients interviewed spoke very little English, they may have interpreted questions differently than did patients with more fluency.

Technical equivalence refers to the method of data collection (e.g. paper-and-pencil, or open-ended interview) and whether or not the method yields comparable results in each culture. For example, in the United States, many people are familiar with filling out paper-and-pencil surveys; however, in many third world countries, people are unfamiliar with this form of data collection. This can lead to inaccurate results.

We tried to ensure technical equivalence by giving very detailed instructions with examples on how to fill out the questionnaires. Furthermore, we tested for technical equivalence by assessing concurrent validity: patients answered the same questions in both an oral format (SAWS-I) and a pencil-and-paper format (SAWS-Q, a Likert-type scale) and results were examined for consistency. However, it should be noted that not all patients filled out

the questionnaires on their own; patients were given the option to have the SAWS-Q read to them (to allow for patients with poor eyesight, illiteracy, poor language comprehension, or unfamiliarity/discomfort with the questionnaire format), and patients could respond by orally stating the number they wished to choose.

Conceptual equivalence refers to the ability of the instrument to measure the same theoretical relationship between variables in different cultures. For example, assume that both culture A and culture B have primary health care systems that provide some form of preventative care to their citizens. Suppose an instrument designed to assess patient satisfaction with health care in culture A demonstrated a positive correlation between satisfaction and number of visits to the health care provider for preventative treatment. If this same instrument, later used in culture B, showed the same correlation in that culture, then the instrument would have conceptual equivalence between the two cultures. For conceptual equivalence in our study, we tested if scores of satisfaction on the SAWS-Q correlated with the CSQ-8 scores of global satisfaction, in both Asian American and non-Asian American groups.

Finally, criterion equivalence refers to the ability of an instrument to adequately study a variable across cultures, and implies that interpretation of results is the same in both cultures. In other words, will the criteria being assessed lead to the same conclusion in two different cultures? For example, an instrument that distinguishes depressed from non-depressed people in culture A may not be able to make such a distinction in culture B. This could be due to culture B not having any depressed people; however, it would more likely be due to the instrument's not having the appropriate diagnostic

criteria to measure the phenomenon of depression in culture B. In this latter case, the instrument would be lacking criterion equivalence. In designing our questionnaires, there was no way to know if the criteria for determining satisfaction are the same between Asian Americans and non-Asian Americans, especially since no satisfaction studies had been done with Asian Americans. Thus lack of criterion equivalence is a potential, yet undefinable, problem in our study.

Overall, we are addressing these issues of cross-cultural equivalence by using this study as an elaborate pilot study, meant not only to try to assess patient satisfaction and acquire patients' comments and suggestions, but also to judge the capability of our instruments to actually perform such an assessment in this cross-cultural population. Furthermore, while none of our instruments has been used with Asian American populations, we chose to administer the CSQ-8 because it has been used successfully with Latinos in this country (with both English and Spanish versions) (Roberts et al., 1983; Roberts et al., 1984), with a Dutch-speaking population in the Netherlands (de Brey, 1983), and with a French-speaking population in Canada (Sabourin et al., 1987).

- **Reliability**

The last problem with assessing satisfaction is the question of *reliability*. Lebow (1982) cites this as one of the major problems in satisfaction studies. In a literature review in which he critiqued more than 100 published studies assessing client satisfaction with mental health services, he found only three studies that tested instrument reliability (usually done by measuring internal consistency).

A reason why we chose to use the CSQ-8 scale as one of our instruments

is that the study about the scale's development was one of the three cited by Lebow. This study by Larsen et al. (1979) indicated that the CSQ-8 showed a high degree of internal consistency; since Lebow's work, many other studies using the CSQ-8 have replicated this finding (Attkisson and Zwick, 1982; de Brey, 1983; Roberts and Attkisson, 1983; Roberts et al., 1984; Soelling and Newell, 1983; Nguyen et al., 1983; Attkisson et al., 1983; Sabourin et al., 1987).

The Instruments of Our Study

In summary, we used the CSQ-8 to assess global satisfaction. After reviewing the literature, we chose this scale because of its psychometric properties, its simplicity, and its successful use with several cross-cultural populations. To determine which components of care contributed to global satisfaction, as well as to check for concurrent validity, we developed the Specific Aspects of Ward Stay Questionnaire. To elicit comments and suggestions, we included the SAWS Interview; this instrument also checked the validity of the SAWS-Q responses.

The items of the SAWS Interview and Questionnaire were selected by doing a literature review, looking at studies that had assessed which components of care psychiatric patients found important. Some of these studies performed cluster analyses or principal component/factor-loading analyses of their results (e.g., Elzinga and Barlow, 1991; Greenley et al., 1985; Hansson et al., 1985; Urquhart et al., 1986); one asked patients to rank dimensions of service in order of importance to them (Pascoe et al., 1983); and another performed loosely structured pilot-interviews to ascertain what issues were significant to patients (Shields et al., 1988). These studies gave us the questions about restrictiveness (rules and regulations), physical

environment (ward appearance), contact with staff (both the quality of contact and availability of staff), recreational activities, medications, individual therapy, and group therapy.

In addition to the items that we collected from this literature search, we included items about which the staff and administration of the unit were interested. For example, community meetings and occupational therapy groups are two separate group therapy activities on Unit 7C, about which the administration wanted feedback. Likewise, the staff and administration desired to know specifically about individual therapy sessions with different providers (i.e. psychiatrists, nurses, and psychologists). Because the family plays such a large role for many Asian American patients, the administration wanted to know how patients felt about the unit's effort to keep families involved (i.e. meetings with the social worker, patient, and family); they also wanted to know how well the social workers dealt with discharge plans. Finally, we added the question about food primarily to see if patients (especially Asian Americans) felt that they needed special foods for therapeutic reasons (e.g. to correct a *yin-yang* imbalance).

Chapter Three: Methods of Our Study

Subjects

The study ran from January 28, 1993 to December 10, 1993. We interviewed as many patients as possible during that period, using consecutive sampling of English-speaking patients. The patient's primary language did not have to be English, nor did the patient have to be highly proficient in English.

Patients were approached when they were clinically ready for discharge (as determined by their psychiatrists), asking their participation in this study. We attempted to interview patients as close to their time of discharge as possible. However, interviewing within one day of discharge was not always possible for two reasons: First, several patients who were about to be discharged suddenly decompensated and were kept hospitalized for some time longer; therefore our interview may have occurred over a week before their true discharge date. Second, we often had to intentionally interview patients several days before their discharge, as a specific date and time of discharge was not known ahead of time. These subjects were patients that were clinically stable, but remained on Unit 7C until an available space (e.g., in a halfway house) was ready; when such a space appeared, these patients were discharged suddenly and unexpectedly, without our notification. Therefore, we tried to interview such patients earlier rather than later, to avoid losing potential subjects.

Ninety-two patients completed the interview. Of these, we eliminated one (non-Asian American) patient, because most of her answers on the SAWS-Q were highly inconsistent with her comments on the SAWS-I.

(Notably, she had given mostly negative comments during the interview, but scored all "7s" on the questionnaire; thus, eliminating this subject would not contribute to the usual positive skew of satisfaction studies.)

Of all the patients that we approached for the study, thirty-two refused. Table 1 presents the reasons for refusal.

Table 1: Frequency Distribution of Patient Acceptances and Refusals

	<u>Asian American</u>	<u>Non-Asian American</u>
Total Approached	51	73
Total Accepted	36	56
Total Refused	15	17
Reasons for Refusal		
a) No English*	7	1
b) Cognitive incapacity	0	6
c) Dystonia affected speech	1	0
d) Being discharged soon or family visiting	2	2
e) Negative feelings about hospital stay	0	2
f) Not feeling well	0	3
g) No reason given	5	3

*Although we were told by the unit chief that these patients spoke English, they actually did not speak enough for the study. From subsequently speaking to the staff, we had reason to believe that some of these patients may have spoken enough English, but used the excuse that they did not to avoid participation in the study.

Aside from the above 32 patients, there were numerous patients we never approached either because 1) we were unable to contact them before they were suddenly discharged, 2) they did not speak English (assessed by the unit chief), or 3) they were judged to be far too unstable or cognitively incapacitated by the unit chief.

Of the 91 patients included in the study, thirty-six (39.6%) were Asian American or Pacific Islander. This was a non-representative sample of the

total patient population (48% Asian American), partly because of the exclusion of monolingual (non-English speaking) patients. (In 1993, 35% of the Asian American patients admitted were monolingual.²⁸) Fifty-two patients (57.1%) were male; 39 (42.9%) were female. Patients ranged in age from 18 to 87 years, with a mean age of 37.6 years. Asian Americans (mean age 33.3 years, s.d. = 11.5) were significantly younger than non-Asian Americans (mean age 40.3 years, s.d. = 13.7) ($t = 2.56, p = .01$). (The average age of all Asian American patients on the unit in 1993 was 38; that of non-Asian Americans was 42.5.²⁹) The average length of stay (from date of admission to date of interview) was 15.99 days. Table 2 presents the ethnicity of patients participating in the study. Table 3 shows the frequency distribution of patients by diagnosis, education, and employment; there were no significant differences between Asian Americans and non-Asian Americans for these demographic variables.

Table 2: Frequency Distribution of Patients by Ethnicity

<u>Ethnicity</u>	<u>Frequency</u>	<u>Percent</u>
Asian American	35	38.5
Pacific Islander	1	1.1
White	38	41.7
African American	13	14.3
Latino	3	3.3
Other	1	1.1
Total	91	100

²⁸Dr. Kenneth Gee, personal contact.

²⁹Dr. Kenneth Gee, personal contact.

Table 3: Frequency Distribution of Patients by Diagnosis, Education, and Employment Status

<u>Diagnosis*</u>	<u>Asian American</u>	<u>Non-Asian American</u>
Affective Disorder	12	21
Schizophrenia	9	10
Psychosis NOS**	11	19
<u>Education completed[§]</u>		
No college	18	26
Some college or more	14	18
<u>Employment Status^{§§}</u>		
Employed	5	8
Unemployed	26	30

*This represents the 3 major diagnostic categories; data unavailable for 3 subjects.

**NOS: Not Otherwise Specified

[§]Data unavailable for 15 subjects (n = 76)

^{§§}Data unavailable for 22 subjects (n = 69)

Methods

A literature review revealed that the scale most widely used in patient satisfaction studies was the Client Satisfaction Questionnaire (8 question version), or CSQ-8 (Larsen et al., 1979). This scale was put together by researchers at the University of California, San Francisco who have carefully studied patient satisfaction, psychometric properties of scales, and scale development. It is a 4-point scale, with 1 demonstrating minimal satisfaction, and 4 maximal satisfaction. The questions ask about patients' satisfaction with the quantity as well as the quality of services received, whether this was the kind of service that patients wanted, and to what extent the patients' needs were met. Further, patients were asked if the services helped them to deal more effectively with their problems, if they would recommend the unit to friends, and if they would come back to Unit 7C in the future, if necessary. One question summarizes the rest: "In an overall, general sense, how

satisfied are you with the service you have received?"

The CSQ-8 was shown to have high internal consistency reliability (Cronbach's $\alpha = .93$). Levois, Nguyen and Attkisson performed a patient satisfaction study using two parallel forms of the CSQ-18 (18 item formats): CSQ-18A and CSQ-18B. The two forms correlated .82, with mean scores not significantly different between the two forms; in other words, the CSQ showed "split-half reliability."³⁰ In addition, the CSQ-18B contains the 8 items of the CSQ-8.

In terms of validity, the CSQ-8 has been shown to be correlated with client and therapist global ratings of improvement (Attkisson and Zwick, 1982), a sign of construct validity. The CSQ-8 was also somewhat correlated with therapists' estimates of how satisfied they believed their clients to be with services ($r = .56, p < .01$), a sign of concurrent validity (Larsen, 1979).

Finally, the CSQ-8 is the only instrument we found that had been used in cross-cultural settings. Its psychometric properties had been cross-culturally validated, so we felt comfortable in using this scale with our study population.

The Specific Aspects of Ward Stay Questionnaire (SAWS-Q), a 14-item questionnaire, was designed using a 7-point Likert-type format, with 7 indicative of high satisfaction and 1 indicative of dissatisfaction. We wanted to stay as consistent as possible with the 4-point format of the CSQ-8, but more recent studies have found that in order to reduce ceiling effect and skew, scales should have at least 7 points. This allows use of more extreme end

³⁰Nguyen et al.: Assessment of Patient Satisfaction: Development and Refinement of a Service Evaluation Questionnaire. *Evaluation and Program Planning* 1983, 6:299-314.

points, which normalizes distribution of scores (Attkisson and Greenfield; Deanne Berger-Moudgil, personal contact).

Furthermore, in order to lessen a halo response caused by patients' circling all the numbers in the same column, we copied the CSQ-8's format of reversing the direction of the Likert scale for half of the questions (i.e., in some questions, the response format was 1-2-3-4-5-6-7, while in others it was 7-6-5-4-3-2-1).

The questions ask how patients felt about rules, ward appearance, recreational activities, food, relations with the staff and staff availability, medications, occupational therapy groups, and community meetings. Two questions deal with the role of the social worker: how patients felt about meetings with their family and social worker, and how patients felt about their discussions with their social worker regarding discharge plans. Finally, patients were asked how they felt about their individual therapy sessions with psychiatrists, nurses, and psychologists.

Our scale, the Specific Aspects of Ward Stay Questionnaire (SAWS-Q) was not constructed using proper and thorough psychometric techniques (due to the time constraints of this project), nor has the completed scale been psychometrically tested. Therefore, we decided to correlate the mean scores on this scale with global satisfaction ratings on the CSQ-8, to assess for concurrent validity. For another judgement of SAWS-Q concurrent validity, we checked that patients' comments on the Specific Aspects of Ward Stay Interview (SAWS-I) were consistent with their scores on the SAWS-Q.

Procedures

Patients were individually approached by myself, or one of two trained research assistants. They were told that this was a patient satisfaction study,

that the interview would last about 30 minutes, and that if they decided to participate, they would be given 5 dollars for their help.

If a patient agreed to participate, the patient was brought to a private room in which the interview was conducted. Prior to the interview, the interviewer emphasized three important points to the patient: 1) the patient's answers were confidential and no staff on the unit would know of the responses; 2) nothing that the patient said would affect his or her care on Unit 7C or elsewhere; 3) the interviewer was not interested in evaluating the patient, but rather, wanted the patient to evaluate the unit. The patient was then told that his or her most honest responses would be helpful and appreciated. Next, the interviewer went over the consent form with the patient, which the patient was required to sign in order to participate. (See Appendix B for consent form.) To maximize patients' comfort, we encouraged each patient to ask any questions he or she had about the interview process or the study in general. Furthermore, during the interview, all responses were transcribed by the interviewer; no recording devices were used, as some psychiatric patients are distrustful or paranoid about tape recorders.

If the patient signed the consent form, the following procedures were performed. First, the interviewer asked the patient questions from the SAWS Interview (SAWS-I), eliciting comments regarding aspects of his or her stay on the ward. The interviewer attempted to elicit reasons as to why the patient was satisfied or dissatisfied with each aspect of their stay.

Following this set of questions, patients were given the SAWS-Q to complete, to numerically rate their satisfaction with the same aspects of care about which they were just asked.

The third part of the session with the patient was the administration of the CSQ-8, to assess global satisfaction.

For both the SAWS-Q and the CSQ-8, patients received detailed verbal instructions with examples on how to complete the forms. The interviewer emphasized that there were no right or wrong answers. Patients were then given the option to fill out the forms on their own (with the interviewer monitoring their responses), or to have the interviewer read the questions and possible responses to them.

At this point, the patient's involvement in the study was complete, and patients who had completed everything up to this point were reimbursed \$5.00. After the interview, the interviewer checked to see that patient's scores on the SAWS-Q correlated more or less with the open-ended comments on the SAWS-I. Any blatant inconsistencies were eliminated. (A response was considered "blatantly inconsistent" if the patient had scored 3 or below after giving a definitively positive comment, or scored 5 or above after giving a definitively negative comment.)

We correlated total scores on the SAWS questionnaire with those on the CSQ-8, to check for concurrent validity. To see what factors of the ward care contributed to overall satisfaction ratings, we first performed a factor analysis with varimax rotation of the SAWS-Q. We then did multiple regression analyses using the mean total CSQ-8 score as a dependent variable, and the SAWS-Q factors, ethnicity, and demographic items as independent variables. The demographic variables included were age, sex, diagnosis, ethnicity, level of education, employment status, and length of stay. (Length of stay was determined from the date of admission to the date of the interview.)

Chapter Four: Results

Our findings show that patients are satisfied with services on Unit 7C, that ethnicity did not affect satisfaction level, and that two factors contribute to overall satisfaction: satisfaction with personal services/external environment and satisfaction with group activities.

Based on the total scores of general satisfaction from the CSQ-8, our study has shown that, overall, patients on the unit were satisfied with their stay; the mean total CSQ-8 score for all patients was 21.98 (s.d. = 6.08), which is above the neutral score of 20. When the sample was divided into Asian American versus non-Asian American groups (see Table 6), there were no significant differences in scoring. However, it is important that neither ethnic group scored very high above the neutral score, especially considering the positive bias that generally occurs with satisfaction studies. The failure to score substantially over 20 may therefore indicate a degree of *dissatisfaction* (see Lebow, 1983).

Table 6: Average Scores on CSQ-8 Items and Total³¹

<u>Question</u>	<u>Asian Am.</u>	<u>Non-Asian Am.</u>	<u>p-value*</u>
1. Quality of service	2.69	2.98	p = 0.14
2. Kind of service you wanted	2.86	2.86	p = 0.97
3. Has program met your needs	2.44	2.67	p = 0.22
4. Recommend to friends	2.72	2.85	p = 0.57
5. Amount of help	2.61	2.86	p = 0.23
6. Help deal effectively with problem	2.83	2.93	p = 0.63
7. Overall satisfaction	2.69	2.93	p = 0.25
8. Would you come back here	2.44	2.61	p = 0.47
Mean TOTAL Score**	21.17	22.53	p = 0.30

* using a Pooled Variances t-test

**Total Score can range from 8 to 32.

As we found the mean SAWS-Q scores to be positively correlated with the total CSQ-8 score ($r = .78$), the mean SAWS-Q score can also be seen as a measure of satisfaction. The mean rating over all items on this questionnaire, for all patients, was 4.95 (s.d. = 1.30). For a scale of 1 to 7, this mean score is fairly well above the neutral rating of 4. The same can be said of the mean rating over all items when patients are separated into ethnic categories: Asian Americans had a mean score of 4.83, while that for non-Asian Americans was 5.04. (The difference was not significant.)

Factor analysis of the SAWS-Q was performed after excluding four questions. (The low number of responses for questions 10 (social worker and family meeting), 11 (social worker/discharge plans), 13 (individual therapy with nurses), and 14 (individual therapy with psychologists) precluded our

³¹A few patients had difficulty understanding the intended meaning of questions 4 and 8. For example, on question 8 ("If you were to seek help again, would you come back to our program?"), despite having an overall favorable attitude about their stay, several patients gave a negative rating, explaining that they would never want to have to be hospitalized again. On question 4 ("If a friend were in need of similar help, would you recommend our program to him or her?"), some patients with generally positive attitudes answered negatively, citing that they did not want their friends to have to be hospitalized, or that they would not tell their friends about 7C because they wanted their own psychiatric hospitalization kept secret.

using these items in the factor analysis program.³²⁾ The remaining 10 questions could be grouped under two factors, which accounted for 55.8% of the total variance. Factor 1, which dealt with satisfaction with personal services and external environment, accounted for 45.2% of the total variance; Factor 2, satisfaction with group activities, accounted for 10.6%. (See Table 7.)

Table 7: Factor Loading of the SAWS-Q

<u>Question</u>	<u>Personal Service/ External Environment</u>	<u>Group Activities</u>
Q5. Staff caring/supportive	0.846*	0.220
Q6. Staff available	0.832*	0.088
Q4. Food	0.596*	0.176
Q2. Ward appearance	0.588*	0.311
Q1. Rules and regulations	0.571*	0.316
Q12. Therapy with psychiatrist	0.548*	0.408
Q7. Medication	0.508*	0.283
Q9. Occupational therapy	0.358	0.706*
Q3. Recreational activities	0.277	0.770*
Q4. Community meetings	0.131	0.863*

* Indicates the factor to which question was assigned.

While the question about satisfaction with recreational activities was not intended to focus on group activities, most patients answered the open-ended version of this question with comments about activities done during occupational therapy group sessions.

It is interesting that while questions about staff relations loaded the highest on the personal service/external environment factor, how patients felt about therapy sessions with psychiatrists played a relatively unimportant

³²Many patients were unable to comment on question 10 ("Did you find the meetings with the social worker and your family helpful?") because they did not have a family, or had not had such a meeting. Likewise, several patients were unable to answer questions 11 ("Did you find your meetings with the social worker about your discharge plans to be helpful?"), 13 ("Did you find your individual therapy sessions with the nurses to be helpful?"), and 14 ("Did you find your individual therapy sessions with the psychologists to be helpful?") because they had not experienced such meetings.

role; even attitudes about food had a heavier loading. This difference in loading may be explained by the amount of time patients spent with various providers. (See below for patients' comments on this issue.)

On the group activities factor, attitudes about occupational therapy loaded quite heavily. Unlike with any other question of the interview, all patients had something to say about the occupational therapy (OT) groups. Most of the patients not only had positive comments, but very positive comments. Also unlike any other question, patients referred to the OT staff by name, offering specific comments about them without the interviewer's asking.

Some of the positive comments from Asian Americans were "I loved OT groups," "You get to learn how to do things so we can take care of ourselves in the outside world," "It keeps us busy so we don't dwell on past events," "I enjoyed those because they had the most structure," and "There should be more of those consistently; there should be more encouragement on the staff's part to encourage patients to attend." Several reported that the OT leaders "liven up the place," and "make the patients feel very good." Non-Asian Americans had similar comments.

Negative comments from a few Asian Americans were that they felt that some activities were childish, and that the OT groups were "not occupational training -- it's just recreational activity." The criticism from non-Asian Americans also fell along these lines.

Asian Americans scored significantly lower than non-Asian Americans on the personal service/external environment factor, but there was no significant difference on the group activities factor. Table 8 summarizes these results.

Table 8: Mean Scores on SAWS-Q Factors

<u>Factor</u>	<u>Asian Americans</u>	<u>Non-Asian Americans</u>	<u>p-value</u>
Personal service/ external environment	4.888	5.247	p < 0.02
Group activities	4.654	4.726	p > 0.80

To assess what may have contributed to this difference on the first factor, we did t-tests on each of the SAWS-Q questions contributing to Factor 1. (See Table 9.)

Table 9: Average Scores on SAWS-Q Items of Personal Service/Ext. Environment Factor

<u>Question</u>	<u>Asian Am.</u>	<u>Non-Asian Am.</u>	<u>p-value*</u>
1. Rules/regulations	4.74	5.13	p = 0.34
2. Ward appearance	4.85	5.63	p = 0.03
4. Food	4.97	4.77	p = 0.66
5. Staff caring/supportive	5.19	5.56	p = 0.33
6. Staff available	4.86	5.36	p = 0.18
7. Medication	4.89	5.18	p = 0.50
12. Therapy with physician	4.71	5.09	p = 0.42

* using a Pooled Variances t-test

The only significant difference is that Asian Americans scored lower than non-Asian Americans on the question regarding ward appearance. The comments from both ethnic groups were similar, however, with people either saying decorations were "fine" or that the unit needed more decorations; almost all patients were quite pleased with the level of cleanliness. Since the comments of both ethnic groups were similar, it is possible that Asian Americans felt less satisfied (as shown in their scores) but were less able or willing to verbally express their dissatisfaction with the ward appearance. Perhaps they wanted to reserve their complaints for items which they considered more important to their stay and care.

Despite no other significant differences, it is worthwhile to review the comments of the patients on the other items of the personal service/external environment factor. Regarding rules and regulations, both Asian Americans and non-Asian Americans had similar complaints. These included not enough cigarette breaks, and feeling that there were too many rules. In addition, many patients only felt restricted by their boredom: when organized activities were not in session, patients felt there were no other options for them -- this is what made the unit feel like a "jail" to some patients.

In terms of food, the complaints from both Asian Americans and non-Asian Americans mostly had to do with personal tastes. Notably, however, four Asian American patients stated that they wanted more Asian food, and that they did not like what was served because they were unaccustomed to the western menus. Nonetheless, some Asian American patients commented that they appreciated having rice, soy sauce, and the option for having family bring in meals. The most consistent comment in both groups was that food arrived on the unit thirty minutes before patients were allowed to eat it, and thus they received cold meals. Finally, patients with special dietary needs (e.g. vegetarians) felt that their nutritional concerns were not addressed (e.g. they were forced to eat meat in order to get enough food).

On the question about staff supportiveness and availability, comments were similar between the two groups. Regarding availability, most complaints (regardless of ethnicity) had to do with the staff being very busy and not always immediately available; patients conceded that they often had to wait for assistance, but generally received it. A few Asian American patients who spoke very little English said that they had difficulty communicating with some staff; however the patients all said they had at

least one staff member with whom they could communicate well. (These patients spoke Chinese, Vietnamese, and Tagalog; the Chinese patient complained that not every Chinese-speaking staff member spoke her dialect.) Nevertheless, one Asian American patient who spoke English fluently felt that having staff who spoke several languages gave this unit "a touch of class."

Regarding medications, Asian Americans had approximately an equal number of negative as positive comments; non-Asian Americans had about three-fourths as many negative comments as positive comments. Most of the complaints from both groups were related to side effects. However, while Asian Americans gave a higher proportion of negative comments, the qualitative content of those comments was generally the same as those of non-Asian Americans. A few patients in both groups complained that they were getting too much medication, and resented the resulting drowsiness. One Asian American woman complained that the drugs "hurt my chest and heart muscles. They made ____, a healthy young man, fall down." On the other hand, another Asian American patient found the medications helpful "because they reduced the positive and negative ionic conflicts in my body."

A few patients, in both ethnic groups, complained that they were not told what they were given, or that their regimens were changed without their notification. In fact, one Asian American patient was angered because his doctors *lowered* his medication without first consulting him: "They decreased my dosage and it's affecting me; they should have at least asked me or explained why [they changed the dosage]." Another Asian American said that he did not like the doctor's reducing his medication, because he was unable to sleep at night, adding, "[The doctor's] complaint is that I take too

many medicines." Finally, a few patients in each group felt that their medication dosages should decrease as their conditions improved.

Lastly, Asian Americans and non-Asian Americans had approximately the same percentages of positive and negative comments regarding individual therapy sessions with their psychiatrists. The general impression obtained from the open-ended comments is that patients were not allowed enough time with their doctor. While the majority of patients had positive comments about the therapy sessions, many of these patients also expressed chagrin about not having enough time to really get to talk to their psychiatrist; many requested more frequent meetings that lasted longer.

The writings of Kleinman and others suggest that Asian/Asian American patients would generally not be familiar with talk therapy, and would tend to accept and be more comfortable with more somatic therapy, such as medications. While this was indeed the case with a few patients, we found that many Asian American patients found talk therapy helpful and/or wished that they had more opportunity to talk about their problems with their doctors. Some pertinent comments from Asian Americans were: "I didn't get to talk to doctors very much. There should be more personal contact between doctor and patient other than just short communication leading to an assessment," "The sessions were too short, too brief," "Sometimes I didn't agree with them, like all the medicines I took weren't working because it was something psychological with me," "I like to talk one-to-one, to talk about your problems and how to solve them, what you need, what's bothering you," and "It stank! They don't pay attention to you ... They say, 'I have more important things to do' and they leave. I'd like to talk about my problems! ... I'd like to talk one-to-one with a doctor, at least one hour a week, with daily check-ins."

There were a few Asian American patients who apparently did not perceive a need for "talk therapy." One had a negative comment: "I do not have a problem and they tried to help me." The other two had positive feelings about their interactions with their doctors: "We don't talk very much. They know that we just need medications -- you just go to a doctor for medications, right? That's okay with me," and "[The sessions were] okay; the doctor's physical exam was very thorough -- a lot of concern that people are not sick."

Finally, two patients complained of language barriers. As one Vietnamese patient (who spoke very little English) stated, "When doctor saw me, and she understood me, I felt happy. When she didn't understand me, I felt unhappy."

A multiple regression analysis was done using the mean total CSQ-8 score as a dependent variable, and the SAWS-Q factors and demographic variables as independent variables. Adjusted R^2 was 0.64 [$F(9, 30) = 8.768, p = 0.0001$]. Both SAWS-Q factors correlated significantly with the CSQ-8 score (see Table 10). Ethnicity and the other demographic variables did not demonstrate a significant correlation.

Table 10: Multiple Regression on Mean Total CSQ-8 Score

<u>Item</u>	<u>Beta</u>	<u>p-value</u>
Personal Service/Ext. Environment Factor	0.596	p = 0.0001
Group Activities Factor	0.495	p = 0.0001
Education	0.183	p = 0.11
Length of Stay (until interview)	-0.111	p = 0.30
Age	-0.106	p = 0.36
Diagnosis	0.080	p = 0.43
Sex	0.075	p = 0.46
Ethnicity	0.017	p = 0.87
Employment Status	0.003	p = 0.98

Subsequent multiple regression analyses were done for each ethnic category, to assess the presence of ethnic differences in predicting overall satisfaction. We used total CSQ-8 score as the dependent variable, and the SAWS-Q factors and education level as independent variables. (We chose to use education since this variable had the third highest correlation on the multiple regression above.) Again, for both ethnic groups, only the SAWS-Q factors correlated significantly with CSQ-8 score. (See Table 11.)

Table 11: Multiple Regression on CSQ-8 Score, by Ethnicity

<u>Item</u>	<u>Asian American*</u>		<u>Non-Asian American**</u>	
	<u>Beta</u>	<u>p-value</u>	<u>Beta</u>	<u>p-value</u>
Personal Service/ Ext. Environment Factor	0.662	p = 0.000	0.549	p = 0.001
Group Activities Factor	0.358	p = 0.004	0.569	p = 0.001
Education	0.204	p = 0.072	0.012	p = 0.937

* Adjusted $R^2 = 0.74$; $F(3, 20) = 23.167$; $p = 0.0001$

** Adjusted $R^2 = 0.45$; $F(3, 24) = 8.249$; $p = 0.0006$

Chapter Five: Discussion -- Implications and Suggestions

Our study shows that in general, patients are satisfied with their stay on Unit 7C. We found no significant differences in overall satisfaction levels between Asian Americans and non-Asian Americans. This, of course, could be due to the fact that we generally excluded less acculturated Asian Americans. An alternative possibility is that, because of the specialized services, Asian Americans do indeed feel as comfortable on a psychiatric unit as do non-Asian Americans, who are perhaps generally more accustomed to using mental health services. Finally, perhaps Asian Americans are actually less satisfied, but because of cultural pressures to assimilate, they rated higher than their true feelings as an effort to please.

Two main factors emerged from analysis of the SAWS-Q, both of which correlated significantly with overall satisfaction scores: 1) satisfaction with personal services and external environment, and 2) satisfaction with group activities. Asian Americans scored significantly lower than non-Asian Americans on the personal services/external environment factor.

The comments of patients (of all ethnicities) demonstrated that many patients want more individualized attention, for example in the form of therapy sessions. Patients' comments indicated that they not only want more of a chance to air their thoughts and troubles, but also to get information regarding their treatment, their progress, and their future (e.g. housing, financial assistance, follow-up psychiatric care). Many patients felt frustrated because of inability to discuss their problems or to get their questions answered.

It must be remembered, however, that we interviewed more acculturated patients who could perhaps benefit more from talk therapy, due to their English skills and level of acculturation. Of course, not *all* Asian American patients (including well-acculturated patients) desire such services as therapy sessions (nor do all non-Asian Americans, for that matter); nonetheless, the unit should assure that patients who do want more time to talk have that opportunity.

Furthermore, giving patients detailed information about post-hospital plans is often (understandably) difficult; for example, the social worker cannot always have a definite discharge scenario in place for a given patient, because bed availability at various post-hospitalization facilities is greatly in flux. An effort should be made, however, to assuage patients who have questions, answering the questions when possible, or giving clear explanations as to why their questions cannot be answered at this time.

There were no clear differences in the open-ended comments between Asian Americans and non-Asian Americans that would indicate why Asian Americans scored lower on the personal service/external environment factor. However, one difference may have been the relative quantity of medication side effects expressed by Asian Americans. Improving communication between doctors and patients could not only let doctors know of patients' concerns regarding medication, but also allow doctors to better explain the planned regimens and changes to patients. If the intent of Unit 7C is to make mental health care more accessible and acceptable to Asian American patients, services should assure that patients do not feel alienated while on the unit.

"Ward appearance" was the only item on the SAWS-Q item where Asian

Americans scored significantly lower than non-Asian Americans. Why this difference was present was not evident in the open-ended comments. Perhaps Asian Americans are more environmentally- or contextually-oriented than non-Asian Americans. Regardless, many patients in both ethnic groups desired to see more posters and decorations, other than patients' own drawings. An inexpensive way to do this might be to use travel agency posters for Asian countries.

On the group activities factor, patients felt particularly strong about the OT groups; in fact, when asked about satisfaction with general recreational activities, most patients talked about what they had done in occupational therapy. Group activities were what kept patients busy. Aside from meals and a few minutes with the doctor each morning, most patients had nothing to do when groups were not in session; many patients ended up sleeping because there was nothing else to do. In fact, when asked how they felt about the rules and regulations, some patients said they only felt restricted when groups were not in session; it was their boredom and lack of options for activity or entertainment (e.g. TV and radio use were limited to selected hours of the day) that made the rules feel restrictive. Giving patients more options for structured activity will most likely improve overall satisfaction with Unit 7C.

Another interesting finding includes the age difference between Asian Americans and non-Asian Americans in our study, with Asian Americans being significantly younger. While this may partly be due to the exclusion of less acculturated patients (who are likely to be older), this argument cannot entirely explain the difference, since the mean age of all Asian Americans admitted to Unit 7C during the year of our study was younger than the mean

age of all non-Asian Americans admitted.

The age difference is perhaps due to the fact that as non-Asian Americans (mostly whites in this sample and in the country at large) age, they tend to lose the financial stability they may have had at younger ages, and therefore end up in public hospitals. In contrast, Asian Americans, a population comprised largely of immigrants and refugees (as well as a population that may face racial discrimination in employment), may not be as financially stable throughout life, and may therefore use public hospitals at all stages of life. This finding demonstrates the need to pursue further studies that assess Asian Americans' opinions about services, as their consumer options are limited.

As discussed previously, the results from the study's questionnaires are not entirely useful on their own. "Level of satisfaction" cannot be defined by a mere number. Now that we know the utility of the questionnaires, however, they can be used in future studies, specifically of Asian American patients on a non-focused inpatient psychiatric unit. (The SAWS-Q could be modified to specifically assess satisfaction related to personal services and satisfaction with group activities.) The scores from such a study could be compared with those of Asian American patients in our study; only then can the true impact of the Asian American/Pacific Islander Focus Unit be ascertained.

Comparing two groups of Asian Americans would be more revealing as to what "satisfaction" means for Asian American patients on Unit 7C. A potential problem with our study is that the definition of a particular level of satisfaction may differ between Asian Americans and non-Asian Americans.

For example, if non-Asian Americans had high expectations on admission to the unit, and the unit had a high achievement level at meeting those expectations, then non-Asian Americans would show a high level of satisfaction. In contrast, if Asian Americans had *low* expectations on admission, and the unit was able to meet those expectations with a low level of achievement, then Asian Americans would also show a high degree of satisfaction. Thus, both groups would show the same level of satisfaction, despite Asian Americans receiving lower quality care. Thus, the methods used in the study may be lacking in criterion equivalence (Flaherty et al., 1988).

Another way to circumvent the problem of defining satisfaction is to study patient outcome. Such an in-depth study could follow Asian Americans after they were discharged from Unit 7C or from a non-Asian-focused unit. Follow-up could include examining patients' post-discharge level of functioning, use of outpatient mental health services, compliance with medication recommendations, and repeat hospital admissions (including whether those admissions were voluntary or involuntary). Treatment outcome, utilization of services, and compliance with therapeutic recommendations have been shown to be indirect measures of patient satisfaction (Hansson et al., 1985; Kalman, 1983; Elbeck and Fecteau, 1990; el-Guebaly et al., 1983).

An important addition to any future study, however, would be the addition of translated interviews and questionnaires, to allow for a full spectrum of acculturation levels. We automatically introduced a source of bias into our study by not including non-English-speaking patients. Though our original intention was to translate and back-translate our materials into

Chinese (Cantonese and Mandarin) and Vietnamese, time and budgetary constraints prevented this. The exclusion of non-English-speaking patients is a major limitation of our study, especially since most of the cultural barriers to obtaining mental health treatment are among the less acculturated (i.e. non-English-speaking). These are the patients who are more likely to exhibit the problems and health-seeking behavior outlined in Chapter One, and are therefore the population for which culturally-directed services are most critical. Furthermore, with less acculturation and poorer language skills, these are the patients who have less of a voice in demanding adequate services.

Several studies have demonstrated acculturation affects attitudes and behavior about mental health services, as well as symptom presentation. Ying and Miller (1992) examined both the help-seeking behavior and the attitude regarding psychological problems amongst Chinese Americans in San Francisco. They found that those who had previously sought professional help for a "nervous or emotional problem" were significantly more likely to be American-born. Furthermore, of those who had not previously sought help, a positive attitude regarding help-seeking was correlated with superior English skills. Thus, the authors conclude, "Acculturation was an important predictor of both behavior and attitude, with the less acculturated most in need of education about the utility of mental health service."³³

Moreover, Nguyen and Peterson (1993) surveyed a sample of Vietnamese-American college students, 98% of whom were born in Vietnam but had immigrated to the United States at a mean age of 8 years. They

³³Ying & Miller: Help-Seeking Behavior and Attitude of Chinese Americans Regarding Psychological Problems. *American Journal of Community Psychology* 1992, 20:549.

assessed the students for symptoms of depression, using both the Beck Depression Inventory (a western depression scale) and the Vietnamese Language Depression Rating Scale³⁴ (which Unit 7C also uses). The authors found that with this population, the Beck Depression Inventory was more reliable at predicting depression than was the Vietnamese scale. The authors noted, however, that development of the Vietnamese Language Depression Rating Scale was done with an older population who had spent more of their adult lives in Vietnam, and were therefore less acculturated than the college students. They suggested that the culturally-specific items on the Vietnamese scale were perhaps more meaningful to the older population than to the younger, more acculturated generation. Further, they speculated that the younger generation "was obviously more affected by U.S. society, perhaps to the point where their very manifestation of depression was influenced."³⁵

This statement suggests that the satisfaction ratings of the more acculturated patients in our study were perhaps influenced by a more westernized view of mental illness. In fact, in a literature review by Wong (1982), the author concludes, "The greater the assimilation, acculturation, or biculturality, the more likely that such individuals will find western-oriented mental health services acceptable and appropriate."³⁶

Nonetheless, our study did involve many first generation immigrants, a

³⁴Kinzie JD, Manson SM, Nguyen TT, Bui A, Pho NP: Development and Validation of a Vietnamese Language Depression Rating Scale. *American Journal of Psychiatry* 1982, 139: 1276-1281.

³⁵Nguyen & Peterson: Depressive Symptoms Among Vietnamese-American College Students. *Journal of Social Psychology* 1993, 133:70.

³⁶Wong: Asian and Pacific Americans. In Snowden (ed.) *Reaching the Underserved: Mental Health Needs of Neglected Populations* 1982, p. 194.

population that most likely experienced its first taste of mental health services in the United States. In addition, many of those patients who were not first generation immigrants had parents or grandparents who were; these older family members often hold influence over the help-seeking patterns of the mentally ill patient. Such a study as ours is therefore important in elucidating what components of care would make mental health services more acceptable to the Asian American individual or family. Our study demonstrated two main ways in which mental health services could be made more palatable to Asian Americans: the first is to improve the external surroundings, including having more Asian art on the walls. Asian food also would contribute to the general comfort level. A second measure would be to improve communication between providers and consumers; discussion could help negotiate differences in explanatory models and treatment expectations between the patient, the family, and the health care provider. This should also include education about western treatment regimens. Such discussions could reduce alienation with mental health services and subsequently enhance utilization rates and compliance with follow-up care.

Family involvement appears to be a crucial role in the provision of mental health services to Asian Americans. I was disappointed with the low number of respondents who had had meetings with both their social worker and their family present; I believe that more of an effort needs to be made to include families in the process. Further studies could also assess the satisfaction of families with the mental health services.

A study such as ours is critical in this era where the competing interests of managed care and budget cuts tend to take precedence over other sociocultural issues. We are living in a time of greatly increasing ethnic

diversity; therefore the needs for culturally-specific services must be addressed. Since the opening of the Asian-focus unit in 1980, SFGH has developed two other ethnic focus units, an African-American-focus unit and a Latino-focus unit, as well as a women's issues unit and an HIV-focus unit. Several of these focus units have recently decided to conduct patient satisfaction studies, to give a voice to traditionally-underserved populations.

Appendix A: Instruments Used in Study

Specific Aspects of Ward Stay - Interview (SAWS-I)

1. Please tell me how you felt about the rules and regulations that patients have to follow on the ward. Did you feel too restricted? Did you feel that there weren't enough rules? Why or why not?
2. Please tell me how you felt about the ward appearance, such as cleanliness and decorations.
3. Please tell me how you felt about the recreational activities on the ward. Did you enjoy them? Why or why not? Were enough activities offered?
4. Please tell me how you felt about the meals served on the ward. Were you satisfied with the type of food that was served? Why or why not? Was the food prepared well? Did you get enough food?
5. Please tell me about your relations with the staff. Were they caring? Did you feel that you could communicate well with them? Why or why not? Were they available when you needed them?
6. Did you find the medications helpful? Why or why not?
7. Did you find the occupational group therapy sessions helpful? Why or why not?
8. How did you feel about the community meetings?
9. Did you have a meeting with the social worker and your family together? Please tell me how you felt about the meeting(s). Were these helpful to you? Why or why not?
10. Did you find the meetings with the social worker discussing your discharge plans to be useful? Why or why not?
11. Did you find that the individual therapy sessions with the doctors helped you with your illness? Why or why not?
12. Did the individual therapy sessions with the nurses help you with your illness? Why or why not?
13. Did you find the individual therapy sessions with the psychologists helpful? Why or why not?

Specific Aspects of Ward Stay - Questionnaire (SAWS-Q)

1. How do you feel about the rules and regulations on the ward?

7	6	5	4	3	2	1
The rules were reasonable and not too restrictive to patients.						The rules placed far too many restrictions on patients.

2. How satisfied were you with the ward appearance? (For example, cleanliness, decorations, etc.)

1	2	3	4	5	6	7
I was disgusted with the ward appearance.						I was extremely pleased with the ward appearance.

3. How satisfied were you with recreational activities on the ward?

1	2	3	4	5	6	7
I was extremely dissatisfied with the recreational activities on the ward.						I was extremely satisfied with the recreational activities on the ward.

4. How satisfied were you with the food served on the ward?

7	6	5	4	3	2	1
I was extremely pleased with the food.						I was extremely displeased with the food.

(SAWS-Q, continued)

5. Did you find the staff caring and supportive?

1	2	3	4	5	6	7
No, the staff were not at all caring or supportive.						Yes, the staff were extremely caring and supportive.

6. Were the staff available when you needed them?

7	6	5	4	3	2	1
Yes, the staff were always available when I needed them.						No, the staff were never available when I needed them.

7. Did you find the medication that you took helpful?

7	6	5	4	3	2	1
Yes, the medication greatly improved my condition.						No, the medication worsened my illness.

8. Did you find the occupational therapy groups helpful?

1	2	3	4	5	6	7
No, I thought the occupational therapy group sessions were a waste of my time.						Yes, the occupational therapy group sessions were extremely useful to me.

(SAWS-Q, continued)

9. Did you find the community meetings helpful?

1	2	3	4	5	6
No, I did not at all like the community meetings.					
					7
					Yes, I found the community meetings extremely helpful.

10. Did you find the meetings with the social worker and your family helpful?

1	2	3	4	5	6
No, I did not find these meetings to be at all helpful.					
					7
					Yes, I found these meetings to be extremely helpful.

11. Did you find your meetings with the social worker about your discharge plans to be helpful?

7	6	5	4	3	2
Yes, these meetings discussing my discharge plans were extremely helpful.					
					1
					No, these meetings about my discharge plans were not at all helpful.

12. Did you find your individual therapy sessions with the physicians to be helpful?

1	2	3	4	5	6
No, the therapy sessions with the doctors did not help me at all.					
					7
					Yes, the therapy sessions with the doctors helped me very much in dealing with my illness.

(SAWS-Q, continued)

13. Did you find your individual therapy sessions with the nurses to be helpful?

7	6	5	4	3	2	1
Yes, the therapy sessions with the nurses helped me very much in dealing with my illness.						No, the therapy sessions with the nurses did not help me at all.

14. Did you find your individual therapy sessions with the psychologists to be helpful?

7	6	5	4	3	2	1
Yes, the therapy sessions with the psychologists helped me very much in dealing with my illness.						No, the therapy sessions with the psychologists did not help me at all.

CSQ-8 CLIENT SATISFACTION QUESTIONNAIRE

Please help us improve our program by answering some questions about the services you have received. We are interested in your honest opinions, whether they are positive or negative. Please answer all of the questions. We also welcome your comments and suggestions. Thank you very much, we really appreciate your help.

CIRCLE YOUR ANSWERS

1. How would you rate the quality of service you have received?

4	3	2	1
<u>Excellent</u>	<u>Good</u>	<u>Fair</u>	<u>Poor</u>
2. Did you get the kind of service you wanted?

1	2	3	4
<u>No, definitely not</u>	<u>No, not really</u>	<u>Yes, generally</u>	<u>Yes, definitely</u>
3. To what extent has our program met your needs?

4	3	2	1
<u>Almost all of my needs have been met</u>	<u>Most of my needs have been met</u>	<u>Only a few of my needs have been met</u>	<u>None of my needs have been met</u>
4. If a friend were in need of similar help, would you recommend our program to him or her?

1	2	3	4
<u>No, definitely not</u>	<u>No, I don't think so</u>	<u>Yes, I think so</u>	<u>Yes, definitely</u>
5. How satisfied are you with the amount of help you have received?

1	2	3	4
<u>Quite dissatisfied</u>	<u>Indifferent or mildly dissatisfied</u>	<u>Mostly satisfied</u>	<u>Very satisfied</u>
6. Have the services you received helped you to deal more effectively with your problems?

4	3	2	1
<u>Yes, they helped a great deal</u>	<u>Yes, they helped somewhat</u>	<u>No, they really didn't help</u>	<u>No, they seemed to make things worse</u>
7. In an overall, general sense, how satisfied are you with the service you have received?

4	3	2	1
<u>Very satisfied</u>	<u>Mostly satisfied</u>	<u>Indifferent or mildly dissatisfied</u>	<u>Quite dissatisfied</u>
8. If you were to seek help again, would you come back to our program?

1	2	3	4
<u>No, definitely not</u>	<u>No, I don't think so</u>	<u>Yes, I think so</u>	<u>Yes, definitely</u>

The Client Satisfaction Questionnaire (CSQ) was developed at the University of California, San Francisco (UCSF) by Drs. Clifford Attkisson and Daniel Larsen in collaboration with Drs. William A. Hargreaves, Maurice LeVois, Tuan Nguyen, Bob Roberts and Bruce Stegner. Every effort has been made to publish information and research on the CSQ for widest possible public use and evaluation. All proceeds from the publication of the CSQ will be used to support postdoctoral training in clinical services research.

UCSF University of California, San Francisco

Appendix B: Consent Form

UNIVERSITY OF CALIFORNIA, SAN FRANCISCO AND SAN FRANCISCO GENERAL HOSPITAL'S DEPT. OF PSYCHIATRY CONSENT TO BE A RESEARCH SUBJECT

A. PURPOSE AND BACKGROUND

Katrina Nelsen, a UC Berkeley graduate student, and Francis Lu, M.D. in San Francisco General Hospital's Department of Psychiatry are conducting a research study to assess the quality of care in the unit where I stayed. I am being asked to participate in this study because Ms. Nelsen and Dr. Lu desire patients' opinions of the quality of care.

B. PROCEDURES

If I agree to be in the study, the following will occur:

1. A research assistant, with a bilingual translator if necessary, will first ask me some questions about my illness.
2. Next, I will be asked some questions about how I felt about my stay on the unit.
3. Finally, I will be given 2 short questionnaires, written in my primary language, asking me to rate my level of satisfaction with my stay on this unit. The research assistant and translator will help me if I have any difficulty reading or understanding the questions.

These procedures will be done in a private room on the ward and will take a total time of about 30 minutes. After the researchers have met with me, they will privately review my hospital chart.

C. RISKS/DISCOMFORTS

1. Some of the questions may make me feel uncomfortable, but I am free to decline to answer any questions I do not wish to answer or to stop the discussion at any time.
2. Confidentiality: Participation in research may involve a loss of privacy; however, my records will be handled as confidentially as possible. All the response forms will have an anonymous code, rather than my name, on them. Only Katrina Nelsen, Dr. Lu, and their research assistant will have access to the response forms. All forms will be kept in locked files of Dr. Lu or Ms. Nelsen. No individual identities will be used in any reports or publications that may result from this study.

D. BENEFITS

There will be no direct benefit to me from participating in this study. However, the information that I provide may help hospital administrators and staff improve the quality of service on this ward.

E. COSTS

There will be no costs to me as a result of taking part in this study.

F. PAYMENT

I will be paid \$5.00 in cash for my participation in this study. I will be paid immediately after completing the required interviews and questionnaires.

G. QUESTIONS

I have talked to Ms. Nelsen, Dr. Lu, or a research assistant about this study and have had my questions answered. If I have further questions, I may call Ms. Nelsen at (510) 528-0151, or Dr. Lu at (415) 206-8984.

If I have any comments or concerns about participation in this study, I should first talk with either Ms. Nelsen or Dr. Lu. If for some reason I do not wish to do this, I may contact the Committee on Human Research, which is concerned with the protection of volunteers in research projects. I may reach the committee office between 8:00 and 5:00, Monday through Friday, by calling (415) 476-1814, or by writing: Committee on Human Research, Box 0962, University of California, San Francisco/San Francisco, CA 94143.

H. CONSENT

I will be given a copy of this consent form to keep.

PARTICIPATION IN RESEARCH IS VOLUNTARY. I am free to decline to be in this study, or to withdraw from it at any point. My decision as to whether or not to participate in this study will have no influence on my present or future status as a patient at this hospital.

If I agree to participate, I should sign below.

Date

Signature of Study Participant

Date

Signature of Person Obtaining Consent

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