

BECOMING A HEALTH ACTIVE OLDER ADULT:  
THE EFFECTS OF A WORKSHOP FOR  
JAPANESE AMERICAN  
OLDER ADULTS

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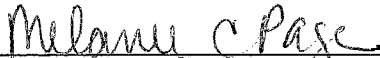
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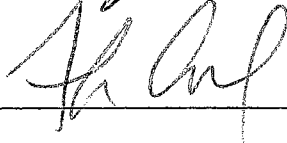
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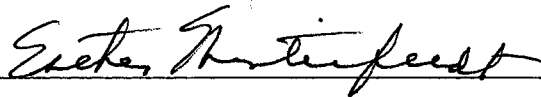
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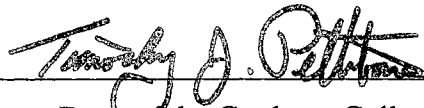
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## Introduction

The population of older adults is growing at such a rate that by the year 2030, it is estimated that there will be 70 million older adults, representing 20% of our population (American Association of Retired Persons [AARP], 1995). Further, of those 70 million older adults in the year 2030, 25% will be from minority populations (AARP, 1995). As individuals grow older, so will their need for medical and mental health services. Older adults age 65 years and older average nine physician visits per year, as compared to five physician visits per year for the general population (AARP, 1992). Further, it is estimated that older adults occupy 50% of the time of physicians and other health care practitioners (Brannigan & Rossman, 1990). As the population of older adults continues to grow, the demand for physician care by older adults is likely going to increase 22% by the year 2000 and 115% by the year 2030 (Haber, 1994). The demand on other health care professionals such as pharmacists, occupational therapists, and social workers, will most likely increase as well.

Society will face many new problems with these changing demographics. One of the greatest problems that society will have to endure is how to pay the costs of medical care accrued by the older adult population. Many health care professionals have begun to generate new strategies that both older adults and health professionals can utilize in order to help contain the costs of medical care. Some suggested strategies discussed to deal with the latter problem include having health professionals routinely educate all clients on disease prevention and health promotion practices, as well as, having continued government encouragement of disease prevention, health promotion education, and



services in the community (Lundberg, 1992). Despite these suggestions, very little research has been conducted on the effectiveness of health education programs in the older adult community.

Since there is little research on the effectiveness of health education programs in the general older adult population, it is not surprising that there also is a paucity of research on the effectiveness of health education programs with ethnic minority older adults. Further, even less information is available when specific ethnic groups, such as Asian Americans, are examined. This is somewhat surprising given the fact that medical professionals have a central role in Asian American communities, particularly with regard to mental health issues (Kleinman, Eisenberg, & Good, 1978). The limited amount of research targeting specific ethnic groups is of concern given that ethnic minority populations are growing at such an enormous rate.

Even though a limited amount of research has been conducted on the effectiveness of health promotion interventions with older adults, in particular ethnic minority older adults, health promotion appears to be of interest among ethnic minority older adults. For example, Hilliard and Iwamasa (1998) conducted a survey at the Seinan Center, a Japanese American Senior Center, in Los Angeles, California, to determine what mental health topics Japanese American older adults would like to learn more about. They found that on a five point scale (1 = not knowledgeable and 5 = very knowledgeable), none of the participants felt very knowledgeable about mental health issues. Thirty-two percent did not feel knowledgeable about mental health issues, 29% felt “sort” of knowledgeable, 32% felt knowledgeable, and 4% felt “pretty” knowledgeable. Further, 67% of the participants indicated that they would like to know more about mental health issues. As

shown in Table 1, two of the top topics that Japanese American older adults indicated that they wanted to learn more about were the aging process and how to deal with medical doctors. Further, most participants indicated that they preferred a group presentation in comparison to written materials or a lecture format, and preferred having such a presentation conducted by a mental health professional. In addition, many of the participants indicated that they preferred that the information was presented by an expert, although most of the participants indicated that they would still attend if their first choice was not presenting.

Given that there is a desire among Japanese American older adults to participate in health promotion educational programs, there is a lack of research examining the effectiveness of health promotion educational programs with ethnic minority older adults. In addition, the changing demographics also points to the need to conduct research in this area. The little that is known about older adults relationships with health professionals and the impact of culture on older adults' sense of personal control and psychological well-being provides more specific directions for future research.

#### Relationships Between Health Professionals and Older Adults

Little research has been conducted examining the relationships between health professionals and older adult patients (Wyatt, 1991). In fact, Wyatt (1991) found that articles examining the relationships between physicians and patients comprises less than 1% of the medical literature. However, what has been published indicates that older adults are treated differently by physicians as compared to younger adults. For example, Greene, Hoffman, Charon, and Adelman (1987) examined the effect of age on physician-patient relationship. The first hypothesis, which stated that older patients would raise

more psychosocial issues than younger patients was not confirmed. The second hypothesis, which suggested that doctors would raise fewer psychosocial issues with older patients than with younger patients was supported. Lastly, doctors were found to be less responsive to the psychosocial concerns of older adults, confirming the third hypothesis.

These findings suggest that older adults might receive differential treatment by their physicians in comparison to younger adults, which may result in negative consequences for older adult patients. The finding that older adults raised fewer psychosocial concerns may have been due to the finding that doctors were less responsive to their psychosocial concerns. These findings are of concern because of the number of psychosocial risks that older adult's face due to health problems, financial difficulties, and lack of social support (Flint, 1994). Krause, Jay, and Liang (1991) studied the effect of financial strain on American and Japanese older adults and found that financial strain tends to erode feelings of control and self-worth leading to increased depressive symptomatology.

The age of the patient has also been found to effect the number and type of prescriptions given by the physician. Linn and Linn (1982) conducted a study to determine whether or not doctor's prescription patterns were different depending upon the age of their patient. They found that patient-rated symptoms differed by age of patients and not by the physician. However, certain physicians tended to treat older adults differently in regard to the use of Digitalis, tranquilizers, and pain medications. Overall, the older patients were prescribed on average 1.5 more medications than younger patients, with Digitalis, tranquilizers, and analgesics being prescribed more often to older patients.

These studies demonstrate that older adults often times receive differential treatment from health care providers.

Despite the research conducted on the effects of age on the physician-patient relationship, there is a paucity of research on the effect of ethnicity on the physician-patient relationship. Haug (1996) discussed how physicians and older adult patients' social and cultural background affect their interactions and how status of the physician affects the doctor-patient interaction. The status of the doctor, according to Haug, is evidenced simply by the fact that the patient addresses the physician as "doctor." He stated that a positive doctor-older adult patient relationship is comprised of six elements: (a) Mutual respect for the interest and needs of each, (b) ability of each to access the other for consultation, (c) adequate and understandable information from each on the health issues involved in the interaction, (d) mutual willingness to make and accept necessary referrals to other experts, (e) reassurance about the appropriateness of each other's behavior, and (f) specific mutually agreed-upon course of action to deal with the health issues raised. Haug believes that demographic characteristics, such as age, gender, and cultural background, influences both the doctors and patient's understanding and expectations of each other. For example, African American patients are less likely to be referred to specialists or to receive advanced surgical procedures than are Caucasians (Haug, 1996).

Kleinman, Eisenberg, and Good (1978) also discussed the effects of culture on the doctor-patient relationship, particularly with regard to symptom manifestation. Western medical practitioners primarily focus on the disease aspect of an individual's sickness, rather than the illness aspect. Kleinman et al. criticized the medical field, claiming that

inattention to illness often results in patient noncompliance, patient and family dissatisfaction with professional health care, and inadequate clinical care. Kleinman et al. suggested that physicians need to utilize an explanatory model of illness (EMI) in order to describe the impact of both disease and illness for particular individuals. The EMI proposed by Kleinman et al. explains the relationship between culture, belief systems, and the pattern of symptom expression and help-seeking behavior among various ethnic populations. According to the EMI, disease refers to abnormalities in the structure and function of body organs and systems, whereas illness refers to the human experience of sickness. Kleinman et al. suggested that illness is shaped by cultural factors governing perception, labeling, explanation, and evaluation of the discomforting experience. Further, illness is a process embedded in a complex family, social, and cultural nexus. Therefore, for any particular individual, illness is a culturally-constructed concept which physicians must learn about from the patient. Levy (1985) also has emphasized the necessity of understanding a patient's cultural background by suggesting that it is important for doctors to familiarize themselves with the cultural background of the patient.

In order to understand the EMI of an ethnic minority patient, health care providers and patients need to have effective communication skills. To date, many researchers have examined the communication patterns between patients and their doctors (Greene & Adelman, 1996; Greene, Adelman, Friedmann, & Charon, 1994; Ong, De Haes, Hoos, & Lammes, 1995; Putnam, 1996). None of these studies specifically examined the EMI of older adult populations. However, Greene and Adelman (1996) are among the few researchers who have examined communication patterns between older adults and their

doctors. They examined the relationship between Caucasian American older adults' satisfaction and degree of communication during a doctor's visit. They found that older adults preferred doctors who are supportive, share laughter, allow plenty of time to ask questions and provide information, and use less questions worded in the negative.

Only one study to date has examined the role of communication with ethnic minority older adults. Ryan, Meredith, MacLean, and Orange (1995) describe the usefulness of the communication enhancement model with ethnic minority older adults. The communication enhancement model promotes health in old age by emphasizing recognition of individualized cues, modification of communication to suit individual needs and situations, appropriate assessment of the health/social problems, empowerment of both elders and providers, and increasing opportunity for communication. The authors stated that the components of this model inhibit ethnocentric behavior by addressing myths and stereotypes, practicing empathy, and being aware of differences within groups. Even though some research has been conducted on communication between older adults and doctors, the lack of studies examining these issues with ethnic minority older adults is of concern.

There are many potential benefits of having a good relationship with health professionals. Older adults are at risk for losing a sense of personal control because of a combination of environmental and medical circumstances. For example, many older adults are financially dependent on social security, while at the same time, often experience an increase in health problems. Assisting older adults to develop effective communication skills with their health care providers might increase their sense of

personal control by developing the skills needed to be an active participant in their health care.

### The Relationship Between Personal Control and Psychological Well-Being

Many researchers have established clear links between one's sense of personal control and psychological well-being. An individual's sense of personal control is multidimensional in nature. The two main dimensions of one's sense of personal control in regard to one's health are self-efficacy and health locus of control. Self-efficacy (Bandura, 1986) is a belief in one's capabilities to implement a course of action. Whereas, health locus of control refers to the notion that an individual's health can be controlled through that person's ability to control his/her behavior (i.e. internal locus of control) or by external forces (i.e. powerful others or luck; Wallston & Wallston, 1982).

Even though self-efficacy and locus of control are dimensions of one's sense of personal control, they differ in one distinct manner. Specifically, self-efficacy can be situation specific, whereas locus of control is a generalized concept (Bandura, 1977). Therefore, an individual can have a high sense of self-efficacy in one area of life (i.e. in one's career), but not in another area of life (i.e. as a parent). Locus of control focuses on outcome expectations, and does not focus on whether or not the individual feels capable of handling a specific situation (Waller & Bates, 1992). However, there are some researchers who have challenged this distinction by stating that a high level of self-efficacy in one situation should generalize to similar life situations (e.g., Tipton & Worthington, 1984).

Regardless of the specific distinctions between these two dimensions of personal control, both self-efficacy and locus of control are variables involved in one's

psychological well-being (Waller & Bates, 1992). Specifically, self-efficacy has been found to be predictive of future health behaviors, especially in the maintenance of behavior change (Pender, 1987; Strecher, DeVellis, Becker, & Rosenstock, 1986). Internal locus of control, among older adults has been positively correlated with optimism (Guarnera & Williams, 1987), better perceptions of health (Speake, 1987), improved psychosocial adaptation (Felton & Kahana, 1974; Linn & Hunter, 1979; Palmore & Luikart, 1972; Reid, Haas, & Hawkins, 1977; Wolk & Kurtz, 1975; Wolk, 1976), more positive coping styles (Kuypers, 1971), and positive self-concept, happiness, and contentment (Reid, Haas, & Hawkins, 1977). Thus, if older adults are at risk for losing a sense of personal control, they may also be at risk for psychological distress.

Research has also demonstrated that there is a relationship between locus of control and service utilization. Goldsteen, Counte, and Goldsteen (1994) conducted a study examining the relationship between health locus of control and the use of medical care services. They found that there was a positive relationship between frequency of serious medical care use and an increased belief in powerful others and chance in regards to health. Chipperfield and Greenslade (1999) also found that individuals who experienced lower levels of perceived control used a greater number of health services than individuals with a high level of perceived control.

As will be discussed, there are many things that older adults can do to increase their sense of personal control when interacting with medical professionals. Unfortunately, little research has been conducted on the effectiveness of educational programs for older adults that focus on increasing a sense of personal control. In fact, in a review of the literature, McCormick, Inui, and Roter (1996), only found two



intervention studies that were found to increase a patient's sense of personal control. No research specifically examining the effectiveness of an intervention study designed to increase one's sense of personal control with ethnic minority older adults has been conducted. However, research has been conducted on the effectiveness of interventions to increase sense of control among younger participants. For example, Flowers and Booraem (1989) found that individuals who participated in a workshop in behavioral medicine scored significantly higher on internal locus of control, indicating an increased belief in their abilities to affect their health status. Some research with Caucasian older adults also has been conducted, but findings have been mixed. Rose (1992) found that a peer-education program on heart disease prevention significantly increased older adults' sense of dietary self-efficacy and exercise self-efficacy compared to the control group, whereas Kocken and Voorham (1998) did not find an increase in self-efficacy among older adults who participated in a peer-led senior health education program.

Health promotion interventions have also been found to increase patient involvement in care. Greenfield, Kaplan, and Ware (1985) conducted a study examining the effectiveness of an educational programs designed to teach patients to read their medical record, ask necessary medical questions, and make medical decisions. They found that participants in the educational program had an increased involvement with their physician, fewer medical complaints, and preferred to be involved in helping to make medical decisions. Additionally, McCann and Weinman (1995) found that a brief written educational program for primary care patients designed to increase patient involvement in care were effective in increasing length of time with physician, as well as, increasing the number of questions asked. This latter study, however, did not find

increase in satisfaction with physician or usefulness of locus of control and self-efficacy as predictors of outcomes.

Little is known about sense of personal control among older adults, particularly ethnic minority older adults. However, research has demonstrated that sense of personal control plays a role in one's psychological well-being. Additionally, health promotion educational programs appear to sometimes increase one's sense of personal control, which has been found to have a significant impact on a patients' involvement in their care and service utilization. With an increase in the population of ethnic minority older adults, there is a need for researchers to examine the effects of culture on one's sense of personal control.

#### Impact of Culture on Locus of Control and Health Promotion Educational workshops

The impact of culture on one's sense of personal control is potentially great. Sastry and Ross (1998) maintain that although researchers have established a clear link between one's sense of personal control and psychological well-being among Western cultures researchers might not find the same results when examining other cultures. For example, they found that when examining levels of personal control and effects of personal control on distress among Asians and Asian Americans, there was a lower level of perceived control when compared to non-Asians. Further, they found that there was less of a relationship between sense of personal control and psychological distress, indicating that a decreased sense of personal control might not be related to increased psychological distress among the Asian American population. The authors did not specifically examine personal control as it related to health or to an older adult population. However, similar findings with older adults were found by Wong, Hexby,

Kameoka, and Dubanoski (1999), who examined the relationship between perceived control, self-reinforcement, and depression among Asian American and Caucasian older adults. Wong et al. (1999) found that self-reinforcement was predictive of depression among both ethnic groups, but perceived control was only predictive for Caucasian American older adults.

A methodological limitation for the latter two studies is that Asians and Asian Americans were examined as a homogeneous group. The authors did not take into account intra-ethnic differences. Sue and Sue (2000) discuss the heterogeneity of the Asian culture (Japanese, Chinese, Korean, etc.) and the importance of conducting research on specific subgroups of the Asian population. The differences in cultural beliefs and values among different Asian subgroups can impact the interpretation of research findings. For example, when examining the Japanese culture, a possible explanation for the above finding that perceived control is not predictive of depression, is that personal control is only one component of health according to Japanese culture and does not play as significant a role as in Western culture. Therefore, a decreased sense of personal control might not necessary lead to psychological distress because there are other components compensating and providing a balance, which in turn maintains one's physical and psychological health. In fact, Japanese older adults define health as a balance between man, society, and the cosmic forces of the universe (Morioka-Douglas, 1990). Defining health as a balance places the responsibility for good health on many aspects of one's life.

Even though external factors play a role in Japanese health, individual responsibility for one's health is also emphasized in Asian culture (Norbeck & Lock,

1987). Therefore, Japanese may place a great deal of responsibility on themselves for maintaining their health. However, this seems to change as one ages. Often, older adults will be encouraged by their caretakers to avoid taking an active role in the maintenance of their health and discourage rehabilitative services (Norbeck & Lock, 1987).

Thus, in Japanese culture, personal control and balance appear to play different roles as one ages. Further, it is likely that Japanese older adults will experience conflict while attempting to maintain a sense of balance between external and internal factors responsible for their health. It is possible that what one might expect of oneself individually might disrupt the balance of the social relationship. For example, some older adults view the doctor-patient relationship as hierarchical in nature and possess cultural beliefs that prohibit questioning a physician because this would imply a lack of trust (Haug, 1991). Even if a Japanese older adult might feel the need to increase question asking to maintain his/her sense of personal control, this might be seen as counter-productive to the doctor-patient relationship. Questioning those in authority would disrupt the balance of the social relationship between the doctor and the patient (Chen, 1996). Thus, the impact of culture on sense of personal control as one ages among ethnic minority older adults is unclear at this time.

Clarifying the role of personal control in the maintenance of health among Japanese American older adults would have many implications in the design of health promotion educational workshops. Yee and Weaver (1994) states that researchers are aware that culture influences health beliefs, but this area still has not received research attention. Further, she discusses a need for a culturally competent health-promotion agenda. The need for culturally appropriate health promotion educational workshops was

also emphasized by Wallace, Villa, Moon, and Lubben (1996) and they discussed the need to base health promotion programs out of community organizations.

Only one study to date has examined the impact of culture on health promotion (Zhan, Cloutterbuck, Keshian, & Lombardi, 1998). Zhan et al. conducted a study to examine the health promoting measures used by ethnic elderly women. The sample consisted of elderly (60 years and older) women from three ethnic backgrounds African American, Chinese American, and European American. The facilitators of health promotion that the participants identified included medical insurance, social support, safe environment, and spirituality. The identified barriers to health promotion included language difficulties, transportation, distrust, and poverty. These authors recommended that culturally sensitive educational programs were needed in order to minimize the barriers and maximize the facilitators of health promotion among ethnic minority older adults. They also identified some differences between groups that should be considered in the design of health promotion educational programs for particular ethnic groups. For example, Zhan et al. found that Chinese American older adult participants relied more heavily on family members for social support in comparison to European American older adults, however Chinese American older adults reported not receiving as much social support from their family as they needed. Therefore, the authors suggest incorporating the development of peer support networks into health promotion educational programs for Chinese older adults to provide them with additional social support. Zhan et al. suggested that there is a need to empower ethnic minority older adults to become health-active older adults.

### Health-Active Older Adults

In order to increase one's sense of personal control, it is necessary for older adults to become "health-active." Health-active people are defined as health-responsible consumers who are determined to play an active role in their own health (Ferguson, 1993). Ferguson (1993) pointed out that a health-active person is one who seeks information and who is able to choose an interaction style that is a balance between one's personal preferences, medical and psychological condition(s).

According to Ferguson, older adults can do a number of things in order to become health-active individuals and to improve their relationships with medical professionals. Older adults who wish to be health-active need to: (a) learn how to choose a health professional, (b) be prepared for their visits with their health professional, (c) be able to provide the necessary information to the health professional, (d) receive specific information from the health professional, (e) learn how to best communicate with their health professionals, and (f) consider bringing a friend or family member with them when visiting a health professional (Ferguson, 1993).

As mentioned above, the first thing that older adults can do to improve their relationship with their health professionals is to learn how to choose a health professional. Most likely as an older adult, one will have to choose a new health professional either due to a diagnosis or insurance requirements. Thus, in order to be a health-active patient, an older adult must know how to successfully choose a new health professional (Senior Scape, 1999). First, the patient needs to decide what to look for in a doctor. Usually, the most important thing to look for when choosing a new health professional is finding someone to whom one can comfortably talk. The second step is to

identify several possible health professionals and then consult with reference sources, current patients, and colleagues. The goal is to learn as much as possible about the health professional one is considering. Lastly, one needs to make a choice based upon the information gathered about the health professionals.

In order to be a health-active older adult, one must know what to bring when meeting with a medical professional. For example, older adults should know the time of their appointment and they should bring with them their insurance card, social security number, allergies to medications, and family medical history (National Institute of Psychosocial Oncology, 1999).

Health-active older adults should tell their health professionals several pieces of information during their appointment (National Institute of Psychosocial Oncology, 1999). For example, older adults should be able to communicate to their health professionals what symptoms they are experiencing and details regarding those symptoms, such as when they began. Older adults should also be able to provide the doctor with information regarding current medication usage. Further, doctors need to be made aware of other health professionals from whom their patients have sought treatment and what those professionals have recommended.

Health-active older adults also should be able to obtain several pieces of information from their health professionals (National Institute of Psychosocial Oncology, 1999). For example, the physician should provide information regarding the hypothesized cause and diagnosis of the patient's symptoms. Then based on the possible diagnosis, the patient should receive information on any diagnostic tests that will be necessary and information regarding treatment options and use of specialists. The patient should also

get information from the health professional regarding any necessary medication changes or additions, as well as any potential drug interactions with current prescriptions. It is also helpful for the patient to obtain information regarding sources for additional information on their condition.

Some other actions that older adults and physicians can take to enhance their communication with each other includes: (a) making sure each understands the language used, (b) that the older adult can hear well, (c) utilizing basic communication skills (e.g. both the older adult and the health professional asking each other questions), and (d) the older adult bringing a spouse/family member to his/her appointment. Prohaska and Glasser (1996) conducted a study to determine patients' view of family involvement in medical care decisions and encounters. The third person in the physician-older adult medical encounter provided the patient with both education and support prior, during, and following the medical encounter. The roles of the third person included providing transportation, physical assistance, emotional support, and making sure the older adult understood the treatment plan and prescriptions. In general, patients who were accompanied by their spouse/family member believed them to be a positive asset during the medical encounter.

There is a paucity of research examining the relationship between medical professionals and older adults, particularly among ethnic minority older adults. As the population of minority older adults continues to grow, there will be an increased need to understand the effects of the medical professionals' relationship on the health and quality of life of older adults. Further, a pilot study indicated that there is an interest in the Japanese American older adult community to learn how to become health-active clients,



which contradicts the literature on sense of personal control. Researchers and health professionals need to capitalize on this interest in order to examine the effectiveness and impact of educational programs with ethnic minority older adults.

#### Purpose of the Proposed Study

There is a paucity of research examining the relationship between medical professionals and older adults, particularly among ethnic minority older adults. As the population of minority older adults continues to grow, there will be an increased need to understand the effects of the medical professionals' relationship on the health and quality of life of older adults. Further, a pilot study indicated that there is an interest in the Japanese American older adult community to learn how to become health-active clients. Researchers and health professionals need to capitalize on this interest in order to examine the effectiveness and impact of educational workshops with ethnic minority older adults.

This study examined the effectiveness of an educational workshop on becoming a health-active older adult with Japanese American older adults. The purpose of this study was three-fold. First, the investigators wanted to determine whether or not Japanese American older adults who participate in an educational workshop group on improving communication skills with health professionals will have an increase in their level of knowledge concerning how to interact with their health professionals. The second purpose of this study was to determine whether or not Japanese American older adults' sense of personal control will increase as a result of being a participant in the educational workshop. Thirdly, the investigators wanted to determine if the educational workshop had an impact on the level of satisfaction that Japanese American older adults report

about their relationships with their health professionals.

## Hypotheses

- Hypothesis 1:** At follow-up, participants randomly assigned to the educational workshop group will have a significantly higher level of knowledge regarding how to most effectively interact with a health professional as compared to participants randomly assigned to the comparison-control group.
- Hypothesis 2:** The mean scores of each of the three Multidimensional Health Locus of Control subscales will be significantly different between groups.
- A) Specifically, the Internality subscale score at follow-up will increase in the educational workshop group as compared to the comparison-control group.
- B) The Powerful Others and Chance subscale scores at follow-up will decrease for the educational workshop participants as compared to comparison-control participants.
- Hypothesis 3:** At follow-up, after an encounter with a health care provider educational workshop participants will rate their satisfaction with their health-care providers higher as compared to comparison-control participants' ratings.

## Method

### Participants and Recruitment:

Participants were 86 Japanese American older adults, ages 65 years and older. The participants were recruited from the Seinan Center in Los Angeles, California. The Seinan Center is a senior citizens day program for Japanese American older adults. The experimenter has had extensive experience with center members over the past four years by conducting several research projects and workshops, with Dr. Gayle Iwamasa, resulting in several publications and national presentations. The Executive Director of the Seinan Center provided consent for the research project to be conducted at the center (See Appendix A).

The project began with the principal investigator conducting an interest survey (Hilliard & Iwamasa, 1998) at the Seinan Center in order to determine what Japanese American older adults wanted to learn more about. Recruitment for the educational program “workshop” continued with an announcement in the newsletter, which was sent to all the Seinan Center members. There are approximately 850 Seinan Center members. In addition, announcements were posted around the Seinan Center (See Appendix B). The Seinan Center members were able to sign up for the workshop prior to or on the same day as the workshop. A sign-up sheet was provided to the Seinan Center Staff by the principal investigator. Ideally, the sign-up sheet would have been returned to the principal investigator in order to randomly assign half of the participants to the educational workshop group and the other half to a comparison-control group. However, based on their schedule, most participants did not want to sign up until the day before or the day of the workshop. Therefore, each group was randomly assigned to be either the

educational workshop group or the comparison control group. The participants were assigned a code number the day that they participated. Each of the questionnaire packets had a cover page for the participant's name, which was separated from the packets after participants were assigned a code number. The participants also were told that everyone who attended a session would have their name entered into a raffle for eight \$25.00 prizes. The raffle took place when the principal investigator returned to the center to give a summary of findings.

### Measures

Demographic Questionnaire (See Appendix C). This questionnaire was designed specifically for this study to assess participants' sex, age, marital status, generational status, internment status, education, primary occupation, annual income, living situation, health status, attendance at the Seinan Center, etc.. The demographic questionnaire also contained questions assessing two of the three dependent measures: How to communicate more effectively with health professionals, and satisfaction with one's health professionals.

The format of questions on the demographic questionnaire assessing participants' level of knowledge regarding how to communicate more effectively with health professionals and satisfaction with one's health professionals were developed based on examples of community health assessment measures (Haber, 1994). The format used also follows the recommendations put forth by Brannigan & Rossman's (1990) to promote the receptivity of older adults to health education. The wording of the open ended questions 1) Fosters the sharing of information and social support among peers and 2) Emphasizes the practical and refers to the experiences of the participants. Lastly, the written open-

ended question format provides participants with an opportunity to share as much information as they know on the topic at hand, similar to an open-ended interview format, but without the time commitment that is required from an individual interview format.

The demographic questionnaire was adapted slightly for each assessment period. For example, specific questions regarding demographic information were not included on the post-test or follow-up questionnaire packet. The post-test and follow-up questionnaire packets also had an additional question regarding usefulness of the workshop. The follow-up questionnaire packet also had a question assessing the type of health professional the participant had an interaction with since the educational workshop.

Multidimensional Health Locus of Control, Form A & B (Wallaston, Wallston, & DeVellis, 1978; See Appendix D). The Multidimensional Health Locus of Control (MHLC) scale was designed to assess people's beliefs that their health is or is not determined by their own behavior. The MHLC is comprised of 18 items divided into three, six-item subscales: Internality (Individual control of own health outcomes), Powerful others (others, such as health experts, are in control), and Chance (health outcomes are due to chance or luck). Participants rated each item on a six-point scale. The directions of the MHLC are about a page long and were edited to decrease the likelihood of fatigue.

The internal consistency reliability using Cronbach's alpha for the MHLC ranged from .67 to .77 for all three subscales and parallel forms (Fisher & Corcoran, 1994). The MHLC also was found to have good criterion validity, correlating with subjects' state of health.

## Procedure

Once recruited, an equal number of participants were randomly assigned to one of two groups, the educational workshop group or comparison-control group. Groups were run with six to ten participants, but comparisons between groups were not possible because which individuals participated in each group was not recorded. This group size allowed for some discussion among participants.

Part I. All participants completed the pre-test questionnaire packet. At this time, they were assigned to visit a health professional during the next two months. The participants participated in the assigned workshop on either what older adults can do to improve the quality of their relationship with their health providers or what are mental health services (See Appendix E). Topics that were covered in the former workshop were based on Ferguson's (1993) suggestions and included: (a) how to choose a health professional, (b) how to prepare for a visit with a health professional, (c) what one would want to tell one's health professional, (d) what information to get from a health professional, (e) how to best communicate with one's health professional, and (f) bringing a friend or family member to one's appointment. Topics that were covered in the latter workshop consisted of general information on mental health services, such as who provides mental health services, who needs mental health services, and forms of therapy. The workshop on what are mental health services served as the comparison-control group in the study.

After participating in the assigned workshop, participants were reminded to visit their doctor, talk with a pharmacist, or talk with a health professional that came to the Seinan Center. The two-month time period was selected to ensure participants would

have enough opportunity to interact with a health professional. Health professionals visit the Seinan Center an average of once a week. Some of the medical needs provided by the health professionals who come to the Seinan Center were blood pressure checks, diabetes management, and podiatry.

Part II. Approximately two months later, the principal investigator returned to the Seinan Center and the participants in both the comparison-control and educational workshop groups had the opportunity to participate in the other workshop. Further, information contained in each of the workshop presentations was left in handout format at the Seinan Center, so all members would have access to the information. The Seinan Center translated the information into Japanese for the members who did not speak English. Further, not all of the participants were available when the principle investigator returned for the follow-up visit. Therefore, a staff member at the Seinan Center who served as a research assistant on past research projects helped to collect data from the participants who were not available.

## Results

### Summary of Demographic Data

Forty-one (47.7%) of the participants were in the educational workshop group and 45 (52.3%) participants were in the comparison-control group. Twenty (23.3%) of the participants were men and 65 (75.6%) were women. One (1.2%) participant did not indicate his/her sex. A significant sex difference between groups was found with more women in the comparison group ( $X^2(4, N = 86) = 23.82, p < .01$ ). Age of participants ranged from 57 to 88 years-old, with a mean age of 74.5 years. A majority of the participants were second generation,  $n=72$  (83.7%), followed by 8 (9.3%) participants



who reported being first generation, and 2 (2.3%) participants who reported being third generation. Four (4.7%) participants did not indicate their generational status. Thirty-seven (43%) participants were interned during WWII, while 8 (9.3%) participants did not indicate whether or not they were interned.

In terms of marital status, 43 (50%) participants were married, 31 (36%) were widowed, two (2.3%) were single, and nine (10.5%) were divorced. One (1.2%) participant did not indicate his/her marital status. The mean number of children that the participants had was 2.2 with a range of zero to five. Forty-one (47.7%) of the participants lived with their spouse, 28 (32.6%) lived alone, six (7%) lived with their children, and seven (8.1%) lived with someone else. Four (4.7%) participants did not indicate with whom they were currently living.

In terms of education level, 48 (55.8%) participants were high-school graduates, 19 (22.1%) attended some college, 10 (11.6%) were college graduates, five (5.8%) had some grade school education, and three (3.5%) had post-graduate degrees. One (1.2%) participant did not indicate his/her highest level of education. About sixty percent of the participants indicated that their annual income was less than \$19,999.

Most of the participants were relatively healthy. A majority of the participants felt healthy,  $n=75$  (87.2%) and rarely or sometimes got sick,  $n=80$  (97.6%). Sixty (69.8%) participants took medication on a daily basis, 25 (29.1%) did not take medication regularly, and 1 (1.2%) did not indicate his/her medication usage. Out of the 85 participants who answered whether or not their medications had side effects, 53 (61.6%) participants reported “no” and 7 (8.1%) reported “yes”. Members of the Seinan Center attended the center frequently. Most participants attended the Seinan Center at least one

or more times a week,  $n=74$  (86%). Participants in the educational workshop group attended significantly more frequently than the participants in the comparison group,  $F(1, 80) = 11.63, p < .01$ . However, the difference was slight, participants in the educational workshop attended Seinan Center two to three times per week, whereas the participants in the comparison group attended four to five times per week. Most participants exercised on a weekly basis,  $n=78$  (90.7%), although two (2.3%) participants did not indicate how often they exercised.

In terms of medical care satisfaction, 78 (90.7%) participants were moderately satisfied to satisfied with the relationship that they had with their primary doctor. Most participants,  $n=59$  (68.6), did not bring someone with them when they went to the doctor. Out of the 59 participants who brought someone with them to the doctor, most often they brought their spouse,  $n=19$  (32%), or a friend or other family member,  $n=6$  (10%). Most of the participants went to a male doctor,  $n=64$  (74.4%), who had an ethnic minority background,  $n=55$  (64%).

#### Psychometric Properties of the Multidimensional Health Locus of Control Scale

Reliability analyses were based upon the 61 participants who completed all items on the MHLC questionnaire. Forty-five (73.8%) of the MHLC questionnaires were completed by women and 16 (26.2%) were completed by men. The overall mean for the three subscales on the MHLC for this sample were as follows: Internal,  $M=5$ , Chance,  $M=3.7$ , and Powerful Other,  $M=4.5$ . No significant sex differences were found for the three subscale scores ( $p > .05$ ). Internal consistency was assessed using Cronbach's alpha. Cronbach's alpha for the three subscales ranged from .66-.72, which was comparable to the Cronbach's alpha of .67-.77 reported in the normative sample.

### Hypothesis 1

In order to assess hypothesis one, a 3 X 2 ANOVA was conducted to determine if the Japanese American older adults who were assigned to the educational workshop group had a significantly higher level of knowledge regarding how to most effectively interact with a health professional as compared to participants assigned to the comparison-control group. This hypothesis was supported (see Table 2 for means). There was a significant main effect for time,  $F(2,104) = 6.465, p < .01$ , as well as a significant interaction between time and group  $F(2, 104) = 7.567, p < .01$ . There was no main effect for group,  $F(1,52) = 1.763, p > .05$ . Simple effects revealed that at time 1, the comparison control group scored higher, but at time 2 and time 3 the educational workshop group scored higher than the comparison control group [ $F(1,52) = 98.85, p < .001$  for time 1;  $F(1,52) = 103.75, p < .001$  for time 2;  $F(1,52) = 9124.45, p < .001$  for time 3].

### Hypothesis 2

In order to assess hypothesis two, a total of three 3 X 2 repeated measures ANOVAs were conducted, one on each of the three MHLC subscales between groups. This hypothesis, which was examined to determine the impact of the educational workshop on each of the three MHLC subscales, was not supported (see Table 3 for means). There were no significant interactions between time and group for any of the three MHLC subscales [ $F(2,110) = .203, p > .05$  for Internal subscale;  $F(2,106) = .956, p > .05$  for Chance;  $F(2,108) = .211, p > .05$  for Powerful Others]. There also were no main effects for time on any of the three MHLC subscales [ $F(2,110) = 1.461, p > .05$  for Internal;  $F(2, 106) = .786, p > .05$  for Chance;  $F(2,108) = .339, p > .05$  for Powerful

Others] or for group for any of the three MHLC subscales [ $F(1,55) = .079, p > .05$  for Internal;  $F(1, 53) = .979, p > .05$  for Chance;  $F(1,54) = .760, p > .05$  for Powerful Others].

### Hypothesis 3

In order to assess hypothesis three, a 2 X 2 repeated measures ANOVA was conducted to determine if at follow-up, educational workshop participants would rate their satisfaction with their health-care providers higher after an encounter with a health care provider as compared to comparison-control participants' ratings. This hypothesis was not supported (see Table 4 for means). For the question on the demographic questionnaire, which assessed level of satisfaction with their health professional, a difference score (follow-up score minus pre-test score) was calculated. There was no significant main effect for time,  $F(1,50) = .085, p > .05$ , or significant interaction between time and group,  $F(1,50) = .085, p > .05$ . There also was no main effect for group,  $F(1,50) = .663, p > .05$ . Further, ethnicity of the participants doctors did not impact satisfaction scores  $F(1, 49) = 1.006, p > .05$ . However, only forty-seven (54.7%) of the participants who reported on their level of satisfaction with health care providers at follow-up, interacted with a health professional at the Seinan Center or other location.

## Discussion

### Summary of Results

#### Hypothesis 1

The hypothesis that participants in the educational workshop group would have a significantly higher level of knowledge regarding how to most effectively interact with a health professional as compared to participants randomly assigned to the comparison-

control group was supported. Participants in the educational workshop group had a greater level of knowledge about how to interact most effectively with a health professional than participants in the comparison control group immediately after the educational workshop. Further, the participants in the educational workshop group continued to have a significantly higher level of knowledge about how to interact most effectively with a health professional at follow-up testing in comparison to their baseline measurement.

These findings provide support that one-time educational workshop workshops may increase the level of knowledge about a particular topic for Japanese American older adults. Further, given that these healthy Japanese American older adults increased their knowledge regarding how to communicate effectively with health professionals, Japanese American older adults who are not as satisfied with their health care providers most likely can benefit from this type of educational workshop.

The fact that educational workshop participants were able to maintain new knowledge over time, not just immediately after the educational workshop took place is also of interest. New knowledge is not useful unless it can be maintained over time and translated into change in behavior (Redland & Stuijbergen, 1993). Adequate knowledge for changing behavior is one of the first steps necessary for behavior change. According to Prochaska, Norcross, & DiClemente (1994) there are six stages of behavior change: (a) Precontemplation, (b) contemplation, (c) Preparation, (d) Action, (e) Maintenance, and (f) Termination. Gathering knowledge for behavior change usually begins once an individual realizes there is a problem and desires change. An individual's desire for

change occurs in the contemplation stage. Adequate knowledge is necessary for individuals to plan a course of action for behavior change and to develop a belief system as to why it is important to change.

### Hypothesis 2

The hypothesis that the mean scores of each of the three MHLC subscales would be significantly different between groups was not supported. As reported previously, this was a healthy sample of Japanese American older adults and the overall MHLC subscale scores were within normal range for this sample. Furthermore, the variability of scores also was restricted. These factors likely contributed to the degree to which we were able to accurately examine this hypothesis.

Another possible explanation for these findings is that although the MHLC was found to be reliable for this population, that does not necessarily mean that the measure has construct validity for this population. As discussed earlier, research has not yet clarified the role of personal control on the health of Japanese American older adults. Thus, the non-significant findings could be due in part to the fact that Locus of Control is not a concept culturally appropriate to this population. Finally, the findings also could be due to the fact that the format of the scale and wording of the items were inappropriate for this population.

### Hypothesis 3

The hypothesis that at follow-up, educational workshop participants would rate their satisfaction with their health-care providers higher after an encounter with a health care provider as compared to comparison control participants' ratings was not supported. The ratings of participants in both the educational workshop and comparison control

groups indicated that overall, the participants in both groups were satisfied with their relationship with their health professionals. Other researchers have found similar findings. Tabak (1988) found that increased question asking as a result of knowledge did not correlate with reported satisfaction among family medicine patients. Once again, the fact that this was a relatively healthy sample of Japanese American older adults and there was little variability in the scores might also have contributed to not being able to detect a difference between groups.

### Implications of Findings

These findings point to the need to continue to assess the psychometric properties of current assessment measures, in addition to examining the effectiveness of particular assessment formats with ethnic minority older adult populations. As discussed earlier, in addition to assessing the reliability of a measure, it is just as important to assess the construct validity of a measure, particularly with ethnic minority populations. Due to the conflicting literature on the role of personal control on the health of Japanese American older adults, and based on the findings of this study, the validity of the MHLC as a measure of Locus of Control is still in question. Further, it is unclear whether or not the concept of locus of control is a culturally universal concept.

Another factor to consider when interpreting these findings is that what is of interest to your population of interest (i.e., in this study the sample was interested in learning more about how to communicate more effectively with health professionals) might not yield distressed results with current assessment measures. For example, it is important to consider the possibility that simply because this sample of Japanese American older adults stated that they wanted to learn more about how to effectively communicate with

their health care professionals, it does not necessarily mean that they felt their relationship with their health care provider was negative. In fact, by their report on the pre-test questionnaire packet, they rated their relationships with health professionals as at least moderately satisfying. However, this should not preclude researchers from examining the effectiveness of educational workshops in this area, because positive behavior change such as wanting to improve a situation that is already satisfactory, should not be discouraged. However, this may be one factor that contributed to why the findings did not yield an increase in level of satisfaction with participants in the educational workshop group was observed.

These findings also point to the level of difficulty involved in measuring change among a healthy sample. When a sample of interest is not extremely distressed at the onset, statistical significant change is more difficult to detect, but the educational workshop may still be of interest to the population. In addition, Entwistle, Sowden and Watt (1998) point to the importance of researchers exploring what criteria should be used to judge the effectiveness of educational workshops designed to promote patient involvement. They point to the necessity to develop and validate new measures to better assess educational workshop effectiveness.

Further, if an educational workshop or a portion of an educational workshop does yield positive change, researchers should be concerned as how to maintain progress over time. Prochaska et al. (1994) emphasize the necessity to replace the inefficient or maladaptive behavior with an adaptive behavior in order to maintain behavior change. Simply removing an inefficient or maladaptive behavior from one's behavior repertoire is not enough; one needs to go one step further and develop a desirable habit to replace the



undesirable habit. Booster sessions and incorporating behavior change into one's overall lifestyle are also other essential key to maintaining progress over time (Redland & Stuifbergen, 1993).

Culturally, these findings potentially point in a different direction than previous findings regarding the role of culture in Asian American older adults' sense of personal control. Even though the findings do not clearly indicate whether or not locus of control is a universal concept, it is interesting to note that this sample of Japanese American older adults appear to have a strong internal sense of control, which is contrary to the limited and outdated literature stating that as Japanese older adults age they tend to rely on others to care for them. Further, their interest in general to learn how to communicate more effectively with health professionals indicates that this sample might not have as much difficulty discussing their health openly with health professionals as previous literature indicates. This is different than a Japanese American who lives by more stringent cultural beliefs, which might prevent him/her from questioning the doctor in order to maintain social balance.

#### Methodological Considerations

The strength of this study was that it was designed from a community research perspective in that it examined a topic that was relevant to the sample population and had a theoretical basis. Typically when deciding on a research topic, more emphasis is placed on the direction the literature leads researchers rather than on what would be important to the population of interest. There are several advantages to a community research perspective. For example, when the sample population is interested in a particular

research topic recruitment is enhanced, useful information is provided to members of the sample population, and psychology establishes a role in the community.

A related strength of this study was that in addition to a community research perspective, both an etic and emic approach was used. Triandis (1994) distinguishes between etic and emic research methodologies. Etics are ideas, behaviors, items, and concepts that are universal in nature, whereas emics are ideas, behaviors, items, and concepts that are culture specific. To date, very little research has examined sense of personal control from an emic perspective. Triandis stated that the only way we can understand the impact of culture is by using an emic approach to research. This study also was designed based on guidelines on how to conduct psychological research with Asian American/Pacific Islander populations (Sue & Sue, 2000). The latter guidelines suggest that the following factors should be taken into consideration: (a) Asian American/Pacific Islander populations are heterogeneous (e.g., Japanese, Chinese, Koreans, Etc.) and have different cultural beliefs, so findings may not generalize across cultural groups, (b) The impact of culture on the reliability and validity of assessment measures needs to be taken into consideration, (c) Alternative explanations for findings, particularly those suggested by Asian Americans should be considered, and (d) Research findings should be disseminated to the Asian community as well as to professionals.

Despite the advantages to a community research perspective, there are a number of methodological considerations of this study. A primary methodological consideration is that traditional scientific methods, such as randomization, are not always possible in a community setting. For example, in this study, traditional randomization did not facilitate the recruitment process because it would have interfered with the participants'

activities at the center. Therefore a modification of randomization was used and although no pre-test differences between groups were found, we cannot be sure how this modification affected the findings. Additionally, the study would have been enhanced if we were able to acquire data from the participants' health professionals regarding their opinion on their patient's level of knowledge regarding how to most effectively interact with a health professional and whether their patient's level of knowledge changed based on whether or not they were in the educational workshop or comparison control group. Although this latter type of data would have been very useful to the research questions, the principal investigator was unable to gain access to this information.

A second methodological consideration to take into account is that the findings are based on Japanese American older adults who were healthy and active individuals. As noted in the previous section, it is more difficult to detect change in attitudes and behavior in individuals who are healthy at the onset. Another related methodological consideration is the fact that although a total of 86 participants were recruited, the total number of participants who completed all three questionnaire packets for inclusion in the analyses was smaller ( $N=61$ ) and resulted in little variability of scores, making it additionally difficult to detect significant findings. Researchers need to be realistic about and sensitive to the type and number of measures they request the participants, particularly older adult participants, to complete. Also, because the sample was healthy and active, these results may not be generalizable to Japanese American older adults who are physically ill and have frequent contact with health professionals.

A fourth methodological consideration is that the types of questionnaires used may not have been the most effective way to collect data. For example, it was observed

that when asked the fill-in-the-blank questions orally, participants were able to generate additional answers to the questions. This observation could be due to the fact that the participants in this study became bored or fatigued while filling out the questionnaire, there were too many questions, or maybe it points to the fact that traditional scientific methods may not be the best way to measure change over time in a community setting. Another explanation may be that the participants in this study might simply enjoy interpersonal interaction more than filling out a survey. Therefore, using an interview format as opposed to a self-report questionnaire format might have enhanced the reliability and validity of the data. This methodological consideration highlights the need to use emic methods rather than assuming etic methods are applicable across cultures and age groups.

A final methodological consideration is the fact that the principal investigator of this study chose health locus of control as opposed to self-efficacy as the primary dependent variable. As discussed earlier, self-efficacy focuses on ability to engage in a specific action and has been found to predict behavior change, while locus of control simply looks at outcome expectancies. It is possible that the MHLC was not specific enough and therefore was not able to tap into specific changes in sense of personal control, which is why significant differences between groups was not observed.

#### Future Research Directions

As a result of these methodological considerations, the results of this study should be used as preliminary findings on which to base future research. First, more research needs to be conducted examining whether or not locus of control is an universal concept across ethnic groups. If locus of control is found to be a universal concept, the the

psychometric properties of current measures of locus of control for Japanese American older adults need to be further examined. The reliability coefficients found for the MHLC score are adequate, but should be verified by future research on larger and more diverse samples of Japanese American older adults. Specifically, research needs to be conducted on Japanese American older adults who are suffering from a physical illness or in a phase of life requiring frequent visits with a health professional. Research focusing on these latter topics will help to clarify whether or not locus of control is a culturally appropriate concept.

Future research also needs to examine the effectiveness of assessment measures and traditional research methods with Japanese American older adults. Due to logistical factors, such as time and adequate sample size for necessary power, researchers prefer to use self-report questionnaires. However, for some populations, such as ethnic minority populations or older adults, an interview format may yield more reliable and valid data. Researchers could address this issue by conducting focus groups with Japanese American older adults to determine whether or not they feel that self-report questionnaires are meaningful to them. Researchers need to determine whether or not participants understand the format of the questionnaire, if they feel comfortable about asking questions when they do not understand, if they would feel more comfortable being interviewed instead of filling out a questionnaire, etc. Researchers also need to determine the impact that random assignment and type of variable measurement have on findings. Research focusing on these issues will promote the development of more appropriate assessment measures to use with this population. As researchers, we need to find a way to adapt to the needs of the participants, the participants should not be forced to adhere to

traditional scientific methodology if it does not yield as reliable and valid results as another approach.

Future research also needs to focus on the long-term impacts of brief educational workshops such as the one conducted in this study. Questions such as is it financially worthwhile to offer this type of workshop, who benefits the most from psychoeducational educational workshops, how should educational workshops be designed to maximally yield behavior change, and how are behavior changes maintained over time need to be examined. There is no immediate financial benefit of the implementation of prevention workshops. However, over the long term, prevention workshops can be financially and socially worthwhile and therefore deserve more research attention.

### Conclusions

The purpose of this study was three-fold. First, this research examined whether or not Japanese American older adults who participated in an educational workshop group on improving communication skills with health professionals would lead to an increase in their level of knowledge concerning how to interact with their health professionals. The second purpose was to determine whether or not Japanese American older adults' sense of personal control would increase as a result of being a participant in the educational workshop group. Third, this investigation sought to determine if the educational workshop had an impact on the level of satisfaction that Japanese American older adults report about their relationship with their health professionals.

Japanese American older adults who participated in the educational workshop group did demonstrate an increase in level of knowledge concerning how to interact with their health professional compared to the comparison control group. However, the

participants in the educational workshop group did not differ from those in the comparison control group on increase in sense of personal control or level of satisfaction with their relationship with their health professionals. Findings indicated that the MHLC scales were reliable measures of Japanese American older adults' beliefs that their health is determined by their behavior. However, future research with a larger and more diverse sample is recommended. Methodological considerations for detecting change in behavior and maintenance of change over time with regard to health promotion educational workshops with Japanese American older adults were discussed.

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## APPENDIXES

APPENDIX A

SEINAN CENTER CONSENT



## *Seinan Senior Citizens' Center*

3116 WEST JEFFERSON BOULEVARD

LOS ANGELES, CALIFORNIA 90018

(213) 734-2175

June 24, 1999

*Miss Kristen Hillard  
Oklahoma State University  
Psychology Department  
215 No. Murray  
Stillwater, OK 74078-0250*

*Dear Miss Hillard:*

*It is with great pleasure that the Seinan Senior Citizens Center join Oklahoma State University, Dept. of Psychology to conduct a survey regarding "Becoming a Health Active Older Adults."*

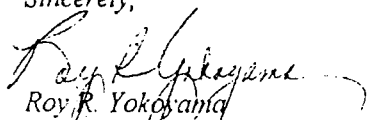
*Our membership which exceeds 1000 is as follows:*

<i>Age Group:</i>	<i>55 years &amp; older</i>
<i>Average Age:</i>	<i>73 years</i>
<i>Sex:</i>	<i>Male 30% Female 70%</i>
<i>Marital Status:</i>	<i>Single 5% Married 60% Widowed 35%</i>


*The study pertaining to "Anxiety Among Japanese American Older Adults" conducted last year was a very successful survey. The individuals who participated were very supportive and indicated that they were very pleased with the results.*

*We look forward in joining your study once again.*

*Sincerely,*

  
*Roy R. Yokoyama  
Executive Director*

APPENDIX B  
RECRUITMENT ANNOUNCEMENT



*Make the Most of Your Visits with  
Health Professionals*

**Sign-up Today!**

*Free 3 Part Workshop to be Held on  
September 13th, 15th, and November 1st*

Presenter: Kristen M. Hilliard, M.S.  
Oklahoma State University

APPENDIX C  
DEMOGRAPHIC QUESTIONNAIRE

## Demographic Questionnaire

### Background Information:

1. What is your sex? (Please Check One)

- Male(1)     Female(2)

2. What is your age? \_\_\_\_\_ years

3. What is your generational status?

- 1<sup>st</sup>(1)     2<sup>nd</sup>(2)     3<sup>rd</sup>(3)     4<sup>th</sup>(4)     5<sup>th</sup>(5)

4. Were you interned during WWII? (Please Check One)

- Interned(1)     Not Interned(2)

**If interned**, what camp? \_\_\_\_\_

And how long? \_\_\_\_\_

5. What is your Marital Status? (Please Check One)

- Single(1)  
 Married(2)  
 Divorced(3)  
 Widowed(4)

6. How many children do you have? \_\_\_\_\_

number of girls \_\_\_\_\_

number of boys \_\_\_\_\_

7. What is your highest level of education? (Please Check One)

- No formal education(1)  
 Some grade school(2)  
 High school graduate(3)  
 Some college(4)  
 College graduate(5)  
 Post graduate degree(6)

8. What is your annual income? (Please Check One)

- I am financially dependent on others(1)  
 Under \$10,000(2)  
 \$10,000-\$19,999(3)  
 \$20,000-\$39,999(4)  
 \$40,000+(5)

9. With whom do you live? (Please Check One)

- I live alone(1)  
 I live with my spouse(2)  
 I live with my children(3)  
 I live in a retirement home(4)  
 Other, please explain(5): \_\_\_\_\_
- 

10. How often do you attend the Seinan Center? (Please Check One)

- Once a month(1)  
 Twice a month(2)  
 Three times a month(3)  
 Once a week(4)  
 Two to three times a week(5)  
 Four to five times a week(6)

Health:

11. How healthy do you feel? (Please Circle One)

<u>Unhealthy</u>		<u>All right</u>		<u>Healthy</u>
1	2	3	4	5

12. How often do you exercise on a weekly basis? (Please Check One)

- None(1)  
 1 to 2 times per week(2)  
 3 to 4 times per week(3)  
 5 or more times per week(4)

13. Are taking medications on a regular basis? (Please Check One)

- Yes(1)     No(2)

If yes, do any of these medications have any side effects? (Please Check One)

- Yes(1)     No(2)

Please list the medications you take: \_\_\_\_\_

---

14. How often do you get sick? (Please Circle One)

<u>Rarely</u>		<u>Sometimes</u>		<u>Often</u>
1	2	3	4	5

Relationship with Health Professionals:

15. How satisfied are you with the relationship you have with your primary doctor? (Please Circle One)

	Moderately		Satisfied	
<u>Unsatisfied</u>		<u>Satisfied</u>		<u>Satisfied</u>
1	2	3	4	5

16. Do you bring someone with you when you go to the doctor? (Please Check One)

Yes(1)       No(2)

If yes, whom do you take with you? (Please Check One)

Friend(1)

Spouse(2)

Family Member(3)

Other(4)

17. What is your primary doctor's sex? (Please Check One)

Male(1)       Female(2)

Depends (Do not have a regular doctor)

18. What is your primary doctor's ethnicity/race? \_\_\_\_\_

19. How would you go about choosing a new doctor? (Please list your answers)

- a. \_\_\_\_\_
- b. \_\_\_\_\_
- c. \_\_\_\_\_
- d. \_\_\_\_\_
- e. \_\_\_\_\_

20. If a friend asked you how to prepare for a visit with a doctor or health professional, what would you tell them? (Please list your answers)

- a. \_\_\_\_\_
- b. \_\_\_\_\_
- c. \_\_\_\_\_
- d. \_\_\_\_\_
- e. \_\_\_\_\_

21. How do you prepare for a visit with a doctor or health professional? (Please list your answers)

- a. \_\_\_\_\_
- b. \_\_\_\_\_
- c. \_\_\_\_\_
- d. \_\_\_\_\_
- e. \_\_\_\_\_

22. What types of information do you want to be sure to provide to the doctor or health professional during a visit? (Please list your answers)

- a. \_\_\_\_\_
- b. \_\_\_\_\_
- c. \_\_\_\_\_
- d. \_\_\_\_\_
- e. \_\_\_\_\_

23. What types of information should you get from a health professional during a visit? (Please list your answers)

- a. \_\_\_\_\_
- b. \_\_\_\_\_
- c. \_\_\_\_\_
- d. \_\_\_\_\_
- e. \_\_\_\_\_

24. What are some things you can do to most effectively communicate with your doctor or health professional? (Please list your answers)

- a. \_\_\_\_\_
- b. \_\_\_\_\_
- c. \_\_\_\_\_
- d. \_\_\_\_\_
- e. \_\_\_\_\_

25. What are some benefits of bringing a friend or family member to a visit with a doctor or health professional? (Please list your answers)

- a. \_\_\_\_\_
- b. \_\_\_\_\_
- c. \_\_\_\_\_
- d. \_\_\_\_\_
- e. \_\_\_\_\_

(Post and follow-up packets only)

26. On a scale of 1 to 5 (1 = not helpful at all and 5 = Very helpful) how would you rate usefulness of the workshop you attended?

<u>Not helpful</u>		<u>Helpful</u>		<u>Very helpful</u>
1	2	3	4	5



(Follow-up packet only)

27. Over the past two months did you interact with a health professional at the Seinan Center or other location?

Yes(1)     No(2)

If yes, check all that apply:	Number of Times Visited	Check if New doctor
<input type="checkbox"/> Medical doctor(1)	_____	<input type="checkbox"/>
<input type="checkbox"/> Dentist(2)	_____	<input type="checkbox"/>
<input type="checkbox"/> Specialist (e.g. heart, poditrist)(3)	_____	<input type="checkbox"/>
<input type="checkbox"/> Pharmacist(4)	_____	<input type="checkbox"/>
<input type="checkbox"/> Herbalist(5)	_____	<input type="checkbox"/>
<input type="checkbox"/> Dietician/Nutritionist(6)	_____	<input type="checkbox"/>
<input type="checkbox"/> Acupuncturist(7)	_____	<input type="checkbox"/>
<input type="checkbox"/> Chiropractor(8)	_____	<input type="checkbox"/>
<input type="checkbox"/> Psychologist/Counselor(9)	_____	<input type="checkbox"/>
<input type="checkbox"/> Psychiatrist(10)	_____	<input type="checkbox"/>
<input type="checkbox"/> Physical Therapist(11)	_____	<input type="checkbox"/>
<input type="checkbox"/> Other _____(12)	_____	<input type="checkbox"/>

28. In general, how satisfied were you with the visits to the health professionals you listed in question 27? (Please circle the answer)

<u>Unsatisfied</u>		<u>Moderately</u>		<u>Satisfied</u>		<u>Satisfied</u>
1	2	3	4	5		

## APPENDIX D

## MHLC SCALE

## Form A

This questionnaire is designed to determine the way in which different people view certain important health-related issues. Each item is a belief statement, with which you may agree or disagree. Each statement can be rated on a scale which ranges from strongly disagree (1) to strongly agree (6). For each item, record the number that represents the extent to which you disagree or agree with the statement.

- 1 = Strongly disagree
- 2 = Moderately disagree
- 3 = Slightly disagree
- 4 = Slightly agree
- 5 = Moderately agree
- 6 = Strongly agree

1. If I get sick, it is my own behavior, which determines how soon I get well again.  
\_\_\_\_\_
2. No matter what I do, if I am going to get sick, I will get sick. \_\_\_\_\_
3. Having regular contact with my physician is the best way for me to avoid illness.  
\_\_\_\_\_
4. Most things that affect my health happen to me by accident. \_\_\_\_\_
5. Whenever I don't feel well, I should consult a medically trained professional. \_
6. I am in control of my health. \_\_\_\_\_
7. My family has a lot to do with my becoming sick or staying healthy. \_\_\_\_\_
8. When I get sick, I am to blame. \_\_\_\_\_
9. Luck plays a big part in determining how soon I will recover from an illness. \_
10. Health professionals control my health. \_\_\_\_\_
11. My good health is largely a matter of good fortune. \_\_\_\_\_
12. The main thing, which affects my health is what I myself do. \_\_\_\_\_
13. If I take care of myself, I can avoid illness. \_\_\_\_\_
14. When I recover from an illness, it is usually because other people (for example, doctors, nurses, family, and friends) have been taking good care of me. \_\_\_\_\_

15. No matter what I do, I'm likely to get sick. \_\_\_\_\_
16. If it's meant to be, I will stay healthy. \_\_\_\_\_
17. If I take the right actions, I can stay healthy. \_\_\_\_\_
18. Regarding my health, I can only do what my doctor tells me to do. \_\_\_\_\_

**APPENDIX E**  
**OUTLINE FOR WORKSHOPS**

Educational program Workshop  
Questions for Discussion

- 1. What would be helpful to learn about in order to help you interact with your doctor more effectively?**
- 2. What should you know when choosing a health professional?**
  - The most important thing to look for when choosing a new health professional is someone you can talk to about your problems.
  - Decide what you are looking for in a health professional
  - Identify several possible doctors
  - Consult reference sources, current patients, and colleagues
  - Learn more about the health professionals you are considering
  - Make a choice
- 3. What should you bring with you for an appointment with a health professional?**
  - Time of your appointment
  - Insurance card
  - Social Security number
  - Family medical history
- 4. What would be some things you would want to tell your health professional during your appointment?**
  - What are my symptoms?
  - When did all of this start?
  - What was I doing, or what had I just finished doing when the symptoms started?
  - If it hurts, where is the pain?
  - Have I ever had anything like this before? When?
  - What prescriptive medicines have I taken in the last month?
  - What over-the-counter drugs am I taking?
  - What natural or alternative medicines or therapies am I using?
  - What healthcare providers am I seeing regularly or have I seen in the last two months?
  - What did I see each for?
  - What did each recommend?
  - What do I expect to happen from this visit?
- 5. What is some information that you would need to get from your health professional?**
  - What conditions have symptoms like mine?
  - What do you think is causing my symptoms?
  - Is there a medical term for my problem different from the one you have told me?
  - If I need a test, what kind do I need?
  - Do I need to see a specialist?
  - Is there more than one way to resolved my problem?

- Is it all right to continue to be active with my symptoms?
- Should I be taking a pain medication?
- Do my prescription medicines need to be changed?
- If so, how should I change them?
- Is there a different medicine that can specifically work for what I have or need?
- Can you give me information to read about my condition?
- Where can I find additional information?
- What is the probability this can be cured?
- How long should it take?
- When should I see you again?
- Take notes
- Remember doctors do not know everything

**6. How do you best communicate with your health professional?**

- Be prepared: make a list of concerns
- Make sure you can see and hear as well as possible
- Consider bringing a family member or friend
- Plan to update the doctor

**7. What to know when you are calling your health professional?**

- When is the best time to call?
- What is the doctor's rule for returning calls?
- Who should you speak to if the doctor can't come to the phone?
- What is the phone number for emergency calls or calls when the office is closed?

*When you reach your doctor or other health care provider by phone, be prepared to:*

- Get to the point of your call quickly, especially if you've phoned after hours
- Define your problems and symptoms. Write these down and keep them by the telephone so you can report them quickly and accurately
- Report results of self-tests you have been keeping track of, such as temperature, stomach problems, etc.
- Ask the doctor what you should do. Write it down.
- Have your pharmacist's phone number handy in case the doctor needs to prescribe medicine.
- Ask if and when you should call back, or if you should come to the office.
- Ask what things might occur that would require you to go to the emergency room
- Thank the doctor for talking with you on the telephone

**8. Do any of you bring someone with you when you go to a health professional?**

**What are the benefits to bring a friend with you to see the health professional?**

- More confident
- Help you to communicate effectively with a health professional
- The friend can help you to remember what a health professional says

- Discuss with your friend how they can be most helpful during the appointment with a health professional
- The friend/caregiver might be able to benefit from the visit
- Friends/caregivers can help you with a health professionals orders' outside of treatment

**8. How does all of what we talked about today relate to other health professionals you interact with when you have health related problems?**

Comparison-Control  
Questions for Discussion

- 1. What are mental health services?**
- 2. Who provides mental health services?**
  - **Psychologists/Counselors**
  - **Social Workers**
  - **Pastors**
  - **Psychiatrists**
- 3. What is the difference between a psychologist and psychiatrist?**
  - **A psychiatrist is a medical doctor and is able to prescribe medications.**
- 4. What types of problems can be treated using mental health services?**
  - **Relationship difficulties**
  - **Depression**
  - **Anxiety**
  - **Adjustment difficulties**
  - **Coping with health problems**
  - **Addictions**
- 5. What are some different types of therapies?**
  - **Behaviorism**
  - **Marriage/Family**
  - **Cognitive**
  - **Empirically Supported Treatments**



APPENDIX F

INSTITUTIONAL REVIEW BOARD APPROVAL FORM

OKLAHOMA STATE UNIVERSITY  
INSTITUTIONAL REVIEW BOARD

Date: August 27, 1999 IRB #: AS-00-083

Proposal Title: "BECOMING A HEALTH ACTIVE OLDER ADULT: THE EFFECTS OF A WORKSHOP FOR JAPANESE AMERICANS"

Principal Investigator(s): Melanie Page  
Kristen Hilliard

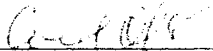
Reviewed and Processed as: Expedited

Approval Status Recommended by Reviewer(s): Approved

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Signature:

  
\_\_\_\_\_  
Carol Olson, Director of University Research Compliance

\_\_\_\_\_  
August 27, 1999  
Date

Approvals are valid for one calendar year, after which time a request for continuation must be submitted. Any modification to the research project approved by the IRB must be submitted for approval. Approved projects are subject to monitoring by the IRB. Expedited and exempt projects may be reviewed by the full Institutional Review Board.

## APPENDIX G

## TABLES

Table 1: Topic Ranking and Percent Interest of Japanese American Older Adults (Hilliard & Iwamasa, 1999)

<u>Topic Ranking</u>	<u>N</u>	<u>Percent</u>
Aging	64	63.4%
Relationship with Medical Doctors	54	53.5%
Mental Health Services	52	51.5%
Health	49	48.5%
Death and Dying	45	44.6%
Stress	36	35.6%
Changing Unhealthy Behaviors	32	31.7%
Family	28	27.7%
Interacting with Younger People	22	21.8%
Pain Management	21	20.8%

Table 2

Knowledge scores by Participants With and Without the Intervention Workshop

---

Group	Pre	<u>M (SD)</u>	
		Post	Follow-up
Intervention	5.89 (5.02)	11.38 (7.59)	10.55 (6.71)
Comparison Control	7.56 (4.89)	6.88 (5.12)	8.12 (5.38)

---

Table 3  
 MHLC Subscale scores by Participants With and Without the Educational Workshop

Group	Internal	Chance	Powerful Others
Pre			
Educational workshop			
<u>M (SD)</u>	4.99 (.79)	3.44 (1.03)	4.25(.97)
Comparison Control			
<u>M (SD)</u>	4.97 (.71)	3.83 (1.22)	4.52 (.93)
Post			
Educational workshop			
<u>M (SD)</u>	4.86 (1.05)	3.45 (1.06)	4.18 (.89)
Comparison Control			
<u>M (SD)</u>	4.94 (.85)	3.76 (1.13)	4.34 (1.02)
Follow-up			
Educational workshop			
<u>M (SD)</u>	4.74 (1.10)	3.46 (1.05)	4.15 (.92)
Comparison Control			
<u>M (SD)</u>	4.86 (.67)	3.51 (1.01)	4.26 (.88)

Table 4

Satisfaction Level With Their Health Professionals by Participants With and Without the Educational workshop Workshop

---

Group	<u>M (SD)</u>	
	Pre	Follow-up
Educational workshop	4.09 (1.07)	4.00 (1.06)
Comparison-Control	4.24 (.94)	4.24 (.89)

---

VITA

Kristen H. Sorocco

Candidate for the Degree of

Doctor of Philosophy

Dissertation: BECOMING A HEALTH ACTIVE OLDER ADULT: THE EFFECTS OF A WORKSHOP FOR JAPANESE AMERICAN OLDER ADULTS

Major Field: Psychology

Biographical:

Education: Graduated from Wilmington Friends School, Wilmington, Delaware, 1991; received a Bachelor of Art degree in Psychology and French from Butler University, Indianapolis, Indiana in 1995; received a Master of Science degree with a major in Clinical Psychology at Oklahoma State University, Stillwater, Oklahoma in 1998. Completed the requirements for the Doctorate of Philosophy with a major in Clinical Psychology and Certificate in Gerontology at Oklahoma State University in December, 2001.

Experience: Resident technician for a group home for the mentally ill; research assistant for Gayle Y. Iwamasa 1995 to 1999; employed by Oklahoma State University, Department of Psychology as a teacher's assistant and graduate instructor; Student Director Psychology Services Center, Oklahoma State University 1998 to 1999; research assistant Affective Communications Research Lab, Oklahoma City Veteran's Administration Hospital 1999 to 2000; Clinical Internship, Palo Alto Veteran's Administration Health Care System, Palo Alto, California 2000-2001; Oklahoma State University, Department of Psychology, 1996 to present.

Professional Memberships: American Psychological Association, Association for the Advancement of Behavior Therapy, and Sigma Phi Omega.