

Improving Mental Health Services for Latino and Asian Immigrant Elders

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Given the changing demographics of the aging population in the United States, it is likely that professional psychologists will encounter elderly clients from diverse backgrounds in their practice. Asians and Latinos represent the 2 fastest growing groups of elderly immigrants. This article offers information and practical suggestions to assist clinicians working with elderly Asian and Latino immigrant clients. Specific recommendations for enhancing assessment and treatment efficacy with these populations are also provided.

The elderly population is growing rapidly in the United States, and the number of ethnic minorities within this group is dramatically increasing (Schneider, 2004). There are currently over 35

million people designated as elderly (65 or older) in the United States (Hetzl & Smith, 2001), and this figure is expected to rise to nearly 70 million by 2030 (Sue & Sue, 2003). Foreign-born elderly people living in the United States constitute 11% of the elderly population, and this group deserves special consideration, as they are more likely to live in poverty and less likely to have health care coverage than their native-born counterparts (He, 2002). Although those born in Europe currently represent the majority of elderly foreign-born individuals in the United States, it is projected that in the next 20 years this population will consist mainly of individuals from Latin America or Asia instead of Europe (He, 2002; Jones, Zhang, Jaceldo-Siegl, & Meleis, 2002).

These demographic statistics underscore a profound challenge for professional psychologists who provide services to elderly people. To rise to this challenge, those working with immigrant elderly clients must be aware of the major problems and issues impinging upon them. Clinicians also need to be familiar with assessment and treatment approaches that are up to date and effective in helping elderly immigrants better manage their mental health needs. The goals of this article are to provide information to better illuminate the challenges of providing mental health services to elderly Latino and Asian immigrants and to describe methods that professional psychologists can use to enhance services provided to elderly immigrants. We focus on the two most rapidly growing elderly immigrant groups, Latinos and Asians, both of whom have mental health needs that are grossly unmet (Ailinger, 1989; Jones et al., 2002). We focus heavily on elderly immigrants from Southeast Asia, as this population represents the largest group of Asian refugees in the United States (Dhooper & Tran, 1998); furthermore, this group has been shown to experience unusually high rates of psychological disturbance, particularly, posttraumatic stress disorder (PTSD; Kinzie, 2001). In our discussion of Latino elders, we acknowledge that although there is a

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great degree of heterogeneity of cultures within this group, its members share certain themes, values, and traditions.

Overview of the Problem

Immigrants and refugees are among the most traumatized and vulnerable groups of people, as they face struggles that include tragic individual or family disintegration and loss, marriage dissolution, and racial prejudice and discrimination (Hsu, Davies, & Hansen, 2004; Yu, 1997). Across cultural groups, the stress of migration and refugee status may be especially severe for elderly people (Bemak & Chung, 2000; Carlin, 1990; Perez Foster, 2001). As compared with their younger counterparts, older people leave behind many more years' or decades' worth of memories and connections when they migrate. Furthermore, physical and cognitive age-related declines and other circumstances (e.g., age discrimination) may make elderly people less able to resume prior levels of occupational and social functioning. Thus, in addition to the common stressors associated with immigrating to a new place, elderly people are likely to face greater difficulties securing the economic and social means necessary to thrive in a new country. This is especially important because mounting evidence indicates that nearly all elderly immigrants underutilize health and social services despite their high need (e.g., Aroian, Khatutsky, Tran, & Balsam, 2001; Damron-Rodriguez, Wallace, & Kington, 1994).

In this article, we provide a review of specific and general issues relevant to recruiting and maintaining Asian and Latino elderly immigrants in treatment. First, we discuss special considerations for working with trauma and loss and dementia in these populations. Then, we present general issues that apply regardless of presenting problem or treatment foci. These issues include approaches to assessment, cultural factors that influence conceptualizations of health and symptom presentation, beliefs about mental illness and psychotherapy, and the role of family. For all of these topics, we present clinical strategies for effectively assessing and addressing each in the context of psychotherapy.

Dealing With Trauma and Loss and Dementia

Working With Trauma and Loss

It is essential that psychologists working with elderly Latino and Asian immigrants appreciate the significance of traumatic experiences often associated with immigration to the United States. Current stressors associated with acculturation may present as the most pressing and salient area of intervention for immigrant clients. However, it is crucial to assess for trauma occurring prior to and during the process of immigration, even though clients may not readily volunteer such information, owing to potential shame or distress associated with recounting such experiences (Perez Foster, 2001). To better understand the client's present situation, it is important to understand that client's life in his or her home country and his or her expectations for immigration. Obtaining a "migration narrative" can provide clinicians with an entrée into a client's cultural and migratory history. Questions that clinicians might ask include how long the family has resided in the United States, who immigrated first, who was left behind, what stressors were experienced, and what strengths and resources the client has for coping (Falicov, 1996). Although gathering information on

trauma is essential in guiding conceptualization, working through the traumas should not occur before the credibility of the clinician is established and efforts have been made to assist the client to gain stability in his or her new surroundings (Dhooper & Tran, 1998; Kinzie, 2001; Ying, 2001).

Latinos are at considerable risk for trauma exposure associated with transit to America from Mexico, Central America, or the Caribbean (Perez Foster, 2001). Southeast Asian refugees also experience a disproportionate amount of psychological trauma due to experiences with war and political repression. In a study conducted by the Massachusetts Department of Public Health, 60% of Cambodians and 48% of Vietnamese surveyed reported being robbed, raped, or tortured during their escape from their country (Pin-Riebe, Connell, Doung, Pham, & Tran, 1999). In the same study, 95% of Cambodians reported having suffered from the loss of at least one family member from an "unnatural" cause. Psychologists should be aware that for many immigrants, particularly from certain regions (e.g., Cambodia, Vietnam, El Salvador), the traumatic experiences of their home country may have enduring psychological consequences (Dhooper & Tran, 1998; Kinzie, 2001).

Loss of the status once held in their country of origin can also contribute to the grief observed in Southeast Asian elderly immigrants (Dhooper & Tran, 1998; Gerber, Nguyen, & Bounkeua, 1999; Pin-Riebe et al., 1999). In addition to leaving behind property and occupations, elderly immigrants can lose the role of the wise and valued person or other social roles that may have given them a sense of status and identity in their home country. Asking clients about losses in both tangible resources and social status can help them feel understood. Furthermore, this line of questioning greatly increases the likelihood that therapists will zero in on salient issues that likely continue to wear on elderly immigrant clients from certain regions.

Clinicians should also be aware that Latino immigrants are a very heterogeneous group, varying in racial makeup, socioeconomic background, level of education, English language proficiency, and country of origin (Garcia-Preto, 1996). Stressors appear to be particularly severe for Latino immigrants, many of whom come from impoverished, rural backgrounds with little formal schooling (Krause & Goldenhar, 1992). These immigrants often arrive with dreams of establishing themselves in the United States and offering their children better opportunities. Challenges in racial or "color" discrimination, language proficiency, and securing basic needs such as housing, food, transportation, and employment may heighten a sense of uncertainty and foreboding. However, individuals from more affluent or educated backgrounds are not immune to adverse responses to migration to the United States (Garcia-Preto, 1996). Latinos who held prestigious or high-paying jobs in their own countries often face a sense of futility when they are unable to find similar types of employment in the United States.

Exposure-based treatments have been established as a highly efficacious treatment for trauma (Rothbaum, Meadows, Resick, & Foy, 2000). Although there is little research to date testing the efficacy of exposure-based treatments in Latino and Asian elderly immigrant populations, the principles of systematic desensitization, in vivo exposure, and mindfulness meditation (Hayes & Feldman, 2004) appear consistent with a here-and-now focus and a practical orientation to care often sought by Latino and Asian clients. Also encouraging is a

recent pilot study demonstrating the utility of cognitive-behavioral therapy in a sample of pharmacotherapy-refractory Cambodian adult refugees with PTSD (Otto et al., 2003). The authors concluded that the interoceptive-exposure component of the treatment was particularly useful in the reduction of fears of PTSD symptoms, particularly more culturally relevant somatic symptoms.

Not surprisingly, treating traumatized refugee populations who are elderly, although rich and rewarding, can be emotionally taxing. Holmqvist and Andersen (2003) reported that therapists who work with survivors of political torture are at great risk for burnout and exhaustion. As such, utilizing professional support systems and other self-care strategies is particularly vital for clinicians working with elderly refugee immigrants, who may be less resilient and may have had more to lose than their younger counterparts.

Working With Dementia

Dementia is a frequent problem in working with elderly clients across cultural backgrounds. However, recent research indicates that rates of dementia may be higher for elderly Latinos than for other ethnic groups (Ayalon & Huyck, 2002). Furthermore, several investigators have reported higher rates of depression in Latino caregivers as compared with other cultural groups (Gallagher-Thompson, Solano, Coon, & Areán, 2003). In a review article, Gallagher-Thompson et al. also stated that Latino caregivers of dementia patients report more dissatisfaction with family support yet at the same time describe feeling bound by cultural values encouraging them to endure and not complain about the stress associated with the caregiving role. Thus, this combination of factors likely makes seeking caregiving services particularly difficult for elderly Latinos, despite an exceptionally strong need for services.

Some specific suggestions have been put forth in the literature for working with culturally diverse elderly clients with dementia and their families. For example, Gallagher-Thompson et al. (2003) described using bicultural effectiveness training (BET; Szapocznik & Kurtines, 1993). A major aim of this approach is to empower the family by teaching them new ways to communicate with one another about coping with memory impairment and caregiving issues and demands. Szapocznik and Kurtines (1993) do not suggest aiming to change the caregiver so much as attempting to alter patterns of communication within the family. The program design is highly personalized, with goals being chosen by the family rather than being determined in advance by the therapist (Gallagher-Thompson et al., 2003). Although BET has not yet been evaluated in Asian families with dementia, this approach appears consistent with the cultural premium placed on interpersonal relationships and recognition of generational hierarchies. We revisit the BET approach in a later section, as it applies to addressing intergenerational conflicts arising from differing levels of acculturation among elderly immigrants, their children, and their grandchildren.

In treating elderly Asian and Latino immigrant clients with serious cognitive decline, it is also important to be aware that dementia tends to rob more recent memories first, before attacking old and established recollections. Thus, in treating elderly immigrants it may be especially helpful to work in the mother tongue and to emphasize culturally sanctioned practices (e.g., religion) of

patients' early life experiences. This is likely to be less stressful for cognitively impaired immigrant clients and may make communication clearer and more accurate.

General Issues

Assessment

As most professional psychologists are aware, treatment plans are only as good as the assessments on which they are based. This is particularly true when working with older immigrants. In addition to facing strains and stresses commonly associated with age-related physical and mental decline, elderly immigrants are often coping with cultural and language barriers that may further compound their problems. Although there are certainly many important areas to consider, this section focuses on three specific areas that may require special evaluation in order to formulate an effective treatment plan for elderly immigrant clients: (a) English language fluency, (b) financial strain, and (c) dementia.

English language fluency is vital to evaluate when working with elderly immigrants, especially if the therapist does not speak the client's dominant language. Older clients are less likely than their younger counterparts to master the language of their adoptive country. As discussed above, this problem may be further compounded by the fact that languages acquired later in life often become impaired prior to mother tongues in the early stages of dementia and general cognitive decline. Thus, evaluation of language proficiency is critical. In some cases this can be done informally by asking clients directly about their language skills and comfort in speaking English and by making marked observations about language abilities during the first few sessions of treatment. In other instances, however, when language difficulties are subtle (e.g., the client seems to have difficulty expressing him- or herself or frequently misunderstands points made by the therapist), a more formal evaluation may be necessary. A well-validated and reliable measure of the ability to understand, speak, and read English among non-native speakers is the Hazuda Scale (see Royall et al., 2003). Adaptations of the Suinn-Lew Asian Self-Identity Scale (Suinn, Ahuna, & Khoo, 1992) have also been used extensively with both Asians (e.g., Kenney, 2002) and Latinos (e.g., Koneru & Weisman, 2005) to measure clients' own perceptions of their English language familiarity, usage, and preference. If lack of English fluency appears to be a hindrance, incorporating a professional mental health translator into the therapy or transferring clients to a psychologist proficient in their mother tongue may be necessary.

Another sociocultural factor imperative to evaluate when working with elderly immigrants is financial strain (Sue & Sue, 2003). Although the rate of poverty among elderly people has been on the decline in the United States since 1992, it has actually remained stable for elderly people in minority groups (Sue & Sue, 2003). Perceived economic deprivation has been found to be associated with various health factors in elderly immigrants. For example, in a sample of older Mexican-origin individuals, Angel, Frisco, Angel, and Chiriboga (2003) found that financial strain was associated with greater depression, lower self-esteem, and less functional mobility. There is some evidence that Asians and Latinos are more private about discussing financial and other personal matters than are their Caucasian counterparts, because public admission of

problems can bring about intense shame and humiliation (Garcia-Preto, 1996; Lee, 1996). In lieu of asking elderly immigrant clients directly about their finances it may be helpful to obtain this information indirectly, through a self-report paper-and-pencil measure. The Index of Chronic Economic Strain (Pearlin, Mullan, Semple, & Skaff, 1990) is an easy to administer four-item scale that has been found to be a reliable measure of financial strain in Latinos and other minorities (Schneider, 2004). If elderly immigrant clients endorse a high degree of perceived financial strain, dedicating time in therapy to help them find ways to reduce their economic burdens and to educate them about available resources for indigent older people (e.g., food stamps, transportation services) could be time well spent. Collaborating with social workers and case managers who can serve as more direct advocates for elderly immigrants seeking government-sponsored financial assistance may also be useful.

As discussed above, dementia and cognitive decline are also common presenting problems among elderly people and should be evaluated formally when in question. However, this may be difficult with Asian and Latino elders, because traditional cognitive screening instruments are vulnerable to linguistic, cultural, and educational biases (López & Weisman, 2004). The General Ability Measure for Adults (Naglieri & Bardos, 1997) is a standardized test designed to measure cognitive ability using nonverbal stimuli. Thus, this test may be useful in evaluating cognitive capacity of older Asian and Latino clients with limited English fluency. Royall et al. (2003) also provide data with a sample of Latinos age 65 and older indicating that clock drawing tests can be validly administered and provide a convenient way to assess dementia and executive and frontal system impairments that may be less dependent on cultural and linguistic factors. Although not yet evaluated, clock drawing tests may be equally useful for assessing the cognitive functioning of elderly Asians who are less acculturated or not fully proficient in English.

Clients' Conceptualization of Health and Distress

Clinicians should be aware that cultural factors may influence the conceptualizations of health held by elderly immigrants, which may in turn influence their symptom presentation. Elderly Latino immigrants, for example, tend to define well-being in a manner that integrates aspects of physical, mental, and spiritual health (Ailinger & Causey, 1995). Similarly, traditional Southeast Asian notions of health involve integration of mind-body and the balance of systems in the body (Gerber et al., 1999). In cultures without widespread recognition and acceptance of Western notions of mental illness, distress is often manifested more through somatic presentation such as problems with sleeping, eating, feeling tired, irritability, and general aches and pains and less in terms of expressed psychological symptoms such as reported sadness, anxiety, or mood swings (Hsu et al., 2004).

For instance, in one study of older Cambodian refugees (Handelman & Yeo, 1996), headaches were a common physical complaint in both psychiatric patients and nonpatient community samples. Of interest, headaches were a significant predictor of psychiatric patient status, and among patients, report of headache was associated with depression, as diagnosed by a clinician. This study also found that the majority of psychiatric patients in this sample (60%) attributed the cause of their chief somatic symptom

to *pruiy chiiit kiit charen*, translated to mean a "worried, sad, suffering heart," which suggests an integrated notion of emotional and physical health. In addition to attributing mental illness to physical causes, it is not uncommon for symptoms to be attributed to spiritual or supernatural causes, such as demons trying to harass the patient, the restless spirit of a deceased relative, or Karma-related consequences of past actions or deeds (Dhooper & Tran, 1998; Gerber et al., 1999; Hsu et al., 2004).

Similarly, clinical studies of depressed elderly Latino patients interviewed both in the United States and in their countries of origin have found that they also report higher levels of unexplained medical symptoms (Escobar, Gomez, & Tuason, 1983; Mezzich & Raab, 1980). Epidemiological studies in Puerto Rico (Canino et al., 1987) have shown higher levels of somatic complaints regardless of social class. These earlier findings were echoed in a recent large-scale study of primary care patients in 14 countries on four continents, which found higher rates of somatic distress in the Latin American countries surveyed (Gureje, 2004). Similarly, in a study examining the influence of culture in the presentation of psychiatric symptoms, Weisman et al. (2000) found that Mexican American patients with schizophrenia endorsed having significantly more somatic thoughts than did Anglo Americans with the disorder. It is unclear whether this phenomenon is a function of actual higher rates of somatic distress in Mexican American culture or if this simply reflects greater verbal acknowledgment of somatic distress.

Given the typically somatic presentation of symptoms and the role of physical health factors in explanatory models for distress for older Asians and Latinos, it may be valuable for psychologists to first focus interventions on the reduction of physical symptoms through a multidisciplinary approach. One study of elderly Cambodian immigrants living in California found that 83% of the sample used traditional Southeast Asian treatments for physical and emotional problems, often in conjunction with Western medical or counseling professionals (Handelman & Yeo, 1996). In maintaining the working alliance, it is important to allow Southeast Asian clients time to discuss physical symptoms in detail; this will often lead to discussions of the emotional factors associated with the symptoms (Ying, 2001). While also encouraging consultation with medical professionals, community religious leaders, or traditional healers (Gerber et al., 1999; Ying, 2001), therapists should consider that techniques such as progressive muscle relaxation and deep breathing exercises may be particularly beneficial for Asian and Latino immigrant elders. These techniques are likely to be more culturally sanctioned in that they often yield somatically identifiable relief in the form of reduced bodily tension, pressure, and strain.

Conceptualizations of Psychotherapy

For many immigrant elders, the notion of psychotherapy is a foreign or unfamiliar concept that may be incongruent with cultural expectations (Garcia-Preto, 1996; Sue & Sue, 2003). Even for Asian and Latino elderly immigrants who do buy into the notion that their symptoms are emotional in nature, many may experience a disconnect between cultural values, which place a premium on long-term relational aspects of interactions, and the values of many medical centers, which are driven by managed care and a push for highly structured and often time-limited treatments, such as

cognitive-behavioral therapy. For Latino and Asian elderly clients, such an approach may be experienced as brusque, cold, and impersonal, thus dampening future follow-up. At the same time, however, psychodynamic and other long-term therapies may also be poorly understood and devalued by many elderly immigrants. Elderly immigrants often seek and expect tangible treatments for their problems and are often dismayed when told to come for weekly sessions for an indefinite period of time and offered no injections, hypnosis, or other material intervention (Dhooper & Tran, 1998; Gerber et al., 1999). Immigrants frequently stop attending therapy after a few sessions, often believing that just talking about their problems will do them no good. Thus, many forms of psychotherapy as practiced in the United States may be discordant with elderly immigrants' expectations (Sue & Sue, 2003). When working with elderly immigrants, clinicians must clearly explain why they need to see a mental health professional and specifically describe how the treatment can help them. A combination of highlighting the importance of the therapeutic relationship and offering concrete psychoeducational instruction may offer a satisfying balance (Garcia-Preto, 1996).

Elderly immigrants may also be unwilling to seek mental health services because of stigma associated with mental illness. For many Southeast Asian elderly immigrants, fields such as psychiatry are generally viewed as "for the crazy" (Gerber et al., 1999; Pin-Riebe et al., 1999). In a nationally representative sample, both Asians and Latinos were more likely than Whites to view psychiatric patients as "dangerous" (Whaley, 1997). It is important to understand these beliefs within a longstanding cultural context. In recent years psychologists and psychotherapy have become more accepted by all cultural groups for a range of problems. However, this shift is new, and the stigma felt by older generations of Latinos when seeing a mental health worker, for instance, may be related to the longstanding label of being *loco* (crazy) for those who see a psychologist. Because a loco person loses socially valued attributes and behaves in a manner that goes against the value system, mental illness can be viewed in a moral context (Rogler et al., 1983). Thus, culturally defined labels of deviance associated with being loco get generalized to other mental illnesses and increase reluctance to seek help for such things as depression or anxiety.

To offer culturally competent treatment to older Southeast Asians, Pin-Riebe et al. (1999) underscored, it is important for the clinician to remain calm and use a listening approach to establish rapport. Gerber et al. (1999) emphasize a focus on the relationship over particular intervention techniques, establishing credibility, and conveying empathy with nonverbal behavior as well as words. Eliciting frequent feedback from clients and demonstrating respect is also important, particularly if the client is older than the clinician. Because of a cultural tendency toward more indirect and deferential communication patterns (Matusui, 1996), many Asian clients will not mention concerns they have with their treatment so as not to appear challenging or burdensome. Sometimes this practice translates into clients altering medications or other treatments without discussing the issue with their health provider. Indirect and covert communication patterns are also consonant with Mexican and other Latino cultures (Falicov, 1996). Therefore, it is especially important to establish good rapport and to educate Asian and Latino elderly clients about the importance and acceptability of openly communicating with their provider.

An additional approach to validating elder clients' experience and addressing stigma is to provide psychoeducation about the role of stressful life events, such as migration and acculturation, in producing psychological distress. Pin-Reibe et al. (1999) suggest that when working with Southeast Asian elderly clients in the United States, assessing patients' own explanatory model of their symptoms is important as well as educating them about Western notions of the cause, manifestations, and prescribed treatments for their presenting problem. Tapping into a client's own explanatory model is also consistent with the recommendations of Kleinman (1988), who argued that pathology stems from an interaction between a patient's psychobiology, his or her social world, and his or her conceptualization of that world.

Outside of the therapy room, psychologists can also play a valuable role in increasing awareness of mental health issues through outreach to the communities in which elder immigrants reside. For immigrants and refugees already in the United States, public education about mental health issues is of paramount importance to the improved access and utilization of services. For example, Rebeca Chamorro, a professional psychologist and one of the coauthors of this article, encourages reaching the Latino community in more passive ways, such as radio, TV, and the Internet, an approach she believes has a twofold benefit. It provides much needed education, and, given the level of stigma associated with mental health, it allows the public to interact with professionals in a more anonymous way. For instance, potential Latino patients may call in their questions to a Spanish radio talk show featuring mental health issues and need not worry about "saving face." This may be especially appreciated by older patients, who may be less mobile or more prone to feeling stigma by having mental illness symptoms.

Role of Family

For Latino and Asian immigrant elders, receiving care from outside the family network may be inconsistent with cultural expectations (Gerber et al., 1999; Kim, Snyder, & Lai-Bitker, 1996; Sue & Sue, 2003) and can be viewed as embarrassing or even disgraceful. Asians, for example, are generally taught to have a great deal of respect for their elderly parents and consider it an honor and a duty to care for them (Braun & Brown, 1998; Pin-Riebe et al., 1999). Consequently, there is a high social price to pay for neglecting aged parents in Asian countries, as one of the greatest shames a person can endure is to be accused of not properly caring for or neglecting elderly family members. A disturbance frequently reported by Latino and Asian elders upon immigration is that in their home country they were more accustomed to extended family and community support, resources often unavailable to immigrants in the United States. Thus, Garcia-Preto (1996) reported, Latinos often view the American people as cold and the American way of life as hostile to what they describe as their tradition of family, personal warmth, and respect for elders. Given the focus on collectivism in many Latino and Asian cultures (Gerber et al., 1999; Weisman, 2005), some form of family consultation or family therapy, when appropriate, may enhance care. Group therapy may also be successful for Latinos and Asian elders because it is in keeping with the cultural premium on extended networks and helps minimize marginality and isolation so often endured by older people.

Acculturative stress for elderly immigrants can be exacerbated by relationships within a multigenerational family. Conflicts may arise when younger generations within the family embrace more typical American cultural practices whereas elderly family members desire that the family uphold cultural values and practices from the country of origin. To address intergenerational cultural conflict among Cuban Americans, Szapocznik and colleagues (see Szapocznik & Kurtines, 1993, for an overview) developed a 12-session family intervention discussed earlier, BET. The stages of BET treatment involve reframing cultural conflict as the “identified patient” to which the family’s “ailment” can be attributed. The therapist helps the family to identify areas of commonality across the generations and aligns the family against the “common foe” of cultural conflict. Finally, the therapist encourages the family to engage in exercises designed to make all family members more comfortable with both cultures. This type of strategy may be effective for both Latino and Southeast Asian elders who have family members who are interested and involved in their care.

Conclusion

Given the changing demographics of the aging population in the United States, it is important to understand the impact of culture on utilization of mental health services. Although many aspects of care generalize to all people, specific knowledge of the cultural context within which care is provided can help to guide professional psychologists and ultimately to improve quality of life, cost efficiency of services, and outcomes for elderly immigrant clients. In this article we examined the cultural context for Latino and Asian groups and made specific recommendations for assessing needs and adapting mental health services for elderly immigrant clients from Latino and Asian countries. However, many of the stresses of immigration and aging are universal, and most of the recommendations made in this article can easily be tailored to meet the needs of elderly immigrants from other countries as well. For example, for all immigrant clients, it is critical to gain knowledge of the guiding values and norms of their country of origin. It is also important to understand the reasons for and the circumstances around their migration to the United States. Finally, using culturally sensitive information-gathering procedures and treatment approaches (e.g., a calm listening approach; incorporation of family and loved ones into the treatment) is likely to enhance services for elderly immigrant clients from all ethnic backgrounds.

References

- Ailinger, R. (1989). Functional capacity of Latino elderly immigrants. *Journal of Applied Gerontology, 8*, 97–109.
- Ailinger, R. L., & Causey, M. E. (1995). Health concept of older Hispanic immigrants. *Western Journal of Nursing Research, 17*, 605–613.
- Angel, R. J., Frisco, M., Angel, J. L., & Chiriboga, D. A. (2003). Financial strain and health among elderly Mexican-origin individuals. *Journal of Health and Social Behavior, 44*, 536–551.
- Aroian, K. J., Khatutsky, G., Tran, T. V., & Balsam, A. L. (2001). Health and social service utilization among elderly immigrants from the former Soviet Union. *Journal of Nursing Scholarship, 33*, 265–271.
- Ayalon, L., & Huyck, M. H. (2001). Latino caregivers of relatives with Alzheimer’s disease. *Clinical Gerontologist, 24*, 93–106.
- Bemak, F., & Chung, R. C. (2000). Psychological intervention with immigrants and refugees. In J. F. Aponte & J. Wohl (Eds.), *Psychological intervention and cultural diversity* (pp. 200–213). Needham Heights, MA: Allyn & Bacon.
- Braun, K. L., & Brown, C. V. (1998). Perceptions of dementia, caregiving, and help-seeking behavior among Asian and Pacific Islander Americans. *Health and Social Work, 23*, 262–275.
- Canino, G. J., Bird, H. R., Shrout, P. E., Rubio-Stipec, M., Bravo, M., Martinez, R., et al. (1987). The prevalence of specific psychiatric disorders in Puerto Rico. *Archives of General Psychiatry, 44*, 727–735.
- Carlin, J. E. (1990). Refugee and immigrant populations at special risk: Women, children, and the elderly. In W. H. Holtzman & T. H. Bornemann (Eds.), *Mental health of immigrants and refugees* (pp. 224–233). Austin, TX: Hogg Foundation for Mental Health.
- Damron-Rodriguez, J., Wallace, S., & Kington, R. (1994). Service utilization and minority elderly: Appropriateness, accessibility and acceptability. *Gerontology and Geriatrics Education, 15*, 45–63.
- Dhooper, S. S., & Tran, T. V. (1998). Understanding and responding to the health and mental health needs of Asian refugees. *Social Work in Health Care, 27*(4), 65–82.
- Escobar, J. I., Gomez, J., & Tuason, V. B. (1983). Depressive phenomenology in North and South American patients. *American Journal of Psychiatry, 140*, 47–51.
- Falicov, C. J. (1996). Mexican families. In M. McGoldrick, J. Giordano, & J. K. Pearce (Eds.), *Ethnicity and family therapy* (2nd ed., pp. 169–182). New York: Guilford Press.
- Gallagher-Thompson, D., Solano, N., Coon, D., & Areán P. (2003). Recruitment and retention of Latino dementia family caregivers in intervention research: Issues to face, lessons to learn. *The Gerontologist, 43*, 45–51.
- Garcia-Preto, N. (1996). *Latino families: An overview*. In M. McGoldrick, J. Giordano, & J. K. Pearce (Eds.), *Ethnicity and family therapy* (2nd ed., pp. 141–168). New York: Guilford Press.
- Gerber, L., Nguyen, Q., & Bounkeua, P. (1999). Working with Southeast Asian people who have migrated to the United States. In K. Nader, N. Dubrow, & B. H. Stamm (Eds.), *Honoring differences: Cultural issues in the treatment of trauma and loss* (pp. 98–118). Philadelphia: Brunner/Mazel.
- Gurejk, O. (2004). What can we learn from a cross-national study of somatic distress? *Journal of Psychosomatic Research, 56*, 409–412.
- Handelman, L., & Yeo, G. (1996). Using explanatory models to understand chronic symptoms of Cambodian refugees. *Family Medicine, 28*, 271–276.
- Hayes, A. M., & Feldman, G. C. (2004). Clarifying the construct of mindfulness in the context of emotion regulation and the process of change in therapy. *Clinical Psychology: Science and Practice, 11*, 255–262.
- He, W. (2002). *The older foreign-born population in the United States: 2000* (U.S. Census Bureau, Current Population Reports, Series P23–211). Washington, DC: U.S. Government Printing Office.
- Hetzel, L., & Smith, A. (2001). *The 65 years and over population: 2000* (U.S. Census Bureau, Census 2000 Brief, Series C2KBR/01–10). Washington, DC: U.S. Government Printing Office.
- Holmqvist, R., & Andersen, K. (2003). Therapists’ reactions to treatment of survivors of political torture. *Professional Psychology: Research and Practice, 34*, 294–300.
- Hsu, E., Davies, C. A., & Hansen, D. J. (2004). Understanding mental health needs of Southeast Asian refugees: Historical, cultural, and contextual challenges. *Clinical Psychology Review, 24*, 193–213.
- Jones, P. S., Zhang, X., Jaceldo-Siegl, K., & Meleis, A. (2002). Caregiving between two cultures: An integrative experience. *Journal of Transcultural Nursing, 13*, 202–209.
- Kenney, K. M. (2002). Parental acculturation and child language preference as predictors of cognitive ability and academic achievement in Asian-American children. *Dissertation Abstracts International, 62* (08), 3843B.

- Kim, Y. J., Snyder, B. O., & Lai-Bitker, A. (1996). Culturally responsive psychiatric case management with Southeast Asians. In P. Manoleas (Ed.), *The cross-cultural practice of clinical case management in mental health* (pp. 145–168). Binghamton, NY: Haworth Press.
- Kinzie, D. J. (2001). The Southeast-Asian refugee: The legacy of severe trauma. In W. Tseng & J. Streltzer (Eds.), *Culture and psychotherapy: A guide to clinical practice* (pp. 173–208). Washington, DC: American Psychiatric Press.
- Kleinman, A. (1988). *Rethinking psychiatry: From cultural category to personal experience*. New York: Free Press.
- Koneru, V., & Weisman, A. (2005). *Acculturation and ethnic patterns in schizophrenia*. Manuscript in preparation.
- Krause, N., & Goldenhar, L. (1992). Acculturation and psychological distress in three groups of older adults who immigrated from Mexico, Cuba, and Puerto Rico. *Journals of Gerontology, 47*, 278–288.
- Lee, E. (1996). Asian American families: An overview. In M. McGoldrick, J. Giordano, & J. K. Pearce (Eds.), *Ethnicity and family therapy* (2nd ed., pp. 227–248). New York: Guilford Press.
- López, S. R., & Weisman, A. (2004). Integrating a cultural perspective in psychological test development. In R. Velásquez, L. Arellano, & B. McNeill (Eds.), *Handbook of Chicana/o psychology and mental health* (pp. 129–151). Mahwah, NJ: Erlbaum.
- Matusui, W. T. (1996). Japanese families. In M. McGoldrick, J. Giordano, & J. K. Pearce (Eds.), *Ethnicity and family therapy* (2nd ed., pp. 268–280). New York: Guilford Press.
- Mezzich, J. E., & Raab, E. S. (1980). Depressive symptomatology across the Americas. *Archives of General Psychiatry, 37*, 818–823.
- Naglieri, J. A., & Bardos, A. N. (1997). *GAMA: General Ability Measure for Adults*. Minneapolis, MN: National Computer Systems.
- Otto, M. W., Hinton, D., Korbly, N. B., Chea, A., Ba, P., Gershuny, B. S., & Pollack, M. H. (2003). Treatment of pharmacotherapy-refractory posttraumatic stress disorder among Cambodian refugees: A pilot study of combination treatment with cognitive-behavior therapy vs. sertraline alone. *Behaviour Research and Therapy, 41*, 1271–1276.
- Pearlin, L., Mullan, L., Semple, S., & Skaff, M. (1990). Caregiving and the stress process: An overview of concepts and their measures. *The Gerontologist, 30*, 583–594.
- Perez Foster, R. (2001). When immigration is trauma: Guidelines for the individual and family clinician. *American Journal of Orthopsychiatry, 71*, 153–170.
- Pin-Riebe, S., Connell, J., Doung, S., Pham, T., & Tran, H. (1999, November). *Along the journey: Perspectives on working with Southeast Asian elderly*. Paper presented at the University of Massachusetts at Boston's Culture, Mental Health, and Aging conference, Boston, MA.
- Rogler, L. H., Santana-Cooney, R., Constantino, G., Earley, B., Grossman, B., Gurak, D., et al. (1983). Help-seeking behavior. In L. H. Rogler (Ed.), *A conceptual framework for mental health research on Latino populations* (Monograph No. 10, pp. 1–20). New York: Latino Research Center.
- Rothbaum, B. O., Meadows, E. A., Resick, P., & Foy, D. W. (2000). Cognitive-behavioral therapy. In E. B. Foa, T. M. Keane, & M. J. Friedman (Eds.), *Effective treatments for PTSD: Practice guidelines from the International Society for Traumatic Stress Studies* (pp. 320–325). New York: Guilford Press.
- Royall, D. R., Espino, D. V., Polk, M. J., Verdeja, R., Vale, S., Gonzales, H., et al. (2003). Validation of a Spanish translation of the CLOX for use in Hispanic samples: The Hispanic EPESE Study. *International Journal of Geriatric Psychiatry, 18*, 135–141.
- Schneider, M. G. (2004). The intersection of mental and physical health in older Mexican Americans. *Hispanic Journal of Behavioral Sciences, 26*, 333–355.
- Sue, D. W., & Sue, D. (2003). *Counseling the culturally diverse: Theory and practice* (4th ed.). New York: Wiley.
- Suinn, R., Ahuna, C., & Khoo, G. (1992). The Suinn-Lew Asian Self-Identity Acculturation Scale: Concurrent and factorial validation. *Educational and Psychological Measurement, 52*, 1041–1046.
- Szapocznik, J., & Kurtines, W. M. (1993). Family psychology and cultural diversity: Opportunities for theory, research, and application. *American Psychologist, 48*, 400–407.
- Weisman, A. (2005). *Integrating culturally-based approaches with existing interventions for Hispanic/Latino families coping with schizophrenia*. Manuscript submitted for publication.
- Weisman, A. G., López, S. R., Ventura, J., Nuechterlein, K. H., Goldstein, M. J., & Hwang, S. (2000). A comparison of psychiatric symptoms between Anglo-Americans and Mexican-Americans with schizophrenia. *Schizophrenia Bulletin, 26*, 817–824.
- Whaley, A. L. (1997). Ethnicity/race, paranoia, and psychiatric diagnoses: Clinician bias versus sociocultural differences. *Journal of Psychopathology and Behavioral Assessment, 19*, 1–20.
- Ying, Y. (2001). Psychotherapy with traumatized Southeast Asian refugees. *Clinical Social Work Journal, 29*(1), 65–78.
- Yu, M. (1997). Mental health services to immigrants and refugees. In T. R. Watkins & J. W. Callicut (Eds.), *Mental health policy and practice today* (pp. 164–181). Thousand Oaks, CA: Sage.

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