Cultural Sensitivity and Aging

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Webster's Third New International Unabridged Dictionary defines culture as "the total pattern of human behavior and its products embodied in thought, speech, action, and artifacts and dependent upon man's capacity for learning and transmitting knowledge to succeeding generations through the use of tools, language, and systems of abstract thought" (1). Culture is increasingly recognized as a crucial variable in the delivery of health care services. Diagnosis and treatment planning and implementation require special skills and sensitivities when the health care practitioner and the patient are from different cultures. This column discusses how the range of cultural variation in North America can impact on mental health care, particularly for elderly persons, and lists resources that address cross-cultural issues in health and mental health care.

Psychiatrists, other mental health professionals, and especially primary care physicians are often called on to acquire competence in dealing with patients from a wide variety of cultures. Such challenges are especially significant for health care providers in gateway cities or points of debarkation or in urban communities along the U.S. border with Mexico or Canada, as well as for those working in rural areas with migrant workers or Native Americans.

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The broad categories used by the U.S. federal government to define ethnic minorities—African Americans, American Indian and Alaska Natives, Asian Americans, Pacific Islanders, and Hispanic Americans—do not capture the wide array of cultural differences that can have an effect on definition of illness and selection of treatment. Examples of groups in the U.S. with particular health care needs include Holocaust survivors of different national origins, Vietnamese, Laotians, Haitians, Somalis, Hutterites, Ethiopians, Russians, and people from other East European countries.

The Refugee Act of 1980 created the Refugee Resettlement Program, administered by the Office of Refugee Resettlement in the Administration for Children and Families of the Department of Health and Human Services. Refugee population profiles and government appropriations are published regularly by this office (2).

It was not until 1995 that the Accreditation Council for Graduate Medical Education added cross-cultural training as a requirement for psychiatric residency. Clinical and didactic experiences must now address such issues as the epidemiology of mental illness in various cultures, the process of acculturation and the stresses it presents, and the potential for misdiagnosis due to cultural differences (3). Other topics include the effectiveness of traditional psychotherapies and modifications of those therapies in treating patients from various cultures and potential ethnic differences in pharmacokinetics and pharmacodynamics. To be most useful, such training should include information that is gender and age specific.

However, only occasionally has culturally specific mental health research addressed the unique issues of persons who have come to the U.S. in late life, often to join sons and daughters who previously emigrated or to collect Supplemental Security Income, now available to them after five years. Most observations and research pertain to the overall cultural group without focus on late-life issues.

The practice guidelines published by the American Psychiatric Association each have a section on cultural issues, but they generally do not address unique issues of late life (4–10). The APA guidelines reflect important work done in the 1970s and 1980s on cultural sensitivity in general psychiatric practice as it pertains to the various diagnostic categories. The APA guidelines on geriatric psychiatry and delirium are currently in preparation.

The Curriculum Resource Guide for Cultural Competence is a joint project of the committee on minority elderly of the APA council on aging and the American Association for Geriatric Psychiatry (3). The guide addresses general issues of cultural variations in mental health and illness but also deals with the specific concerns of elderly persons and specific clinical manifestations among elderly patients. The guide contains a rich list of resources, including audiovisual materials and names of facilities known for their excellence in providing culturally sensitive mental health care for elderly persons.

Elderly persons with mental health problems are more likely to seek help in primary care facilities than in mental health settings. They are also more likely to have physical comorbidities, compared with younger patients. The primary care physician plays a pivotal role as the first health care contact for an aged population and should work closely with a geriatric psychiatrist to achieve positive health outcomes.

Cultural assessment

To complete a cultural assessment, the practitioner may require the assistance of a competent interpreter. Interpreters need both didactic and on-the-job training. The triangle relationship between the patient, the interpreter, and the clinician, including task definition for each and mutual dependence and appreciation, requires special skills (11). In crisis situations and in situations in which an appropriately trained interpreter is not available, a language service provided by AT & T can be consulted 24 hours a day at 800-528-5888. Fees for the language service include a sign-up fee, a monthly charge, and a fee per minute of each call.

The assessment should address the patient's and family's expectations of the health care system, perceptions of physical and mental health and aging, use of health practices unique to patient's culture, food preferences, and spiritual beliefs or lack thereof. The practitioner should also ask about the structure of the patient's family and family members' expectations of each other, as well as the patient's and family's level of assimilation, acculturation stresses, and resettlement issues, including financial concerns (12).

Barriers to identification of mental illness

The clinician's interest, understanding, and empathy with the cultural identity of the patient will enhance a working alliance. However, many barriers remain to identifying and treating mental illness among patients from cultural minority groups (13).

These barriers may originate with the patient or with the health care provider. They include language differences and symptom presentations that are unique to a particular culture. Lack of insurance may prevent access to care; for example, Russian immigrants may neglect to obtain insurance because they are accustomed to the government's providing health care and other necessities. Patients' poor physical health or health-related disabilities may mask mental health problems. Patients may be preoccupied with resettlement issues such as learning about a new currency, finding housing, and obtaining training and employment. Cultural beliefs—for example, the belief among some Asian cultures that suffering is inevitable—may hinder help seeking.

Some recent immigrants, such as Afghans, Bosnians, and Somalis, may be suffering from overlooked posttraumatic stress disorder resulting from war, torture, or ethnic conflict. Elder abuse in family or institutional settings may also result in posttraumatic stress disorder. Resistance to forming any relationships outside of one's own culture may present obstacles to consulting mental health professionals. Health care providers may be unable to distinguish culturally determined behaviors from psychopathology and may lack appropriate cross-cultural measures or scales for assessing mental health impairments. Both practitioners and patients may be unaware of the culturally sensitive resources that may exist in their community. Cultural differences in help seeking may also create barriers to identification of mental illness.

Because elderly persons' first contact for health care is usually in a primary care setting, the primary care physician should work closely with a geriatric psychiatrist to overcome barriers to identification and treatment of mental illness (14).

Resources for health and mental health care

Griswold and colleagues (15) observed that the needs and demands of recent immigrants and refugees seen at a primary care clinic differ from those of more culturally assimilated immigrants. For example, VIVE La Casa in Buffalo, New York, an 80-bed shelter, harbors refugees en route to Canada. Most are from Asia, Africa (Somalia and Ethiopia), and South America. Their length of stay at the shelter can range from days to weeks and even months. Their health problems include chronic conditions such as diabetes and hypertension and acute conditions such as pneumonia. Depression, anxiety, and psychosis are not unusual. These conditions require immediate and skilled attention to help the recent immigrants function in their rapidly changing environment and to prevent complications and chronicity. Refugees who have experienced torture may be referred from the shelter to the specialized center in Toronto for victims of torture.

The National Health and Education Consortium has published a resource guide *New American: New Needs* (16). The guide is intended to assist health care providers and educators in helping immigrants and refugees better utilize the U.S. health and education systems.

A branch of the Substance Abuse and Mental Health Services Administration (SAMHSA) is dedicated to refugee mental health (17). Resettlement organizations supported by the federal government have a coordinator in each state (2). Such organizations provide refugees with cash, medical assistance, and a broad range of social services, including English language training, employment counseling, vocational training, job placement, transportation, and day care.

Facilities that are known for their excellence in culturally sensitive mental health care for elderly persons currently exist in various parts of the country. An outstanding example is the range of ethnic-minority psychiatric inpatient programs in the department of psychiatry at San Francisco General Hospital (18). The department offers different inpatient programs focused for Hispanic, Asian and Pacific Islander, African-American patients, as well as programs for women, HIV-positive patients, lesbian and gay patients, and forensic patients.

Elder abuse has been studied in Australia, Finland, Greece, Hong Kong, Israel, India, Ireland, Norway, Poland, and South Africa (19). In other countries such as Great Britain, Canada, and the U.S., ongoing studies are examining the epidemiology of elder abuse, neglect, and exploitation and are identifying resources for assessment and intervention (20).

Culture and treatment

The APA practice guideline for treatment of patients with Alzheimer's disease and other dementias of late life highlights ethnic background as affecting symptom presentation, acceptance of the behavioral disorder, and caregiving style (4). The practice guideline for treatment of patients with schizophrenia notes studies demonstrating that African-American

patients with affective disorder or organic brain disorders are more likely to be misdiagnosed with schizophrenia than are Caucasian patients (5). In addition, Asian-American patients generally have higher blood levels of haloperidol compared with Caucasian patients given the same oral dose. Patients of Jewish descent have been found to be at higher risk for clozapine-induced agranulocytosis, compared with those of non-Jewish descent. Native Americans with a diagnosis of schizophrenia are at higher risk for coexisting alcoholism than are non-Native American patients with schizophrenia. Economically deprived African-American and Hispanic patients with schizophrenia have a high incidence of substance dependence.

Attention to cross-cultural issues is especially important in treatment of patients with bipolar disorder because of the association of psychosocial stressors and precipitation of mania. Some ethnic groups, notably Hispanics, have been found to differ from other groups in their response to antidepressant agents (6). These ethnic variations must be attended to in the treatment of patients with major depressive disorder (7).

Hispanic women often use somatization as a help-seeking behavior. Although somatization among Hispanic women early after their arrival in the U.S. tends not to be an equivalent of depression, somatization is more likely to be a manifestation of depression among Hispanic women who have become more assimilated (21). Studies have shown that African Americans are more likely to seek help in medical than mental health facilities. In these primary care settings, they report more severe somatic symptoms and a higher prevalence of panic disorder than Caucasians (10). In general, migrant groups have been found to have higher rates of psychiatric disorders than nonmigrants.

Cross-culturally-validated scales

Developing and using appropriate survey instruments and rating scales for depression, dementia, and caregiver burden among culturally different elderly patients and populations is a challenge for the cross-cultural research methodologist. Use of assessment scales that are validated, reliable, specific, and sensitive and that can be used cross-culturally would allow early detection of mental illness and facilitate early intervention among various cultural groups in the community and institutional settings.

Practitioners' attitudes toward various levels of dementia, ranging from early memory loss to agitated and disinhibited behaviors, as well as informal caregiver attitudes have been studied cross-culturally. Reviews of selected cross-cultural perspectives among Argentinian, Indian, Caribbean, and Native American groups have been published (22). Variations in attitudes toward dementia among African Americans and Caucasians have been studied both in nursing homes and in other institutional settings (22). The Geriatric Depression Scale (GDS) has been studied as a screening instrument for use among elderly Chinese immigrants in the community (23). The translated GDS has been found to be culturally appropriate, reliable, and valid for this population, but so far these findings cannot be generalized to Chinese persons who are being assessed in clinics or living in institutional settings.

Summary

Cultural sensitivity should be taught in residency and continuing medical education programs, and age- and gender-specific aspects of cultural identity should be addressed. Additional attention to cultural sensitivity in research is needed to facilitate positive health outcomes. Collaboration between medical disciplines is vital to prevent misdiagnosis and foster culturally sensitive interventions. ♦

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