

American Psychiatric Association Ethnic Minority Elderly Curriculum

A Product of APA EME Committee, 2004-2006

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Introduction

Training needs for work with culturally diverse individuals

Kenneth M. Sakauye

Background and Initial Focus

This monograph is an update of an earlier (1997) Resource Guide by the APA Committee on Minority Elderly in partnership with the American Association for Geriatric Psychiatry's Committee on Ethnic Minority Elders.

The initial monograph was prompted by two factors. First, there was a longstanding concern by the APA about the availability and adequacy of services for minority populations that led to a Task Force to map problems of minority elderly (APA, 1993). This was followed by the formation of a standing committee on Minority Elderly within the Council on Aging to address these problems. There have been many subsequent efforts within the APA, including a formal position statement on minority populations in 1998, and the appointment of a special steering committee to reduce disparities in access to psychiatric care and implement recommendations of the 2001 Surgeon General's Report on "Mental Health: Culture, Race and Ethnicity." Simultaneously, the Accreditation Council for Graduate Medical Education (ACGME) added the requirement that residency programs address cultural training in 1995, prompting the completion of the first Resource Guide. The Residency Review Committee (RRC) of the ACGME special requirement reads:

"Each resident must have supervised experience in the evaluation and treatment of patients of different ages throughout the life cycle and from a variety of ethnic, racial, sociocultural and economic backgrounds."

"The residency program should provide its residents with instruction about American culture and subcultures, particularly those found in the patient community associated with the training program."

"This instruction should include such issues as gender, race, ethnicity, socioeconomic status, religion / spirituality, and sexual orientation."

(Sections V.A.2, V.8.1, and V.B.2.d)

The initial guide was intended to help training programs develop their curricula to address the special training requirements for all age groups, with extra information about minority populations in general, and an additional focus on minority elderly. The current version is focused on minority aging issues and has been revised to address teaching methods and the new core competencies required by the ACGME. It is designed to be useful for general psychiatrists, students, and other health care professionals.

The initial guide distilled core topics from published curriculum guides and programs known to the committee members. A series of core lectures was recommended with sample readings and learning objectives. Recommendations were made for subsequent clinical seminars on cultural issues throughout later years of residency to reinforce knowledge and look at cultural issues in more depth, commensurate with the increased levels of sophistication as trainees evolved in their

experience. In general, the guide recommended provision of core information through seminars using clinical and research material, with discussion early in training and anchor learning through individual supervision and case experience in subsequent years.

The initial working group was very aware of several barriers to implementing recommendations. Those barriers have not changed since the first report. They include:

Limited time for new coursework

Few minority faculty in most programs

Lack of expertise in multiculturalism in most programs

Lack of interest in teaching this area by faculty in most programs

Some programs may serve few minority patients

Skewed clinical case experience with minority patients may not be generalizable

Only the most severely psychotic or behaviorally disturbed minority patients are seen because others do not seek help or cannot afford care

Training about a single ethnic group, e.g. African Americans, may not be transferable to other groups

General guidelines may be too superficial to be useful

Another concern was that sensitivity training of the type done in industrial workplaces, that utilizes exercises (e.g. role playing, encounter groups, listening to minority speaker's experiences, etc.) to uncover stereotypes and images about other cultures was not felt to be the best model for teaching professionals in the social sciences. This type of information and sensitization exercises should be remedial to a social scientist. However, it might still be necessary in programs where there is strong resistance to cultural education or denial of the importance of the issues. For example, one trainee in an institution with few minority residents or faculty was reported to express his view that racial prejudice is a thing of the past and that cultural education is about political correctness. Programs like this probably benefit from sensitivity training.

In addition, it is clear that faculty also need to develop multicultural competency. In general, there are few minority faculty members at many institutions, and they may be researchers who are not the most competent to teach in this area. There should be CME approved cross-cultural clinical programs that include faculty participation, and evaluations of programs should be analyzed to insure adequate depth of presentations. Faculty development workshops also should be offered.

Curriculum: Integrating Standards

An APA workgroup met on June 11-12, 2001 to address standards for training. Representatives included the APA (American Psychiatric Association), AADPRT (American Association for Directors of Psychiatric Residency Training), ACGME (Accreditation Council for Graduate Medical Education), ABMS (American Board of Medical Specialties), ABPN (American Board of Psychiatry and Neurology), CMHS (Center for Mental Health Services from SAMHSA (Substance Abuse and Mental Health Services Administration)), AAP (Association for Academic Psychiatry), GAP (Group for the Advancement of Psychiatry), SSPC (Society for the

Study of Psychiatry and Culture), and ADMSEP (Directors of Medical Student Education in Psychiatry).

Discussions were held around five key issues:

Conceptual content (what should be taught)

Curricular elements (sequential over PGY 2-4 years)

Environmental issues (resources, policies, values)

Didactics (how this should be taught)

Evaluation (how programs and outcomes should be monitored)

This meeting, as well as new monographs such as National Standards for Culturally and Linguistically Appropriate Services in Health Care (Office of Minority Health, DHHS, 2001), and a new guide on Resources in Cultural Competence Education for Health Care Professionals (MJ Gilbert from the California Endowment, 2003) further catalyzed changes in this revision. The California Endowment guide is formatted similarly to the initial APA Curriculum Guide, but is more detailed.

This revision has been organized around ACGME guidelines about better teaching methods that favor case based learning and evidence based practice, psychiatry journal clubs, and new assessment methods to insure that six core competencies are met, specifically (1). Patient Care, (2). Knowledge, (3). Practice-Based Learning, (4). Interpersonal Communication, (5). Professionalism, and (6). Systems Based Practice. It also focuses exclusively on ethnic minority elderly issues given, the increase in information about ethnic minority elderly since the original monograph. The curriculum employs the following working definitions of key concepts that are taken from the original monograph.

Working Definitions of Key Concepts (from initial monograph)

Terms such as race, culture, and ethnicity have different interpretations depending on the context in which they are used. Definitions of these terms are important to provide clarification that will assist in the discussion of issues about the minority elderly.

Race has been used in the past as a synonym for ethnicity. Race, however, does not imply a cultural or social component. Crews and Bindon (1991) define race as a sociological construct that is poorly correlated with any measurable biological or cultural phenomenon other than the amount of melanin in an individual's skin. Racial groups are comprised of several ethnic groups and cross-mating may alter racial composition while maintaining a fundamentally similar ethnic group.

Culture and ethnicity are more closely related to each other. Culture describes attitudes of a population that are learned or non- biologically determined and which are passed down from generation to generation. Culture may thus be defined as socially transmitted behavior patterns and beliefs. Ethnicity is a socio-cultural construct that is usually associated with discernible features of a group of individuals. Valle defines ethnicity as a group identification based on a common cultural heritage, on customs followed and beliefs held, as well as on the predominant language used (Valle, 1989). Ethnicity, based on identification with one's place of origin (e.g. African-American, Irish, etc.) or religion (e.g. being Jewish), incorporates cultural features such as shared customs, beliefs, and social interaction patterns. It also reflects underlying nonnative

expectations, self-identification or self-concepts, religion, dietary habits, language, style of adornment and dress, and relative skin color (Valle, 1989). Anyone of these items might be an identifying feature in a particular setting. It is important to realize that while ethnicity remains primarily a socio-cultural category, it is different from culture in that it has biological precursors, parameters, and consequences for both individuals and groups (Jackson, 1992).

Ethnic minorities in the United States are generally defined under four broad racial groups: American Indian/Native American; Asian American/Pacific Islander; African-American, and Hispanic American. Different ethnic groups exist within each of these broad categories, and the size and distinctive features of an ethnic group change with time. Perceived differences between ethnic groups often create substantial conflicts and biases. Ethnocentric bias is often predicated on the belief that one's own ethnic group members are superior to those of another ethnic group.

Differences between ethnic groups require that assessment instruments be valid for the specific ethnic group being studied. Culture free assessment refers to a type of assessment that can be done across cultures or ethnic groups with high validity. A culture fair assessment refers to an assessment that varies with the cultural group and improves validity of the assessment with the cultural group. It may be as simple as the use of an analogous assessment instrument used in another culture that taps the same domains as an assessment instrument commonly used in the United States. The concept of culture-bound syndromes refers to a collection of signs and symptoms (excluding notions of cause) that are only seen in a small number of cultures and are due to unique culturally influenced psychosocial features (Jackson, 1992).

What follows in the succeeding chapters is the application of the concepts mentioned here to the major ethnic groups, African Americans, Latinos, Asian Pacific Islanders and Native Americans. In addition, since this is a curriculum an effort has been made to describe teaching methods, and provide an evaluation tool to assess cultural competency in the six broad competency areas for trainees, particularly general and geriatric psychiatry residents. This tool can be further refined and adapted to meet the needs of individual programs. In addition to the references cited in the individual chapters, resources including key articles, books and book chapters, videos, and web sites are provided. The list is not comprehensive, but it should be helpful in starting the process of teaching cultural competency to trainees.

The literature on culture and ethnicity as it relates to the elderly is somewhat limited, so some of the literature for all ages is included in order to provide relevant cultural background information. Where possible age specific information relating to the elderly is provided. Areas covered include cultural-demographic issues, culture bound syndromes, and culture as it relates to specific psychiatric disorders.

Cultural competence in geriatric psychiatry: teaching and evaluative methods

Iqbal “Ike” Ahmed
Mia J. Robinson

Learning Objectives

These objectives are to develop cultural competency in the four of the six general competencies established by the Accreditation Council for Graduate Medical Education (ACGME) in Patient Care, (Medical) Knowledge, Interpersonal Communications, and Systems Based Care. These competency areas appear to be the most relevant for trainees.

Patient Care:

Interviewing: Solicits data for all elements of socio-cultural/ethnic history.

Diagnosis and formulation: Independently identifies major socio-cultural problems. Constructs an accurate multi-axial diagnosis and rudimentary cultural formulation

Patient management: Shows sound judgment about socio-cultural factors. Incorporates awareness in treatment planning with assistance. Understands the effect of his/her own cultural background on their attitudes toward patients.

Knowledge:

Consistently demonstrates an adequate fund of knowledge about culture, ethnicity, and their relevance to psychopathology. Applies this knowledge and clinical principles to patient care.

Interpersonal and Communication Skills:

With Patients: Communicates effectively incorporating awareness of socio-cultural factors; demonstrates caring, respectful behaviors that supercede self-interest.

Works effectively with colleagues of all socio-cultural backgrounds. Invites mutual respect.

Systems Based Practice:

Understands the factors that affect cross-cultural interactions in geriatric mental health care in terms of the cultural backgrounds of the providers and patients and the culture of the setting.

Appreciates organization of mental health systems which serve specific ethnic or socio-cultural groups; plans individual patient care accordingly. Assists patients in dealing with system complexities.

Teaching Methods

Several different teaching methods should be utilized to not only provide knowledge in this area, but to increase cultural sensitivity, and ultimately lead to cultural competency. Some of the teaching methods suggested are didactics, experiential techniques, use of bibliographic and video resources, small group learning, clinical teaching, and research based teaching. Most of these techniques have been well described and used in the comprehensive ethnogeriatric curriculum developed by Stanford (Yeo, G et al, 2000).

Didactics

Didactics on basic cross-cultural psychiatry should include:

Concepts of culture, ethnicity, genetic issues, race, diversity, disadvantaged populations, immigration issues, acculturation, cultural sensitivity, cultural competency, cultural formulation, diagnostic issues, diagnostic bias, use of interpreters, treatment issues including ethnopsychopharmacology, principles of psychotherapy, systems issues such as attitudes toward health, healthcare, and healthcare givers, accessibility to care, healthcare utilization, culturally competent systems etc.

Most of these are described in texts on cross-cultural psychiatry, including a number of them published by the American Psychiatric Press (Tseng WS, 2001 & 2004; Gaw A, 1993 & 2001, Lim R, 2006).

Didactics on cross-cultural geriatric psychiatry should include: general concepts and specifics, especially as they relate to the different ethnic groups on topics such as . . . :

Demographics of ethnic groups, especially the ethnic minority elderly

Concepts of normal & abnormal aging

Healthcare beliefs and behaviors,

Interaction of cultural factors with age factors Acculturation issues

Concerns of ethnic elders and their families

Protective factors against and risk factors for mental illness

Specific disorders-ethnic differences

Ethnopsychopharmacology and other treatment issues

Systems issues such as attitudes toward health, healthcare, and healthcare givers, accessibility to care, and healthcare utilization

Most of these issues are covered in the ethnic specific chapters. General issues related to ethnic elders have also been reviewed in some of the chapters given as resources (Baker 1993, Ahmed 1997, Takeshita 2004, Sakauye 2005)

Experiential Techniques

Techniques encouraging students to examine their own cultural attitudes and values that could affect their interactions with elders from diverse backgrounds. This can be done by assigning:

-a paper asking students to examine the influence of their own cultural background on attitudes towards people of different cultures;

-use of reflection (journaling)and/or

-reflective narratives about their own ethnic background, values and beliefs about health, health care, the interaction between spirituality and health, and death.

Discussion sessions in which learners are asked to:

-share the health beliefs of their own families based on cultural and religious backgrounds;

-explore the similarities and differences; and

-respect the differing values and beliefs.

Inviting elders from diverse ethnic populations to discuss the important historical events in their lives and health beliefs that they and others of their ethnic group hold.

Videos and Biographical Resources

Viewing profiles of elders from films of various ethnic groups, asking learners to place the elder in a specific cohort, and discussing the possible influences on their clinical care.

Encourage reading of biographies of ethnic elders

Comparison of two generations of elders from the same ethnic population in terms of the responses to health care system based on their historical experiences.

Small Group learning techniques

Problem based format to discuss cultural, ethnic, socioeconomic, diversity issues etc.

Ask groups to analyze census data and report the variations in characteristics within ethnic populations.

Have residents/fellows analyze the system level indicators of cultural competence within a health care system in their own community.

Discussion of public policy and public advocacy related to disadvantaged groups as it impacts psychiatric care issues. Focus on ways to reduce disparities in access to psychiatric care

Create and use a cultural competence training manual focusing on use of culturally appropriate assessment tools for older patients from one or more cultural backgrounds

Clinical Teaching

Conduct geriatric assessments with culturally diverse older adults and elicit feedback from the elder and their family members.

Clinical supervision to teach cultural sensitivity and observe resident interactions in dealing with patients, families, and other caregivers with cultural sensitivity.

Assignment to have students conduct an assessment using an interpreter followed up by discussion of the benefits, difficulties, and strategies to promote communication.

Cultural psychiatry case conference with different themes. Demonstration of cultural formulation in case discussions

Role modeling by faculty in their professional interactions with patients, families, colleagues, staff, consultees, students, trainees, employees etc.

Research Based Teaching:

Journal Club focusing on papers with a particular focus on cultural, ethnic issues in geriatric psychiatry.

Development of research projects involving ethnic minorities, health beliefs, customs, and family systems of different ethnicities. Focus on increasing recruitment of ethnic minority elderly.

Development of consent forms which are culturally relevant. Developing culturally relevant instruments.

Modules on specific ethnic groups

Visit a local nursing home or personal care home for the older ethnic groups for a pre-arranged question and answer session talking about the history of their health and health care.

Participation or observation through grand rounds and/or conferences can also be useful ways of developing and reinforcing insights into conceptions of illness and treatment approaches.

Invitations to a traditional medicine practitioner to make a class room presentation and/or visit his/her office to discuss his/her conceptions of illness, treatment and health.

Observe a case conference of an interdisciplinary team meeting with a focus on an older Ethnic minority patient.

Assigned readings, lecture, and discussion can be augmented with the following assignments:

downloading the latest data on life expectancy and mortality rates for elders

from different ethnic populations from web sites (e.g., Trends in Health and Aging at www.nchs.gov) and making comparisons,

interviewing Ethnic elders on the help they give and receive, or other specific topics

presenting the results of the interviews in class to compare and discuss similarities and differences,

group projects that address differences in ethnic groups of diseases such as depression, dementia, suicide and differences in treatment approaches such as use of psychotropic drugs and their risks of complications such as TD, diabetes, hypercholesterolemia, and stroke. This can be followed by conducting interviews with Ethnic Elders who have the different diseases

a field trip to a historical museums dealing with the ethnic group to see film, pictorial displays and other objects pertinent to the health history of the Ethnic Group

film and video depiction of issues relevant to the ethnic group that can be taken from the accompanying list of resources such as Celebrating African-American culture (1994) or the Culture of Emotions (2002).

Evaluation

Evaluation of student performance can be based on: Objective tests to test for retention of information

Assigned papers, especially to reflect increased self-knowledge of residents' own cultural attitudes and values

Reports from individual or group projects. Evaluation of student understanding of culturally appropriate health care is best evaluated via essay questions or written report. This format allows the student to explore differences more fully

Essay questions Essay questions can be used to evaluate their understanding of the sources and limitations of data

Use of the Cultural Competence Evaluation form to document specific areas of competence (see below)

Geriatric Psychiatry Cultural Competency Evaluation Form

Resident Name:

Date of Evaluation:

Attending Evaluator's Name:

Be as specific as possible, including reports of critical incidents and/or outstanding performance. N/A = not applicable, insufficient contact to judge

Unsatisfactory=1

Marginal=2

Satisfactory=3

Excellent=4

Exemplary=5

•Patient Care/Clinical Skills •

Interview skillst

1	2	3	4	5	N/A
Incomplete, disorganized, awkward. Lacks focus. Does not take a social history. Misses important cultural patient cues.	Obtains basic socio-cultural data but often misses significant cultural/ethnic historical findings.	Conducts complete interviews. So data for all elements of socio-cultural history. May lack logical, flowing sequence or transitions. Some backtracking.	Conducts well-paced logically sequenced interviews. Rarely misses important findings. Skillfully solicits sensitive data. Shows flexibility in style...	Artful, efficient, focused interviews. Accurately detects subtle or sensitive findings. Handles difficult issues effectively...	N/

Diagnosis and Formulation

1	2	3	4	5	N/A
Misses major socio-cultural problems. Can't interpret basic data. Unable to correctly identify a working diagnosis without assistance.	Usually identifies the major socio-cultural problems correctly. May not integrate all aspects of data. May report data without analysis. Socio-cultural problem list and is incomplete.	Independently identifies major socio-cultural problems. Constructs an accurate multi-axial diagnosis and rudimentary cultural formulation.	Regularly identifies predisposing, precipitating and maintaining factors, including socio-cultural factors. Cultural formulation shows appreciation of interaction between patients problems & various elements of the formulation. Correctly prioritizes socio-cultural problems	Sophisticated biopsychosocial and cultural assessments. Formulation supported by theoretical framework and/or evidence-based sources of understanding.	

Patient Management

1	2	3	4	5	N/A
Unsafe, erroneous or neglectful practices. May fail to monitor or follow-up patients closely. May cause patient distress by cultural insensitivity. Does not apply principles of cultural psychiatry to psychosocial and psychopharmacologic treatments	May have narrow focus in patient care. Does not seem to appreciate socio-cultural context of patient care	Shows sound judgment about socio-cultural factors. Incorporates awareness in treatment planning with assistance	Provides comprehensive care incorporating ethnic and socio-cultural factors. Able to anticipate problems. Effectively handles patient's bio-psycho-socio-cultural independently.	Reasons well in complex or ambiguous socio-cultural issues. Shows high level of initiative and independence in monitoring and planning care. Applies preventive interventions before problems arise.	

Specific comments recognizing excellent performance or areas for improvement in patient care/clinical skills:

•Knowledge•

1	2	3	4	5	N/A
Major deficiencies in basic concepts and key socio-cultural facts; minimal interest in learning; does not understand complex relationships and mechanisms of disease and treatment, including effect of culture and ethnicity on psychosocial and psychopharmacologic treatment	Weak knowledge base. Many gaps in fundamental facts.	Consistently demonstrates an adequate fund of knowledge. Applies basic science and clinical principles to patient care.	Strong fund of knowledge. Considerable, expanded understanding of psychopathology and socio-cultural factors in normal development, psychopathology and treatment, both psychosocial and psychopharmacologic	Comprehensive and up-to-date knowledge; demonstrates strong analytical thinking; articulates current issues in controversial or unresolved areas of cultural psychiatry, sociology and anthropology; supports statements with literature references.	

Specific comments recognizing excellent performance or areas for improvement in patient care/clinical skills:

•Interpersonal and Communication Skills•

With Patients

1	2	3	4	5	N/A
Shows insensitivity to patient concerns; unable to establish rapport; lacks awareness of cultural in communication; lacks respect for patients cultural beliefs and values; not empathic	Lacks skill in listening and communicating effectively; difficulty managing boundaries; episodes of miscommunication with and families due to cultural insensitivity	Creates and sustains a therapeutic and ethically sound relationship with patients and their families. Communicates effectively incorporating awareness of socio-cultural factors; demonstrates caring, respectful behaviors that supersede self-interest.	Able to establish a relationship with patients with more difficult socio-cultural issues. Demonstrates consistent empathy. Expanded listening and verbal skills. Overcomes cultural barriers and mistrust	Creates and sustains therapeutic relationship with patients with very challenging or difficult socio-cultural issues. Effectively manages a volatile family meeting. Handles complex boundary issues skillfully. Manages own anxiety well. Shows maturity in use of self	

With Colleagues

1	2	3	4	5	N/A
Irrsensitive to cultural differences, and communication styles. He/she may be the source of complaints by personnel.	Shows difficulty working with others. May show inflexibility, minimal consideration or respect to cultural differences.	Works effectively with colleagues of all socio-cultural backgrounds. Invites mutual respect.	Shows ability to be flexible, compromise, admit errors. Recognizes the strengths and limits of others' communication styles, beliefs and values	Shows high level of teamwork, collegiality, leadership; effectively uses skills, cultural beliefs and values of others for consultation/super-vision. Brings out the best in others.	

Specific comments recognizing excellent performance or areas for improvement in interpersonal and communication skills:

•Professionalism•

Learning Behaviors

1	2	3	4	5	N/A
Does not show evidence of reading. Fails to acknowledge errors or limits to knowledge. Poor response to constructive criticism.	Fails to seek supervision. Only partially responsive to feedback. May require reminders to seek information.	Works at expected level of independence. Completes reading assignments reliably; recognizes own limits and errors; seeks help when needed; accepts feedback without defensiveness.	Demonstrates curiosity and eagerness to learn. Seeks additional reading. Seeks out and responds to feedback.	Exemplary drive to learn. Demonstrates regular habits of self-learning. Goes out of his/her way to help others learn.	

Specific comments recognizing excellent performance or areas for improvement in professionalism:

•Practice-Based Learning and Improvement•

1	2	3	4	5	N/A
Fails to perform self-evaluation; poor understanding and application of principles of evidence-based practice (EBP); resists or ignores feedback; passive or negative participant in seminars	Weak evidence of self-directed learning; limited use of EBP skills patient care.	Shows a growing habit of self-assessment and disciplined self-directed learning; shows at least novice-level information searching skills; accepts feedback without defensiveness and uses it for change.	Committed to learning excellence. Seeks out and consistently incorporates feedback into improvement. Demonstrates regular, disciplined self-directed learning. Expanded EBP skills.	Constantly evaluates and improves effectiveness of own performance. Shows high level of initiative, eagerness and success in self-directed, EBP learning; positive participant/leader in seminars and rounds.	

Specific comments recognizing excellent performance or areas for improvement in practice-based learning and improvement:

•Systems-Based Practice•

1	2	3	4	5	N/A
Unable to access/mobilize outside Resources, especially systems which cater to patients socio-cultural background ;actively resists efforts to improve systems of care.	Significant weaknesses in ability to adapt treatment to the available socio-cultural resources for the patient.	Appreciates organization of mental health systems which serve ethnic or socio-cultural groups; plans individual patient care accordingly. Advocates for quality culturally sensitive patient care. Assists patients in dealing with system complexities.	Shows initiative in assisting patients with proper resources and them through the system.	Sophisticated understanding of socio-cultural factors in mental health care systems. Develops elegant and imaginative strategies to maximize care. May be active as advocate in mental health policy or community service.	

Specific comments recognizing excellent performance or areas for improvement in systems-based practice:

Estimation of how many patients this evaluation was based upon: _____

Estimation of direct supervision hours: _____

Methods of evaluation include: Chart Stimulated Recall Case Discussion or Report Patient Care Observation

Other supporting records: _____

•Overall Competence•

Based on the level of skill expected from the satisfactory resident at this stage of training

Unsatisfactory
1

Marginal
2

Satisfactory
3

Excellent
4

Exemplary
5

Overall comments:

The resident met the goals and objectives of the clinical site/rotation. Yes No

If no, please explain in overall comments section.

This evaluation has been discussed and reviewed with the resident. Yes No

Resident Signature

Date

Supervisor Signature

Date

African Americans

Warachal E. Faison

Background

Mental disorders are common in the elderly population—afflicting approximately 20% of the elderly (Faison and Armstrong, 2005). Mental illness among the elderly is a growing public health concern given the growth and diversity of this segment of the population (Harris et al, 2004). The African American elderly population is expected to increase from 8% to 10% by 2050 (Mintzer, Hendrie, Faison, 2005), and there will be a dramatic increase in those 85 years of age and older. It is anticipated that this age group will increase from 223, 000 in 1990 to 1.4 million by 2050. The steady growth in diversity is predominately due to the increasing number of immigrants from Africa and the Caribbean, particularly the Dominican Republic, Haiti, and Jamaica (US DHHS, 2001). Yet, research on the mental health of elderly African Americans is lacking. In order for our field to have a better understanding of psychiatric disorders in the Black elderly community, it will be critical for research studies to include representative samples of African American elders as well as various ethnic groups within the Black community (Faison and Mintzer, 2005; Cohen et al, 2005). It also is critical for our field to have guidance on topics that are important to include in curricula devoted to the mental health of African American elderly.

Previous reports have examined mental health of the elderly, mental health in African Americans, and/or mental health of ethnic minority elderly (Lim R, 2006; Mintzer, Hendrie, Faison, 2005; Sadock, 2005; US DHHS, 2001; APA 1994; Gaw, 1993). In this chapter we will attempt to focus exclusively on mental health issues pertinent to African American elderly. It is recommended that the previous reports referenced above be used as a foundation to develop a greater understanding of mental health issues involving elderly African Americans.

Specific learning objectives for this module include the following:

- Increase awareness of the significance of the diverse elderly African American population
- Understand the impact of misinterpretation of symptoms or misdiagnosis in African American elders
- Increase awareness of culture-bound syndromes of African Americans
- Develop deeper understanding of barriers to mental health access
- Increase awareness of special considerations associated with African American elders and depression, anxiety, substance abuse, and Alzheimer's disease
- Improve understanding of the impact of patient-clinician culture distance in the assessment and treatment of African American elders

Access Issues

Research findings suggest that African Americans are less likely to seek mental health treatment, compared to whites (Cohen C et al, 2005; US DHHS, 2001). Barriers to accessing mental health services include the following: lack of health insurance, stigma, language barriers, geographic

factors, clinician-patient cultural distance, and mistrust (Cohen C et al, 2005; US DHHS, 2001). Often clergy or non-psychiatrists are used preferentially for mental health treatment (Marwaha et al, 2002; Beigel et al 1997; Baker and Lightfoot, 1993). In terms of treatment, data suggest that African Americans may have less emergency room evaluation time, shorter inpatient psychiatric lengths of stay, and higher mental health treatment drop out rates (Kales et al, 2000). Clinicians must also be aware of alternative healers as well as alternative medications that African American patients may use. African Americans' fear of mental illness-associated stigma, distrust of the health care system, or reliance on faith may lead them to seek advice from ministers, relatives, or non-mental health professionals (Primm AB, 2006; US DHHS, 2001). Further, the use of folk medicine and of plants and herbs for medicinal purposes has been passed down from African ancestors and remains quite prominent in African American culture. (Primm AB, 2006).

Diagnostic Issues

Cultural awareness and sensitivity are critical in the evaluation of African American elderly patients. Clinicians must be careful not to interpret cultural expression as psychopathology. African Americans often use sorcery, spiritual possession, and witchcraft to explain psychological symptoms (Mintzer, Hendrie, Faison, 2005). African Americans may exhibit "healthy paranoia" as a result of previous traumatic experiences that should not be interpreted as psychosis (Chen et al, 2000). Somatization may hinder the diagnosis of psychiatric disorders and may mask psychiatric symptoms. Although many racial and ethnic groups may somatize, it appears to be more common in African Americans (US DHHS, 2001).

It is important to be mindful of culture-bound syndromes, particularly those that may be prominent in African Americans. There are numerous sources with detailed descriptions of these syndromes. (Primm AB, 2006; Faison WE and Armstrong D, 2003; US DHHS, 2001; DSM-IV, 1994). Examples of culture-bound syndromes that may affect this population include the following:

Isolated sleep paralysis-This condition is noted to be highly prevalent in African Americans and involves complaints of inability to move the trunk or limbs at sleep onset or upon awakening. Isolated sleep paralysis may be associated with hypnagogic hallucinations.

Falling out-This syndrome involves lapsing into a state of semi-consciousness, perhaps as a means to escape from an intolerable condition.

Brain fag-Africans, particularly Nigerians, may endorse brain fag, which is primarily associated with concentration difficulties. Other complaints may include blurred vision, burning sensation, head and neck pain. Brain fag occurs predominantly in students.

Spell-This syndrome is associated with a trance state and communication with deceased relatives or spirits.

Boufée Delirante-This syndrome is associated with a sudden onset of aggression, disorganized behavior, and psychomotor changes. Paranoid ideation and hallucinations may accompany these symptoms.

Rootwork-This syndrome involves various mental illness symptoms that are thought to be caused by a hex.

Psychosis

Prevalence, Misdiagnosis, Treatment

Research on the prevalence of psychotic disorders among ethnic minority elderly lacks rigorous methodological approaches (Mintzer, Hendrie, Faison, 2005; Faison and Armstrong, 2003; US DHHS, 2001; Baker, 1995a). A significant body of literature, however, documents the misdiagnosis of psychosis in African Americans (Faison and Armstrong, 2003; US DHHS, 2001; US DHHS, 1999). Several studies have reported higher rates of psychotic disorders in African Americans than Caucasians (Leo, Narayan, Sherry et al, 1997; Strakowski, Flaum, Amador, et al, 1996; Strakowski, Shelton, and Kolbrener, 1993; Adebimpe, 1994; Coleman and Baker, 1994; Fabrega, Mulsant, Rifai, et al, 1994; Mulsant, Stergiou, Keshavan et al, 1993; Adebimpe, 1981a; Adebimpe, 1981b; Jones and Gray, 1986; Lawson, 1986). Much of the literature cited above has concentrated on cross-sections of African American and Caucasian adult populations, in which older adults were included. A growing number of studies that focus on adults, however, also document higher rates of psychotic symptoms or disorders in African American elders than Caucasian elders. (Cohen and Magai, 1999; Leo, Narayan, Sherry et al, 1997; Mintzer, 1996; Fabrega, Mulsant, Rifai, et al, 1994; Cohen and Carlin, 1993; Cooper, Mangiest, Wexler, 1991; Deutsch, Bylsma, Rovner, et al, 1991; Fabrega, Mezzich, Ulrich, 1988). However, when patients are diagnosed via structured clinical interviews or research diagnostic criteria, the rates between African Americans and Caucasians are similar (Baker and Bell, 1999).

Pilot studies have shown that African American elderly who were previously diagnosed with schizophrenia were found to have affective disorders or other psychiatric disorders upon reevaluation (Baker, 1995b; Coleman and Baker, 1994). The consequences of misdiagnosing psychosis are deleterious (Faison and Armstrong, 2003; Mintzer, Hendrie, Faison, 2005). The actual clinical picture of elderly who are treated inappropriately with neuroleptics will be blurred with neuroleptic side effects or masking of other symptoms (Strakowski SM, Shelton RC, Kolbrener ML, 1993). Further, these patients will not receive the appropriate treatment for their correct diagnoses. The reasons for misdiagnosis are multifactorial and may include the following: clinician bias; misinterpretation of psychotic symptoms; culturally-biased diagnostic tools; and patient-clinician culture distance (US DHHS, 2001; US DHHS, 1999; Baker FM and Bell CC, 1999; Griffith and Baker, 1993; Adebimpe, 1981). Therefore, it is critical that all elderly patients be reevaluated, as their old diagnoses may not be correct (Baker FM and Bell CC, 1999).

There are important treatment issues to consider in regard to African Americans. In the treatment of psychotic disorders, the effect of ethnicity on psychopharmacology is important to consider. African Americans and other ethnic minorities may metabolize medications more slowly than Caucasians, which may result in the need for lower medication doses (Lin et al, 1997). African American elderly also may exhibit increased risk for developing tardive

dyskinesia as well (Jeste DV et al, 1996). Research findings also suggest that African Americans may be prone to receive higher dosages of neuroleptics and may be less likely to receive atypical antipsychotics (Daumit et al, 2003; Wang et al, 2000; Kuno, Rothbard, 2002; Mark et al, 2002; Diaz and De Leon, 2002; Kales et al, 2000; Lehman and Steinwachs, 1998; Segal Bola, and Watson, 1997; Chung, Mahler, Kakuma, 1995; Strakowski, Shelton, Kolbrener, 1993). Some studies report, however, that rates of neuroleptic use, including atypical antipsychotics, among African Americans are similar to other racial groups (Copeland LA et al, 2003; Jeste DV et al, 1996).

Mood Disorders

Depression/Suicide and Anxiety

Although the overall literature reports higher rates of psychotic disorder, diagnoses in African Americans compared to Caucasians, lower rates of mood diagnoses are reported in African Americans (Kales, 2000). The literature is fraught with contradictory results regarding the prevalence of depression in African American elders (Mintzer, Hendrie, Faison, 2005). Although some studies have shown no racial differences in point prevalence of depressive symptomatology between African American elders and Caucasian elders, others have shown that the point prevalence rate of depressive symptoms in African American elders is lower. (Harralson et al, 2002; Smallega, 1989; Callahan and Wolinsky, 1994; Murrel et al, 1983; Zung et al, 1998). Further, some research has shown that African American older adults also have lower lifetime depression prevalence with less likelihood of endorsement of dysphoria and anhedonia (Gallo et al, 1998; Blazer et al, 1987; Somervell et al, 1989). Yet, as with other psychiatric disorders, research findings suggest that when structured interviews are used, the prevalence rates of depression in African American older adults are similar to those of Caucasians (Harralson, 2002).

Ethnic differences have been noted in suicide rates as well as suicide ideation among elders. African American elders appear to have lower rates of suicide than Caucasians (Cook et al, 2002). Further, African American elders have less suicidal ideation and tend to have passive as opposed to active suicidal ideation (Gallo et al, 1998; Lish et al, 1996).

Ethnic differences also have been reported in regard to psychopharmacology (ie drug metabolism) and prescription patterns of antidepressants. African Americans may develop higher plasma concentrations of antidepressants, which may lead to faster response rates (Lin, Poland, and Nakasaki, 1993; Lefley, 1990). Some studies have shown that antidepressants, particularly selective serotonin reuptake inhibitors, are less likely to be prescribed for African American elders (Blazer et al, 2000).

Anxiety

The Epidemiologic Catchment Area study (ECA) suggests that blacks may have higher rates of anxiety than whites (Blazer D et al, 1991). The 1-year prevalence of generalized anxiety without panic disorder or major depression was 1.02% for older black men, 0.83% for older white men, 0.0% for older Hispanic men, 2.71% for older black women, 2.28% for older white

women, and 0.0% for older Hispanic women. The 1-year prevalence for phobic disorders revealed that blacks were almost twice as likely to be identified as whites. The 1-year prevalence of panic disorder and obsessive compulsive disorder in older adults was surveyed in the ECA study and found to be <0.5% and <2%, respectively, with similar rates among groups. Although no assessment of anxiety symptoms was performed, one study reported that use of sedative, hypnotic, and anti-anxiety medication in an aging cohort was three times higher in whites than blacks (Blazer D et al, 2000).

Substance use

An increasing percentage of older adults misuse alcohol, prescription drugs, or other substances (Bartels SJ et al, 2005; Blow FC, 2000). The number of older adults who will require substance abuse treatment is anticipated to increase from 1.7 million in 2000 to over 4 million in 2020 (Bartels SJ et al, 2005). The 2002/2003 Substance Abuse and Mental Health Services Administration (SAMHSA) National Survey on Drug Use and Health reported that approximately 17.1 percent (13.7 million persons) of older adults (50 years of age and older) had smoked cigarettes in the past month. (NSDUH Report, April 2005). Data suggest that non-Hispanic blacks have significantly more past month cigarette use than non-Hispanic whites and Hispanics (NSDUH Report, April 2005). According to the 2002/2003 NSDUH, approximately 45.1 percent of older adults (36.0 million persons) drank alcohol during the past month, with non-Hispanic whites being the highest (48.3%), followed by Hispanics (33.6%) and non-Hispanic blacks (30.2%) (NSDUH Report, April 2005). There appears to be no significant difference in the past month rates of illicit drug use binge alcohol use, or heavy alcohol use across the groups (NSDUH Report, April 2005).

Dementia

Currently there are 4.5 million individuals afflicted with Alzheimer's disease (AD) in the United States, and this number is expected to reach 16 million in 2030 (Herbert et al, 2003). Prevalence is anticipated to increase in all age groups (65-74; 74-85; 85 +), with the most dramatic increase in those 85 years and older. Numerous studies have shown that African Americans and Hispanics have higher incidence rates of dementia than Caucasians (Tang MX et al, 2001; Demirovic J et al, 2003; Perkins P et al, 1997). It is anticipated that non-Caucasians with AD over 65 years of age will increase from 16% to 34% by the year 2050 (NIA, 2000). In patients 85 years and older, African Americans have increased incidence rates of Alzheimer's dementia compared with Caribbean Hispanics and Whites.

ApoE-e4 allele is a significant risk factor for AD. Its frequency is noted to be higher in African Americans and Caribbean Hispanics, compared to Caucasians (Tang MX et al, 2001). Yet, regardless of the ApoE genotype, African Americans and Hispanics have a higher frequency of AD (Tang MX et al, 1998). This suggests that other genes and risk factors may play a role in the increased risk of AD in these two ethnic groups.

Ethnic and cultural barriers hinder the diagnosis of AD, such as bias in cognitive/screening tests, differences in knowledge and perceptions about AD language and religious barriers (Ayalon L, Arean P, 2004; Roberts JS, 2003; Dilworth-Anderson P and Gibson B, 2002; Hinton L et al,

2000; Levkoff S et al, 1999). These factors not only delay access to care but also may lead to overdiagnosis of AD (Teng EL and Manly J, 2005; Manly J et al, 2004; Stephenson J, 2001; Lampley-Dallas VT, 2001; Borson S et al, 1999; Fillenbuam G, 1990).

With more than 4 million people estimated to have AD, significant numbers are not diagnosed or do not receive the appropriate treatment. There is still much to learn about ethnic minorities and the treatment of Alzheimer's disease. Lack of minority recruitment into research trials is a significant contributing factor to the knowledge gap. Data support that ethnic minorities represent a small percentage of participants in Phase I and Phase II clinical trials of donepezil, galantamine, sabeluzole, and rivastigmine. Of a total of 10,800 subjects: 10,450 (96.8%) were white; 210 (1.9%) were African American; 100 (0.9%) were Asian; and 40 (0.4%) were Hispanic (Faison and Mintzer, 2005; Faison et al, 2002).

American Indian and Alaska Natives

Elizabeth J. Kramer
Iqbal “Ike” Ahmed

There are many terms of reference for the indigenous populations of North America, including American Indians, Alaska Natives, Native Americans, Native Indians, Native American Indians, Indians, Natives and First Nations. It is preferable to use an individual’s specific tribal or village name as a group reference (Fleming, 2006). According to the 2000 US Census, 4.1 million citizens (less than 1.5% of the total US population) identified themselves as American Indians or Alaska Natives (US Census Bureau 2001). Most of these people live in Western states, primarily California, Arizona, New Mexico, South Dakota, Alaska and Montana, and 42% live in rural areas. (Rural Policy Research Institute, 1997). Despite widespread availability of reservations and trust lands for Indians, 62% reside in urban, suburban or rural non-reservation areas (US Census Bureau, 1993). However, most maintain close family and political ties with reservations and trust land communities.

Despite their small numbers, American Indians are a heterogeneous group, whose sub-groups are defined by the different geographic regions in which they live. These regions have defined the following North American Indian cultural areas that are unique and complex: Arctic, Subarctic, Plateau, Northwest Coast, California, Great Basin, Southwest Plains, Northeast and Southeast. Indigenous groups that shared environments tended to develop similar skills, knowledge, beliefs and customs. Indian language families (Algonquian, Athabascan, Siouian, Iroquoian, and Eskimo-Aleut) are an additional hallmark of diversity. Scholars have estimated that at the beginning of European colonization of North America there were between 200 and 300 distinct Native languages. Today, more than half of these are extinct and another large group is nearly extinct. The transmission of the nuances of cultural beliefs and ways is severely compromised when a native language is known by only a few people within an Indian community. As a result, literacy in Native language has become a high priority for contemporary tribal nations.

There are approximately 562 federally recognized tribes in the United States with a total membership of about 1.7 million. At least 550 tribal entities have received sovereign nation status from the Federal government, and hundreds more are recognized by state governments. Sovereignty for each tribal group, and the right of each group to be treated as having unique strengths and challenges, are core issues that pervade every aspect of tribal life, including health and mental health, today.

American Indians/Alaska Natives have seen a dramatic increase in life expectancy, from 51 years of age in 1940 to 70 in 1992 (John, 1996). Although the expansion of the Native elder population is expected to continue (John, 1996), our knowledge about mental illness in this population has failed to keep pace. Most of the information on mental health issues in American Indians and Alaskan Natives is based on what little information is available in the overall group rather than specifically related to the elderly.

Historical Issues That Relate to MH Risk and Protective Factors Affecting Mental Health

Mental and emotional disturbance among American Indian and Alaska Native individuals is best understood in the context of the multigenerational trauma that Native people have experienced (Duran and Duran, 1995.) These psychological patterns of colonization may be transmitted through family dynamics even while rapid social change is occurring (Yellow Horse Brave Heart and DeBruyn, 1998). The trauma dates back to colonial and military subrogation that contributed to the loss of connection to tribal lands, separation of family members, and the disappearance of tribal languages. This trauma is closely associated with high rates of alcohol and drug use, interpersonal violence and suicide among American Indian and Alaska Native people.

Mental Health Needs and Service System Issues

American Indians and Alaska Natives are considerably more likely to be hospitalized for psychiatric illness than Asian Americans/Pacific Islanders and Caucasians. (Snowden and Cheung, 1990). Except for small studies, data on the prevalence of mental illnesses among American Indians and Alaska Natives die not really exist until the National Epidemiologic Survey on Alcohol and Related Conditions (NESARC), a nationally representative face to face survey of 43,093 respondents 18 years or older, which had an 81% overall response rate. In that study, Native Americans had the highest prevalence of alcohol use disorder (12.1%), drug use disorder (4.9%), mood disorders (15.3%), anxiety disorders (15.3%) and personality disorders (12.1%) of all race-ethnic groups (Huang et al, 2006).

American Indians are the most underserved ethnic group in the United States. Congressional appropriations for the Indian Health Service (IHS), the primary provider of care to American Indian and Alaska Native people, grew by 8% from 1994 to 1998, but after adjustments for inflation and population growth, funding actually declined by 18% (Dixon et al. 2001). In 1998, the IHS established the Level of Need Funded (LNF) Workgroup, which compared the IHS's per capita spending level with the Federal Employees Health Benefits Program. The study concluded that the IHS budget for personal health care services falls short of parity with other Americans by an estimated 46% (LNF Workgroup 1999). The IHS is able to address only 43% of the known need for mental health services (Dixon et al. 2001). One in five Indians and Natives report that they have access to health services provided by the IHS to those living on or near reservations and trust lands (Brown et al. 2000). Because of chronic under-funding, mental health services are often extremely limited – if they are available at all. The vast proportion of Indians and Natives are uninsured or underinsured and thus do not have access to mainstream mental health services.

Often there is great mistrust of formal health care systems. It therefore is important to learn the patient's history of mental health problems and where and how he or she has obtained prior help for them. Many contemporary Indian/Native communities have long-standing traditional healing and support for personal and family development. Usually, family leaders arrange access to this healing. American Indians commonly use native healers. The medicinal use of plants and roots is common in some Indian communities. Several targeted studies suggest that American Indians

and Alaska Natives use alternative therapies at rates that are equal to or greater than the rates for the rest of the population.

While American Indian and Alaska Native elders are an important at-risk population in need of mental health services, yet little is known about the factors that influence Indian/Native elders to actually seek mental health services. A study done to identify need as well as enabling and predisposing factors for mental health service use in a national sample of reservation and urban American Indian and Alaska Native elders indicated that self-perceived need is the strongest predictor of mental health service use for elders living on reservations. However, for Indian/Native elders in urban areas, degree of mental impairment is most likely to predict use of mental health services. For both groups of elders, enabling variables, such as total income, level of education and access to medical insurance, were the least important in influencing whether or not an elder elected to use mental health services (Barney, 1994).

The American Indian Service Utilization Psychiatric Epidemiology Risk and Protective Factors Project found that alcohol dependence posttraumatic stress disorder and major depressive disorder were the most common lifetime diagnoses in the American Indian populations (Beals et al., 2005).

The origins and concept of mental illness and stigma among AIA N people remain elusive. Thompson et al. (1993) found that the degree of stigma attached to a mental disorder is correlated with the level of deculturation (the loss of cultural ways) from traditional belief systems that remains with the individual and family members, and to reculturation (incorporating the ways of the majority) that puts AIAN people into the Western health belief system.

Mental illness among various AIAN groups is seen as a form of supernatural possession; an imbalance and disharmony with the inner and outer forces in the world; the expression or a special gift; the terminal phase of an illness (Grandbois, 2005). From a prevention and treatment perspective, the body, mind and spirit are inexorably connected.

Grandbois (2005) suggests that four domains must be addressed if efforts to provide culturally competent and equitable care to AIAN people are to be realized: federal trust responsibility; income, education and poverty; access to care and health disparities. AIAN populations are younger than their Caucasian counterparts because of higher overall mortality, less education and lower incomes. Thirty-eight percent of AIANs are children, and 20% live in families in which no adult graduated from high school, and 55% have incomes below the federal poverty level. Like all other groups, AIANs experience severe barriers to access to mental health services.

With regard to mental health status, suicide rates are among the highest in the US (Gary et al, 2005); rates of depression continue to rise among children, adults and the elderly, and severe mental disorders such as schizophrenia and other forms of psychoses are not addressed from a perspective of cultural competence, in which the patient's story is the focus. There is a dearth of culturally competent mental health professionals.

Culture Bound Syndromes

Ghost sickness is a syndrome that includes bad dreams, weakness, fainting and a sense of suffocation, danger and dread. It is common among the Navajo, who believe that it is caused by witches' supernatural powers (Faison, 2003).

Mood and Anxiety Disorders

Depression

The prevalence of any mood disorder (15.3%), major depressive disorder (12.4%), and dysthymia (3%) were significantly greater in Native Americans than in Blacks. Major depression and dysthymia also were significantly different from whites.

In 2001-2002, 5.3% of the US population had experienced major depressive disorder in the previous year and 13.2% of people had experienced it during their lifetimes. Those at greatest risk were women, Native Americans, people aged 45-64, those who were widowed, separated or divorced, and those with lower incomes (Hasin et al, 2005). Being Asian, Hispanic or Black decreased risk.

One Canadian study noted that First Nation populations lost three times as many potential years of life to suicide as did Canadians overall. Contributing factors included poverty, frequent interpersonal conflict, prolonged or unresolved grief, chronic family instability, depression, alcohol dependence/misuse and a family history of a psychiatric disorder (Cutcliffe, 2005). Studies of Alaska Native elders suggest that cultural factors affect suicide rates. During the Alaska "oil boom," suicide rates more than tripled for the general population but decreased to zero for Alaska Native elders. Cultural teachings from the society's elders were more important during this time of culture upheaval. Subsequently, the cultural changes dissipated, and suicide rates for Alaska Native elders, although lower than those of White Alaskans, increased.

Anxiety Disorders

Native Americans have higher rates of any and all anxiety disorders than whites or any other minority group. Data from the NESARC indicate that 12 month rates for any anxiety disorder, (15.3%) and panic with agoraphobia (1.2%) were significantly higher in Native Americans than in blacks (10.4% and 0.36% respectively) and whites (11.7% and 0.65% respectively). Panic with agoraphobia and social phobia was significantly higher for Native Americans (1.2% and 3.6% respectively) than for blacks (0.4% and 2.0% respectively). These figures are for all study participants, and not merely those aged 65 and over. (Smith et al, 2006).

Alcohol and Substance Use

Alcohol dependence among Native Americans and Alaska Natives is twice that found in the general population, and Alaska Natives are seven times more likely to die of alcohol related problems (Malcolm et al, 2006). Risk factors for alcohol, drug and mental disorders include lack of jobs and educational opportunities, harsh living conditions, racial discrimination, geographic isolation and acculturation stress. (Duran et al, 2005).

Prevalence of alcohol dependence and drug dependence were significantly greater among Native Americans relative to Whites and Blacks, while rates of alcohol abuse and drug abuse among Native Americans exceeded those of Blacks (Smith et al, 2006). Drug dependence was significantly associated with panic disorder without agoraphobia and social phobia.

For the sample as a whole and for males and females separately, the rate of driving while drinking was significantly ($p < 0.0001$) greater than those of Blacks, Asians and Hispanics (Chou et al, 2006).

Dementia

It has been estimated that as many as 25% of all elderly, community residents in the US have some symptoms of dementia. However, very little has been reported on dementia in older minority populations (Espino and Lewis, 1998). The prevalence of dementia in minority populations is not well documented, and there are marked deficiencies in published data on the incidence of cognitive impairment among elderly Native Americans (Espino & Lewis, 1998). Diagnostic difficulties are compounded by limited education. To wit, 46% of Native Americans have 8 years or less of formal education. The scant literature that exists on this topic suggests that dementia, especially AD, may be less common among Natives. For instance, dementia represented only 0.0008% of all discharges nationally from the Indian Health Service (IHS) in 1993, the primary source of health care for most reservation-dwelling Natives (Kramer, 1996). Of the dementias that were identified, almost half were listed as AD and half as vascular dementia. More recent statistics from the IHS, however, suggest that the age-adjusted AD death rate grew from 0.3 per 100,000 people in 1979–1981 to 1.2 per 100,000 in 1994–1996—a 300% increase (Jervis & Manson, 2002)

Anthropologic research in several Native American nations has revealed an attributional system for dementia-derived hallucinations that is non-pathologic, yet not “normal”. The biomedical model defines dementia as the pathologic product of brain dysfunction, and many lay people consider forgetfulness in late life to be a normal part of aging. Similarly, various tribes, it has been suggested, may differ greatly in their attitudes about confusion in older people, some considering it to be a part of normal aging and others seeing it as part of the dying process (Kramer, 1996). In addition, NA people may also consider the hallucinatory symptoms of dementia to be communications with the “other side”, the place where spirits go after death of the body. Specifics of the “other side” are contextually founded in the larger cultural meaning systems and vary from nation to nation. The person communicating with the “other side” now occupies a position of esteem. This aspect of senility is revered, rather than being feared (Henderson & Traphagan, 2005).

Asian American Pacific Islanders (AAPI)

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Introduction

Demographics

Asian American Pacific Islanders (AAPI) are the fastest growing population in the United States, comprising more than one-quarter of the foreign-born population. According to the US Census Bureau, the population had increased to 10.2 million in 2000 from 3.5 million in 1980. The distribution of Asians in the US is as follows: Chinese (25.4%), Filipino (19.3%), Asian Indian (17.6%), Vietnamese (11.7%), Japanese (8.3%), Korean (8.3%), Pacific Islander (4.2%), and other Asian (13.4%). Of the current 10.2 million Asian Americans (3.6% of the total population), more than 800,000 are over the age of 65 years (He, 2005).

The term Asian American Pacific Islanders encompasses a diverse ethnic and cultural realm. There are some 43 different ethnic groups - 28 Asian and 15 Pacific Islander - who speak at least 32 primary languages and a host of dialects, many of which are not spoken outside their own communities. English proficiency varies according to the country of origin, level of education and whether the person was born in America. Some Asians who were born in the US speak fluent English, but have little understanding of their native language (Lee, 1997).

There is some correlation between education and the socioeconomic status (SES) of AAPI groups in the US. Asian Indians, Chinese, and Japanese have higher levels of educational attainment than members of other groups. College and postgraduate training rates are usually higher in these groups compared to some of the others. Laotians and Cambodians have lower graduation rates and also are among those with the lowest incomes. Sixty-six percent of Laotians and 49% of Cambodians live below the poverty level (Lee, 1997). Educational attainment in the country of origin does not always equate to a high SES in the United States. Many professionals and highly skilled workers are forced into lower level jobs, where they may earn minimum wage, or less, after immigrating to the US.

Many Asian Americans are Christians or Muslim, but the predominant religions are Buddhism, Confucianism, Taoism, and Animism. Religious teachings often influence the beliefs of an individual about mental health issues (Kramer et al, 2002). For example, Buddhism, which promotes spiritual understanding of the cause of disease, teaches that current problems are most likely a manifestation of transgressions in a former life. One may feel that he or she must suffer mental illness as retribution for past mistakes.

Confucianism stresses filial piety, justice, benevolence, fidelity, scholarship and self-development. It also discourages open displays of emotion and personal weakness. Asians who practice Confucianism believe that the welfare of the family outweighs that of the individual. It may be more important to conceal the mental illness of a family member than to seek treatment, because seeking help would bring shame to the individual and the family, and reflect negatively

on the family lineage. It could even ruin one's chances for employment or for getting married. Many elders are secretly cared for by their family members, and do not present to a medical professional until the family is overwhelmed and no longer able to conceal the problem.

Taoism stresses the balance within the body of two forces, Yin (the female energy) and Yang (the male energy), or "hot" and "cold". This balance is obtained by movement of vital energy called "chi." (sometimes spelled "qi"). Traditional Chinese medicine practitioners use herbs, foods, acupuncture and massage to preserve, improve, or restore the balance of Yin and Yang in the body (Reid, 1994).

Concerns of the Elderly and the Asian Family

Asian families place a high value on the family and community. In most Asian families, there is a mutual interdependence between generations. The parents care for their children with the expectation that when they become old, their children will take care of them. This is a very different view from most American elders who take pride in their independence and insist on not being a burden to their children. Most Asian families do not consider caring for the elderly a burden. In contrast to frail American parents who usually move in with their children, Asian children often live with their parents. In many traditional Chinese families elders maintain full authority and financial control over the households of all their children, whether the children live with them or not. The eldest male, usually the grandfather, father, uncle, or eldest son is the decision maker, although in some cases, the leader may be an elder female. Therapists need to identify and respect the particular family's hierarchy when treating any of the family members.

Many Asian elderly are forced to deal with the stresses of divergent family and cultural values as well as the trauma of migration to a new country. Many move to the US in their later years to be with their children, causing a harsh disturbance in their normal life cycles. They can sometimes experience an uneasy role reversal, because the children have power, since they speak English, and the elderly are dependent on them. It is far easier to age gracefully in a familiar society that values and highly respects the elderly, as most Asian societies do, than in a Western society that values youth and individualism over aging. This disruption in the life cycle places Asian American elders at higher risk for mental health problems. However, they are more likely to underutilize services because of the stigma attached to mental illness, language barriers, social isolation, and limited access to services. Those who immigrated at younger ages have a better chance of adapting to new roles as their life progresses, putting them at lesser risk for mental health issues surrounding assimilation and acculturation and are more likely to access services (Kao & Lam, 1997).

Impact of Acculturation on Mental Illness

More than seven million Asian Americans were born outside the US. These persons comprise 2.6 % of the current US population. The Chinese were the first group to immigrate to the US in large numbers. The Immigration and Nationalization Act of Amendments of 1965, which repealed portions of the Chinese Exclusion Act of 1888, brought greater numbers of Chinese, Koreans, and Filipinos by repealing the national origin quota system established in

1943 (Chan, 1982). Most Japanese Americans are descended from groups that migrated to Hawaii or the US mainland before 1924, and most Southeast Asians arrived as refugees after the Vietnam War ended in 1975. A second wave of AAPI came to the US after 1978 to escape persecution. These groups included Vietnamese, Chinese-Vietnamese, Cambodians, Lao, Hmong, and Mien (Lee, 1997). Elderly Asians from these later groups would face greater challenges than previous groups, as they are less acculturated.

The length of time that AAPI families have been in the US influences the level of acculturation. Evelyn Lee presents five family types as hypothetical constructs that demonstrate the varying levels of acculturation that can be seen among AAPI families. Type 1 is the “Traditional Family,” which consists of Asian born, unacculturated immigrants, most of who live in ethnic Asian communities and have very little contact with mainstream America. Most members continue to hold on to their traditional values and speak their native languages. The second type is the “Cultural Conflict Family” where there are older members whose values and customs are more traditional, and younger acculturated members with more Western values and beliefs. Conflicts arise over marriage, educational goals, and career choices. Older members may need to use the younger members, who have a better command of English, as “cultural brokers,” and this dependence may cause anger and resentment in both generations because of the role reversal mentioned earlier. The third type, the “Bicultural Family” is comprised of parents who are bilingual, bicultural, and often professionals. This system is less patriarchal and there is more communication between the older and younger members. Type 4 is the “Americanized Family” whose members were born in the US, speak only English, and do not seem to maintain their traditional values. The fifth type (10-15% of Asian marriages) is the “Interracial Family” that consists of members from different ethnic backgrounds. Japanese Americans lead the trend with more than half marrying outside their group. Some of these families are able to integrate both cultures with success, whereas others experience conflicts over values, religion, communication, child-rearing and in-law relations.

Mental Health Service Utilization

In AAPI cultures, any form of mental illness is highly stigmatized. Families try to hide their loved ones suffering from mental illness. Mental health issues are not commonly discussed with family members or friends, and Asian Americans frequently underutilize mental health services. For example, 12 % of Asian Americans would discuss mental health issues with friends or relatives, compared to 25 % of Caucasian Americans, and only 4 % of Asian Americans would consult a mental health provider, compared to 26% of Caucasians (Zhang, Snowden, and Sue, 1998). Stigma can interfere with a patient’s ability to seek or remain in treatment. Asians typically do not seek psychiatric services until their illness is severe and is often at the point of requiring hospitalization. They also tend to terminate treatment prematurely (Sue and Sue, 1987). Often they consult traditional Chinese medicine practitioners prior to seeking allopathic services. Because of their belief in the oneness of mind and body, and a tendency to somatize their problems, when they do consult physicians, they generally see primary care providers. The degree of acculturation, lack of insurance, concerns about their immigration status and a critical shortage of bilingual, bicultural mental health providers also influence utilization of mental health services.

Health Care Beliefs and Behaviors

A study by Aroian et al. (2005) shows that Chinese elders under-utilize services because of problems related to language, transportation, cost, and long waits for appointments. Problems also stemmed from cultural norms and values related to need for care, preference for self care-over professional treatment, fear, and distrust of western biomedicine, and the obligation to refrain from using formal services. A number of Asian Americans will use complimentary or alternative medicine (CAM) or visit a traditional healer before consulting a Western doctor. One community-based study that included Asians, Hispanics, and non-Hispanic whites showed that 47.8% of respondents reported using CAM over the past year. Dietary supplements (47.4%), chiropractic (16.3%), home remedies (15.9%), acupuncture (15.1%), and Oriental medicine (12.8%), were the most frequently cited therapies. The majority of CAM users (62.4%) did not inform their physicians that they were using it, but 58% consulted their physician for the same problem for which they used CAM. Asians were more likely to use CAM when pain was the complaint, which is also important to note because of the high degree of somatization with mental illness in this population (Najm et al, 2003). The therapist should always ask about all past and current use of traditional and alternative healing in an effort to understand and respect the patient's choices.

The influence of Confucianism stresses respect for authority figures, including therapists. Therefore, patients who present for treatment may not voice objections to treatment plans during sessions, but later fail to implement them if they do not agree with the therapist's recommendations. The therapist should not assume that recommendations are being followed and should check in periodically with the patient in a non-confrontational manner to assure that the patient is following the treatment recommendations. For example, the therapist can ask to see pill bottles at each visit.

Kleinman (1978) differentiates between disease, which involves biological deviation from normal, and illness, which refers to the subjective distress that patients feel that frequently leads them to seek health care. The following questions from his health explanatory belief model can be very helpful when eliciting a history and attempting to negotiate a treatment plan:

What do you call your problem?

What causes your problem?

Why do you think it started when it did?

How does it work – what is going on in your body?

What kind of treatment do you think would be best for this problem?

How has this problem affected your life?

What frightens or concerns you most about this problem and treatment?

Unique Protective Factors against Mental Illness

Family and traditional values, especially for elders and new immigrants, are the strongest protective factors against mental illness. Because of the stigmatization of mental illness, families will rally around a psychotic individual to try to manage the problem within the family. This

provides a high degree of psychosocial support and acceptance for the affected person and can be helpful in the course of treatment. It is important that a mentally ill patient's social life be restored so that they can function successfully in the family unit. This is most readily accomplished by involving the family in treatment decisions and therapeutic interventions (Gee and Ishii, 1997). Asian American families have a strong tradition of family care giving and a tradition of respect for elders, which provides social and instrumental support for their elders with dementia. Foreign-born immigrants or refugees may be able to rely on traditional values to cope with the stresses of living in a new country. This can be protective against substance use, especially if the person has an extended family network that can assist with the transition. American-born Asians may not have this unique coping mechanism and may become susceptible to substance use.

Psychopharmacologic Issues

Another major treatment consideration is the metabolism of psychotropic medications in ethnic minority populations. There may be both genetic factors as well as factors related to diet and use of herbals (Lin et al, 2000). In addition, cultural beliefs may affect drug response and medication adherence (Ahmed, 2001). Twenty percent of Asian patients metabolize medications, such as benzodiazepines, metabolized by the enzyme cytochrome P450 2C19 poorly (Schatzberg and Nemeroff, 2004). In addition there may be slower rates of metabolism of antipsychotic medications metabolized by CYP 2D6 and CYP1A2, including haloperidol and Clozapine (Lin et al, 2000 and Pi et al, 2000). Medications may have to be given in smaller doses to avoid adverse effects. There are also different risks for adverse effects in ethnic groups, particularly because of differences in baseline rates of certain risk factors. This is seen particularly with differences in rates of obesity, diabetes, metabolic syndrome, cardiovascular and cerebrovascular risk factors. This would notably impact risk for adverse effects from atypical antipsychotics (Henderson 2005)

Psychotic disorders

Prevalence

APIs have traditionally been underrepresented in large psychiatric epidemiologic studies, especially in the United States. Prevalence data on schizophrenia and other psychotic disorders in elderly Asians are limited. Studies conducted in Asian countries may shed some light on the impact of schizophrenia on Asian families. The Taiwan Psychiatric Epidemiologic Project (Hwu, Yeh, & Chang, 1989) revealed an overall lifetime prevalence of 0.27%, with 0.3% in urban areas and 0.23% in rural areas. A similar study in Seoul, Korea, (Lee et al, 1990) yielded rates of 0.47% overall (0.34% for urban and 0.65% for rural). Additional studies of Chinese and Japanese revealed lifetime prevalence rates of 0.19-0.47% and 0.19-1.79% respectively (Gee and Ishii, 1997). The six-month prevalence rates of schizophrenia for all US residents reported by the National Institute of Mental Health Epidemiologic Catchment Area Program (NIMH-ECA) were 1.1% for urban dwellers and 0.6% for rural residents (Regier et al, 1984; Freedman, 1984).

Disability, Morbidity & Mortality

When approaching Asian patients about mental illness, it is important to first understand that perceptions of mental illness among many ethnic groups may be different from those of Western cultures. Many Pacific Islanders perceive mental illness, especially psychosis, as a supernatural phenomenon (Razali et al, 1996). This is important because those who believe in the supernatural are more likely to seek the services of a traditional healer, and can be less compliant with medications and follow-up care. In 90% of the world's populations, the idea that evil spirits or witchcraft is the cause of mental illness is culturally accepted (Ward, 1989).

Culture bound syndromes and other presentations associated with psychosis

When evaluating a psychotic patient, certain factors pertaining to ethnicity must be explored. Culture bound syndromes are one such factor. Awareness of culture-bound syndromes, which are pathological and deviate from societal norms, but do not have exact correlates to criteria specified in the Diagnostic and Statistical Manual, Fourth Edition, Text Revision (DSM-IV-TR) (APA, 2000), is especially useful in evaluating Asian patients with psychotic symptoms. Culture bound syndromes generally are found in only one geographic area or culture, and they usually present with symptoms that appear strange to Western culture, but are widely accepted in the culture of origin. There is a glossary of culture bound syndromes in appendix I of the the DSM-IV-TR. Examples of these syndromes include:

- Amok: in Southeast Asians, the syndrome occurs mostly among males and causes a sudden rampage that renders the patient suicidal and/or homicidal. It has been described as a “murderous frenzy” and usually ends in amnesia of the event (Kaplan and Sadock, 1998).
- Hsieh-ping: in Taiwan, is characterized by prodromal dysphoria, agitation, possession by spirits, glossolalia, and hallucinations (Gee and Ishii, 1997).
- Pa-leng/Pa-feng: in China, avoidance of and paranoia about cold temperatures or the wind, respectively (Gee and Ishii, 1997).
- Phii pob: in Thailand, a syndrome involving possession of a spirit by this name that usually occurs in females (Gee and Ishii, 1997).
- Qi-gong psychotic reaction: acute and time-limited episode of dissociation, paranoia, and psychosis seen after participation in the Chinese folk health-enhancing practice of qi-gong (APA, 2000).

Although these syndromes rare in this country, awareness of them can significantly enhance the differential diagnosis and occasionally save an individual with a self limiting problem from treatment with psychotropic medication.

Unique risk factors

Mental illness, especially psychosis, is associated with a stigmatization that affects both the patient and the family. It is often thought that this form of mental illness will be passed on to further generations, disrupting the family lineage and making it difficult for others to want to marry into the family. Psychosis is a major embarrassment to the family, which is often concealed by the family. Patients usually present for evaluation much later in the course of their illness and are most often floridly psychotic and require hospitalization.

Because herbal medications are aimed primarily at symptom relief, Asian American patients who are treated with psychotropic medications may use them for only a short time until the acute episode has subsided. Patients may be less willing to comply with medications for fear that they may become addicted or suffer bodily harm. The side effects that are often experienced contribute to the fear of bodily harm and patients may discontinue the medications without notifying the treating physician, placing them at higher risk of relapse.

Treatment modalities/Treatment concerns

Help-seeking behavior in those with mental illness can be seen as a several step process. First there is denial of the problem, which usually is followed by attempts made by the family, extended family, and community to contain or conceal the problem. The first effort to obtain help outside the family usually is consultation with a traditional healer. Traditional healers are widely used in many cultures, both in conjunction with and in place of Western Medicine (Ma, 1999). These efforts are usually followed by a visit to a primary care provider, and, as a last resort, referral to a psychiatrist or psychiatric hospitalization. Once a patient is hospitalized on a psychiatric ward, the family will tend to visit less frequently and decline family meetings, for fear of being recognized by others in the community (Gee and Ishii, 1997).

It is important to understand some of the methods that may be employed by the traditional healer, as they leave physical markings on the body that may be interpreted as signs of abuse. These methods may be used in the treatment of psychosis and other mental disorders. They are coining, pinching, cupping, and moxibustion:

- Coining is the practice of using a coin or similar dull edge object to superficially scratch a certain area on the body until the skin turns deep red to get the “bad wind” out of the body. The deeper the redness on the skin, the more “bad wind” has been released from the body. This method is applied mostly to the back or the back of the neck.
- In pinching the traditional healer uses fingers to pinch the skin in sensitive areas until a contusion occurs, indicating that the “bad wind” has been removed or released.
- Cupping is a method of applying heated cups on the back, forehead, or abdomen to suck out the “bad wind.”
- Moxibustion is a method of treatment that involves burning incense or combustible herbs to cause superficial small burns on the torso, head, and neck to remove the “bad wind” (Wong et al, 1999).

Another major treatment consideration is the impact of cultural and ethnic factors on drug metabolism, treatment adherence and treatment responsiveness as outlined in the section on psychopharmacology. 2000). Finally, when evaluating patients, it is imperative to obtain a complete history of recent use of all medications, including herbal remedies. Certain herbal medications, such as the Japanese *Swertia japonica* and *kamikihi-to*, have been shown to cause psychosis when combined with psychotropic medications (Smith et al, 1993).

Mood disorders

Prevalence

The reported rates for major depression are lower in Asian Americans than in the general population. The 12-month prevalence of major depression is 3.4% in Asians compared to 5.3% in the general US population. The lifetime prevalence is 6.9% in Asians compared to 13.2% in the general US population (Takeuchi et al, 1998; Hasin et al, 2005). Other studies show high rates of depression in elderly immigrants from various AAPI groups. Using the 30-item Geriatric Depression Scale (GDS), about 40% of a representative sample of Asian elderly immigrants was considered to be depressed. Both the 30-item GDS and the 15-item GDS Short Form have been found to be reliable measures to assess depression in community-dwelling Asian immigrant elders (Mui et al., 2003). Another study revealed a depression rate of one in five elderly Chinese using the Chinese GDS (Lai, 2003). The prevalence of depression may be underestimated because of the stigma attached to mental illness. Fewer Asian patients may seek mental health care than their Caucasian counterparts (Sue and Sue, 1987). Rates of depression may also be higher in populations that have a large number of refugees. A study of 476 adult Vietnamese patients 2 months after they arrived in the US found that as many as 20% met criteria for depression (Buchwald et al, 1993).

Disability, Morbidity & Mortality

There is a high incidence of somatic complaints in Asian patients with depression and other mental illness (Chen, Chen and Chung, 2002). The health care provider must ask specifically about physical and psychological symptoms before making the diagnosis. In Chinese Americans, this concept of somatization can be explained by an imbalance of Yin and Yang. These patients may feel that both the mind and body deserve attention and should not be looked upon as distinct entities (Ying, 1997). Patients who have co-morbid depression and post traumatic stress disorder (PTSD) tend to improve less rapidly and experience more frequent recurrence of symptoms than patients with depression alone. It is important to evaluate for trauma and PTSD, especially when immigrant and refugee patients present with depressive symptoms. Also many older patients have medical problems, such as diabetes and hypertension, which can mimic some of the symptoms of depression. Antihypertensive medications can exacerbate depressive symptoms in some patients (Kinzie et al, 1997). The Honolulu-Asia Aging Study examined the link between depression and mortality in elderly Japanese men and found that depressive symptoms are a risk factor for mortality in elderly people, particularly in physically healthy individuals (Takeshita, 2002). In addition, Asian American elderly, especially elderly Asian women, have the highest rates of death ideation, suicidal ideation, and completed suicide of all ethnic minority elderly, (Bartels 2002). Risk factors include acculturation stress with the accompanying change in gender roles in the West (Baker, 1994).

Culture bound syndromes and other presentations associated with depression

Providers need to be aware of culture bound syndromes that have presentations similar to depression and how they may differ from depression in Asian Americans.

□ Hwa-byung: also known as the “illness of fire” or “anger illness,” is seen in Koreans and is thought to be the result of suppressed anger. Patients complain of pressure in the chest or a mass in the epigastrium, accompanied by dysphoria, fear, dyspnea, headaches, fatigue,

anhedonia, and suicidal thoughts. Hwa-byung affects women more than men (Kim, 1993). This syndrome also can be misdiagnosed as psychosis or anxiety.

□ Shenjing shuairuo: also known as neurasthenia. Common among Chinese patients, this syndrome is characterized by weakness of the nervous system and manifests as physical and mental exhaustion, problems with concentration and memory, dizziness, insomnia, loss of appetite, sexual dysfunction, irritability, and headaches (Levine and Gaw, 1995).

Unique risk factors

Asian patients are less likely to seek care from psychiatrists, and when they do, they present with more severe illness. This results in increased use of emergency rooms (Chow et al, 2003) and longer inpatient hospital stays (Snowden and Cheung, 1990). Asian patients who have experienced huge losses and trauma as a result of warfare are at risk for developing mood disorders, particularly major depressive disorder (Kinzie et al, 1997). Acculturation also seems to have some impact on the expression of positive affect. A study of less acculturated older Korean Americans showed less endorsement for positive affects such as feeling happy or feeling hopeful, compared to more acculturated elders with comparable depression rates (Jang et al, 2005). The risk of becoming depressed at or soon after arrival in the US is greater for immigrants who came at older ages (Hwang, 2005).

Treatment modalities/Treatment concerns

In treating mood disorders, as with other psychiatric disorders, it is important to question alternative treatments, including traditional healers and herbal remedies. Noncompliance continues to be of concern in treating Asians, as previously discussed. Most Asians require medications like SSRI's that have fewer side effects, but unfortunately cannot be monitored by blood levels (Kinzie et al, 1997). Patients who are accustomed to using herbal remedies to treat their symptoms will expect rapid relief and may consider the provider incompetent if they do not feel better quickly. Some therapists handle this situation by prescribing short courses of benzodiazepines to tide the patient over until the selective serotonin re-uptake inhibitors (SSRIs) reach therapeutic levels. (Chen et al, 2002). Patients also may stop taking their medications when they begin to feel better. It therefore is important to check in with the patient periodically to make certain he or she is still taking the medication. Explaining depression as a biochemical imbalance in the brain, which requires continuous regulation with the medication can be helpful (ibid). As always it is important to involve family in the treatment decision-making process.

Anxiety Disorders

Prevalence

In a community-based sample of more than 18,000 subjects to determine the prevalence of mental disorders in minority populations, Zang and Snowden (1999) found that Asian Americans had lower rates of obsessive-compulsive disorder and panic than Caucasians. There was no difference, however, in the rates for phobia. Only 1.9% of the participants in this study were Asian, and not all of them were elderly.

Disability, Morbidity & Mortality

The coexistence of anxiety with depression is commonly seen in patients, especially in the Chinese who may have lower awareness of depression and a limited vocabulary for expressing such symptoms. Their common idioms of distress are "worry" for anxiety and "sadness" for depression. Adjustment to a new culture, language, and environment can present as agoraphobia. New immigrants often tend to stay at home and refuse to venture out. As with depressive disorders, some Asians may feel that anxiety disorders are caused by an imbalance or depletion of bodily functions because of character flaws, unhealthy lifestyles or a weak constitution (Lo and Lau, 1997). Asians who were affected by warfare have losses due to migration into another country that is complicated by histories of severe physical and psychological trauma. As these refugees settled in the US, they faced further adversity by experiencing prejudice, poverty, family conflict and increased use of alcohol and drugs (Kinzie et al, 1997).

Culture bound syndromes and other presentations associated with anxiety

A number of culture bound syndromes may be mistaken for anxiety disorders at first presentation. They include:

- Dhat: in South and Southeast Asia, males experience hypochondria and extreme anxiety associated with discharge of semen, discolored urine and feelings of weakness or exhaustion (APA, 2000).
- Koro: reported most frequently in south and East Asia, males have an intense anxiety about their penis retracting into their abdomen and possibly causing death. In females, there is fear of the breasts, labia, or vulva retracting (Kaplan and Sadock, 1998).
- Latah: typically seen in Malaysian females and considered a possession disorder in which an alien spirit is thought to have taken possession over one's body. It is characterized by hypersensitivity to startle with echolalia, echopraxia, command obedience, and dissociative behavior (Simon and Hughes, 1985).
- Shen-k'uei (Taiwan)/Shenkui (China): describes marked anxiety or panic symptoms associated with somatic complaints that seem to have no physical cause. Symptoms include generalized weakness and fatigue, dizziness, backache, insomnia, frequent dreams and sexual dysfunction. Symptoms are attributed to excessive loss of semen which represents loss of vital fluids and is believed to be life threatening (APA, 2000).
- Shin-byung: in Korea, this syndrome consists of initial phases of anxiety and somatization in the form of weakness, dizziness, fear, insomnia, anorexia, and gastrointestinal upset. These symptoms are later followed by dissociation and possession by one's ancestors (APA, 2000).
- Tajin kyofusho: among the Japanese, is characterized by an extreme fear that one's body, body parts or bodily functions will offend others around them. It rarely affects the elderly and symptoms usually occur in the context of interpersonal situations (Levine and Gaw, 1995).

Cultural and language barriers can contribute to the misdiagnosis of anxiety or related symptoms. The frequent somatization of emotional states seen in Asian patients can be misleading and is often extensively worked up as physical ailments, which may increase the patient's anxiety. Depression can easily be misdiagnosed for an anxiety disorder because these disorders often present together (Lo and Lau, 1997). Social phobia can be misdiagnosed as a personality

disorder or paranoid psychosis, especially in Japanese Americans (Tseng, 1992). Symptoms of PTSD can be misdiagnosed as depression, generalized anxiety disorder, dissociative disorder or psychosis (Du and Lu, 1997). These disorders should be considered in the differential diagnosis.

Unique risk factors

Immigration and environmental stressors can increase anxiety. PTSD can be the result of the many traumatic events endured by Asians over the years due to war and political strife. The traumas experienced include torture, imprisonment, forced labor, sexual abuse of women, forced migration, and starvation (Du and Lu, 1997).

Treatment modalities/Treatment concerns

Asians often will seek treatment from traditional healers who will use herbal tonics and formulations in the treatment of anxiety disorders that can cause an increase in sympathetic activation. It is imperative that psychiatrists ask patients if they have been used because the sympathetic activity can be misinterpreted as anxiety. Primary care practitioners are frequently the first to see patients. They might make referrals to psychiatry after the medical workup for the patient's complaints yields negative results. Patients often will manage anxiety themselves with, or consult a practitioner who specializes in alternative medicine and treatment methods. Patients can seek treatment through a combination of these methods at the same time, so it is important to ask about the different methods used to cope with stress and anxiety. Patients often will expect rapid results and may discontinue treatment or seek treatment elsewhere if they feel that the treatment process is progressing too slowly (Lo and Lau, 1997). Individual psychotherapy has been proven effective in the treatment of PTSD, but Asian PTSD sufferers may have a difficult time with the Western psychotherapy concepts that emphasize individualism, mastery of nature and freedom of choice. They may also have a harder time sharing the story of their trauma because of past experiences with betrayal, physical and psychological abuse (Du and Lu, 1997).

Substance use disorders

Prevalence

Asians Americans are typically underrepresented among substance abuse treatment patients. According to the National Drug and Alcoholism Treatment Survey (1989), the percentage of Asians in substance abuse treatment (0.6%) was disproportionate to the total Asian population in the US (2.9% at the time of the study) (Ja and Yuen, 1997). The low number of Asians represented in this and other studies of substance use treatment can be attributed to the low number of Asian participants in such studies. It has been suggested that serious alcohol and drug problems exist in AAPI communities (Ja and Aoki, 1993; Zane and Sasao, 1992). There are no data on the prevalence of substance use specific to AAPI elderly.

Disability, Morbidity & Mortality

One of the few studies that examined substance use patterns in the Asian elderly questioned a random sample of 612 elderly Chinese about their alcohol consumption. The results showed that

36.5% never drank, 50.3% drank less than once a month, 10% drank between one and three times a month, and 3.2% drank four or more times a week. Only two participants had symptoms consistent with mild alcohol dependence and another two had alcohol-related gastritis (Kau, 1990).

Unique risk factors

Substance use can be correlated to the stresses of immigration. Many newly immigrated Asians or those who are political refugees come to other countries to escape poverty or flee political persecution, risking their lives and the lives of their families. Separation from family, financial strain, racism, overcrowding and family conflict can all put immigrants and refugees at risk for increased use of drugs and alcohol. Also, acculturated, American-born Asians are more aware and susceptible to institutional racism and discrimination. The pressures of this environmental stress can lead to increased substance use as well.

Treatment modalities/Treatment concerns

Asian American patients who suffer from substance use need to try to avoid bringing shame to themselves and their families. Families often try to resolve the issue of substance use by criticizing, threatening, or rejecting the member with the problem. In addition, families often confront the individual, first within the immediate family, and if unsuccessful, then bringing in members of the extended family or family friends. If these methods fail to bring about the desired response, the patient may then enter a treatment program. The societal stigma associated with substance use often makes professional help a last resort. Many Asians view substance use as a physical rather than a psychological problem and will often initially seek treatment from a traditional healer or primary care practitioner before seeking help from a substance use center or mental health professional (Ja and Yuen, 1997).

Dementia

Prevalence

There is a paucity of information about dementia in the different Asian minority groups. One longitudinal prospective study of cognitive impairment among elderly adults in Shanghai, found the prevalence rate of dementia in persons aged 65 years and older was 4.6%. This is much lower than what is reported in Western countries (Zhang et al 1990). In another study in Hawaii, the prevalence of dementia in a cohort of Japanese-American men, ranged from 2.1% in those aged 71 through 74 years to 33.4% in men aged 85-93 years. Prevalence estimates for the cohort were 9.3% for dementia overall, 5.4% for Alzheimer's disease, and 4.2% for vascular dementia (White et al 1996).

Disability, Morbidity & Mortality

In a study of Japanese-American men in Honolulu, 21% of family members failed to notice that their elderly relative had memory difficulties, and considered dementia to be a consequence of normal aging (Ross et al 1997). When families did recognize that there were memory

difficulties, they were concerned about the stigma regarding the diagnosis (Mahoney et al, 2005). In a qualitative study of Chinese and Vietnamese family caregivers, stigma was present in 88% of the interviews reflecting chronic mental illness as well as negative stereotypes of aging or the aged (Liu et al, 2006). This kind of stigma allows patients to go without treatment for longer periods, which adds to the potential for increased levels of impairment and disability upon initial presentation.

Unique risk factors

Individual characteristics, including language and communication differences, can create difficulties in diagnosing and treating dementia. This can lead to avoidance of health care services by community members as well as errors in diagnosis by clinicians (Gilman et al, 1992). This is compounded by practical concerns such as difficulties with transportation to clinics and lack of available culturally-competent services (Espino and Lewis 1998).

In addition, in many Asian American communities, there is a limited understanding about the diagnosis of dementia as well as stigma surrounding the diagnosis. In studies of ethnic minority caregivers, Asian American caregivers were most likely to endorse folk explanations such as stress rather than biomedical models, for causes of dementia (Hinton et al 2005). However, despite this view of dementia as a part of normal aging, Asian American elderly with dementia are particularly vulnerable to the stigma of chronic mental illnesses such as schizophrenia, because they share a set of similar behavioral symptoms, such as depression, delusions, hallucinations, and agitation (Braun 1998).

Treatment modalities/Treatment concerns

Because of this strong family tradition of care giving, combined with limited biomedical knowledge and stigma regarding the diagnosis of dementia, Asian Americans tend to rely less on formal support and more on their families for support. In a survey, Japanese American elders were more likely to respond that they would rely on their families in case of illness in comparison to Caucasian American elders (Young et al 2002). Thus as in other illnesses, when treating Asian American elderly with dementia, it is necessary to involve family and caregivers, especially when framing the diagnosis, treatment, and potential additional psychosocial supports that are available in the community.

Latino Elders

Cynthia I. Resendez

Introduction

Definitions and Demographics

Latino elders are a diverse group. In this chapter the term “Latino” will be used to refer to individuals in the United States whose origin is, or who have ancestors from Mexico, Puerto Rico, the Dominican Republic, Cuba, and Central and South American countries. Elders of Mexican origin make up the largest percentage of Latino elders, at 49%. Those of Cuban origin comprise 15%, while Puerto Rican elders comprise 12%, and Central & South American elders make up 25% (Administration on Aging). In 1990, 5.1% of the Latino population were age 65 years or older. It is anticipated that by 2020, this will increase to 14.1% (US Bureau of the Census).

It is important to note that these subgroups of Latinos have differing life experiences, national histories, and risks of psychiatric disorders. Of special significance are the different immigration experiences and traumas, as well as war experiences and traumas. One can imagine that an elder’s migration from Guatemala via Mexico to the US that took one year, and may have involved physical assaults, would be different from that of someone who came from Cuba in the Mariel boatlift of 1980, or someone who came from Puerto Rico and can cross from Puerto Rico to the US mainland freely. In addition, Latinos are racially diverse, with backgrounds that include a mix of indigenous or native people, Blacks, and White Europeans.

Most Latino elders share the Spanish language. However, there are dramatic variations in the Spanish spoken by different subgroups, for example Cubans and Mexicans. Some Latino elders do not speak Spanish at all; for example, some indigenous elders who have emigrated from Mexico speak only Nahuatl or other native languages.

Latino elders have different levels of acculturation. Acculturation is the degree to which immigrants from one culture modify their attitudes and behavior to what they perceive as the norms of the host culture (Rogler et al 1991). Some Latinos in the US retain the traditions and health behaviors of their native countries, while others assimilate to the US culture. Still others develop a bicultural perspective that is thought to be a healthier adaptation. Acculturation has been largely associated with poorer health outcomes for Latinos, as demonstrated by more psychiatric disorders, illicit substance use, and smoking (Wilkinson et al 2005; Vega et al 2004; Vega et al 2003; Vega et al 1998; Welte & Barnes 1995). It is hypothesized that as immigrants become more acculturated to the US culture, they lose protective health behaviors and traditions from their native culture, and acquire less healthy behaviors from the US culture (Rogler et al 1991).

Latino elders may be isolated, live in poverty and lack health insurance. Though it is a popular belief that they live with family members, a significant proportion (27% of elder Latinas and 14% of elder Latinos) live alone. More than 18 % of Latino elders live in poverty. Latino

elders who previously worked often were employed in jobs that paid low wages, and offered no health insurance or pension plans. Latino elders may lack health insurance because previous employers did not provide it or because they are not legal residents of the United States (Applewhite & Torres 2003).

The majority of Latinos in the United States identify themselves as Christian, with as many as 89% declaring themselves Catholic, and 13% Protestant. Latino elders have been shown to become more active in religious activities as they age (Stolley & Koenig 1997). In addition to ascribing to religions such as Catholicism and Protestantism, these same individuals may also include *Santeria*, *Espiritismo* and *Curanderismo* in their belief systems.

Health Service Utilization

Latinos utilize mental health services less frequently compared to other ethnic minorities and White Americans (Wells et al 2001; Hu et al 1991). Mexican American elders are less likely to visit physicians, than Cuban American and Puerto Rican elders (Burnette & Mui 1999). Reasons for this include greater use of informal providers (religious, spiritual, folk healers), lack of insurance, and lack of access to linguistically and culturally competent mental health providers (Mutchler & Brallier 1999; Burnette & Mui 1999; Hu et al 1991).

Although lack of insurance is a barrier to accessing mental health services for some Latinos, insured Latinos are also less likely than Whites to use outpatient mental health services (Padgett et al 1994; Schwartz et al 1998).

Stigma regarding mental illness, and lack of knowledge regarding mental health disorders and treatments, also may play a role in lower utilization of mental health services. . Mexican Americans with less acculturation have lower rates of mental health care use than more acculturated Mexican Americans (Vega et al 1999). It has been postulated that less acculturated Mexican Americans have likely been in the US less time, speak only Spanish, and are not familiar with the US health care system. In addition, some Latino elders have mistrust of the formal service system given past experiences of discrimination (Gelman 2002).

Measuring acculturation

Although various acculturation scales have been developed in the last twenty-five years, they have not been used consistently. The scales are listed in Box 1.

Box 1. Acculturation scales

Acculturation Rating Scale for Mexican Americans (Cuellar et al 1980)

Bicultural Involvement Questionnaire (Szapocznik et al 1980)

Bicultural/Multicultural Experience Inventory (Ramirez 1983)

12-item short acculturation scale (Marin et al 1987)

Cultural Life Style Inventory (Mendoza 1989)

Multigroup Ethnic Identity Measure (Phinney 1992)

Short Acculturation Scale for Mexican-American populations (Coronado et al 2005)

Epidemiologic studies have used historical indicators as proxies for acculturation. For example, preferred language, place of birth, and years in the US. Escobar and Vega (2000) have suggested that for the time being, objective variables, such as place of birth, age at arrival in the US, years residing in the US, primary language use including a measure of proficiency of the second language, be used in research studies.

Cultural Issues & Values

Añez and colleagues (2005) and Gloria & Peregoy (1996) have described useful constructs to be aware of in working with Latinos. These constructs are not unique to Latinos; however, they do play a significant role in social interactions, especially among Latino elders, recent immigrants, and first generation Latinos in the US.

Familismo is exemplified by the emphasis on close relationships with extended family and friends. The family is viewed as the center of one's experience, and the family's needs are more important than those of the individual. Family loyalty, reciprocity and solidarity are highly valued (Añez et al 2005; Gloria & Peregoy 1996; Marin & Marin 1991; Hoppe & Martin 1986). *Familismo's* extended family structure can serve to minimize the emotional and economic strain of a family member's mental illness (Lefley 1990). *Familismo* may exert a strong influence, both positive and negative, on how individuals of Latino origin seek and utilize mental health and addiction services and may significantly influence the course of treatment.

Personalismo is exemplified by the valuing of interpersonal harmony and relating to others on a personal level. Latinos may prefer interpersonal contact that promotes getting to know the mental health clinician as a person. An example of *personalismo* is Latinos initiating "small talk" with the clinician in the lobby of the mental health clinic. In working with Latinos, demonstrating some *personalismo* is going to be much more conducive to a good therapeutic alliance. In fact, not practicing *personalismo* may result in inability to form a working relationship. (Añez et al 2005; Gloria & Peregoy 1996; Comas-Diaz 1996).

Simpatía is the general tendency toward avoiding interpersonal conflict, emphasizing positive behaviors in agreeable situations, and de-emphasizing negative behaviors in conflictive circumstances. It emphasizes the need for behaviors that promote smooth and pleasant social relationships. An example of *simpatía* is when a Latino patient may appear to agree with the clinician during the office session, but after the session does not follow the recommendation or plan (Gloria & Peregoy 1996; Marin & Marin 1991).

Respeto is exemplified by the adherence to a hierarchical structure, in which individuals defer to authority and to elders (Añez et al 2005; Santiago et al 2002). Latino elders are valued for their knowledge and experience, and sought out for advice. Included in *respeto* is children's obligation to take care of and support their elder parents (Beyene et al 2002).

Presentismo is a tendency to be focused on the present time and present problems. This focus on the "here and now" may interfere with Latino elders seeking preventative care, and may delay treatment of illnesses.

Traditional gender roles suggest that in *Machismo* men are expected to be strong and provide for the family while in *Marianismo* women are expected to be nurturing, take care of children at home, devote themselves to caring for their children and husband, be self sacrificing, and submissive to men. In *Marianismo* women are seen as spiritually and morally superior to men, and serve as the “emotional heart of the family” (Dreby 2006).

Fatalismo is the expectation of adversity, the notion that life’s outcomes may not be fully under one’s control, suggesting a belief that outcomes may be decided by fate, luck, or a higher power such as God. It may be manifested in a belief of an external locus of control (Añez et al 2005). *Fatalismo* may also be viewed as a realistic and adaptive response to stress. (Hoppe & Martin 1986)

Vergüenza (Shame) may limit Latinos’ willingness to seek outside help for problems within the family. It is vital to be aware of this, as Latinos will attempt to avoid bringing shame upon their families (Gloria & Peregoy 1996).

Curanderismo is a diverse folk healing system practiced by many Mexican Americans, which includes beliefs originating from Greek humoral medicine, early Judeo-Christian healing traditions, the Moors, and Native American traditions. A main tenet of this belief system is those natural forces, supernatural forces, or a combination of these cause illness. Examples of beliefs include *suerte* (luck), *Susto* (soul or spirit loss resulting from a traumatic event), *mal de ojo* (the evil eye), *caida de la mollera* (fallen fontanel). Healing practices may include physical and supernatural healings via *limpias* (spiritual cleansings), prayer, massage, and herbal preparations (Luna 2003; Padilla et al 2001; Keegan 2000; Gafner & Duckett 1992). Healing is administered by *Curanderos*, who have a divine gift (*don*) for healing (Applewhite 1995).

Santería is a religious system that blends African (Yoruba tribe) and Catholic beliefs, and is practiced by many Cuban Americans. It may also include elements of spiritualism and magic. Beliefs include that *oricha* saints (identities based on a combination of African deities and Catholic saints) may influence people on earth, *embruajamiento* (casting spells), and *mal ojo* (evil eye). Healing practices include *despojamientos* (expelling bad spirits), amulets, magic medicines, animal sacrifice, and care of blessed animals. *Santero* group beliefs and practices may vary, based on the needs of the group or the *Santero* priest (Baez & Hernandez 2001; Alonso & Jeffrey 1988; Suarez et al 1996).

Espiritismo is a spiritual belief system practiced by many Puerto Ricans in Puerto Rico and in the US. It includes beliefs in reincarnation and the power of mediums. Individuals are affected by fluids, which are spiritual emanations that surround the body. These fluids are derived from a combination of the individual’s spirit, spirits of the deceased, and the spirits of others close to the individual. Mental and physical illnesses are the result of fluids being either sick or disturbed. Fluids may be negatively affected by karma (past actions influencing the present), religious negligence, *brujeria* (witchcraft), spirits, *mal ojo* (evil eye), and inexperienced mediums. Healing practices include prayer, group healings, house cleansings, personal cleansings with herbal baths, and possession trance (Harwood 1977 & Richeport 1975, 1982, 1985 as cited by Hohmann et al 1990; Baez & Hernandez 2001)

Religiosity serves as a resource for support and coping among Latino elders (Beyene et al 2002; Weisman et al 2005). Latino elders who participate in church activities have been shown to

manage better than those who are socially isolated (Angel & Angel 1992). God may be seen as the source of stressful events, including mental illness for Latinos, (Lefley 1990), thus, Latinos may feel obligated to be compassionate and tolerant among those with mental illnesses (Guarnaccia et al 1992). It is also hypothesized that if there is belief in an afterlife, that suffering during the present life may be more endurable (Hovey 1999).

Latino elderly commonly use herbal medicines. These include spearmint, chamomile, aloe vera, garlic, brook-mint, osha, lavender, ginger, ginseng, camphor, rue, anise, wormwood, orange leaves, sweet basil, oregano, peppermint and lime (Zeilmann et al 2003; Rivera et al 2002; Trotter 1981), as well as marijuana tea (Pachter 1994). *Tilo* (Linden flower) tea and Sarsaparilla may be used for nervous disorders (Pasquali 1994). Mercury (*Azogue*) may also be used (Pachter 1994) by elders practicing *Espiritismo* or *Santeria*, as it is believed to provide good luck and protection from evil and the envy of others (Zayas & Ozuah 1996).

Somatization and pre-occupation with somatic concerns among Latinos have been widely described in the literature (Escobar 1995; Canino et al 1992; Escobar 1987; Escobar et al 1986;). Somatic symptoms are culturally sanctioned expressions for seeking and receiving care and treatment, and are reported by patients with and without Axis I diagnoses (Barrio et al 2003; Weisman et al 2000; Escobar et al 1986). It would be stigmatizing to express psychological distress explicitly, as this would indicate mental illness. Thus for Latinos, especially elderly Latino women, somatic symptoms may be manifestations of psychological distress (Angel and Guarnaccia 1989). In fact, Latinos have tended to present to primary care providers for assistance with mental health issues such as depression, rather than seek out mental health specialty care (Vega et al 1999).

The assessment and diagnosis of Latino elders may be affected if the interviewer and the Latino patient do not speak the same language or dialect, or if there is not a well-trained interpreter available.

It is imperative that we understand the unique issues in working with Latino elders. Reasons for this include (1) reducing distress of Latino elder patients, especially immigrants who are not knowledgeable about mental health care and are now seeking assistance, (2) to reduce our own possible uncertainty about working with this population, (3) To reduce our own possible bias in assessment and treatment, and to establish a therapeutic alliance, increase treatment efficacy and reduce health disparities.

Risk and Protective Factors

Depression

Risk Factors: Medical risk factors include chronic medical conditions such as diabetes and heart disease, as well as cognitive impairments. These can then lead to impaired function, which, in turn, puts the elder at a higher risk of depression. Psychosocial risk factors for depression include low socioeconomic status, financial strain, isolation, immigration issues, legal problems, providing care for a relative's child, substance use and lack of insurance. (Robison et al 2003; Range et al; Chiriboga, et al 2002; Black, et al 1998; Swenson et al).

Immigration hardships vary according to the cohort, and can lead to significant strain and depression. For example, Puerto Rican elders in the US do not worry about deportation in the manner that undocumented elders from Mexico may. Lack of documentation makes Latino elders more vulnerable to discrimination, poor housing and poor working conditions, as they may fear being reported to law enforcement or immigration if they make a complaint. It is important to assess and take note of the immigration experience of Latino elderly as this may contribute to depression. Assessment should include asking about social and personal variables in the society of origin, society of settlement, and what their immigration experience was like. (Berry 1997 as cited in Cuellar et al 2004)

Whether level of acculturation correlates with depression among Latino immigrants continues to be debated. A study comparing US-born Mexican Americans to foreign-born Mexican Americans found that those who were born in the United States were at higher risk of major depression and dysthymia (Grant et al 2004). Studies that demonstrate higher prevalence of depression in less acculturated older Mexican Americans and immigrants compared to those who are more acculturated may be related to the cultural barriers encountered by those who are less acculturated (Gonzalez et al 2001).

Duration of time in the United States may be a risk factor for depression among Latino elders. A study of Latino immigrants in the US found that longer residence was associated with increased depression, anxiety, substance use and worse health (Vega, et al 1998). However, like acculturation, this issue is more complex than just how long Latinos have been in the US. For example, in a study of Mexican immigrants, those who resided in the US for long periods of time (average 32 yrs) were found to have better wellbeing than those who were in the US less time. The authors hypothesized that these Latinos were at less risk of depression because they resided in culturally receptive and compatible environments, and remained closely tied to their culture of origin (Cuellar et al 2004).

At least some English language knowledge is associated with improved well-being among Latino elders. In a study of subgroup differences among Mexican American, Cuban, and Puerto Rican elders, those with English language knowledge were less socially isolated and had fewer financial problems (Krause & Goldenhar, 1991).

Protective Factors: *Familismo* may be protective in that family members may give emotional support and advice to a relative with depression. They also may encourage the affected relative to seek assistance from either formal (primary care or mental health care) or informal (curanderismo) sources. Residing in a culturally receptive and compatible environment is protective. In a study of elder Mexican Americans, those who lived in neighborhoods that had more Mexican Americans had fewer symptoms of depression (Ostir et al 2005).

Fatalismo may be protective in that the individual may use the expectation of adversity as a coping mechanism to deal with life circumstances that are out of his or her control (Hoppe & Martin 1986).

Religiosity has been demonstrated to be helpful. Self perception of religiosity, influence of religion and church attendance were significantly negatively associated with suicidal ideation among Latino immigrants (Hovey 1999; Stolley & Koenig as cited in Robison et al 2003).

Anxiety Disorders

Risk factors: Exposure to political violence is one of the experiences leading to post traumatic stress disorders in Latinos from Mexico, and Central and South America. In a study of exposure rates to political violence among Latino adult primary care patients who immigrated to the US from Mexico, and Central and South America, 54% reported political violence experiences in their countries of origin, and 8% reported torture. Exposure to political violence led to higher rates of PTSD and depression symptoms. Of those who reported political violence exposure, 36% had symptoms of depression and 18% had symptoms of PTSD, compared to the group that denied exposure to political violence in which 20% had symptoms of depression and 8% had symptoms of PTSD (Eisenman et al, 2003).

Acculturation affects the risk of anxiety disorders in Latinos. Studies have demonstrated that Latinos with low acculturation have lower rates of anxiety disorders, compared to those who are more acculturated (Grant et al 2004; Ortega et al 2000; Vega et al 1998; Karno et al 1989). Foreign-born Mexican Americans were at significantly lower risk of panic disorder and generalized anxiety disorder compared to US-born Mexican Americans, and at significantly lower risk of panic disorder, social phobia, specific phobia and general anxiety disorder compared to US-born Whites in the 2001-2002 National Epidemiologic Survey on Alcohol and Related Conditions (Grant et al 2004).

Protective factors: *Familismo* may be protective in regard to anxiety disorders as family members may give emotional support and validation to the patient. They also may encourage the affected relative to seek assistance from either formal (primary care or mental health care) or informal (*curanderismo*) sources.

Fatalismo also may be protective in that the individual may use the expectation of adversity as a coping mechanism to deal with life circumstances that are out of his or her control and would otherwise lead to anxiety (Hoppe & Martin 1986).

Presentismo may be protective, as being focused on the present would discourage one from looking too far ahead into the future. Anxiety disorders usually have to do with being worried or fearful of some event in the future, thus *presentismo* would be in opposition to this.

Psychotic Disorders

Protective factors: *Familismo* may be protective for patients with psychotic symptoms, as family members' sense of loyalty and solidarity may lead to their being more supportive and tolerant of a family member with psychosis. In fact, family cohesion is associated with less general emotional distress and fewer psychiatric symptoms among Latinos with schizophrenia (Weisman et al 2005). Family members may be viewed as allies in the treatment process.

Religiosity also may be protective of Latinos with psychotic symptoms. If Latinos see God as the source of a psychotic mental illness, their family members may feel obligated to be compassionate and tolerant to family members with psychotic illnesses. (Guarnaccia et al 1992). In fact, studies of relatives of Latinos with schizophrenia have demonstrated that they use spirituality and religion to cope with the stress involved with caring for their afflicted family member. (Weisman et al 2003; Weisman et al 2005).

Espiritismo and other supernatural belief systems such as *Curanderismo* and *Santeria* may provide a support system for psychotic patients, as well as their families. In addition, it may serve as a cultural explanatory model for the psychotic illness (Lefley 1990).

Fatalismo also may be protective for a Latino with a psychotic illness, as psychotic and problematic symptoms may be viewed as being out of the patient's control. This may result in family members being more supportive and tolerant. In addition, belief may help the family cope with the stress of having a psychotic family member.

Simpatia may be helpful to Latinos with schizophrenia and their family members, as maintaining harmony among family and friends is highly valued. In the previously described study of Latinos' attitudes toward a family member with schizophrenia, relatives denied anger and negative emotions toward their family member with schizophrenia (Weisman et al 2003).

Risk factors: *Vergüenza* (Shame) may interfere with family members seeking medical and psychosocial services for a family member with psychotic illness. It may be believed that revealing this private family issue to outsiders will bring shame to the family, and should be handled within the family.

Substance Use

Risk factors: As with other psychiatric disorders, increasing acculturation and United States nativity have been demonstrated to be risk factors for alcohol and illicit drug use among Latino men and women (Grant et al 2004; Vega et al 2003; Ortega et al 2004; Vega et al 1998; Welte & Barnes 1995). In a study of co-occurring alcohol, drug and other psychiatric disorders among Mexican-origin people in the US, 12.3% of US born and 3.5% of immigrants had dual diagnoses (Vega et al 2003). Similarly, acculturation is associated with smoking history (Wilkinson et al 2005).

Protective factors: Gloria and Peregoy (1996) have discussed the inclusion of cultural constructs when working with Latinos with alcohol and substance use problems. Given the importance of *familismo*, this construct may be protective in that it may discourage individuals from using substances that will interfere with their contribution to the family system. Individuals who are separated from their families, for example if they are in the US alone while their family remains in their country of origin, may be isolated and at higher risk of substance use and depression. If someone is seeking treatment for substance abuse, this construct as well as family members and friends may be called upon to aid in attaining and maintaining sobriety during treatment. Exploring how an individual's substance use may be interfering with maintaining *simpatia* within the family system may also be helpful. Emphasizing the ability to fulfill the

positive aspects of gender roles (*machismo* and *marianismo*) for Latinos with substance use problems also may be effective.

Vergüenza (Shame) is an important concept among Latinos, and they will attempt to avoid bringing *vergüenza* to their families. If an individual or a family member has a substance use problem, it may be minimized or hidden from outsiders. In addition, substance use may be seen as an example of moral inferiority or lack of will power, which would bring further *vergüenza* to the individual and their family. Seeking substance use treatment outside the family system may be seen as shameful to one's family. Gloria and Peregoy (1996) suggest therapists be mindful and respectful of this, and not treat shame as a resistance or lack of motivation for treatment. Therapists may also consider collaborating with practitioners of *Curanderismo*, *Espiritismo*, and *Santería*, if the Latino seeking treatment ascribes to one of these systems.

Dementia

Risk factors: APOE-ε4, which has been described as a risk factor for AD in Caucasians, has not been consistently demonstrated to be a risk factor in Latinos. Harwood and colleagues (1999) demonstrated that increased risk of AD was associated with APOE-ε4 in Cuban Americans. However, other variables that have been shown to be risk factors for dementia among Caucasians, such as low level of education and hypertension, were not shown to be risk factors for dementia in this Cuban American cohort. In addition, APOE-ε4 has been demonstrated to independently increase the risk of familial AD in Caribbean Latinos (Rippon et al 2006; Romas et al 2002). In a study conducted by Tang & colleagues (1998), Latinos had an increased frequency of AD, regardless of APOE genotype. The authors hypothesized that other unidentified genes, unmeasured socioeconomic factors, or cultural attributes may contribute to AD risk among Latinos.

A Presenilin 1 mutation (Gly206Ala) has been identified in unrelated Caribbean Latino families with early-onset familial AD, and may be one of the risk factors for dementia among Caribbean Latinos (Athán et al 2006).

Diabetes has been shown to increase risk of stroke-associated dementia among Hispanics, with the population attributable risk for diabetes in relation to stroke-associated dementia being twice as great in Latinos compared to Caucasians (Luchsinger et al 2001).

Vergüenza (Shame) may interfere with family members seeking medical and psychosocial services for a family member with dementia. It may be believed that revealing this private family issue to outsiders will bring shame to the individual with dementia, as well as to the family.

Protective factors: *Familismo* may be protective for elders with dementia, as it can have a positive impact on caregivers' appraisals of stress, psychological and physical symptoms. In addition, *familismo* may lead to deterrence of institutionalization by emphasizing familial reciprocity and the family as the most important source of social assistance.

Respeto also may be protective for the elders with dementia, as Latinos tend to respect elders and defer to them.

Fatalismo may also be protective in that the caregivers of elders with dementia may use the expectation of adversity as a coping mechanism to deal with the stressors of caregiving (Hoppe & Martin 1986).

Latino elderly and Culture Bound Syndromes

Culture bound syndromes have been described in DSM-IV as well as in the literature (APA 1994; Guarnaccia & Rogler 1999; Weller et al 2002, Juntunen 2005; Niehaus 2005). When working with Latino elders, it is important to be aware of these syndromes so as not to misdiagnose patients with psychiatric illnesses, and also to not mistakenly attribute psychiatric illness to a culture bound syndrome.

Nervios is a common idiom of distress among Latinos. The term *nervios* may be used to refer to an individual's general state of vulnerability to stress and to a syndrome of symptoms triggered by stress. Symptoms of *nervios* include headaches, irritability, stomach disturbances, trembling, and dizziness. *Nervios* captures a spectrum, which can range from being sensitive to stress (*padecer de nervios*) to other presentations that may include adjustment, anxiety, depressive, dissociative, somatoform or psychotic disorders (APA 1994; Guarnaccia et al 2003).

Another cultural idiom of distress among Latinos is *Ataques de nervios* (attacks of nerves). *Ataques* are within the spectrum of *nervios*. An *ataque* occurs in reaction to a stressful event, such as a family conflict. Symptoms include fear, loss of self-control, uncontrollable shouting, attacks of crying, trembling, fainting, disorientation and dissociative experiences (Guarnaccia et al 1989, DSM; Lewis-Fernandez et al 2002;). *Ataques* may also be associated with perceptual distortions, which may be identified as psychotic symptoms (Guarnaccia et al 1993). *Ataques* are reported more frequently among Caribbean Latinos, though this syndrome is also found among other Latinos. The presentation of *ataques* may sound similar to the DSM-IV description of panic attacks, however, they are different given that *ataques* usually have a trigger, and panic attacks do not (APA 1994). However, there may be some overlap in these two presentations. Lewis-Fernandez and colleagues (2002) demonstrated that in a sample of Dominican and Puerto Rican adults, 36% of *ataques de nervios* also fulfilled criteria for panic attacks, and between 17 and 33% fulfilled criteria for panic disorder.

Susto (fright) is a culture bound syndrome which includes psychological and somatic symptoms such as appetite disturbances, sleep disturbances, dreams, sadness, lack of motivation, feelings of low self worth or dirtiness, muscle aches and pains, headache, and stomach disturbances. This syndrome is attributed to a frightening event that causes one's soul to leave its body. Healings, such as those in *Curanderismo*, are focused on calling the soul back to the body and restoring body and spiritual balance. Other names for *susto* include *espanto*, *pasmo*, *trip ida*, *perdida del alma* and *chibih*. (Baer et al 2003; APA 1994).

Mal de ojo (Evil eye) is a culture bound syndrome, which includes symptoms of fitful sleep, crying without an apparent cause, diarrhea, vomiting and fever. Infants and children are

most at risk, though adults (usually females) may also be affected (APA 1994). *Mal de ojo* is thought to occur when an adult looks admiringly at a child or adult, but does not show physical affection, such as a pat on the head. It is believed that this results in heating of the blood and causes fever and vomiting in the afflicted person.

Latino elderly and mood disorders

Prevalence

The prevalence of major depression varies among studies, largely as a result of the populations being studied. In largely Caucasian primary care samples, the prevalence has been demonstrated to range between 6.5% (Lyness, et al 1999) and 13.5% among elderly homecare patients (Bruce, et al 2002).

In studies of Latino elderly, prevalence rates of depression vary, based on the subgroup, as well as acculturation. The depression prevalence rate among community dwelling Mexican American elders in Sacramento was 25.4 %, with higher rates for immigrants (30.4%) and those who are less acculturated (36.1%) (Gonzalez et al 2001). In a study of community dwelling Puerto Rican, Dominican, “other” Latino, and Caucasian elders in Massachusetts, 44% of Puerto Rican, 32% of Dominican, 30% of “other” Latino elders and 22% of Caucasian elders had significant symptoms of depression (Falcon & Tucker 2000). In the San Luis Valley Health and Aging Study, Latina women had significantly higher rates of depressive symptoms (18.3%) compared to Caucasian women (9.6%) Latinas who were less acculturated had more symptoms of depression compared to those who were more acculturated (Swenson et al 2000).

It has been hypothesized that perhaps Latinos are disproportionately diagnosed with depression compared to other ethnic groups. In a study of diagnostic patterns in Latino, African American, and European American psychiatric patients, Latinos were disproportionately diagnosed as having major depression, despite self-reported psychotic symptoms. The authors hypothesized that this difference may be secondary to “self selection”, culturally determined expression of symptoms, difficulty in the application of DSM-IV diagnostic criteria, bias related to lack of clinicians’ cultural competence, and imprecision inherent in the use of unstructured interviews, possibly combined with clinician bias” (Minsky et al 2003).

Disability, Morbidity & Mortality

Depression is associated with increased morbidity and mortality among elders (Yaffe, et al 2003; Unützer, J et al 2002; Schultz, et al 2002; Penninx et al 1999). Those with depression have worse outcomes following acute medical events such as stroke (Morris et al 1992) and hip fracture (Mossey et al 1990).

Mexican American elders with depression and major chronic medical conditions such as cardiovascular disease, hypertension, stroke, diabetes and cancer, have higher mortality rates (Black & Markides 1999). Latinos with mood disorders have been found to be twice as likely to be persistently ill as whites (Breslau et al 2005).

Although recognition rates for depression have increased in elders, Latino elderly with depression continue to be under-treated (Crystal et al 2003).

Assessment and treatment modalities

It is essential that primary care providers inquire about the mood and other psychiatric symptoms of Latino patients with chronic medical conditions. This is particularly important among Latino elders, as they often experience greater barriers to care as a result of lower education and income, less acculturation and less insurance coverage than older non-Hispanic Whites (Black & Markides 1999).

Treatment of depression has been demonstrated to improve physical functioning in older adults (Callahan et al 2005). Psychotherapy, including cognitive behavior therapy (Arean et al 2002; Laidlaw 2001), interpersonal therapy (Reynolds et al 1999), problem-solving therapy (Arean et al 1993; Mynors-Wallis et al 2000; Alexopolous et al 2003) and psychodynamic psychotherapy (Gallagher-Thompson et al 1990), have been demonstrated to be effective in the treatment of depression in elders. However, there are limited studies regarding psychotherapy for Spanish-speaking elders (Eisdorfer et al 2003). It is hypothesized that cognitive behavioral techniques may be especially useful in working with Latinos, because those who are not acculturated tend to view their problems as based on social and interpersonal issues rather than intrapsychic issues. Latino patients tend to expect that treatment will include giving advice, have a concrete focus and a problem centered approach (Arce & Torres-Matrullo 1982). Further research on effective treatment modalities for Latino elders with depression clearly is needed.

Other factors that would help Latino elders receive treatment include medical and mental health care with clinicians who are adequately trained in language and culture to minimize barriers, involvement of available family in treatment, and addressing external sources of stress (insurance, poverty, isolation, discrimination, etc.) via social services in combination with mental health services. (Robison et al 2003; Gonzalez et al 2001)

Latino elderly and anxiety disorders

Prevalence

Anxiety is prevalent among elders in the community. The Epidemiologic Catchment Area Study, which included five community samples in the United States, demonstrated a prevalence rate of 5.5% in adults aged 65 years or older (Regier et al 1988). This study did not include screening and diagnosis of generalized anxiety disorder (GAD), thus the prevalence of anxiety disorders is probably higher. In the Longitudinal Aging Study of Amsterdam, the prevalence of DSM-III anxiety disorders was 10% (Beekman et al 1998). The prevalence of GAD among adults aged 65 years and older in a large US national survey was found to be 1.0% for 12-month prevalence and 2.6% for lifetime prevalence (Grant et al 2005).

The available information regarding the prevalence of anxiety disorders among Latino elders is limited, as most studies of anxiety in Latinos involve young and middle aged adults (Breslau et

al 2005; Grant et al 2004; Eisenman et al 2003, Ortega & Rosenheck 2000). In one study of anxiety disorders, including generalized anxiety disorder, specific phobia, and panic attacks among Puerto Rican adult primary care patients aged 50 years and older in the northeastern United States, the prevalence was found to be 24% (Tolin et al 2005). This study did not include screening and diagnosis of post-traumatic stress disorder (PTSD), thus the prevalence of anxiety disorders probably is higher.

A study comparing primarily Puerto Rican Latinos to White American psychiatric outpatients found that Latinos endorsed higher levels of anxiety and obsessive-compulsive symptoms. It was hypothesized that perhaps these differences were partially due to the assessment tool including questions that captured the culture-bound syndrome of *nervios* (Coehlo et al 1998).

Disability, Morbidity & Mortality

Anxiety disorders are associated with increased heart disease, all cause mortality (Weitof & Rosén 2005), and significant disability (Grant et al 2005) in adults. Similarly, anxiety disorders are associated with significant impairment in Latino elders. In a study of Puerto Rican adults aged 50 years and older, anxiety disorders were demonstrated to be associated with increased levels of suicidality, decreased functional status, decreased perceived health status, and decreased well being (Diefenbach et al 2004).

Treatment modalities

There are few studies on treatment effectiveness in anxiety among elders (Wetherall et al 2005). The limited available literature suggests anxiety in geriatric patients may be relieved with antidepressant medications, such as citalopram (Lenze et al 2005), and cognitive behavioral therapy. There are no known studies of treatment of anxiety in Latino elderly. As with depression, cognitive behavioral techniques may be useful in working with Latinos with anxiety disorders, as those who are not acculturated tend to view their problems as based on social and interpersonal issues rather than intrapsychic issues. Latino patients tend to expect that treatment will include giving advice, having a concrete focus and a problem centered approach (Arce & Torres-Matruillo 1982).

Latino elders and Psychosis

Prevalence

Several diagnoses are associated with psychotic symptoms in the elderly. These include schizophrenia, mood disorders, post traumatic stress disorder, substance use disorders, Alzheimer's Disease (AD), Parkinson's Disease (PD), delirium, drug-induced psychoses, and psychoses due to medical conditions (DSM-IV). Psychotic symptoms also may be present without resulting in impairment, or meeting criteria for a psychiatric condition (Eaton et al 1991). In fact, the prevalence of psychotic symptoms among elders in the United States ranges from 4 to 10% (Christenson & Blazer 1984; Blazer et al 1996). In a study of adults attending an

urban general medical practice, patients endorsing psychotic symptoms were more likely to be Latino and to speak Spanish as their primary language (Olfson et al 2002).

Disability, Morbidity & Mortality

Psychotic symptoms and schizophrenia among elders are associated with poor health outcomes, increased mortality, cognitive and functional impairment, depressive symptoms, social isolation, low socioeconomic status and substance use (Copeland et al 2006; Goff et al 2005; Goff et al 2005; Karim et al 2005)

Belief systems regarding psychotic symptoms and illnesses

Latinos' beliefs regarding the origins of schizophrenia vary considerably. One study of their attitudes and behaviors toward a relative with schizophrenia demonstrated that they tended to conceptualize the cause of their relatives' symptoms and behaviors as due to either (1) an illness such as a genetic abnormality, mental disorder other physical factor, or (2) some stressor, either interpersonal or external environmental in origin, or (3) God or related spiritual belief (Weisman et al 2003). Of note, even when the cause of the symptoms was attributed to a mental disorder, few of the relatives referred to it as "schizophrenia", calling it *nervios* instead.

Latinos may refer to psychotic disorders, including schizophrenia, as *nervios*, which has mental and somatic components (Guarnaccia et al 1992). Guarnaccia and colleagues have described *Nervios* as a spectrum. They further have demonstrated that Puerto Ricans differentiate among categories within *nervios*. Thus an individual may be viewed on a continuum that ranges from being nervous (*ser nervioso*) which is a result of traumatic experiences or suffering, to suffering from nerves (*padeecer de nervios*), which is more of an illness, to losing touch with reality (*locura*). (Guarnaccia et al 2003; Weisman et al 2003; APA 1994). Likewise, Jenkins (1988) demonstrated that Mexican Americans also applied the concept of *nervios* to their family members with schizophrenia.

Unique presentation of psychosis

Although schizophrenia is present in all cultures and ethnic groups, ethnic and cultural factors can influence the expression of this disease (Lin & Kleinman 1988; Coehlo et al 1998; Weisman et al 2000). Mexican American patients with schizophrenia have been demonstrated to have fewer persecutory delusions, less nervous tension, and less blunted affect than White Americans with the same diagnosis (Weisman et al 2000).

Mexican Americans with schizophrenia are more likely to report physical symptoms compared to White Americans with schizophrenia (Weisman et al 2000). In two other studies, Latinos reported more somatic symptoms than white Americans (Barrio et al 2003; Escobar et al 1986)

“Latinos tend to make greater religious attributions than do Euro-Americans and these attributions play an influential role in shaping reactions to schizophrenia” (Weisman & Lopez 1996; Weisman 1997; Weisman 2000)

Differential diagnosis of psychosis

Idioms of distress among Latinos may be mistaken for psychotic disorders. For example, Latinos may report auditory, visual and tactile misperceptions during depressive and anxiety states and may attribute these symptoms to forms of spiritual influence, not a psychotic disorder (Guarnaccia et al 1992).

Ataque de nervios (Attack of nerves), a culture bound syndrome which has been described in the Culture bound syndrome section of this chapter, may also be mistaken as a psychotic disorder, as it can include dissociative symptoms that may be mistaken for psychotic symptoms (Guarnaccia et al 1993).

Latinos may screen positive on questionnaires that are used to screen for psychotic disorders if the questions ask about beliefs that are included in *Curanderismo*, *Espiritismo* and *Santeria* traditions, such as supernatural forces, possession, witchcraft and casting spells (Olfson et al 2002). Although *Santeria* includes the belief in spirit possession, it may also complicate the diagnosis and treatment of patients who both practice *Santeria* and have psychotic disorders (Alonso & Jeffrey 1988). In order to distinguish *Santeros* who may have a psychotic disorder from those who do not, Alonso & Jeffrey (1988) recommend examining the *Santero's* daily functioning and judgment.

Latinos with PTSD related to traumas in their countries of origin or during their migration journeys may demonstrate paranoia and dissociative symptoms, which can be misdiagnosed as part of a psychotic disorder. It is important to complete a thorough interview, including cultural formulation to elucidate this.

It is important to re-evaluate the diagnoses of Latino elders who were previously diagnosed with schizophrenia or other psychotic disorders, as they may have been misdiagnosed at the time of their initial evaluation if the people evaluating them were not familiar with Latino cultural constructs, belief systems, idioms of distress and culture bound syndromes.

Treatment modalities/Treatment concerns

In a recent survey of American experts regarding treatment of older adults, atypical antipsychotic medications were recommended for the treatment of late-life schizophrenia, delusional disorder, and geriatric psychotic depression (Alexopolous et al 2004). In the early 1990s, Latinos were more likely to receive typical antipsychotic medications than atypical antipsychotic medication when compared to whites. During recent years, however, the use of atypical antipsychotic medications for Latinos with psychotic disorders is now comparable to whites (Daumit et al 2003).

In response to community-based psychosocial interventions Latinos with schizophrenia have been demonstrated to have similar outcomes, compared to whites and African Americans (Sung-Woo et al 2004).

Latino elders and substance use

Epidemiology

Alcohol and illicit substance use are increasingly recognized in the literature, although they are often not recognized among elders in primary care and mental health settings, (Oslin 2004; Black et al 1998; Holroyd & Duryee 1997; Adams, et al 1996). The prevalence of excessive alcohol use has been demonstrated to be as high as 15% among elders (Adams et al 1992; Adams et al 1996). There is literature regarding substance use among Latino adolescents and adults (Winters et al 2004; Ompad et al 2004; Vega et al 2003). However, there is not much literature available describing substance use among Latino elders (Grant et al 2004; Artner et al 2002).

In one study the prevalence of alcohol abuse among Latino elders was 1.56%, compared to 1.21% for White elders, and 0.78% for Black elders. The prevalence of alcohol dependence among Latino elders was 0.36%, compared to 0.18% for White elders, and 0.87% for Black elders (Grant et al 2004).

Most of the available literature regarding Latinos and substance abuse has focused on those of Mexican origin. This is probably because Mexicans make up the largest subgroup of Latinos in the United States (Vega et al 2003). However, studies have not yielded consistent findings regarding substance use among the different Latino subgroups. For example, in one article, people of Mexican origin were described as consuming more drinks on their heavy drinking days, compared to other Latinos, and Caribbean Latinos were less prone to heavy drinking than other Latinos (Dawson 1998).

Disability, Morbidity & Mortality

Alcohol and illicit substance use are associated increased morbidity and mortality. Diseases related to substance use include cirrhosis, pancreatitis, cardiomyopathy and hypertension. Substance use also is related to increased memory and cognitive problems, sleep disturbances, falls and motor vehicle accidents. In addition, there are potential interactions between alcohol and illicit substances with elders' prescription medications (Oslin, 2004).

The number of studies describing the negative health outcomes of alcohol and substance use among Latino elders is limited. However, it is known that they are disproportionately affected by alcohol related liver cirrhosis. The mortality rate for alcohol related liver cirrhosis was 13.3 deaths per 100,000 among Latino males, compared to 8.3 deaths per 100,000 among African American males and 5.2 deaths per 100,000 among White males (Saadatmand et al 1999).

Alcohol related-health disparities among Latinos in the US have been recognized in the literature (Stinson et al 2001, Yoon et al 2001). Latino adults have less access to alcohol and substance use treatment and poor quality of care compared to Whites. Latinos experience greater delays in receiving care, lower satisfaction with care and lower rates of active treatment. (Wells et al 2001).

Treatment modalities

There are limited studies of treatment of substance use among elders (Fleming et al 1999; Oslin et al 1997; Kofoed et al 1987) and none found at this time target Latino elders specifically. Substance use among Latino elders must be investigated in order to develop appropriate prevention and treatment efforts to target this population.

Latinos and Dementia

Demographics/Prevalence

Prevalence rates of dementia vary among Latinos, and within Latino subgroups. Some studies have demonstrated higher prevalence of cognitive impairment (Mulgrew et al 1999) and dementia among Latinos, compared to Caucasians (Demirovic et al 2003). Gurland and colleagues' (1999) study of prevalence rates of dementia among Caucasian, African Americans and Latinos found "prevalence of dementia in the three age strata (65-74, 75-84, 85+) for Latinos of 7.5%, 27.9% and 62.9%; for African Americans 9.1%, 19.9% and 58.6%; and for Caucasians, 2.9%, 10.9%, and 30.2%. However, there was no difference among prevalence rates when rates were adjusted for age and education.

The incidence rate of Alzheimer's Disease (AD) among Caribbean Latinos has been demonstrated to be higher than for Caucasians, even when taking years of education, illiteracy, or a history of stroke, hypertension, heart disease and diabetes into account. Reported incidence rates per person-year of probable and possible AD in two age strata (75-84, 85+) were 4.4% and 8.8% for Caribbean Latinos, 4.4% and 11.4% for African Americans, and 2.6% and 4.2% for Caucasians (Tang et al 2001; Perkins et al 1997). Studies of incidence and prevalence rates of dementia among Latinos have tended to demonstrate inconsistent rates that may be due to differing methodologies. (Fitten, Corrada et al 1995).

Demirovic and colleagues (2003) were unable to report prevalence rates of dementia for Cuban Americans in their study of prevalence rates of dementia among three ethnic groups, as the measure used (SPMSQ) had low specificity as a screening test for Cuban men. According to their multivariate analyses, Cuban ethnicity was significantly and independently associated with the risk of AD.

In a study of Latino and Caucasian elders with Alzheimer's disease (AD), Latino elders had a mean age of symptom onset that was 6.8 years earlier than Caucasian elders. The difference between the two groups remained even after adjustment for education. Of note, there was no difference in the age at symptom onset between the Latino patients of mostly Caribbean origin on the east coast, and Latinos of mostly Mexican American origin on the west coast. It did not appear that confounders such as depression, comorbid medical conditions, years of education or acculturation was associated with the younger age of onset (Clark et al 2005).

Types of dementia. Gurland & colleagues' (1999) study already cited, found no significant difference in the rate of AD among the different ethnic group patients diagnosed with dementia.

Explanatory models

A study of Latino caregivers' explanatory models of dementia revealed that Latinos tended to hold folk models of dementia, or a combination of folk and biomedical models. Folk models explanations for dementia emphasized psychosocial stress or the normal effects of aging. The combined folk and biomedical models explanation was described as including biomedical labels such as Alzheimer's disease, dementia, and stroke, with folk models to explain the illness. The authors hypothesized that folk models may be adaptive for caregivers by reducing the stigma associated with the diagnosis of Alzheimer's disease and related behavioral disturbances (Hinton et al 2005). They suggested that public health education messages regarding dementia might be more effective if they included aspects of folk models.

Some caregivers of Latinos with dementia have reported that a major deterrent to the recognition of initial symptoms in their relative was lack of knowledge regarding dementia, rather than culturally influenced beliefs (Neary 2005).

Disability, Morbidity & Mortality

A study of survival among patients with dementia, which included Latinos, did not reveal differences in the age at symptom onset. In this study, median survival time for Latinos with any form of dementia from onset of symptoms and from diagnosis was comparable to that of Caucasians and African Americans, however, the authors cautioned that the number of Latino patients in the study was limited (Waring et al 2005).

Latino elders with dementia have been shown to have more neuropsychiatric symptoms compared to other ethnic groups (Sink et al 2004; Hinton et al 2003; Chen et al 2000). In a study of dementia-related behaviors among a multiethnic sample of community-dwelling patients with moderate to severe dementia, Latinos (who were predominantly of Cuban origin) had a significantly higher likelihood than Caucasians of having hallucinations, episodes of uncontrollable anger, combativeness and wandering (Sink et al 2004). In another study of AD behavioral symptoms, Latino elders with AD manifested higher levels of neuropsychiatric symptoms as compared to African American, Asian American, and Native American elders with AD (Chen et al 2000). In a study of clinical aspects of dementia in a multi-ethnic sample, Latinos had a lower risk of depressed mood compared to Caucasians (Hargrave et al 2000).

Assessment and treatment modalities

Neuropsychological tests that have been developed for and validated in English speaking Caucasian elders have been shown to have lower specificity among Latino elders, partly due to cultural bias and less education (Loewenstein et al 1993; Teresi et al 1995; Tombaugh & McIntyre 1992). Thus, various scales and measures have been translated and developed during the last twenty years with the intent of more effectively assessing the cognitive function of Spanish-speaking elders. A discussion of these instruments is beyond the scope of this curriculum, however, the scales and measures are listed in Box 2. In addition, test batteries have been translated and developed to assess cognitive function among Latinos (Taussig et al 1992).

Box 2. Neuropsychological tests

Mini-Mental State Examination (Escobar et al 1986; Bird et al 1987; Bohnsted et al 1994; Mungas et al 1996; Marshall et al 1997; Hohl et al 1999)

Mattis Dementia Rating Scale (Hohl et al 1999)

Behavior Problems Checklist-Spanish (Harwood et al 2001)

Cognitive measures developed for the Asset and Health Dynamics Among the Oldest Old (AHEAD) study (Herzog & Wallace 1997)

Multilingual Aphasia Examination (Rey & Benton 1991)

Boston Diagnostic Aphasia Examination (Goodlass & Kaplan 1979)

Current recommended therapies for AD include acetylcholinesterase inhibitors. However, Latino elders with dementia utilize these less frequently than Caucasian elders with AD (Mehta et al 2005). Hypotheses for this underutilization include less access to physicians and medications due to insurance, economic and educational barriers, as well as physician bias.

In addition to pharmacologic therapies, psychosocial and behavioral interventions and support services are recommended for the care of elders with dementia. However, Latinos are less likely to utilize formal support services, as demonstrated by Latino elders being more likely to be discharged to the community rather than to nursing facilities as compared to Caucasians & African Americans (Kales et al 2000), Latinos being more likely to delay institutionalization of family members with dementia as compared to Caucasians (Mausbach et al 2004), and Latino elders using skilled home nursing half as often as Caucasian elders (Mui et al 1998). Aranda and colleagues (2003) and Gallagher-Thompson and colleagues (2003) have demonstrated that Latino families will seek out and utilize formal support services if they are informed that dementia is a medical illness, and aware of culturally appropriate services that meet the elder and family's needs. In another study of Latino caregivers, caregivers viewed family-centered home care as a culturally embedded value, but were willing to consider placement when home care became impractical (Neary 2005).

Ethnic Minority Elderly Books and Chapters Resource List

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A visit with Maria.

Salt Lake City, UT: Innovative Caregiving Resources, 1994.

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Green-Field Library Call no. WM 220 VC no.203 1994

Alzheimer's: a family affair.

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Green-Field Library Call no. WM 220 VC no.291 1990

Alzheimer's disease: a multi-cultural perspective.

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Green-Field Library Call no. WM 220 VC no.198 1994

The Culture of Emotions

Harriet Koskoff, producer

Length: 58-minutes

DSM-IV Outline for Cultural formulation

Fanlight Productions Media Library

www.fanlight.com

Dr. Fen-lei Chang on CHINA CROSSTALK

Westone Media.

Brisbane, CA: KTSF-Channel 26, 2002.

1 videocassette (? min.) Mandarin-based, live call-in TV program that aired June 18, 2002.

Green-Field Library Call no. WM 220 VC no.758 2002

Enhancing relations between Asian elders and health & social service providers.

Jennifer Salmon and Jane Hagen.

Portland, OR: Oregon Geriatric Education Center, Portland State University, 1995.

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Ethnic and cultural differences in mental health and aging.

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Green-Field Library Call no. WM 220 VC no.236-1 1992

Helping families understand Alzheimer's disease.

Honolulu, HI: State of Hawaii, Office of the Governor, Executive Office on Aging, 1992.

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Each videocassette contains information in Hawaiian, Japanese, Cantonese, Illocano, Vietnamese, Samoan, Korean and provides booklets in each of those languages.

Green-Field Library Call no. WM 220 VC no.63 1992

Hispanic healthcare beliefs attitudes and practices that affect the client.

Chicago, IL: University of Illinois at Chicago, Office of Media Services and Illinois Geriatric Education Center, 1991.

1 videocassette (77 min.).

Green-Field Library Call no. E 184 VC no.217 1991

La enfermedad de Alzheimer y el cuidador.

El Paso, TX: Alzheimer's Association Star Chapter, 2002.

1 videocassette (25 min.). In Spanish.

Green-Field Library Call no. WM 220 VC no.908spa 2002

Memory loss and special issues for African-American and Hispanic caregivers.

Southfield, MI: Detroit Chapter, Alzheimer's Association, 1993.

1 videocassette (60 min.).

Green-Field Library Call no. WM 220 VC no.639 1993

Orientation to Alzheimer's disease. Cantonese voice over of the Alzheimer's Association "Orientation" video.

Hong Kong: Hong Society for Rehabilitation, 1995.

1 videocassette (17 min.).

Green-Field Library Call no. WM 220 VC no.428chi 1990

Programa de capacitacion para cuidadores de personas con Alzheimer. [Home Care Companion's

Alzheimer's training program.]

Medford, OR: Healing Arts Communications, 2003.

1 videocassette (30 min.) + print materials. In Spanish.

Green-Field Library Call no. WM 220 VC no.776spa 2003

Summer Snow

[Nu ren sishi] by Chen Wenqiang; Xu, Anhua; Xiao, Fangfang; et al.

In Cantonese with Chinese and English subtitles.
Tibei Shi: Ju deng yu le gy fen you xian gong si, 1995.
1 videocassette (102 min.).

The forgetting.
St. Paul, MN: Twin Cities Public Television, 2003.
1 videocassette (120 min.). Dubbed in Spanish.
Green-Field Library Call no. WM 220 VC no.862spa 2003

You're not alone facing Alzheimer's: an African American perspective.
Chicago, IL: Halstead Terrace Nursing & Rehabilitation Center, 1996.
1 videocassette (21 min.)
Green-Field Library Call no. WM 220 VC no.425 1996

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