Aging in a Diverse Society: The Role of Cultural Competency in Mental Health Care for Older Adults

By Elizabeth Bowen

The elderly population in the United States is becoming increasingly diverse, and this trend underscores the need for culturally competent health care services for older adults. As attitudes about mental illness are strongly shaped by cultural values, there is an acute need for cultural sensitivity in the mental health care sector. This article explores the meaning of cultural competency in the context of mental health service provision, and offers a brief overview of service models that emphasize cultural sensitivity. The unique role that social workers can play in enhancing cultural competency in mental health care for older adults is emphasized.

With regard to health status, socioeconomic status, race, ethnicity, and culture, America's elderly are a diverse group. Of all these factors, culture is among the most critical to consider in providing effective mental health care for elderly clients. In spite of this, the mental health care system has historically been inadequately responsive to the varying needs of culturally diverse elderly clientele (Aranda, 1990). Given the growing diversity of the elderly population, and the impact that clients' cultural contexts have on the diagnosis and treatment of mental illness, there is currently a critical need for cultural understanding and sensitivity in the mental health care system. The social work profession can play a unique role in ensuring cultural competency in mental health care, at both the micro and macro practice levels.

In order to demonstrate the need for cultural competency in mental health care, this article will explore theoretical explanations of the role that culture plays in conceptualizing both mental health and aging. In addition, the article will seek to define cultural competency, to demonstrate the need for

culturally competent mental health care for the elderly, and to evaluate the policy implications of these objectives. The role of the social work profession in providing appropriate, sensitive care will be explored, and this article will suggest exemplary service designs that can provide truly culturally competent mental health care for older Americans.

CULTURE AND ITS RELEVANCE TO MENTAL HEALTH CARE FOR THE ELDERLY

In considering the treatment of mental health conditions of the elderly, culture plays two roles. First, culture affects the ways that mental illnesses are viewed, diagnosed, expressed, and treated in any society. In addition, culture shapes perceptions and ideas about aging. On a fundamental level, David Takeuchi and Katherine Kim (2000) postulate that mental illnesses are defined by arbitrary boundaries. These boundaries depend on how a culture labels different behaviors as deviant or sick. Within a society, cultural biases and prejudices toward certain groups may affect who is judged to have a mental illness. For example, since the U.S. Census Bureau began collecting data on patterns of mental health treatment in 1930, nonwhites have shown higher rates of insanity than whites in every census report (Vega and Rumbaut, 1991). While the actual prevalence of mental disorders may be affected by such factors as the overrepresentation of racial and cultural minorities in the United States among lower socioeconomic classes, the role of culture (and cultural biases) cannot be dismissed in defining and diagnosing mental illnesses.[1]

Culture also influences the ways that symptoms of mental disorders are expressed. In many cultures, including those of Mexico and China, there is a tendency to somaticize symptoms of mental illness, manifesting psychological discomfort in physical complaints (Vega et al., 1999). Takeuchi and Kim (2000) offer the example of both Chinese mental health professionals and their clients preferring a diagnosis of neurasthenia rather than depression, with its focus on emotional distress. Neurasthenia is a term used to describe physical discomfort and fatigue as a response to stressful events.

Once the symptoms of mental health disorders are expressed and identified, culture affects the avenues through which individuals seek treatment. The methods of intervention for mental health problems are varied. Some examples include turning to one's extended kin network for social support, using formal psychotherapy and drug treatment, and obtaining the services of a shaman or indigenous healer. Culture is one of the primary factors determining the interventions to which a person may have access, and culture also influences preferences for different modes of treatment. In addition, stigmas associated

with mental illness vary from culture to culture, and their weight affects whether or not a person will seek any sort of treatment in the first place (Takeuchi and Kim, 2000).

In providing mental health care for culturally diverse elderly clients, professionals and service providers must be aware not only of the role that culture plays in conceptualizing mental health and mental disorders, but must also be knowledgeable concerning the wide-ranging effects of culture in shaping beliefs and values about aging. Simon Dein and Sarah Huline-Dickens (1997) propose that in every society, different rights, duties, expectations, and privileges are associated with reaching old age. These rights and privileges may be enforced both through formal laws and informal social sanctions. So too, old age is culturally defined, and varying definitions may take into account physical and social functioning, as well as chronological age.

Dein and Huline-Dickens (1997) also point out that there has been relatively little cross-cultural research examining which aspects of aging are universal (and thus unavoidable) and which aspects are culturally defined (and therefore not an inevitable part of the aging process). According to Dein and Huline-Dickens (1997), there is no empirical support for the notion that social disengagement among elderly people is an inescapable, universal phenomenon. Disengagement may be relatively widespread among elderly people in Western cultures and may be intensified by the Western emphasis on the connection between a person's social worth and productivity. However, this is not true in every society (Dein and Huline-Dickens, 1997). The Sherbro people of Sierra Leone, for example, interpret incoherent speech in old age as the elderly person's communications with revered ancestors and, thus, associate elderly status with wisdom and good fortune (Palmer, 1997).

In any assessment of the influence of culture on perceptions of aging, it is also important to consider the role of religion. Religious values strongly influence beliefs about death and the extent to which death is feared. Such beliefs often serve as a source of comfort for elderly people who are dealing with loss and grief (Dein and Huline-Dickens, 1997). In certain religious traditions, such as Taoism and Confucianism, being elderly is associated with wisdom, honor, and mastery (Palmer, 1997).

WHAT DOES IT MEAN TO BE CULTURALLY COMPETENT?

In the context of mental health care for elderly people, cultural competence refers to integrating an understanding and awareness of the client's culture into all aspects of service delivery, including assessment and diagnosis, treatment

interventions, and termination. This may involve the creation of programs designed specifically for elders of certain racial, ethnic, or religious backgrounds. Cultural competency can be practiced in agencies that serve a diverse body of clientele. Donna Yee (1997) defines cultural competency as the use of social work problem-solving techniques to respond to the elderly client's needs in the context of the client's culture and family. In its essence, this process should involve emphasizing the client's culturally based strengths while strategizing to overcome barriers that threaten to prevent minority elders from receiving effective treatment.

THE NEED FOR CULTURAL COMPETENCE IN THE AMERICAN HEALTHCARE SYSTEM

With sharp increases in both the number of elderly persons and the minority population, cultural competency in mental health care for older adults has never been more important. Census figures show that in 2002, 30 percent of Americans classified themselves as African American, Latino, Asian American, or Native American (U.S. Census Bureau American Community Survey Office, 2003). Richard Schaefer (2000) reports that this number is expected to rise to 47 percent by 2050. Focusing on the segment of the population that is over 65, Tobi Abramson, Laura Trejo, and Daniel Lai (2002) summarize a 1992 Census Bureau report predicting substantial increases in the number of elders of color. Among the elderly in some racial and ethnic groups, the rate of increase could be as much as 625 percent or as little as 150 percent.

Despite these remarkable demographic trends, the mental health care system has not kept pace in providing effective care for diverse elders. A recent report from the U.S. Surgeon General reveals that cultural minorities of all ages are significantly less likely than whites to receive adequate mental health care in the U.S. (McCarthy, 2001). This is due to a host of factors, including lack of health insurance, unavailability of treatment in minority communities, and the failures of therapists and treatment models to acknowledge the cultural context of mental health. When coupled with the potential barriers to treatment that elders experience regardless of racial and cultural identification, minority elders are truly in a position of "double jeopardy" (Dowd and Bengston, 1978, p. 427). Such barriers include strong stigmas associated with the presence and treatment of mental disorders.

A more detailed investigation is warranted of the barriers to treatment faced by elderly minorities. Jennifer Alvidrez (1999) studies minorities across the age spectrum and classifies barriers to treatment into two categories: instrumental and psychological. The term "instrumental barriers" refers to

resource factors that prevent people from seeking treatment, including lack of health insurance, money, time, or transportation (Alvidrez, 1999, p. 516). In 2001, Bernadette Proctor and Joseph Dalaker (2002) reported U.S. Census Bureau data showing that minorities live in poverty in numbers disproportionate to whites; this is especially true for Latinos and African Americans, over 20 percent of whom were living below the federal poverty line in 2001. This information is critical in understanding barriers to treatment, because the stresses associated with living in poverty may exacerbate the rates of such mental disorders as depression and anxiety. Both are already prevalent in the elderly population, complicating efforts to obtain treatment. A related factor is lack of health insurance. Takeuchi and Kim (2000) report that an estimated 44.3 million Americans do not have health insurance. This problem is particularly severe among immigrants and racial and ethnic minorities. About one-third of all Latinos, for example, are uninsured (Carrasquillo et al., 1999).

The second type of barrier identified by Alvidrez (1999), "psychological," refers to cultural factors that prevent people from seeking treatment even when services are financially accessible (p. 516). These factors include stigmas associated with mental illness, family and cultural beliefs about the causes and expressions of mental disorders, and exposure within a cultural context to different systems of mental health treatment. Elderly people across cultures are often unfamiliar with the range of mental health services available in their communities, and many attach a negative stigma to seeking treatment, believing that mental health problems should be addressed individually or within the family (Burstein, 1988). These trends may be especially pronounced in particular cultural communities. For example, African-American, Latino, and Native-American cultures traditionally emphasize family support and frequently advocate treating problems within the family, extended kin network, or immediate community. Nonetheless, mental health care providers must take care not to assume that all minority elderly prefer or will have access to adequate care within their family or community (Dein and Huline-Dickens, 1997).

Even if elderly minorities are able to overcome these instrumental and psychological barriers to seek treatment for mental health problems, they still face a system of care that historically has not responded effectively to their needs. For example, many of the standardized measures used to diagnose mental illnesses were developed with inadequate representation of both minorities and elderly persons in the research samples (Vega and Rumbaut, 1991). Dein and Huline-Dickens (1997) assert that measures of dementia may be especially susceptible to cultural biases, because these measures often do not

account for the elderly person's level of education, and conceptions of dementia differ significantly across cultures. Furthermore, many mental health agencies are not able to match elderly clients with therapists who share a knowledge of their cultural background and native language. For example, despite the fact that the population of Latino elders in Southern California numbers upward of 160,000, a 1987 survey in Los Angeles County revealed that programs for Spanish-speaking elders, staffed by bilingual therapists trained to work with older adults, were offered by only three of the 81 agencies in the county (Aranda, 1990).

SOCIAL WORK AND THE PROVISION OF CULTURALLY COMPETENT CARE

The role of social workers in providing culturally competent mental health care for a diverse elderly population is delineated by professional ethical standards and by a strengths-oriented philosophy in both micro and macro practice. To begin, cultural competence is an ethical guideline set forth by the National Association of Social Workers (NASW) as a standard for the entire profession. To this end, the NASW Code of Ethics states that social workers should demonstrate a working knowledge of their clients' cultures, and provide services in a manner that is sensitive to the cultural differences among people of diverse backgrounds and groups (NASW, 1999).

Beyond this, culturally competent practice with elderly adults provides an avenue for tapping into a client's full range of strengths and resources. For example, Gene Cohen (1993) argues that African Americans have generally developed a greater array of coping mechanisms by the time they enter into old age. This is perhaps due to a lifetime of dealing with prejudice and other threats to self-efficacy and self-esteem. A skilled social worker can tap into this wellspring of strengths to provide effective mental health treatment, helping African-American elders maximize their growth and functioning.

Cultural strengths may also be drawn from the ways that families from different cultures respond to the potential strain of caring for an elderly member. For example, Vicki Hines-Martin (1992) finds that African-American caregivers show less strain, on average, than whites in caring for chronically ill elderly relatives. So too African Americans are less likely to place elderly family members in nursing homes or other institutions. As social workers strive to provide competent mental health care for an increasingly diverse population of older adults, potential community resources, including extended kin networks and religious institutions, must be acknowledged and integrated into treatment plans.

SERVICE DESIGNS AND MODEL PROGRAMS

While the minority elderly population may be underserved as a whole, there are a number of culturally competent mental health care programs for older adults. These programs should serve as examples to other care providers in the field. To begin, the American Society on Aging (ASA) has developed a number of innovative programs addressing both the mental and physical healthcare needs of the multicultural elderly population. In 1996, ASA founded "Serving Elders of Color: A Training and Networking Initiative" (Jeung, 2004). Under this project, ASA works with other organizations, such as the American Association of Homes and Services for the Aged and the National Association for Home Care, that provide care for the elderly. Together, the coalition seeks to maximize cultural competency. The Serving Elders of Color project shows agencies how to conduct diversity needs assessments and provides diversity trainings to staff. The initiative also establishes a network and newsletter through which participants can share information and provide advice to one another.

Another initiative created by ASA, the California Multicultural Institute for Aging and Healthcare is designed specifically to meet the needs of elders of color and gay, lesbian, and bisexual elders throughout the state of California (American Society on Aging, 2002). The Institute works with agencies that provide health and mental healthcare services to the elderly, helping them to conduct research that evaluates baseline data on the services that each agency provides. This is achieved by setting goals for maximizing the cultural competency of care (for example, improving diversity on governing boards and increasing bilingual staff), by implementing trainings and additional service provision to meet these goals, and by evaluating the results.

In addition to the ASA, other service providers across the country are responding to the need for cultural competence. One exemplary program is Realizing Empowerment and Service Possibilities for Elders in Communities Together (RESPECT), based in Roxbury, MA (Yee, 1997). This project trains elders of color from historically underserved communities to work as cultural translators and peer advocates. These recruits help to identify other elders in the neighborhood with mental health care needs, and to inform them of available services. The peer advocates also accompany staff from mental health and elder care agencies on their home visits, facilitating communication while helping to bridge gaps of culture and age between the client and the service provider. According to Yee (1997), this helps clients feel more in control and less vulnerable. It may also help service providers and case managers feel more comfortable in bringing up sensitive issues that they might otherwise be

tempted to ignore.

Another example of culturally competent mental health care for the elderly can be found on the opposite coast, at the San Antonio Mental Health Center in Los Angeles County. This clinic primarily serves a low-income clientele, 10 percent of which is elderly, and the majority of which is Latino (Aranda, 1990). The San Antonio Mental Health Center is committed to cultural competence at all levels of service provision, from outreach to program design. To make the community more aware of the services that the center offers, the staff conducts outreach activities in places where elders of color are likely to congregate, such as predominately Latino churches, and provides informational materials, such as videos and pamphlets in Spanish, to educate the public on such mental health conditions as Alzheimer's disease.

When elderly Latino clients come in for treatment, the staff assesses the client's level of acculturation, as well as that of his or her family (acculturation levels may differ significantly within a family, as many Latino elders are immigrants). Treatment progresses with an integration of traditional values that are important to the elder, such as family reliance and interdependence. Staff at the center also explores with clients the cultural beliefs about aging. A yearly celebration of El Dia del Los Muertos, or Day of the Dead, is held at the agency. The event raises awareness of the values about death and aging that are conveyed by this Mexican tradition. The clinic also does group work with elderly clients and their families. Such work includes hosting the country's first Spanish-language Alzheimer's support group and offering peer counseling to clients with trained elderly Latino volunteers.

POLICY IMPLICATIONS

At the level of social policy, there are numerous opportunities to advocate for individuals facing the triple challenges of old age, mental health problems, and membership in a cultural minority. Culturally competent social workers can engage these issues in several ways. A starting point might be lobbying insurance providers, including providers of Medicare services, for parity in reimbursement for physical and mental health services. Under many insurance plans, reimbursement rates for mental health treatment are not comparable with those for treatment of physical diseases and disorders. Medicare, for example, elicits a copayment of 50 percent for outpatient mental health services. By comparison, outpatient medical treatments for physical health problems have only a 20 percent copayment (Takeuchi and Kim, 2000). Since socioeconomic resources limit many elders of color from accessing treatment, achieving parity in reimbursement would greatly reduce this barrier, at least for

those elders who have coverage from Medicare or other insurance plans.

The policy implications of cultural competency also include an attentiveness to laws that may further restrict the access of elders of color to treatment and social services. One example is California's Proposition 187. Passed in 1994, the act was intended to make undocumented immigrants of all ages ineligible for state-funded health and mental health services. Though later declared unconstitutional and never fully enforced, this measure decreased service usage for both illegal and legal immigrants who feared they might unintentionally implicate undocumented friends or relatives through their connection with the health care system (Fenton, Catalano, and Hargreaves, 1996). Social welfare policy developed from a perspective of cultural competency must take into account the needs of immigrant as well as native-born elders. Social workers must be aware of legislation, such as Proposition 187, that would render culturally competent policy impossible.

Because extending social policies to cover immigrant elderly persons implies that there will be fewer resources available for native-born elders, policy makers are likely to encounter some opposition. As many will recall, Proposition 187 sparked a contentious national debate. In the bigger picture, however, policy makers may encounter controversy in simply trying to provide resources for elderly people. Elderly people in our society, and particularly elders with mental health problems, are often victims of numerous (and untrue) negative stereotypes. These stereotypes include the notion that old age is a period of inevitable decline, as well as the perception that all elderly people are set in their ways and unable to change (Golden and Sonneborn, 1998). Consequently, some might argue that investment in social services for the elderly is a lost cause and that our society's resources should be directed at children or younger adults.

CONCLUSIONS AND FUTURE NEEDS

As the proportion of the population that is elderly continues to grow, so does the percentage of Americans identifying themselves as belonging to an ethnic or racial minority group (Abramson et al., 2002). It is thus critical, now more than ever before, that social workers respond to the needs of elders of color. Responses should focus on the provision of culturally competent care for the mental health conditions that some elderly adults experience. Depression, anxiety disorders, and dementia are among the most common.

Varied work efforts are needed to achieve culturally competent care. These include developing diagnostic tools that are culturally sensitive and designing programs that integrate an understanding of culture into treatment.

Such programs should also pay particular heed to cultural mores concerning aging and mental health. Programs such as RESPECT, with its innovative utilization of peer advocates to bridge cultural divides, serve as models that other service providers can implement as they work to ensure cultural competency (Yee, 1997). In addition, the creation of culturally competent care requires advocating on a policy level for the allocation of resources to the programs that care for elders in a culturally competent manner. Striving for cultural competence in mental health care for elderly people presents a challenge to society and gives social workers the opportunity to actualize some of the profession's most cherished values, diversity and an emphasis on client strengths. ■

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NOTE

1. The term "cultural minority" will be used throughout this article to refer to Americans who identify themselves as belonging to a racial, ethnic, or religious minority group.

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