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Clinical Intervention With Ethnic Minority Elders

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In addition to the well-documented increase in the number of individuals who will live into old age, our nation faces a second, less noted demographic trend that promises to shape its future—specifically, the disproportionate growth of ethnic minority elders within the older population. By the year 2040, approximately 40% of the population over 65 years will be composed of ethnic minorities (Markides & Mindel, 1987). Across all ethnic minority groups, the growth rate of elders is higher than the average for all ages within each group (U.S. Bureau of the Census, 1993a). This demographic trend ensures that clinicians will treat an increasing number of ethnic minority elders. As the makeup of the elderly population changes, so do the needs change. In anticipation of these changing needs, we propose clinical recommendations regarding the treatment of ethnic minority populations.

Rather than make specific recommendations about the treatment of ethnic minority elders that have the potential to perpetuate inaccurate stereotypes, we present different ways clinicians might regard ethnicity in their work with the

elderly. Specifically, we discuss how differences across ethnic minority groups (e.g., their historical experiences in the United States) may come to influence the experience of old age and what implications these differences may have for clinical work with ethnic minority elders. We also note possible sources of within-group variation (e.g., acculturation, place of residence, role of ethnicity) that have received minimal attention in the existing literature. We focus on various Asian American, African American, Hispanic American, and Native American populations.[1]

Following a brief definition of *ethnicity,* we begin with thumbnail sketches of the demographics and service needs of particular subgroups of ethnic minority elders. As we show, the backgrounds and the issues these subgroups face may be as different from one another as from mainstream European Americans, attesting to the dubiousness of considering minority elders as one group. Next, we overview the cultural, political, and social circumstances that brought these peoples to the United States, factors that continue to influence the current needs and values of different subgroups and that may influence the type of problems individuals present in mental health and medical settings. We end the chapter with a section on the influence that ethnicity may have on the experience of old age as well as aspects of the therapeutic process. Our goal is not to prescribe specific approaches for specific subgroups, which we argue would only perpetuate stereotypic beliefs, but to highlight special problems (and offer possible solutions) that arise in working with older members of ethnic minority groups in the United States.

What Is Ethnicity?

We define *ethnicity* as membership in a subgroup that views itself and is viewed by others as distinct from the majority culture in history, language, religion, physical characteristics, ancestral homeland, or any combination of these (Yinger, 1986). Specific components of ethnicity range from relatively concrete aspects of daily life (e.g., holidays, customs, traditions, religious practices) to more abstract, intangible components, such as social expectations, patterns of emotional response, and identification with minority group status. We stress that individuals within an ethnic group vary in the degree to which they identify with and adhere to the particular norms and values of their group. Clearly, the concrete components are easier to discern than the abstract ones. Both must be considered in clinical work with the elderly.

In this chapter, we focus on ethnic minority elders in the United States—members of ethnic groups that have been traditionally underserved, marginalized, and underrepresented by mainstream U.S. culture. This includes groups that fall under the broader ethnic categories of African American, Asian American, Hispanic American, and Native American.

Today's Ethnic Minority Elders

As we will document, minority elders constitute a vastly heterogeneous group bringing very different life experiences to bear on old age. Perhaps the main similarity across ethnic minority groups is their shared experience of discrimination. Within each group lies tremendous variation. In this section, these differences will become obvious as we briefly introduce each group of ethnic minority elders by covering their basic demographic information and current service needs.

AFRICAN AMERICANS

Of the ethnic minority groups discussed in this chapter, African Americans are the largest, comprising 8% of today's elders (compared with European Americans, who constitute 87% of the elderly). By the year 2050, the percentage of aged African Americans is expected to increase to 10% of the elderly population, whereas the percentage of European Americans will decrease to 67% (U.S. Bureau of the Census, 1993a). Currently, the majority of African American elders are 75 years and older.

There is tremendous heterogeneity within the African American population. One such aspect is geographic residence. Often in the literature, African Americans from the southern regions of the United States are distinguished from those from the Northern regions; more than half of today's African American elders reside in the South (Davis & Fuller, 1991; U.S. Bureau of the Census, 1993a). Another source of individual variation is the degree to which individuals identify with Black culture (Helms, 1990).

Most of the existing literature contrasts African Americans with their European American counterparts. Although this is common practice in the literature regardless of ethnic subgroup, it is especially so for African Americans because, unlike immigrant groups such as Chinese Americans and Mexican Americans, the distinction between African American and mainstream American culture is less clear.

Compared to European American populations, as a group, African American elders are disadvantaged in a number of ways. In general, functional old age occurs at an earlier chronological age for African Americans than for European Americans (e.g., 55 years vs. 65 years of age) because of higher rates of disability and the accumulated effects of low education and financial disadvantages (Jackson, 1988). Although African Americans constitute the poorest of the poor and have relatively low literacy rates and levels of education compared to the majority European American group (Bell, Kasschau, & Zellman, 1976; Jackson, 1988; Richardson, 1990), 65% of African

American elders are not at all or only mildly limited in everyday functioning (Jackson, 1988). African Americans also have earlier onsets of most chronic diseases as well as higher rates of severe impairment compared to their European American counterparts. It is interesting to note that this trend reverses during the later stages of old age. By the age of 80, African American elders have lower mortality and morbidity rates than their European American counterparts. The cause of this crossover effect is unknown, but several hypotheses have been proposed, including (a) selective survival (i.e., African Americans who survive to age 80 may be the strongest of both African American and European American groups), (b) hardships of life in the United States result in the development of coping skills that ease the transition to old age, (c) cultural practices indigenous to the African American community protect elders from external stresses in old age, or (d) a combination of these (Jackson, 1988).

Stereotypes of African Americans in the United States often obscure the strengths of this group. For example, African American elders are stereotyped as suffering from unstable home and family environments, whereas in actuality, older African Americans have more frequent contact with and receive higher levels of social support from family members than their European American counterparts (George, 1988; Taylor, 1988). Compared to their European American counterparts, older African Americans are also more likely to live with their own children and relatives (other than their spouses) (George, 1988). In part, this appears to be due to the considerable exchange of financial and child care support between elders and younger family members (Taylor, 1988). With the increased migration of young African Americans to urban areas, however, this familial source of support may be on the decline, forcing elders to rely on other resources, such as friends and religious organizations (Bell et al., 1976; Faulkner, Heisel, & Simms, 1975; Richardson, 1990; Taylor, 1988).

ASIAN AMERICANS

Currently, Asian American elders account for 7.3% of Asian/Pacific Islanders of all ages and 1.6% of all Americans 65 years of age and older. As mentioned earlier, these percentages are steadily increasing, and it is expected that Asian Americans will constitute 8% of the elderly in 2050 (U.S. Bureau of the Census, 1993a). The ethnic category, "Asian American," refers to any of 20+ different Asian ethnic groups that include Chinese, Filipinos, Japanese, Koreans, and Southeast Asians (Morioka-Douglas & Yeo, 1990). Although these groups share some characteristics and values (e.g., the importance of family), there are significant differences between the groups that may affect

Asian American elders. Most obvious are the different historical backgrounds, reasons for immigrating to the United States, and experiences in the United States (described in the following sections). In addition to differences across various Asian American ethnic groups, numerous differences between individuals exist, including the degree of acculturation—namely, the extent to which individuals have adopted the values, norms, and traditions of a majority culture (Szapocznik et al., 1978).

Although 81% of Asian elders were born outside of the United States, many have spent the majority of their lives in the United States, predominantly in urban cities in California, Hawaii, and New York (Morioka-Douglas & Yeo, 1990; U.S. Bureau of the Census, 1993a; Yeo & Hikayeda, in press). Despite the length of time they have spent in the United States, most Asian American elders are relatively unacculturated to mainstream U.S. ways. They have resided in highly structured ethnic enclaves, such as Chinatowns and Japantowns, in which their customs and traditions have been staunchly maintained (Morioka-Douglas & Yeo, 1990). This explains why the vast majority (75%) of Asian American elders speak only in their native tongue (Morioka-Douglas & Yeo, 1990).[2]

Two commonly held stereotypes regarding Asian Americans are that they are the model minority group and that they "take care of their own" (Kalish & Moriwaki, 1973). The model minority myth depicts Asian Americans as a group of well-educated, upper-middle-class individuals who have succeeded in achieving the American dream. Such stereotypes, however, reflect a minority of the Asian American population that is primarily young. In actuality, the socioeconomic status of the majority of Asian Americans is similar to that of other ethnic minority groups. For example, although Asian Americans have a higher median income than other ethnic minority groups, the prevalence of poverty is comparable to the others. Ethnic enclaves, in which most Asian Americans reside, are really impoverished ethnic ghettos. Also contradicting prevailing stereotypes, a large percentage of Asian American elders are uneducated (Morioka-Douglas & Yeo, 1990). Clearly, the stereotype of affluence does not apply to a large percentage of Asian American elders, many of whom are in dire need of services; however, this stereotype may contribute to the fact that Asian American elders receive lower levels of poverty assistance and welfare than the general population (Lee, 1986; Sakayue, 1992).

Service providers often erroneously attribute relatively low rates of mental health service use among Asian American elders to stereotypic portrayals that Asian elders are cared for by their families. Indeed, allocation of mental health service funds to Asian American elders is low relative to other ethnic minority groups (Lee, 1986; Lum, Cheung, Cho, Tang, & Yau, 1980; Morioka-Douglas & Yeo, 1990; Sakayue, 1992). Some recent research, however, suggests that the low rates of mental health service use are due to the reluctance of Asian

Americans to seek outside help and the cultural insensitivity of the mental health services themselves more than a lack of need (Sue, 1977). Thus, low rates of mental health service use tell us little about the care Asian American elders may need and are receiving. In the worst case, many Asian American elders may be suffering in silence and isolation.

HISPANIC AMERICANS

Approximately 22.4 million Hispanic Americans—persons of Spanish descent from Central America, Latin America, Mexico, Cuba, and Puerto Rico—currently reside in the United States (Leslie, 1992; U.S. Bureau of the Census, 1993a), not including the vast number of undocumented immigrants. Recently, Hispanic Americans have come to compose one of the largest ethnic minority groups residing in the United States (U.S. Bureau of the Census, 1993b).

The elderly currently compose about 7.8% of the Hispanic population; as with other ethnic minority groups, this figure is expected to increase as a result of declining birthrates and increasing life expectancies (Sanchez, 1992; U.S. Bureau of the Census, 1993a). Of the elderly in the United States, 4% are of Hispanic descent. Although there are great similarities across Hispanic ethnic groups in culture and language, there are differences across subgroups (Maldondo, 1975; Sanchez, 1992). For example, whereas most Mexican Americans came to the United States desiring improved economic status, the majority of Cuban Americans immigrated for political and religious freedom (Boswell & Curtis, 1983). Hispanic ethnic groups also differ in their service needs. For example, the Puerto Rican elderly may have lower health status and income than the Cuban elderly, placing them in greater need for social and health services. Thus, it is not surprising that for the Puerto Rican elderly, the need for services is the greatest predictor of service use, whereas for Cuban elderly, knowledge of services is the greatest predictor of use (Starrett, Todd, & DeLeon, 1989). Within each Hispanic ethnic group, individual differences in levels of acculturation to U.S. culture and language proficiency exist. In most cases, the two are strongly correlated; those who speak Spanish primarily are often the least acculturated to U.S. culture (Marin, Sabogal, Marin, Oter-Sabogal, & Perez-Stable, 1987). Despite these differences across Hispanic subgroups, much of the literature has either not distinguished between groups or has focused primarily on Mexican American elders.

Among the minority elderly, the Hispanic population has the second highest illiteracy rate and receives twice as high a proportion of income below the poverty line than do European Americans (Sanchez, 1992). In addition, many Hispanic elders do not have any form of health insurance, rendering many health care services inaccessible (Sanchez, 1992).

As with Asian American elders, stereotypes about Hispanic culture persist regarding the family's role in caring for the elderly. Although the family plays an important role in caregiving, it is becoming increasingly more difficult for younger relatives to care for older members. As a result, many Hispanic elders are in greater need for formal, outside services (Mahard, 1989).

NATIVE AMERICANS

We know remarkably little about Native Americans as a group and even less about Native American elders in particular (Bell et al., 1976; Cuellar, 1988; Gelfand & Baressi, 1987). This may be because, given their previous experiences with the U.S. government, Native American tribes are extremely suspicious of outsiders, making it considerably difficult for non-Native Americans to conduct research on Native American populations (Gelfand & Baressi, 1987). As a result, much of the research on Native American elders is described in unpublished reports or presented at Native American community centers (American Association of Retired Persons, no date).

Currently, approximately 1.9+ million individuals are Native American (U.S. Bureau of the Census, 1993a). No doubt, however, this figure is a gross underestimate because it excludes the large number of Native Americans who have less than 25% Native American ancestry and who are not officially recognized as Native Americans by the U.S. government (Bell et al., 1976).[3] Approximately 9% of the Native American population is composed of individuals 60 years of age or older, and Native Americans compose approximately 3% of the elderly (U.S. Bureau of the Census, 1993a).

As with the other groups, Native Americans are a heterogeneous group comprising 500+ separate tribes, including the Navajo, Cherokee, Sioux, Chippewa, Laguna Pueblo, and Hopi (Bell et al., 1976; McCabe & Cuellar, 1994). Another source of distinction is place of residence. Thirty-five percent of Native Americans live on reservations and other areas allocated for Native Americans, whereas others live in urban areas, primarily in California (U.S. Bureau of the Census, 1993b). Although there appears to be a constant flux of Native Americans who move from reservations to urban areas, at some time during the course of their lives, approximately 40% of Native Americans return to the reservations (Sue & Sue, 1990). The extent of urban migration varies by tribe. Urban and reservation-dwelling Native American elders differ along multiple dimensions, including financial status, nature and degree of social contact, proximity to friends, life satisfaction, subjective health status, and patterns of assistance (John, 1985).

Most Native Americans live in impoverished conditions. Housing is poor and rates of infectious diseases are high (Bell et al., 1976). Moreover, in education and health, Native Americans rank far below other minority populations (Bell et al., 1976). For example, according to Mick (1983), Indian communities may be as much as 10 to 15 years behind the general population with respect to the availability of nursing homes.[4] In terms of economic, social, and health status, reservation-dwelling Native Americans over 45 years of age and urban-dwelling Native Americans over 55 years of age are comparable to members of the general population over 65 years of age (National Indian Council on Aging, 1981). For members of the Navajo tribe, however, there is a crossover effect; before age 65, Navajos have higher mortality rates than non-Native American populations; after age 65, they have lower mortality rates, particularly among women (Kunitz & Levy, 1989).

Stereotypes regarding Native Americans surround their need for services. With the existence of the Bureau of Indian Affairs, many health care providers assume that Native American physical and mental health care is completely provided for. However, there are many urban Native Americans who reside in communities that lack the services they need and who are not eligible for services because they do not reside on the reservation (Bell et al., 1976).

Historical Sketches

Clinicians need to have contexts in which to place their ethnic minority clients. Becoming informed about the historical experiences of ethnic minority elders is one step in this direction. These historical experiences have important clinical implications. For example, they may influence how these elders interpret their surrounding environments; they may be related to daily life stresses; and they may be the source of discomfort with and suspicion of mental health services. In fact, these historical experiences have been used to explain ethnic differences and similarities in other aspects of mental health, including life expectancies and prevalence rates of mental illness.

One systematic difference across ethnic minority groups concerns the historical circumstances under which individuals came to the United States. In addition, individuals' experiences in the United States differ. Being familiar with an ethnic minority elder's historical background may be important when assessing that elder's mental status, identifying the source(s) of symptomatology, understanding the elder's concerns, and providing a context for treatment (Yeo & Hikoyeda, 1992). Toward this aim, we present historical sketches of the four ethnic minority groups described earlier and certain subgroups within them. Although these are obviously not comprehensive accounts, we intend to illustrate how life circumstances have been different for these groups and may influence physical and mental health.

AFRICAN AMERICANS

The majority of today's African American elders are descendants of people who were brought involuntarily to the United States as slaves. African American history is marked by efforts to be recognized fully as Americans by their European American counterparts and to reclaim their ethnic heritage.

African Americans were and continue to be victims of intense discrimination. At the same time, African American culture is distinguished by impressive strength and resolve. In Giovanni's (1994) words,

> Throughout these centuries, Black Americans have been breaking open doors that others would close, opening lands that others stumbled through, finding emotional strength to carry on when a lesser people would have capitulated. Emmett Till found the strength to put his socks on before he was carried out to be brutally murdered; his mother found the strength to open his casket. Rosa Parks found the strength to stay seated; Martin Luther King found the words to define a movement. (p. 92)

Today's African American elders were born in the early 1900s and raised during a time when both African American achievements and discrimination were on the rise. At the same time that Booker T. Washington started the Tuskagee Institute for African American students, "Jim Crow laws," the "separate but equal" doctrine, and massive racial violence continued. In the early 1900s, the Ku Klux Klan brutally violated African Americans by lynching them and burning their homes and schools. In response to this violence, the National Association for the Advancement of Colored People was established in 1909 by a group of African Americans and European Americans. One of the founders was sociologist Dr. W.E.B. DuBois, the first African American individual to graduate from Harvard University (Yeo & Hikoyeda, 1992).

From 1910 to 1920, there were large migrations of African Americans from the rural South to the urban North. When World War I broke out, many African Americans joined the military to fight for the United States overseas and accumulated various military honors and accolades. When they returned to the United States, however, many were attacked and beaten by errant European American mobs (Yeo & Hikoyeda, 1992). By the 1920s, Ku Klux Klan membership rose to 5 million and demonstrated its strength in 1925 when 400,000 members marched through Washington, D.C. At this time, Marcus Garvey encouraged African Americans to return to Africa, where they "would have freedom and receive just treatment" (Yeo & Hikoyeda, 1992, p. 20). Although few African Americans actually moved to Africa, Garvey's message instilled a greater sense of racial-cultural pride, which promoted the exploration of their cultural roots. During the Harlem Renaissance, African Americans were formally recognized for their outstanding achievements in the arts, music, and sports (Yeo & Hikoyeda, 1992).

During the Great Depression of the 1930s, African Americans were harder hit than their European American counterparts. In response to these difficult times, African Americans increased their political influence by organizing labor unions, which led to legislation that racially integrated labor. African American figures such as Robert C. Weaver and Mary McLeod Bethune served as advisers to Presidents Roosevelt and Truman. In 1941, Executive Order 8802 outlawed racial discrimination in all national defense contract plants (Yeo & Hikoyeda, 1992). During World War II, African Americans demonstrated their valor once again and received numerous honors and distinctions for their military performance. Despite these advances, however, the armed forces did not become truly integrated until 1948.

In the 1950s, the Civil Rights Movement took a series of steps toward racial integration. The Supreme Court ruling that racially segregated schools were not equal, Rosa Parks's refusal to sit in a segregated section of a public bus, and the subsequent bus boycott led to the passage of legislation prohibiting segregation in schools and public transportation. As a result of the efforts of numerous civil rights leaders, including Dr. Martin Luther King, Jr., the Civil Rights Movement culminated with the passage of the Civil Rights Act in 1965, which completely integrated public facilities and schools. Although racial-ethnic prejudice and discrimination continue today, the Civil Rights Movement, spearheaded by many African American groups, has had significant consequences for the promotion of rights of all ethnic minority groups in the United States, including the relaxation of immigration restrictions (Yeo & Hikoyeda, 1992). These historical successes continue into current times as African American contributions pervade all aspects of American life.

Clearly, today's African American elders have lived through a time of tumultuous change. Many are now confronted with an additional set of concerns. A large-scale drug epidemic has hit younger generations of African Americans and subsequently, numerous elders have assumed primary caretaking responsibilities for young grandchildren and great grandchildren (Burton, 1992). Increases in rates of teenage pregnancies, out-of-wedlock births, and the premature deaths of adult children, often due to homicide and drugs, present further challenges to this group of older Americans.

ASIAN AMERICANS

Chinese Americans

From 1854 to the 1870s, approximately 12,000 to 15,000 Chinese entered the United States each year. Most of these sojourners were men who intended to return to China with the riches they had accumulated in the United States.

They settled on the West Coast and began their lives in the United States as indentured servants, or *coolies,* contracted to work in the gold mines or on railroads. By the year 1870, 100,000 Chinese immigrants had arrived (Bell et al., 1976). Because they intended to stay in the United States only temporarily, they resided in ethnic enclaves and made few efforts to adopt American ways. These enclaves protected Chinese laborers from the racism and discrimination that they received from European Americans. With the onset of the Sino-Japanese war in 1894, however, their plans to return to China were thwarted, and these Chinese were essentially stranded in the United States (Bell et al., 1976).

Chinese sojourners were further isolated from their relatives and mother country by a series of discriminatory acts that severely curtailed immigration. In 1882, the Chinese Exclusion Act excluded laborers from coming to the United States for work. Only sons of naturalized citizens were allowed to immigrate to the United States (Yeo & Hikoyeda, 1992). Because few Chinese males were actually granted citizenship, this legislation only reinforced already severe quotas. In 1906, however, an earthquake destroyed a substantial set of immigration records, allowing many Chinese to bring their "paper sons," or relatives into the United States via false documentation. A few families also entered the United States under immigration laws that allowed merchants and their families to immigrate. Many of these people, however, were detained for weeks on Angel Island, until two "credible" non-Chinese witnesses testified that they were legitimate merchants and not laborers. These families typically ran Chinese restaurants, laundromats, grocery stores, and other businesses that did not conflict with the interests of local European Americans. When witnesses did not arrive, families were sent back to China. In 1924, another exclusion act entirely outlawed the immigration of Chinese single women, wives, and families.

A bachelor society of Chinese laborers emerged and developed *tongs,* or family associations, which functioned primarily to support and protect Chinese laborers. Tongs also ran gambling, prostitution, and drug rings in Chinatown communities. Other sources of support included *fongs* and *clans,* which played important roles in maintaining Chinese traditions and values (Takaki, 1989).

Around World War II, the United States began to open its doors to the Chinese. In 1943, all exclusion acts were repealed; by 1946, although quotas remained rigid, wives were allowed to immigrate. In 1965, the immigration act that accompanied the passage of the Civil Rights Act substantially relaxed quotas. At this time, the majority of Chinese immigrants were either relatives of earlier Chinese immigrants or Chinese with professional and entrepreneurial skills.

Today's Chinese American elders compose 30% of the Asian American elderly (U.S. Bureau of the Census, 1993a) and are a diverse group of

individuals with different levels of acculturation to mainstream U.S. culture. For example, the Chinese bachelors are considered "geriatric orphans" (Kalish & Moriwaki, 1973), who have spent the majority of their lives in the United States, speak little English, have few financial or educational resources, live in crowded one-room apartments, and lead relatively isolated lives. Other Chinese elders have only recently arrived in the United States to join their children; 35% have immigrated since 1970 (Yeo & Hikayeda, in press). They also speak little English and are unaccustomed to American ways (Yeo & Hikayeda, 1992). Still others are well-educated and highly acculturated, corresponding closely to the stereotypic view of Chinese Americans as a model minority group.

Filipino Americans

Today's Filipino elders share some experiences with Chinese American elders and differ in others. There have been three main waves of Filipino immigration to the United States. The first occurred shortly after the Philippines became a U.S. protectorate in 1898. Approximately 2,700 Filipinos, called *pensionados,* received pensions to study in the United States. Most pensionados did not complete their degrees but settled permanently in the United States.

The second wave, *pinoys,* came to the United States to work on sugar plantations in Hawaii and in mines and farms in Washington and California. In 1934, the Tydings-McDuffie Act limited immigration to 50 Filipino immigrants per year. Immigration steadily dwindled until 1946, when the Philippines became an independent nation. Filipinos were then permitted to apply for citizenship, which allowed family members to join relatives already residing in the United States. As with Chinese Americans, immigration quotas were relaxed a little more in 1965. This gave way to the third wave of immigration, which has been composed primarily of female professionals and health care providers (Yeo & Hikoyeda, 1992).

Unlike other Asian American groups, Filipino Americans were considered *Malays* rather than *Mongolians*—they were thought to be of different racial ancestry than other Asian Americans. This afforded them rights that other Asian groups did not have. For example, except in California, although they were still targets of much racism and discrimination, Filipino Americans were legally allowed to intermarry with other ethnic groups, including European Americans. In addition, they were allowed to serve in the American military forces (Fong, 1992). As a result, compared to other Asian groups, Filipino Americans, on the average, are more acculturated to American culture.

Filipino Americans compose 24% of the Asian American elderly (U.S. Bureau of the Census, 1993a). As with Chinese American elders, some

Filipino American elders are bachelors who lead relatively isolated lives in the United States; others have only recently immigrated to the United States to join their children. The majority of today's Filipino American elders, however, are quite unlike their Chinese American counterparts. They tend to speak English, and many are war veterans and have extensive family networks in the United States (Yeo & Hikoyeda, 1992).

Japanese Americans

Like the Chinese sojourners, the first wave of Japanese immigrants (called *Issei*) were men in search of wealth who intended to return to Japan after amassing financial riches. In many ways, however, the experiences of the Japanese were different from those of the Chinese. First, these men were primarily second sons who were forced by the Japanese primogeniture system to establish their own sources of income. Second, because these Japanese immigrants arrived after the Chinese, they anticipated potential ethnic conflicts. The Japanese government was fully aware of the discrimination waged against the Chinese sojourners by Americans. Attributing it to the "ignominious conduct and behavior" and "inferior character" of the Chinese, the Japanese believed that if they "behaved" and assimilated to U.S. culture, they would be welcomed by U.S. citizens and escape the discrimination suffered by their Chinese predecessors. As a result, Japanese immigrants were carefully selected, closely monitored, and held responsible for "maintaining Japan's honor" by the Japanese government (Takaki, 1989). Third, the Japanese immediately sent women and families to the United States; as a result, the Japanese immigrants were able to establish families and communities in addition to institutions that regulated business and maintained religious and cultural traditions (Bell et al., 1976; Fong, 1992; Takaki, 1989). By 1900, 90,000+ Japanese had settled in Hawaii and the United States mainland.

It is not surprising that the efforts of the Japanese to evade U.S. discrimination were futile. Part of the discrimination waged against Japanese Americans was in response to their agricultural success. Most of the Japanese immigrants were skilled farmers in Japan and pursued this work in the United States. Their success quickly surpassed that of their European American competitors. In retaliation, U.S. farmers lobbied for legislation that limited Japanese American agricultural success by denying them citizenship and land-ownership rights. To circumvent this discriminatory legislation, Japanese Americans purchased land in the names of their children who were American citizens by birth (Bell et al., 1976; Takaki, 1989).

In addition to severe discriminatory agricultural legislation, strict quotas were placed on Japanese American immigrants. In 1907, under the Gentlemen's Agreement, the immigration of Japanese was severely curtailed; in 1924, the Immigration Exclusion Act completely restricted immigration of the Japanese along with other Asian groups. The curtailment of immigration, however, had a different effect on the Japanese than it did on the Chinese. Because a relatively high percentage of Japanese immigrants already living in the United States were women and families, the quotas did not preclude the emergence of a substantial second generation of Japanese Americans (called *Nisei*, or second generation).

As American citizens, the Nisei grew up less isolated than their predecessors and Chinese American counterparts. As a result, they readily adopted American ways as their own. Ironically, they were the victims of the worst discrimination waged against Japanese Americans. In 1942, Executive Order 9066 interned 120,000 Japanese (66% of whom were American citizens) because of their potential threat to the welfare of the United States during World War II (Yabusaki, 1993). The internment not only stripped Japanese Americans of their possessions (including their land) but also tore apart families. After the war, many Japanese Americans attempted to reconstruct their lives, but few were able to achieve their preinternment economic success, and many lost contact with family members entirely. In 1989, Congress appropriated $20,000 to each internment survivor to compensate for these gross injustices. Little attention has been paid to the psychological effect of the internment on today's Japanese elders (Yabusaki, 1993).

Given the maltreatment of Japanese Americans by the federal government, it is not surprising that the immigration act in 1965 did not result in a large influx of Japanese to the United States. Currently, Japanese Americans compose 24% of the Asian American elderly. Most of today's Japanese American elders are U.S. natives or have spent the majority of their lives in the United States and, compared to other Asian Americans, are highly acculturated to mainstream American culture (Fong, 1992; Kalish & Moriwaki, 1973).

Korean Americans

In the early 1900s, the first Koreans immigrated to the United States from Japan. They accompanied Japanese laborers to the sugar cane plantations of Hawaii and were sometimes misidentified as Japanese immigrants (Fong, 1992). Because many of the opportunities in Hawaii were less "golden" than expected, many moved to the mainland (Takaki, 1989). Other Koreans, predominantly political exiles and students, immigrated directly to the U.S. mainland from Korea.

Like the Chinese and Japanese, Korean Americans experienced severe discrimination, and soon, a bachelor society of men emerged (Takaki, 1989). The Korean American experience, however, was distinct from those of Chinese

and Japanese groups in several ways. First, Koreans in the United States were a relatively unknown group. Because Korea was formally annexed by Japan in 1910, Korean Americans were represented by the Japanese Council. As a result, few Americans were aware that Korea was a separate nation with its own set of norms and traditions, and instead, misidentified Koreans as Japanese. Second, the small number of Korean Americans in the United States made it virtually impossible to develop ethnic neighborhoods or supportive community networks comparable to the Chinatowns and Japantowns. The majority of Korean immigrants, however, were Christians, and churches became the centers of political resistance movements to extricate their homeland from Japanese domination (Fong, 1992).

Eight percent of Asian American elders are Korean (U.S. Bureau of the Census, 1993a). Many Korean American elders, in order to return to their homeland, actively participated in the movement to liberate their country. These Korean elders are only beginning to reconcile the fact that they will probably never return to Korea. In addition, many Korean American elders have only recently immigrated to the United States to join their children, who immigrated to the United States several years prior (G. Yeo, personal communication, January 11, 1995). Currently, the Korean American population is growing, and the number of Korean American ethnic enclaves is increasing. Korean Americans have recently also become the most visible targets of ethnic conflict, particularly since the Los Angeles Rodney King riots, during which the conflict between Korean Americans and African Americans erupted in brutal violence.

Southeast Asian Americans

The most recent Asians to arrive in the United States are refugees from the Southeast Asian countries of Vietnam, Cambodia, and Laos. Before 1975, Southeast Asian immigrants in the United States were well-educated, young urban students or married couples. Since 1975, one million Southeast Asians have arrived in the United States. The majority are refugees who have only narrowly escaped political and social persecution and turmoil (Ying, 1993). Although most Southeast Asian Americans are young (i.e., between the ages of 20 to 30 years), a substantial proportion of Southeast Asian elders in the United States have experienced similar trauma.

After the Vietnam war and subsequent Communist takeover, the first waves of South Vietnamese came to the United States in 1968. These Vietnamese were relatively well-off and often had connections with U.S. military personnel or government officials. In 1975, however, after the fall of Saigon, hordes of "boat people" fled to the United States, as well as other countries. The flight of these less fortunate Vietnamese was more chaotic. For example, the small, overcrowded fishing boats often left Vietnam without the food or equipment necessary to provide for its passengers, and disease and pestilence were rampant. Boats fled Vietnam with no clear final destination and were often ransacked by pirates or sunk. Families were often separated; women and children were regularly raped and beaten (Gordon, 1980).

From 1978 to the mid-1980s, the majority of refugees were Cambodian. When the Communist Khmer Rouge gained control of the government, most of these refugees fled to miserable, pestilence-ridden camps in Thailand before arriving in the United States (Sughandabhirom, 1986). Most Cambodian refugees have lost at least one family member, either in Cambodia or en route to the United States. Thus, it is no surprise that of Southeast Asian refugee groups, the Cambodians are the most traumatized.

Laotians are the most recent arrivals to the United States from Southeast Asia. Within Laotians, there are ethnic groups that differ both historically and culturally (Luangpraset, 1989). Half of Laotians are the ethnic Lao who lived in relatively large villages in the lowlands of Laos. Two hillside tribal groups, the Hmong and Mien, compose the other half. Although two separate tribes, the Hmong and Mien are culturally similar. They were both self-sufficient, relatively small groups that existed through slash-and-burn farming in the mountain regions of Laos. During the Vietnam War, the Hmong were employed by the CIA to fight against the Communist Lathet Lao. When the Communists took over Laos, about 100,000 Hmong fled for their lives to refugee camps in Thailand and ultimately settled in the United States (McInnis, 1991).

Among the Asian elderly, 4% are Vietnamese, 0.8% are Cambodian, 0.8% are Laotian, and 0.6% are Hmong (Yeo & Hikayeda, in press). Despite the different histories behind the journeys of Vietnamese, Cambodians, and Laotians to the United States, in general, Southeast Asians are a population of refugees who are under intense emotional, psychological, and physical strain. Among what appears an endless list of sources of stress, the majority of Southeast Asian Americans have lost family members, friends, possessions, and their homelands; are socially isolated in an alien culture; experienced severe migratory stress; and must adjust to drastic changes in social and economic status. Not surprisingly, the majority of refugees suffer from both posttraumatic stress and depressive disorders (Mollica & Lavelle, 1988) as well as chronic adjustment or acculturation disorders (Cerhan, 1990). In addition, Southeast Asian elders must also accept tremendous losses in status and the shattering of their expectations for a peaceful old age. Many recent immigrants from Southeast Asia are elders who have followed their children to the United States (G. Yeo, personal communication, January 11, 1995).

In addition to the Asian American subgroups that we have discussed, there are others that deserve attention but who have received minimal attention in

the literature (Yeo & Hikoyeda, in press). They include Asian Indians, who compose 5% of the Asian American elderly, and Pacific Islander groups, who compose 3.2% of the Asian elderly (U.S. Bureau of the Census, 1993a; Yeo & Hikayeda, in press).

HISPANIC AMERICANS

Central Americans

As we have mentioned, most literature on Hispanic American elders focus on Mexican American populations. Central Americans compose a much smaller percentage of the Hispanic elderly (G. Yeo, personal communication, January 11, 1995). As a result, Central Americans are often overlooked, despite the fact that Mexican Americans and Central Americans differ in ways that may influence physical and mental health.

Unlike most Mexican Americans, who came to the United States primarily for economic reasons, most Central Americans fled their homelands to escape religious and political persecution. The U.S. government does not recognize this difference, and instead, places Central Americans in the same immigration category as Mexican Americans. As a result, despite the severe trauma they experienced before they arrived and the tenuousness of life in the United States, Central Americans are not eligible for services provided to refugees (Leslie & Leitch, 1989).

Because the government classifies Central Americans with Mexican Americans, little is known about Central Americans in the United States in general, and Central American elders in particular. It is estimated that 3% of Central Americans in the United States are over the age of 65; however, the percentage of elders in each of the specific Central American groups (e.g., Salvadorans, Hondurans) is unknown.

Although there are no exact figures of the number of immigrants or refugees from particular Central American countries (Carrillo, 1990), it is estimated that Salvadorans alone constitute a significant percentage of the population. Approximately one half million Salvadorans entered the United States in the 1980s (Leslie, 1992). The majority of Salvadorans left their homeland to escape the intense human rights violations of the Salvadoran military (Lopez, Bocellari, & Hall, 1988). Psychologically, the war had profound effects on Salvadorans, creating feelings of vulnerability, exacerbated alertness, loss of control, and an altered sense of reality (Lira, as cited in Martin-Buro, 1989). This is perhaps just a hint of the types of issues that may concern Central American elders.

Cuban Americans

As with most of the ethnic minority groups discussed in this chapter, an integral part of Cuban American history revolves around the migratory experiences of Cubans to the United States. Immigration from Cuba began between 1959 and 1962, when Fidel Castro overthrew the Batista government and dramatically changed Cuba's social, political, and economic systems. The "Golden Exiles"—215,000 Cubans, most of whom were members of the upper-middle-class—fled to escape political imprisonment, harassment, and persecution. More than half of the immigrants were women and children sent by their husbands and fathers for safety and protection. Although most of the immigrants were members of the upper-middle-class, a substantial proportion were also members of the working class. Many settled in New York and Florida and were forced to take unskilled jobs; however, many of these immigrants were able to improve their socioeconomic situation rapidly. For the most part, U.S. citizens were sympathetic to the plight of these Cuban exiles and therefore, they were well-received (Boswell & Curtis, 1983).

Castro's affiliation with the Soviet Union and the identification of Cuba as a socialist state led to the break of diplomatic relations with the United States in 1961. That same year, the unsuccessful Bay of Pigs invasion and the Cuban Missile Crisis heightened tensions between the United States and Cuba (Boswell & Curtis, 1983).

Between 1962 and 1965, despite Castro's formal cessation of immigration to the United States, 56,000 Cubans arrived, either directly or via another country. Between 1966 and 1972, Castro allowed immigration to the United States once again; during this time, 297,318 Cubans left on "Freedom Flights"—airlifts between Miami and Havana. The majority of these immigrants were the elderly or individuals who already had family in the United States. Restrictions were placed on young males of military age as well as skilled workers, making it difficult for them to leave Cuba (Boswell & Curtis, 1983).

From 1973 to 1980, there was a temporary hiatus in immigration to the United States; despite this, 38,000 people immigrated at this time, most of whom were imprisoned criminals. In 1980, Castro opened the immigration doors once more, allowing only Cuban "undesirables," such as prisoners and the disabled, to leave. Of the 124,779 Cubans who left at this time, 26,000 had prison records. Because crime rates increased significantly in Dade County, Florida, where many of these immigrants settled, for the first time, Cuban immigrants were viewed negatively, and there was a strong tension between "old" and "new" Cubans. Since 1980, there has been a steady decline of Cuban emigration (Boswell & Curtis, 1983).

Among elders, Cuban Americans are the second largest Hispanic subgroup, composing 15% of the Hispanic elderly (U.S. Bureau of the Census, 1993a).

Many Cuban elders are babysitters of their grandchildren. Because many Cuban elders are keepers of Cuban traditions and customs, they are often the ones who pass Cuban culture onto the younger generations. This often creates intergenerational conflict and stress between younger Cuban Americans who are assimilating rapidly to mainstream American culture and Cuban elders who are not (Boswell & Curtis, 1983).

Mexican Americans

Much of Mexican American history revolves around labor relations between Mexican immigrants and the U.S. government. In the mid-1800s, the United States annexed most of northern Mexico; as a result, movement across the Mexican-U.S. border (into California, Arizona, and Texas) was relatively informal and relaxed until the early 1900s. Like the Chinese, most Mexicans came to the United States in search of economic gains. Mexicans also faced widespread discrimination in employment, housing, and education. The Texas Rangers committed atrocities against Mexicans that were comparable to those of the Ku Klux Klan (Yeo & Hikoyeda, 1992).

In 1910, many Mexicans, mainly from the upper and middle classes, immigrated to the United States to escape the Mexican Revolution, uncertain whether they would ever return to Mexico. Another wave of immigration occurred between 1920 and 1928, when quotas preventing the entrance of Chinese and Japanese laborers allowed thousands of Mexicans to enter the United States to fill agricultural labor and domestic service needs. However, the number of Mexicans who immigrated far outweighed the existing quotas, and border patrols were established to curb illegal Mexican immigration. In the 1930s, many Mexicans were hit hard by the Great Depression. U.S.-born Mexican Americans were either forced to repatriate or became migrant workers living under substandard conditions. Because many Mexican Americans were uprooted during this time, few were able to attend school regularly; as a result, most elder Mexican Americans are illiterate (Yeo & Hikoyeda, 1992).

During World War II, again due to a labor shortage, Mexicans were allowed to enter the United States as *braceros*, or temporary workers. In addition, many Mexican Americans valiantly fought for the United States in World War II. Despite these contributions to the war effort, Mexican Americans continued to be victims of harsh discrimination. In response, the G.I. Forum was formed, which became the foundation for the Mexican American civil rights movement (Yeo & Hikoyeda, 1992).

In the 1970s, wives and families of Mexican domestic workers were allowed to immigrate to the United States again to meet the increasing need for female domestic workers. Due to declines in agricultural work, many

Mexican Americans moved to cities in the midwestern, eastern, and northwestern United States. At the same time, Mexican Americans became more politically active, creating organizations such as the Mexican American Political Association and the United Farm Workers, which fought for social, economic, and educational reforms (Yeo & Hikoyeda, 1992).

Mexican Americans comprise 49% of the Hispanic elderly (U.S. Bureau of the Census, 1993a). Many of today's Mexican American elderly came to the United States as braceros but settled permanently in the United States. Others have only recently immigrated to join their children (G. Yeo, personal communication, January 11, 1995). Twenty percent to 30% live in poverty (G. Yeo, personal communication, January 11, 1995), and over 60% have low levels of education and literacy. Despite advancements made in Mexican American civil rights in the past 20 years, many Mexican American elders, especially the oldest-old, do not consider themselves Americans.

Puerto Ricans

Puerto Rico was freed from Spanish control and became a U.S. possession in the Treaty of Paris after the Spanish-American War. Until 1900, a U.S. military government ruled Puerto Rico and initiated many civil works projects that improved sanitation, established an education system, and built highways. In 1900, the Foraker Act replaced the military government with a two-house civil government, of which Puerto Ricans were allowed to elect the lower house. Due largely to the efforts of Luis Munoz Rivera, the Jones Act in 1917 granted Puerto Ricans U.S. citizenship, and Puerto Rico became a U.S. territory. Many mainland-U.S. businesses built factories and developed farmland; however, few Puerto Ricans reaped rewards from U.S. investments. In 1930, devastating hurricanes and the Great Depression virtually wiped out Puerto Rico's economy, and it soon became the "Poorhouse of the Caribbean" (Larsen, 1973).

The economy improved immensely in 1933, with the establishment of the Puerto Rico Emergency Relief Administration and the Puerto Rico Reconstruction Administration, which provided clothing, food, and training programs for Puerto Ricans and reestablished failed industries. In 1948, Puerto Ricans were allowed to elect their own governor. They chose Muñoz Marin, the son of Luis Muñoz Rivera, who was committed to improving the economy under Operation Bootstrap, a program whose goals included industrialization, improved health and education, slum clearance, agricultural expansion, and land redistribution. With World War II, Operation Bootstrap experienced severe setbacks. During this time, many Puerto Ricans moved to the U.S. mainland in search of jobs. By 1955, 675,000 Puerto Ricans lived in the United States, and 500,000 of them were in New York City. In 1950, Public

Law 600 gave Puerto Rico the right to draft its own constitution, and in 1965, federal acts that prevented non-English-speaking citizens from voting were repealed, allowing Puerto Ricans to vote. In 1967, Puerto Rico voted on the future of its political status; 60% voted to continue its status as a commonwealth of the United States. At this time, Operation Bootstrap was successful, creating less of a need for employment on the U.S. mainland; as a result, many returned to Puerto Rico (Larsen, 1973).

Of the Puerto Ricans who remained on the U.S. mainland, most had limited knowledge of English, had low-income jobs, and lived in the inner-city slums of Spanish Harlem—"El Barrio." Women usually had an easier time finding work than their husbands, which often created marital conflict; this breaking of traditional gender norms often led to high rates of divorce (Larsen, 1973) and may explain why many of today's Puerto Rican elderly women are divorced or separated (Mahard, 1989). Intergenerational conflict due to different rates of acculturation between parents and children was also common. Because many parents did not understand their Americanized children, gangs of Puerto Rican adolescents emerged (Larsen, 1973). Today's second generation Puerto Ricans are considerably better off than their predecessors.

Currently, Puerto Rican elders residing on the U.S. mainland comprise 12% of the elderly Hispanic population (U.S. Bureau of the Census, 1993a). Physical disabilities, homesickness, and acculturation stress due to language difficulties are common problems among the elderly. Even though the majority of the elderly were born in Puerto Rico and immigrated after World War II, most are relatively unacculturated and speak only Spanish. Many rely on their children, primarily adult daughters, to be their translators and primary sources of emotional support (Sanchez-Ayendez, 1989). Many Puerto Rican elders also consider themselves Puerto Ricans rather than Americans and often express wishes to return to Puerto Rico, although few have actual plans to do so (Mahard, 1989).

NATIVE AMERICANS

Most of the conflicts between Native Americans and European American have revolved around land struggles. When European settlers first arrived in America, they viewed Native American uses of the land as "inefficient and incapable," (Olson & Wilson, 1984, p. 21) and therefore, felt justified in taking land from the Native Americans. Year after year, the U.S. government moved Native Americans to less and less valuable land (Olson & Wilson, 1984). The tribes were promised permanent control over these lands, but this promise was continually revoked.

Throughout the 19th century, Native Americans continued to be at the political mercy of European Americans. Two political attitudes about Native

Americans prevailed at the time. On the one hand, there were assimilationist political groups who espoused the "protection" of Native Americans from their own "savage" culture by transforming them into "law abiding farmers who believed in property and Jesus Christ" (Olson & Wilson, 1984, p. 23). On the other hand, there were "Indian haters," who saw Native Americans as "blood thirsty savages" (Olson & Wilson, 1984, p. 23) that needed to be expelled from society. Ultimately, both groups advocated the eventual decimation of Native American culture.

By the late 19th and early 20th centuries, the assimilationist camp prevailed and enacted a series of programs aimed to "civilize" Native Americans. For example, the Dawes Act of 1887, the Curtis Act of 1898, the Dead Indian Land Act of 1902, and the Burke Act of 1906 took a total of over 90 million acres of land from Native Americans and then attempted to turn Native Americans into family farmers. Consistent with other policies, most Native Americans lost their land and received nothing in return.

During World War I, thousands of Native Americans fought for the United States. In 1924, Native Americans were granted citizenship. However, this did little to address economic problems or acknowledge Native American culture. In 1934, the Indian Reorganization Act attempted to restore tribal authority, but in actuality, it only replaced direct with indirect supervision of Native American affairs by the federal government. After World War II, the U.S. government renewed efforts to assimilate Native Americans into the rest of American society by implementing urban relocation and training programs. Similarly, civil rights activists tried to rally for Native American integration into mainstream American society. Both movements only contributed to existing Native American resentment that these activists assumed that they wished to relinquish their culture. The relationship between Native Americans and non-Native Americans continues to be fragile, "marked by mutual suspicion and enormous cultural differences" (Olson & Wilson, 1984, p. 25).

Little is known about the status of Native American elders. One current concern is the mass exodus of young Native Americans to urban areas. Many of the older Native Americans are left on reservations with poor services and care (Murdock & Schwartz, 1978), lack of housing, and high crime rates (Twiss et al., 1989). Those who follow their younger relatives to the cities often have difficulty adjusting to urban life (Bell et al., 1976).

The Influence of Ethnicity on Old Age

To provide a general context within which to view individuals who seek treatment, we have considered the backgrounds and cultures of various ethnic minority elders and the circumstances under which they immigrated (or were

forcibly brought) to the United States. Next we consider how ethnicity may influence the presentation of problems and the therapeutic process. Wherever possible, we suggest ways that professionals might enhance their work with ethnic minority elders. Because we know of no systematic studies comparing different styles and approaches, our suggestions are derived largely from clinical experience or inferred from empirical findings in the literature. We cannot emphasize enough the need for more empirical work.

ATTITUDES TOWARD AGING AND ETHNIC IDENTITY

Aging is viewed differently by the various groups we review in this chapter. Indeed, the timing of old age varies by subgroup (Freed, 1992). The Hmong consider old age to start at 40 years old (Hayes, 1987). Mexican Americans and African Americans consider old age to begin at 59 years and 63 years, respectively, compared to the 70 year average at which European Americans demarcate entry into old age (Bengtson, 1979). European Americans have traditionally related old age with retirement, due to its association with eligibility for social security and pension income. For many ethnic minority elders, this association is less meaningful. Many are not eligible for retirement income because of lifetime employment in low-paying occupations without benefits and, thus, must continue to work. Instead of retirement, these subgroups associate old age with other factors, many of which are represented by more gradual change, such as health impairment. In addition to functional health, factors include the acceptability of aging, aging milestones (such as grandparenthood) and life expectancy (Gibson, 1988). For example, for African Americans, their view of the life cycle may be influenced by grandparenthood at 40 to 50 years of age, lowered life expectancy, an earlier age of widowhood, and poor functional health (Burton, 1992).

INTERGENERATIONAL SUPPORT AND ETHNICITY

Although we have noted throughout this chapter ways in which minority status may systematically disadvantage ethnic minority elders, in other ways, ethnic identification and cultural values of ethnic groups may also contribute positively to the aging process. Among the Navajo, for example, life and death are viewed as part of a continuous process and thus, aging is relatively less threatening (Shomaker, 1981). Ethnographic and anthropological investigations also suggest that aging may be viewed more positively among other

ethnic subgroups than in mainstream U.S. culture. In a comparison of African Americans, Mexican Americans, and European Americans, for example, Bengtson (1979) found that, of the three groups, African Americans held the most positive views toward aging. Quite possibly, survival itself, in the face of tremendous racial discrimination, represents a major accomplishment in the African American community. It is interesting to note that Mexican Americans reported the most negative views.

It is widely believed that many ethnic subgroups provide better intergenerational support than European Americans (Kalish & Moriwaki, 1973; Sanchez-Ayendez, 1989). This portrayal, however, may be overly simplistic and contrasts with European Americans may not be as large as one might expect. It is important to stress that regardless of ethnicity, most of the care that older people in the United States receive is provided by family members. Nevertheless, there are some interesting differences in interpersonal relationships and social support as well as nursing homes across ethnic subgroups. Mexican Americans, for example, are more likely to receive care from families and report greater closeness to families than either African American or European American elders (Bell et al., 1976)

Among Chinese Americans, the situation appears to be more stressful. Of all ethnic minority subgroups, Chinese Americans are the most likely to live with their children (Raskind & Peskind, 1992). Yet compared to other groups, Chinese Americans report that they have the least contact with their children (Lubben & Becerra, 1987). Differing expectations by younger and older cohorts may contribute to this apparent paradox. Many Asian American elders grow old expecting to be surrounded and cared for on a daily basis by daughter-in-laws and younger relatives; the reality they face is often quite different from these expectations (Kalish & Moriwaki, 1973; Kobata, Lockery, & Moriwaki, 1990). For the many who do not live with relatives (even if they receive financial support from them), a deep sense of abandonment may occur. Even those who live with younger relatives may feel that they do not receive the respect they are due. Contributing further to intergenerational conflict are different levels of identification with ethnic culture. Elder relatives often see their role as cultural expert or advisor, whose function is to preserve cultural values. Among younger generations of Asian Americans, however, assimilation to Western culture is often a primary goal, which can seriously threaten the self-esteem of Chinese American elders and cause considerable intergenerational conflict.

Compared to their European American counterparts, African American elders interact more frequently with family members and report higher levels of support from them. In addition, African Americans include in their extended social networks *fictive kin*, namely, nonblood relatives who assume roles similar to family members (Markides & Mindel, 1987). Intergenerational

conflict is also common, however, particularly among poor African American families who have been seriously affected by the drug epidemic of the past 20 years. Many older African Americans have lost their adult children to drugs or crime. Many have assumed primary caretaking responsibilities for grandchildren at a time in life where their own physical health makes this a particularly burdensome task (Burton, 1992). For the current cohort of African American elders who endured lifelong fights for civil rights during their lives and saw each decade bring them closer to equality with mainstream America, this experience has been devastating.

Intergenerational support is also affected by migration trends among younger relatives. Increasingly, younger cohorts of Native Americans are relocating to urban areas where ties to the ethnic community are threatened. And yet, sociocultural marginality in older Native Americans, often brought about by accompanying relocation, is associated with negative self-concept and even physical health (Wiebel-Orlando, 1989).

ETHNIC TIES

Strong ties to ethnic communities appear to affect psychological and physical health in several ways. Ethnic communities appear to provide elders with greater access to informal information sources about available services. For example, Cuban elders with greater contact with children and other relatives were more aware of and more likely to use available social services (Starrett, Decker, Araujo, & Walters, 1989). In addition, many ethnic communities instill a sense of purpose in elders. Many Native American elders see their purpose in life as transmitting cultural values to younger generations (Red Horse, 1980). Serbian American elders also identify strongly with their designated role of preserving their ethnic heritage (Simic, 1987), similar to the roles that Meyerhoff (1987) described for ethnic Jews and Luborsky and Rubenstein (1990) described for Irish, Italian, and Jewish widowers. In the latter study, ethnic identification played a crucial role in adjustment to widowhood. An awareness of the strength with which ethnic minority elders identify with their heritages is important for clinicians in assessing and devising treatment plans. The elder who identifies strongly with his or her ethnic heritage may respond well to treatments oriented around it.

LIFE EXPECTANCY AND MENTAL HEALTH

Ethnic elders vary in their average life expectancies and mortality rates. Compared to European Americans, Native Americans and African Americans

have shorter life expectancies. The average age of death for European Americans is 76.6 years old; for African Americans, 70.4 years old; for Asian Americans, 82.9 years old; and for Hispanic populations, 79.0 years old (U.S. Bureau of the Census, 1993a). The average life expectancy for Native Americans appears to have changed dramatically over the years. In 1979, Native Americans were expected to live to 46 years of age (Varghese & Medinger, 1979); however, according to the 1993 U.S. Bureau of the Census, at birth, Native Americans are expected to live until 76.9 years of age. This change may be due to improved health services and fewer deaths due to infectious diseases such as tuberculosis and gastroenteritis (McCabe & Cuellar, 1994). It is interesting to note that African Americans demonstrate a crossover effect during later old age. Asian Americans and Hispanic Americans, on the other hand, have lower mortality rates than European Americans at all ages of the life span (Markides & Mindel, 1987; Sakayue, 1992). More and more, this appears to be the case for Native American elders as well (U.S. Bureau of the Census, 1993a).

Ethnic elders also vary in their prevalence rates of mental illness. In many cases, ethnic minority groups have higher rates of mental illness compared to European Americans. Older Hispanic women are at a higher risk for depression (Cuellar, 1988), alcohol abuse, phobias, and cognitive impairment compared to European American older women (Stanford & DuBois, 1992). Kemp, Staples, and Lopez-Aqueres (1987) examined 700 older Hispanics residing in Los Angeles County and found that more than 26% met the diagnostic criteria for major depression or dysphoria. Most of these depressions were related to physical health complications. In addition, socioeconomic status, health behavior, and family variables were related to these Hispanic elders' affective states (Kemp et al., 1987). Older African Americans report higher levels of psychological distress than old European Americans (Fillenbaum, Hughes, Heyman, George, & Blazer, 1988). Similarly, elderly Chinese American and Japanese American women have higher rates of suicide than their European American counterparts (Morioka-Douglas & Yeo, 1990).

These ethnic differences in prevalence rates may be a function of differences in socioeconomic resources and advantages rather than ethnic differences per se. In fact, when socioeconomic status is controlled for, many ethnic differences in prevalence rates disappear. Markides, Martin, and Sizemore (1980) showed that elderly Mexican American and European Americans did not differ in the number of psychological symptoms of distress; African American and European American elders demonstrate similar rates of depression (Stanford & DuBois, 1992). In the Kemp et al. (1987) study described earlier, only 5.5% (compared with a total of 26%) of the Hispanic elders studied suffered from depressions that were not related to concomitant physical problems.

In some cases, however, ethnic differences in psychopathology prevail even after controlling for differences in socioeconomic status. In a community sample, Raskind & Peskind (1992) found that even after controlling for socioeconomic status, European American elders showed more psychopathology and reported more somatic complaints than Chinese Americans. Ironically, European Americans were also more socially competent than Chinese Americans. Chinese Americans had more problems with memory but performed better overall on gross mental status exams.

As this review illustrates, life expectancies and prevalence rates of mental illness often distinguish between the groups, and therefore, no general statements regarding life expectancies and prevalence rates of mental illness can be made across ethnic minority groups. These differences may stem from the various historical experiences of each of the groups. For example, higher mortality rates of Native Americans and African Americans compared to European Americans may be the aftermath of tremendous discrimination, slavery, and genocide (Richardson, 1990). They may also reflect differences in the availability of resources, which also may be related to different historical experiences and treatment (e.g., economic and political disparities). It is also possible that differences in prevalence rates are a function of the more abstract components of ethnicity (e.g., belief systems). For example, in community samples, normal European American elders may have reported more somatic symptoms because they felt more comfortable disclosing their psychological distress to researchers than would Chinese American elders, who were influenced by the stigma of mental illness in Chinese culture.

Awareness of ethnic differences in prevalence rates of mental illness is critical in planning treatments, assessing the prognosis of ethnic minority elders, and placing the illness of the elder in context. Historical experiences, socioeconomic disparities, and beliefs and customs may all influence ethnic differences in life expectancies and rates of mental illness. Unfortunately, research on the influence of within-group differences (such as acculturation levels) on life expectancies and mental illness has yet to be conducted.

THE THERAPEUTIC PROCESS

Clinicians need to be sensitive to the expectations of ethnic minority elders about appropriate communication styles and the clinician-patient relationship. In many cases, establishing rapport determines whether or not patients return after the first session (Sue & Sue, 1990). Communication styles should be adjusted according to the degree of acculturation. Among foreign-born elders for whom language differences create a barrier, nonverbal communication, such as interpersonal space and body movements, may be particularly important, whereas among fluent English speakers, the content of conversation may be more critical (Sue & Sue, 1990).

We recommend that surnames be used in the default and that explicit permission be obtained when more informal address seems to be desired by the patient. We also recommend that clinicians use terms used by their patients (e.g., "hot" and "cold" to describe emotional states) rather than school patients in more mainstream terminology. In addition, depending on their ethnic background, patients may expect more or less involvement of family members in the therapeutic process. In some cases, failure to involve the family may signify a lack of serious commitment on the part of the therapist to ameliorate problems. It is very important, however, not to assume that such preferences exist. We believe strongly that clinicians explicitly ask patients about their desires for family involvement. They should be told that confidentiality will be maintained unless they desire otherwise. If they do expect that family members will be involved, clinicians should be ready to pursue family approaches.

We recommend that clinicians unfamiliar with their patients' cultural backgrounds inquire about them directly in a respectful and interested manner, placing the ethnic minority elder in a teaching role. Allowing sufficient time for this purpose may serve to inform clinicians, provide an opportunity for the clinician to empathize with the patient, and help to establish a trusting working relationship.

Finally, almost all ethnic minority elders have encountered severe discrimination and prejudice in the United States. Many may be dealing with the psychological consequences of discrimination without adequate assistance but may be reluctant to seek assistance because they are suspicious of mental health agencies and the largely European American health care system (Sue & Sue, 1990). For example, today's Japanese American elders continue to carry the ghosts of the internment inside themselves (Yabusaki, 1993). Native American elders also suffer from fears that they will be exploited by the U.S. government yet again. Thus, perhaps the most critical aspect of the therapeutic process is building a trusting relationship with the ethnic minority elder.

ACCEPTABILITY OF TREATMENT

Ethnic patients may also have different views of mental and physical illness, regarding their causes, medication, and specific culture-bound syndromes. For example, many Asian and Hispanic cultures embrace holistic views of health in which the mind-body dichotomy is nonexistent. In these cultures, the key to health is balance (between hot and cold, yin and yang, or other life forces; Morioka-Douglas & Yeo, 1990). Different views of physical

and mental health may influence the ways in which symptoms are presented. For example, Chinese patients may somatize their symptoms; somatization is the expression of emotional, psychological, or social distress through bodily complaints in primarily medical settings (Kleinman, 1986). An awareness of the patient's views of health and illness may improve clinicians' understanding of their ethnic minority patients as well as how much these patients comply with prescribed treatments (Baker et al., 1990).

For example, some ethnic minority elders believe that once symptoms subside, the illness is gone; therefore, despite instructions to do otherwise, they erroneously assume that their medication is no longer necessary. Similarly, for groups that view health in terms of a balance between hot and cold, Western medicines are often considered too hot and therefore, are not taken at regularly recommended dosage levels. In some cases, usually for biological rather than cultural reasons, an actual adjustment in dosage based on ethnicity may be appropriate. For example, some studies suggest that Asian Americans require only half the dosage of medication given to European Americans (Lin, Poland, & Lesser, 1986).

In addition, ethnic minority elders often combine Western with traditional treatments. Clinicians' lack of appreciation for traditional treatments may result in clients' discontinuation of Western treatments rather than traditional ones. Moreover, these traditional treatments may contain substances that counteract or significantly alter the effects of Western medications (Hikoyeda & Grudzen, 1991).

Many ethnic minority elders may also suffer from culture-bound syndromes—disorders known in other cultures that have no recognizable Western analogs. For example, in Southern China, Hong Kong, and Taiwan, *frigophobia* is an excessive fear and intolerance of the cold in temperature and foods. African American elders may experience *falling out*, which has been presented as a disorder of the central nervous system or a metabolic abnormality with a sudden onset and of brief duration during an emotionally intense situation (Richardson, 1990). For some Hispanic Americans, *susto*—a constant state of anxiety and fear—occurs when a person is frightened by a traumatic event (e.g., witnessing an accident, being frightened by a snake). For the Oglala Sioux, *wacinko* is a form of reactive depression that may also require more traditional healing approaches (Lewis, 1975).

Many of these culture-bound syndromes are often thought to have supernatural causes; therefore, Western medications may be ineffective. As a result, different types of folk healing may be invoked. For example, *curanderismo* is a type of Indian folk healing that uses prayers, messages, and herbs to treat *susto* and *mal puesto*—a hex placed on one by his or her enemies (Comas-Diaz, 1989; Martinez, 1988). Clinicians should be aware that these traditional forms of healing may be in use.

Conclusion

Our goal in this chapter has been to make the general recommendation that clinicians familiarize themselves with the different ways in which ethnicity may affect their patients as well as to be aware of differences between and within ethnic groups. We have discussed a range of ways in which ethnicity may have an effect on clinical work with ethnic minority elders. Historical experiences, life expectancies, and prevalence rates of mental illness are characterized, for the most part, by group differences across the three ethnic minority groups. Ethnic groups also differ in the more abstract aspects of old age, such as attitudes toward aging, perceptions of old age, and milestones of old age. We have also emphasized that within-group differences may be as strong as between-group differences. Acculturation and ethnic identity are two sources from which within-group differences may stem.

We believe that by seriously considering the different ways by which ethnicity may influence clients and treatment efficacy, clinicians will be best prepared to work with ethnic minority elders. Implementing stereotyped ways of interacting with members of different ethnic minority groups can sometimes suggest ethnic insensitivity rather than ethnic sensitivity by obscuring the ways in which the elder differs from his or her ethnic group. Ultimately, it is most important that clinicians view all of their patients as individuals, some of whom are highly influenced by their ethnic heritages and some of whom are less so. In many ways, the quality of care that the ethnic minority elder receives depends on the willingness of clinicians to appreciate the complexity of ethnicity and its relationship to their patients' lives. Furthermore, clinicians must also be willing to tackle and question their own assumptions, biases, and values; to examine how these may carry over to their clinical work; and to determine how accurate or appropriate they are for their ethnic minority patients. For example, our biases and assumptions may occur at the most basic of levels and may cause us to impose our own notions of ethnicity, aging, and mental health onto our patients.

Working with ethnic minority elders, especially those whose backgrounds are vastly different from one's own, is a challenging but rewarding task. As this chapter has illustrated, the multitude of ways in which ethnicity may influence aging renders simple answers virtually irrelevant. However, this is what, in the end, will continue to make work with these groups so interesting and rewarding. We have much to learn from these ethnic minority elders, whose lives are a rich montage of traditions, experiences, and beliefs. Although a daunting task, it is one that we look forward to as our contact with ethnic minority elders increases in the years to come.

Notes

1. We use the term *European American* for non-Hispanic White populations with European ancestors, who are also commonly referred to in the literature as Anglo Americans and Caucasians.

2. In much of the literature, a distinction has been made between Asian Americans living in Hawaii and those who live on the U.S. mainland (Takaki, 1989). In this chapter, we will be primarily discussing the latter group of Asian Americans.

3. This percentage is relatively arbitrary and is used, along with the requirement that Native Americans live on a reservation, as an eligibility criterion for federal aid from the Bureau of Indian Affairs (Bell et al., 1976).

4. Although there is much debate over whether nursing homes are appropriate for Native American elders, we use this example to illustrate the lack of services available to them (Lustig, Ross, Davis, & Old Elk, 1979).

5

The Significance of Gender in the Treatment of Older Adults

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This chapter highlights biological and socially constructed differences between older women and men. Some of these factors begin in old age, whereas others represent cumulative effects that have persisted throughout life. The most fundamental of these differences between men and women—and one that relates to many subsequent differences—involves mortality. At birth, the average life expectancy for men is 73 years and for women, 80 years (U.S. Bureau of the Census, 1992a). Healthy women in the United States who celebrate their 65th birthdays will, on average, live an additional 20 years, with 16 of those years independent and in good health. Men, at age 65, are expected to live for 15 more years, with 13 of those years in good health (Suzman, Willis, & Manton, 1992). These statistics vary by ethnicity, but the absolute difference between men and women remains (U.S. Bureau of the Census, 1992a, 1992c).

Researchers examining sex and gender differences commonly compare the average older man to the average older woman. When working with older