
Diagnosis of mental illness in elderly people from ethnic minorities

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From the 1991 census (Office of Population Censuses and Surveys, 1993) it is estimated that 5.9% of the total population of England and Wales belong to an ethnic minority, and that 3% of this ethnic minority population are aged 65 years and older. This compares with 17% aged 65 years and older in the indigenous population. Although the numbers of elderly people from ethnic minorities are small in absolute terms, these groups are growing rapidly, and mental health professionals working with elderly patients will increasingly need to be equipped with the necessary services and skills to meet their specific needs. The elderly ethnic minority population of the UK is extremely diverse; the largest groups originate from the Indian subcontinent and the Caribbean, but there are also significant communities of Chinese, Somali, Vietnamese, Eastern European, Mediterranean and Irish origin, all of which require consideration when planning and providing services, whatever their numbers. This diversity is also important when considering the various factors that influence the presentation and diagnosis of mental disorders in these groups.

Epidemiology

Epidemiological studies of psychiatric symptoms and disorders in ethnic minority elderly communities in the UK are few in number and fraught with methodological problems: small numbers, inadequate sample frames, non-response and refusal to participate, and the lack of valid and reliable tools to identify and quantify psychiatric disorder and to compare rates with those in the indigenous elderly population. There are also differences between studies regarding the definition of who is 'elderly';

it is argued that the conventional boundary of 65 years is not appropriate for some groups, where the social role of 'elder' is normally assumed at a younger age. This issue is also of clinical importance, as the conventional UK boundary of 65 years between general adult and old age psychiatry services may not be appropriate for some ethnic groups.

Most information to date about rates of mental illness in ethnic minority groups has been obtained from hospital admissions, and is therefore biased by factors that may impede presentation, referral and diagnosis. A few community surveys have been carried out, and they have found rates of anxiety, depression and dementia to be at least comparable with those in the indigenous elderly population. For example, a recent survey of the elderly ethnic minority communities in Liverpool (McCracken *et al*, 1997) found rates of depression that were slightly higher than in the indigenous population. The non-English speaking ethnic minorities had higher rates of dementia than those minorities that spoke English, who had rates similar to those in the indigenous population. This raises the important issue of the effects of language, education and culture on performance on cognitive function tests; Bhatnagar & Frank (1997) also obtained a higher prevalence of dementia using a standardised instrument (Geriatric Mental State Schedule; Copeland *et al*, 1976) than was found following psychiatric interview in a sample of elderly Asian immigrants in Bradford. Similar findings with regard to rates of disorders are reported from other surveys of elderly Asian communities. Silveira & Ebrahim (1995) found that elderly Bengali and Somali people in London had comparable rates of mental health problems to the indigenous elderly population. Elderly Gujarati people also appeared to have broadly similar rates of depression and

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anxiety as the indigenous population (Ebrahim *et al*, 1991; Lindesay *et al*, 1997a). However, Lindesay *et al* (1997a) found that the Gujarati people reported more 'psychosomatic' symptoms, suggesting that they may have higher levels of psychiatric morbidity not detected by standard methods.

The limited evidence available about service utilisation indicates that mental health services are under-used by elderly people from ethnic minorities compared to the indigenous population, although this experience is not universal (Redelinghuys & Shah, 1997). The possible reasons for this are (see Box 1):

- (a) Elderly people from these groups are unaware of what services are available, and do not know how to access them (Brownlie, 1991).
- (b) The available services are inaccessible or inappropriate for these groups' needs, or else are culturally insensitive (Hopkins & Bahl, 1993).
- (c) The stigma attached to mental illness deters individuals or their families from seeking help (Barker, 1984). This may be a significant factor in some groups, but its importance should not be over-generalised (Manthorpe & Hettiaratchy 1993).
- (d) Some ethnic groups may have different explanatory models for the symptoms of psychiatric disorder in old age. For example, cognitive impairment may be popularly regarded as a natural and inevitable consequence of ageing, as it was in the UK until recently. Since both the DSM-IV (American Psychiatric Association, 1994) and ICD-10 (World Health Organization, 1992) diagnostic criteria for the dementias require that cognitive impairment should be sufficiently severe to impair activities of daily living, this raises the possibility that different cultures may have different thresholds for this diagnosis,

depending upon the social roles and cognitive demands that are placed upon elderly people (Pollitt, 1996). Depression in some cultures may be regarded as a spiritual rather than a medical problem (Kleinman, 1987).

- (e) Individuals may receive all of their care and support from other sources, such as the family. It is true that many elderly Asian, Chinese and Vietnamese people live in multiple and trans-generational households; however, this is by no means universal and the elderly in some groups, such as Afro-Caribbean, are as likely to live alone as the elderly indigenous population (Patel, 1990). Of course, if service providers believe that particular groups 'look after their own', then they may be accorded a lower priority for services as a result.
- (f) Although the available epidemiological evidence does not suggest it, elderly people from ethnic minorities may have lower rates of some psychiatric disorders. This might be as a result of the 'healthy migrant effect' (those who emigrate are healthier than those who do not), although this attenuates over time (Williams, 1993). Conversely, in older age groups, it could be due to a 'survivor effect' (those who survive into old age are healthier than those who do not). Another possibility is that different ethnic minorities have different exposures to the risk of developing psychiatric disorders in old age. For example, the prevalence of genetic risk factors for Alzheimer's disease may vary between populations (Osuntokun *et al*, 1987), or the roles and social supports that certain groups provide for their elderly members may protect against depression. Since ethnic elders as a group are currently younger than the indigenous elderly population, they should have lower rates of age-associated disorders such as dementia, although the impact of other factors may limit this effect. A number of ethnic minority groups in the UK suffer from higher rates of conditions that are definite or possible risk factors for cerebrovascular disease, such as hypertension (Afro-Caribbean people), diabetes (Asian people) and cardiovascular disease (both groups).
- (g) It is likely that psychiatric disorders are under-recognised by health professionals in elderly patients from ethnic minorities. While this may be due in part to bias and prejudice (Soloman, 1992), lack of experience and the necessary assessment and diagnostic skills are probably more important.

Box 1. Factors that may impede referral to mental health services

Lack of knowledge of what is available.
 Inappropriate, inaccessible, insensitive services
 Stigma
 Different attitudes to and explanations for psychiatric symptoms
 Alternative sources of care available
 Lower rates of some mental disorders
 Under-recognition by health professionals

Cross-cultural psychiatric assessment

The effects of culture on the presentation and diagnosis of mental illness have been discussed previously by Bhugra & Bhui (1997). The general principles and guidance they give apply to the psychiatric assessment of all patients from ethnic minorities, whatever their age, and will not be repeated here. Factors more specific to the assessment of elderly patients from ethnic minorities include those listed in Box 2.

Particular history

In most of the ethnic minority groups in the UK, the majority of elderly individuals are the first-generation migrants. Their personal histories may therefore include experiences of trauma and hardship that may have rendered them vulnerable to mental disorder. The experience of Holocaust survivors from continental Europe is an extreme example of this, but the impact of cumulative losses and multiple deprivations upon other first-generation immigrants is also significant, and the effect of these on self-esteem and perceived locus of control needs to be sensitively addressed as part of the assessment. Recency of migration is also an important consideration. Some individuals migrated to the UK relatively late in life in order to be with their children, and as a result are more likely to have had greater problems adjusting to the host culture, particularly if the migration also involved a move from a rural to an urban domicile. First-generation immigrants are less likely to assimilate into the host culture than subsequent generations, and this is reflected in their particular attitudes and

expectations. Where these differ significantly from those of their more assimilated and Westernised children and grandchildren, this can lead to significant family conflicts and tensions that may contribute to the development and maintenance of mental illness in both parents and offspring. Since less assimilated first-generation migrants are perceived as having greater differences by the host culture, they may also be more vulnerable to racist attitudes and behaviour. However, it has also been suggested that having a distinct ethnic and cultural identity is a positive asset, helping to maintain self-esteem in these individuals as they grow older. A significant 'loss' that some members of this group may experience is the disappointment of long-cherished expectations of returning home following retirement from work.

Communication

Another consequence of the limited acculturation of first-generation immigrants is that among non-English speaking ethnic minorities, elderly individuals tend to have less proficiency in spoken and written English. For example, in a recent survey of elderly Gujarati people in Leicester, 65% did not speak English and 79% were unable to read or write in English. Moreover, 27% were also unable to read or write in Gujarati (Lindesay *et al*, 1997a). This has important consequences both for the process of psychiatric assessment and for the communication of information about treatments and services. The use of an interpreter may be unavoidable if the assessor does not speak the patient's language, but the limitations of this approach are considerable. In particular, patients may not be forthcoming with sensitive information if a family member or someone of the opposite gender is used as the interpreter (Ebden *et al*, 1988). Inability to communicate in English is also a factor increasing the isolation and vulnerability of those individuals who live alone.

Box 2. Important factors influencing the assessment of older adults

Language and communication
Do they regard themselves as 'elderly'?
Age and gender of the assessor
Context and setting of the assessment
Patient's attitudes and expectations
Family's attitudes and expectations
Status and role within the family / community
Careful informant history
Assurance of confidentiality

Social circumstances

Cross-sectional surveys consistently show older Afro-Caribbean and Asian people to be disadvantaged in important areas such as income and health compared to older White people, and the concepts of 'double' and 'triple' jeopardy are often used to summarise the multiple disadvantages experienced by these groups (Dowd & Bengston, 1978; Norman, 1985). To what extent does belonging to an ethnic minority confer specific additional disadvantage in old age? As first-generation migrants, these groups will have suffered significant

inequality throughout much of their adult lives; longitudinal data are lacking, but it may be that the social disadvantage that comes with age does in fact have a disproportionate effect on indigenous White people. That is, over the lifespan of this generation, ageing exerts a levelling influence on ethnic differences in this respect. It remains to be seen whether future generations of ethnic minorities in the UK will show similar inequalities in their old age (Blakemore & Boneham, 1994).

Within an ethnic minority community, the position of an elderly individual may in fact be more advantageous than that of his or her indigenous counterpart. In some cultures, notably Muslim, Sikh and Hindu, the elderly are well respected, and they often have a status and a role to give their life meaning and purpose; this may account for the low rates of suicide currently seen in elderly immigrants from the Indian subcontinent, compared to the indigenous elderly population (Raleigh *et al*, 1990). In Asian communities, the status that an individual comes to enjoy in old age is determined to some extent by the provision they have made for the family earlier in life, either materially in the case of men, or by providing male heirs in the case of women. Some women acquire a considerable degree of authority and independence as they age, and are powerful decision-makers within their families, a point to remember when carrying out a clinical assessment. Conversely, those elderly individuals in these communities who have been unable to achieve any status in their old age may find themselves trapped in an uncaring and even abusive household with no means of escape. Such individuals, often women, are at high risk of developing a mental disorder.

Informant histories

The informant history is a vital part of the mental health assessment of an elderly patient, since it can provide important information about the onset, course and characteristics of any mental health problems, and the impact of these on the lives of the patient and others close to them. In assessing patients from ethnic minorities, a number of factors will influence the history that is obtained from families and friends (White, 1992). Well-intentioned family members may withhold information if they think it will present their relative in a bad light; in particular, 'mad' and disinhibited behaviour may not be reported. Similarly, they may not volunteer any difficulties and problems they are experiencing, out of fear that this will be regarded as a failure of their duty to care. If the culture has limited expectations of its elderly members, then informants may be unaware of significant functional in-

capacities, or else not consider them relevant and worth mentioning. Conversely, apparent deficits in the performance of activities of daily living and instrumental activities of daily living may simply reflect age- and gender-specific norms for that ethnic group.

Assessment of cognitive function

It is usually assumed that human cognitive and neuropsychological processes are universal, and the impact of disorders such as dementia on cognitive function is not culture-bound. However, performance on cognitive function tests is affected by both demographic and cultural factors (see Box 3). It is important to distinguish these effects from those due to illness.

It is a principle of good cognitive function testing that every effort should be made to ensure that the subject does their best, and that their performance is not impaired by extraneous factors. Ideally, patients should always be assessed directly in their mother-tongue by someone who speaks that language, as it is difficult to judge test performance through the medium of an interpreter, particularly if the impairments are relatively mild. It is also important to ensure that other barriers to communication, such as deafness and visual impairment, are compensated for so far as is possible; for example, the higher rates of visual impairment in elderly Gujarati people adversely affect test performance (Lindesay *et al*, 1997b).

Standardised testing procedures are valuable because they allow the individual's performance to be compared against norms established either by research or by personal clinical experience with the test instrument. There are very few validated, reliable screening and diagnostic instruments available for use with most ethnic minority groups in the UK. Some, such as the Mini-Mental State Examination

Box 3. Factors affecting the assessment of cognitive function

- Language and literacy skills
- Level of education
- Sensory impairments
- Culturally biased items in screening tests
- Unfamiliarity with test situations
- Anxiety

(MMSE; Folstein *et al*, 1975), have been translated into a number of different languages, including Hindi (Ganguli *et al*, 1995), Gujarati (Lindesay *et al*, 1997b) and Chinese (Katzman *et al*, 1988). Their performance has been studied in general population samples, but there is little evidence of their utility as screening or diagnostic tools in clinical settings. Instruments developed for use in one population may not perform comparably in another; for example, a Hindi version of the MMSE developed in a rural population in India may not be appropriate for an immigrant Hindi-speaking population in the UK, and vice versa.

Factors affecting performance on cognitive function tests

Education is known to have a significant effect on performance on cognitive function screens such as the MMSE (Tombaugh & McIntyre, 1992), and probably accounts for much of the difference observed between immigrant groups and the indigenous population (Lindesay *et al*, 1997b). For example, illiterate patients cannot manage items that require reading of test material or writing of responses. Similarly, innumerate individuals will not be able to do mental arithmetic. Even design copying may pose difficulties for those unfamiliar with using writing materials. Completely uneducated individuals may have difficulty grasping the concept of a test situation, and perform badly as a result.

In some ethnic groups, many elderly individuals may not know their exact age or date of birth, and this will put them at a disadvantage in tests which ask for this information, such as testing for discrepancies between age and birth-date (McCracken *et al*, 1997). Similarly, some individuals do not use the Western calendar to measure the passage of time, and the phrasing and scoring of orientation items should reflect this. In some cultures, the concept of orientation in time is of less relevance than it is in the West (Ganguli *et al*, 1995), and failure on these items may not therefore be indicative of cognitive impairment. Illiteracy may limit an individual's access to information about the date. Questions that ask for culture-specific information, such as the names of political leaders or the Royal Family, may also disadvantage certain ethnic and cultural groups.

In the absence of adequate instruments, a good deal of careful clinical judgement is needed when testing cognitive function. The purpose of the test should be carefully explained, and instructions should be explicit and simple. Some unscored trial runs on examples may be given before the test to

ensure that the patient understands what is required. In subjects who are unused to being examined in this way, an initial 'dummy' test to familiarise them with the test situation may be useful (Chandra *et al*, 1994). Always be alert to the possibility that errors in performance are due to factors other than cognitive impairment, and be prepared to adapt test items to compensate for these. Patients are likely to find cognitive testing an anxiety-provoking experience, and a calm, patient and reassuring approach on the part of the assessor is important if they are to obtain the best performance.

Assessment of mood

If the impairments and disabilities associated with organic disorders such as dementia and delirium are relatively invariant across cultures, the same cannot be said for disturbances and disorders of mood. Different cultures experience and express depression and anxiety in different ways, and diagnostic procedures designed for the indigenous population may not be applicable to ethnic minority groups. The important factors that shape a culture's expression of emotion include: definitions of self, the language of emotional expression, the selective elaboration of emotional experience, and effect of context on disclosure (see Box 4; Manson, 1995). Definitions of self vary from the Western 'egocentric' model to the more 'socio-centric' traditions found in many non-Western societies (Schweder & Bourne, 1984). Individuals from socio-centric cultures express their distress more in terms of its impact on relationships with others; for example, they feel shame rather than guilt. It is well known that the language of emotional expression varies considerably across

Box 4. Culture-specific factors affecting the expression of emotion

Definition of self (egocentric *v.* socio-centric)
 Terms used to describe emotional experiences (psychological and somatic)
 Constructs of normal and abnormal mental states
 Norms and ideals regarding emotional expression
 The contexts in which emotional disclosure is permitted or forbidden

cultures, and that the simple translation of terms, for example in depression inventories, is rarely sufficient to ensure equivalence of meaning. Indeed, there may be no words in one language that precisely convey the meaning of an emotional descriptor in another. Even if different ethnic groups share a common language, this does not mean that they will necessarily use it in the same way to describe their emotions. The physical and biological symptoms of anxiety and depression are relatively easily identified, and should be taken seriously by the clinician if they are reported, but there are significant cross-cultural differences in the language and the terms used to describe, for example, tension and autonomic hyperactivity. These differences in the language of emotion are a result of the different ways in which cultures construct and emphasise these experiences, and encourage or discourage their expression according to specific norms and ideals. The interpersonal contexts in which emotional disclosure is permissible or possible are also culture-specific, with factors such as the gender, age, family relationship, and professional status of the participants all being important in this respect. When assessing an elderly patient from an ethnic minority, it is important to arrange the circumstances so that they are as facilitating as possible for the expression of emotion.

These cross-cultural differences in the experience and expression of emotion pose considerable problems when it comes to identifying qualitatively and quantitatively abnormal mental states. One approach to the problem of characterising distress and disorder in immigrant groups is to start from within the culture in question, with its own concepts of mental illness and distress, and to develop a phenomenology of the common forms of mental disorder based on interviews with those regarded by the community as being ill (Kleinman, 1977). In this way, important symptoms and the language used to describe them can be identified. An example of this approach is a study of elderly Afro-Caribbean people in London, which developed a culture-specific screen based upon the idioms used by this community to describe emotional distress (Abas, 1996). The content of this scale has some overlap with conventional depression screens, but some of the items have no direct equivalent, such as feeling 'cut off' or 'empty/spiritless inside'. The practical implication of research such as this is that clinicians need to be aware of the particular ways in which emotional distress is experienced and communicated by patients, if they are to identify correctly those who need help and treatment. Furthermore, if the language and concepts used by the clinician accord with those of the patient, then

treatment is more likely to be accepted. It is also more likely to be effective, since the powerful placebo component inherent in most treatments of emotional disorders requires a common understanding of the problem, its causes and the appropriateness of the treatment.

It is commonly asserted that patients from ethnic minorities somatise their distress and depression. This notion is a familiar one to old age psychiatrists, as the same has often been said about the elderly compared to the younger adults in the indigenous population. In both of these contexts, the concept of somatisation is often rather derogatory, implying that ethnic minorities and the elderly are somehow less 'psychologically minded'. To some extent, this view may be a consequence of the fact that it is those individuals with somatic complaints who will be more likely to consult their doctors. The evidence also suggests that while ethnic minority groups may indeed report rather more somatic complaints, their frequency is correlated with that of psychological complaints (Mumford, 1993; Farooq *et al*, 1995). That is, somatic complaint in these groups is a parallel, and not an alternative, expression of distress. If these patients are described as 'somatising', this suggests that communication between doctor and patient is poor, and the accompanying psychological expression of distress is not being recognised (Bhugra & Bhui, 1997).

Another factor that affects the experience and reporting of psychiatric symptoms is their relationship to, and congruence with, the patient's religious and spiritual beliefs. For example, Muslim religious practice involves regular ritual cleansing before prayer, and the fending-off of forbidden thoughts with the repetition of prescribed phrases. In this context, there may be a low awareness of the pathological significance of obsessive-compulsive phenomena. Conversely, there is also the danger that normal religious practice may be mistakenly regarded as evidence of mental illness if the clinician is unaware of its meaning within the patient's culture. Western psychiatry is a secular discipline, and there is a tendency to treat all forms of extreme, unusual or unfamiliar religious experience and behaviour as manifestations of psychiatric disorder. It is often difficult for the clinician to distinguish between intense religious experience and an episode of mental illness, but some guidelines have been proposed, based on studies of strict religious groups. In general, psychotic episodes are more intense than the normal religious experience of the community; they are more frightening and pre-occupying; they are associated with deteriorating social skills and self-care; and they often involve special, personal messages from religious figures (Greenberg & Witzum, 1991).

Conclusions

The principles of effective psychiatric assessment are the same, whatever the background and culture of the patient: a facilitating setting; clear, unimpeded communication; a shared understanding of terms and concepts; an awareness of context; assurance of confidentiality; and a sensitivity to the effect that the assessor's behaviour can have on the process (Bhugra & Bhui, 1997). Health professionals working in old age psychiatry services are well aware of the importance of these principles; indeed, their specialist skills are not dissimilar to those required to carry out culture-sensitive assessments. The main challenges facing these services are to engage with ethnic minority communities and to develop interventions for elderly people and their carers that are acceptable and effective.

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Multiple choice questions

1. First-generation migrants to the UK:
 - a have fewer problems with language
 - b have lower self-esteem
 - c are less assimilated into the host culture
 - d are less vulnerable to racist behaviour
 - e eventually return home.

2. The following may adversely affect performance on tests of cognitive function:
 - a limited education
 - b visual impairment
 - c use of an interpreter
 - d anxiety
 - e use of a standardised instrument.

3. The under-use of mental health services by elderly people from ethnic minorities is due to:
 - a lack of knowledge about what is available
 - b culturally-sensitive services
 - c lower rates of mental illness
 - d under-recognition by health professionals
 - e stigma.

4. The following are helpful in the assessment of elderly people from ethnic minorities:
 - a use of family members as interpreters
 - b appropriate language to describe feelings
 - c a male assessor in all cases
 - d knowledge of religious practices
 - e assurance of confidentiality.

5. The following are vulnerability factors for depression in elderly people from ethnic minorities:
 - a low status within the community
 - b living with extended families
 - c traumatic experiences in the past
 - d recent migration
 - e illiteracy.

MCQ answers

1	2	3	4	5
a F	a T	a T	a F	a T
b F	b T	b F	b T	b F
c T	c T	c F	c F	c T
d F	d T	d T	d T	d T
e F	e F	e T	e T	e F