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Am J Geriatr Psychiatry. Author manuscript; available in PMC 2022 February 02.

Published in final edited form as:

Am J Geriatr Psychiatry. 2021 December ; 29(12): 1267–1273. doi:10.1016/j.jagp.2021.07.009.

Engaging an Asian Immigrant Older Adult in Depression Care: Collaborative Care, Patient-Provider Communication and Ethnic Identity

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Abstract

Minority older adults face multiple barriers when trying to access mental health services and often present with more severe symptoms of mental health conditions. We describe the multilevel factors that contributed to the engagement of an Asian immigrant older adult with depression. Systems-level innovations such as collaborative care in primary care can increase access to care for all, including minority older adults; however, one size fits all interventions may not meet the needs of communities of older adults with different life experiences, language needs, norms and values regarding help-seeking for mental health. Health outcomes remain unequal , suggesting the need to tailor interventions for minority older adults. For the patient, specific factors related to language and ethnic concordance between patient and healthcare provider, communication behaviors, ethnic identity, and social norms may be important to take into account. The recognition of the heterogeneity of patients and the limitations of cultural competence approaches defined as broad, general knowledge about ethnic cultures may be needed. A need to learn continuously from clinical experience and adopt a patient-oriented model of communication and decision-making may successfully engage Asian immigrant older adults in depression care services.

Keywords

Mental health services; primary care; integrated care; depression; dementia; Asian elderly

THE PATIENT

The patient is a 65-year-old Asian woman who presented with a chief complaint of depression. Her depression began in 2014 shortly after her husband of 30 years passed

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AUTHOR CONTRIBUTIONS

JJ conceptualized and wrote the manuscript and all authors reviewed the final draft of the manuscript.

The contents of this manuscript have not been presented orally or by poster at any conferences.

DISCLOSURE

The authors have no conflicts of interest to declare.

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away. Upon the death of the patient's husband, Ms. A relocated from her own home to that of her eldest daughter who assumed care for her. Their relationship was emotionally distant and the move led to feelings of loneliness that significantly contributed to worsening mood and decreased her quality of life. Other symptoms included anhedonia, poor appetite, guilt surrounding her husband's care at the end of his life, irritable mood with agitation, passive death wish without history of self-harm, suicidal ideation or psychosis. The depressive symptoms that were initially mild increased in severity over 4 years during which time she received intermittent treatment. At the initial evaluation, the patient had severe depression (PHQ-9–25).

In terms of other health conditions, the patient had hypertension and was diagnosed with mild dementia about one year ago. Cognitive symptoms included short-term memory problems and inability to drive without getting lost. Her mini mental status exam score was 23 at initial evaluation. The patient was a "war bride" who had immigrated to the United States in her 20s in the 1970s, and who had three children who did not speak her native language. She was subject to domestic violence in her first marriage and struggled financially throughout her life in the United States. In late-life, the patient developed ambivalent feelings about immigration to the United States because of strained family relationships and isolation in late-life from her family in Korea.

The patient had engaged in treatment with a psychiatrist for a few months prior to presenting at her initial evaluation. She was prescribed antidepressants that improved appetite and sleep but did not reduce her depressive symptoms. After a few appointments, the psychiatrist, due to a perceived language barrier, suggested that Ms. A seek another clinician who could provide services in her native language. Ms. A's daughter had difficulty finding another psychiatrist and eventually the patient's primary care provider referred her for an assessment to an integrated behavioral health care program that had recently become available in the primary care clinic. The primary care provider referred her to the health behavioral specialist (HBS), a Master's level licensed clinical social worker specializing in mental health, and embedded in primary care sites associated with the Johns Hopkins Medicine accountable care organization (ACO), previously, and now with the Maryland Primary Care Program. Ms. A benefitted from statewide program that funds and supports integration of behavioral health in primary care clinics.

Within 4 weeks of the referral, the HBS met with the patient and the daughter, conducted an initial assessment and developed a treatment plan. The patient and the HBS communicated in English without problems and the patient was forthcoming in describing her distress since her husband's death. The HBS provided counseling for psychosocial stressors using a problem-solving approach and referred the patient to local community-based social services relevant to her needs. Initially, the patient was referred to Korean community-based resources, but the HBS discovered that the patient preferred English language resources instead.

After several visits of counseling with the HBS and antidepressant treatment which was initially prescribed by the primary care provider, the patient's depressive symptoms did not significantly decrease. In this program, the HBS's work closely with the psychiatrist who

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provides consultation and also short-term follow up care until symptoms are stabilized, at which point, the primary care provider assumes the patient's depression care. The HBS coordinated an evaluation with the psychiatrist who incidentally was able to offer an evaluation in the patient's preferred language. Despite communicating in the patient's native language, the patient was reserved about the details of her mental health history, focusing on appetite, sleep and memory problems, and minimizing her mood problems.

The psychiatrist titrated the antidepressant medications, provided psychoeducation about depression and memory problems, explained the treatment, and benefits of using community-based services. The HBS and psychiatrist problem-solved clinical issues together (e.g., fluctuating engagement in care and poor adherence to medications by addressing poor health literacy and family conflict exacerbated by language and lack of understanding of Korean customs on the daughter's part). After a period of 4 months, Ms. A's symptoms began to decrease; her mood, appetite and sleep improved and the intensity of the depression decreased. The daughter's understanding of the patient's depression and future planning needs improved. Given the patient's dissatisfaction with her living situation the daughter identified an assisted living facility to which Ms. A could transition and both were hopeful that an assisted living facility would provide a safe and supervised living arrangement.

DISCUSSION

Engaging and retaining Asian older adults in mental health care is challenging. The prevalence of depression among Asian immigrant older adults ranges from 7% to 39% with higher rates among those with difficult migration experiences and medical comorbidity.[1,2] They are often at greater risk than White older adults, but the majority of minority older adults do not use mental health services. In a study of Korean elderly immigrants in the Baltimore-Washington, DC region, 11% of Korean immigrant older adults had clinically significant depression and 14% endorsed suicidal thoughts or thoughts of self-harm. Despite indicated need for care, only 6% reported using mental health services.[3]

Barriers to access for minority, immigrant older adults are well known and are due to multiple factors such as different beliefs about mental health, negative perceptions of mental health services and the negative consequences of help-seeking for mental health problems in their communities. For older adults, depression may be perceived as a personal weakness and help-seeking for mental health problems stigmatizing for the individual and the family.[4,5] To avoid negative judgement in Asian communities, older adults may suffer in silence. Despite the negative impact of social judgment associated with help-seeking, some immigrant older adults do want to access depression care services, but many do not know how to access care or are frustrated by language barriers.[6] The majority of Asian older adults are not proficient in English and do not have the ability to communicate with their health care providers. Language-concordant professional mental health care is often not available.[7,8]

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Benefits of Collaborative Care in Primary Care

Barriers to depression care are significant but innovations at the health systems level such as collaborative care models in primary care can benefit all older adults with depression.[9,10] Minority patients are more likely to seek care from a primary care provider rather than a mental health specialist so that engagement, retention and depression outcomes may improve when the care provided is located in this setting.[11-14] The collaborative care approach is characterized by an interdisciplinary team and may consist of primary care providers, care managers and psychiatric consultants with the patient's needs driving clinical activities.[15] The patient-centered orientation and interdisciplinary collaboration are important characteristics that contribute to the effectiveness of this model.[16,17]

In the behavioral health program in which Ms. A received treatment and services, the approach is a stepped approach that focuses on patient engagement, warm hand-offs, outreach calls and support by telephone. The program provides equal to attention to a important psychosocial needs and psychiatric treatment. In Ms. A's case, referral by a trusted primary care provider already familiar with the patient and caregiver decreased reluctance to accept behavioral health services that are stigmatizing.[18] The health behavioral specialist provided active outreach, individualized psychosocial assessment and care planning, counseling, referral to community-based services, and care coordination that facilitated engagement. When psychosocial intervention did not reduce depressive symptoms, the patient received evaluation and treatment from a psychiatrist who provided follow-up visits until symptoms were stable and could be managed by her primary care provider. The prior difficulties with navigating the complex mental health system were obviated by the availability of specialty mental health care in the primary care setting. The availability of an interdisciplinary, team-based approach with close coordination between HBS and psychiatrist, meeting the needs of the patient based on their individual expertise, was an advantage that improved the experience of patient care and had a positive impact on the patient's illness.

Evidence-based innovative models of depression care relieve barriers to access for mental health care, but they do not raise all boats. Not all older adults benefit from these interventions equally. Studies of collaborative suggest that minority and low-income older adults have unique needs that need to be accommodated[19,20] and interventions that reflect the patient's communication needs as well as beliefs and preferences for depression care may be more effective than a 'one size fits all' approach.[21] For example, Asian immigrant older adults may adhere to a worldview where personal health is a family matter so that family-centered decision-making may be the norm that needs to be considered in the clinical encounter.[22] From a practical point of view, many East Asian older adults in the United States are immigrants who have come to the United States in mid to late-life to unite with their children. Depending on their level of acculturation, they may not speak English fluently and they often cannot navigate the health system without the assistance of their children who serve as cultural brokers.[23] The norm among immigrant older adults may be one of reliance on children for care and support, and especially so if language and acculturation issues exist in accessing care. Close involvement of family members in obtaining history and involvement in decision-making is likely critical in ensuring good clinical care.[24]

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In our patient's case, it is unlikely that the patient would have been able to access care without family involvement. The HBS worked with the daughter closely, who had low health literacy. As part of patient care, the HBS provided psychoeducation to the daughter regarding depression and cognitive impairment, particularly information regarding managing behaviors related to depression and dementia, and brainstorming with her to find practical and feasible solutions to increase activities for the patient. The HBS also guided and supported the daughter through the process of finding an assisted living facility.

Complexity of Patient-Provider Communication

Effective patient-provider communication is critical to achieving good health outcomes. Clinicians who provide language-concordant services communicate with patients in a way that helps them understand their illness and better engages them to return for subsequent appointments.[25] Patients may express more satisfaction in health provider-patient relationships and improved engagement in ethnically concordant dyads.[26] If the communication is effective, the patient may show improved adherence to treatment and self-care skills through increased satisfaction, patient understanding, trust, patient-provider agreement, and health outcomes.[27-30]

For ethnic minority older adults, the ability to communicate with a mental health provider through a shared language is often the exception rather than the rule. Language-concordant services are typically unavailable and even if they are, patient-provider communication can be suboptimal.[31] Many health systems offer interpretation by telephone or video, but interpretation may decrease the quality and effectiveness of what is expressed between provider and patient, leading to low perceived quality of care.[28,32]

Although patients prefer ethnic and language concordant providers, however, concordance does not ensure effective communication.[33] Patients and providers may bring their implicit and explicit stereotypes about patient preferences and characteristics that may influence the quality of communication with the patient.[26,34] Physicians tend to dominate conversations with minority patients,[37] and physician dominance reduces engagement, which is related to health outcomes.[38] Studies have shown that language–concordant minority patients may be less likely to discuss their mental health needs with their physicians than English language–concordant patients.[35] Depending on the patient, the norms that disparage speaking openly about emotional health could also apply in an ethnically concordant relationship, so that awareness and training may be useful even when patient and provider share the same culture..

Adding to the complexity, studies have not clearly shown that ethnic concordance improves health outcomes. In some cases, ethnicity may not be the decisive factor in effective communication, but rather the attitudes and the overall quality of communication that the physician brings to the encounter.[30,36] Effective communication is facilitated by a shared language as well as communication behaviors that ensure understanding of meaning and building of rapport. Communication that is patient-centered prioritizes the patient's agenda, preferences, and goals to tailor the treatment plan or service delivery and this approach to communication has been shown to be more important than ethnic concordance in some studies.[30,36]

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In our patient's case, the relationship with the first psychiatrist did not endure ostensibly due to language barriers. As a result,the daughter sought an ethnically concordant psychiatrist however, the lack of a common language may not have been the barrier. During the initial evaluation with the language-concordant psychiatrist. the patient was able to speak in her native language, but she remained reserved, focusing on sleep, appetite and memory problems, hesitant to talk about depressive symptoms. In the counseling sessions with the HBS, the patient was more open. The HBS perceived the difficulty communicating with the patient which she felt was not due to lack of English language ability but embarrassment associated with disclosing personal problems to a stranger. The HBS accepted the patient's communication style and with patience and gentle persistence over multiple meetings, helped the patient open up. In this case, specific cultural knowledge about Asian older adults was less important than the HBS' ability to discover and address her needs using a patient-centered approach. The HBSavoided generalizations about Asian older adults, focused on eommunicating effectively andasked questions of daughter and patient to understand the patient's unique needs. When rapport was established, the patient engaged with the HBS , and disclosed personal information without difficulty. We learned that an interdisciplinary approach can be useful to ensure that accurate information is gathered and included in clinical decision-making so that complex barriers that are present in clinical encounters with minority older adults are mitigated.

The Matter of Ethnic Identity

Ethnic identity is a multidimensional concept that describes a person's identification and attachment with a specific ethnic group and is one among various ways in which persons can define who they are. It can change over time and can impact a person's mental health and influence mental health service use.[39,40] In the case of Ms. A, making clinical decisions based on her Asian ethnic identity seemed straightforward but was not. First, English language fluency was not an issue when working with the HBS and assumptions about patient needs based on her Asian identity that might be considered 'culturally competent' did not hold. Ms. A had a unique background, belonging to a small minority of Korean women who immigrated as wives of American servicemen in the 1960s who often faced discrimination from American and Korean communities alike.[41] She was part of a bicultural family who lived in the United States for over 40 years, with an American husband and children who were unfamiliar with her country of origin and did not speak her native language. She did not go to Korean community gatherings or attend Korean churches that provide much of the social activity and social services for Korean-speaking older adults in the United States. The patient may have desired to affiliate with the Korean community during her life in the United States but did not.

Culturally competent care often consists of mastering a body of knowledge that consists of descriptions and generalizations of ethnic communities that is useful but insufficient. Asian immigrant older adults are heterogeneous in terms of how they identify ethnically, their immigrant experience, and their wider social and family contexts. Ethnic minority patients in particular may need a patient-centered approach in which effective communication that seeks to understand their needs, preferences, and goals may be more difficult but critical toensure effective clinical decision-making and patient outcomes.

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CONCLUSION

The majority of Asian older adults are immigrants who face unique barriers when accessing mental health care. New models of care such as collaborative care are effective in increasing access, engaging, retaining and improving the mental health outcomes of all older adults, including minority older adults. The patient-centered nature of the model with consistent outreach, understanding patient priorities and integration of psychosocial intervention and psychiatric care are factors that led to a positive outcome in our patient's case. Patient-centered communication approaches that acknowledge ethnic cultural norms and also try to understand the individual patient with their unique life experiences, language needs, ethnic identity, norms and values is also an important factor that contributes to successful engagement and retention of minority older adults.

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Highlights

- **What is the primary question addressed by this study?** How can clinicians increase access and engage Asian older adults in mental health treatment and services?
- **What is the main finding of this study?** An Asian older adult who faced barriers to obtaining depression care, had unique needs in terms of language and experienced a complicated social context used mental health services in primary care that used a patient-oriented, collaborative approach. During the care process, the interdisciplinary team was able to understand and navigate the complexity of physician-patient communication and patient ethnic identity with reduction of depression and provision of important social resources to the patient.
- **What is the meaning of the finding?** Asian immigrant older adults can access and engage in mental health services, and specific models of depression care as well as use of strategies to understand and address the unique needs of the Asian patient may contribute to successfully serving this underserved group.