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COGNITIVE–BEHAVIORAL THERAPY WITH CULTURALLY DIVERSE OLDER ADULTS

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Currently, one in every eight Americans is 65 years or older, and it is predicted that by 2030 the proportion of older adults in the United States will grow to 20% of the general population (Administration on Aging, 2000; Siegel, 1999). By the year 2030, 25% of United States elders will be from ethnic minority cultures—a 328% increase in the older ethnic minority population (American Association of Retired Persons, 1997; Haley, Han, & Henderson, 1998). In part, this latter growth is because of post–World War II legislation that enabled ethnic minorities to immigrate to the United States in record numbers many years ago (e.g., the War Bride Act, GI Fiancées Act, Refugee Relief Act of 1953, and U.S. Refugee Act of 1980). Also adding to the increase has been the improved mortality of ethnic minorities living in the United States and an increase in the number of adult immigrants sponsoring aging parents to come to the United States and live with them.

Several empirical and case studies suggest that cognitive–behavioral therapy (CBT) is effective with older adults (Gatz et al., 1998; Knight & Satre, 1999). CBT modified to accommodate older adults has been effective for late-life depression (Gatz et al., 1998), generalized anxiety disorder (Durham, Chambers, MacDonald, Power, & Major, 2003), and insomnia

(Morin, Kowatch, Barry, & Walton, 1993). A cognitive–behavioral approach has been effective in reducing anxiety, anger, and depression in middle-aged and older adult caregivers of patients with dementia (Gallagher-Thompson et al., 2000). Researchers are beginning to demonstrate the utility of CBT with medically ill elders in primary care settings and skilled nursing facilities (Cook, 1998; Stanley et al., 2003). And cognitive and behavioral therapies also appear effective in treating cognitively impaired elders (Cohen-Mansfield, 2001; Teri, Logsdon, Uomoto, & McCurry, 1997).

However, despite the growth in cognitive–behavioral research with older adults, the majority of the work focuses on European American elders (Areán & Gallagher-Thompson, 1996). In a literature review, Arean and Gallagher-Thompson found that only 22% of controlled treatment outcome studies for older adults with mental disorders included ethnic minority participants. This lack of inclusion is due in part to the difficulties in recruiting and retaining older minority participants (Lau & Gallagher-Thompson, 2002). However, the results of the few studies that do include diverse elders are promising. Specifically, CBT has been found effective in the treatment of anxiety and depression in Japanese and Asian Indian elders (Gupta, 2000, 2003; Kinoshita & Gallagher-Thompson, 2004), in reducing depressive symptoms and somatic complaints in community-dwelling Chinese American elders (Dai et al., 1999), and in the treatment of depression in diverse ethnic minority elders (Arean & Miranda, 1996). Furthermore, the results of these studies emphasize the importance of understanding the interaction between age and culture within the clinical process, and the need to tailor assessment and therapy to incorporate clients' traditions, worldviews, cultural practices, and beliefs (Hays, 1995; Sue & Sue, 2003).

Before embarking on a discussion of culturally diverse groups, it is important to acknowledge the variability within these populations; there is great diversity within ethnic groups in terms of culture, language, immigration and acculturation histories, and life experiences based on particular cohorts. Thus, not all members of these groups will fit into the categories that will be mentioned throughout this chapter. The groupings are discussed as a model for the reader. CBT therapists are responsible for conceptualizing each of their culturally diverse clients' cases with the particular individual's life experiences and worldviews in mind. Although the focus of this chapter is on CBT with elders of ethnic minority cultures, the information presented is also relevant to elders of European American heritage, elders who identify with more than one (dominant or minority) culture, and ethnic minority elders who identify more with the dominant culture than with their ethnic minority origin.

TREATMENT ISSUES WITH ETHNIC MINORITY ELDERS

The issues mentioned in this section are generally more apparent among less acculturated elders of ethnic minority groups. First, members of ethnic minority cultures often hold explanatory models of illness that differ from the biomedical model of the dominant United States culture (Kleinman, 1980). These different explanatory models contribute to different concepts of what constitutes appropriate treatment and functional coping strategies. For example, many individuals of Chinese, Mexican, and Native American heritage believe that illnesses are the result of imbalances in one's life. Proper treatment involves restoring balance through diet, herbal remedies, religious practices, and environmental manipulation (Braun & Browne, 1998; Gallagher-Thompson, Talamantes, Ramirez, & Valverde, 1996; Harris, 1998). African American, Native American, and Latino/Hispanic elders are also more likely to believe spiritual or mystical forces are responsible for their maladies and therefore seek folk medicine or a spiritual practitioner rather than pharmaceutical relief or psychotherapy (Harris, 1998; Parks, 2003).

Some ethnic minority elders believe that psychological difficulties are the result of moral misconduct by an individual or by one's ancestors (Braun & Browne, 1998; Gallagher-Thompson et al., 1996). Such a belief decreases the likelihood that the individual will seek mental health services because admission of these problems would bring shame and stigma to the family (Gallagher-Thompson et al., 1996). For example, a Chinese family that believes Alzheimer's disease is punishment for an individual not complying with Confucian traditions and values may not seek help for the individual with dementia. Moreover, if the dementia is considered a justified punishment by spiritual forces (e.g., ancestors, gods, spirits), family members may choose to experience the difficulties as atonement rather than seek support services to improve the condition or circumstances.

Elders, especially ethnic minority elders, are also less likely to seek or accept help from "outsiders," especially mental health providers. In response to experiences of discrimination, abuse, and exploitation, minority communities have often developed their own institutions and support networks to meet the physical and emotional needs of their members. These supports can include religious communities and institutions, extended family including non-blood-related kin, and aid societies. Ethnic minority elders and their families also may strongly subscribe to cultural expectations regarding the responsibility and obligation of younger generations to care for their elders (Gallagher-Thompson et al., 2000).

When ethnic minority elders do finally reach out to mainstream systems of care, they are more likely to see a medical doctor than a mental health specialist (Black, 2000; Cooper-Patrick et al., 1999). Furthermore, older adults, including ethnic minority elders, are more likely to be brought in by a concerned family member or referral from a primary care physician rather than by self-referral (Baker, 1990, as cited in Baker & Takeshita, 2001; Hindrichsen & Dick-Siskin, 2000). Given the cautiousness with which many elders approach mental health services, therapists will need to take special care in the initial stages of therapy to develop rapport with and engage older clients.

Finally, regardless of culture, ethnic minority elders are often experiencing a decline in physical and cognitive functioning. Therapists must be sensitive to possible sensory losses (e.g., impaired hearing and vision), slower cognitive processes (e.g., slowed motor responding and the need for more time to recall information), and other physical changes (e.g., in sleep, appetite, and libido). Therapists should also be aware of life changes and stressors that are more common in later life, including loss (e.g., retirement, death of family members and friends), chronic and acute illness, disability caused by or exacerbated by chronic or acute medical conditions, and a shift in or renewal of interests and relationships (e.g., volunteerism, travel).

COMMON PRESENTING PROBLEMS

There are a number of mental health issues with which older clients commonly present, and being prepared for these and how different cultures understand these issues will aid therapists in treating these populations. These problems are shared by older adults of most cultural and ethnic groups: somatization, depression, dementia, grief, bereavement, intergenerational conflict, and caregiver stress. There are also a number of mental health conditions that may develop secondary to the physical illness or disability common among this population. We discuss all of these issues in this section.

Somatization

Somatization is negatively correlated with level of acculturation; that is, somatic complaints are more common among individuals who are less acculturated to the dominant European American culture in the United States (Gonzalez & Griffith, 1996; Lam, Pacala, & Smith, 1997). For example, more traditionally oriented elders of Asian and Latino heritage are more likely to express depression, anxiety, stress, and anger in more culturally accepted somatic forms such as headaches, backaches, fatigue, gastrointestinal problems, and insomnia (Gonzalez & Griffith, 1996; Lam et al., 1997; Sue & Sue, 2003). To ensure appropriate treatment and at the same time reassure elders that their somatic complaints are being taken seriously, it is essential that therapists thoroughly explore possible medical causes for somatic symptoms. At the same time, the better understanding the therapist has of his or her client's worldview and explanatory model of the illness, the more effective the therapist can be.

Depression

Studies have found that ethnic minority elders report higher rates of depression and depressive symptoms than do European American elders (see

Black, 2000), with a strong negative correlation between level of acculturation and depression (Lam et al., 1997; Zamanian et al., 1992). Ethnic minority elders may be more susceptible to depression because of life stressors that include racism, language barriers, limited education and finances, and, as a result of immigration, smaller support networks and intergenerational conflict within the family. Depression in older adults is also strongly associated with the loss in functional status resulting from physical illness or disability (Zeiss, Lewinsohn, Rohde, & Seeley, 1996). Therapists need to be aware that depression can cause mild to moderate cognitive impairments (e.g., difficulty with short-term memory, impaired ability to focus and sustain attention) that may be misdiagnosed as dementia. However, with successful treatment of the depression, these impairments can improve (Meyers, 1998).

Dementia

Dementia is the most common mental disorder in older adults, with prevalence rates increasing exponentially with each decade after age 65 (Evans et al., 1989). Ethnic minority families are less likely to seek help for an older family member with Alzheimer's disease or a related dementia (Gallagher-Thompson et al., 2000; McCormick et al., 1996). Reasons for this reticence include the belief that cognitive impairment is a part of the normal aging process, that there is no hope for the condition, and that seeking outside assistance would bring further shame and stigma to the family. However, individuals in the early stages of dementia are likely to experience depression and anxiety that can be treated. Early-stage dementia patients may also benefit from memory-enhancement strategies that capitalize on their existing strengths and compensate for cognitive weaknesses (Clare & Woods, 2004). Although some older adults will present with concerns about declining memory, it is more likely that family members will bring the elder's cognitive difficulties to the attention of a health care professional. As the disease progresses, families may seek and benefit from assistance in managing difficult behaviors exhibited by the older adult, such as agitation, aggression, paranoia, hallucinations, wandering, or other unsafe behaviors.

Caregiver Stress

Ethnic minority families are more likely to keep a disabled or ill elder in the community and provide care at home than to hire a paid caregiver or place the older adult in a skilled nursing facility or other external living arrangement (Lockery, 1991; McCormick et al., 1996). As a result, many caregivers are spouses or adult children who are also older adults. Caregivers often experience social isolation and frustration from their caregiving responsibilities and the cultural expectations placed on them as caregivers (e.g., to provide care without complaint or assistance). The stress and burden of caregiving can result in depression, anxiety, anger, increased somatic complaints, and the exacerbation of existing health problems (Ory, Yee, Tennstedt, & Schulz, 2000).

Grief and Bereavement

With advancing age, it is inevitable that older adults will experience losses caused by death. Losing a spouse, relatives, friends, and even adult children becomes more common. Also, it is not unusual for an older adult to begin to experience anticipatory grief for someone who is in the dying process or has been placed outside the home or, in the case of people with Alzheimer's disease, is functionally no longer the same person.

Intergenerational Conflict

Ethnic minority elders who are less acculturated and abide by traditional values and role expectations are more likely to experience conflict with younger generations who have become acculturated to Western values and worldviews. These older adults are likely to experience increased stress, anxiety, and depression because of the conflict. Unfortunately, the culture gap also may reduce the older adult's support system and ability to engage in formerly effective coping or problem-resolution strategies, particularly if the elder does not learn English while younger generations forget their native language or never learn it. The shame of a perceived loss in authority or culturally expected role may further prevent the ethnic minority elder from seeking support from others.

Mental Disorders Secondary to Physical Illness or Disability

Older adults are at greater risk for developing psychological difficulties secondary to physical illness or disability because they are more likely to experience medical problems. Over 75% of older adults have at least one chronic health problem, and 50% have multiple medical conditions (Fried & Wallace, 1992, as cited in Black, 2000). Adjustment disorder, major depression, and anxiety disorders are common reactions to losses associated with a change in functional status. Common medical conditions that result in changes in functional status include diabetes mellitus, hypertension, stroke, chronic obstructive pulmonary disorder, cardiovascular disease, insomnia, cancer, sexual dysfunction, and chronic pain (Sarkisian, Hays, Berry, & Mangione, 2001). These conditions are also associated with symptoms of depression and anxiety (Finch, Ramsay, & Katona, 1992; Zeiss et al., 1996).

Ethnic minority status is significantly related to poorer health outcomes as a result of a lack of preventative care and treatment, poorer quality of life (e.g., because of inadequate pain management), increased disability, and increased mortality (see Institute of Medicine, 2003). Of note is a pattern of discrimination in the physical and mental health treatment of minority clients that cannot be attributed to known factors other than race and ethnicity (e.g., access to health care; Institute of Medicine, 2003). It is clear that ethnic minority elders are at risk for mental disorders secondary to physical illness and disability.

Cohort-Specific Problems

Therapists will also want to be aware of mental health problems within specific cohorts of ethnic minority elders. For example, many immigrant populations, including refugees from Central America, Southeast Asia, and Africa, have experienced trauma associated with political oppression, civil unrest, and war. Consequently, these individuals are more susceptible to posttraumatic stress disorder (PTSD) and its sequelae. Older ethnic minority veterans are also more likely to experience PTSD than are European American veterans, possibly as a result of racial discrimination that placed them in greater danger with less support (Allen, 1986; Loo, 1994).

Culture-Bound Syndromes

Therapists need to be aware that certain symptom clusters are more common in particular cultures. These clusters are recognized in the most recent revision of the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text rev.; *DSM–IV–TR*) as culture-bound syndromes but are not formal *DSM–IV–TR* diagnoses (American Psychiatric Association, 2000). However, these syndromes are widely accepted and formally recognized in many non-Western cultures. Less acculturated individuals are more likely to present with a culture-bound syndrome than are more acculturated older adults.

Advantages of CBT With Ethnic Minority Elders

CBT is structured, psychoeducational, oriented toward problem solving, and directive in its treatment approach, all of which are compatible with the style of relating of many ethnic minority groups (Hays, 1995; Lin, 2001). At the same time, CBT allows for creativity in adapting each treatment plan to individual needs and resources. CBT's focus on the present, specific behaviors, goal-setting, skill practice, and evaluation can decrease clients' anxiety regarding the ambiguity and vulnerability that often arise during therapy (Lin, 2001). And conceptualizing therapy as "going to class" can help to decrease the stigma associated with mental health care (Gallagher-Thompson et al., 1997; Lin, 2001).

CBT emphasizes listening to the client and understanding his or her worldview. It also encourages therapists to interface with the client's environment and support network to identify appropriate change mechanisms for a successful treatment plan. This approach lends itself well to elders who hold a collective worldview and whose thoughts, feelings, and behaviors are intertwined with those of other family and community members. Working with the client's support network has the added benefit of helping the therapist gain the trust of the elder and his or her family, which in turn facilitates learning and increases the likelihood that the new behavior will be maintained over time.

Limitations of CBT

Ethnic minority elders may lack the formal education necessary to be comfortable with the record keeping, homework assignments, and other school-related behaviors typical of a cognitive–behavioral treatment plan. Many immigrant elders from rural areas and developing countries will have limited literacy skills in English and their native language. Moreover, because of social and economic barriers related to segregation and racism, members of ethnic minority groups who grew up and were educated in the United States are also likely to have had less formal education than European Americans.

Another limitation of CBT is its assumption that the client holds an internal locus of control (i.e., sees himself or herself as an agent of change). An internal locus of control requires a sense of autonomy and independence in relation to the external world. In contrast, ethnic minority elders from cultures that value collectivism and interdependence often experience the world with an external locus of control, and thus may have difficulty accepting and engaging with cognitive–behavioral treatment.

The need to identify and address affect in CBT may also be difficult for older adults from cultures in which disclosure of one's emotions is considered a sign of weakness or shameful. Similar difficulties may arise when such elders are asked to isolate, identify, and admit to negative cognitions.

COGNITIVE–BEHAVIORAL THERAPY WITH ETHNIC MINORITY ELDERS

A number of interventions can enhance the assessment process when working with culturally diverse older adults. In this section, we review assessment methodologies, discuss ways to adapt CBT interventions for this population, and conclude with a case example that illustrates a culturally sensitive approach to CBT.

Initial Assessment

In the initial assessment, it is important to schedule extra time to develop rapport so that the elder is more likely to openly report information and engage with therapy. In addition, obtaining elders' personal histories takes longer because elders' histories *are* longer. Because elders may experience some embarrassment in revealing personal information to a stranger, the therapist may wish to emphasize the confidential nature of all therapy sessions. A therapist may establish trust and a personal relationship with the client through some ritual of reciprocity (e.g., an exchange of personal information or a "gift" in the form of helpful information). For example, with a Mexican American elder, sharing some personal information while engaging in small talk (*plática*) can help to establish trust (*confianza*) with the client. At the same time, clinical information can be gathered during this informal conversation.

A source of discomfort for some ethnic minority elders may be the identity of the therapist. Older clients in general may have less confidence in a therapist who is significantly younger than they are. Similarly, ethnic minority elders may have difficulty trusting therapists who are ethnically different from themselves. A therapist can work to overcome this distrust by learning as much as possible about the client's culture, working to understand the elder's explanatory model of his or her illness, and, as much as possible, incorporating this model into the therapist's explanation of the problem and the treatment plan. For example, interviewing techniques such as the LEARN model (***L**isten* with sympathy and understanding to the patient's perception of the problem, ***E**xplain* your preception of the problem, ***A**cknowledge* and discuss the differences and similarities, ***R**ecommend* treatment, ***N**egotiate* agreement; Berlin & Fowkes, 1983, p. 934) and the work by Kleinman and colleagues have been used to elicit a person's explanatory model and to negotiate treatment compliance (Berlin & Fowkes, 1983; Carillo, Green, & Betancourt, 1999; Kleinman, Eisenberg, & Good, 1978).

Incorporating a client's cultural beliefs and vocabulary regarding feelings and emotions is crucial when working with clients who speak English as a second language. Given that individuals tend to be more comfortable expressing intense emotions in their primary language, it can be helpful to allow clients to express their feelings in their native language, although this places responsibility on the therapist for learning the meaning of the words. It may also be helpful to use analogies or stories from the client's culture, life history, or past experiences to help the elder understand the therapist's point and to engage and motivate the client in the therapy process. Therapists should keep in mind that ethnic minority elders may adopt a passive communication style when asked questions. As a result, therapists need to be careful to avoid pathologizing verbal and nonverbal responses that are acceptable within the client's context (e.g., lack of eye contact, difficulty verbalizing feelings, being overly agreeable with the therapist, denial of negative experiences).

Although confidentiality is important, in many ethnic groups the immediate and the extended family are an important aspect of the older client's worldview and value system. Therefore, with the client's consent, interviewing the client's family, friends, and other members of the support system can provide valuable information and help the therapist to better understand the client's values, beliefs, strengths, and community. Such information also helps in determining whether particular thoughts and behaviors are culturally congruent or not. In some cases, inclusion of a traditional healer or religious leader will enhance the elder's acceptance of therapeutic recommendations and commitment to therapy.

After rapport is established, it is important for the therapist to set a clear expectation of the client's role. In the first few sessions, the therapist should introduce the CBT model, educate the client about the importance of therapy compliance and homework, emphasize the client's active role in therapy, and explain effective agenda setting. Some clients may believe that the therapist will "fix them" like a physician. Therefore, it is helpful for the therapist to discuss his or her role in therapy as a guide and active collaborator who will coach the client throughout therapy.

Because older adults are more likely to fatigue, taking short breaks during formal cognitive assessments and extensive clinical interviews is important. This time can also be used to develop rapport with the older adult.

Standardized Assessments

The use of standardized tests with older adults requires caution for at least three reasons (Hays, 1996). First, older adults frequently experience standardized tests as intimidating, confusing, or simply irrelevant. Second, older people referred for mental health problems frequently have physical health problems that can interfere with the attention and concentration required for such tests. Finally, few standardized assessments include age-appropriate norms for older people, particularly elders of ethnic minority cultures. When a standardized assessment is necessary, written assessment tools in the client's native language can help to reduce the probability of the client misunderstanding questions in a second language.

Assessing Affect

Likert and Likert-type rating scales can be less biased in assessing mood states than formal assessment measures and can provide a less threatening medium for disclosure. For example, rating scales that use pictures to depict the anchor points have more face validity and may be perceived as a more innocuous request for information (e.g., using a continuum of happy to sad or angry faces). Another strategy for assessing affect involves asking the client to describe his or her feelings from the point of view of a third party (e.g., "If Mrs. X were [in a similar situation], how and what do you think she would feel, think, or act?"). This may allow the client to feel more distance and therefore increased comfort in talking about emotions.

Adapting Cognitive–Behavioral Interventions

A number of adaptations to CBT can be helpful when working with culturally diverse elders. Given the cognitive changes that arise as a result of the aging process, adapting CBT approaches to accommodate how older adults learn and recall information has been effective (Knight & Satre, 1999). To enhance the learning of specific skills, the therapist will want to keep sessions simple and structured, with regular review of important concepts. Recall of therapy concepts can be enhanced by the use of visual aids such as boards, charts, and handouts, with enlarged print when needed. Allowing the older adult to take notes or audiotape sessions can facilitate the maintenance of behavior change at home. For clients who have impaired vision or hearing, the therapist may use and recommend a magnifying glass with good lighting and a pocket-talker to enhance the therapist's voice for clearer understanding.

In general, older adult clients prefer sessions during the daytime rather than the evening when visual difficulties may make it hard to travel to and from the therapist's office. A number of older adults experience a change in their circadian rhythms that results in an advanced sleep phase pattern in which they are most alert and active in the morning (Ancoli-Israel et al., 2003). Reliance on family members or the use of public transportation means that therapists will need to be flexible regarding the scheduling of appointments. For some clients who are too physically weak or ill to travel, conducting therapy sessions in the client's home or nursing facility may be necessary.

When assigning homework, therapists need to consider what is normal within the client's cultural context and daily routine. Therapists should be careful to keep homework assignments as culturally compatible as possible, assigning tasks that fit easily into the client's existing activities. Tasks may be stigmatizing if too far outside the norms of the client's life, or if they require too much external assistance to complete. However, enlisting the assistance of the client's significant others can facilitate the completion of homework.

When addressing the affective or cognitive components of CBT, using analogies, a third-party example (see the *Assessing Affect* section in this chapter), or examples from folktales, historic lore, or cultural proverbs may help the client to feel more comfortable and increase the person's ability to understand the concepts. Therapists may need to be more directive in the beginning of therapy to point out and provide examples of the client's maladaptive thoughts and their consequences to model and guide the client in his or her ability to attend to metacognitions.

CASE EXAMPLE

The client, AC, was an 82-year-old Chinese American man referred to therapy by his primary care physician for increasing somatic complaints. Initially, AC reported having difficulty caring for his wife, who was in the moderate stage of Alzheimer's disease. When asked, AC denied feeling depressed but reported physical symptoms of upset stomach, low back pain, frequent headaches, insomnia, and heart palpitations. His medical history was significant for hypertension and Type II diabetes mellitus, both managed with medications. He had no prior history of mental illness or psychological treatment.

During the initial assessment, AC reported the following. He and his family had emigrated from mainland China to the United States 40 years ago, in search of better economic opportunities. In China, he had had 8 years of formal education and worked as a deliveryman for various businesses. After moving to the United States, he and his family settled in San Francisco's Chinatown. AC worked as a butcher a block away from his residence and rarely left the community, even after retiring. His primary language was Mandarin, and he spoke some limited English. He denied having a hearing impairment but frequently asked the therapist to repeat herself. He required glasses when reading.

With AC's consent, his daughter Mei was included in the intake process as a source of additional information. Mei worked full time and lived in a separate house with her two teenaged children. She helped to care for her mother to the extent that she could, and AC had become increasingly dependent on her for the management of their household. Contrary to AC's self-report, Mei described him as increasingly irritable, emotionally labile, and apathetic. She reported that he frequently exhibited depressed mood, hopelessness, and passive suicidal ideation. She said that he was becoming more isolated because of his caregiving responsibilities. On the basis of AC's self-reported symptoms, Mei's description, and the therapist's observations, the therapist diagnosed AC with major depressive disorder.

Initially, AC was uncomfortable with the idea of therapy because he did not perceive the therapist as having any credibility. Although the therapist was Chinese American, he believed that she could not be competent because she was a woman and much younger than he. After the first session, AC did not attend the next scheduled session. When the therapist called to reschedule his missed appointment, she carefully listened to his concerns regarding his wife, gave empathic responses, and provided information regarding how behavioral interventions could help him to better manage his wife. This informational exchange was meant to be a form of gift giving aimed at building rapport and trust with AC, and it worked. After the interaction, AC began attending therapy sessions regularly. Over time, he was able to learn more about the therapist as a person and to experience her knowledge and empathy regarding his immigration experiences. To reinforce his willingness to attend sessions, the therapist was careful to accommodate AC's scheduling needs, which involved relying on his daughter for transportation. This also allowed for the opportunity to occasionally include AC's daughter in the therapy sessions.

The therapist assessed AC's comfort and proficiency with the English language and found that although AC was not fluent in English, his comfort level and grasp of the language were sufficient to continue therapy together. To better understand her client's explanatory model of illness, she asked AC what he believed caused his somatic problems and what he believed would result in their resolution. AC stated he believed that his physical problems were caused by an imbalance of his *chi* (i.e., energy or life force). He explained that he was not eating right or exercising regularly as he did before caring for his wife. He did not see how he would benefit from mental health services, as he believed he could eliminate his symptoms if he made a concerted effort to eat a balanced diet and exercise daily. The therapist did not challenge his explanatory model of illness. She instead used his belief in the interaction of body and mind to describe his presenting problems, and she incorporated elements of his explanatory model (e.g., the importance of enhancing one's chi during times of stress) to describe the rationale for the treatment plan. Although the therapist's knowledge of the basic principles of Chinese medicine facilitated the therapeutic process, it was her solicitation of and listening to AC's explanatory model, and the incorporation of his beliefs, that resulted in AC's engagement in the therapy process.

The therapist spent four sessions educating AC about the CBT model, emphasizing the importance of homework assignments and agenda setting, and discussing therapy goals. She also explained her role as his therapist. She said that the sessions would be very structured, using an agenda. They decided collaboratively that his goals would be to reduce his physical distress and to improve his ability to cope with his caregiving responsibilities. They agreed that they would focus a portion of each session on caregiving concerns (i.e., questions about behavior management regarding his wife), and the rest of the session would be dedicated to attaining his goals of reducing the physical distress and improving his coping skills.

Initially, AC's mood was assessed weekly via his verbal self-report and completion of the Chinese version of the Geriatric Depression Scale (Stokes, Thompson, Murphy, & Gallagher-Thompson, 2001). However, his self-report and responses on the questionnaire were not congruent with his clinical presentation or with his daughter's report. Consequently, the therapist changed her approach to incorporate a Likert-type rating scale anchored by a happy face and a sad face. This method of assessment appeared to more closely reflect the therapist's observations and his daughter's reports and was incorporated into the weekly assessment of AC's stress and somatic symptoms.

Because of AC's apathy at the beginning of therapy, behavioral rather than cognitive interventions were the initial focus. The therapist asked AC to complete the Older Person's Pleasant Event Schedule (OP-PES; Gallagher & Thompson, 1981) at home. The OP-PES is a self-report measure that asks the client to rate the frequency and enjoyment of a number of activities that older people often find enjoyable (e.g., kissing, touching, showing affection, listening to birds sing). Although Mei helped translate unfamiliar words while he completed the scale, AC did not endorse many of the items because they were not culturally relevant to him. At the next session, the client and therapist collaboratively developed a list of pleasant events on the basis of his response to the OP-PES, and he was asked to complete at least three of the pleasant events on his list. The next week he reported that he did not do any of the activities. When the therapist explored his homework noncompliance, he reported that he did not like the activities listed. In the session, the therapist asked him to create a list of activities he enjoyed. This list included items such as doing tai chi and Chinese calligraphy, walking, reading the Chinese newspaper, and visiting Chinatown and his friends. After revising the list, his homework compliance was 100%. Within a month, his mood had improved as assessed by his daily mood ratings, his daughter's report, and the therapist's observations; he reported fewer somatic symptoms and reduced caregiver stress; and he showed an increased ability to manage his wife's problematic behaviors.

Once AC became more behaviorally engaged, the therapist began to introduce cognitive interventions into therapy. AC appeared to have several maladaptive thoughts that contributed to his depressed mood. One of these was the belief that his daughter's refusal to drop her employment and other responsibilities, to provide full-time care for her parents, was a reflection on his authority as head of the family. He believed that it was shameful that she was not more willing to fulfill her obligation to her parents according to Confucian laws. He expressed some catastrophic thoughts that Mei's behavior was evidence that he had lost his potency as a father and as a man, and that none of his children would care for him if or when he became ill or disabled. The therapist recognized that within AC's culture, such a situation *would* be seen as pitiful and shameful. A related belief held by AC was that men should not be engaged in "women's work"; his difficulty performing traditionally female responsibilities only added to his feelings of inadequacy.

The therapist helped AC complete thought logs that specified his beliefs, thoughts, and feelings regarding his daughter's behavior, the caregiving situation, and his role within the family. She explained how what people believe and think about something affects how they feel. She also pointed out how feelings can include emotions (e.g., his frustration with his daughter) and physical symptoms (e.g., the stomachache he experienced when frustrated). She then helped AC to look for and record evidence of the many ways in which his daughter did provide support.

In addition, with the therapist's help, AC was able to engage his other two children to assist in the caregiving responsibilities for their mother. To facilitate this, the therapist asked all three adult children to attend a family session in which the client's request for increased support was reinforced by the therapist. Finally, via several discussions of the cultural norms regarding traditional roles and responsibilities for men in AC's culture, the therapist helped AC to reframe the tasks he considered traditionally feminine as acceptable for a strong husband who wishes to provide for his wife.

At the end of his 20-week treatment, AC's depressive and somatic symptoms had decreased significantly, and he reported his caregiving role to be less stressful and burdensome. He described feeling more competent in his ability to care for his wife and to manage his household effectively. He was also receiving more help from his children.

CONCLUSION

The population of elders and particularly ethnic minority elders in the United States is growing rapidly. To provide effective care, therapists need to be culturally competent and knowledgeable regarding the diversity of older adults. This chapter offered suggestions for modifying cognitive–behavioral assessment and interventions with culturally diverse elders. Although it may take more time, effort, and patience, working with ethnic minority elders can be a rewarding experience for both the client and the therapist.

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