

MENTAL HEALTH CHALLENGES  
OF OLDER IMMIGRANTS IN  
CANADA

by

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### **Abstract**

The aim of this thesis is to offer an extensive review of current research on the barriers that older immigrants face upon entry to a new host country. Evidence has shown that older immigrants, particularly those from cultural backgrounds that are incongruent with those found in immigrant receiving communities in North America and Europe, are susceptible to relocation stress that manifest in higher levels of depressive symptoms. In general, immigrants and refugees are less likely than their Canadian-born counterparts to seek out or be referred to mental health services, even when they experience comparable levels of distress. Considerable evidence supports the tendency for immigrant older adults and their family members to hide mental health challenges and avoid seeking help out of fear of shame or rejection.

Based on the findings of this comprehensive review this thesis offers therapeutic implications for professional who may work with or encounter these older adults. This includes but is not limited to social workers, medical professionals, and community outreach workers. My review will include an assessment of existing programs for older adults in British Columbia

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## MENTAL HEALTH CHALLENGES OF OLDER IMMIGRANTS IN CANADA

### **Chapter 1- Introduction**

The purpose of this chapter is to introduce my study, which is focused on the barriers that older adult immigrants face after settling into their new homeland. I will outline the purpose of my thesis, its relevance, and offer a brief overview of literature on the topic. I will also define key terms and phrases, situate myself as the author, and explain the structure of the thesis. This chapter also includes an overview of existing projects and outreach services in British Columbia that specifically target older immigrants who may be at risk for ill mental health.

### **Research Question**

The main research question that my dissertation is intended to answer is what do clinicians and policy makers need to know to effectively support the older immigrant population in Canada with their challenges and struggles that may lead to mental health disorder? To answer my question I will be reviewing a number of relevant studies on the association of migration and mental health statuses of older immigrants, and examine services available for them that can help with their assimilation process and mental well-being.

### **Purpose Statement**

I am doing this study with the three foci, all of which are centred on the optimal health defined below and mental health, also defined below of older immigrants in

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Canada and BC. These three foci are:

- To identify and evaluate the efficiency of existing programs that target potentially at risk older adults in BC;
- To identify the barriers that older (define older) immigrants face after arriving in the new host country;
- To formulate implications for therapeutic intervention and community outreach so that these older immigrants can be better served.

### **Relevance & Scholarly Context**

Evidence (Koehn, Jarvis, Sandhra, Bains, & Addison, 2014.) has shown that older immigrants, particularly those from cultural backgrounds that are incongruent with those found in immigrant receiving communities in North America and Europe, are susceptible to relocation stress that manifest in higher levels of depressive symptoms. Yet these same older adults are least likely to seek out mental health services. Considerable evidence (Koehn et al., 2014) supports the tendency for immigrant older adults and their family members to hide mental health challenges and avoid seeking help out of fear of shame or rejection, in order to “save face” and to protect family honour and reputation. This is strongly related to stigma—mental illness is labeled as incurable in some cultures or it may have connotations of being ‘crazy’ or ‘maniac’, for example in Farsi. Stigma around mental illness is a big problem among the immigrant population.

In addition, some 80% of adults who arrive in Canada after the age of 60 are

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sponsored by their children and the sponsors of these older family members are financially responsible for them for ten years post-migration, during which time they may not be eligible for pensions, social services, extended medical and housing subsidies, depending on the province in which they live (Koehn et al., 2014). These immigrants struggle with limited knowledge of Canadian society and the local environment, loss of social connections and role reversals as a result of dependency for their everyday activities (Koehn et al., 2014). They often find themselves isolated and dependent on their adult children for information, translation and transportation, as well as basic needs (Koehn et al., 2014). These factors can influence their mental health and access to services.

Mourning the loss of one's native country is emotionally exhausting, since immigrants in general encounter multiple losses when leaving a homeland behind in hope of cultivating one's life. Immigration disrupts every aspect of an individual's life, and it can influence her or his mental health. World Health Organization (as cited in Ebrahimian, 2005) considers mental health to be a major international public health issue. The mental health of older immigrants deteriorates over time and this group experiences unique physical, psychological, and social changes that individually and/or in combination with one another may challenge their mental health, sometimes resulting in mental illness (Guruge, Thomson, & Seifi, 2015). Mental disorders represent 4 of the 10 leading causes of disability worldwide with huge costs in terms of human misery, disability, and economic loss (Ebrahimian, 2005).



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Canada has an increasingly aging population and we experience population growth based on immigration—a large proportion of the growing population of older adults in Canada are immigrants (Guruge, Thomson & Seifi, 2015). According to statistic Canada for the first time, there are more persons aged 65 years and older in Canada than children aged 0 to 14 years. Nearly one in six Canadians (16.1%), a record 5,780,900 Canadians was, in 2015, at least 65 years old, compared with 5,749,400 children aged 0 to 14 years (16.0%) (Statistic Canada, 2015). With the continuous increase in the immigrant population in Western countries, it is essential for practitioners and policymakers to understand the factors that facilitate optimal health and well-being in older immigrants, who are often considered one of the most vulnerable immigrant groups due to the multiple challenges they face as immigrants and older adults (Lai & Chau, 2007, p.261). This is even more crucial knowing that people of ethnic minorities in the Western countries face more barriers than people of the majority mainstream culture. Plus, service barriers are detrimental to the health of older immigrants (Lai & Chau, 2007) and encountering barriers for accessing health care services and other resources in Canada is an ongoing struggle for older immigrants due to language incompatibility and cultural differences.

Considerable evidence supports the tendency for immigrant older adults and their family members to hide mental health challenges and avoid seeking help out of fear of shame or rejection (Sandhra, Bains, & Addison, 2014). This thesis aims to close this gap in mental health support access for this particular population and in doing so foster and promote health and well-being (defined below).

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### **Method**

This thesis is based on an extensive literature review, which will focus on recent studies on the challenges and barriers older adults may face as they enter a new country and culture. The literature review will focus mostly on immigrants entering North America, and where possible I will focus on Canada. One reason for option for a literature based methodology is that not only is this population difficult to locate or find (many older adults end up living in with their children and as outlined above, many will hide their inner struggles for fear of judgment or due to cultural stigma), they are also vulnerable to be harmed in the process of the research. A literature based method avoids this issues all together. My aim is to offer an extensive review of current research on the barriers that older immigrants face upon entry to a new host country. Based on the findings of this comprehensive review I aim to offer therapeutic implications for professional who may work with or encounter these older adults. This includes but is not limited to social workers, medical professionals, and community outreach workers. My review will include an assessment of existing programs for older adults in British Columbia, which I am discussing next.

### **Current Programs and Outreach for Older Adults in BC**

In 2009, the Ministry of Advanced Education and Labour Market Development and the Ministry of Healthy Living and Sport dedicated \$780,000 to expand services for older immigrants. In addition, the Province invested at that time an additional \$782,000 for eight community-led projects to help immigrant seniors improve their English

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language skills, increase their access to services and increase their knowledge of life in Canada (Ministry of Advanced Education and Labour Market Development & Ministry of Healthy Living and Sport, 2009).

Expanded services included modified English language and computer skills training; information and support services, referral resources, community outreach, peer support and mentorship programs, as well as skills development and training to enhance access to volunteer opportunities (Ministry of Advanced Education and Labour Market Development & Ministry of Healthy Living and Sport, 2009). The projects were targeted especially to include those older immigrants who are isolated from the broader community, to help increase their awareness of community and government resources.

Through a province-wide public procurement process, agencies in the Lower Mainland, Fraser Valley, Vancouver Island and the Interior were selected to provide a range of services that will create a sense of belonging and well-being among older immigrants and refugees (Ministry of Advanced Education and Labour Market Development & Ministry of Healthy Living and Sport, 2009). The projects were focused on immigrant seniors over the age of 55 with priority given to permanent residents who are recent arrivals (Ministry of Advanced Education and Labour Market Development & Ministry of Healthy Living and Sport, 2009).

The agencies were to partner with established seniors' and health service networks to support their ability to provide responsive services to immigrant seniors from increasingly diverse ethno-cultural backgrounds (Ministry of Advanced Education and Labour Market Development & Ministry of Healthy Living and Sport, 2009).

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The Province established these projects through WelcomeBC, which provides services to immigrants and refugees to support their integration into their new communities and builds on the province's history of welcoming newcomers and creating inclusive communities (Ministry of Advanced Education and Labour Market Development & Ministry of Healthy Living and Sport, 2009).

WelcomeBC is supported through the Agreement for Canada-B.C. Co-operation on Immigration, which provides funding through the transfer of approximately \$120 million per year from Citizenship and Immigration Canada to the B.C. government, which is responsible for administering settlement services for new immigrants. (Ministry of Advanced Education and Labour Market Development & Ministry of Healthy Living and Sport, 2009, par. 12).

My review will include an evaluation and review of these projects and their impact on the access to mental health services for the population identified.

### **Key Terms and Phrases**

*Older Adults:* When I use the term older adults, I am referring to adults who are 65 years or older. In this thesis I will not use terms such as elderly or seniors as these are umbrella terms that reduce the older adult to her or his age. Following APA, I therefore use “people first” language and will consistently refer to this population throughout this work as *older adults*.

*Mental Health:* When referring to mental health, I am using the term in the meaning that the WHO (2014) gives it, namely, as a state of well-being, “in which every

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individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community”.

*Mental health services:* I am adopting the definition of the Canadian Mental Health Association (2012), namely within the framework of the determinants of health.

While medical services are necessary, they are by no means sufficient to deal with the crippling social and economic factors that often accompany serious mental illness. People also need psychosocial services to assist with activities such as securing housing, income supports, education, and employment, and resources outside the formal service system such as peer and family support or generic community organizations. (par. 2)

*Barriers:* Timely access to needed mental health services is critical (Canadian Mental Health Association, 2012). Barriers to service access include: stigma; poverty; lack of integration between mental health and health services; shortage of mental health professionals; regional disparities and cross cultural diversity (Canadian Mental Health Association, 2012). As a result, demand for services often exceeds supply (Canadian Mental Health Association, 2012). Some populations (children/youth, older adults and people with severe and persistent mental illness) are in particular need (Canadian Mental Health Association, 2012).

*Immigrants and newcomers:* These terms are used as synonymous and refer to persons residing in Canada who were born outside of Canada, excluding temporary

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foreign workers, Canadian citizens born outside Canada and those with student or working visas (stats Canada, 2010).

*Health:* The World Health Organization (WHO) defines health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” (2014). This statement conveys a strong message; healthy mental health is vital to individual’s functioning in the society as well as their well-being. It is very hard to live life to the fullest if the individual is dealing with mental health disorder.

### **Situating the Author**

Through my family’s experience with migration, as well as my recent work experience with senior newcomers in Canada, I have come to recognize that older adults who immigrate to a new country may face many obstacles, and tackling these obstacles require a sense of self-determination and a strong set of adaptation skills. Yet it is almost impossible to foresee and to plan for most of the barriers that arise following migration. According to my experience assisting older immigrants with the integration process, I recognize that for the majority of older immigrants this process is accompanied by a number of stressors and challenges. And, considering that immigrants in general experience enormous losses when they leave their homeland, the presence of mental health issues is very predictable. It is also important to note that immigration could trigger stress and psychological complications for individuals, since so much change occurs during the process. Some of the losses that the older immigrants that I worked with stated during assimilation included lifestyle changes, as well as a loss of language,

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identity, culture, values, food, friends, and relatives. John Bowlby, who was a notable psychologist that helped to develop the concept of attachment theory, noted that "there is a marked tendency for humans, like animals of other species, to remain in a particular and familiar locale and in the company of particular and familiar people" (Ecke, 2005, p. 9). The feeling of unfamiliarity is a fragment of the assimilation process, and I believe coming to a new environment where nothing is recognizable is one of the main barriers that immigrants encounter. All of these factors will most likely make it difficult for these older immigrants to acclimate to their new environment. There are limited research studies available that highlight the mental health of immigrants in Canada, and there are certainly only a few available for older adults; therefore, I believe it is essential that more studies are conducted in the near future. It is my hope that this work will contribute to the alleviation of their challenges.

### **Structure of this Thesis**

In this chapter I have outlined the purpose and relevance of this study, and I have offered a brief scholarly context for it. I have outlined key terms and phrases and I have situated myself as researcher. The next chapter will offer an extensive overview of the literature on the barriers that older adults may face after immigration. The final chapter will recap findings, offer implications for counsellors, and offer suggestions for future research.

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### **Chapter 2- Literature Review**

This chapter will review existing literature on older adults who migrate. Specifically, I will address Ageism and Discrimination, Depression and Suicide Risk, Relocation Stress, Mediating Dependency Needs, Loss of Home and Loss of Attachments, Language Barriers, Financial Barriers, Service Availability and Service Access, and the Special Case of Health Care (the elderly use health care more than the young, and all the barriers above tend to combine where access to health care is concerned)

#### **Ageism and Discrimination**

As Canada's population ages, we grow more and more concerned about our health-care system's ability to pay for the escalating costs of caring for older citizens (McCallion, 2016). It is almost impossible to foresee and to plan for most of the barriers that arise following migration. The mental health of older immigrants deteriorates over time and this group experiences unique physical, psychological, and social changes that individually and/or in combination with one another may challenge their mental health, sometimes resulting in mental illness (Guruge, Thomson, & Seifi, 2015).

Ageism is circumstantial, and in my belief elder immigrants experience further difficulties, as they also must combat discrimination and racism. Older citizens deal each day with the most widely tolerated form of social prejudice in the country: ageism (McCallion, 2016).

According to a new report released by senior-living company Revera and the



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Sheridan Centre for Elder Research—Revera Report on Ageism: Independence and Choice As We Age, one in four Canadians admit treating someone differently because of their age. The report found that half of all Canadians aged 77 and older say that younger people automatically assume the older people can't do things for themselves. And more than one-quarter of older seniors say that because of their age, younger people make choices for them without asking their preference (McCallion, 2016). Yet studies by Yale University found that holding ageist views hinders a person's ability to recover from severe disability and shortens lifespan.

Winerman (2006) cites gerontologist Robert Atchley, PhD, who, 30 years earlier, contacted every resident over the age of 50 in the town of Oxford, Ohio (Winerman, 2006). About two-thirds of them—over 1,100 people—agreed to participate in Atchley's Ohio Longitudinal Study of Aging and Retirement (Winerman, 2006). The participants answered multitudes of survey questions about their physical and mental health, socioeconomic status, work life, family and other topics (Winerman, 2006). Included in the questions were a few that measured the people's attitudes toward their own aging—they were asked to agree or disagree with statements such as "I am as happy now as I was when I was younger," and "As you get older, you get less useful" (Winerman, 2006).

Over the years, the participants returned several times to answer more questions, giving the researchers a detailed snapshot of the course of aging in late 20th-century America (Winerman, 2006).

In the late 1990s, Yale University psychologist Becca Levy, PhD, (as cited in Winerman, 2006) wondered whether the aging-attitudes questions from the Ohio study

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could inform her answer: Could people's attitudes toward aging influence how long they lived?

Levy collected death records to find out whether each participant was still alive or the age at which they had died (Winerman, 2006). When she matched up the records with the people's survey answers, she found that people with more positive views of their own aging lived, on average, 7.6 years longer than people with more negative views (Winerman, 2006). This significant survival advantage remained after controlling for other relevant factors.

Levy's study is one of many over the past several years that have begun to suggest that your personality, attitude toward aging and other psychosocial variables might help either grant you extra years or shorten your life (Winerman, 2006). Personality and attitude may also influence your physical and mental abilities as you age (Winerman, 2006).

If that's true, ageism and negative stereotypes relating to older adults could have serious consequences that go beyond just making people feel bad. Indeed, ageism and negative images of aging could be a public health issue (Winerman, 2006). Older people who believe they have little or no control over their health tend to be less likely to engage in preventative health behaviours or seek medical help when they encounter health issues (Nelson, 2016). Ageism presents a clear and direct threat to the healthy aging of older persons. Negative age stereotypes, whether perpetuated by younger persons or health care workers or even believed and internalized by older persons themselves, have been demonstrated to cause real harm to the mental health of older persons, reduce their will to

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live, impair memory, and lead older persons to avoid preventive health behaviors (Nelson, 2016, p. 280).

### **Suicide**

Older people have a greater risk for committing suicide than younger individuals (Roy, 2003). According to the National Institute of Mental Health (NIMH), adults age 65 and older represented only 12% of the population in the United States in 2004, but they accounted for about 16 percent of all suicide deaths in the United States (Kandel & Adamec, as cited in Roy, 2003). In considering suicide rates, the national average in the general population was 10.0 suicide per 100,000 people, but the rate for individuals age 65 and older was 14.3 per 100,000 people (Roy, 2003). Older adults have a higher rate of death due to suicide than younger adults do (Kandel & Adamec, 2009). Dealing with mental illness like depression, poor health, anxiety, stresses in life, and feeling useless can be some of the reasons why older adults commit suicide, with depression being the most common diagnosis in older adults who have attempted suicide (Zweig & Hinrichsen, as cited in Roy, 2003). Depression commonly accompanies a chronic disease, particularly when the disease impairs function (Casten, Rovner, & Edmonds, as cited in Roy, 2003). Physical health status is the most consistently reported risk factor for the onset and persistence of depression in late life (Gatz & Fiske, 2003). Several other common correlates have been associated with older adult depression, such as cognitive dysfunction, genetic factors, interpersonal relations, and stressful life events.

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Depression can also be brought on by anxiety in older adults (Roy, 2003). In fact, the relationship between anxiety and depressive symptoms in later life are relatively common among older adults (Wetherell, Gatz, & Pederson, 2001). However, little is known about the particular features that may distinguish elders with anxious depression from elders with depression alone (Lynch, Compton, Mendelson, Robins, & Krishnan, 2000).

### **Dependencies**

According to research compiled by a group of scholars in Canada, there is a higher risk of mental illness in people who migrate after 65 years of age (Hansson, Tuck, Lurie, & McKenzie, 2010). Seniors often depend heavily on their families for their everyday planning, relying on their children and grandchildren to assist them in daily activities, and unlike younger age groups who are able to socialize at school or work, the elderly are much more isolated and their families may often be their only social contacts or support. A significant research study by Haideh Moghissi (2009) who conducted multiple interviews with Iranian seniors living in Toronto concluded that a major concern of Iranian seniors was the idea of being an imposition on their children in the management of their day-to-day lives because of language incompatibility. They also emphasized that they do not want to burden their children with their health problems. Another reason that seniors become dependent on younger adults in their family is the inability to learn the language quickly. Lack of communication also limits them from

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having access to services such as ESL classes, labour markets, health facilities, and social engagements.

### **Loss of home**

Mourning the loss of one's native country is emotionally exhausting and complex since immigrants in general encounter multiple losses when they leave their homeland behind in hopes of cultivating their lives. For instance, some of the losses my older clients expressed included lifestyle changes, as well as a loss of language, identity, culture, values, food, friends, and relatives. John Bowlby (1973), who was a notable psychologist that helped to develop the concept of attachment theory, noted that, "there is a marked tendency for humans, like animals of other species, to remain in a particular and familiar locale and in the company of particular and familiar people" (p. 147). The feeling of unfamiliarity is a fragment of the assimilation process, and for my senior clients in particular, the loss of familiar and safe surroundings and moving to a new environment in which nothing was recognizable was very difficult.

As human beings when we are separated from our tribe – meaning our social support group including our family and friends – we feel anxious. I believe that humans have relied on each other for survival for thousands of years, as they have built communities, languages, and cultures. And, when people are detached from the elements that they have shaped their identities on, they often experience a grieving process. Winokuer and Harris (2016) explained that, "relationships are linked to our primary, instinctual need to be close to significant others in order to feel safe and to feel a sense of

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‘anchoring’ in our world” (p. 27). As human beings, when we are incapable of forming meaningful connections in a new environment and lose touch with the people who we were close to, it is common that we feel distressed. The feeling of displacement and being far away from those who matter to us is part of the fate of an immigrant. Social isolation has damaging effects on the quality of life for immigrant seniors, and for this population it takes considerable energy and time to rebuild these networks that were lost when they left home.

### **Language And Financial Barriers**

Senior immigrants may find it harder to make new connections in Canada because of inadequate language ability and as a result find themselves isolated. According to Statistics Canada, among recent immigrant seniors who arrived between 1991 and 2001 and lived in Vancouver, some 60% could speak neither English nor French (Kaida & Boyd, 2011). In a recent study done by a group of researchers at the University of British Columbia, it was found that one of the main struggles that older immigrants encounter is the ability to learn a new language and converse in dialect with others. The participants in another research study conducted by Jafari, Baharlou & Mathias (2010) at the University of British Columbia believed that the inability to speak English might create isolation, marginalization, anxiety, and mental health problems for adults. In this same research study, a 64 year old elderly immigrant who had been in Canada for five years, shared the following:

If English is not your first language, even if you are highly educated and

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successful in your own country, you cannot find a good job or sometimes, any job, in the new community... It's not just speaking the language, it is communicating with the host society... (p. 103)

Another drawback for seniors with language problems is the inability to find work and contribute financially to theirs and their family's lives. In Canada, in order to be a successful candidate for a job application, the individual needs to submit a resume and cover letter, and if the candidate is selected there is an interview that follows. All of these steps in the job search process require adequate language skills and without this knowledge or language competency, senior immigrants are at a major disadvantage in securing work in Canada. When trying to enter the labour market, there is often a lack of recognition of non-Canadian educational credentials and local work experience from out of the country, which is one of the challenges all immigrants experience, however the impact is even greater for older immigrants. All of these factors can add to the isolation and acculturative stresses of seniors and negatively affect their mental health and wellness. In their research, Kaida and Boyd (2011), using data from the 2006 Canadian Census of Population discovered that, "in 2006, about 30 percent of immigrants aged 65 and older who were in Canada fewer than 20 years were living in households having incomes below Statistics Canada's Low Income Cut-off" (p.83). According to this article, some senior immigrants live in poverty and are struggling to make ends meet and have limited access to resources, which is very similar to the situation of my clients at SUCCESS.

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### **Access to (Mental) Health Care**

Access to care is a major issue. Where particular immigrant, refugee, ethno-cultural and racialized (IRER) groups have higher or a lower rate of illness is a moot point given they all have difficulty getting care (Hansson et al., 2010). Equity of service provision is a particular concern. Canadian literature cites additional barriers to care such as stigma, awareness of services, language difficulties, transportation costs, socio-economic factors and differences in illness models between services and clients as factors that delay treatment (Hansson, Tuck, Lurie, & McKenzie, 2010)

There are a number of studies, which also list factors that have been demonstrated to facilitate service use. These include literacy, trust in services, cultural competence, targeted health promotion, an increased diversity of services, and links between different types of services (Hansson et al., 2010).

Hansson et al. and Kirmayer et al. also make similar claims. When seeking resources and being referred to service providers that can provide the appropriate services to help this group of individuals, there are obvious barriers. “In general, immigrants and refugees are less likely than their Canadian-born counterparts to seek out or be referred to mental health services, even when they experience comparable levels of distress” (Kirmayer et al., 2011, p. 962). This can reflect both structural and cultural barriers, including the lack of mobility or ability to take time away from work, lack of linguistically accessible services, a desire to deal with problems on one’s own, the concern that problems will not be understood by practitioners because of cultural or linguistic differences, and fear of stigmatization. (Kirmayer et al., 2011, p.962)



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Specific challenges in migrant mental health include communication, cultural shaping of symptoms and illness behaviour, the effect of family structure and process on acculturation and intergenerational conflict, and social integration (Kirmayer et al., 2011). There is limited but consistent evidence from qualitative studies and clinical experience in intercultural primary care that these challenges can be addressed through specific enquiry into social and cultural context, the use of interpreters and culture brokers, meetings with families and consultation with community organizations (Kirmayer et al., 2011).

With a plan in place, a data stream and an engaged community, services can forge a path of collaboration and internal development. According to research gathered by (Hansson et al., 2010) there are five groups of action required to improve mental health services for IRER groups:

1. Changed focus—an increased emphasis on prevention and promotion.
2. Improvement within services—organizational and individual cultural competence.
3. Improved diversity of treatment—diversity of providers, evaluation of treatment options.
4. Linguistic competence—improved communication plans and actions to meet Canada's diverse needs.
5. Needs linked to expertise—plans to offer support by people and services with expertise to areas with lower IRER populations so they can offer high quality care.

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The report recommends that a national panel of experts—academics as well as members of the communities served—work together on these issues.

### **Stigma**

According to Guruge et al. (2015) “older immigrants with mental health problems face overlapping stigma: the stigma of mental illness, the stigma of being older, and the stigma of being an immigrant” (p. 433). In addition to the ordeals that result from the natural process of aging, elder immigrants face enormous challenges in the process of assimilation.

Mental disorders are highly stigmatized in most countries, and patients are extremely reluctant to attribute symptoms to a mental disorder (Kirmayer et al., 2011). The stigma of a psychiatric diagnosis affects those who are suffering from mental illness. In most instances, hiding it is the only possible option for older immigrants.

Culture influences the way people view mental illness and whether people even seek help in the first place, or if they would conceal their symptoms. Public attitudes toward mental illness can be very negative and stigmatizing in certain culture like Chinese. According to Statistic Canada (2015) the immigrant population comprises 20.6% of Canada's population, so one in five people living in Canada is an immigrant. In Addition the number of immigrants from China grew 63.9% from 332,825 in 2001 to 545,535 in 2011, making Chinese the second largest foreign-born group in Canada. A recent study that investigates the stigma experienced by Chinese immigrants indicates that close to half of the participants reported that family members looked down on them

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because of their mental illness and treated them poorly using interpersonal forms of aggression or perceived them to be less of an individual (Cheng, Tu, Li, Chang, & Yang, 2015).

Chinese immigrants who struggle with mental illness face discrimination in variety of domains. Because mental illness is perceived as a barrier in acquiring work Chinese immigrants that have mental illness may face higher levels of social rejection by their families given the context and pressures of their immigrant community. In addition to the negative consequences from stigma in terms of service utilization, stigma against those with mental illness is associated with lower quality of life for Chinese immigrants with mental illness, as well as experiences of discrimination (Cheng et al., 2015).

In terms of anti-stigma efforts, prior studies have shown that both contact with those with mental illness and education about mental illness are effective ways to lower stigma among the public (Cheng et al., 2015). Anti- stigma efforts can help immigrants with mental illness who won't seek help for fear of being labeled and rejected by their support system to get the appropriate health care services at the right time.

### **Possible solutions**

When working with different cultures, it is important to not generalize the experiences as each individual is unique and what seems appropriate to one may not be a cultural norm to another person. Therefore service providers understanding of cultural barriers when older immigrants want to access health care services are vital for recovery. These services need to meet social, cultural and linguistic needs of the immigrant

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population and failure to provide culturally competent care can greatly increase the stresses experienced by this group.

Also, working with different agencies and policy makers to assist them in understanding the needs of culturally appropriate services is important. Creating safe and community-based mental health services for older immigrants who are socially isolated can help them participate in different activities and feel welcomed. There are also a number of studies that also list factors that have been demonstrated to facilitate service use. These include literacy, trust in services, cultural competence, targeted health promotion, an increased diversity of services, and links between different types of services (Hansson et al., 2010).

### **Conclusion**

For some, the experience of being an immigrant builds resilience and is a positive experience, but for others it undermines their mental health. Immigration involves major transitions in one's life, and therefore the prevalence of mental health problems is very probable. Risk factors for psychological distress among newly arrived older immigrants include less education, unemployment, poor self-rated health, chronic diseases (heart disease, diabetes, asthma), widowhood or divorce, and lack of social support or living alone (Kirmayer et al., 2011).

The mental health of a person, their family or community depends on their resources and histories and their current social circumstances (Hansson et al., 2010). When there is lack of resources or inappropriate services for older immigrants, their

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families and community around them will be impacted as well. Older immigrants may find mainstream mental health services disrespect their values and discriminate against them.

Canada is one of the most diverse countries in the world but its mental health policy and services do not embrace that diversity, since people from IRER groups often have poorer access to care and poorer treatment (Hansson et al., 2010). Improving services and outcomes for IRER groups is a common challenge for mental health systems in Canada and increased rates of illnesses, poorer access to care and poorer satisfaction with services have previously been reported (Hansson et al., 2010). Canada is a multicultural country, and every year thousands of immigrants enter this promising land in hopes of a better life than the one they left behind. The issue of experiencing poor services in the mental health field increases the chances of major mental illness in the future and wellbeing in a community.

Understanding both the unique characteristics of elderly immigrants and the challenges some of them face is important for me to learn as a competent counsellor. I believe that since Canada relies heavily on immigration for creating a prosperous society, further research is needed to enhance understanding and strategies related to the mental wellbeing of all immigrants, in particular seniors who are more vulnerable. As a former immigrant, I have discovered that I embody a sense of empathy while conversing with other immigrants, regardless of their religion or race. Immigration is a loss of many aspects of life, and as a compassionate counsellor, I need to recognize my client's suffering and understand their struggles from their worldview. I believe helping clients to

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accept their new living situation in their host country is the first step toward transformation. Empowering older clients to transform their loss into an experience they can grow from can be a very rewarding practice for the therapist.

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### **Chapter 3- Methods**

In this chapter I will outline my methodology, which is a content analysis. In this chapter, I heavily borrow from Cresswell's 2007 text title *Qualitative Inquiry and Research Design*. In this chapter I will first address my method and remind my reader of the purpose of this theses. I will address the data base in this study and spend most of this chapter addressing the data analysis process and its thematic outcome.

#### **Method**

To remind the reader, the goal of this thesis is to discover what do clinicians and policy makers need to know to effectively support the older immigrant population in Canada with their challenges and struggles that may lead to mental health disorder? To answer my question I have reviewed and gathered literature that addressed my research question. This is not a meta-analysis. Rather, this is a content analysis to identify themes and clinical priorities.

Analyzing text and multiple other forms of data, let alone representing them in tables or narrative, is challenging for qualitative researchers (Cresswell, 2007). Deciding how to represent the data in tables, matrices, and narrative form adds to the challenge. In this section, I will follow Cresswell's approach, and first discuss general procedures for qualitative data analysis and then detail the analysis procedures often used in each of the five approaches to inquiry. I then discuss Cresswell's data analysis spiral that I find useful to conceptualize a larger picture of all steps in the data analysis process in qualitative research. I use this spiral as a conceptualization to further explore each of the

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five approaches to inquiry, and I examine specific data analysis procedures within each approach and compare these procedures. Overall, my method is very similar to qualitative analysis, except I am looking at published papers as a data set, and not at original interview or raw documents. However, the process is the same.

### Data

The data set in this thesis is the literature review presented in Chapter 2. Literature from the past 10 years with a preference for the past five years was included. Peer reviewed articles were prioritized.

### Data Analysis

“Data analysis is not off-the-shelf; rather, it is custom-built, revised, and "choreographed" (Huberman & Miles, as cited in Cresswell, 2007, p. 151). The processes of data collection, data analysis, and report writing are not distinct steps in the process—they are interrelated and often go on simultaneously in a research project (Cresswell, 2007). Qualitative researchers often "learn by doing" (Dey, as cited in Cresswell, 2007, p. 151) data analysis. For that reason, some suggest that qualitative research is intuitive, soft, and relativistic or that qualitative data analysts relies on the three "I's"—"insight, intuition, and impression" (Dey, as cited in Cresswell, 2007, p. 154). However, with Cresswell, I believe that the analysis process conforms to a general contour, which Cresswell represented as a spiral image, a data analysis spiral. Following this model the researcher engages, while analyzing her data, in a process of moving in analytic circles rather than following a fixed linear approach (Cresswell, 2007). The researcher starts with data of text or images (e.g., photographs, film) and exits with an account or a



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narrative (Cresswell, 2007) after having touched on several facets of analysis and after circling around and around (Cresswell, 2007).

The first step in this process is data management, the first loop in the spiral (Cresswell, 2007). At an early stage in the analysis process, researchers organize their data into file folders, index cards, or computer files (Cresswell, 2007). In this study, computer files were used and coded for themes. Besides organizing files, researchers convert their files to appropriate text units (e.g., a word, a sentence, an entire story) for analysis either by hand or by computer, and materials must also be easily located in large databases of text (or images) (Cresswell, 2007).

Following the organization of the data, researchers continue analysis by getting a sense of the whole database. Agar (as cited in Cresswell, 2007, p. 159), for example, suggests that researchers "read the transcripts in their entirety several times. Immerse yourself in the details, trying to get a sense of the interview as a whole before breaking it into parts." Writing memos in the margins of field-notes or transcripts or under photographs helps in this initial process. In this study, this took the form of notes.

This process was a loop of describing, classifying, and interpreting (Cresswell, 2007). In this loop, the establishment of code or category (and these two terms will be used interchangeably) are the heart of qualitative data analysis. During this process of describing, classifying and interpreting, qualitative researchers develop codes or categories and to sort text or visual images into categories (Cresswell, 2007). Typically, researchers develop a short list of tentative codes (Cresswell, 2007). Cresswell suggests "lean coding" or a short list of five or six categories.

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Cresswell (2007) also suggests that code labels emerge from several sources. In this study, code names are drawn from social and mental health sciences (e.g., depression), or names that best described the information.

Moving beyond coding, classifying means looking for categories, themes, or dimensions of information (Cresswell, 2007). Typically, classification involves identifying 'five to seven general themes. These themes, says Cresswell, should be seen as a "family" of themes with children, or subthemes, and even grandchildren.

Researchers engage in interpreting the data when they conduct qualitative research. Interpretation involves making sense of the data, the "lessons learned," as described by Lincoln and Guba (1985). Cresswell writes:

Several forms exist, such as interpretation based on hunches, insights, and intuition. Interpretation also might be within a social science construct or idea or a combination of personal views as contrasted with a social science construct or idea. In the process of interpretation, researchers step back and form larger meanings of what is going on in the situations or sites. For postmodern and interpretive researchers, these interpretations are seen as tentative) inconclusive, and questioning. (p. 167)

In the final phase of the spiral, researchers present the data in the form of text, tables, or figure form (Cresswell, 2007).

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Following this method, the following themes were identified:

- Ageism and Discrimination
- Depression and Suicide Risk
- Relocation Stress
- Mediating Dependency Needs
- Loss of Home and Loss of Attachments
- Language Barriers, Financial Barriers
- Service Availability and Service Access
- Special Case of Health Care

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### Chapter 4- Results

This study was focused on the barriers that older adult immigrants face. The main research question that my dissertation is intended to answer is what do clinicians and policy makers need to know to effectively support the older immigrant population in Canada with their challenges and struggles that may lead to mental health disorder? To answer this question I reviewed studies on the association of migration and mental health statuses of older immigrants, and examined services available for them that can help with their assimilation process and mental well-being. In this chapter I will summarize the main findings of the study.

#### Main findings

- **Ageism and discrimination**

**Major studies reviewed:** McCallion (2016), Guruge, Thomson, and Seifi (2015), Winerman (2006), Levy and Nelson (2016)

Ageism is a direct threat to the healthy aging of older persons. Negative age stereotypes, whether perpetuated by younger persons, health care workers or even believed and internalized by older persons themselves, have been proven to cause real harm to mental health, reduce the will to live, impair the memory, and even cause avoidance of preventive health behaviours altogether (McCallion, 2016; Guruge, Thomson, & Seifi, 2015; Winerman, 2006, Levy, Nelson, 2016). Elder immigrants experience further difficulties with ageism than their Canadian born counterparts as they

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must also battle discrimination and racism simultaneously (McCallion, 2016; Guruge, Thomson, & Seifi, 2015; Winerman, 2006, Levy, Nelson, 2016).

- **Depression and suicide**

**Major Studies reviewed:** Roy (2003), Kandel and Adamec (as cited in Roy, 2003), Kandel and Adamec (2009), Zweig and Hinrichsen (as cited in Roy, 2003), Casten, Rovner, and Edmonds (as cited in Roy, 2003), Gatz and Fiske (2003), Wetherell, Gatz, and Pederson (2001), Lynch, Compton, Mendelson, Robins, and Krishnan (2000).

The elderly population has a greater risk of committing suicide than younger individuals. Dealing with poor health, anxiety, and feeling useless are some of the reasons why the elderly commit suicide, with depression being the most common factor. Depression often accompanies a chronic disease or a deteriorating physical health status, both of which can become prominent as one ages or else is brought on by stressful life events, such as immigrating to another country (Roy, 2003; Kandel & Adamec, as cited in Roy, 2003; Kandel & Adamec, 2009; Zweig & Hinrichsen, as cited in Roy, 2003; Casten, Rovner, & Edmonds, as cited in Roy, 2003; Gatz & Fiske, 2003; Wetherell, Gatz, & Pederson, 2001; Lynch, Compton, Mendelson, Robins, & Krishnan, 2000).

- **Dependencies**

**Major Studies reviewed:** Hansson, Tuck, Lurie, and McKenzie (2010), Haideh Moghissi (2009)

The elderly frequently depend heavily on their families for their daily activities, and unlike younger age groups who are able to socialize at school or work, are much more isolated as their families are often their only social contacts or support. Elder

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immigrants in particular are concerned with being an increased imposition on their family because of language barriers as this lack of communication limits them from having access to services, labour markets, health facilities and simply enjoying every day social engagements (Hansson, Tuck, Lurie, & McKenzie, 2010; Haideh Moghissi, 2009).

- **Loss of home**

**Major Studies reviewed:** Bowlby (1973), Winokuer and Harris (2016)

Immigrating to another country results in significant lifestyle changes as well as a loss of language, identity, culture, values, food, friends, and relatives, all of which contribute to a general feeling of a loss of home (Bowlby, 1973; Winokuer & Harris, 2016). More so than any other population, it takes elderly immigrants considerable energy and time to rebuild these networks upon arrival in their new country (Bowlby, 1973; Winokuer & Harris, 2016).

- **Languages and financial barriers**

**Major Studies reviewed:** Kaida and Boyd (2011); Jafari, Baharlou and Mathias (2010); Kaida and Boyd (2011)

Elderly immigrants may find it harder to make new connections in Canada because of inadequate language ability (Kaida & Boyd, 2011; Jafari, Baharlou & Mathias, 2010; Kaida & Boyd, 2011). The inability to speak English might create isolation, marginalization, anxiety, and mental health problems (Kaida & Boyd, 2011; Jafari, Baharlou & Mathias, 2010; Kaida & Boyd, 2011). Another drawback for elderly immigrants with language problems is the inability to find work and contribute financially to both their own and their family's lives (Cheng et al., 2015).

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- **Access to health care**

**Major Studies reviewed:** Hansson et al. (2010); Kirmayer et al. (2011)

Access to health care is a major issue for elderly immigrants. Barriers to care include language difficulties, stigma, lack of mobility, lack of awareness of services, the concern that problems will not be understood by practitioners because of cultural differences and, differences in illness models (Hansson et al., 2010; Kirmayer et al., 2011).

- **Stigma and mental illness**

**Major Studies reviewed:** Guruge et al. (2015), Kirmayer et al. (2011), Statistic Canada (2015), Cheng, Tu, Li, Chang, and Yang (2015)

Mental disorders are highly stigmatized in most countries and many older people are extremely reluctant to attribute symptoms to a mental disorder. In addition, elderly immigrants must also face the stigma of their age and the stigma of being an immigrant (Guruge et al., 2015; Kirmayer et al., 2011; Statistic Canada, 2015; Cheng, Tu, Li, Chang, & Yang, 2015). However, studies have shown that contact with those with mental illness combined with education about mental illness is an effective way to lower stigma among the public. These anti-stigma efforts can help elderly immigrants dealing with mental health issues find the courage to obtain the appropriate health care services they require (Guruge et al., 2015; Kirmayer et al., 2011; Statistic Canada, 2015; Cheng, Tu, Li, Chang, & Yang, 2015).

- **Possible solutions**

When working with elderly immigrants, it is important not to generalize the

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experiences as each individual is unique and what seems appropriate to one may not be a cultural norm to another. Service providers must be understanding of cultural barriers and ensure their services meet social, cultural and linguistic needs of the immigrant population. Additionally, working with different agencies and policy makers to assist them in understanding the needs of culturally appropriate services is important, as is an increased emphasis on prevention and promotion. Further and more specific recommendations will be offered in Chapter 5.

### **In Conclusion**

In this chapter I summarized the main findings from the literature review of this study. In the next and final chapter I will draw implications for future research and draw implication for practitioners as well.



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### Chapter 5- Discussion

The study was focused on the barriers that older adult immigrants face after settling into their new homeland. The main research question that my dissertation intended to answer was what do clinicians and policy makers need to know to effectively support the older immigrant population in Canada with their challenges and struggles that may lead to mental health disorder? To answer my question I reviewed a number of relevant studies on the association of migration and mental health statuses of older immigrants, and examine services available for them that can help with their assimilation process and mental well-being.

This study had three foci, all of which are centred on the optimal health of older immigrants in Canada and BC:

- To identify and evaluate the efficiency of existing programs that target potentially at risk older adults in BC;
- To identify the barriers that older (define older) immigrants face after arriving in the new host country;
- To formulate implications for therapeutic intervention and community outreach so that these older immigrants can be better served.

In the remainder of this chapter, I will recap main findings and highlight areas for future research, but the main portion of this chapter will focus on clinical implications for counsellors.

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### **Main Findings**

The following themes were identified in the literature:

- Ageism and Discrimination
- Depression and Suicide Risk
- Relocation Stress
- Mediating Dependency Needs
- Loss of Home and Loss of Attachments
- Language Barriers, Financial Barriers
- Service Availability and Service Access
- Special Case of Health Care

### **Implications for Counsellors**

#### **The trajectories and cultural integration of immigrants**

There are two dominant theoretical approaches to the study of the cultural integration of immigrants: one is based on the idea that it is a linear process in which the culture of origin is discarded and the host culture adopted (a process that is commonly referred to as *assimilation*), while the other is based on the notion that it is a bi-dimensional process in which both the host culture is embraced and the heritage culture is maintained (commonly referred to as *assimilation*) (Hausmann-Stabile & Guarnaccia, 2015; APA, 2013).

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Promoters of assimilation endorse cultural homogeneity, and often use metrics such as economic achievement or intermarriage rates to explain that assimilated immigrants do better than non-assimilated immigrants. Acculturation has been widely studied in terms of the mental health of immigrants (Hausmann-Stabile & Guarnaccia, 2015; APA, 2013). Scholars who see acculturation as a bidirectional process embrace cultural heterogeneity (APA, 2013). For them, the aim is biculturalism or the integration of cognitions, attitudes, and behaviours, from the culture of origin and the dominant culture (Hausmann-Stabile & Guarnaccia, 2015; APA, 2013).

The way we understand the process of cultural change in immigrants has implications for counsellors, as clinical services will be different, depending on one's view. Promoters of assimilation Western understandings of mental health and treatment models (Hausmann-Stabile & Guarnaccia, 2015; APA, 2013). Little attention is paid to the patient's cultural models of symptom presentation, illness behaviours, treatment models, and help-seek behaviours (Hausmann-Stabile & Guarnaccia, 2015; APA, 2013). Translators may be part of treatment, but cultural differences between providers and clients are often ignored (Hausmann-Stabile & Guarnaccia, 2015; APA, 2013). Endorsers of acculturative theories call for multiculturalism and promote culturally-competency. Culturally-sensitive therapy incorporate clients' cultural beliefs, values, attitudes, and conventions (Bhui, Warfa, Edonya, McKenzie, & Bhugra, as cited in Hausmann-Stabile & Guarnaccia, 2015; APA, 2013).

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Culturally competent therapists avoid imposing their own values and practices on the client, and allow clients to work through their mental health challenges in culturally meaningful ways (Guarnaccia & Rodriguez, as cited in Hausmann-Stabile & Guarnaccia, 2015; APA, 2013). Culturally competent mental health services are critical for immigrant clients as they are more effective than standard mental health services among ethnocultural minorities (as cited in Hausmann-Stabile & Guarnaccia, 2015; APA, 2013). These services must include considerations about (a) the client's social and cultural characteristics, and how these frame her or his migrant experiences and mental health; and (b) the clinician's response to immigrant clients (Hausmann-Stabile & Guarnaccia, 2015).

A special consideration now regarding elderly adults, who often immigrate to North America as part of family reunification. Sometimes they join the family to help care for younger children while the parents work outside the home. While some elderly migrants could feel isolated if they left behind family and friends, others could feel empowered by their caregiver roles. Older adults may have a harder time adjusting to the new environments, learning the new language, and building social networks. Sometimes, their acculturation issues can be confused with cognitive decline; for example, an older adult may get lost navigating her or his new neighbourhood and may not have the vocabulary to ask for help.

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### **The immigrant paradox**

The *immigrant paradox* refers to the phenomenon of newly arrived immigrants being more successful at navigating life and healthier in their host societies than more assimilated individuals of immigrant backgrounds (Hausmann-Stabile & Guarnaccia, 2015). This phenomenon has been found in Latinos (Alegria et al., as cited in Hausmann-Stabile & Guarnaccia, 2015), Black Caribbeans (Williams et al., in Hausmann-Stabile & Guarnaccia, 2015), Africans (Venters & Gany, as cited in Hausmann-Stabile & Guarnaccia, 2015), and among Asian American women (Takeuchi, as cited in Hausmann-Stabile & Guarnaccia, 2015). The premise of the paradox is that newly-arrived immigrants show good adaptation in a number of outcomes despite poor socioeconomic contexts and low education background (Coll & Kerivan, as cited in Hausmann-Stabile & Guarnaccia, 2015). The positive outcomes among newly-arrived immigrants have been detected in a myriad of mental health outcomes including psychosis, substance abuse, and depression (Hausmann-Stabile & Guarnaccia, 2015). Hu-DeHart and Garcia Coll (2010) suggest that the paradox can be attributed to the strong roles played by immigrant families and communities, both of which place a big emphasis on education.

The immigrant paradox shows that the effects of international migration processes spill over multiple generations (Hausmann-Stabile & Guarnaccia, 2015). Therapists should “pay special attention to immigrants who belong to groups more likely to undergo downward mobility post-immigration, and thus face the combined effects of discrimination due to their race, immigrant backgrounds and their SES” (Hausmann-

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Stabile & Guarnaccia, 2015, p. 11). Mental health professionals can also explore the process of adaptation and mobility of immigrant clients, including opportunities for upward mobility, cultural integration, and exposure to discrimination (Hausmann-Stabile & Guarnaccia, 2015).

### **Implications for clinical practice**

Clinicians should collect a comprehensive narrative of the patient's migration trajectory, including reasons for migration, conditions of exit and entering, and exposure to stressful events prior to, during, and post migration (Hausmann-Stabile & Guarnaccia, 2015). In addition, clinicians could ask how the process of migration affected the client's emotional well-being, his or her social network, and the quality of his or her relationships (Hausmann-Stabile & Guarnaccia, 2015). Disruptions in social networks, along with changes in family dynamics, should be the focus of attention during services (Hausmann-Stabile & Guarnaccia, 2015). Exploring family immigration processes is important, as well as trans-national family experiences, and what meaning clients give to these experiences (Hausmann-Stabile & Guarnaccia, 2015). Clinicians should explore the conditions of separation and, if applicable, reunification (Hausmann-Stabile & Guarnaccia, 2015). Supportive services and culturally competent family therapy could work to ease potential conflict emerging during family separations and reunification (Hausmann-Stabile & Guarnaccia, 2015).

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Therapists also need to be sensitive to the patient's immigrant status, and how this status impacts his or her mental health (Hausmann-Stabile & Guarnaccia, 2015). Some clients may worry that having mental health challenges could carry a negative effect on their future ability to secure legal immigrant status (Hausmann-Stabile & Guarnaccia, 2015). Thus, counsellors need to stress confidentiality.

Cultural and contextual variables impact immigrants' help-seeking pathways. The choice of treatment provider is strongly influenced by culture, while the opportunities to meet those providers are shaped by contextual factors. For instance, some immigrants may approach ethnic healers, such as *curanderos*, or spiritual leaders, such as Imams, instead of seeking the assistance of a therapist (Hausmann-Stabile & Guarnaccia, 2015). Others may complement western mental health services with spiritual or folk practices (Hausmann-Stabile & Guarnaccia, 2015).

### **Best Practices for Assessment and Diagnosis**

APA (2013) lists the following best practices to cultivate best practices in assessing and diagnosing immigrant clients:

- Examine the extent of cultural and linguistic differences between the clients and the dominant culture (e.g., WisC-iii Spanish and the WisC-iV Spanish; ortiz, 2008; APA, 2013).

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- Use revised culturally sensitive versions of classic measures (e.g., tell me a story [teMAs]; Constantino, Malgady, & roglar, 1988), which is a revision of the Thematic Apperception Test.
- Incorporate cultural variables as central to all phases of the assessment process (Yeh & Kwan, 2010).
- Use comprehensive assessment approaches—for example: the Multicultural Assessment procedure (Ridley, Li, & Hill, 1998) and the Multicultural Assessment-Intervention process (Dana, 2005).
- Incorporate culturally sensitive assessment interviews, collecting information on acculturation, language, religious practices, racism and prejudice, and cultural values as part of the assessment process.
- Use a contextual approach that attends to clients' explanatory models and to clinicians' assumptions and biases.
- Recognize the conditions and circumstances under which assessment and diagnosis take place.
  - Assess the possibility of culture-bound syndromes.
- Recognize that disorders can lie on a continuum.
- Work with translators and interpreters.
- Work with families and community members when appropriate.
- Consult with colleagues.



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### **APAs (2013) Principles For Effective Mental Health Services to Immigrants**

To increase the accessibility and efficacy of services, APA (2013) suggests that clinicians and practitioners should adhere to the following guiding principles:

- Use an ecological perspective.
- Integrate evidence-based practice with practice-based evidence.
- Provide culturally competent treatment.
- Partner with community-based organizations.
- Incorporate social justice principles in providing service.

I will in the following section expand on these principles

An **ecological framework** is based on the assumption that the human experience is a result of reciprocal interactions between individuals and their environments in a certain context, culture, and time (APA, 2013). Ecological approaches acknowledge that behaviour does not occur in a vacuum but is affected by the larger culture and society, as well as the local community and its institutions (APA, 2013). Thus, the social climate and receiving environment into which immigrants arrive help shape their experience in and adaptation to a new culture (APA, 2013). Further, immigrants have varying positions of resilience or vulnerability. This, together with effects of migration, legal status, acculturation, risk factors, cultural and religious beliefs, age and developmental stage, race, ethnicity, gender, social class, sexual orientation, disability/ability, experiences of racism and discrimination, language and educational barriers, and access to services and

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resources are critical sources of information developing a complex understanding of the individual's experiences of distress (APA, 2013).

To maximize effectiveness, clinicians should select interventions that are rooted in **evidence-based practice (eBp) and practice-based evidence (pBe)** (APA, 2013).

The eBp approach is rooted in research (APA, 2013). Evidence-based therapeutic practice is also rooted in the notion that individual characteristics and sociocultural context are both important in assessment and intervention (APA, 2013).

**Cultural competency** should be an inherent principle that underscores all work performed by psychologists. As defined here, culturally competent mental health care provides services in ways that are “acceptable, engaging, and effective with multicultural populations” (Birman et al., as cited in APA, 2013, p. 12). Cultural competence involves therapists' cultural knowledge, therapists' attitudes and beliefs toward culturally different clients and self-understanding, and therapists' skills and use of culturally appropriate interventions (APA, 2013).

APA (2002; APA 2013) provides six major principles of culturally competent psychological practice, research, education and training, and organizational change:

**Guideline 1:** Recognize that, as cultural beings, we may hold attitudes and beliefs that can detrimentally influence their perceptions of and interactions with individuals who are ethnically, racially, culturally or nationally different from us (APA, 2013).

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**Guideline 2:** Recognize the importance of multicultural sensitivity/responsiveness, knowledge, and understanding about ethnically, racially, culturally, or nationally different individuals (APA, 2013).

**Guideline 3:** Employ the constructs of multiculturalism and diversity in psychological education (APA, 2013).

**Guideline 4:** Recognize the importance of culture-centred and ethical psychological research among persons from ethnic, linguistic, and racial minorities (APA, 2013).

**Guideline 5:** Strive to apply culturally appropriate skills in clinical and other applied psychological practices (APA, 2013).

**Guideline 6:** Use organizational change processes to support culturally informed organizational (policy) development and practice (APA, 2013).

In sum, cultural competence involves the use of appropriate cultural knowledge, positive attitudes toward culturally different clients, self-understanding, and the use of culturally appropriate interventions (APA, 2013).

### **Areas for Future Research**

More research in this area is needed. In particular, more qualitative research is needed—research that is focused on the lived experiences of older immigrants. This research should focus on the health status of older immigrants as well as economic status

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and sources of income for older adults. In addition, more research needs to focus on the lived experience of loneliness and social isolation of older adults (Community Development Halton, 2016).

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