

Cultural Competence

In order for us to work with individuals of diverse backgrounds, we must become culturally competent. One of the most salient features is knowledge of particular ethnocultural groups. This includes knowledge of a group's diversity, history, culture and contemporary reality.

There are five elements for becoming culturally competent:

1. **Value Diversity/Awareness and Acceptance of Differences** – understand the way the "person/client" defines health and family.
2. **Self-Awareness** – understand how one's own culture influences how one thinks and acts.
3. **Dynamics of Differences/Be conscious of the dynamics inherent when cultures interact** – two people may misjudge the other's actions based on learned expectations. Both will bring culturally prescribed patterns of communication, etiquette and problem solving. Also both may bring stereotypes or underlying feelings about working with someone who is different. Without an understanding of their cultural differences, misinterpretations or misjudgments may occur.
4. **Knowledge of Client's Culture** – institutionalize cultural knowledge and become familiar with aspects of culture.
5. **Adaptation of Skills** – develop programs and services that reflect an understanding of diversity between and within cultures. Adapt the helping approach so it "fits" cultural differences and preferences.

Although focused on ethnocultural groups, the same applies to diversity from a geographical as well as sexual orientation. The bottom line is we must be open-minded, respectful and non-judgmental.

Ten Steps To Providing Culturally Sensitive Dementia Care

- Consider each person as an individual, as well as a product of their country, religion, ethnic background, language, and family system.
- Understand the linguistic, economic and social barriers that individuals from different cultures face, preventing access to healthcare and social services. Try to provide services in a family's native language.
- Understand that families from different cultures consider and use alternatives to Western healthcare philosophy and practice.
- Do not place everyone in a particular ethnic group into the same category, assuming that there is one approach for every person in the group.
- Respect cultural differences regarding physical distance and contact, appropriate eye contact, and rate and volume of voice.
- Cultivate relationships with families over time, not expecting immediate trust in and understanding of the Alzheimer's Association.
- Consider the family's background and experience in determining what services are appropriate.
- Consider the culture's typical perceptions of aging, caring for elderly family members and memory impairment.
- Understand that a family's culture impacts their choices regarding ethical issues, such as artificial nutrition, life support and autopsies.
- Regard the faith community for various cultures as a critical support system.

Culturally Sensitive Dementia Care

Black/African American Culture

Africans were forced to leave their native continent by European settlers who sold them into forced labor in North America. Many had been kings and queens in their country. The mid 1800's brought the Civil War fought between the Northern and Southern States, reinventing the issue of slavery. The war ended with President Abraham Lincoln's Emancipation Proclamation and the 13th Amendment, abolishing slavery. Over the past 137 years, African American civil rights leaders have led the struggle for equal treatment, regardless of color.

More recently, a large number of immigrants have come to the United States from Africa, as well as people of African descent from Caribbean Islands such as Jamaica, Haiti and parts of South America. Each of these groups has distinct cultural and social identities.

Today, African Americans are the largest minority group in this country, representing 12% of the population. There are 2.7 million African Americans age 65 and over and, by the year 2050, it is projected that this number will increase to 8.6 million.

Family and Home

- Care is usually provided by extended family, including a network of friends who are considered family.
- Elders are respected, obeyed and considered a source of wisdom.
- Generations often live in the same home, with care provided to children and elders at the same time.
- Long term care is a last resort for most families
- Families may refuse services because they do not believe they need it, in spite of high levels of stress.

Help Seeking Methods

- Families frequently seek support from their faith community, including ministers and church groups.
- It is believed that the cultural context in which care is given and received is shaped by the legacy of slavery and African traditions. The institution of slavery provided few vehicles for individuals and families to receive support for survival outside the slave community. Therefore, the availability of social support was internal to the slave community –survival was a group effort.
- Caregivers often find solace in their religion, and use it as a means of coping with their feelings about their loved one's illness.

- Families are typically very private, not sharing concerns with strangers.
- Blacks/African Americans are less open to physical contact and are acutely aware of personal space.
- Families may not be aware of care options/community resources, or there are barriers to access.
- One-third of Blacks/African Americans live in poverty, preventing access to health care and services to ease the caregiving tasks.
- Blacks/African Americans face increase incidence of disease, including heart disease, stroke, kidney disease, diabetes, vascular dementia and Alzheimer's disease.
- Family caregivers may lack trust in service providers and this can show in their response. Time is necessary to building a trusting relationship.
- Important to address elders with titles such as "Mrs." or "Sir."

Alzheimer's Disease

- Many members of the Black/African American community attribute the symptoms of cognitive impairment to normal aging.
- Few participate in research studies of dementia.
- The most frequently used coping strategy is prayer.

Hispanic/Latino Culture

Hispanic Americans are widely diverse groups who come from many different countries, including Spain, Mexico, Puerto Rico, Cuba and throughout Central and South America. Hispanics can be of any race.

Mexican Americans constitute the largest group among Hispanics. Because their history links them to the southwest part of the United States, they have the largest kinship ties in this region of the country. Unlike African American families, whose ancestors were enslaved, Mexican Americans' ancestors were conquered and subordinated as a result of losing the Mexican-American War.

Today Hispanics/Latinos make up about 9% of the population and are the second largest minority group in this society. By the year 2050, it is projected that the current number of 1.5 million elders of this group will increase to 13.8 million.

Family and Home

- The family unit is extremely important in the Hispanic/Latino community. It is the center of most activity and support.
- Care for elders is provided by the extended family, often residing in the same home.
- Families are unlikely to seek out long term care options, taking on the responsibility of caregiving themselves.

- Adult children and grandchildren can help bring knowledge to older family members and support them in accessing health care services.
- Cubans, unlike Mexican Americans, are more likely to include friends in their definition of family, but Puerto Ricans are more likely than both Cubans and Mexican Americans to include non-blood kin in their family.

Religion and Spirituality

- The majority of Hispanic/Latino Americans practice Catholicism, although some are members of Protestant denominations.
- Hispanic/Latino families often seek emotional and spiritual support from their church.
- Caregivers often seek solace in their religious beliefs as a means of coping with stress.

Help Seeking Methods

- Doctors are respected and viewed as authority figures.
- Hispanic/Latinos may receive health care information from Spanish language media, including newspapers, radio and television.
- It is important not to confuse a person's country of origin. Acknowledge accordingly, rather than generalizing.
- Hispanic/Latinos typically desire a personal relationship with service providers, and may be uncomfortable with a distant approach.
- Hispanic/Latino cultures are more open to physical contact, less aware of personal space.
- Older Hispanics/Latinos often do not drive; often lack transportation and mobility to access services.
- An individual's country of origin, i.e. Cuba, Mexico, has particular customs and dialects.
- Cuban Americans have largely duplicated their culture of origin in culturally homogeneous ethnic enclaves in which their sociocultural needs can be met. This enclave is a source of effective support in later life.
- Mexican Americans rely more heavily on family rather than including friends in their support system.

Alzheimer's Disease

- Particularly in the early stage, Alzheimer's disease is viewed as normal aging.
- Alzheimer's disease may be looked at as punishment for past sins, bad blood or mental illness. Caregivers must bear this cross.
- Families may not seek out services because they do not wish to bring shame upon the family.
- Alzheimer's disease may be attributed to "el mal de ojo" –the evil eye or "nervios" –nerves.

Asian/Pacific Islanders Culture

There are many ethnocultural groups, which fall under this very broad category. Included among Asian/Pacific Islanders Americans (APIA) are Chinese Americans, Japanese Americans, Filipino Americans, Vietnamese Americans, Cambodian Americans, Korean Americans, Hawaiians, Samoans, other Pacific Islanders and multiple other Asian groups.

These diverse groups emigrated to the United States for several reasons, including economic opportunities, political persecution, and education.

Japanese Americans are the longest living ethnic group in the United States with socioeconomic and health profiles that closely resemble those of Whites.

Asians represent 3% of the American population. Elderly people among these diverse groups, similar to other older minorities are expected to increase in the future.

Let's examine two members of this cultural group.

Vietnamese Culture

Vietnam is one of three nations on the Indochinese Peninsula. Cambodia, Laos, China, the Gulf of Thailand, the Gulf of North Vietnam and the Pacific Ocean to the east border it. France ruled Vietnam from the mid-nineteenth century to the 1940s. Resistance to French occupation led to war between France, Japan, Vietnam and China. Vietnam was divided into North and South in 1954. Civil War continued over two decades. The United States became involved in support of South Vietnam in 1964. The conflict continued until 1975, when Communist forces took the city of Saigon. Vietnamese living in other countries are called "Viet Kieu" which translates into "Vietnamese Overseas."

Family and Home

- Family is the foundation of daily living. Family members have a strong sense of duty to care for each other.
- Elders are highly respected and obeyed.
- Multigenerational family ties exist, with families often living together.
- Families typically oppose long term care, believing it is shameful to place loved ones in residential care.

Religion and Spirituality

- Two thirds of the population practice Buddhism. It has a substantial influence on their beliefs and lifestyle.
- Confucianism and Taoism are two other religions practiced by Vietnamese.

Community Life

- Elders retain a strong commitment and loyalty to Vietnam.
- Most elderly do not speak English and may be illiterate in Vietnamese as well.
- Vietnamese often have trouble adjusting to American culture.
- Most Vietnamese immigrant elderly have experienced trauma from the Vietnam War, torture and incarceration in camps.
- Elders are often limited by lack of transportation in their community, leading to social isolation and lack of services.

Cultural Guidelines

- Most Vietnamese elderly are shy and reluctant in displaying physical affection.
- Do not assume that physical contact is acceptable or desired.
- Speak softly when addressing an elder and look into their eyes. Staring is considered disrespectful.
- Almost all Vietnamese elderly follow Confucian, male centered laws.
- Wait for older adults to begin activities, including meals.

Korean Culture

Korea is named for the Koryo dynasty, which ruled the Korean peninsula from 918 to 1392. The peninsula is in Southeast Asia, west of Japan. Korea has been divided into Northern and Southern states since the end of World War II. The United States was involved in the Korean War, the civil war between these states.

Family and Home

- Korean American life revolves around family and home. A person's priority is to family, and family interests are often more important than the individual.
- The eldest son is often the care provider for elders.
- Social and cultural ties among Korean-Americans are very strong.
- The family provides most caregiving for elders. Long-term care is not often considered as an option.

Religion and Spirituality

- Religious beliefs and practice are central to Korean American's life.
- The majority of Korean Americans are Christian (predominately Protestant or Buddhist).

Community Life

- Few Korean elderly drive. Limited transportation lessens social interaction.
- Korean elderly tend to preserve their native customs.

Help-Seeking Methods for Asian-Pacific Islanders

- Korean elderly may find it very hard to ask for help from individuals or agencies, such as home-care or case management.
- Language barriers prevent access to health care information and other services.
- The family provides most care for elders. Traditional long-term care is often disregarded.
- Filial piety operates to foster respect and obligation to individual family members, especially one's parents.
- Among traditional Chinese American families, it is the expectation of parents that they will be taken care of in later years by the eldest son and his wife, or by another offspring.
- Filipino American families may also be reluctant to seek services for impaired elders due to perceptions of stigma and the shame of having an impaired family member.
- Strong internal cultural mechanisms help shape their support system, which includes having values that address the care and support of elderly family members.

Alzheimer's Disease

- Among most, APIA groups, Alzheimer's disease and other forms of dementia are perceived as forms of mental illness with shame attached.
- This sense of shame extends beyond the diagnosed individual to the entire family.
- The behavioral symptoms of dementia are seen as a natural consequence of aging.
- Traditional Chinese attitudes believe the symptoms of AD to be exacerbated by migration and culture shock.
- When the course of dementia includes hallucinations, delusions, paranoia and suspiciousness, it is viewed as mental illness in the Chinese American community.
- Family caregivers who are unable to care for an impaired family member may suffer shame and loss of face if other members of the Chinese American community perceive that the family has not cared adequately for the impaired elder.
- Loss of face and shame are equally evident in the Japanese-American community.
- Traditional Japanese Americans may view AD as a form of mental illness, and therefore shameful to the family if this condition becomes known to people outside the family.

Native American Culture

The term "Native Americans" encompasses diverse ethnocultural groups. According to the Bureau of Indian Affairs, there are approximately 275 federally recognized reservations, 550 federally recognized tribes, bands or Alaska Native villages, and more than 100 non-recognized tribes in the United States.

The history of Native Americans shows they were uprooted, disenfranchised, and subjugated within this society.

Although age 65 has become the standard age at which individuals are considered elderly in American society, there is no such consensus among Indians. The Older Americans Act permits individual tribes to determine the age at which Indian elders are eligible to receive aging services provided by the tribe. In exercising their discretion on this issue, tribes differ in their designation of the chronological age at which a person is entitled to services.

Native Americans make up less than 2 percent of the American population. Six percent of Native American people are elderly.

Family and Home

- Traditionally, elders are respected for their wisdom, experience and knowledge.
- Although the vast majority of Native Americans speaks English and has attributes and traits of American culture, they also maintain available native languages, practice ceremonies and rituals of a particular tribal group, and identify strongly as Indian.
- Tribal, cultural and regional diversity is evident in health behaviors and incidence of disease.
- About one-quarter live on reservations. Over one half are concentrated in the Southwestern states of Oklahoma, California, Arizona, New Mexico and Texas.
- Folk or traditional medical beliefs and practices are often practiced in the home.

Help Seeking Methods

- Elders, regardless of tribe, assume significant roles as teachers and caretakers of young. Thus elders on reservations tend to rely primarily of some form of extended family for caregiving.
- Native Americans tend to shy away from traditional social service network agencies.
- The Indian Health Service sees many Native Americans. The Indian Health Service maintains a database on the health of reservation dwelling Native Americans, but there is no comparable data on the health of urban Native Americans.

- Native Americans seek out help that is consistent with Native American traditions. Of particular importance are the use of shamanic healing, alternative understanding of psychopathology, and an emphasis on spirituality.

Alzheimer's Disease

- Dementia among older American Indians/Native Americans appears to occur at low frequencies.
- Signs and symptoms are attributed to normal aging.
- Some refer to the disease as "old timer's disease."
- The sense of stigma and shame associated with caregiving to cognitively impaired elders appears to be absent in American Indian communities.

Diversity Programmatic/Policy/Research Implications

In the interest of supporting efforts to improve knowledge and care of Alzheimer's disease and other dementing illnesses in ethnic minority communities the following should be addressed:

- ❑ It will be extremely important to describe the unique service needs of minority and ethnic groups in the United States and in other parts of the world. Awareness of unique service needs will result in more so-called "culturally competent" services that are more valued by persons in need of service.
- ❑ There is an urgent need for population-specific analysis of health care expenditure and utilization of Medicare beneficiaries with Alzheimer's disease. If African Americans and other minority groups are shown to have greater AD symptom severity, then current Medicare capitation payments may need to be adjusted accordingly.
- ❑ Dementia screening guidelines should be expanded to meet the needs of ethnic minority elderly populations and to address potential comorbid conditions that may differ by ethnicity (U.S. Preventive Task Force, 1996).
- ❑ There should be a national call for improved training and education of primary care health professionals on screening for dementia in older ethnic minority populations, including elders for whom English is not their primary language.
- ❑ Policy makers need to investigate whether ethnic differences in rates of nursing home use are related to discrimination. The lower rate of Medicaid reimbursement makes a poor minority elderly resident seeking nursing home care a less attractive candidate than a private paying White elder.
- ❑ More clinical trials are needed to evaluate population-specific approaches to support caregivers of persons with dementia. The tendency to use less formal long-term care services does not necessarily indicate that their care needs are being met.
- ❑ Successful strategies for recruitment and retention of ethnic minorities in clinical trials should be disseminated and replicated in different geographic regions in order to meet the need for more data on the biology and treatment outcomes in underserved populations.
- ❑ A substantial investment should be made to expand awards to include more disciplines, to train new minority scientists, and to enhance investigator initiated awards for research among underserved communities.

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