ETHNOGERIATRIC CURRICULUM: MODULE FOUR
CULTURALLY APPROPRIATE GERIATRIC CARE: ASSESSMENT

DESCRIPTION
This module introduces the learner to basic background and skills needed to provide a culturally competent geriatric assessment. Targeted areas within the module include strategies for effective communication, guidelines for use of standardized assessment instruments, and the five domains of ethnogeriatric assessment (client background, clinical domains, problem specific information, intervention specific data, and outcome criteria). This content forms the basis for development of culturally competent geriatric assessment by health practitioners.

LEARNING OBJECTIVES
After completion of this module, learners will be able to:
1. Conduct culturally appropriate assessments that are respectful of individuals and families.
2. Describe strategies for development of culturally appropriate verbal and non-verbal communication skills.
3. Identify benefits and weaknesses of using different types of interpreters.
4. Describe the process and use of translation/back-translation to achieve better conceptual equivalence of materials and assessment tools.
5. Conduct an ethnogeriatric health assessment including elicitation of:
   a. background/contextual data,
   b. clinical geriatric assessment domains,
   c. problem specific information (including explanatory model),
   d. intervention specific data, and
   e. outcomes criteria.
6. List the major components of geriatric assessment and related cultural issues.

CONTENT OUTLINE

I. Preparatory Considerations
   [The following guidelines are general and may not apply to all cultural groups and individuals. Please refer to ethnic specific modules for additional information.]
   A. Demonstrating respect (deference) to older patients in culturally appropriate ways to establish a trusting relationship. Specific strategies to foster development of trust include the following:
      1. Asking informed individuals what is culturally appropriate.
      2. Generally, acknowledge and greet older persons first.
      3. Generally, use formal term of address (Mr., Mrs.), at least initially.
      4. Consider use of informal conversation prior to formal assessment. It may not be respectful to ask business oriented questions without first acknowledging the patient in a more personal way. For example, Mexican Americans may prefer to begin a conversation with questions such as “How is your family?” or “Did you
have to travel long to come here?" before they wish to respond to more formal questions such as "What brings you here today?"
5. Avoiding the "invisible patient syndrome": Older patients need to be talked to and with, rather than talked about. Talking to someone else in the room as if the patient weren't there, or is incapable of understanding demonstrates disrespect.
6. Acknowledge the importance of ethnicity and ask for the patient’s help as a cultural expert in understanding the current situation and incorporating salient cultural components in the plan of care.

B. Communication Issues
1. Selecting Interpreters [Interpreters convert verbal language; translators work with written language.]
   a. If practitioners do not speak the same language as the patient or the patient has limited English proficiency, then trained interpreters should be used (Diaz-Duque, 1982).
   b. Use of family members, especially young children, as interpreters is strongly discouraged because of: possible lack of appropriate language skills in one or both languages; culturally based modesty barriers to discussion of certain topics, especially across genders and age hierarchy that lead to difficulty in discussing family problems (Jackson, 1998)
   c. Avoid using untrained interpreters.
   d. Providers can be advocates for effective on-site interpreter services and access to telephone based interpretation services (Villarruel, Portillo & Kane 1999).
   e. Always keep in mind that the interpreter is a member of the team to be treated with respect. Develop a means to establish rapport.
The following table lists benefits and limitations of various types of interpreters.

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<tr>
<th>Interpreter Alternatives</th>
<th>Description</th>
<th>Strengths</th>
<th>Limitations</th>
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| Professional Interpreters on Staff | Agency employs and trains interpreters who are available for interpreting languages that are most frequently represented in the particular patient population. | • Available during operating hours.  
• Consistent personnel fosters rapport and trust with clients and health care providers. | • Not a feasible, cost-effective alternative for small agencies.  
• Not all languages covered. |
| On-Call Interpreters          | Agency maintains a list of interpreters of various languages who are willing to interpret as need arises.  
• May be paid or volunteer. | • Covers a broader variety of languages. | • May have questionable interpretation abilities unless the agency has a method of testing each person.  
• May be trained or untrained.  
• Untrained interpreters make more errors: omissions of pertinent information, additions of information that the client did not say, substitutions of information, condensed summaries that omit details, and breaches of confidentiality (Lee, 1977; Marcos, 1979)  
• Dependent upon the availability of the interpreter at the time one is needed. |
| Bilingual Staff               | Health care staff (nurses) or support staff (e.g., dietary aides or security personnel) are temporarily utilized as the need arises to interpret for patients with whom they would otherwise have no contact. | • Availability | • Inconsistent availability  
• May experience conflict of duties between the roles for which they were hired and the ad hoc interpreter duties.  
• May create resentment in staff member or co-workers.  
• May be unfamiliar with specialized vocabulary.  
• Usually untrained.  
• Untrained interpreters make more errors (see above).  
• Inconsistent ability |
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<th>Interpreter Alternatives</th>
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</table>
| Family Members or Friends     | • Family or friends who accompany the patient to the agency are used as interpreters                                                                                                                       | • Availability                                                                                                                              | • Untrained, thus likely to make errors (see above).  
• Usually unfamiliar with specialized vocabulary.  
• May interfere with family dynamics, confidentiality, or revelation of sensitive information.  
• Use of children for interpretation is never appropriate except in emergency situations until other alternatives can be arranged. |
| Language Line Service          | **Telephone Interpreter Services**  
provide over-the-phone interpretation for agency or individual use. Agencies needing at least 20 minutes of interpretation per month would establish Subscribed Interpretation that involves a $200 set-up fee, and at least $50 charges per month for usage.  
Interpretation rates range from $2.20 to $4.50 per minute based upon the language and time of day. (Language Line Service, 1999). | • Covers over 140 languages  
• Available 24 hours/day, 7 days/week.  
• Interpreters are native speakers with training in interpretation and health care terminology.  
• Rapid access.  
• Training kit for users includes a video and quick reference guides. | • Speakerphone needed for easiest use.  
• Requires prior arrangement by agency to establish an account.  
• Interpreters may or may not be trained in mental health applications. |
2. Basic guidelines for providers working with interpreters
(Sources: Randall-David, 1989; Roppe, 1996; http://www.diversityrx.org;
http://hslib.washington.edu/clinical/ethnomed/index.html)
   a. The provider should meet with the health care team members who serve as
      interpreters on a regular basis to review interpreter roles and procedures,
      provide in-service training, and develop collegial relationship.
   b. The provider should speak in short units and ask short questions. Interpreters
      will have difficulty interpreting long, involved statements without forgetting
      something important.
   c. Avoid technical terminology, abbreviations, and professional jargon (or
      explain them thoroughly).
   d. Avoid colloquialisms, abstractions, idiomatic expressions, slang, similes, and
      metaphors.
   e. Encourage the interpreter to translate the patient's words as much as possible
      rather than paraphrasing or polishing with professional jargon. This approach
      will give a better sense of the patient's understanding and emotional state.
   f. During the interaction, look at and speak directly to the patient, not the
      interpreter.
   g. Listen, even though you do not understand the language and look for
      nonverbal cues.
   h. Be patient. Interpretation takes time when done right.
   i. Have the interpreter ask the patient to repeat as accurately as possible the
      information that has been communicated, to see if there are gaps in
      understanding.

3. Basic principles for using interpreters during health care situations
   a. Professional interpreters are trained to create conceptual transfer rather than
      verbatim translations.
   b. They make sure that concepts get across correctly in both directions of the
      clinical interaction.
   c. Technical clinical concepts in one language are translated into acceptable
      social terminology that conveys the clinical meaning in the second language.
   d. Interpreter knows the technical concepts, preferably in both languages, and
      how to express them in terms that the patient will understand.

4. Non-verbal communication
   a. Pace of conversation: Some cultures are comfortable with long periods of
      silence, while others are fast paced and consider it appropriate to speak
      before the other person has finished talking.
   b. Physical distance: Provide patients with a choice about physical proximity
      by asking them to sit wherever they like. Individuals from some cultures (e.g.,
      Northern European) tend to prefer to be about an arm's length away from
      another person while those from some others cultures tend to prefer closer
      proximity (e.g., some Hispanic cultures) or greater distance (e.g., some Asian
      cultures).
c. Eye contact: While European Americans typically encourage members to look people in the eye when speaking to them, some others may consider this disrespectful or impolite (e.g., some Asian and Native American groups). Some Moslem groups may consider eye contact inappropriate between men and women. Observe the patient when talking and listening to get clues regarding appropriate eye contact.

d. Emotional expressiveness: Some cultures value stoicism (e.g. British), while others encourage open expressions of feelings, such as sorrow, pain, or joy. Elders from some backgrounds may laugh or smile to mask other emotions (e.g. Japanese, Thai).

e. Body movements: Body gestures can be easily misinterpreted based on what is considered culturally appropriate. Individuals from some cultures may consider some types of finger pointing or other typical American hand gestures or body postures disrespectful or obscene (e.g. Filipino, Chinese, Iranian), while others may consider vigorous hand shaking as a sign of aggression (e.g. some American Indian) or a gesture of good will (e.g. European). When in doubt, ask an interpreter or other cultural guide.

f. Touch: While physical touch is an important form of non-verbal communication, the etiquette of touch is highly variable across and within cultures. Practitioners should be thoroughly briefed about what kind of touch is appropriate for cultures with which they work.

C. Use of Standardized Assessment Instruments (e.g., cognitive status, depression, functional status). See Appendix for Examples of Translated Standardized Instruments.

1. Assess appropriateness of English version
   a. Educational level: Results of the test may be influenced by variables other than culture, such as socio-economic/educational status. For example, high false-negative rates of cognitive impairment have been reported among highly educated subjects, whereas high false-positive rates of cognitive impairment have been reported among less educated clients (Fillenbaum et al., 1990; Gurland et al., 1992; Mulgrew et al., 1999; Mungas et al., 1996).

   b. Language fluency

   c. Established population norm
      • Validated measures are usually available only for the largest of the specific language groups
      • Importance of using versions adapted for subgroup of language category (e.g., Puerto Rican, as opposed to generic Spanish)

   d. Appropriateness of format
      • Technical approach (interview, self report)
      • For example, some elders or family members from Asian backgrounds may be more reluctant to express their feelings in interviews than self-report, and/or may tend be more likely to respond in accordance to social desirability rather than their true feelings/attitudes in interviews compared to self-report format.
• Response format (e.g. true false/, multiple choice, Likert, semantic differential, visual analogue).
• Font size
• Reading level [e. g. Smog index (McLaughlin, 1969)]: Literacy levels can be problematic since elders in many ethnic communities had little access to formal education in English language, or sometimes in their native language.

2. Assess adequacy of translated version (Flaherty et al., 1988; Gilmer et al., 1995).
   a. Content equivalence: to ensure the content in each item in the instrument has consistent cultural relevance.
   b. Semantic equivalence: to ensure the meaning of each item remains conceptually and idiomatically the same.
   c. Technical equivalence: to ensure that the methods of assessment (interviews, observation, self-report) elicit comparable data.
   d. Criterion equivalence: to establish the normative interpretation of the variable.
   e. Conceptual equivalence: to ensure the same theoretical construct is being measured in each culture.

II. Ethnogeriatric Assessment
   A. Background/Contextual Topics
      1. Ethnicity
      2. Level of acculturation
         a. Placing older patients on the continuum of acculturation can help providers avoid mistaken assumptions about expected differences or similarities from mainstream elders.
         b. Informal indicators of acculturation that can be used quickly are:
            • Length of time older patients or their ancestor has been in the U.S.
            • Language used at home, fluency in spoken and written English
      3. Degree of ethnic affiliation
      4. Religion
      5. Patterns of decision-making (e.g, individual vs. inclusive of family members)
      6. Preferred Interaction patterns
         a. Language
         b. Direct/indirect communication
         c. Formal vs. informal
         d. Other (see communication section)

   B. Clinical Assessment Domains  
      (please note: may vary by practice profession)
      1. Health and social history
         a. Please see comments on communication and written measures above.
         b. Issues of elder abuse may emerge anywhere throughout the assessment, but particularly in sections IIB2 (physical exam), IIB3 (cognitive and affective status), IIB4 (functional status), and IIB6 (family assessment). Particularly consider when:
            1) there are physical signs (bruises, burns, etc.) and/or
            2) behavioral symptoms (e.g. depression) (Tatara, 1999).
2. Physical examination
   a. Cross gender physical examinations are unacceptable in many cultures.
   b. Ask for preference of presence of other family members during physical exam.
   c. Throughout the assessment, inform elder of procedures and ask for permission to examine different areas of the body.
   d. Preferred amount and type of information communicated to the elder and their family during and after the physical exam varies cross-culturally.
   e. Symptom recognition, meaning, and report is expressed differently by elders of different cultures [e.g. “air heavy” or "air not right” may mean dyspnea for some Native American elders (Kramer, 1996); "heavy heart” may indicate depression among Chinese]

3. Cognitive and affective status: Dementia and depression are considered mental illness in some cultures and highly stigmatized. In others dementia is seen as a normal part of aging and define it as a minimal problem. (See comments on assessment instruments above.)

4. Functional status: Activities of Daily Living and Instrumental Activities of Daily Questions can be translated, if needed, and administered orally or in writing if literacy and reading levels are adequate. Drawings, illustrations, and other culturally appropriate symbols may also be used. (Also see comments on translations comments and assessment instruments.)

5. Home assessment
   a. Living patterns: Who lives in the home, relationship to elder, and length of time in the home
   b. Support from those people who live with the elder
   c. Safety, comfort, and convenience of the home to elders health status
   d. Economic stability and adequacy

6. Family assessment
   a. Composition and structure
   b. Kinship patterns: expectations of and for family members (e.g. for elder care) Stereotypes that ethnic families "take care of their own" can be very misleading since some elders from ethnic backgrounds are not part of strong family networks and are vulnerable to loneliness and isolation.
   c. Decision-making: In many cultures, there is not the assumption of patient autonomy in decision-making as there is the U.S. ethical paradigm, and the family is assumed to be the decision-maker about health care.
   d. Spokesperson
   e. Gender sex-role allocation
   f. Support from family members
   g. Family connectedness. Culture influences whether the elder and family are more individualistic or collectivistic (allocentric).

7. Community and Neighborhood Assessment
   a. Overall features of the community and neighborhood: e.g. involvement of ethnic elders in community planning, use of space.
b. Population characteristics: e.g. ethnic community, length of time in community, proportion of elders, children, and adults in population, intergenerational relations, status of elders.

c. Environmental and safety conditions: e.g. topography, sidewalks, pavement, air and water quality, crime rate.

d. Services available and used by elder and their family: e.g. allopathic, folk and alternative health practitioners, social services, religious, shopping (such as food, clothing, banking), educational, transportation, recreational and elder services (such as senior center).

e. Support from neighborhood and community members

8. End of life preferences (when appropriate)
   a. Preparation for death including availability of advance directives. Since talking about death is considered inappropriate in some cultures (e.g., Chinese, Navajo) the issue should be approached carefully and sensitively, and only in the context of an established trusting relationship. A possible introduction after several visits might be, "In case something happens to you and you are not able to make decisions about your care, we need to know what your preferences are."
   b. Preference for hospital or home end of life care
   c. Death rituals for care of the body and mourning behaviors during and after death
   d. Attitudes about organ donation and autopsy

C. Problem Specific Data: Elicit Explanatory Models of Illness from Patient and Relevant Family Members
   1. The use of explanatory models has been demonstrated to be effective in improving patient-provider communication and showing respect for the patient's point of view; ultimately, it is argued, its use will increase patients' trust of providers and appropriate clinical management.
   2. The object is to elicit the older patient's view of his illness experience, its causes, potential consequences, and possible treatments.
   3. To elicit the patient's explanatory model of illness, questions such as the following can be used (Kleinman, Eisenberg, Good, 1978; Harwood, 1981).
      a. What do you think caused your problem?
      b. Why do you think it started when it did?
      c. What do you think your sickness does to your body? How does it work?
      d. How severe is your sickness?
      e. How long do you think it will last?
      f. What are the main problems your sickness has caused you?
      g. Do you know others who have had this problem? What did they do to treat it?
      h. Do you think there is any way to prevent this problem in the future? How?

D. Intervention specific data (Tripp-Reimer, Brink, and Saunders, 1984).
   1. What are you and/or your family doing for this problem? What kinds of medicines, home remedies, or other treatments have you tried for this sickness? Have they helped?
2. What type of treatment do you think you should receive from me?
3. Elicit cultural specific content as needed for specific interventions. For example, if dietary recommendations are being made, elicit data about food preferences and practices; if discharge planning is needed, elicit information regarding family care patterns, resources, and residential preferences.
4. Is there any other information that might help us design a treatment plan?
5. How should family be involved: family structure, roles, and dynamics, and lifestyle and living arrangement need to be identified. How should family members treat one who has this condition/problem?
6. Does anyone else need to be consulted?

E. Outcomes specific data: Negotiating therapeutic outcome criteria with older adults/family members.
   1. What are individual/family expectations for quality care?
   2. What are the most important results you hope to receive from this treatment?
   3. What is best outcome from family/individual perspective?
   4. What is worst outcome from family/individual perspective?

INSTRUCTIONAL STRATEGIES
1. Reading assignments
2. Didactic lectures
3. Discussions
4. Modeling through Video training
5. Case studies
6. Experiential Projects:
   a. Assignment to have students use Language Line with bi-lingual simulated patient.
   b. Assignment to practice taking social histories using cohort analyses or eliciting explanatory models, with one student as the interviewer and another role playing an elder with a specific history or set of health beliefs.
   c. Assignment to have students interviewed in a different language.
   d. Assignment to have students conduct an assessment using an interpreter followed up by discussion of the benefits, difficulties, and strategies to promote communication.
7. Group projects: Students create a cultural competence training manual focusing on use of culturally appropriate assessment tools for older patients from one or more cultural backgrounds.
8. Conduct geriatric assessments with culturally diverse older adults and illicit feedback from the elder and their family members.
**EVALUATION**

1. Structured objective tests
2. Essay tests
3. Presentations from group projects:
4. Demonstrate effective interview techniques (by video or observation) with simulated patient/family
5. Videotaped Ethnogeriatric Assessment with ethnic elder

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<th>LEARNING OBJECTIVES</th>
<th>EVALUATION CRITERIA</th>
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| Conduct culturally appropriate assessments that are respectful of individuals and families. | • Demonstrate effective interview techniques (by video or observation) with simulated patient/family.  
• Videotaped ethnogeriatric assessment of ethnic elder.  
• Presentations from group project, 6B and 6D.* |
| Describe strategies for development of culturally appropriate verbal and non-verbal communication skills. | • Demonstrate effective interview techniques (by video or observation) with simulated patient/family.  
• Videotaped ethnogeriatric assessment of ethnic elder.  
• Presentations from group project, 6A, 6C, and 6D.* |
| Identify benefits and weaknesses of using different types of interpreters | • Structured objective tests  
• Essay tests  
• Presentations from group project 6D. |
| Understand the process and use of translation/back-translation to achieve better conceptual equivalence of materials and assessment tools. | • Structured objective tests  
• Essay tests  
• Presentations from group project 6A and 6C.* |
| Conduct an ethnogeriatric health assessment including elicitation of:  
• Background/contextual data,  
• Clinical geriatric assessment domains,  
• Problem specific information (including explanatory model),  
• Intervention specific data, and  
• Outcomes criteria. | • Demonstrate effective interview techniques (by video or observation) with simulated patient/family.  
• Videotaped ethnogeriatric assessment of ethnic elder.  
• Presentations from group project, 6B and 6D.* |
| List the major components of geriatric assessment and related cultural issues. | • Structured objective tests  
• Essay tests |

*Numbers refer to the Instructional Strategies listed above.*
REFERENCES AND RESOURCES


Web Sites

**DIVERSITYRX**
- [http://www.diversityrx.org](http://www.diversityrx.org)

**ETHNOMED**

**NATIONAL CENTER FOR CULTURAL COMPETENCE**
- [http://www.dml.georgetown.edu/depts/pediatrics/gudc/cultural.html](http://www.dml.georgetown.edu/depts/pediatrics/gudc/cultural.html)
  - 1-800-788-2066

**OFFICE OF MINORITY HEALTH RESOURCE CENTER**
- [http://www.omhrc.gov](http://www.omhrc.gov) 1-800-4446472

**Video Resources**

The following were all produced and are copyrighted by:

- CSU, Fullerton, Learning Technology Center
  - Ethnicity and Counseling: Counseling the African American Client
  - Ethnicity and Counseling: Counseling the Native American Client
  - Ethnicity and Counseling: Counseling the Mexican American Client
  - Ethnicity and Counseling: Counseling the Vietnamese American Client

*Available through: DUBS Incorporated, 1220 N. Highland Ave., Hollywood, CA 90038 Phone: 219-461-3726 Fax: 213-466-7406*
## Appendix
### Examples of Translated Standardized Instruments

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<th>Measurement Domain</th>
<th>Standardized Assessment Instruments (English)</th>
<th>Additional Languages</th>
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<tr>
<td>Cognitive</td>
<td>Blessing Dementia Rating Scale</td>
<td>Spanish</td>
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<td></td>
<td>Boston Naming Test</td>
<td>Spanish</td>
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<td></td>
<td>CARE (the Comprehensive Assessment and Referral Interview)</td>
<td>Spanish</td>
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<td></td>
<td>CASI (Cognitive Abilities Screening Instrument)</td>
<td>Chinese/Japanese/Spanish/Vietnamese</td>
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<td></td>
<td>Geriatric Mental State</td>
<td>Chinese/Spanish</td>
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<td></td>
<td>ICD-9/10 (International Classification of Disease)</td>
<td>Chinese/Italian/Japanese/Korean</td>
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<td>Iowa Screening Test</td>
<td>Romanian/Russian/Yiddish</td>
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<td>IQCODE (Informant Questionnaire on Cognitive Decline in the Elderly)</td>
<td>French</td>
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<td>Kahn-Goldfarb Mental Status Questionnaire (MSQ)</td>
<td>Spanish</td>
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<td></td>
<td>MMSE (Mini Mental State Examination)</td>
<td>Chilean/Chinese/German/Greek/French/Maltese/Russian/Spanish/Thai</td>
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<td>NINCDS-ADRDA (National Institute of Neurological and Communicative Disorders and Stroke and the Alzheimer’s disease and Related Disorders Association)</td>
<td>French/Italian/Nigerian/Spanish</td>
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<td></td>
<td>SPMSQ (Short Portable Mental Status Questionnaire)</td>
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<td>WAIS (Wechsler Adult Intelligence Scale)-R</td>
<td>Spanish</td>
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<tr>
<td>Emotion</td>
<td>CES-D (Center for Epidemiological Studies-Depression)</td>
<td>Chinese/Japanese/Korean/Spanish/Filipino</td>
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<td></td>
<td>Depression Adjective Checklist</td>
<td>Chinese/Hebrew/Spanish/Vietnamese</td>
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<td>DSM-III/III-R</td>
<td>Chilean/Chinese/German/Lebanese/French/Italian/Japanese/Korean/Spanish</td>
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<td>Geriatric Depression Scale</td>
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<td>Hamilton Depression Scale</td>
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<td>MMPI (Minnesota Multiphasic Personality Inventory)</td>
<td>Japanese/Korean/Spanish</td>
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<td>OARS (Old Americans Resources and Services)</td>
<td>Japanese/Korean/Spanish</td>
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<td>Self-Rating Depression Scale</td>
<td>Japanese/Spanish</td>
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<td></td>
<td>State-Trait Anxiety Scale</td>
<td>Over 40 languages</td>
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<tr>
<td>Function</td>
<td>DAFS (Direct Assessment of Functional Status)</td>
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<td>International ADL Scale</td>
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