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REVIEW

Cultural Considerations for Comprehensively Assessing Foreign Born Older Adults in the United States

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Abstract

Purpose of Review As demographic patterns in the United States (US) shift rapidly toward an increased prevalence of older adult residents from diverse ethnoracial backgrounds, it is especially important for healthcare practitioners to familiarize themselves with the unique attitudes, beliefs, and practices of their patients. The life stories of foreign-born older adult patients are individually unique, and they can intimately impact their bio-phyco-social profiles and needs that may not be captured in full by the traditional domains of the comprehensive geriatric assessment (CGA). This review paper attempts to describe some of the most frequently encountered themes in current literature that may potentially impact how the CGA is approached in this patient population.

Recent Findings Ethnoracial identity and belonging is a personal and dynamic experience, which continues throughout life and into older adulthood. CGA should explore any personal, familial, gender-specific, or community centered factors, beliefs, and cultural practices, as well as how patients individually relate to them. Effective communication involves closely collaborating with foreign language interpreters. Loneliness and isolation can be perceived even in the presence of family and are crucially impactful on healthcare practice and wellbeing. Immigrants are more likely to report serious psychological distress the longer they live in the US. Cultural considerations are now incorporated into specific diagnostic criteria for psychiatric illnesses. Screening tools for assessing cognitive impairment, delirium, social isolation, and loneliness have been validated across differing cultures.

Summary Addressing the traditional domains of CGA are useful, though additional considerations need to be taken for the foreign-born older adult. The practice of cultural humility is superior to cultural competence, and it is rooted in curiosity, equity, receptiveness, and commitment to lifelong learning.

Keywords Ethnogeriatrics · Foreign-born · Older adults · Geriatric assessment · Multicultural · Cultural humility

Introduction

Immigration has fundamentally impacted social, political, and economical structures in the United States (US). According to a report from the U.S. Census Bureau, immigrants accounted for roughly 13.7 percent of the total U.S. population in the year 2019 [1]. The demographic trends across the country are shifting rapidly. The number of immigrants aged 65 years and older residing in the U.S. is projected to increase to 22.0 million, or 23.3 percent of the total older adult population, by the year 2060 [2]. This increase is attributed to several factors, including those who entered the country in the 1970s through 1990s and have aged in place, coupled with younger immigrants sponsoring the naturalization of their loved ones as part of the process of family unification [2]. A large proportion of these individuals tend to reside in three states: California hosting the largest numbers, followed by Florida, then New York [2]. Healthcare disparities disproportionately affect older adults in general via socioeconomic and health-related factors. Individual characteristics, experiences, situations, and healthcare needs of foreign-born older adults are unique, and diversity not only exists between different groups of people, but also within them. "Ethnogeriatrics" refers to the influence of culture, race, and ethnicity on the health care for older adults from diverse ethnic and racial backgrounds [3]. It promotes cultural awareness in healthcare, and it is particularly important

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in those regions across the country that are more vastly multicultural in their population distribution.

The comprehensive geriatric assessment (CGA) has been deemed as the gold standard for the care of geriatric patients across multiple specialties and care settings, particularly for vulnerable populations [4, 5]. The CGA is a multi-dimensional, interdisciplinary diagnostic tool developed to determine the medical, psychosocial, and functional abilities of adults aged 65 years and older. Traditionally, the following domains are assessed: cognition and mental status, mental health, functional abilities, social and environmental issues, and advance care planning. Obtaining a CGA has the potential to impact a myriad of individualized interventions, including increased care satisfaction, better clinical outcomes, improved function and mentation, and reduction in need for emergency department utilization [6]. Yet, challenges exist to performing the CGA uniformly for all geriatric patients who may most benefit, and they are largely rooted in the inconsistencies in standardization and validation within diverse populations and healthcare settings [7••]. While the traditional domains of the CGA provide abundantly useful information, additional considerations may need to be factored in for immigrants. Healthcare providers should maintain awareness of existing information available in literature and combine that with the humility and curiosity toward learning the varying cultural beliefs, norms, and practices of immigrant patients, as well as their uniquely faced challenges.

There currently is not one single validated recommendation for performing a multicultural CGA; however, there are many papers describing unique themes encountered by different ethnoracial populations and experiences of older immigrants across different countries. In addition, foreign born individuals have unique life stories which are impacted by the contingencies of their arrivals to a host country. In the literature appraisal process, it is important to be aware of the general definitions of "race" and "ethnicity", their internal definitions, as well as the implications of this basis of stratification of individuals into subgroups. In simple terms, all people are not homogenous, they do not fit into neat categories, and the definitions of race and ethnicity are changing in the US. Race is typically defined by an individual's inherited physical traits and characteristics, and it groups many different people into few narrow categories. Ethnicity is a broader term which constitutes a person's race, national origin, tribal heritage, religion, language, and culture [8]. Ethnicity is relational and multidimensional. It is based on the sense of belonging around the elements of a shared culture or place [9]. While "ethnorace" attempts to combine race and ethnicity, shifts in ethnoracial self-identification continue into older adulthood [10].

An immigrant is someone who consciously leaves their home to settle in a foreign country. Immigrants become permanent residents, are naturalized, or remain undocumented. Migrants move from place to place, within or across countries. Immigrants and migrants are similar, in that their moves are not forced upon them. Refugees and asylum seekers are those who leave their home for protection from dangers. Refugees are protected under international laws prior to arrival to a new country, while asylum seekers must apply for protection upon the arrival and meet specific criteria [11]. In this paper, whenever the term "immigrant" is used, it encompasses a broad definition of all foreign-born older adults, regardless of the reasons surrounding migration, their naturalization status, and intent to stay temporarily or permanently. This is done for the purpose of simplicity in summarizing the evidence. However, healthcare providers must be aware of the presence of distinct past and current factors in life experiences of foreign-born older adults depending on the circumstances under which they arrived to the US. In addition, while the inclusion of racial and ethnic data in prominent journals has increased over the last 20 years, there is an inconsistency between whether or how race and/or ethnicity are defined and measured [9]. Therefore, the need for integration of open curiosity and cultural humility into the medical care of older adult immigrant patients is crucial for providing comprehensive care, that curtails the potential for contamination with stereotypes and unconscious biases.

This review paper attempts to describe some of the most frequently encountered themes in current literature that may potentially impact how a comprehensive geriatric assessment is performed in foreign born older adults. These additional considerations are not validated for all foreign-born older adults, and therefore intended to be complementary to the traditional CGA. To minimize the potential for unintentional generalization of groups of people that could perpetuate stereotyping of specific populations, examples describing observed trends in specific ethnoracial groups will not be used; however, a complete list of citations of studies used in this review is provided and has this information.

Cultural Considerations and Tools for Assessing Dementia, Delirium, and Depression

Immigrant status may have the potential to both positively and negatively impact the risk for developing dementia in certain ethnoracial individuals living in the US, as compared to their native born counterparts [12]. This is due to a myriad of life experiences, socioeconomic, and health related factors affecting both immigrants as well as certain vulnerable and marginalized people who were born in America. The elements moderating the risk for dementia vary across ethnoracial groups, and may depend on the individual's country of origin, education inequities, and the presence of healthcare

disparities. Additionally, the stigmatization of Alzheimer's disease (AD) or the false belief that it is contagious or a normal part of aging, which is common to some cultural beliefs, can impact the insight to the degree of cognitive impairment present, thereby delaying care, or not seeking the care altogether [13]. Clinicians must therefore approach cognitive impairment screening with sensitivity, nonjudgment, and receptiveness to any presence of pre-exiting ideas or misinformation. This creates opportunities for education and rapport building with patients and families and can positively influence the acculturation process. Cognitive screening tools that are not majorly impacted by variations in language, culture, and education should ideally be used. The Rowland Universal Dementia Scale (RUDAS) has been frequently described in literature for assessment of cognitive impairment in older adult immigrants, as it appears to not be influenced by varying demographic factors, educational variables, including illiteracy, and has been validated in multiple languages and care settings. The RUDAS does not require extensive training for clinicians and takes approximately 10–15 min to complete. It is scored from 30 points, with the generally recommended value of 22 or less, as positive for cognitive impairment and grounds for further investigation. Subtle variations in the cut-off value have been reported in literature during the validation process in certain countries; therefore, scores which are slightly above 22 should be approached with caution and interpreted on an case-by-case basis [14, 15].

Delirium is well-established in literature for negatively impacting future cognition and function, and increasing the risk for mortality, particularly if it is unrecognized [16]. Detection of delirium can be challenging due to many patient- and clinician-centered factors. Language discordance between healthcare providers and patients can contribute to difficulties with accurate diagnosing of delirium [17]. It has been observed that non-English speaking acute care patients are at an increased risk for receiving physical and chemical restrains for delirium, which, are associated with significant hazardous consequences including oversedation, aspiration, and serious injury [18]. Several validated screening tools for the delirium detection exist across care settings; of these, iterations of the Confusion Assessment Method (CAM) are commonly preferred due to ease of administration and high sensitivity, specifically in presence of limited English language proficiency (LEP). The CAM-ICU (Intensive Care Unit) version is simple and quick to administer (under 2 min when not foreign language interpreter mediated) and incorporates brief neuropsychiatric assessments of inattention, that can be easily adapted into medical settings outside of the ICU [19]. It is validated in several languages, making it the most commonly studied delirium screening tool in diverse ethnoracial populations [20–22]. Accuracy of screening may be clinician-skill dependent, and translated CAM-ICU training manuals and flowsheets are available for download via the Vanderbilt University—Critical Illness, Brain Dysfunction and Survivorship Center [23]. Even so, it is important to mention that uncertainty continues to exist among healthcare practitioners regarding the validity of the recommended screening tools for foreign born older adults, and clear evidence-based guidance for delirium detection in this patient population is lacking [16]. Examples of barriers described in literature include limited access to interpretation services, varying time constraints, the presence of sensory impairments and poor health literacy, and some have questioned whether the typically assessed questions, such as "spell 'world' backwards" can be accurately applied to primarily non-English language speakers [17]. Recently, the Journal of the American Geriatrics Society (AGS) published a letter to the editor suggesting the consideration of delirium assessments which rely heavier on clinical observation rather communication for patients with LEP, specifically the Richmond Agitation Sedation Scale (RASS) and an interactive computer "serious tablet game", the PrEDICT [24]. Neither of these have been widely validated for use in immigrant patients, and PrEDICT in particular, requires further study. However, they are mentioned here for the purpose of additional consideration and possible future exploration ideas for broader clinical research.

Immigrants in America are exposed to unique factors influencing their health outcomes, which may be introduced pre-, peri-, and post-migration; these include and are not limited to experienced loss, perceived discrimination, marginalization, acculturative stresses, isolation, and varied cultural beliefs and stigmatization surrounding the presence of mental health disorders. Depression is a leading cause of morbidity among older adult immigrants in part due to its' association with decreased physical, mental, and social functioning [25]. Studies show that age at immigration as well as the length of time spent living it the United States influences the prevalence of serious psychological distress (SPD) and depression in US immigrants [25, 26]. It seems that overall, immigrants are less likely to report SPD compared to US born adults, and this likelihood is lowest in those who newly immigrated to this country [26]. Several conclusions have been drawn from these findings, including "the healthy immigrant phenomenon" which describes that certain immigrant groups are relatively healthy upon arrival to the US, but their health declines over time [27]. Additional hypotheses include the presence of adaption challenges but also the protective effects the acculturation process with regard to the increased openness to report mental health problems with greater assimilation to American beliefs surrounding mental health [25, 26]. Variation between depression literacy including beliefs about etiology, treatment, and prognosis have been documented across different ethnoracial groups, highlighting the importance of providing general

mental health education as part of the assessment process [28, 29], and educational materials should be available in a variety of languages and literacy levels. Given all of this, targeting newly arrived and longer-term US immigrants when addressing mental health struggles is equally important, though it seems that there is a higher propensity for having a positive depression screening test for those who immigrated > 15 years prior [26]. The geriatric depression scale (GDS) is widely suggested for assessing the presence of depression in foreign born and non-English speaking older adults, and has been translated into many languages and validated in multiple countries [30–35]. Efforts have additionally been made to improve the care for foreign-born patients with mental health needs by enhancing the way clinicians diagnose psychiatric conditions. The fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) provides updated criteria reflecting the differing ways people from varying cultures and communities present and describe their psychiatric symptoms, and changes have been made to specific diagnostic criteria in accordance with varying ethnoracial considerations [36]. The manual also provides guidance for interviewing patients while assessing for the presence of any cultural factors influencing perspectives, symptoms, and treatments. More recently, in 2022, the DSM-5 released an updated version, the DSM-5-Text Revision (TR), which includes considerations of how racism and discrimination influences mental health [37].

Using the patient's native language is the ideal method for obtaining information about mental and general health and wellbeing of patients. Inter-professional metacommunication has been suggested as a crucial component of successful interpreter-mediated psychiatric and other medical assessments. Weber et al. identified several communication challenges existing between interpreters and clinicians with regard to speech, emotions, subjective perceptions, interruptions, and non-verbal communication [38]. The authors propose that clinicians collaborate with their interpreters as early as possible and provide context to any difficulties which may arise, agree on ways to signal unintentional cultural missteps by the clinician, and minimize on-the-spot interruptions. One way of achieving this is through incorporating pre-, within, and post- encounter debriefings with the interpreter and allowing for ample visit time.

Assessing for Loneliness and Isolation in Foreign-born Older Adults

The quality of social supports as well as the negative consequences of isolation, are two of the most commonly encountered and crucially impactful health-influencing factors for older adult immigrants in the United States. Social support and isolation are associated with physical and mental well-being for older adults across multiple ethnoracial backgrounds [39••]. In addition, an individual's perceived isolation can impact their self-rated health [40]. The awareness of how patients relate to their immediate social environments is crucial to providing culturally sensitive healthcare. It can provide valuable insight into complex medical decision-making processes and understanding of how patients cope through medical hardships. Literature shows that while healthcare providers are often seen as credible sources of medical information for foreign-born older adults, specific attitudes and beliefs family members, as well as the quality of inter-family relationships can also significantly impact healthcare practices of patients, the risk for elder risk, and the overall feelings of wellbeing [41, 42]. Low levels of acculturation force older adults to heavily rely on their immediate families for many of their activities of daily living. For some, being dependent on family can strengthen their familial bonds, while for others, it may significantly stress them. A study examining the associations between the types of family relationship dynamics and risk for elder abuse in one foreign born ethnoracial population found that having a tight-knit family may be protective against the occurrence of elder abuse, as well as caregiver burnout [42]. This was likely influenced by the value of filial piety in that particular culture, and, the erosion of those values was associated with a greater risk for the presence of elder abuse [42]. Low acculturation can also limit an individual's abilities to engage socially and build support networks outside of the family unit [43]. Perceived isolation is an individual's subjective experience of having inadequate or lacking social networks and resources [44]. Perceptions of a lack of belonging have been documented even in those older adult immigrants who had access to their families [39••, 45]. Perceived isolation in immigrants can be influenced by many unique factors including racism, socioeconomic disadvantages, linguistic barriers, and experiences of discrimination [46]; therefore, it may be especially important for clinicians to take the time to explore beyond the sole presence or absence of family when assessing the social and environmental domains of the CGA in this patient population. There are no single recommendations for measuring social isolation in older adult immigrants, and healthcare providers should avoid generalization and pre-defined cut-offs when capturing this data [47•]. Several scales are cited in literature, of which, the 6-item de De Jong Gierveld Loneliness Scale (DJGLS) and the abbreviated 6-item Lubben Social Network Scale (LSNS) seem to be most applicable to older adult immigrant patients. Both scales in their abbreviated versions have been validated and proven reliable in several languages and countries [48–54].

Additional Multicultural CGA Domains

Ward et al. describes a "multicultural geriatric assessment" in an article that includes six unique domains in addition to the traditional CGA elements; these are, the assessments of baseline preventative care, chronic conditions, language, communication barriers, health literacy, and acculturation level [7••]. Baseline preventative care describes prior access to general medical care and preventative care such as vaccinations and cancer screenings. Assessment of chronic conditions explores delays in diagnoses and any consequences of untreated illnesses. The language domain includes not only the preferred language for communicating, but also the determination of literacy level. Suggestions for identifying barriers to communication incorporate screenings for cognitive, hearing, and visual impairments. The proposed approaches to evaluating health literacy include exploring education level, print literacy, and using the teach-back method to ensure proper understanding. Finally, measurement of acculturation involves assessing the patient's self-related health, both at time of immigration and in the years following [7••]. The authors acknowledge the presence of existing challenges regarding further management following obtaining some of this information, including insufficient evidence-based guidance for this patient population as well as need for more longitudinal studies addressing acculturation, personal well-being, and their associations with specific health-outcomes. One example given, is uncertainty in knowing how to approach cancer screening in foreign-born individuals who surpassed the maximum recommended age for screening and have had no such prior examinations to date [7••]. In these cases, individualized decision-making considering risks, benefits, and the patient's unique culture and preferences is appropriate. These conversations require very thoughtful communication strategies and humility on the clinician level. There are many varying health beliefs and behaviors among older aged immigrants impacting individual medical decisions. These include specific exercises, preventative diets, and herbal remedies which are often used alongside physician prescribed treatments; there is also significant intragroup sociocultural diversity in how they are practiced [55–58]. Thus, the curiosity to explore our patients' distinct cultures is a key component to patient centered care and shared decision making.

Summary and Conclusions

Ethnoracial identity and belonging is an individual and dynamic experience, which continues throughout life and into older adulthood. As demographic patterns in the US shift rapidly toward an increased prevalence of older adult residents from diverse ethnoracial backgrounds, it is especially important for healthcare practitioners to familiarize themselves with the unique attitudes, beliefs, and formalities of their patients. While all immigrants are at some point migrants, this is not true for the latter, as not all who migrate do so under the same circumstances, nor do they decide to stay in a host country permanently. The life stories of our foreign-born older adult patients are distinctively unique, and they can intimately impact their bio-phyco-social profiles. There has been a significant increase in promoting cultural competency as part of medical career training; however, when such teachings focus on the general traditional practices across different subsets of people, rather than encourage curiosity for their personal mannerisms and ideologies, there is potential for breeding unintentional and harmful stereotyping.

Physicians can considerably impact healthcare messaging and uptake for foreign born older adults [41]. Several attitudes and barriers to obtaining medical care among newcomers have been identified, including varying inter- and intra-cultural norms and personal beliefs, knowledge gaps, as well as insufficient access to social support and healthcare [55]. The CGA is a multidomain bio-psycho-social needs assessment aimed to identify potential limitations to maintaining overall health and function, thereby allowing for optimization of resources, increased care satisfaction, and wellbeing, via a coordinated and individualized care plan. Screening tools for certain components of the CGA have been validated in different languages and countries, although subtle modifications have been sometimes needed, and the interpretation of results should not solely rely on cut-off values, but rather consideration of the patient as whole, including their past and present experiences, and in conjunction with the clinician's prior knowledge and judgment. In some cases, objective and nonverbal screening methods may be necessary. Effective communication, with appropriately allocated visit time, and using the patient's native language is essential. Clinicians and interpreters can collaborate via pre-visit huddling centered around explaining the encounter context, as well as mutually sharing any information about cultural norms and beliefs and how they relate to communication [59]. Acculturation levels impact how healthcare is perceived and received [60]. Addressing healthcare disparities and barriers to acculturation may facilitate access and receptiveness to medical advice and care. Insight into whether there exist any familial, gender-specific, or community centered factors, cultural practices, and beliefs, as well as how patients individually relate to them, is central to providing culturally responsible medical care. Screening for the presence of depression and social isolation, allowing for cultivation of community relationships via healthcare initiatives in community centers to reduce stigmatizing health-related misinformation, working collaboratively with

medical interpreters, as well as providing translated educational material for those with limited English language proficiency are all ways in which we can better care for older adult immigrant patients [60].

Specific examples regarding shared healthcare related attitudes and behaviors observed across population groups have purposefully been omitted from this paper to promote the concept of cultural humility. Clinicians must consider the presence of many other impactful circumstances which have not been addressed here and are deserving of future review publications; those include, experiencing past and recent trauma, having undocumented immigration status, non-Western health related practices, the influence of filial piety, as well as social norms and beliefs surrounding death and dying, and advance care planning.

Comprehensively assessing foreign born older adults requires that medical practitioners maintain respectful inquisitiveness about their patients, as well as a lifelong dedication to learning, that is grounded on continuous self-reflexivity, self-assessment, and appreciation that each patient is their own expert on the social and cultural contexts surrounding their lives [61••].

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