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Communicating with ethnic minority elders: a review of the literature

Introduction

International migration and ageing populations of immigrants to the United Kingdom have created the need for health care research to address communication problems between ethnic minority elders and those that provide care for them. This is further illustrated by research, which project an increase of ethnic minorities over the coming years, in several western countries such as the USA (Vincent & Velkoff, 2010), Canada (Durst, 2005) and Australia (Gibson et al, 2001). The minority ethnic population of the UK has increased to 16.5% from the 8% of the 2001 census (UK Census, 2011) and is expected to keep on increasing. This will the proportion of ethnic minority elders who need care. Communication with the people from different ethnic groups can be challenging for healthcare workers (Likupe, 2011). Health care workers need to develop sensitivity to cultural diversity, stereotyping and prejudice, good communication skills generally and specific skills to negotiate communication barriers (Kai, 2005).

NMC (2010) standards for pre-registration nursing education stipulate that nursing students should use support structures to develop self-awareness, challenge their own prejudices and develop relationships that enable them to

provide care without compromise. A supportive environment and culture could be achieved when diversity issues are taken into consideration in care-giving relationships. However this requires training and financial resources which may be a limiting factor.

Most literature on communication with minority elders is concerned with translation of either the spoken or the written words (Yehieli, et al 2004). Age Concern for example, promotes the practice of producing translated materials from English to other languages for ethnic minority elders who may not be fluent in English (Age Concern England, 2006). In addition, Policy Research Institute on Ageing and Ethnicity Research Briefing (2004) reported that Ethnic minority care is compromised by limited communication and little involvement of elders in their care. Minority elders wish to be treated with respect and for all staff to behave with integrity. The form of respect may be different from person to person and from culture to culture. Therefore individual and cultural differences need to be recognised and taken into account. For example in most African cultures older people may not prefer to be addressed by their first names preferring to be addressed as uncle, aunt, or mama depending on the relationship and age differences. In Asian cultures older people may prefer to be addressed by their titles such as doctor, Mr, or Mrs.

This paper reviews experiences of communication from both ethnic older peoples' and carers' perspectives in the care giving process. Several themes on communication involving older people in general and minority elders in particular have been identified in the literature, these are: perception of elders

by the young, barriers of communication and overcoming communication barriers. These will be discussed in more detail below.

Perception of elders by the young

A number of studies into ageing and communication have reported decreasing levels, both in actual and perceived in communicating capacities of people as they age (Ryan et al, 2004) and little contact between people of different generations. In addition the little communication found was deemed unsatisfactory. Communication was shallow and ageism was found to be communicated in various degrees of explicitness, including portrayal of elders as nagging, longwinded, and various forms of physical decline (McCann and Giles 2002, McCann, et al 2004). In some cases elders were stereotyped as slow thinking, incoherent, inarticulate, demanding and complaining (Harwood, 2007).

Younger people have been reported to “overaccommodate” to older people as a social category regardless of these individuals’ functional autonomies (Giles & Dorjee, (2004). The overaccommodation tend to involve depersonalization of the older person as the younger person becomes overly polite and warm, slower in speaking rate, louder in volume, and use an exaggerated intonation , higher in pitch and grammatically and /or ideationally simple when speaking to the older person. Many elders regard this behaviour as lack of respect as these modifications are not based on realistic needs of the individual (Giles & Dorjee, 2004). Although this research is not specific to ethnic minority elders, this

behaviour may be exaggerated if there are cultural and language differences between the young person and the elder. Overaccommodation can lead to negative outcomes such as feeling loss of personal control, low self-esteem and reduced social interaction (Ryan Meredith, Maclean and Orange, 1995).

Similarly 'elder speak' is defined as a type of communication style which is patronising and unknowingly reinforces dependency and engender isolation and depression in older adults in nursing homes. This includes use of terms of endearments such as honey, sweetie and darling (Williams et al 2003). This type of communication is condescending to the older person and results in increased dependence interaction as the older person tries to conform to the way they are seen or perceived by the carers.

Using three Asian and three Western nations Giles et al (2003) found intergenerational communication with non-family elders was perceived less positive than that with family elders and that with peers. This quantitative study using a questionnaire across three continents with a sample of 730 young people heightens the problems faced by ethnic minorities in western countries as very often this interaction will be between young carers and non-family elders. These researchers asked the participants to reflect on conversations they had with three different groups of older people. The participants were randomly assigned to different social groups and conditions, further strengthening the rigour of the study. Giles et al (2003) found that young people evaluated interactions with non-family members more negatively than interactions with family members in both Western and Asian nations. This

finding emphasises the importance of communication training in care giving situations as care givers interact with non-family members.

Mold et al (2005) also reported in their review that ethnic minority elders experienced racism from residents, their families, and employee's co-workers. Racism often took the form of inappropriate language use by residents and carers. However examples of racist language are not given in the paper.

Although most of the literature reviewed by Mold et al (2005) was from the USA, the authors conclude that further clarification is needed to explore how services may be able to acknowledge the needs of ethnic minority elders in care. They emphasise that views of elders regarding their care can only be known 'if researchers are willing and able to involve residents and workers in the research process and choose methodologies that can adequately explore their views, for example, interviewing and observation' (p. 112).

Barriers of communication

In a quantitative study using a self administered questionnaire among ethnic minority elders in Finland Erikson-Backa (2008) found that barriers to communication originated with both seekers and providers of information. These included use of medical technology although examples are not given, and arrogant attitudes among doctors as well as lack of time. Respondents reported not receiving answers to their questions about their examinations and treatment. Older people did not ask for clarification on misunderstood information because of concerns about being labelled confused and demented while some respondents reported experiencing language barriers. This problem

was common among immigrants and ethnic minorities. Detailed information from health professionals revealed that respondents experienced barriers to desired information because of feelings of inferiority, lack of time of information and confusion caused contradictory information.

Yehieli et al (2004) explain that language barriers can mean patients' questions are not understood, not adequately communicated or misunderstood. Doctors or nurses' instructions could be misunderstood. Some minorities such as black Africans might be stoic and not likely to discuss their problems. However, the authors did not specify how this problem was determined.

Murphy and Macleod Clark (1993) interviewed 18 nurses who had looked after ethnic minority clients about their experiences of looking after this client group. Nurses reported that they felt unable to give holistic care because of communication and cultural barriers which caused them frustration. Views of ethnic minority clients were not sought in this study. Therefore the results have a nurse bias since only nurses' views were sought. Although dated the findings could be applied to nursing practice today, in particular the recommendation for nurse education to include cultural training. The study also raises issues of communication training in pre-registration training, post-registration training and health carers' training.

Johnson et al (2004) reported that White physicians in the USA, dominated conversations with African American patients during medical visits more than with White patients. Communication with African American patients was not patient centred as compared to that with White patients. This had a less positive effect on both patients and physicians. Patients were less adherent to

treatment and were less satisfied with their care while physicians experienced less patient participation in their care. The authors concluded that patient engagement and participation in their care rather than the overall time spent with the physician may contribute to health disparities. They explained that communication skills programs that focus on patient- centeredness and building rapport with patients benefit patients in general and ethnic minorities in particular.

Factors such as racism, poverty and the desire for cultural maintenance may be difficult to communicate to authority figures of white population and this may lead to stress. Being appraised according to stereotypes as above may cause offence and lead to stress which may cause physical problems (Yehieli et al, 2004). Further Yehieli et al (2004) adds that different cultures might have different concepts of health and different ways of communicating. Elders may have different ideas about the role of health care professionals. Culture may be a barrier if minority ethnic elders cannot be seen by providers familiar with their own culture.

Mold et al, (2005) reported a paucity of literature concerned with minority elders in care homes with only three journal articles in their review originating from the UK and the majority from the USA and Canada. These authors reported that there were racial disparities in access to care homes with minority ethnic groups having poor access to quality homes and quality care. Establishment of good communication with ethnic elders was described as important for the achievement of individualised care.

This view is also endorsed by Sims (2010) who reported that African American women received different treatment from white women and that stereotyping shaped their treatment by health care workers. This stereotyping affected their interactions with health care providers and they sometimes felt that their statements were misinterpreted. One woman in the study described how a doctor was scared as she used her hands a lot during speaking and the doctor thought she was going to hit him.

Overcoming communication barriers

Ryan et al (1995) developed a communication enhancement model for older people (Communication enhancement model for interactions with elderly people) and claimed that their model was especially beneficial to ethnic minority elders and those suffering from dementia. In this model Ryan et al demonstrates that after education, the health provider has a different perception of the older person. The health care provider understands the ageing process and acts as an advocate and partner in decision making regarding the older persons care. They demonstrated this using two case studies, one from an ethnic minority elder and the other from an elder suffering from dementia. Although the communication model demonstrated some benefit, its construction did not involve the population which it was meant to help and neither did the authors seek information from health provides. This information needs to be incorporated into the model if maximum benefit to health is to be realised. For example information related to specific needs such as diet of the ethnic elder and various forms of respect could be included.

Building on Ryan's et al (1995) communication enhancement model, Edwards and Chapman (2004) included role expectations from both care givers and care receivers. The authors developed the Health Promoting Communication Model to promote constructive communicative outcomes within families. This model focuses on individual rather than stereotypical expectations about the older person's competence or ability but fails to address specific communication needs that ethnic minority elders may have such as cultural beliefs.

Using a survey of 153 health care staff in government and private hospitals in United Arab emirates EL-Amouri and O'Neill (2011) identified need for translation of material and need for people to be orientated to different cultures. They also identified the ability to critically evaluate patient's background and needs, provision of staff professional development and need for provision of translators and interpreters in ethnically diverse cultures. In addition the study identified need for team building activities and a focus cultural celebrations and socialisation activities. However no specific activities are suggested in the study. Nurses suggested that to improve culturally competent care the following were needed: skills to assess and understand different cultures; staff professional development programs, improved interpreter/translator support; more multimedia resources and visual aids to support communication, greater empowerment of staff in decision making process and provision of help and support for low socioeconomic and elementary educated patients. These suggestions require additional resources from service providers and an ongoing commitment from healthcare staff. Cultural competence training is also required. This means that staff are able to appreciate fully other cultures and integrate this with care of the elder.

Recognising that a paucity of research examining how the quality of communication between health professionals and patients with different English abilities can affect care exists. Gerrish (2001) conducted an ethnographic study in an English community NHS involving 8 district managers 22 nursing nurses and minority South Asians (number not specified) using in depth interviews and participant observation. She found that patients who spoke little or no English were disadvantaged in their care as they could not understand and follow treatment instructions. Furthermore Gerrish (2001) found that psychological support for these patients was limited and that identification of patients needs in such circumstances was questionable. She suggested that in such cases care provided might be based on the norms of the White population.

When older people are involved in research, their experiences and wishes can be used to formulate care which reflects respect and dignity is acceptable to them. For example, Heikkilä and Ekman (2003) conducted a qualitative study which reported on wishes and expectations of older Finns living in Sweden. Thirty nine interviews were conducted with older people at home. Data revealed that older Finns wanted to feel settled where ever their care was provided. They wanted continuity in their daily lives. Nursing homes were viewed negatively as they could increase older peoples' dependency. All but one nursing home in Sweden provided care for Finnish immigrants. Finnish older people reported that companionship and security were priorities during their care. Culturally appropriate care was thought to provide the means for communication and companionship between staff and fellow residents.

Johnson (1996) reported on 200 studies in health and health services delivery relating to communication issues between practitioners and members of minority ethnic groups or communities. He found that effective communication can be achieved by focusing on strengths of different cultures and examining the role of social structures rather than blaming individual behaviour. He emphasised that communication is a two way process between the health service provider and their clients. 'This process includes all forms of information transmission, and attempts by patients and potential users to access health services'. Although dated, Johnson's study is still relevant as evidenced by recommendations below some of which, have not yet full been met.

Johnson (1996) made several recommendations designed to improve communication between ethnic minorities and health care workers included: more research into training, communication and use of such professional workers; staff need training in cultural sensitivity; communication with minority groups require more personal, individual intervention rather than reliance on the printed methods; staff should be aware of stereotypes which suggest that ethnic minorities present communication difficulties, and not rely on stereotyped notions of culture or language ability in communicating with minority clients. He also recommended that health workers should identify their communication needs and courses should be arranged for all health –delivery staff and initial training amended to include aspects of multi-cultural working.

Johnson (1996) states that telephone and postal surveys have a poor response in researching communication issues in minority groups in the UK. They recommend 'personal visits, if necessary to the home, and using wherever

possible 'matched' interviewers (certainly by gender, and preferably by origin as well as language competence'. Moreover Johnson states that studies should pay attention to issues of race, ethnicity, language as well as culture.

Gunaratnam (2008) reported that care givers often said it would be helpful to know the patients culture in order to give holistic care following interviews with 33 older people and 56 professionals to elicit accounts and views on the relationship between ethnicity and health care. However some respondents emphasised that it was important to know the patient's wishes instead of categorising them into a particular culture. Gunaratnam (2008) argues that although cultural knowledge may sometimes facilitate culturally responsive care, it can give primacy over individualised care and this may not be desirable. The author points out that most of the time minority elders are expected to be custodians of the culture and to tell professionals what is expected. When this is not forthcoming the elders may become the objects of anger and resentment as such knowledge is then not readily available to professionals and may be seen as an obstruction to routines of care. Although the author claimed to have interviewed minority elders, there was no evidence in the discussion as only interviews from health care workers were reported. This was a limitation of the study that promised so much as the views of the elders were not heard. This would help health workers to design communication models that can be of help in improving assessment and care of the elders and bring satisfaction to the care professionals.

Suggestions for improving communication between elders and carers include recruitment of nurses from different ethnic groups, development of translation

services and leisure clubs offering 'culture specific activities as well as investment in education and training for carers (Mold et al 2005).

Improved confidence and communication in nursing students was observed after training with a simulated computer program (Kluge et al 2007). The researchers emphasise the need for health care workers to develop communication skills with older people as the demographic reality of people living longer will mean that increasing healthcare workers will be providing care to older people. Issues of ethnicity however, were not addressed in this study.

Kai (2006) explains that communication can sometimes be challenging in interactions with those who are perceived as different from us. He advocates that to communicate successfully, health care workers need to accept the discomfort of unfamiliarity and uncertainty. Challenges of stereotyping and prejudice need to be confronted with sensitivity and negotiated to overcome communication barriers. Kai also explains the importance of understanding culture in communication and how such factors as gender, age, education, socio-economic background, language, family, religion, sexual orientation, disability and previous experiences may as well as the health workers own culture may all affect communication. It is therefore wise to include an individual perspective when investigating communication issues.

Previous research on needs of minorities has not been successful because of difficulties in communication and lack of knowledge about cultural differences Gerrish (1997). Poor communication, stereotyping, lack of understanding, and derogatory attitudes are often cited by other minority patients as key issues in care. She argues that although human caring is seen as a universal

phenomenon, patterns and expression of caring vary among cultures and within cultures. Therefore nurses need to develop an in depth understanding of different cultures in order to provide individualised patient-centred care. Gerrish (1997). recognises critics of this approach to care, citing Stokes (1991) who argues that a transcultural approach ignores issues of gender, class, race, religion, politics and employment. Issue of discrimination through racism and institutional racism which may be associated with ethnic minority status are also ignored. However Gerrish states that in respect of nurses' education it is important to take a broad view of ethnicity.

Giuntoli and Cattani (2012) reported similarities between older migrants and older British nationals in their 'abstract expectations' of care and support from care services. These expectations included respect for dignity, high professional standard and communication. However ' pragmatic expectation', views of what was important to maintain dignity in older age, which issues were important in the caring communication and what professional practices were sensitive were expressed differently among different migrants. Older migrants described the need for ongoing dialogue within and between services, between services and patients and between carer the person needing care about individual entitlements and preferences. Cultural and spiritual backgrounds were also identified as important in determining specific issues that older migrants considered as important in the communication process. Another expectation was the older persons need for increased time to process information which had a major impact on face -to- face interactions with care staff. Carers suggested that older people should be given more time to process

information and share it with next of kin if possible. This is even more important for ethnic elders as there may be language problems and cultural issues.

Implications for practice

This review has demonstrated that younger adults perceive older people as declining in various capacities and that this can lead to unsatisfactory communication such as over-accommodation and elder speak between the younger person and the older person. Many elders feel disrespected and may develop negative outcomes such as low self-esteem and reduced social interaction as a result. Ethnic minority elders are at a particular disadvantage as they may experience racism and poor care as a result of barriers in communication. These barriers include language, culture and negative attitudes from health care workers.

Research has reported that racism, poverty and cultural differences may make it difficult for ethnic minority elders to communicate their needs to authority figures such as doctors and nurses. This could result in poor treatment and care for the elders. Communication models such as the communication enhancement model by Ryan et al (1995) have been devised to overcome communication barriers between health care workers and older people. However, as discussed in this review, such models have lacked the views of the elders in their development. Johnson (1996) recommends personal visits and matched interviews should be used in research with minority elders in order to seek their views in their care. This is vital to practice if culturally sensitive care is to be delivered. Any future communication models concerned with minority elders should incorporate views from elders obtained through

research. This would help to inform all those involved what patients and health care workers require in cross cultural communication.

Health care providers need to become culturally sensitive to the cultures of ethnic minority elders they are caring for. This includes being aware to their own values and beliefs and recognising how these influence attitudes and behaviours. Being aware and sensitive to ethnic elders' cultural values and beliefs and how these may influence the elder's attitudes and beliefs. Staff needs to be aware of the style of communication used in a particular culture and of the respect afforded to elders in these cultures. Above all care providers need to be aware that people are individuals and that the use of stereotypes is demeaning should be avoided. All healthcare staff should participate in cultural training and education and essential messages arising from this review are summarised:

- Be sensitive to your own values and beliefs.
- Be aware of different cultures and values.
- Understand communication styles and values from different cultures.
- Respect individuality while recognising diversity within cultures.
- Adopt a holistic approach when caring for elders.
- Involve elders in their own care.

Development of communication skills requires training and financial provision for training. These challenges could be partly addressed by including cultural

training in pre-registration training, continuous development training, Learning Beyond Registration (LBR) modules and training sessions for nurses and support staff in care homes. Medical training in the case of doctors could also include cultural training. However it is acknowledged these suggestions demand a change of culture attitude for academics service providers.

Conclusion

The majority of nurses in the UK will work regularly with patients from different cultural backgrounds. People are living longer and therefore healthcare staff will encounter more older patients from ethnic minorities. Effective communication is integral to good quality and compassionate care and therefore it is essential that all staff working in the health service have an understanding of how to communicate with people from diverse cultures. However as this review has shown there is a dearth of research on how to promote better communication between healthcare staff and ethnic minority elders and therefore more research, education and training is urgently required to promote better care for these patients.

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