Developing Culturally Diverse Direct Caregivers for Care Work With Older Adults: Challenges and Potential Strategies

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Turnover is high for direct care workers who care for the increasing number of older persons and those with dementia, whether these workers are part of the fast-growing contingent of home health care providers or work in nursing homes and long-term care communities as nursing assistants. In the absence of additional pay or insurance benefits, what helps to keep most direct care workers on the job is preliminary or on-site training that speaks to their values and preferred learning styles. Another important factor is the perception of respect for the quality of their work from supervisors and administrators (Bishop et al., 2008). Different generational cohorts of staff have differing values and perceptions, and the need to provide training to a culturally diverse cohort of workers is an additional complication.

The authors are a nurse educator (M.K.S.) who directs a training program for nursing assistants and home health care workers and a linguist and gerontologist (B.H.D.) who works with communication and aging issues. This discussion examines three cultural factors that underlie challenges for nursing educators and supervisors in dementia care who oversee direct care workers: (1) the effect of immigrant cultures and languages; (2) the effect of different intergenerational cultural constructs; and (3) the effect of culturally derived attitudes about aging and dementia. Strategies to address these challenges are offered.

Abstract
This discussion presents real-world examples of challenges that occur in geriatric training as a contribution to the ongoing conversation about tailored training for direct caregivers. Numerous discussions are available on the need for more geriatric training in nursing, including aspects of care for patients with dementia, but few if any studies have identified a similar need on behalf of direct care workers, including home health care aides, personal care aides, and nursing assistants who are not part of a licensure track or a baccalaureate-based nursing curriculum. This discussion examines three cultural factors that underlie challenges for nursing educators and supervisors in dementia care who oversee direct care workers: (1) the effect of immigrant cultures and languages; (2) the effect of different intergenerational cultural constructs; and (3) the effect of culturally derived attitudes about aging and dementia. Strategies to address these challenges are offered.

The Challenge
The current and projected prevalence of Alzheimer’s disease and similar dementias has increased the need for direct caregivers. According to the Alzheimer’s Association—
tion (2012a), an estimated 5.4 million Americans have dementia: one in eight adults 65 years and older and nearly half of those who are 85 years and older. Although approximately 80% of those with dementia remain in the community, of those living in residential care, 42% of those in assisted living (Park-Lee et al., 2011) and 60% of those living in nursing homes have Alzheimer’s disease or another form of dementia (Alzheimer’s Association, 2012b). In addition, persons with Alzheimer’s disease require roughly three times the Medicare payments of those who do not have this condition, typically because of the need for hospitalization and skilled nursing home care (Alzheimer’s Association, 2011). It is easy to understand the growing need for knowledgeable care by direct care workers: the projected demand is expected to reach 1.1 million by 2018 (National Clearinghouse for Direct Care Workers, 2011).

CHALLENGES TO TRAINING CAREGIVERS IN HOW TO COMMUNICATE WITH GERIATRIC PATIENTS AND THOSE WITH DEMENTIA

A key issue in training direct care workers in how to provide culturally sensitive care for geriatric patients, including those with dementia, is a combination of intergenerational, language, and cultural factors that are interwoven with direct care workers’ attitudes about aging and dementia. This article discusses three interwoven challenges: (1) the effect of immigrant cultures and languages; (2) the effect of different intergenerational cultural constructs; and (3) the effect of culturally derived attitudes about aging and dementia. The 2008 report by the Institute of Medicine, *Retooling for an Aging America: Building the Health Care Workforce*, began with the statement that the health care workforce needs greater training in the care of geriatric patients and expanded roles for geriatric care (Institute of Medicine, 2008). In the case of direct care workers, the need for training in geriatric care is even greater, given Bureau of Labor Statistics projections for growth in the number of home health care aides and personal care aides of 50% and 46%, respectively, by 2018 (Bureau of Labor Statistics, 2012). The 2007 report by the Institute for the Future of Aging Services, “The Long-Term Care Workforce: Can the Crisis be Fixed?” lists the following as a goal: “Make larger and smarter investments in the development and continuing education of the long-term care workforce” (Institute for the Future of Aging Services, 2007). Maas, Specht, Buckwalter, Gittler, and Bechen (2008) highlighted the training needs of direct care workers in the context of reviewing staffing and training at nursing homes. Research has linked the empowerment of direct care workers to job satisfaction and retention (Coogle, Parham, & Rachel, 2011). Although numerous discussions in prominent nursing journals, including this one (Notarianni, Curry-Lorenco, Barham, & Palmer, 2009), have alerted nurses and administrators to the need to understand the effect of four different generations on management styles and interprofessional discourse in long-term care settings, few studies have identified a similar need on behalf of direct care workers, including home health care aides, personal care aides, and nursing assistants who are not part of a licensure track or a baccalaureate-based nursing curriculum.

Effect of Immigrant Cultures and Languages

In 2010, the U.S. population of those 65 years and older was 40.3 million, or 13% of the population (Werner, 2011). Leutz (2007) noted the growing diversity in the U.S. elderly population as a result of immigration from Africa, Asia, and Latin America since World War II. This change reflects an increase from 8.6% of the total population to 10.0% between 1990 and 2003. Feng, Fennell, Tyler, Clark, and Mor (2011) reported that the number of Hispanics and Asians in nursing homes increased by 54.9% and 54.1%, respectively, between 1999 and 2008, whereas the number of White residents declined by slightly more than 10.0%. According to Khatusky, Wiener, and Anderson (2010), one in five certified nursing assistants was born abroad, and these workers are predominantly persons of color. Khatusky et al. (2010) used data from the 2004 National Nursing Home Survey (Centers for Disease Control and Prevention, 2004) to show that concerns held by administrators and staff about language barriers and acculturation for second-language immigrants are valid, although communication problems are also concerns of non-immigrant aides. They noted discrepancies for immigrant workers between high levels of job satisfaction and significant discrimination, with discrimination contributing to dissatisfaction (Khatusky et al., 2010). Sloane, Williams, and Zimmerman (2010) used a multivariable logistic regression of the National Nursing Home Survey data to identify a significant relationship between citizenship status and the likelihood of turnover within 1 year. They found that recent immigrants were more likely to say that they intended to leave within 1 year (Sloane et al., 2010). A sizable number of immigrant direct care workers are better educated than non-immigrant direct care workers and use their earnings to support enrollment in certificate or degree programs in health care. Nonetheless, given the low pay—the National Clearinghouse for Direct Care Workers (2011) estimated that 46% of direct care workers re-
ceive Medicaid or food stamps—and low education of many native and foreign-born direct care workers, Leutz (2007) called for training programs that incorporate teaching or expanding English skills as well as addressing child care and immigration issues. To these issues the authors add a call for expanding both health literacy and print literacy.

One element of health literacy is understanding how to use the health care system. Novice direct care workers are unfamiliar with the health care system, according to Lindquist, Jain, Tam, Martin, and Baker (2011), who found that more than one third of paid caregivers in their study had inadequate health literacy and nearly two thirds made errors in following directions for giving medications. Their sample of 98 randomly recruited Chicago caregivers included 37% who were born in the United States. The remaining 63% were non-native: 33% were from the Philippines, 19% were from Mexico, and the rest were from Africa (5.1%), Eastern Europe (3.0%), and India (1.0%). Martin, Lowell, Gózdziak, Bump, and Breeding (2009) identified several language issues: only one-fourth of the foreign-born direct care workers in their study were from countries where English is spoken. Among the rest, 29% were from the Caribbean, 21% were from Mexico and Central America, and the remainder were from Asia and Africa. As with discussions based on the National Nursing Home Survey, researchers agree on the need for training that includes an emphasis on workplace English, and not just for newcomers.

Newcomers—second-language immigrants who arrived in the United States in the preceding 3 years—are not the only people who struggle with workplace expectations for English proficiency. Although studies are only now beginning to appear, a growing number of members of “Generation 1.5” are attending training classes for direct care workers. A typical mix in any section of the authors’ community college classes may include one or two newly arrived immigrants as well as two more students who are apparently, from their writing and their self-introductions, Generation 1.5, a term used to describe students from immigrant families who have graduated from American high schools but are still not completely proficient in English (Harklau, 2003; Singhal, 2004). The Figure shows the countries/cultures of the second-language and Generation 1.5 students in the authors’ 2011 training courses for direct care workers.

Generation 1.5 students usually have appropriate reading skills and often have outstanding oral and interpersonal skills; however, their writing skills are typically deficient. In addition, whereas newcomers typically furnish the name of their home country and the time they have spent in the United States, Generation 1.5 students often “hide” their place of origin and report instead the names of schools they attended in the United States. The Table shows the number of second-language and Generation 1.5 students in the 12 nursing assistant course sections directed by one of the authors (M.K.S.) throughout 2011. Second-language students are immigrants who arrived in the previous 7 years but did not attend school in the United States. In contrast, Generation 1.5 students were either born in the United States or came as very young children and attended high school in the United States. The Table shows the major (world) languages spoken in the country of origin and probably at home in the United States but does not show local or regional dialects or languages.

**Effect of Different Intergenerational Cultural Constructs**

Several lines of scholarship in multiple fields discuss intergenerational communication. The first may be more familiar to nursing educators: the recent spate of discussions about the characteristics of four (McCready, 2011) or, in some cases, five generations of patients and staff that nursing supervisors and managers encounter. In 2012, patients are more likely to be from the Greatest Generation (born 1901 to 1924), the Silent Generation (born 1925 to 1942), or the Baby Boom Generation (born 1940 to 1959). Note that birthdates for cohorts have some overlap. On the other hand, staff are predominantly from the Baby Boom Generation, Genera-
tion X (born 1960 to 1974), and Generation Y or the Millennial Generation (born 1975 to 2004), which includes the Net Generation (born 1980 to 2004; see Billings & Kowalski, 2004).

According to Wilson, Squires, Widger, Cranley, and Tourangeau (2008), generational differences affect job satisfaction, which in turn affects staff turnover. These generational differences are not limited to direct care workers from the United States: they are worldwide phenomena. Wessels and Steenkamp (2009) discussed teaching South African students belonging to Generation Y, and Australian educators called attention to leadership styles across the last three generations—the Baby Boom Generation, Generation X, and Generation Y (Yu & Miller, 2005). Direct care workers from other countries fall into the same generational cohorts; training that does not address generational differences and that does not help to retain them may lead to their becoming dissatisfied and leaving the health care work force. Smith (2007) noted that direct care workers who leave their jobs, particularly those who are home health care workers, may be leaving any form of health care work as well. Baughman and Smith (2011) found that direct care workers stay in a particular job for a mean of less than 1 year, and fewer than one third of them go to another direct care position. There are additional concerns affecting the satisfaction of the growing cohort of home health care workers, whether they are home care aides with minimal training, certified aides, or registered nurses (RNs). Approximately three fourths of this cohort reported working for agencies, nearly half of which are located in the South (Bercovitz et al., 2011). The concerns of these workers included abuse from clients and unpaid overtime (Delp, Wallace, Geiger-Brown, & Muntaner, 2010). In addition, these workers are typically slightly older than other workers; therefore, they are more likely to be members of the Baby Boom Generation than members of Generation Y (Faul et al., 2010). This generational difference can affect training design and reception.

Another line of research on intergenerational communication includes studies of language and aging by linguists and communication researchers, gerontologists, and nurse educators. These researchers usually focus on how younger persons talk with older people. For example, Coupland, Coupland, and Giles (1991) identified pervasive ageism in conversations between young adults and elderly people. Ryan (2010) found

<table>
<thead>
<tr>
<th>2011 Sections</th>
<th>Total</th>
<th>Men</th>
<th>Women</th>
<th>Countries of Origin</th>
<th>Languages Other Than English</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spring 01</td>
<td>16</td>
<td>2</td>
<td>14</td>
<td>Vietnam</td>
<td>Vietnamese, French</td>
</tr>
<tr>
<td>Spring 02</td>
<td>19</td>
<td>4</td>
<td>15</td>
<td>3 Mexico and Latin America, 2 Spain, 2 Persia, 1 Russia, 1 Vietnam</td>
<td>Spanish (3 varieties), Iranian, Russian, Vietnamese</td>
</tr>
<tr>
<td>Spring 03</td>
<td>17</td>
<td>3</td>
<td>14</td>
<td>Saudi Arabia, Vietnam</td>
<td>Arabic, Vietnamese</td>
</tr>
<tr>
<td>Spring 04</td>
<td>18</td>
<td>2</td>
<td>16</td>
<td>2 Korea, 2 Mexico/Latin America, 1 India</td>
<td>Korean, Spanish (2 varieties), Hindi</td>
</tr>
<tr>
<td>Spring 05</td>
<td>11</td>
<td>1</td>
<td>10</td>
<td>1 Vietnam</td>
<td>Vietnamese</td>
</tr>
<tr>
<td>Summer 01</td>
<td>26</td>
<td>3</td>
<td>23</td>
<td>2 Colombia, 1 Dominica, 1 Vietnam</td>
<td>Spanish (2 varieties), Vietnamese</td>
</tr>
<tr>
<td>Summer 06</td>
<td>22</td>
<td>4</td>
<td>18</td>
<td>1 Vietnam</td>
<td>Vietnamese</td>
</tr>
<tr>
<td>Summer 07</td>
<td>22</td>
<td>5</td>
<td>17</td>
<td>2 Latin America, 1 Vietnam, 1 Russia</td>
<td>Spanish (2 varieties), Russian, Vietnamese</td>
</tr>
<tr>
<td>Fall 08</td>
<td>16</td>
<td>2</td>
<td>14</td>
<td>1 Russia, 1 Italy</td>
<td>Russian, Italian</td>
</tr>
<tr>
<td>Fall 09</td>
<td>11</td>
<td>4</td>
<td>7</td>
<td>1 Puerto Rico, 1 Cuba</td>
<td>Spanish (2 varieties)</td>
</tr>
<tr>
<td>Fall 10</td>
<td>20</td>
<td>4</td>
<td>16</td>
<td>1 Peru, 1 Virgin Islands</td>
<td>Spanish (2 varieties)</td>
</tr>
<tr>
<td>Fall 11</td>
<td>20</td>
<td>4</td>
<td>16</td>
<td>1 Panama, 1 Kosovo, 1 Korea, 1 Thailand</td>
<td>Spanish, Korean, Russian, Thai</td>
</tr>
<tr>
<td>12 sections</td>
<td>218</td>
<td>38</td>
<td>180</td>
<td>See the Figure</td>
<td>Minimum of 15 (excluding local varieties)</td>
</tr>
</tbody>
</table>
ageism to be the basis for the Communication Predicament of Aging Model, which may underlie the use of Elderspeak, a specific method of addressing older adults.

The Communication Predicament of Aging Model shows how ageist stereotypes about older adults, such as that they are deaf, slow-witted, or garrulous, or that their communication is trivial, can bring about social withdrawal and helplessness. Elderspeak, which is a patronizing speech style that can sound like baby talk, with its higher pitch and overly familiar nicknames (e.g., “Hi, sweetie,” “OK, sugar, let’s get dressed”), is no doubt meant to signal affection on the part of the caregiver, but instead it often creates anger and resistance to care (Williams, Herman, Gajewski, & Wilson, 2008). Few studies, however, have considered the effect on nursing instructors of the multiple language needs brought to the training courses.

Effect of Culturally Derived Attitudes About Aging and Dementia

Individuals enrolled in the authors’ training courses for direct care workers in 2011 included many who had not expected to be there but who wished to change career directions and get a job—any job. Only a few had planned from the outset to enter health care, and most were primarily interested in improving their financial status and job possibilities when they started the course. The students, like those before them, brought with them unexamined attitudes and stereotypes about aging and also about dementia and communication with patients with dementia. A growing number, especially from the Hispanic/Latino communities, came from cultures that stigmatize or hide dementia, as amply illustrated in the valuable online Stanford Ethnogeriatrics Curriculum (Yeo, 2010).

Often, these students’ experiences with aging and dementia in their own families can account for their attitudes and subsequent actions. Too often, direct care workers talk over, talk across, or talk for patients with dementia (Davis & Pope, 2010). It is reasonable to surmise that cultural orientation to aging and dementia plays some part in ways that direct caregivers may objectify residents, talk about them as “fictive kin,” or see them as autonomous persons (Fisher & Wallhagen, 2008). A focus group study by Boughtwood, Adams, Shanley, Santalucia, and Kyriazopoulos (2011) looked at attitudes of Australian caregivers who spoke Arabic, Chinese, Italian, and Spanish. The authors drew on North American research for their background, finding some differences in the Australian experience, but noting some distinctions between cultural groups. They found that African Americans who have cared for patients with dementia often have had negative experiences with formal health services and see family members as the key caregivers. Chinese families tend to stigmatize dementia and emphasize filial piety, or the need for family members to care for elders. In Hispanic/Latino families, familismo, or familism, prioritizes family over individual needs, which affects the choice of home care. These findings supported an earlier report by Scharlach et al. (2006), who also identified filial obligation and the importance of kinship networks among African Americans and Asians as well as the need to maintain cultural traditions, as with Russian-speaking Americans and Native Americans.

Brodaty, Draper, and Low (2003) found that nursing home staff experienced greater stress when working with cognitively impaired patients and derived no job satisfaction from working with these patients. This report supported earlier findings that indicated that RNs had greater empathy and less burnout than front-line staff (Astrom, Nilsson, Norberg, & Winblad, 1990), whereas a set of focus group interviews with rural care-givers identified a lack of understanding of dementia and a tendency to stigmatize dementia as “crazy” behaviors that could be expected as people aged (Connell, Kole, Avey, Benedict, & Gilman, 1996). Although training and education can be associated with an improvement in attitude (Kada, Nygaard, Mukesh, & Geitung, 2009), in many cases, new learning and new techniques demonstrated through training and in-services are not enabled or facilitated by supervisors (see also Google et al., 2011).

NEXT STEPS: THREE STRATEGIES SUGGESTED FROM THE LITERATURE AND EXPERIENCE

Strategy 1: Expanding the Language Training Needed by Direct Care Workers

Administrators and supervisors of direct care workers, whether they work in home health care or in nursing homes and long-term care facilities, must be prepared to train, direct, and retain a work force in which at least two thirds need help with both print literacy and health literacy skills and at least one-fourth have difficulty understanding speech from residents, patients, peers, and supervisors. These workers will need help with spoken workplace English, with its bewildering number of pronouns and tenses and its use of directions, requests, and assertions that are unaccompanied by polite phrasing, such as “Would you please?” In addition, speakers have expectations for feedback and praise that are specific to their generational cohorts. Another consideration is the cultural baggage that comes with a language in context,
including cultural references, such as idioms, proverbs, and sayings; expectations for certain colors and decorations on holiday occasions; and even varying cultural attitudes as to why families would bring in outsiders to care for their elders or lodge them in residential communities outside the home.

Not all immigrant trainees have been able to enroll in English as a second language courses, often because of the familiar barriers of limited time and money. Generation 1.5 students often do not think that they need additional training because they have attended school in the United States. Training courses can emphasize how to navigate the health care system, how medical directions are given, and how to handle greetings and requests through the use of dialogues and role-play. Instructors can include miniature modules on cultural practices and expectations. To address this need, the authors created a very short caregiver’s phrasebook. Like a traveler’s guide, this online set of links includes phrases that could be used to start and end conversations and to expand conversations by introducing topics associated with holiday customs across the United States.

To assist these students in expanding their command of professional and everyday English and to extend their writing skills, the authors’ curriculum materials, funded originally by the National Alzheimer’s Association (Davis & Smith, 2009), required short online written assignments every day of the course. Instructors respond to each written assignment with a single phrase or sentence, again online. The use of the Internet can be beneficial for second-language and Generation 1.5 learners (Koch et al., 2011) because it allows learners additional time to review prompts. These brief written assignments begin with self-introductions and move through a sequence that is progressively more difficult in the way it asks the students to think about the course components. Early in the course, students respond to case study scenarios that require critical thinking, such as the following example, a version of which is typically included in almost every nursing assistant textbook:

You are employed as a nursing assistant and are assigned to work 7:00 a.m. to 3:00 p.m. on a long-term care unit that has 35 residents. The unit is staffed with two RNs and three nursing assistants. It is now 7:30 a.m., and Helena, a nursing assistant who is assigned to work on the unit, is not there yet. The RN in charge tells you that both of the RNs will be busy with all of the medications that must be given out before breakfast, so the RNs will not be able to help you.

When the nursing assistant is late, what happens? Give three to four examples of what happens to each of the following:

1. Patient care.
2. The rest of the health care team.
3. The nursing assistant who is late.

Be specific. Your answer should show that you understand both the role of the nursing assistant and the use of communication/interpersonal skills.

The authors do not correct the responses for spelling or grammar. In addition to the constraints of the online format and the time constraints for instructors, student writing improves in each course as a result of the act of daily reading and writing, as advocated by Mina Shaughnessy’s (1979) standard work with basic writers. Instead, the authors model the corrected forms in the brief replies, as in the following examples: “Yes, Marta, patient care is damaged . . .” “Max, the CNA [certified nursing assistant] certificate is a good choice to begin with . . . .”

Strategy 2: Training Techniques for Working With Intergenerational Issues

Although no studies have formally united multiple lines of research on intergenerational communication, it is possible to surmise some associations that enhance current training practices, such as those illustrated for generational expectations by Billings and Kowalski (2004). First, training for direct care workers needs to emphasize the need for respectful, low-key communication with older patients, as opposed to loud, patronizing speech. Next, the training needs to be brief, fast paced, and highly interactive. This training can be offered both online and face-to-face, if possible, to involve both Generation X and
Generation Y, and frequent brush-ups are needed. Instead of lectures and conventional tests, it is important to offer immediate and positive reinforcement, both during training and at subsequent regular intervals, particularly for Generation X and Generation Y students. For the Baby Boom Generation, trainers can link communication techniques to the mission of the organization or agency. Asking Generation Y trainees to find slogans or jokes about communication on the Internet can make use of their technology skills. Generation X learners can easily design communication reminders. An example is a cartoon contest, with entries illustrating lines such as “My name’s not Honey.” The cartoons could be posted on staff bulletin boards or in staff bathrooms. In addition, role-plays, scenarios, or vignettes illustrating preferred forms of address and suggestions for offering choices to confused residents or clients (e.g., “Would you like to wear the red or the blue shirt today, Mr./Mrs./Ms. Grant?”) would allow Generation Y learners to practice new language techniques.

Strategy 3: Using a Scale for Working With Attitudes Toward Aging and Dementia

Norberg, Helin, Dahl, Hellzén, and Asplund (2006), as well as other researchers, used semantic differential techniques to identify attitudes toward people with dementia, in the context of attitudes toward aging. For teaching or training purposes, items on the new Dementia Attitudes Scale (O’Connor & McFadden, 2010) can provide useful talking points for short discussions or role-plays with staff (e.g., “I feel confident . . . uncomfortable . . . relaxed . . . frustrated” around persons with dementia). Another item that can promote discussion during training or in-service sessions is the following: Persons with dementia “can enjoy life . . . like having familiar things nearby . . . can feel when others are kind.” Discussing the items allows participants to share opinions and experiences, which leads to greater investment in learning. In addition, it can be helpful to present staff and students with online and PowerPoint vignettes that incorporate cultural aspects of activities of daily living. The Sidebar shows a vignette about dining that includes a question-and-answer format with a set of answers provided and evaluated for potential usefulness.

Both scenarios and vignettes are useful teaching techniques that provide learners with a problem to be solved and allow learners to draw on experience as well as research. Clark, Ahten, and Macy (2012) commented that problem-based learning lets students consider multiple solutions and analyze challenges that they may be experiencing at work. Participants recognize the real-world problems and can watch actors or other students enact the roles of a particular scenario. With a short vignette, such as the dining situation, students can practice the actions presented by the questions before reviewing and evaluating the answers.

CONCLUSION

This discussion has considered three culturally based challenges faced by supervisors and educators of direct care workers: language barriers, intergenerational issues, and culturally based attitudes toward dementia. The educator or supervisor who responds to any of these challenges will need to address the other two as well because they are interconnected. However, to ensure culturally sensitive care for patients with dementia, with direct care workers providing culturally appropriate services, it is necessary to review the literature, consider the evidence, develop new strategies, and join the discussion.

REFERENCES

Billings, D., & Kowalski, K. (2004). Teaching learners from varied generations. The Journal of Continuing Education in Nursing, 35,

key points

Direct Caregivers

1. The care of U.S. patients with dementia requires an increasing number of direct care workers.
2. Training for direct care workers needs to include training in language, print literacy, and health literacy.
3. Retaining direct care workers means understanding cultural attitudes toward dementia and age cohort attitudes toward work.


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