From Ellis Island to Assisted Living: Meeting the Needs of Older Adults From Diverse Cultures

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Among the rapidly increasing population of older adults, the minority elderly have also been increasing in numbers and are projected to grow at a more rapid rate than the white population well into the next century (American Association of Retired Persons, 1989). This factor, together with the existence of substantial ethnic diversity among both white and minority elders, mandates that our profession examine how we address the associated needs of all older adults who receive occupational therapy services in order to promote optimal performance and quality of life. Rationales for providers to increase personal awareness of these factors as basic contextual determinants in providing services are offered. The inclusion of cultural and ethnic considerations in all interventions with older adults as critical components in the provision of quality service is given, together with suggestions for methods of implementation.

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Like other members of mainstream American society, most of these providers have immigrant origins and take pride in their roots. A basic question comes to mind: Has the group of providers actually translated this important aspect of their life-style into their practice in their considerations for each client? Possibly not, since health care providers have often been taught to keep their personal and professional lives separate (Kozier, Erb, & Bufalino, 1989). During the past two centuries, the medical model of service provision has further dissected approaches to direct service by defining disease as an entity apart from the client, thereby giving permission to treat the complex systems and body parts as separate from the whole person (Mattingly, 1990b). This has resulted in fragmented approaches to servicing those aspects of the client that make him or her unique.

Occupational therapy personnel have not escaped this process. As an allied health profession consisting mostly of white providers, we have been an integral part of the progression of medical science in this century. We have been highly dependent on the medical model for many reasons. According to Mattingly (1990b), although occupational therapists often function within the medical model in service provision, we tend to treat “a phenomenological body...what medical anthropologists have come to call the ‘illness experience’” (p. 2). Mattingly contended that this approach expands the image of disability as an organic process and also views disability as a cultural, social, and psychological process. Because of this interrelatedness, we have had a unique, historic opportunity to contribute to the multidisciplinary efforts to provide holistic interventions, because the most basic tenets of our profession emphasize the treatment of the whole person (Mattingly, 1990b).

I believe that most occupational therapy personnel are sincere in their attempts to approach clients in an objective manner, as has been considered appropriate for optimal therapeutic use of self. They are reflecting their educational preparation because occupational therapy programs are governed by educational Essentials (American Medical Association, American Occupational Therapy Association, 1983a, 1983b) maintaining that curricula address the importance of sensitivity to the individual client’s background and values (Reed & Sanderson, 1980; Sayles-Folks, 1990).

**Culture and Ethnicity: Basic Human Performance Components**

Is the expectation that occupational therapy practitioners use an objective approach realistic? Thompson, Ellis, and Wildavsky (1990), who discussed their anthropologically derived theory of sociocultural viability, stated that “human perception is everywhere culturally biased” (p. 3). That is, each of us interacts with others with some form of bias, which is a basic component of the whole person we have become. Thompson et al.’s theory purports that a person is constrained by the social relations that form him or her and that societies are constituted by ways of life. **Culture** is defined as consisting of values, beliefs, norms, rationalizations, symbols, and ideologies (mental products). The authors continued by stating that culture refers to the total way of life of a people, their interpersonal relations as well as their attitudes. Each of us, therefore, can be considered to be the product of the way of life in which we have been reared and that we have chosen to follow as adults. Aiming for objectivity of approaches in the provision of occupational therapy services in the truest sense, then, is not possible.

**Ethnicity** is often confused with **culture** and is defined as the component of identity originating from membership in a racial, religious, national, or linguistic group or subgroup, usually through birth (Hartog & Hartog, 1983). **Culture** is the whole way of life of the person, of which ethnicity is a part. In her discussion of personal awareness of ethnic origins, Waters (1990) indicated that it is primarily through interacting with others that persons better understand their own ethnicity. In describing her ethnographic research with college students, Waters stated, “By contrasting their own approaches to life, values, food, and personality to those of others from different backgrounds, these young people became aware that their ethnic backgrounds had the effect of making them different from others, and sometimes similar to those from the same ethnic group” (pp. 4–5).

Ringer and Lawless (1989) commented on the concepts of “we-ness” and “they-ness” of race and ethnicity. They maintained that what makes an ethnic group a distinctive sociological phenomenon is its “we-they” character. They defined **they-ness** as “the way a given ethnic or racial group is perceived and defined by other ethnic and racial groups in society. The **they-ness** includes the beliefs, stereotypes, and the like held by these others about a given ethnic or racial group and also the actions and policies that may be directed against this group” (p. xi). These researchers stated that, in today’s American culture, there is a renewed emphasis on the we-ness of ethnicity and that various types of ethnic characteristics and solidarity have both hindered and helped groups to overcome past hardships. These experiences may relate directly to our older clients and play an important part in their overall life experiences.

Waters (1990) reviewed comments from several sources that indicated that ethnic identity becomes increasingly important among older people. She stated, “The argument is that ethnicity provides an integrative mechanism to counteract some of the alienation associated with aging” (p. 46). Some of the ethnographic accounts in her research recount older adults’ feelings of the need to relate to a specific identity and to their ethnic roots. She indicated that some older adults gain satisfaction from identifying with an ethnic group in a type of
symbolic ethnicity. Additionally, older adults may associate the close ties that they value with nuclear and extended families, close friends, and neighbors with an overall sense of community.

The Changing Cultural Demographics of Older Adults

Our country was developed and has been influenced largely by immigrants. Although our nation has always comprised diverse groups of people culturally, ethnically, and racially, minority groups will expand to a much greater extent (Diehl, 1988). Regarding minority older adults, the American Association of Retired Persons (AARP), in their publication titled The AARP Minority Affairs Initiative: A Portrait of Older Minorities, stated, “In recent years, the elderly population has been growing faster among minorities than among whites, and we can expect that trend to continue. In 1980, over 2.5 million persons, or 10% of the population 65 and over, were nonwhite. By 2025, 15% of the elderly population are projected to be nonwhite, and by 2050, 20% are likely to be nonwhite” (AARP, 1990, p. 3). Even with these increases in minority older adults, white elders are expected to continue to outnumber minority elders. In addition, an important source of the diversity among older adults is ethnicity (AARP, 1990).

The elderly in this country represent a wide range of differences in income, and the AARP’s Minority Affairs Initiative states that social and economic discrimination experienced earlier in life has affected the status and resources of many minority elderly. In addition, older adults who emigrated to the United States have experienced basic cultural and language differences. As a result, older adults who are members of minority groups have higher risks of encountering malnutrition, substandard housing, poverty, poor education, and overall poor health (AARP, 1990).

Access to health care varies substantially among older adults. Concerning access to providers of health care, several culturally related questions may be raised. First, does the older adult wish to be the recipient of services? Within several ethnic, cultural, and religious groups, highly technological, state-of-the-art medical services are not welcomed. In fact, they may not be valued at all. This is apparent in some of the Appalachian, Asian, and native American cultures in which different belief systems prevail. These values serve to limit or preclude motivation to use traditional medical care (Ellmer & Olson, 1983; Sanchez-Ayendez, 1989; Tien-Hyatt, 1990; Youksetter & Schore, 1989). Second, are the available services geographically and economically feasible? Third, are the services user-friendly, that is, are they located in a receptive environment in which age-related cultural differences are respected (Levine, 1987)? In summarizing some of the basic barriers to accessible health care for older adults, the Minority Affairs Initiative states, “Cultural and language differences, along with physical isolation and lower income, often make using health care services difficult” (AARP, 1990, p. 3).

A number of challenges to accessing health care, therefore, may exist, depending on the individual client’s circumstances. Diehl (1988) recommended that when we consider disease patterns in ethnic minorities, we be “splitters” rather than “lumpers” (p. 90). This concept implies that we cannot treat all persons from the same cultural group alike. To identify specific group characteristics that further highlight this point, AARP’s Minority Affairs Initiative (1990) described the salient features of the primary minority groups, as discussed below.

Black Older Adults

Of the total black population, the elderly black are the fastest growing segment. They are concentrated in the eastern, southern, and midwestern states as well as in California. Primarily educated within the school systems of the United States at a time when educational resources were limited, black older adults differ from many immigrant minorities. They never had the benefits of the affirmative action and minority scholarship programs that have developed within the past two decades. Interestingly, however, only 6% of black older adults have had formal education, compared with 2% of white older adults. Within the elderly black group, 17% completed high school, as compared with 41% of the elderly white group.

Although compared with whites, blacks have lower levels of lifetime labor-force participation and are more likely to have experienced periods of unemployment due to discrimination, approximately 13% of blacks and whites continue to work after the age of 65 years. Black men, however, acquire less work experience and are more likely than white men to leave the work force earlier.

The economic status of the black elderly is generally lower than that of the white elderly and of all other minority groups in the United States. Annual median incomes for all races aged 65 years and older show that white older adults earned almost twice as much ($7,408) as black older adults ($4,113) (AARP, 1990). Approximately 33% of the urban black elderly live in poverty, compared with 11% of the urban white elderly. Almost 50% of rural black elderly live in poverty.

Although a gap of 5 years exists between the life expectancies of blacks (69.6 years) and whites (75.2 years), the survival rate for blacks who reach the age of 70 years is higher than for whites. Regarding health status, black elderly persons are more often ill and disabled and perceive themselves as having poorer health than do white elderly persons. Conditions existing to a higher degree among the black elderly are cancer, especially...
types related to improper diet and lifestyle (e.g., smoking habits); cirrhosis of the liver and secondary mortality (especially among men); hypertension; stroke (twice as many for black men as for white men); coronary disease; diabetes with frequent secondary complications; and obesity, which is seen as a major problem among blacks.

Hispanic Older Adults
The majority of the Hispanic population in this country is concentrated in four states, each of which has a different cultural basis. New York has attracted Puerto Rican and Caribbean Island immigrants; Florida, Cuban immigrants; and California and Texas, Central American and Mexican immigrants. Although these immigrants share a common language, they originate from diverse cultures. Elderly persons from Hispanic cultures are the least educated of all minority groups. “The proportion with no formal schooling is eight times as great as for whites. Of Hispanics 65 years and older, 16% have had no education and only 19% graduated from high school” (AARP, 1990, p. 8).

Similar to elderly white women, widowed Hispanic women who remain single equal nearly half the number of Hispanic married men over the age of 65 living with spouses. However, twice as many older Hispanic men and women are divorced, as compared with elderly white persons. The number of older Hispanic workers in the labor force equals that of older white workers. In addition, rural Hispanic women are the most impoverished group among older adults.

At least one chronic health problem is reported by 85% of Hispanic older adults, a percentage that is the highest among minority groups. The Hispanic elderly report a rate of 45% in limitations in performing daily activities “and have more days per year in bed because of illness” (AARP, 1990, p. 9). Interestingly, they have a relatively low incidence of hip fracture, as compared with other groups. In addition, Mexican Americans, the nation’s largest ethnic minority, demonstrate an incidence of diabetes mellitus triple that of whites (Diehl, 1988).

Asian and Pacific Islander Older Adults
Older adults from Asian and Pacific Islander cultural groups, including Asian Indian, Cambodian, Chinese, Filipino, Guamanian, Hawaiian, Japanese, Korean, Samoan, and Vietnamese, are concentrated in various states. Most of the distribution lies in the northeastern states and in California, Florida, Hawaii, Illinois, Michigan, Oregon, and Texas. Although diverse in origin, Asian/Pacific Islanders share an immigrant history and similar treatment under U.S. law. The Asian/Pacific Islander elderly consist mainly of three groups: migrants who arrived during the turn of the century; children born to these immigrants; and elderly migrants, primarily from Southeast Asia who entered the U.S. in the 1970s with their families” (AARP, 1990, p. 10).

Longevity among elderly Asian and Pacific Islander men is greater than for women, as compared with the white elderly and all other elderly minority groups. A smaller number of Asian and Pacific Islander women are single in their later years than are white elderly women.

As compared with elderly white workers, Asians and Pacific Islanders often continue working after 65 years of age, and up to 16% of all members of this group work beyond the age of 75 years, perhaps due to the number of self-employed persons. As many as 25% of Asians and Pacific Islanders are farmers or own small businesses. Poverty levels compare with those for older white adults.

Major health concerns for the Asian and Pacific Islander elderly include certain types of cancer, hypertension, and tuberculosis. These older adults have been found to use formal health services less often than do other older adult groups, for such reasons as a distrust of Western medicine, cultural and language differences, and a reliance on folk medicine.

Native American Older Adults
Populations included in these groups are of American Indian as well as Eskimo and Aleut origins. The risks of living below the poverty level in substandard housing and experiencing malnutrition and poor health are increased for this group due to the federal government’s role as the final determinant of availability of various resources to native Americans. Because the proportion of native American older adults has increased at a faster rate than that of the white or black elderly, this policy has presented major problems for this cultural group.

Most states have some native American older adults, with more than half of this population concentrated in Arizona, California, New Mexico, Oklahoma, and Texas. Approximately 25% of these persons are living on reservations in the continental United States or in Alaskan native villages; the rest live in northern border states. The number of elderly in this group is proportionately greater than for any other minority group. Additionally, more than half of the native American elderly live in rural areas, more than in any other group of minority elderly. Marital status of older native Americans is comparable to that of the white population, except native Americans share with Asian and Pacific Islander women the greater likelihood of being married in later years. Like other minority groups, the proportion of native American elderly in nursing homes is low. “This trend is most apparent among the oldest-old (85+), with 13% of Native Americans compared to 23% of whites living in nursing homes” (AARP, 1990, p. 14).

Like the minority Black elderly, the native American elderly were educated almost solely in the substandard conditions that existed in their segregated U.S. school
systems. Almost 12% of this group have no formal education; nearly 22% are high school graduates.

Although older native Americans mirror the rate of employment of older white persons, nearly twice as many are seeking work and are unemployed. The income of native American men is little more than half of that of older white men. The range of persons in this group living below the official poverty level is 25% in urban areas and 39% in rural areas, with an overall percentage of 32%, as compared with 13% for elderly white persons.

Factors often neglected by health care providers seeking to treat this minority group are their different understandings of disease and their historic reliance on ritual folk healing. Lack of transportation is an additional barrier, especially for persons living in isolated areas.

Summary Projection

Education, living conditions, nutrition, employment, and income have affected the health status and overall quality of life of the current members of these minority groups and have contributed to their status. It is thus unlikely that the overall status of these groups will change dramatically for those persons already nearing retirement (AARP, 1990). It is hoped that, as conditions change for succeeding generations, members of these groups will be able to achieve a higher quality of life than the preceding generations.

Addressing the Cultural Needs of Older Adult Clients

As providers of occupational therapy services, we must constantly evaluate our individual interactions and interventions with older adult clients, especially those from different ethnic groups. Because of our backgrounds and current life-style, we may be partially or totally unaware of our own cultural biases.

Krefting and Krefting (1991) described what they called a cultural filter, that is, the cultural bias that all of us bring to client interactions, as that “veil through which people perceive life’s experiences” (p. 108). They further stated that because each of us experiences life differently, “each person has a unique filter” (p. 108). To provide meaningful treatment, we must understand that no one’s experience is shared by anyone else, that we meet each person as one who has seen even the same event differently because of his or her own cultural filter, and that those for whom we provide services also enter the therapeutic relationship with their own cultural filters.

This critical understanding can make the difference between success or failure with our clients, whether they are young or old. We especially need to be sensitized to this interpersonal issue when treating older adults, because the differences in ages between the practitioner and the client can be substantial and, thus, may provide an additional barrier.

Because of our own cultural biases, we may be ignorant of the customs, language, social relationship patterns, religion, and other practices of various ethnic and minority groups. In other words, we often do not know what we do not know. We may not realize that our backgrounds, personal values, and education have not prepared us to meet this need in our older clients. We may not believe that we could be incapable of meeting the needs of our clients simply because we do not understand their life-styles. We may assume that our sincerity in wanting to provide quality service and our attempts at being objective will carry us through any and all situations. But this is not enough. Along with our ignorance about different life-styles, we may make assumptions based on our cultural biases. One such assumption may relate to the perception that what is different must be inferior. Knowingly or unknowingly, we may therefore devalue various aspects of a client’s culture. Another assumption refers to our belief that our own life experience is generalizable. We may thus expect that the same conditions do or do not exist for our client. An additional potential barrier to meeting the individual needs of older minority or ethnic group clients lies in inferring similarities of persons from that group. Because of our experience with one or a few members of a cultural group prior to meeting a particular client, we may assume that similar circumstances exist for him or her. For example, we may assume that because we know some persons of the Jewish faith, all persons of that faith practice their faith alike, from one generation to another. This is not necessarily so (Neustadt, 1982).

Last, although few if any of us readily admit to racism or bigotry, many of our cultural life experiences may be so colored by elements of these kinds of attitudes that the lens through which we view persons from different cultural groups is shaded so as to distort the reality of the client’s unique personage. This applies to members of all cultural and ethnic groups, whether they function as providers or as recipients of services. Thus, health care practitioners who represent cultural groups different from that of the older client may be viewed by that client through shaded lenses.

If our client’s language or dialect is different from ours, this may also become a barrier, thereby compounding the challenge to provide effective care. If we as the practitioner show even the slightest rejection, we may serve to totally discourage the older patient from interacting with us or participating in treatment. Whether English is the client’s second language or the client is from a different way of life, his or her use of the wrong words may preclude our accurate understanding of the client’s condition and needs. In addition, the older client’s misunderstanding of occupational therapy personnel’s directions may result in a lower level of motivation. That is, the client may be reluctant to make mistakes that can result
from such misunderstandings when attempting to comply. Some older adults have not learned English since their immigration to the United States. This group is not limited to recent immigrants, but also includes persons who have been living in a community in which the inhabitants use their native language.

Persons who have been assimilated into certain aspects of the mainstream culture, such as the work force or religious community, but who continue to practice customs relative to their original culture, are said to be bicultural (Krefting & Krefting, 1991). Krefting and Krefting indicated that the young in such immigration groups may acquire knowledge that assists them in adapting to the new culture and may pass this information to other generations in multigenerational familial living situations. This factor, then, assists older generations in adapting to the new culture. This support by younger generations within the family can make a major difference in our considerations for discharge planning as in many other aspects of service provision.

Many kinds of cultural conditions and gaps exist between health care providers and clients, some of which are cited above. These can be costly in terms of the client’s possible refusal of care or minimal compliance with the treatment program. We as a profession must therefore recognize that deficiencies in our individual understanding of other cultures exist, and we must approach every client ready to observe and listen in order to learn about his or her cultural experience as it relates to our intervention plans.

Krefting and Krefting (1991) discussed the importance of occupational therapy personnel trying to understand the client’s own life experience and how that may affect assessment and intervention. In addition to attempting to understand the client’s life-style frame of reference, the occupational therapy provider needs to be aware of the similarities and differences between her or his own way of life and that of the client, without imposing unwanted cultural expectations on that client.

Culturally Relevant Interventions

As indicated earlier, we can promote optimal performance and cooperation by addressing the preferences of the older adult with particular cultural needs. Levine (1987) stated that cultural considerations in planning treatment can influence outcome as therapy becomes more meaningful to the client. Blakeney (1989) indicated that for the Appalachian elderly, who are accustomed to discrimination, bigotry, or second-class citizenship.

Although these factors may affect related treatment outcomes in physical disabilities, they may be fundamental to any degree of successful intervention with older adults with psychiatric disorders or dementia (Anderson, 1990). In looking toward managing our programs to promote culturally sensitive interventions with all older adults, we may undertake a number of activities, including the following:

1. Provide for departmental in-service training or other learning experiences that will sensitize all occupational therapy service providers to the need for culturally sensitive approaches to their older adult clients.
2. Examine admission and referral protocols (i.e., are there ways that new clients may be managed which will immediately assess their lifestyle needs?). According to Krefting and Krefting (1991), it may be critical to determine who in the family or support system makes the health care decisions and how these decisions are made. This information should be included in all initial assessments.
3. Identify methods that will ensure continued awareness of and response to any individual cultural needs that can be employed throughout the treatment program or provision of services. Ensurance of these measures may directly affect the client’s functional performance (Becker, 1980; Brockett, 1987; Lewis, 1990). Are there built-in mechanisms that address whether our service expectations are congruent with the client’s life-style frame of reference? Has the family or other
support system been considered and included, where appropriate, in each phase of the program to promote optimal support of functional outcomes?

4. Whenever feasible, identify specific groups (e.g., ethnic, racial, religious) of the older adults for which interventions are customarily provided. Encourage and support staff members’ interest and efforts in learning activities that will enhance their ability to address their clients’ cultural needs. These activities may be broadly defined, from reading publications targeted for these groups and historic accounts of these groups, to attending special events targeted for these groups, such as fashion shows, performances, and meetings. One should also consider visiting the places of worship, shopping areas, and even other health care institutions that primarily address the needs of members of these groups. Additionally, staff who are interested in becoming more involved may volunteer in community agencies or serve on the boards of those institutions that provide services to special minority or ethnic groups.

If departments or individuals wish to become additionally informed, a multitude of educational offerings exist, including formal education courses as part of a degree program that emphasizes studies of various groups as well as a multitude of continuing education classes, institutes, seminars, workshops, and teleconference opportunities.

Occupational Therapy as a Culturally Holistic Discipline

Occupational therapy as a profession is extremely well suited to a culturally holistic approach. We are accustomed to thinking about our clients in terms of the whole person. Because one’s way of life is an integral part of each of us, to provide holistic services we must address our clients’ cultural nature and attributes. Most of us are sensitive to our friends’ and family members’ specific cultural preferences, so why not treat the consumers of our services with the same sensitivity?

Mattingly (1990a), in her discussion of occupational therapy as a collaborative practice, commented, “One of the unique aspects of occupational therapy practice is that therapists ask patients to do things for themselves. Most other health professionals in the hospital setting ‘do for’ or ‘do to’ a patient” (p. 1). In explaining these remarks, Mattingly indicated that engaging patients in activities in which they do for themselves is a primary therapeutic approach.

If this is so, it follows that in our development of realistic goals for these clients, we must make every effort to interest them in treatment and intervention. The occupational therapy provider has an opportunity to maximize his or her skills by considering the client’s unique cultural life-style. The inclusion of culturally sensitive approaches and activities will promote optimal motivational environments in which we can serve these older adults.

If DEMOCRACY in a pluralistic nation is to SURVIVE & FLOURISH, citizens of different and sometimes DIVERGENT religious, racial, and ethnic backgrounds must learn to live TOGETHER without bigotry or discrimination and without compromising their distinctive GROUP IDENTITIES. (Jacqueline G. Weiler, President, National Conference of Christians and Jews)

References


