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## Dementia, Communication and Culture: Implications of linguistic and cultural diversity in intercultural dementia care

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# Dementia, Communication and Culture

## Implications of linguistic and cultural diversity in intercultural dementia care

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### Abstract

Several dementia subtypes affect either some aspect of speech fluency and/or comprehension. Linguistic diversity affects healthcare delivery, not the least in the field of dementia care. In-depth interviewing were conducted with a total of 26 family members of patients with dementia and 35 nurses experienced in dementia care in six geriatric facilities (one in Oslo, Norway, one in a Sami town in northern Norway, and four in Tshwane, South Africa). In all these facilities many nurses had different cultural and linguistic backgrounds than their patients. Language difficulties constituted a central communicative challenge in intercultural dementia care as patients often lose their knowledge of the majority language and the nurses' knowledge of the patient's language and culture may be limited or non-existent.

**Keywords:** *culture, dementia, intercultural communication, patient-nurse relationship*

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### Introduction

Difficulties with speech are often the first noticeable symptoms in people with dementia. Language impairment is studied and described clinically (e.g. Cosentino, Brickman & Manly, 2011; Albert, DeKosky, Dickson *et al.*, 2011; Blair, Marczyński, Davis-Faroque *et al.*, 2007) as well as regarding its impact on the patient-nurse/healthcare professional relationship (e.g. Ekman, 2007; Jones & Watson, 2012; Taylor, Lindeman, Stothers *et al.*, 2012). Within intercultural communication one finds that words and their usage are culturally defined (Mesulam, 2003) and that cultural and linguistic acumen becomes increasingly important as the patients' language skills and understanding deteriorate (Rao, Warburton, Barlett (2006). According to Jones & Watson (2012), "language barriers, differing cultural codes for communicating, stereotyping, ... and the lack of cultural awareness of health professionals" are all factors that "are implicated in poorer health service delivery and poorer outcomes" (p. 7).

This paper is based on three sub-studies within a larger international study on good dementia care in intercultural settings. The focus is on factors that may make communication and reciprocal understanding particularly difficult when health personnel and patient with dementia hail from different cultural and linguistic backgrounds, and the consequences this may have on the quality of patient care.

### Background

Linguistic diversity affects healthcare delivery, not the least in the field of dementia care as "several of the dementia subtypes affect either some aspects of expressive (e.g. fluency) or receptive (e.g. comprehension) language abilities" (Cosentino *et al.*, 2011, p. 343). According to Blair *et al.* (2007, p. 238) language decline is common in both "Alzheimer's disease (AD) and fronto-temporal dementia (FTD) regardless of the stage examined". It is impossible to specify the rate of language deterioration in persons with dementia as it depends on type of dementia, what part of the brain is affected and/or the severity of the illness (Cosentino *et al.*, 2011; Blair *et al.*, 2007). The language impairment "includes word-finding problems, syntactic problems, and finally also a disturbance of pragmatic functions. The linguistic problems are related to cognitive impairments in

especially the episodic and semantic memory systems together with declining executive functions” (Samuelsson & Hydén, 2011, p. 563).

This language impairment process makes it increasingly difficult for persons with dementia to understand what others are saying. Additionally, face and gestures of the person with dementia become less expressive and they have problems reading other people’s facial expressions (Ekman, 1993).

In **later stages** of dementia the patient may only have a small set of repetitive words that gradually turn into nonverbal vocalizations (Samuelsson & Hydén, 2011). Many bi- or multilingual persons may revert to their mother tongue as the first language learned in most cases is the longest remembered. This may be because the more frequently used language requires a lower level of mental activation, or because “a language learnt after the first was acquired may never be fully automatized” (de Picciotto & Friedland, 2001, p. 151).

Comprehension of speech with non literal meaning is often needed to understand a speaker’s intended meaning. This requires an understanding of both the words uttered and the implicit meaning behind the words, which is often alluded to in a culture specific manner. Each culture has its own way of using language, with differences in how metaphors, sarcasm, humour etc. are expressed.

There may also be specific cultural norms for how to communicate and collaborate with people (Maki, Yamaguchi, Koeda *et al.*, 2012). Kim, Woods, Phillips *et al.* (2015) hold that for instance older Korean immigrants with dementia who are not met with what to them is cultural appropriate verbal and non-verbal communication may “experience high levels of the environmental stress believed to elicit and escalate behavioural symptoms of dementia (BSDs)” (p. 187). Citing various authors they describe BSDs as activities that are seen as disruptive, challenging, dysfunctional and/or disturbing, “such as agitation, aggression, screaming, pacing, wandering, and resisting care” (p. 187). This because the patients’ cognitive impairments make them less able to tolerate environmental stressors (lower stress threshold) compared to those without dementia (*ibid.*).

The issue of communication came to the fore during interviews with non-Scandinavian nurses caring for ethnic Norwegian patients with dementia in Oslo, Norway. Some of the nurses spoke excellent or good Norwegian, while in others language rhythm, pronunciation, limited vocabulary and/or grammar made understanding difficult. Literature concerning this problem from many parts of the world (e.g., Heikkilä & Ekman 2000, de Picciotto & Friedland 2001, Maki *et al.* 2012, Kim *et al.* 2015), indicate the universality of communication problems when a patient with severe dementia and his or her nurse hail from dissimilar linguistic and cultural backgrounds. Both these empirical and literature findings made me want to study the issue of communication within the context of dementia, language and culture further.

My research questions were: What factors may cause added communication problems when a patient with severe dementia and his or her nurse hail from dissimilar linguistic and cultural backgrounds? Are nurses and patients’ family members aware of these problems?

After having discussed these issues with some Sami nurses I was invited to interview family members of persons with dementia belonging to this indigenous people of northern Norway and these patients’ nurses. When asked “what constitutes good dementia care?” the majority of the Sami interviewees, family members as well as nurses, pointed to a common language as pivotal and that communication problems are based on culture as well as language.

A chance to further the international research project “*Good dementia care in a multicultural society*” [1] and thusly continue the investigation of intercultural communication in dementia care came through a chance to also conduct the study in South Africa, a truly multicultural and multilingual society.

## Method

A qualitative design with an in-depth interview approach was chosen. Because persons with grave dementia are vulnerable and unable to answer interview questions we interviewed close family members and nurses – both

registered nurses (RNs) and nurse assistants (NAs) – experienced in dementia care (Table 1). The main question was: “According to your experience as a nurse/son/daughter of a patient with dementia in this institution, what constitutes good dementia care?” The interviews took form of an electronically recorded talk where the respondents were encouraged to share their thoughts and recount their experiences. Follow-up questions and the “mirroring” of statements were used to develop, clarify and verify statements.

**Table 1:** The interviews[2]

Interviews conducted in	No. of geriatric facilities	No. of nurse interviewees		No. of family interviewees		Interview languages			
		women	men	women	men	Norwegian	English	Afrikaans	Setswana
Sami town, Norway	1	8	1	6	2	15			
Oslo, Norway	1	6	1	0	0	7			
Tshwane, South Africa	4	18	1	16	2		31	5	1
<b>Total</b>	<b>6</b>	<b>32</b>	<b>3</b>	<b>22</b>	<b>4</b>	<b>22</b>	<b>31</b>	<b>5</b>	<b>1</b>

The interviews with nurses were conducted in the respective institutions. The family interviews were either done in the interviewees’ homes or in the institution where their family member was a resident (Tshwane), or their places of work or in the author’s hotel (Sami town). A team of five interviewers[3] conducted the Tshwane interviews. The Afrikaans and Setswana interviews and translations into English were done by two of these co-researchers[4].

### **Sami town setting**

The Sami are the indigenous people of northern Scandinavia and North-Western Russia. The majority live in Norway where nearly 56 000 have registered themselves as being Sami (Slaastad, 2014). Only about one third of the Sami population speak a Sami language, but in “our” town Sami is the primary language of about 80 % of the townspeople.

In the geriatric facility nearly all patients’ primary language was Sami. Most spoke, or used to be able to speak, Norwegian and some also Finnish and/or Russian. Besides Sami nurses there were ethnic Norwegian nurses and nurses from various foreign, also non-European, countries. The non-Sami nurses tended to speak limited Sami or did not speak the language at all. All but two of the interviewed Sami town nursing staff were Sami.

### **Oslo setting**

Oslo is Norway’s capital city with 31 % “immigrant” inhabitants (born in a foreign country or of two foreign born parents) (Statistics Norway, 2014). Many first generation immigrant non-Scandinavian nurses work in Oslo, particularly in geriatric facilities, as in the facility where the interviews were conducted. All the interviewees happened to be from Asia.

### **Tshwane setting**

The city of Tshwane, of which Pretoria, South Africa’s national capital constitutes a part, is situated in the Gauteng province. Of the country’s 11 official languages, the main languages spoken among the Gauteng residents are: isiZulu (19.8 %), English (13.3 %), Afrikaans (12.4 %), Sesotho (11.6 %) (SouthAfrica.info,

2014).

In the four geriatric facilities studied the vast majority of patients were of European descent with Afrikaans[5] as first language. Some had English as second language, a few as primary language. The very few Black African patients spoke various African languages. Some knew English. All the white nurses were Afrikaaners and “Sisters” (in senior positions) who spoke good or excellent English. The Black African nurses were in majority, had an African language as primary language, and covered all levels from “Sisters” to auxiliary nurses. All spoke English, but some did not understand Afrikaans.

These very different settings are all multicultural and multilingual and ideal for studying the consequences of disparate cultural and linguistic backgrounds between patients with dementia and nurses.

Literature searches were conducted through the electronic search engines Cinahl, Medline, PubMed, and Google Scholar using the terms dementia, Alzheimer’s disease, inter-/multi-/cross-cultural care, language/linguistic development/impairment, intercultural communication, and culture in various combinations.

### **Data analysis**

All the Norwegian, English and translated interviews were transcribed verbatim by the author as first step of the analytic process. A content-focused approach was chosen to formulate themes that touched the core of the situations or meanings found in the texts (van Manen, 2001). The analysis was hermeneutic in character to enable the exploration of the thoughts, feelings, and cultural meaning described. Gadamer (1989) points to interpretive analysis as a creative activity, striving for depth of understanding through a circular investigation of texts. Through reading and re-reading the interview texts I tried to “remain open to the meaning of the other person or the text” (ibid, p. 268). Both sets of texts – the transcribed interviews and the research articles – were read and re-read all the while re-evaluating conceptions and deepening understanding. Gadamer teaches us to be open, curious, and realise that the fusion of horizons through the reading of texts leads to the creation of something new.

The various contexts and local cultures were prominent analytic issues. This text has been discussed with a Sami nurse steeped in her people’s traditional culture and with the South-African co-researchers to validate the Sami and South African results and the ensuing discussion.

### **Ethical aspects**

All interviewees were informed in writing and orally about the project and about being free to withdraw from the project at any time before signing an informed consent form. The recorded interviews were deleted after transcription. Participating institutions and interviewees were made anonymous during transcription. Transcriptions are stored according to ethical research guidelines (Helsedirektoratet, 2011).

The entire project is approved by the Regional Committee for Research, South-Eastern Norway and The Norwegian Social Science Data Services. The Tshwane sub-project is also approved by the Ethics Committee of the University of Limpopo, South Africa. The local heads of the respective nursing homes all approved the sub-study that was conducted in their facility.

### **Critical remarks**

None of the Tshwane or Oslo interviewees and only two of the Sami town interviewees were native English or Norwegian speakers. Some interviews would have been richer and more detailed if conducted in the interviewees’ primary language. The offer to be interviewed in their first language, which was possible, should have been communicated clearer and in a way that choice of language could not be perceived as a question of pride.

As no observations of communication between nurses and patients with dementia were conducted, no data on non-verbal communication is forthcoming from this study.

## Results

The patients described in the interviews had from mild language deterioration to total aphasia and muteness. Most Sami family members of previously bi- or multilingual patients found that patients lost the most recently learned language first while the primary language deteriorated more slowly. One said about her mother: “Norwegian disappeared first, then Finnish, and then she kind of grew quiet. But we could see that she understood when we talked to her in Sami.” However, two Sami and one Tshwane family member found that in their parents both or all languages were deteriorating at the same rate. Only one family member of the entire sample found a progressive change in her mother’s linguistic ability while her memory loss still seemed to be moderate. These differences indicate that other forms of dementia besides Alzheimer’s disease are represented among the facilities’ patients.

The interviewees may roughly be divided into three categories: Those who

- held a common language as essential in dementia care.
- perceived their interaction with patients with dementia as adequate in spite of wanting language skills.
- seemed unaware of language problems being caused by the patients’ dementia.

### **Interviewees seeing a common language as essential in dementia care**

The majority of the Sami interviewees – both nurses and family members – held language as primary in dementia care: “If you don’t speak the patient’s language, the patient becomes restless and worried when you are to nurse him or her. You need to be able to explain what you do, and you cannot do that unless you speak the language well.” Lack of a common language tends according to these interviewees to make patients fret and be less cooperative, which may cause procedures to become more of a ‘fight’ and thusly be more stressful and sometimes also more painful for patients. The Sami nurses held that to be spoken to in a familiar language created a feeling of security in the patients. When not recognising the language “they become ... oh, they pinch and grab on to the shirt and ... because when you cannot explain to patients what you do, they become anxious when you enter the room.”

Lack of linguistic skill in healthcare personnel was a problem. As a Sami family member put it: “Many of [the non-Sami nurses] are capable, competent people and give very good care and help and that kind of thing, but even so they fall short when it comes to the language.” The “language barrier becomes very evident” when for instance patients “ask for more bread, and the nurse believes the old person is satisfied and leads them away from table”.

As opposed to the Sami interviewees’ preoccupation with language, none of the Oslo and only two of the Tshwane interviewees explicitly talked about the relationship between dementia and language deterioration, and the resulting communication problems: “They will often lose the languages that they previously was able to speak” and the nurses “don’t always understand as well what the patients are trying to tell, seeing that the language has been going down and the way of speech is going down” (Tshwane nurse).

Besides language skill, one of the Sami nurses underlined the importance of the staff understanding the various cultural codes used by patients: “When one becomes demented and does not remember everything with words, there are various codes that one has to understand to be able to interpret what the patient wants” and why persons with dementia behave the way they do. While this was a theme emphasised by several of the Sami nurses and family member, it was not mentioned by any of the Oslo and Tshwane interviewees.

### **Interviewees perceiving their interaction with patients with dementia as adequate in spite of wanting language skills**

Among the nurses with a different first language than their patients, some had an excellent command of the language(s) used in their place of work, while others had limited language skills. Of the latter group some spoke with good grammar and vocabulary, but poor intonation and pronunciation. Others had good pronunciation and intonation, but incorrect grammar and limited vocabulary. An example of both is this Tshwane interview excerpt: “These people ... the others they can do, but when you don’t tell them, they just their mind that just go

down. Then they don't more [a few words impossible to catch] and they begin to talk things they can understand and work." As to this, a Tshwane nurse said that "I try, but sometimes I can't pronounce it" which makes patients "look like a question and I have to find somebody, the Sister, [...], then they explain". A few of the Black African Tshwane nurses did not speak Afrikaans, the home language of most of their patients, at all.

Several of the Asian nurse interviewees in Oslo had communication problems and a Norwegian nurse in the Sami town admitted that "for me who cannot speak Sami it is difficult. One understands a little, but not everything? I think that many understand what I say, but they answer in Sami. But there are those who do not know Norwegian at all." She and other nurses in her position in all three settings tried to make up for the language problem through sign language and patience. One explained: "One must not give up in spite of lack of words. And we show them that we have patience, so that they feel safe." This latter view was supported by several of the South African nurses and Asian nurses in Oslo. One of the latter nurses emphasised that "the voice is important. [...] I think all the helpers here understand that and use a good voice."

Although most of the South African and the Asian nurses in Oslo held that communication with their patients with dementia was fairly unproblematic, some Tshwane nurses found the language situation difficult as the patients "can't tell you where [the problem] is, you have to find other ways to find it out. So you start with the feet and go upwards to see where their pain is or what is wrong with the patient." In spite of language difficulties the general opinion was that it was possible to communicate fairly well with the patients: "Maybe you want to tell her to eat, you take her hand, you don't just stand there and say 'eat!'. You are showing it to her." And: "I just try to ask, ask [...] 'this one?', 'this one?' 'is it this?', 'are you saying this?' till they say 'yes'. [...] maybe she's talking, you can't understand but you just say 'yes'. [...] You just agree everything. [...] I can see she is happy about the story, that I am listening" (Tshwane nurse).

The importance of knowing the patient's cultural background was much less focused in the Tshwane and Oslo interviews than in the Sami town interviews. A Tshwane nurse, for instance, held that they were informed about what they needed to know about their patients through the "Sisters" and others. Whether this information included cultural issues, was not mentioned. The level of knowledge about Norwegian culture among the Asian interviewees in Oslo varied from hardly any at all to being totally bicultural.

### **Interviewees who seemed unaware of language problems being caused by the patients' dementia**

That patients "do not want to speak English, only Afrikaans" was by some Tshwane nurses perceived as patients being difficult. The only language problem recognised tended to be that "a lot of the Blacks talk English because their Afrikaans may not be fluent". This, however, "is no problem with the permanent people who work here". Black African student nurses could have communication problems, though, "because they can't Afrikaans and the other people can't really talk English," a family member explained. When asked if it was difficult for patients to understand accented Afrikaans spoken with limited skill, the nurses' answers were generally in the negative: "No, not really. You must explain and you must talk again and must say again."

Also the Tshwane family members tended to deny there being any communicative problems: "I don't think it is a problem because in our country you get used to black people speaking Afrikaans, and they usually speak with a slight accent. [...] That, I think, it is inborn with [mother] now". "No, not really. [...] Even if it is a broken Afrikaans, they can help her. [...] If they don't understand, they will call somebody that will help ... that can assist her."

Regarding the fact that some patients were not able to respond the way they used to, a Tshwane nurse said: "I'm asking myself what is wrong? Maybe she or he forgot something or remember something. That's why, maybe, they doesn't talk to me. Or maybe they're acting he can hear or not hear you. [...]. Maybe some other day he or she will answer me."

That language problems did exist is illustrated in the following quotation from a Tshwane nurse:

*"When you say maybe 'come, let us go for the bath', then ... she is not taking any action. She is sitting and looking at you, so you have to go to her or to him and take him with your hand and go with her in the bathroom. [...] You have to do it yourself: take your hands out and do it with your*

*own action, then she communicate. But when you talk to her, when you don't take action, then she is also doing nothing. You'll talk, but no action."*

## Discussion

Communication constitutes a central challenge in intercultural healthcare, particularly in relation to patients with dementia, either when minority elders lose whatever of the majority language they once knew (e.g., MacCaffrey, 2008; Jacques & Jackson, 2000), or when the healthcare workers' knowledge of the patient's language and culture is limited or non-existent (e.g., Goudsmit Nielsen, Parlevliet *et al.* 2013; Ekman, 1998).

### The need of linguistic and cultural understanding

One of the Asian nurses in Oslo pointed out that to "use a good voice" is important. This is supported by Dementia Care Central (2013): "[A] caregiver's physical presence may be appreciated long after words no longer make sense or even after the person with dementia no longer recognizes people around him. The person may still understand tone of voice at this point; touch is also another important means of communication." A good voice is, however, not enough. Kim *et al.* (2015) point to the importance of dementia-appropriate communication, which includes announcing a task before providing care, giving instructions step-by-step, and using simple and familiar words. Furthermore, "appropriate communication includes both knowing and practicing the care recipients' familiar language, communication rules and symbols, and manners of interaction" (*ibid.* p. 187).

The Sami nurses' experiences told them that when "a person who do not know the language comes to do the nursing care, the patients become uneasy". This is supported by Kiata & Kerse (2004), Taylor *et al.* (2012), and Kim *et al.* (2015). To be surrounded by healthcare personnel speaking languages the patients do not understand, may exceed the stress threshold of patients with dementia and cause them to be frustrated, frightened, insecure and alienated, feelings that may be expressed as BSDs. This seems to be a universal trait.

In persons with dementia the ability to speak languages learned in later life may be lost. An example of this is a relative of a Sami interviewee. He had moved south, married an ethnic Norwegian and had lived a totally "Norwegian" life. As an old man he developed dementia and gradually lost his ability to speak Norwegian and only spoke his childhood Sami, a language neither his Norwegian family nor the healthcare personnel understood. He lived as if in a "foreign country", unable to make himself understood and unable to understand those around him. In his helplessness and social isolation he became aggressive and tended to shout a lot.

Literal lexical-semantic comprehension of a language is not always sufficient (table 2). Also comprehension of non literal implications is often required to infer the speaker's intended meaning (Maki *et al.* 2012). Every culture has its own way of using language, with different connotations given to words, differences in how metaphors, sarcasm, humour etc. are expressed, and specific cultural norms for how to communicate and interact with people may be different from the norms one oneself has internalised from childhood. Additionally the language impairment makes it more difficult for the person with dementia to understand "certain words, rapid speech, high pitched speech, and complex speech" (Dementia Care Central, 2013). It becomes progressively more difficult for patients to understand and be understood in general, but even more so when communicating with healthcare personnel who do not have the necessary intrinsic knowledge of the patient's cultural background, verbal symbolism and non-verbal communication.

*Without knowing* the patient' language really well, one is probably also ignorant of his or her cultural background and upbringing and will have problems understanding patients who's language is deteriorating because of dementia. Research supports this. Heikkilä & Ekman (2000) found that cultural background influences the experiences of care and how people with dementia react. Culture specific issues are furthermore significant for creating trust in care, according to these authors.

**Table 2:** *Intercultural communication between patient with dementia and healthcare workers.*

<b>Communication between healthcare personnel and patients with dementia may among other factors</b>
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<b>be affected by:</b>	
<b>The patient with dementia's</b>	<b>The healthcare worker's</b>
progression of language deterioration both re speaking and understanding	skill communicating in the patient's primary language and ability to understand what the patient tries to express verbally and non-verbally
loss of ability to understand his/her primary language spoken brokenly or with different intonation, grammar and/or pronunciation	ability to speak the patient's primary language/dialect in a way the patient still is able to understand
loss of second/third language	
degree of loss of memory and being affected by dementia intellectually, emotionally and behaviourally, and influence on activities of daily living	the patient's mental and linguistic deterioration increases the danger of the patient's behaviour not being understood/misunderstood if patient and healthcare worker have different cultural backgrounds

Some of the African Tshwane nurses used to believe dementia was a white people's disease, none-existent within the black population, a notion supported by de Beer (2009). Furthermore, dementia is an unknown term in the Black African communities (Steyn 2010). Correspondingly, dementia is an unknown term also in many Aboriginal Australian communities. Taylor *et al.* (2012) claim this is not uncommon in what they with reference to Cornell (2007) call "Southern theory" of illness and behavioural and attitudinal change. Many South African healthcare practitioners lack the education needed to recognize symptoms caused by dementia (Steyn 2010). The nurses' lack of understanding of the relationship between patients' dementia and inability to understand what is being said to them, is therefore not surprising. Educating healthcare personnel who understand the local culture, speak the local language, and who may be accepted in the various communities need to be a priority in the future (Taylor *et al.*, 2012, Lindeman *et al.* 2012). In Norway gerontology and geriatric care is part of bachelor level nursing education and many nurses take specialty courses or Master degrees within this field. The Sami town nurses are offered an internet course on gerontology, dementia, and geriatric care, and many have taken this course and found it very useful in their day-to-day work.

However, also in Norway the difference in culture tends not to be recognised (Stortingsmelding, 2007). If the nurses are neither able to understand how the patient thinks nor have knowledge about his or her cultural background and upbringing, this make it impossible for them to follow the patient's conversation. A Sami family member exemplified this point thusly: Her father tended to talk about reindeer husbandry, her mother about the sewing of traditional winter shoes, activities important to them throughout their lives. Nurses who did not know anything about these activities were not able to respond in a meaningful way. A further example is Shanley, Leone, Santalucia *et al.*, (2013) who found through focus group interviews with Italians living in Australia that "there were references to the nature of Italian families and belief systems. [...] These references and cultural nuances would have been missed if the group was facilitated by someone who did not understand the culture" (p. 281).

### **Unawareness of language problems being caused by the patients' dementia**

The impression is that many of the Tshwane nurses realised that linguistic understanding was a problem, but that they were not aware that this was a result of the patients' dementia. Even when specifically asked about it, language deterioration due to dementia was only touched upon by a few of the Tshwane interviewees, irrespective of them being nurses or family members. Patients who did not understand what was being said to them tended to be described as unwilling to respond: "If the patient is an Afrikaans one, they like that language Afrikaans. When you talk with them English [...] they make as they don't hear you. They just look at you: 'Na, na!' They just like their language Afrikaans", or it was shrugged off as a difficulty solved by turning to a 'Sister' – most of whom were Afrikaaners – for help. Even so, many interviewees thought that the patients

“can’t understand always. I think it is a problem. You must have patience. You must have very much patience.”

Some wondered about the reason behind the language problem: “I am asking myself what’s going wrong, what went wrong to this patient to be like this?” Not only did this nurse not seem to be aware that patients’ inability to communicate was caused by dementia, she and others also seemed not to recognise that the communication problem may be reciprocal: that it was caused by language deterioration in the patients which made them less able to understand language spoken in a different way than they were used to and that some patients might have responded if spoken to in a language and with a pronunciation, intonation, and grammar they were able to recognise.

## Conclusion

Impaired communicative ability has been identified as a primary predictor of resistiveness to care (Williams & Herman 2011). Interaction with patients with dementia is thusly more demanding than with healthy elderly persons, and more so when the patient and the healthcare personnel have different cultural and/or linguistic backgrounds. As the proportion of older adults and hence the incidence and prevalence of age-related conditions such as dementia increase, so does “the need for cultural and linguistic knowledge and awareness among professionals serving these populations” (Müller & Guendouzi, 2009, p. 199). Heikkilä & Ekman (2000) and Ekman (2007) found that patients who do not speak the majority language are much less involved in conversation and much more left to their own devices than are majority ethnic patients. It is most likely also true that nurses who do not speak the (local) majority language are much less involved in conversation and are more likely to leave patients to their own devices than are nurses with the same ethnic and linguistic background as their patients. In long-term geriatric care, this constitutes a great problem as communication is important for the maintenance of mental functioning and the support of ‘personhood’ and quality of life (Young, Manthorp, Howells *et al.* 2011).

In all the facilities I visited I found highly dedicated nurses focused on their patients’ subjective wellbeing. It is therefore important here to state that this study was not intended to pass judgement on the care offered the patients in the various institutions visited. Rather, the purpose was to point to cultural factors that may influence the care offered. Among these communication is pivotal (Taylor *et al.* 2012, Lindeman *et al.* 2012). In many countries there is also an increase in immigrant healthcare personnel who’s knowledge of the majority language and culture varies (e.g., Kiata & Kerse, 2004). Many authors (e.g. Rao *et al.* 2006, Lindeman *et al.* 2012, Jones & Watson 2012, Maki *et al.* 2012) point out the importance of implementing intercultural communication skills and appropriate resources in the education of caregivers from culturally and linguistically diverse backgrounds. Teaching materials for caregivers should be translated into “local languages as a step in the process of raising awareness, countering stigma and improving service access and addressing unmet needs” (Lindeman *et al.* 2012, p. 191). This challenges administrators of geriatric institution to be aware of their healthcare workers’ linguistic and cultural backgrounds and to use their various skills in the best interest of their patients. Nurses who speak the “new” groups of patients’ languages and are conversant with their culture have become an increasingly valuable asset.

Intercultural research on good dementia care provides an opportunity to identify what caring issues essentially remain the same across various populations and what issues are culture specific. Language and intercultural communication in dementia care is such an issue that need to be studied further.

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Ingrid Hanssen is a nurse with intercultural work experience from both Norway and the United Arab Emirates. She is a Master of Nursing Science and Dr; Politic sciences from the University of Oslo. Her doctoral dissertation was "Facing Differentness; An empirical Inquiry into ethical challenges in intercultural nursing" (2002), later published by VDM Verlag, Dr Müller, Saarbrücken, Germany, 2010). She is a Professor at Lovisenberg diakonale høgskole (Lovisenberg Deaconal University College), Oslo, Norway.

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[1] This is an international umbrella project headed by the author with studies conducted in Norway (Oslo and Finnmark), and in Montenegro, Serbia, and South-Africa. While co-researchers are participating in the international studies, the Norwegian part-studies are conducted by the author only. Data from Montenegro and Serbia are not included here as patients and nurses in the two facilities visited there share cultural and linguistic backgrounds.

[2] Of the 15 Sami town interviewees 2 of the nursing staff doubled as family respondents as they had close family members with dementia.

[3] South African co-researchers: From the MEDUNSA Campus, University of Limpopo: Malmsey Segane, RN, PhD, Florence Mkhonto, RN, Psychiatric Nurse Specialist, and Yolanda Havenga, RN, PhD, now affiliated with Tshwane University of Technology. Norwegian co-researchers: Hilde Øieren, RN, Ma.Nurs.Sci., Diakonova University College, Oslo, and the author, head of the entire international research project.

[4] Y. Havenga and F. Mkhonto.

[5] Afrikaans is a Low Franconian West Germanic language descended from Dutch and spoken mainly in South Africa and Namibia (Ager, undated).

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