ORIGINAL RESEARCH

A theory of cultural translation in healthcare for multilingual older adults living with dementia and their caregivers

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ABSTRACT

Objective: The United States is a multicultural, multilingual country; as a recognized feature of the American population, the challenges of caregivers seeking services for multilingual older adults still need to be better understood. This study aims to understand the experience of caregivers who sought healthcare services for a multilingual older adult living with dementia.
Methods: Using Constructivist Grounded Theory, formal and informal caregivers participated in semi-structured interviews to ascertain their experiences seeking health services for multilingual older adults with dementia.
Results: Several themes emerged, including Cultural Translator, Mitigating Relationships, Leaning, Seeking Help, Meeting them where they are, and a Rigid Healthcare System. Lastly, the participants' descriptions unveiled a phenomenon identified as cultural translator stress. Cultural Translator stress may occur due to the added responsibilities of advocacy, healthcare system navigation, language interpretation, and explanations of culturally based idioms on behalf of the multilingual older adult with dementia for the healthcare provider.
Conclusions: As our understanding of care for multilingual older adults with dementia improves, awareness of their caregiver's needs and mechanisms to support this unique population should emerge. Factors such as culture, access to culturally appropriate services, and services needed to support family caregivers are needed. Further studies are needed to understand the stressors related to caring for a multilingual adult living with dementia or the phenomenon of cultural translator stress.

Key Words: Dementia, Caregiver, Stress, Multilingual, Bilingual, Culture

1. INTRODUCTION

Researchers have identified the need for resources to support the aging population in mental health and primary care.[1,2] Continued research focuses on the growing older adult population or the "Silver Tsunami", with particular attention on the healthcare needs and delivery of services to those who speak English as a primary language.[3]

However, the linguistic diversity of the United States (U.S.) population signals a need for increased awareness and research regarding the unique experiences of multilingual older adults and older adults who speak a language other than English.[4] Multilingual older adults living with dementia are an understudied population; thus, seeking the insights of those who care for this population to develop the depth and breadth of knowledge needed to encourage a flexible and responsive healthcare system is warranted. This population may have

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unmet needs that require our attention, and determining how to support their caregivers is essential in a similar fashion as support is necessary for primary English speakers.

Complexity for health care increases when multilingual older adults have been diagnosed with Alzheimer's, a form of dementia. The Alzheimer's Association estimates that 6.7 million people in the U.S. with dementia are over 65;[5] however, we are unaware of the number of people within this population who speak a language other than English or are multilingual speakers. When multilingual older adults develop dementia, they typically experience language mixing, often using both languages when communicating and relying on the use of the better-preserved language for communication, which may not be English, currently the dominant language in the U.S.[6–8] Thus, the purpose of this study is to understand the experiences of multilingual older adults with dementia and their caregivers, which is necessary to identify potential health disparities, improve health outcomes, and increase their use of services within the healthcare system.

Gaining insights regarding this population's needs could highlight the resources and services they access when seeking care while also identifying areas of unmet need.

1.1 Background

The growth of Alzheimer's and associated dementias has been deemed a public health priority by the World Health Organization (WHO) due to its debilitating effects on the affected person, the significant need for dependency on caregivers, and the cost associated with caregiving.[9] Cognitive decline has been linked to dementia and other neurological disorders such as Parkinson's disease, multiple sclerosis, and traumatic brain injuries.[10, 11] In addition, previous research has indicated that multilingual adults with dementia often revert to their primary language.[6] This phenomenon is likely to occur in the U.S. due to the country's multicultural and multilingual nature. A report published in 2022 by the American Community Survey[12] estimated that 75 million people aged 60 years and above living in the U.S. speak a language other than English at home. While many spoke English very well, this data supports the need for healthcare providers to be aware of the risk of language mixing and language erosion with dementia in this population. It also reinforces the continuous emphasis on cultural competence in healthcare.[13] A lack of cultural understanding, lack of communication or knowledge of services, and proximity of services have been identified as barriers to accessing community services for multilingual populations.8 Thus, there is an urgency to increase awareness regarding the needs of multilingual older adults with dementia and their caregivers.

1.1.1 *Older adult challenges*

As the monolingual and multilingual older population grows, they will face similar challenges, including changes in cognitive abilities such as those associated with dementia.[14] Some of these challenges will differ simply due to the language abilities of the multilingual population. Language retrieval/lexical access is the ability of a speaker to select a word or term with little hesitation while speaking. This type of language retrieval/lexical access is often called the "tip of the tongue" phenomenon and can occur in anyone. The frequency with which this occurs increases significantly in those with dementia, often disrupting sentences and thoughts when speaking.[15, 16]

Another linguistic challenge is language mixing or using several languages within a conversation. This phenomenon was well recorded in a Swedish study by Ekman et al.[17, 18] which indicated that formal caregivers experienced challenges with communication, including difficulty understanding their patients since they often switched between languages. Language mixing or code-switching, as has been recently called in the literature, can make communication challenging for multilingual speakers.[16]

Hallberg's[19] research indicated that mapping the healthcare system to identify the services available to multilingual older adults with dementia was necessary to support this population and their caregivers to meet their needs. In a systematic review, Chejor[14] concluded that the experiences of multilingual older adults partly differ because of language and cultural beliefs. Conducting this study is one small but essential step toward understanding the experiences and needs of this population as they interact with the U.S. healthcare system.

1.1.2 *Family challenges*

Many families attempt to support young children while supporting aging parents in a phenomenon called the "sandwich" generation.[20, 21] These families are experiencing high levels of stress aiding young children in school and social activities while helping older parents with provider visits, managing medications, and other healthcare needs. The challenges become complex due to language and cultural barriers. The multilingual older adult may have trouble communicating in English. Thus, a family member must often be present to support the older adult with the interpretation. The literature indicates that multilingual older adults are usually cared for at home by family and friends; these are informal caregivers who provide varying forms of support due to familial and cultural expectations, resulting in positive outcomes for the care receiver.[17, 22, 23]

1.1.3 *Caregiver challenges*

Direct caregivers and healthcare providers face other unique challenges, especially when they need to speak the patient's language. The patient's inability to communicate in English or the dominant culture's language can make relaying healthcare information difficult, leading to barriers regarding health literacy, healthcare decision-making, access to healthcare resources, and treatment adherence.[14] While the U.S. has enacted mandates requiring healthcare organizations to provide care in the patient's language, access to these services still needs to be improved due to cost and, at times, linguistic dialect. The lack of access to linguistic and culturally appropriate services can cause added stress for the family caregivers involved in the multilingual older adult's care.[22]

2. METHOD

Constructivist grounded theory (CGT) was chosen as the qualitative method to guide this study. This method, developed by Charmaz,[23,24] enables the researcher to examine the context in which their worldview can influence the study design and results. This type of self-analysis is essential to gain in-depth insight into the data collected. Part of the researcher's responsibility as a co-constructor is to gather the data and critically determine whether the theoretical assumptions support the data. This method allowed the researcher to be acknowledged as a co-contributor of data due to family history and work interactions. CGT also acknowledges that research is conducted under pre-existing, structural, or political conditions.

Furthermore, a researcher's worldview based on life experiences or privileges may influence research processes.[25] Thus, a process is operationalized to outline those perspectives through memo-writing or memoing. Memoing is a crucial step in the research process for grounded theory because it requires the researcher to capture their thoughts, make links, compare language and incidents where needed to formulate questions and develop insights.[25] This leads to theoretical sampling, which allows the researcher to identify and define concepts as they emerge from the data provided by the participants.[26] Essentially, through constant comparison, the researcher identifies the attributes that define instances of data saturation.[25,26]

2.1 Recruitment and sample

Participants were recruited by posting flyers written in English at small shops and churches in multiethnic neighborhoods in New York, Colorado, and Massachusetts. Recruitment materials were also distributed to multidisciplinary care professionals in a home care organization and an adult day program. Other efforts included posting flyers on social media platforms. Fourteen participants (three men and eleven women) were recruited for this study. The sample size is consistent with another study that used the CGT method.[27]

2.2 Ethical considerations

This study required added scrutiny in part due to the political climate. Upon initial approval for the study by the University of Colorado Denver Anschutz Medical Campus Internal Review Board (IRB), participants were asked to read and provide written consent with their signature to participate. However, with the inauguration of President Trump and the rhetoric shared by the administration, participants expressed discomfort, and many who initially agreed to participate ultimately canceled. Many feared their information would be accessible to immigration centers and were concerned that their work permits or student visas would not be renewed. After approval from the University IRB for an amendment to the study, the participants were given written consent forms but were not required to sign their names on the forms. Therefore, verbal consent was obtained from each participant. Voice and video recordings of interviews were deleted once transcripts were reviewed for accuracy. Finally, participants' names were changed to support their anonymity.

2.3 Data collection and analysis

An iterative process was applied using CGT while reviewing data after interviewing each participant with selective coding.[24,26,28] The participants in this study were from various backgrounds and were fluent in multiple languages, including English. Participants were offered a variety of platforms for conducting the interviews, such as video, in-person, and by telephone. Participants were encouraged to select the platform most conducive to their needs. One interview was conducted by video, six interviews were done in person, and seven interviews were conducted by telephone. All interviews were recorded and transcribed verbatim.

Initial data analysis was conducted using line-by-line, and section-by-section coding to learn and understand the participant's perspective. This process allows the researcher to develop an understanding of the participant's actions, and understand a pattern of their behavior to identify themes. Hearing the participants' experiences in their own words provided a glimpse into their lives, their values, and how they made decisions in an effort to support their family members or their clients. Hearing similar responses from participants to certain questions and finding no new data was an indicator of data saturation. Discussing data and codes with another researcher supported concordance regarding the codes.[25]

Memos were developed to organize and identify patterns and create codes from the transcripts. Memos were pivotal in the study process; they prompted further interaction with the data to grapple with the message and underlying links being presented by participants.[25,26] Memo writing also helped capture conflicting perspectives, decide how to proceed in the study, and determine when enough data had been collected to appraise saturation for an aspect of the study.[29]

To ensure rigor, data was analyzed by two researchers. Data analysis was completed by listening to the videos and reading the transcripts. During this process, the researchers sought clarification, meaning, and understanding of context when there were changes in the participants' tone of voice and hesitations when responding to questions and comments.[26,29] Participant statements were often summarized during the interview to confirm the researcher's understanding and increase the accuracy of the interpreted message. This process effectively supported or reinforced thick descriptions regarding the interview context.

2.4 Trustworthiness

In qualitative research, validity and reliability are established through credibility, transferability, dependability, and confirmability. Credibility was achieved by maintaining a set of documents and applying behaviors to demonstrate consistency as the study's primary investigator and research conduct. Transferability was ensured by providing detailed descriptions of the interviews to determine the applicability of the research to other settings and populations. To achieve dependability, the researcher maintained an audit trail throughout the study outlining how and why decisions were made, including modifying questions for future interviews and determining what questions were important and which participants to follow up with for further interviews.[25,26,29] Finally, to attain confirmability, a journal was used to document thoughts, potential biases and process the rich data provided by the participants.[25]

3. FINDINGS

Participant interviews helped identify several themes that outlined the process of cultural translation.

3.1 Cultural translation process

In many instances, informal caregivers actively directed the care provided to their loved ones. Due to the language barrier, informal caregivers often interpreted their loved one's statements and the sentiment being conveyed.[30] They often clarified their loved one's meaning to the formal caregivers, who may have displayed confusion or difficulty understanding the patient's statement or behavior because of a lack of familiarity with the language and culture.

One participant explained, "If you don't have the cultural translation, it's perceived differently. . . So maybe to translate behaviors and levels of comfort based on their culture and upbringing, especially when they have mental issues because they'll go back to the beginning."

3.2 Cultural translator

When a person living with dementia used terms and referenced a time of which the caregiver may have been unaware, the family and other informal caregivers took on the role of cultural translator. The cultural translator often supported the person living with dementia while also informing and educating healthcare providers about the person's culture and how best to interact with them.[30]

3.3 Seeking help

Most participants expressed feeling unprepared to care for a person with dementia.[20,31] Instead, they experience the scope of the disease through moments of confusion. "Then, when we would go to visit, we noticed that things were in disarray in her bedroom, and she wasn't putting things away like the way she used to be; she was meticulous about everything and so thorough about everything. Those were the first signs that something was not right." The family immediately understood that their brilliant mother, a physician who immigrated from Greece to the U.S., was experiencing significant challenges and began seeking medical help to understand what was wrong; this prompted the initial visit for a future diagnosis of dementia.[31]

For another family, the need for support progressed once the diagnosis of dementia was obtained, and support from the community was inadequate, especially from a cultural perspective.[17] This prompted moving the person with dementia to another area. More support was needed, primarily due to the lack of cultural awareness from healthcare professionals, including homecare staff such as nurse aids and healthcare providers such as physicians who did not understand the family's culture.

There were instances in which everyday activities and the use of household items were suddenly unknown to the person with dementia. One participant explained, "I realized that I didn't quite understand how bad it was. . . It wasn't just that she didn't remember people, remember the words, but things she couldn't remember, like what the toilet looks like. . . the toilet is right there. She didn't understand that, and she peed in my chair because she thought that she was sitting on the toilet." Seeking help becomes more urgent because the time needed to provide care increases along with the nuances and responsibilities regarding the care.

3.4 Mitigating relationships

For some participants, especially family caregivers, there is a sense of time lost, important moments with their spouses, and their children missed due to caregiving responsibilities.[20,27] "The fact of the matter is that my mother is 94, my younger son is 16, my eldest son is 18. This has impacted their growing-up years . . . My mom needed help, a significant amount of help for at least eight years, this is since my younger son was 8 and my oldest son was 10. Instead, I feel bad because. . . the fact of the matter is it would be nice to be able to go to a movie on a Saturday afternoon out of whim, and I can't do it." This participant worked hard to maintain positive relationships with her children while bearing the brunt of caring for her mother because her siblings offered little support., Spontaneous family outings were not feasible because every part of their lives had to be planned, thus sacrificing valuable time with her children.[32,33]

3.5 Leaning

This theme described one aspect of the informal caregiver's persistent support for a person with dementia. The informal caregiver was the role most healthcare staff members relied on for education regarding the person's culture, behavior, and mood. This often felt like an added stressor to ensure that the interpretation matched the expression and sentiment conveyed.[21] One participant conveyed how much they relied on the cultural translator, often a family member. "We have multicultural people here. . . How are you going to get across to them, especially if they have dementia? I had one lady who was Italian; she only spoke in Italian now. . . that's the only way she would communicate . . . when her daughters frequently came, one would come during the day, and the other (adult daughter) would come in the evening. They would help us with that."

Participants expressed other ways that culture and language had to be considered while caring for a multilingual, multicultural person living with dementia;[8,13] one person stated, "I remember a couple of years ago, she got up one morning and she went to the bathroom and my husband has helped her walk. She was talking to him in Italian. My husband's irate". He called me up and said, "She's talking Italian; what do I do?" I said, "Tell her to speak in English. That worked for a little while". Another participant shared a similar experience, stating, "My mother began this path of dementia, and she's forgotten how to speak in English. So, she argues with you and talks to you in Spanish, but she thinks she's speaking English."

Another participant expressed the need to surround her mother with people who were familiar with Haitian culture and could respond accordingly.[14,18] This included the need to provide meals that her mother could recognize, such as traditional Haitian bread paired with peanut butter, stating, "We always have to make sure that there's as much as possible Haitian bread and peanut butter. If you can't get her to eat anything you have to know that peanut butter will do it for her." In the context of meals[34] delivered to the home an informal caregiver explained "they never were really interested in doing any of that because pretty much their diet does not really jive with that–The American diet, Meals on Wheels. They don't do any beef or cow products because of their religion." Reinforcement of this perspective came from a caregiver whose grandparent was from Jamaica and stated, "like my grandmother. . . spaghetti and meatballs for her, she's like What's that? You need rice and peas then a meat. . . Or if you wanted a hamburger, McDonald's as a meal, that in her mind, she didn't understand that was food, she didn't consider it food you know."

A formal caregiver working within homecare echoed similar sentiments while sharing her experience, stating, "They sent me to this lady's house. . . I knew nothing about this lady's background. . . it was the middle of winter, I walked in, I had my boots on. I couldn't speak her language, and she couldn't speak mine. . . she threw her bath chair at me, she threw her Bible at me. Language barrier, yes, yes, I knew nothing, nothing at all. Nobody warned me ahead of time or anything . . . When I got back to the agency, I ran into the nurse." I said, "That woman just beat me up", he said, "Oh, you probably shouldn't have your shoes on." "Thanks for that . . . My feelings were hurt. I probably hurt hers (the person living with dementia) because I didn't know about that."

While challenges communicating with multilingual older adults living with dementia associated with language may be apparent, other nuances, such as increased recognition of culturally relevant meals rather than those of the dominant culture, may be more difficult.[17] Culture encompasses several dimensions: language, traditions, food, and behavior.[30] Positive memories may be encouraged through the senses, especially olfactory and visual through education culturally relevant meals and behaviors. Thus, including access to culturally based meals should be part of providing culturally congruent care for the multilingual older adult living with dementia.

3.6 Meeting them where they are in time and space

Time is what the person with dementia indicates it is, which is the reason many caregivers do not argue or contradict them. For persons with dementia, the past event is their current reality; thus, attempting to reorient or correct the person can lead to changes in mood and agitation.[35,36] Essentially, reorientation is unnecessary since the disease does not allow the person to store the new information for recall.

One participant stated, "She's in a different time zone, where– It's a much slower pace. I have the time to gather my thoughts and my words and communicate better with her. It's not quick, like I'm trying to rap her or tell her something in a quick way or get her to rush somewhere. She controls her time and how it works around her."

3.7 Rigid healthcare system

One participant who often provides hands-on care to older adults with dementia explained her experiences with a client who spoke Arabic. She needed help understanding the language, and the organization she worked for had no interpreter services for her to decipher the communication attempts by her client, and often, her family was unavailable for interpreter support. As she indicates, "... You have to sometimes remind them that you can't understand them even though they might be able to understand you. I don't get it, 'Can you speak English?' And they'll be like, 'Okay, okay.' It takes them back to when they first started speaking in English, they have basic still ... At some point in time, these facilities need to realize that I get the strict no cellphone policy, but they don't get that it's so beneficial because I can pull up how to say, 'Do you want water or juice?' on my phone through Google."

Google Translate is an application that can interpret statements from one language to another. It is not a medical interpretation application. However, these participants explained that this application was beneficial when no other resources were available. In this instance, the participant was disciplined for using the Google Translate application for interpretation at work and felt they were hindered from understanding their client's needs. Often, leaders can discern when to discipline those who report to them; in this instance, a nurse supervisor disciplined a nursing assistant for using the most appropriate and available method to understand their client. The nursing supervisor could have applied their leadership and clinical judgment skills to support this staff member and their client. Blind use of organizational policies without critical analysis can negatively affect client care, decrease staff morale, and, in this instance, hinder care by removing access to the only available resource for interpreter services.[37]

4. DISCUSSION

The results of this study indicate a lack of awareness of the needs of formal and informal multilingual dementia caregivers. While formal caregivers know how to navigate the healthcare system, informal caregivers understand their loved ones well enough to interpret their needs using their cultural knowledge. The education provided by the informal caregiver supports the multilingual older adult with dementia by proxy, making communication and care delivery less challenging for the formal caregiver. This added responsibility increases the informal caregiver's stress.[22]

Formal caregivers of multilingual caregivers experienced significant challenges ensuring the multilingual older adult living with dementia was understood, primarily through communication. Often, they experienced discomfort when they could not understand the language or the meaning behind their client's gestures.[14, 18] Ensuring the meals were appealing was also a challenge because often the multilingual older adults with dementia recognized and enjoyed meals based on their culture.

Formal caregivers often reached out to the client's family members to understand their client's needs, at times asking family members to interpret statements and the underlying meaning behind the statements. These cultural nuances are not easily accessible in a text or a mobile application, thus some form of education or information is often sought from the family member by the formal caregiver to provide effective care when needed.[4] This highlights the reliance of the healthcare system on informal caregivers for caregiving.

We must address the challenges related to accessing services and the risk of increased stress that may be inherent in the role of the cultural translator. Challenges include communication barriers associated with language mixing, lack of cultural awareness within the healthcare system to meet the needs of such a diverse population, and other issues associated with a lack of English proficiency or difficulty communicating in English related to cognitive decline. In addition, we have become more aware of concepts such as caregiver burden. However, further exploration of this concept in the context of the caregivers of multilingual older adults is warranted.

4.1 Strengths and limitations

Several strengths are noted in this study; first, several participants worked in different areas and lived in different states. Thus, when they discussed their difficulties regarding access to interpreter services and interacting with healthcare providers, this strengthened the evidence regarding their experiences. The linguistic diversity of the participants, including Greek, Japanese, and Italian provided important insights about their lives and experiences which was another strength. Despite the participants' varying backgrounds, they shared many similar life experiences (see Table 1).

Table 1. Participant attributes and linguistic interactions

Caregiver Languages Spoken	Years as caregiver	Caregiver Type	Linguistic Interactions
English	22	Formal	Spanish, Polish, Italian
English	20	Formal	Polish, Ukrainian, German, Vietnamese, Spanish, Karen
English	9	Formal	Italian, Polish, Mandarin, Nepali,
English	14	Formal	German, Italian, Ukrainian
Spanish/English	7	Formal/Informal	Spanish in varying dialects Cuban, El Salvadoran, Guatemalan, Catalan, Mexican
Spanish/English	12	Formal/Informal	Spanish in varying dialects (Cuban, El Salvadoran, Guatemalan, Mexican) Hebrew, Jamaican Patois
Jamaican Patois/English	23	Formal/Informal	German, Greek, Vietnamese, Jamaican Patois, Spanish, Italian
English	5	Formal	Greek, Ukrainian, Italian
Jamaican Patois/English	7	Formal	Spanish, Arabic, Italian, German, Polish, Ukrainian
Haitian Creole/English	16	Informal	Haitian Creole
Italian/English	9	Informal	Italian
Haitian Creole/English	4	Informal	Haitian Creole
English/Greek	8	Informal	Greek
English/Japanese	5	Informal	Japanese

Note. Formal caregivers are compensated for providing care to the person living with dementia. Informal caregivers are family members or family friends who provide services for the person with dementia and are not compensated for the service. Some participants hold both formal and informal caregiver roles by working as nurse aids, nurses, or physical and occupational therapists.

One of the substantial challenges of this study was the fear of participation by non-US citizens. Most informal caregivers were of another ethnicity or cultural background; at the time, the United States executive branch implemented an immigration policy that instilled fear, creating a hostile recruitment environment. Other individuals who expressed interest in the study did not proceed for fear of retaliation, including being denied renewal for a work permit, being denied permanent residency to the U.S., or being unable to renew their student visas.

Fear of participation affected the number and demographic of participants willing to share their stories regarding their experiences of caregiving in a multilingual context.[38] This means that some participants of diverse backgrounds, such as recent immigrants and international students working in healthcare, decided to refrain from participating, thus limiting the data available to inform aspects of this study. While recruitment was challenging, the individuals who chose to participate showed courage by sharing their experiences to increase the awareness of the healthcare community.

4.2 Nursing implications for practice

A constructivist grounded theory study helped identify the process and patterns leading to the role of the cultural translator and cultural translator stress as a new phenomenon. However, further studies are needed to understand this role and its implications in the daily lives of caregivers. From this perspective, a future study should explore the role of the cultural translator as a phenomenon. Delving deeper into the lived experiences of the person who is actively and consistently interpreting and educating the providers and other actors within the healthcare system about the person's culture, language, and idioms is needed to increase the ability of the healthcare system to meet their needs.

While further studies are needed, nursing and other healthcare leaders can encourage the use of interpretation tools by staff to increase effective caregiver-staff communication. Recognizing the diversity of the United States population, the responsibility to effectively respond to patient and family needs should not rest solely on the informal caregiver. The current healthcare system emphasizes patient-centered care; this can be challenging if those within the system are limited in the ways they can access interpretation assistance due to cost or organizational policies. Leaders in acute care, rehabilitation, and long-term care can evaluate the tools currently accessible to the staff to determine their efficacy while also investigating why staff may use other tools before deciding to seek disciplinary action against staff. As an organization, leaders can evaluate needs on a case-by-case basis to track changing demographics and determine how to scale available resources. Assessing, evaluating, and tracking communication and care improvements could work well as part of an organization's quality improvement efforts.

Currently, many organizations collect data on the primary language spoken; other practical considerations, including questions regarding often-used terms, idioms, gestures, and their meaning, may benefit those providing care. Documenting these can help increase the efficacy of person-healthcare provider communication. This information readily available to the healthcare teams may help decrease the added effort and education the informal caregiver provides as the cultural translator. Nurses are patient and family advocates. As such, they inherently shoulder the responsibility to guide change within the healthcare system with the unique needs of this population in mind.[39] These implications may catalyze innovative practice-initiated interventions to support multilingual older adults with dementia and their caregivers.

5. CONCLUSIONS

Understanding why a multilingual older adult living with dementia's frequent use of their primary language can affect interactions and relationships should help providers become more empathetic to the needs of informal caregivers. Furthermore, considering the need to learn about a person's culture, the context of statements, their cultural meal preferences, and behaviors to understand how this affects interactions may help increase the multilingual older adults' comfort with care within the healthcare organization while also supporting their culture.

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AUTHORS CONTRIBUTIONS

Maria Roche-Dean Ph.D. RN. was responsible for study design, implementation, manuscript draft, and revisions. Angela Groves Ph.D. RN. BC. CNE. was responsible for article draft and revisions. All authors read and approved the final manuscript.

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