

Willingness to be Screened and Tested for Cognitive Impairment: Cross-Cultural Comparison

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Abstract

Objective: The purpose was to describe (a) individuals' reasons for participating in cognitive screening and (b) reasons to pursue testing after screening across 4 ethnic groups: African American, Afro-Caribbean, European American, and Hispanic American. **Methods:** Prior to memory screening, 119 adults were interviewed regarding their thoughts about memory screening and follow-up testing. Interviews were coded and differences between ethnic groups were compared. **Results:** More African Americans and European Americans were concerned about their memory. More Hispanic Americans planned to seek professional help if needed. Hispanic Americans were most optimistic about treatment. **Conclusions:** Future research is needed to better understand cultural factors that influence older adults' willingness to be screened for cognitive impairment and to pursue follow-up testing when recommended.

Keywords

Alzheimer's disease, dementia, cross-cultural differences, screening, memory

Cognitive screening is designed to identify individuals who need additional testing for Alzheimer's disease (AD) and other related disorders.¹ Most of the limited research on community interest in cognitive screening has been focused on whether or not individuals (a) seek cognitive screening or (b) pursue follow-up diagnostic evaluation if they screen positive. Factors that influence these 2 decisions are poorly understood, particularly in minority elders. The purpose of this study was to describe (a) individuals' stated reasons for participating in cognitive screening and (b) stated plans and reasons to pursue follow-up testing after receiving positive screening results across 4 ethnic groups: African American, Afro-Caribbean, European American, and Hispanic American.

There has been some controversy regarding the value of cognitive screening.²⁻⁴ In a state of the science paper, Bain and colleagues² identified a number of reasons to screen such as the individual's right to know, financial and health care planning, education about the diagnosis, support from community-based resources, optimal management of comorbidities, and the chance to make lifestyle changes that may slow cognitive decline. Powers and associates¹ summarized the literature on major reasons to avoid screening as fear of discovering a problem, stigma, and being subjected to expensive but perhaps unnecessary follow-up cognitive testing. A concern expressed by Dale and colleagues³ is the lack of a Food and Drug Administration (FDA)-approved drug specifically for the

treatment of mild cognitive impairment (MCI). Others have raised the question as to whether MCI should be treated at all given that only some individuals with MCI go on to develop dementia.^{4,5} Despite the lack of consensus on diagnostic criteria or treatment for MCI, behavioral, educational, and spiritual interventions have the potential to improve overall health and quality of life of affected individuals and to better prepare them and their families for the possibility of future challenges.⁴

In a recent report from the Alzheimer's Foundation of America, the authors strongly support the development of a national strategy for memory screening to increase early detection of dementia.¹ Although the "warning signs" of dementia have been widely publicized, structured screening would increase the number of individuals who could plan for their future health care and financial needs, make positive lifestyle

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changes, seek community support and education related to cognitive impairment, and receive early intervention such as medication to slow the progression of the disease.

Literature Review

Willingness to be Screened

Willingness to be screened for memory problems has been studied by 3 research teams.⁶⁻⁸ Using a survey mailed to 500 white, affluent residents of 2 continuing care communities in the United States, Boustani and colleagues⁶ found that less than half of the 318 respondents (49%) agreed to be screened for memory problems. After examining the characteristics of respondents who would agree to routine memory screening, they reported that most were individuals aged 50 or older with at least a high school education. More males (53%) agreed to screening than females. Those willing to be screened were more likely to use assistive devices (60.4%) and were taking more medications. Of those willing to be screened for depression, 97% were also willing to be screened for memory problems. The researchers suggested that those who were willing to be screened might have greater awareness of vulnerability than those who were not. They also conjectured that those who were unwilling may have believed that screening would result in harm.

In 2003, Werner⁷ conducted a study of intentions to seek cognitive testing in 186 healthy, affluent, community-dwelling Israeli adults born in Europe, America, or Israel, with a mean age of 65 (SD = 7.7). To illuminate reasons for willingness to be screened, Werner⁷ developed 4 hypothetical scenarios and asked participants to report their intentions to seek cognitive screening in 2 situations (not able to find keys or not able to name close relatives), each presented under 2 conditions (with or without a family history of AD), using a 7-point scale from 1 ("definitely will") to 7 ("definitely will not"). The researcher also measured components of the Health Belief Model related to cognitive examination: perceived benefits, perceived barriers, perceived susceptibility, perceived severity and social cues to action. Social cues were measured by an item related to whether significant others would be in favor of screening. In these hypothetical situations, intention to seek cognitive testing was correlated with higher social influence from significant others to obtain screening, more perceived benefits, and fewer perceived barriers. In response to scenarios in which there was a family history of AD, participants were more willing to seek cognitive testing if they were younger, better educated, and had higher income.⁷ The hypothetical scenarios were constructed to confront participants with their vulnerability to AD, yet participants believed they were only moderately at risk. With further education about the risks, individuals may become more willing to be screened. In a second Israeli study with a similar sample, Werner and Heinik⁸ recruited 93 adult children of patients with AD from a memory clinic to participate in a telephone survey. About half were primary caregivers, 67% were female. Participants were asked about their intentions to be screened in the next year and within

5 years. Forty-two percent responded that they were willing to have cognitive screening within 1 year to 5 years. Sons or daughters of individuals of memory clinic patients with AD who were concerned about their own memory reported only moderate intentions to seek testing. Higher income caregivers of patients with behavior problems, and those with a higher perception of futility about treatment had the lowest intentions to seek testing. Because their family members were affected by AD, it would seem that these participants would be more aware of their risk and would be receptive to screening. Still, the findings regarding only moderate willingness to be screened were similar to Boustani and colleagues⁶ and to Werner's⁷ previous study. Although the findings⁸ regarding income seem to contradict previous findings,^{6,7} the effect of having a care recipient with behavior problems may be more salient in determining willingness to be screened. A possible explanation is that difficult experiences with a parent's AD-related behavioral problems may profoundly increase anxiety and perhaps a sense of futility about screening.

Pursuing Follow-Up Evaluation

Two research teams have examined pursuit of follow-up diagnostic evaluation following cognitive screening. Demirovic and associates⁹ screened 2759 community-dwelling individuals in south Florida. Sixty-six percent were from minority populations (30% African American, 36% Hispanic American). More African Americans screened positive (20.9%) than did Hispanics (11.6%) or non-Hispanic whites (12.1%). Of the 310 who screened positive and were referred for further testing, only 42% actually sought a clinical examination. Those who sought further testing were younger and more likely to be African American. African Americans may have been more willing to be screened because of their increased susceptibility.⁹

After examining the prevalence of cognitive impairment in a diverse ethnic community of adults from several primary care and public hospital sites in Indianapolis, Boustani and associates¹⁰ compared those who agreed to further testing with those who refused. A total of 434 adults who screened positive were included out of an original population of 3340 screened. Of those who screened positive, 47% were later diagnosed with AD. Those who agreed to a diagnostic interview were a little younger (mean age 73.8 vs 75.4), had slightly worse overall screening scores (nonsignificant finding), and were less oriented (performed worse on temporal items of a 6-item Community Screening Interview for Dementia) than those who refused diagnostic interviews. African Americans older than 80 declined diagnostic testing more often than those younger than 80 ($P \leq .001$). White patients older than 80 were more likely to refuse further assessment than were African Americans younger than 80 ($P \leq .03$). As in the study by Demirovic and associates,⁹ African Americans younger than the age of 80 were more willing to be evaluated for AD than Whites in the same age range. Perceived susceptibility to AD may explain African Americans' willingness to be further evaluated except in

those older than 80. Participants older than 80 may have responded differently because they believed cognitive impairment was “normal” or that treatment for AD would be less useful or necessary at their advanced age. Those who may have had some mild impairment were also more willing to be evaluated. Perhaps their awareness of deficits increased their receptivity.

Ethnic Group Differences

Although the primary risk factor for Alzheimer's disease is age, several sources report that older adults from minority communities are at higher risk than their White non-Hispanic counterparts.^{9,11-14} According to Demirovic and associates,⁹ African American men are at highest risk for dementia followed by African American women, Hispanic women, Hispanic men, and white non-Hispanic men. Non-Hispanic white women had the lowest risk. These results were similar to the results of other studies in Boston, New York, and Europe.¹²⁻¹⁴

Despite their higher risk, ethnic minorities have not been included in most studies of screening behavior. Two studies did provide some information about the relationship of culture and willingness to pursue follow-up testing. In the study by Demirovic and associates,⁹ African Americans were more likely both to screen positive and to seek a clinical examination than Hispanic or non-Hispanic whites. Boustani and associates¹⁰ also reported that African Americans were more likely than white patients to pursue further testing.

Summary of the Literature

A sense of personal vulnerability or perceived susceptibility seemed to be an important factor determining individuals' willingness to be screened for impaired cognition. Findings supporting this conclusion come from the study by Boustani et al^{6,10} in which men who had poorer health were more willing to be screened and African Americans were more willing to pursue follow-up testing (presumably because they were aware of their higher risk for AD). Werner's⁷ participants were more willing to be screened when responding to scenarios in which there was a family history of AD. Finally, Werner and Heinik⁸ found that first-degree relatives who were concerned about their memory had stronger intentions to be screened.

Age seemed to be another important factor influencing willingness to pursue diagnostic testing following positive screening results. Both Boustani et al¹⁰ and Demirovic et al⁹ found that younger participants were more likely to choose follow-up testing.

Given the higher prevalence of dementia among minority older adults¹¹ and the lack of studies that include ethnic minorities, further study is needed to better understand the role of knowledge of susceptibility among ethnic minority adults as well as cultural values and their impact on health behaviors such as screening and follow-up behavior.¹⁵

Methods

Study Sites

Screening sites were churches, senior centers, and health fairs in south Florida, which served primarily minority older adults. Prior announcements were made at these centers and flyers were distributed by their organizers to attract individuals to the health fairs.

Procedures

The study was approved by the committee for protection of human participants at Florida Atlantic University. At the screening site, potential participants received detailed information from a trained research assistant and received answers to their questions about the study. Written consent was obtained from those who agreed to be screened. Participants were eligible if they attended a memory screening event and were English-speaking or bilingual English-Spanish adults.

This investigation was part of a larger multicultural study of 793 community-dwelling older adults who agreed to memory screening. A subset of 119 participants was interviewed prior to cognitive screening using a structured interview guide with questions about their reasons for agreeing to be screened and intentions to pursue diagnostic testing if they had positive screening results. Interviews were conducted by the investigators and research assistants trained by the investigators. Respondents were asked 5 open-ended questions (1) “How did you learn about this screening?” (2) “What led you to come here for screening? Have you had any concerns about your memory?” (3) “Do you think there is any value in finding out that you may have a memory problem? Why or why not?” (4) “If, after screening, you are told that you might have a memory problem, what do you think you will do about it?” (5) “Do you believe, in general, that older people should have their memories tested? Why or why not?” Follow-up questions were designed to encourage participants to elaborate on their intentions and their values and beliefs about screening. Participants were interviewed in English or Spanish. Responses were recorded verbatim. All participants' responses were translated by trained Spanish-English bilinguals who followed the standard procedures.^{16,17}

Data Analysis

Qualitative analysis involved a 4-step process of data reduction, display, interpretation, and transformation (quantizing).^{18,19} Using Atlas/TI software,¹⁹ each participant's responses were entered by question and ID number so that coders would be blind to ethnic group membership. One investigator (K.N.) developed a preliminary coding scheme after close reading of the entire set of responses. Three additional investigators (R.T., C.L.W., M.R.) refined the coding scheme upon additional reading of the entire transcript to capture both common and outlying participant responses. A numerical,

dimensional coding strategy was generated with an associated coding sheet and explanatory key to facilitate data transformation. Each participant's response was considered as a whole. Coding of each response by question was done by 2 investigators expert in AD but blinded to ethnic group membership of the respondent. A third coder reviewed the findings for disagreements. All disagreements were reconciled through further discussion. Quantized differences in responses across ethnic groups were then subjected to χ^2 analysis.

Results

Sample Characteristics

Participants were males (20%) and females (80%) from 4 ethnic groups: African American ($n = 26$), Afro-Caribbean ($n = 31$), European American ($n = 29$), and Hispanic American ($n = 33$). For this study, the African American ethnic group was defined as individuals born in the United States, who traced their ancestry to Africa, and who self-identified as black or African American. European Americans were also individuals born in the United States, who self-identified as European American or Anglo. Hispanic Americans were individuals residing in the United States, who traced their family back to one of the Spanish-speaking countries and self-identified as Hispanic or Latino. The Afro-Caribbean group was defined as individuals residing in the United States, who self-identified as Black or African American, and who traced their ancestry to the Caribbean.

The mean age was 68.81 ($SD = 11.49$), mean education was 12.15 years ($SD = 4.75$), and mean Mini-Mental State Exam (MMSE) score²¹ was 26.15 ($SD = 3.76$). Almost half the participants were married (48%) and most were living in single-family homes (92%). There were no differences between groups in age or MMSE scores. However, the Hispanic American group had significantly less education than the other groups (see Table 1). African Americans were more likely to be female ($\chi^2[3, N = 119] = 11.61, P > .0089$), and divorced or separated (46% vs 5% [European American], 13% [Afro-Caribbean], and 21% [Hispanic American]; [$\chi^2(12, N = 119) = 24.43, P = .0033$]). Most Hispanic and Afro-Caribbean participants were born outside of the United States (see Table 1).

We analyzed the first interview question regarding how participants learned about screening and found that in all 4 groups, participants came from at least 4 different recruitment sources including word-of-mouth, health fairs, ongoing senior groups, churches, flyers, and other media. There were 2 noteworthy differences among groups. As compared to Hispanic American and European American participants, more African American and Afro-Caribbean participants were recruited from churches (6%, [2 of 33], 0% [0], 37% [10 of 26], 24% [8 of 33]) respectively ($\chi^2[3, N = 119] = 19.09, P = .003$). More Hispanic Americans were recruited by word-of-mouth (36% [12 of 33]) when compared to African American, Afro-Caribbean,

Table 1. Characteristics by Ethnic Group

Characteristic	Ethnic group	Mean (SD)
Age	African American	66 (13.78)
	Afro-Caribbean	66.74 (9.89)
	European American	73.36 (11.77)
	Hispanic American	69.09 (11.16)
MMSE	African American	27.26 (2.83)
	Afro-Caribbean	25.45 (3.80)
	European American	27.10 (2.94)
	Hispanic American	25.33 (4.50)
Education in years ^a	African American	14.15 (3.80)
	Afro-Caribbean	11.32 (4.79)
	European American	13.57 (3.18)
	Hispanic American	10.03 (5.71)

MMSE = Mini-Mental State Exam

^a $F(3, 105) 4.76, P = .0037$.

and European American participants (4% [1/26], 13% [4/31], 11% [3/29]; ($\chi^2[3, N = 119] = 11.29, P = .01$).

Willingness to be Screened

More Hispanic Americans (85% [29 of 33]) came to the screening purposefully rather than by chance when compared to African American (58% [15/26], Afro-Caribbean 58% [18 of 31] and European American participants 46% [13 of 29]; ($\chi^2[6, N = 119] = 13.69, P = .03$). This may have been the result of more Hispanic Americans being recruited by personal contacts.

Most participants volunteered to be screened because they wanted to know more about their memory status and were concerned about the possibility of memory loss. Eighty-nine percent ($n = 105$) of the participants stated that they valued the screening and 92% ($n = 109$) would recommend screening to others. Some participants implied a sense of perceived susceptibility to impairment in their responses. One woman said "So many people are confused. My sister is very depressed with memory impairment." Another remarked "there are so many cases of Alzheimer's disease these days." Participants were willing to be screened to "take care of" themselves, "detect early problems," or because they or others were concerned about their memory. One participant stated "I don't want to forget my children" and another told interviewers "I'm over 50 with no children. I need to know how to be prepared." Only 4% ($n = 5$) indicated that they did not value screening at all. One participant said this was because "Generally people are self-aware and know." All who disagreed ($n = 3$) that others should be screened were European Americans.

Most participants (65%, $n = 77$) agreed to be screened because they or family members were concerned about participants' memory. One participant said that he wanted to "catch it before it's too late." Another said "I think I have it (AD)." Other participants (29%, $n = 34$) simply decided to take advantage of the opportunity to be screened. These participants were

not worried about their memory nor did they expect abnormal results. Statements such as “Everybody likes to know” and “It will give me peace of mind knowing” illustrated this intent. The remainder (6%, $n = 7$) of the sample provided no clear reason for participating in screening.

Significantly, more African Americans (73%, 19 of 26) and European Americans (86%, 24 of 29) were concerned about their memory or worried that they may have a problem ($\chi^2[6, N = 119] = 14.04, P = .0292$) than were the Afro-Caribbean (48%, 15 of 31) or Hispanic American (54%, 18 of 33) respondents. One African American participant remarked “I have had concerns about my memory ... Both my parents have Alzheimer's disease.” A European American participant said “My wife wanted me to come because I forget things sometimes.”

Intention to Pursue Follow-Up Diagnostic Evaluation

When asked what they would do if they screened positive for memory problems, 39% (46 of 119) replied that they would seek professional help following positive screening. Some statements indicated that they planned to find ways to slow the decline associated with memory loss, “correct” the problem or make plans to manage life with a memory deficit. Some respondents said they would not seek help (7%, 8 of 119), did not know what they would do (5%, 6 of 119), or planned to delay seeking help and preferred to use the information as a baseline for future evaluations or just for their own knowledge (2%, 2 of 119). More Hispanic Americans (70%, 23 of 33) planned to seek help than did European Americans (35%, 10 of 29), African Americans (31%, 8 of 26), or Afro-Caribbeans (16%, 5 of 31; $\chi^2[9, N = 119] = 30.80, P = .0003$).

Certainty About Responding to Screening Results

Answers to the question “If, after screening, you are told that you might have a memory problem, what do you think you will do about it?” were also coded according to certainty of plans within each ethnic group.

Most of the participants (82%, 97 of 119) were certain about their course of action if the screening results were positive. Their responses were “find out more,” seek professional help,” “see a doctor or specialist,” “get medications,” “do whatever is necessary,” “talk to my family,” “try to correct it,” “use complementary treatments,” or “do nothing, nothing can be done.”

European Americans. Fewer European Americans were certain about what they would do than members of the other 3 groups. Out of 29, 17 European Americans (59%) were certain about what action they would take if their screening results were positive. Two planned to find out more (“I’ll find out anything I can”), another 9 planned to seek professional help or to “do whatever is necessary.” Only 4 mentioned trying to “correct” the problem and 1 stated that he would “talk to family.” Another mentioned using a complementary treatment (“drink more Mon Avie”).

African Americans. Most African American participants (88%, 23 of 26) were certain about what they would do, 67% stated that they would seek professional help or do whatever was needed. One respondent said, “I would . . . consult my primary physician for additional tests.” Five (19%, 5 of 26) would seek more information. For example, 1 respondent remarked, “I would like to go into it and find out what can be done about it.” Talking to family about the problem was mentioned by only 1 respondent. Only 1 person was uncertain of what he would do and stated he would “see about improvement.”

Afro-Caribbeans. Most Afro-Caribbean participants (87%, 27 of 31) were also certain about what they would do. Sixty-four percent said they intended to seek professional help. Four (13%) planned to find additional information and 3 (10%) were planning to try to correct the problem. One mentioned using a complementary treatment method. Some expressed unrealistic expectations such as “I will find a way to correct it,” “look to repair it” suggesting they were uninformed about the limitations of current treatment” while others were more realistic: “(I would) . . . seek care and do things to keep my mind active for as long as possible.”

Hispanic Americans. Even more Hispanic Americans (94%, 31 of 33) were certain about what they would do. Twenty out of 31 (65%) stated they would seek help from a professional. Four of 31 (13%) stated they would seek help but did not specify from whom. Two (6.4%) stated they were certain they would do “nothing.” Two (6.4%) would not seek help because they were certain that they did not have a problem. Another (3.2%) would seek help from family. Two (6.4%) stated they would “correct” the problem. Hispanic Americans were also the most optimistic about the outcomes (99%, 32 of 33) compared with 45% (13 of 29) of the European Americans, 50% of the African Americans (13 of 26) and 65% (17 of 26) of the Afro-Caribbeans. These differences only approached significance [$\chi^2(6, N = 119) = 12.03, P = .0613$].

Complementary and Alternative Treatment

Only a few (6%, 7 of 119) preferred complementary approaches rather than traditional professional help (eg, “I would get vitamins or food to help the memory,” “I would try the nutritionist first,” “I don’t think today’s medications do anything. They’re not advanced. Maybe some herbs,” and “Drink more Mon Avie”).

Concerns About the Future

Concern about safety should a memory problem develop was a commonly expressed theme. Some participants wanted to know their cognitive status so that they could inform their family members. “Safety with medications” and “safety of others” were mentioned as important considerations. One respondent stated, “It is dangerous, especially driving with memory problems.”

Discussion

The results of the study were limited by several factors including a modest sample size and an unbalanced distribution of gender and level of education across ethnic groups. An additional limitation is that we only interviewed people willing to be screened and therefore we could not address why some adults chose not to be screened.

Willingness to be Screened

Although the study was not designed to address causation, we were able to report stated reasons that participants were willing to be screened. Most of our participants (65%, $n = 77$) came to the screening because of concern about their memory rather than as a routine health check. These findings were consistent with the Health Belief Model²² that postulates that individuals will take action if they perceive themselves to be at risk for a health condition. The Health Belief Model has been used by other researchers to explain and predict such health-related behaviors as willingness to be screened and intentions to access health care.²² According to the theory, an individual will act based on perceived susceptibility to a health threat, perceived severity, perceived benefits, and perceived barriers to action. Knowledge about the condition will affect perceived susceptibility and social factors such as stigma may increase perceived barriers to action. Our participants who had perceived vulnerability combined with a convenient opportunity for screening were interested in being screened.

Our findings were also consistent with Werner's⁷ results in which participants were most receptive to cognitive screening when they believed there was a family history of AD and Werner and Heinik's⁸ results that first degree relatives of individuals with AD had at least moderate intentions to seek screening. In both cases, information about personal susceptibility may have generated concern that led to a desire for screening.

Interestingly, Werner and Heinik⁸ found that caregivers of patients with AD-related behavior problems had low screening intentions. Personal experience with a relative who had AD would seem to increase personal vulnerability and according to the Health Belief Model, should influence those participants to accept screening. Experiences with relatives' behavior problems could have been a deterrent by further increasing the threat. Mild anxiety related to vulnerability may promote action (willingness to be screened) but severe anxiety may be a deterrent. This should be investigated in future studies.

Pursuing Follow-Up Evaluation

Only 39% (46 of 119) of our culturally diverse respondents intended to seek follow-up if they screened positive for memory problems. Our results were consistent with the findings from 2 other studies in which less than 50% of adults who screened positive would be willing to undergo a follow-up evaluation. In the study by Demirovic and associates,⁹ 42% (130 of 310) sought a clinical examination following positive

screening and in Boustani and associates,¹⁰ 204 of 434 (47%) agreed to a diagnostic interview. The reasons for such low percentages seems to be a combination of lack of perceived vulnerability and in some cases a sense of futility about treatment. Our participants did not mention fear of harm from screening but those who did not elect to be screened (not included in our sample) may have had those concerns.

Most participants in our study were certain about what actions they would take following positive screening. As a group, European Americans were the least certain of the 4 groups although the difference was not significant. When compared to other groups, fewer European Americans planned to seek professional help. Because European Americans are less likely to face barriers to accessing care and are more likely to trust the health care system than individuals from minority groups, we expected that they would be more certain about seeking professional care and more likely to pursue follow-up. Surprisingly, more Hispanic Americans were certain about what they would do and a greater number planned to seek professional help than those in the other 3 ethnic groups. Hispanic Americans also had a more optimistic outlook regarding the potential for successful treatment (perceived benefits) than participants from the other groups. Their positive expectations about treatment could have influenced their intentions to seek follow-up care. Historically, Hispanic Americans have faced language barriers and discrimination when they have interacted with the health care system. Perhaps less access to health information including the shortcomings of available treatments resulted in less skepticism. Future research is needed to better understand these differences.

In light of the higher risk for cognitive impairment in ethnic minority elders,¹¹ we need to better understand cultural differences in knowledge, values, and intentions toward memory screening and diagnostic testing that may affect help-seeking behavior in diverse populations at risk for AD. In our study, African Americans and European Americans were more concerned about their memory than Afro-Caribbeans and Hispanic Americans. The concern among African Americans was also noted by Dale and associates³ in 2006. In their study, African Americans were more willing to be screened and treated than whites. Knowing someone with cognitive impairment may increase perceived susceptibility and willingness to be screened. Further study is needed to identify whether concern leads to greater likelihood of taking action regarding follow-up diagnostic evaluation and treatment.

Clinical and Policy Implications

If perceived susceptibility is important in explaining willingness to be screened and evaluated, then resources would be allocated to educating the public about AD, the high prevalence of AD among minorities and the potential for emerging treatments that either slow decline or lessen the impact of the disease on quality of life. If perceived barriers are of greater importance, emphasis could be placed on education about available resources. In either case, education and a cautiously

optimistic message about the treatment options available and the benefits of screening are needed.

Targeting African Americans and Hispanic Americans for screening is warranted because of their higher risk for cognitive impairment. If further study produces similar findings, we could expect that screening would be at least as acceptable to minority populations as majority group members. The problem remains that for about half of all adults studied regardless of ethnic group membership, cognitive screening and follow-up were declined. Strategies to increase the number of adults screened and evaluated should include making screenings convenient and accessible and public education about the risks and available treatments. Should more reliable treatments be developed, the early identification of cognitive impairment has the potential to result in significant cost savings to the health care system and reduced suffering for millions of future older adults and their caregivers.

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