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Strategies for Research Recruitment and Retention of Older Adults of Racial and Ethnic Minorities

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Abstract

The numbers of Hispanic and African American older adults in the United States are expected to increase by 86% and more than 31%, respectively. African American and Hispanic American individuals are more likely than Caucasian individuals to have chronic health conditions, and researchers have argued that these health disparities may contribute to their higher rates of dementia-related illnesses. The current article explores strategies to improve participation in cognitive aging research by older adults, particularly minority older adults. The cultural aspects of cognitive aging are examined, especially the role of stigma and stereotype threat. The perceptions of cognitive aging of African American and Hispanic older adults are also described. Specific strategies are presented that have been successfully implemented to improve recruitment and retention in research targeting minority older adults. Strategies that yielded retention of minority older adults included advertising and marketing a randomized clinical trial, media relations, intervention tailoring, and adaptation of psychometric instruments.

In the United States, the numbers of Hispanic American and African American individuals 65 and older are expected to increase sharply between the years 2012 and 2050. In 2050, Hispanic older adults are expected to account for 20% of the population, up from 7% in 2010, whereas African American older adults are projected at 12%, up from 9% in 2010 (Vincent & Velkoff, 2010). Despite changes in the U.S. population, racial and ethnic minorities remain underrepresented in research.

Twenty years of research have produced insights into recruiting and retaining older adults from diverse ethnic and racial backgrounds in research (Ballard, Nash, Raiford, & Harrell, 1993; McDougall, Holston, & Wilke, 2001). However, the issues for minorities have not diminished, and several systematic reviews have documented reasons (Auster & Janda, 2009; Provencher, Mortenson, Tanquay-Garneau, Belanger, & Dagenais, 2014; Rabinowitz & Gallagher-Thompson, 2010). These issues include the lack of perceived benefit, distrust

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of research staff, poor health and mobility problems, and other barriers to frail older adults' participation.

Racial and ethnic older adults, women, and individuals with chronic and disabling conditions are particularly vulnerable for cognitive impairment (Hebert, Scherr, Bienias, Bennett, & Evans, 2003; Weintraub et al., 2000). Recently, the National Alzheimer's Project Act developed a National Plan to address Alzheimer's disease (access <http://aspe.hhs.gov/daltcp/napa/NatlPlan2013.shtml>) with aims to increase enrollment and retention of ethnically diverse older adults in cognitive aging research, to inform clinical practice, and reduce health disparities. Yet, the plan, as noted by Sood and Stahl (2011), recognizes that enrollment of racial and ethnic older adults from marginalized communities in Alzheimer's disease research remains a difficult challenge. The current article evaluates barriers to participation in cognitive aging research by minority older adults and describes strategies for recruiting and retaining them in this research.

THE IMPACT OF CULTURE

Understanding the impact of culture and social class on research participation is a useful paradigm for exploring issues of recruitment and retention in cognitive aging research. Ethnicity, race, and culture are important considerations in cognitive aging and how cognitive changes are perceived by various ethnic and racial groups. In one study, a positive correlation between memory performance and socioeconomic status (SES) was observed, although evidence was not sufficient to show that SES was differentially related to memory performance (Herrmann & Guadagno, 1997). The prevalence of negative aging stereotypes in American culture and the patronizing treatment of older adults in accordance with these stereotypes create circumstances conducive to stereotype threat (Hess, 2005).

Stereotype threat refers to the discomfort individuals experience when confronted by a negative stereotype in a situation where their behavior could be construed as confirming the stereotype (Steele & Aronson, 1995). A variety of cultural stereotypes attribute dispositional

deficits to certain groups (e.g., “Black people aren’t intelligent,” “Women can’t do math,” “Older adults have poor memories”), and group members are as aware of the stereotypes as anyone in the culture whether or not they agree with them. In situations where a devaluing stereotype is relevant (e.g., a memory activity), individuals targeted by the stereotype (e.g., older adults) experience an extra mental burden stemming from concern that poor performance will reinforce the stereotype.

Once initiated, stereotype threat produces a number of disruptive effects, including decreases in executive functioning and increases in physiological arousal (Aronson & Mc-Glone, 2009). Over time, stereotype threat may prompt defensive adaptations, such as disengagement from activities in which the stereotype is relevant (e.g., memory-intensive games, such as bridge) and thus diminish proficiency in these activities (Wheeler & Petty, 2001). Another long-term consequence is *stigma consciousness*, in which self-relevant stereotypes become chronic and render an individual highly susceptible to stereotype threat across contexts (Pinel, 2002). Thus, the phenomenon can result in a self-fulfilling prophecy whereby individuals come to resemble the very stereotype they feared. In recent years, numerous studies have documented decrements in the memory performance of older adults when cues in the testing made negative aging stereotypes salient (Hess, Auman, Colcombe, & Rahhal, 2003; Levy, 2003; Rahhal, Colcombe, & Hasher, 2001). These studies also found that performance decrements were reduced or eliminated when threatening cues were muted. The negative effect of aging stereotypes on recall performance was strongest among older adults who most valued their memory ability.

Hispanic Older Adults

In Hispanic culture, a generalized stigma is associated with mental disorders; any afflicted individual is considered to be *crazy* or have *bad blood* (Henderson & Gutierrez-Mayka, 1992). Memory problems and fear of developing Alzheimer’s disease are particularly acute among Hispanic older adults (Taussig & Trejo, 1992). Alzheimer’s disease symptoms occur in older Latino individuals a mean 6.8 years earlier than among Anglo individuals (Clark et al., 2005). One study found that 89 Mexican American older adults seen in a memory evaluation clinic had not only greater than expected moderate and severe memory impairment, but high levels of impairment in instrumental activities of daily living (83%); in addition, 63% had high levels of depressive symptoms (Espino et al., 2002). Older Mexican-origin cohorts also have low levels of education, a risk factor for Alzheimer’s disease (Nguyen, Black, Ray, Espino, & Markides, 2002).

The Duke Established Populations for Epidemiological Studies of the Elderly (EPESE) found that Mexican American individuals were 2.2 times more likely than European American individuals to have Mini-Mental State Exam (MMSE; Folstein, Folstein, & McHugh, 1975) scores <24, indicating cognitive impairment (Espino, Lichtenstein, Palmer, & Hazuda, 2001). In the Hispanic EPESE study, only 35.6% of the Mexican American older adult sample passed both the MMSE and executive clock-drawing task (Black et al., 1999; Royall, Espino, Polk, Palmer, & Markides, 2004). In a Sacramento Valley epidemiological study of Latino older adults, dementia prevalence was 4.8%, but reached 31% in those 85

and older (Haan et al., 2003). Among participants whose family informants reported no memory loss, 75% were diagnosed with dementia or cognitive impairment.

Hispanic older adults' memory complaints may be misclassified by the MMSE as cognitive impairment or dementia if other sociodemographic and medical conditions (e.g., diabetes) are ignored (Mulgrew et al., 1999; Nguyen et al., 2002; Wu et al., 2003). The prevalence of type 2 diabetes is high in Hispanic individuals. However, whether Hispanic individuals with diabetes are at an increased risk for cognitive impairment is unclear (Lindeman et al., 2001). Few cognitive aging studies have assessed the overall health and physical functioning in these older adults (Kuo et al., 2005; Vahia et al., 2010; Zimmerman, Mast, Miles, & Markides, 2009).

African American Older Adults

Cognitive impairment was significantly more severe when Alzheimer's disease was recognized in African American older adults than in Caucasian older adults when using traditional testing, specifically the MMSE and Blessed Dementia Rating Scale (Shadlen, Larson, Gibbons, Mc-Cormick, & Teri, 1999). Education has particular relevance for African American and Hispanic older adults, who often have less formal education than their White counterparts and are particularly afraid of cognitive or mental disorders (Bazargan & Barbre, 1992, 1994; Gallagher-Thompson et al., 1997; Taussig & Trejo, 1992). Marenberg (2004), who compared African American and European American adults older than 60 on a battery of tests designed to evaluate memory and other mental functions, found that when controlling for age and education, 35% of African American older adults scored low enough to warrant a diagnosis of mild cognitive impairment (MCI), compared to only 15% of European American older adults. However, when the researchers applied racially sensitive scoring methods, the difference in MCI rates disappeared—17% of European American older adults and only 12% of African American older adults met MCI criteria. In a sample of community-dwelling older adults, age and race were significant predictors of memory performance, even accounting for education, depression, gender, and memory complaints (Mc-Dougall, Vaughan, Acee, & Becker, 2007).

BENEFITS OF AND BARRIERS TO RESEARCH PARTICIPATION

Numerous reasons exist for participating in research, including the need for new knowledge, development of treatments for age-related ailments through exploration of innovative technologies, and altruism, or giving back to the country. Altruism is often cited by older adults who wish to improve the health of others, contribute to science, obtain the best medical care, and improve their own health (93% to 96% [$n = 3,511$] (Mattson, Curb, & McArdle, 1985). Others identify personal benefits, such as medical monitoring and securing a second opinion (44%), personal awareness and reassurance (38%), physical improvement (22%), free services (11%), and interactions with concerned individuals (8%) (Mattson et al., 1985). Others participate in research to pass improvements on to grandchildren and all future generations and to share their wisdom.

However, researchers face both community- and individual-level barriers to engaging ethnic minority aging participants and community organizations and/or service providers in

community-based studies or clinical trials. In communities of color, individual- and community-level barriers include fear and mistrust, economic and time constraints, cultural stigma, study demands, culturally inappropriate assessment measures, and lack of social presence in the communities (Corbie-Smith, Thomas, Williams, & Moody-Ayers, 1999; Curry & Jackson, 2003; Gauthier & Clark, 1999; Jones & Jablonski, 2014). Many racial and ethnic minority communities, especially marginalized communities of color, view academic institutions and governmental research agencies as suspicious and self-serving. The current study authors are aware that as professors from an academic institution, their position places them as “outsiders” of minority cultural communities, requiring intentional efforts to overcome these barriers.

STRATEGIES TO OVERCOME BARRIERS IN RECRUITMENT AND RETENTION

Using a previous study as an example, the authors of the current study present strategies that yielded recruitment and retention of minority older adults.

The SeniorWISE (Wisdom is Simply Exploration): Improving Everyday Memory in At-Risk Elderly (R01 AG15384; G. McDougall, principal investigator) 2001–2006 was the first memory clinical trial to include a tri-ethnic sample of Hispanic, African American, and Caucasian community-dwelling adults older than 65. This federally funded, 5-year longitudinal study tested the effects of a memory training intervention on memory self-efficacy, metamemory, anxiety, depression, and memory performance. Participants were randomly assigned to two groups: (a) an intervention group that received a self-efficacy based memory intervention designed to maintain or improve memory performance, and (b) a comparison group that received structured lectures on health improvements. The classes consisted of 90-minute lectures that included questions, discussions, and a brief questioning on the subject matter. Three months after the classes, four booster sessions were held to refresh participants’ memories and reinforce learning from the curriculum. Over a 26-month time period, participants were required to complete classes and testing five times for executive function, functional ability, and memory performance, and were interviewed for subjective assessments of anxiety, depression, memory self-efficacy, and health. Participants were paid a total of \$180 over the course of the study.

The target enrollment reflected the local demographics of an urban community in central Texas, which was majority White (52.9%), followed by Hispanic (30.5%) and African American (9.8%) (Austin-Wells, McDougall, & Becker, 2006). Among the 265 participants, African American and Hispanic older adults represented 11% and 17% of the sample, respectively. In the overall sample, the average age was 75 years, and the majority of participants were female (77%). The average score on the MMSE was 26 (i.e., normal cognitive function) in both groups. Completed longitudinal data were available on 205 individuals; the 26-month retention rate was 80%.

Fear and Mistrust

Researchers established relationships with health care providers or gatekeepers in the community, who assisted in building credibility and trust among research participants (Levkoff & Sanchez, 2003). Recruitment was conducted primarily through advertisements and senior centers; the memory-training component was implemented in community-based settings, including senior centers and apartment complexes for low-income older adults. Participants were recruited from two senior centers; one was predominantly African American and another attracted primarily Hispanic older adults. In both centers, researchers depended on cultural gatekeepers to assist with recruitment. Initially, few African American older adults participated in the study; the credibility of the project was then established through an African American community liaison who assisted with recruitment. In addition, the first classes scheduled at the predominantly African American senior center included individuals who were not members of that center, but found it the most convenient location. As staff members and classes became a part of the center, members expressed more interest, and the researchers began to receive inquiries about the project. At this point in the recruitment phase, it became clear that the study was perceived as positive and the researchers were successful in recruiting additional participants from the center.

Based on lessons learned at the African American senior center, the researchers enlisted the director of the Hispanic senior center to help, and she was instrumental in recruiting members and teaching the researchers methods for overcoming mistrust. The director reduced participants' initial mistrust of the research team through assurances about the project and helped with recruitment through identification of individuals who would benefit from participation. Finally, to reinforce the presence in the community and forge a stronger sense of trust with this population, members of the research team visited senior centers frequently, joined in several celebrations, and played Spanish Bingo with the members (Austin-Wells et al., 2006). Social engagement with senior center members increased the research team's presence in the center, and gradually members increased their levels of trust, welcomed the researchers, and responded well to the project.

Economic and Time Constraints

Previous longitudinal, community-based studies in minority and economically marginalized communities found that high economic and time constraints were two barriers difficult to address (Ejiogu et al., 2011). In the Hispanic senior center, the director emphasized that the researchers needed to inform participants about the monetary incentive being offered to participants and to clarify just what monies would be paid to participants at each stage of the investigation. The director recognized that her community members faced economic hardships and monetary remuneration for their time was a motivating factor. In addition, as the researchers began recruitment for the study, they realized it would be more effective if recruitment took place immediately before scheduling classes. Interest was high at that point, and participants could have input into the times when classes were held. Many participants had active lives, and it was necessary to consider their other activities when scheduling classes. Therefore, classes and tests were scheduled at times that were convenient for participants. Flexibility in scheduling improved enrollment and retention rates.

Cultural Stigma of Dementia

In Hispanic culture, individuals with minimal education about dementia may associate a generalized stigma with this disease and view any afflicted individual as having the *evil eye* (Gallagher-Thompson, Talamantes, Ramirez, & Valverde, 1996). Thus, they may avoid involvement with research or diagnostic assessments. In African American communities, cultural values and beliefs influence how dementia-related diseases are perceived and treated by family members; thus, individuals may prevent or delay seeking treatment (Dilworth-Anderson & Gibson, 2002). To address cultural issues and stigma associated with dementia-related research, the researchers worked closely with their community partners.

Media and advertisements from city-run senior centers, churches, health fairs, and festivals were most successful in facilitating recruitment when the research team moved to a new senior center. From the outset, a strengths-based perspective was embedded into media advertisements by avoiding language that some groups might view as stigmatizing. For example, the words “memory training” were used and the SeniorWISE study was described as a program to learn successful strategies for aging well (McDougall, Becker, Acee, et al., 2010). It was noted that the study represented the culmination of 10 years of research on factors that enhance or detract from older adults’ use of memory skills. It was also emphasized that individuals’ positive or negative perceptions of their memory skills strongly influence how well they can use these skills. Finally, evidence from previous studies was used, including the finding that the more confidence individuals have in their memory, the better they perform on everyday memory tasks (McGougall, 1994; McDougall & Kang, 2003).

Media advertisement served as another investment in the community and kept participants and community members informed about participation in the clinical trial. Community agencies and participants were informed about potential benefits of involvement in the trial, and the advertisements further established the researchers’ credibility in the community.

Use of Culturally Appropriate Strategies

Developing Culturally Appropriate Health Topics.—Before launching the study, three focus groups were conducted in the community to determine interest in different types of health topics for the comparison group (Austin-Wells et al., 2006). As the study progressed, additional health topics were added and lectures built around them, as more topics appeared in the news and participants expressed interest in more subjects. Ultimately, lectures were developed on 18 topics covering a wide range of health concerns related to successful aging (Austin-Wells et al., 2006). Each topic was covered completely in one class session, except for alternative medicine, which occupied two class sessions. Complementary and alternative medicine was the first topic offered because of its interest to a wide assortment of individuals and the media coverage of scientific trials, which seemed to appear in newspapers daily. Participants chose all other topics from a list of prepared lectures. The topics chosen most often were *exercise*, *weight management*, *spirituality*, and *health*. Each health class participant received numerous handouts and requested additional materials to share with family and friends (Mc-Dougall & Becker, 2010).

From the focus groups, the researchers learned about hearing and visual deficits of older adult participants and the best approach for overcoming these barriers. Participants with both visual and hearing deficits preferred PowerPoint® presentations with large graphics, fewer words, and animation (Austin-Wells, Zimmerman, & McDougall, 2003). Participants with hearing problems explained that they could more easily discern the meaning if they could see it as well as hear it.

Reducing Participants' Test Anxiety.—After the first testing session, the researchers realized that the testing situation caused anxiety among participants, particularly among the less educated, who were unaccustomed to tests. It was explained that these tests were assessments and/or interviews, not a pass-or-fail examination. This strategy had limited success; however, anxiety was found to decrease when the sessions were referred to as “interviews” rather than “tests.” Because the testing sessions were lengthy, two separate sessions were offered to reduce fatigue. In addition, the testers spent a considerable amount of time establishing rapport with participants, chatting with them about their lives in the period preceding the testing.

Finally, research assistants sat with participants as they completed the written self-report portions of the battery. Client anxiety was reduced when the research assistants offered to help interpret and read the questions to participants. Many participants did not read well, did not read English well, or had vision problems. Research assistants explained, “Some people prefer to do this part themselves and others prefer for us to read it. Which do you prefer?” This reduced embarrassment on the part of the participants. It was also explained that some questions were confusing, and the administrator was there to help.

Culturally Tailoring Cognitive Instruments and Performance Testing.—Initially, the original version of the Memory Self Efficacy Questionnaire (MSEQ; Berry, West, & Dennehey, 1989) was administered. The MSEQ is a Guttman scale that consists of 50 questions, 5 questions each for 10 everyday tasks: (a) everyday objects, (b) text details, (c) shopping list, (d) people's names, (e) main points from a story, (f) digits, (g) line drawings, (h) animal names, (i) phone numbers, and (j) objects. Hispanic and African American older adults were observed to have difficulty comprehending and completing the 50-item MSEQ. Therefore, the scale was reduced to 35 questions, with approval from the developer, Dr. Robin West. The revised MSEQ was more efficient and user-friendly, without loss of reliability and validity. In a study with African American community-dwelling older adults using the 50-item MSEQ, McDougall (2004) found the coefficient of reproducibility to be $r = 0.96$. Across the longitudinal study at each of the five testings, Cronbach's alphas were in the range of 0.94 to 0.96.

Adapting Performance Testing.—Adaptations were necessary in the performance tests. The researchers wanted to shorten the Direct Assessment of Functional Status (DAFS; Loewenstein et al., 1989, 1992) for the purpose of more efficiently assessing participants who were less impaired than the population of individuals with dementia for which the DAFS was originally designed. To do this, items were evaluated for their empirical ability to discriminate among less impaired individuals (i.e., individuals in the SeniorWISE sample). A strong consideration was whether an item exhibited little ability to differentiate among

members of the sample; therefore, it was important to include even if its administration and scoring was a trivial matter. This particular version of a shortened DAFS considered these factors. A thorough explanation of this process has been published previously (McDougall, Becker, Vaughan, Acee, & Delville, 2010).

The performance-based functional ability measure required participants to identify road signs. Many participants no longer drove, and some never had driven. In these cases, the instructor asked them to imagine riding in a car as a passenger and remember seeing the signs along the road. Most participants correctly identified the more common signs, such as “Stop” or “RR Crossing.” However, sometimes signs denoting “No Left Turn” or “Do Not Enter” proved confusing. An interesting note is that when the “Do Not Enter” sign was identified, the tester would ask what steps the participant would take if he or she suddenly saw this sign while driving. Most would solve the problem by turning around or turning down a different street. However, a number of participants said they would pull off the road and wait until help, such as the police, arrived.

One section of the DAFS asked participants to demonstrate writing a check. Many participants did not handle their own finances, or did not have checking accounts. When this was the case, the tester asked the participant to examine the wording of a check and try to assess what was needed, such as date or amount. No participants refused to complete this section of the assessment.

Maximizing Retention

Additional strategies used to maximize retention were based on establishing rapport with participants during and after the clinical trial and addressing stereotype threat. The lecturer sought to build rapport with participants; rapport among the participants was an unexpected bonus. Every group of participants except one decided to exchange e-mail addresses and phone numbers. One group had several social gatherings during and after the end of classes. In several instances, participants who had not known each other became friends.

It was important to find a way to deliver the lectures and answer questions in language that could be understood by all and was insulting to no one. Many participants had little or no education, and some participants had obtained advanced degrees. The presenter made a special effort to express admiration for those who had not had the advantage of education but had led successful and fulfilling lives. She complimented them on their skills in interacting with individuals with more educational advantages and recognized that the rigor of their lives had served to strengthen them. Those who had felt uncomfortable often lost their reluctance to discuss their lives and joined the group. For example, at the beginning of one class, three women who could not read sat together in a corner. The lecturer addressed the participants' comprehension skills by carefully choosing sentence structure and length, words and details, and by using humor. In addition, examples given during lectures were carefully chosen to use situations familiar to all participants. These all combined to help bridge the gaps among participants. By the third class, the women who could not read were mingling with other participants and conversing with their neighbors.

Birthday cards were sent to all participants, and a monthly newsletter was published and distributed. The birthday cards were positively received, with many individuals sending thank-you notes for the cards. Participants told researchers that they saved the newsletters and filed them away for future reference. In each monthly newsletter, the next group to be taught or tested and approximate times for subsequent meetings were mentioned. Each group that had completed the final testing was also mentioned and thanked for their participation. The newsletter contained a column aimed at the interests of the participants. The importance of grandparenting, role modeling for younger family members, passing on family traditions, and other matters of interest to this age group were addressed.

Building Confidence

The beliefs about cognitive functioning from which individuals derive memory self-efficacy are sometimes at odds with scientific evidence. Despite widely held beliefs among younger and older adults regarding older adults having poorer memory, research indicates that these differences are typically context-specific and frequently attributable to non-physiological factors that can influence older adults' self-efficacy and memory performance (Cavallini et al., 2014; Hess, 2005; McDougall, 2001). The researchers' study was designed to help participants overcome stereotype threat and complete the study; retention efforts were successful.

It should also be mentioned that African American and Hispanic older adults must contend not only with the prospect of confirming aging stereotypes that impugn their memory abilities, but also with ethnic stereotypes that degrade their intellect in general. As a result, older adults in these groups are susceptible to a "double" stereotype threat. Moreover, a lifetime of awareness of ethnic stereotypes and repeated exposure to aging stereotypes make this population high in *stigma consciousness* (i.e., chronic exposure to negative stereotypes renders individuals especially susceptible to stereotype threat). Researchers interested in recruiting minority older adults would be wise to attend to these issues in recruitment and retention.

WEB RESOURCES

Two online resources are available to assist researchers with recruitment and retention in minority populations. The 2014 National Alzheimer's Project Act (updated from 2011) developed a National Plan to address Alzheimer's disease (access <http://aspe.hhs.gov/daltcp/napa/NatlPlan2014.shtml>); one aim was to increase enrollment and retention of ethnically diverse older adults in cognitive aging research to inform clinical practice and reduce health disparities. The plan recognizes that enrollment in Alzheimer's disease research of racial and ethnic older adults from marginalized communities remains a difficult challenge.

The National Institute on Aging has funded seven Resource Centers for Minority Aging Research (RCMAR; access <http://www.nia.nih.gov/research/dbsr/resource-centers-minority-aging-research-rcmar>) across the United States. The RCMAR mission is to decrease health disparities. One aim is to improve recruitment and retention methods used to enlist minority older adults in research studies.

NURSING IMPLICATIONS

The lessons learned in implementing trials in minority communities were summarized and examples of strategies that improve study outcomes were provided. These strategies include advertising and marketing a randomized clinical trial, media relations, intervention tailoring, and adaptation of psycho-metric instruments. These strategies can provide a model for recruiting and retaining older members of minority communities in a broad spectrum of studies.

The phenomenon of culture was emphasized as a theme to add depth of understanding to the recruitment and retention of minority older adults. Depending on the group of older adults recruited, slightly different approaches were used to market the research and/or program. Many individuals from minority communities do not understand the purpose of research and desire more immediate rewards for their effort and time; therefore, an emphasis on the programmatic aspects is important. Focusing on the altruistic dimension, such as sharing wisdom and experiences, is one type of approach or strategy that emphasizes familial bonds. An emphasis on the scientific contribution, such as development of innovative technologies or developing new knowledge, appeals to groups with greater years of education. Finally, the personal benefits to be gained, such as free services and improving health care for future generations, is valuable to all older adults who are grandparents.

CONCLUSION

Memory loss affects a large percentage of the U.S. older adult population. The prevalence of Alzheimer's disease doubles for every 5 years of age interval beyond age 65. A recent report from the National Institute on Aging (2012) illustrates the magnitude of this illness. In 2010, based on official death certificates, Alzheimer's disease was the sixth leading cause of death in the United States. Between 2000 and 2010, deaths from Alzheimer's disease increased 68%, whereas deaths from other major diseases decreased (National Institute on Aging, 2012). Data from the 2011 Behavioral Risk Factor Surveillance System survey determined that 12.7% of respondents older than 60 reported increased confusion or memory loss in the preceding 12 months (Centers for Disease Control and Prevention, 2013). As Baby Boomers age, it is projected that the number of new and existing cases of Alzheimer's disease will escalate (Plassman et al., 2007).

In the United States, groups at high risk for cognitive impairment include racial and ethnic minorities, women, individuals with chronic and disabling conditions, and older adults (Hebert et al., 2003; Light, 1991; Weintraub et al., 2000). The age-specific prevalence of dementia is higher among African American adults than among Caucasian adults—estimated to be from 14% to 100% higher (Katz et al., 2012). The greater prevalence of cognitive impairment among racial and ethnic older adults is attributed, in part, to low educational attainment and poor physical health due to a number of factors, including health disparities (Wessels et al., 2011).

Racial and ethnic minority older adults, inclusive of special populations, face additional vulnerabilities as each group requires innovative recruitment and retention strategies to

address social, cultural, health, regional, literacy, and community level barriers. Dissemination of knowledge about lessons learned in recruitment and retention strategies of vulnerable older adults in mental health and other health-related research are essential for informing clinical practice and reducing health disparities.

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Activity Objective

1. Identify strategies and barriers for the recruitment and retention of older adults of racial and ethnic minorities in cognitive aging research.

A variety of cultural stereotypes attribute dispositional deficits to certain groups...and group members are as aware of the stereotypes as anyone in the culture whether or not they agree with them.

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KEYPOINTS

McDougall, G.J., Jr., Simpson, G., & Friend, M.L. (2015). **Strategies for Research Recruitment and Retention of Older Adults of Racial and Ethnic Minorities.** *Journal of Gerontological Nursing*, 41(5), 14–23.

1. Ethnicity, race, and culture are important considerations in cognitive aging.
2. Reasons to participate in research include the need for new knowledge, treatments for age-related ailments, and giving back to the country.
3. Offering participants choices and being respectful of their busy lives generates trust.
4. Individuals' anxiety seems to decrease when testing sessions are referred to as "interviews" rather than "tests."

African American and Hispanic older adults must contend not only with the prospect of confirming aging stereotypes that impugn their memory abilities, but also with ethnic stereotypes that degrade their intellect in general.

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