




RESEARCH ARTICLE

Older adults' experience of neuropsychological assessments for dementia screening in South India: a qualitative study

[version 1; peer review: awaiting peer review]

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Abstract

Background: In community settings, neuropsychological assessment is the most commonly employed method for early recognition of dementia. However, little is known about the experience and perspectives of older adults when they undertake neuropsychological assessments in low-and middle-income countries (LMICs), including India.

Methods: We conducted semi-structured interviews for 11 individuals (aged between 64 and 88 years) who had undergone cognitive assessment in the CST International (Cognitive Stimulation Therapy-International) study and were free from dementia. The transcripts were analysed manually utilising Interpretative Phenomenological Analysis to develop key themes.

Results: When data were analysed three superordinate themes (experiences related to the process, content and outcomes) each with a set of subordinate themes emerged.

Conclusions: This study highlights the need for a thorough planning of pre-assessment briefing for equipping participants with adequate information related to the neuropsychological assessment: its indication, length of procedure, contents of the test, possible outcomes, medical implications of those outcomes, possible therapeutic options if diagnosed with lower cognitive function. We discuss our findings in relation to extant knowledge and explore

issues clinicians should consider when conducting neuropsychological assessments in LMIC settings.

Keywords

Neuropsychological assessments; qualitative; lived experience; LMIC settings



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Background

Globally, neurocognitive disorders are a major cause of disability and burden in later life. This burden is much higher in lower-and middle-income countries (LMICs) like India when compared to higher income countries (HICs). The National Dementia Report of India¹ and the Dementia Strategy for India² have emphasised the need for a timely and early diagnosis of dementia by conducting culturally appropriate and validated neuropsychological assessments. Unlike many HICs where screening for dementia is perhaps common, such assessments are not routinely administered to community dwelling older adults in either primary or secondary health care services in India¹.

In India, older adults are largely screened for dementia in specialist health services such as memory clinics or when participating in research related to cognitive health. Administering neuropsychological assessment in these settings may support and improve the accuracy of a dementia diagnosis and collate some differential diagnoses. Such assessments may provide valuable insights into both the nature and severity of cognitive problems to assist clinical decisions related to treatment and care³⁻⁶. Active engagement with patients and exploring their experiences should be the cornerstone for accessing care and treatment⁷. Evidence suggests patients and their families living in HICs may experience stress and anxiety prior to cognitive assessment at memory clinics due to uncertainty regarding what would occur post-diagnosis⁸. However, some studies found their overall experiences were more positive than negative and most were satisfied with the dementia diagnostic process⁹⁻¹³. Even older adults with dementia valued their experiences of Neuropsychological assessments in neuropsychology services, with very few reporting lower levels of satisfaction with diagnostic process¹⁴. A small number of studies involving those with Mild Cognitive Impairment (MCI) reported participants experienced mixed positive and negative feelings towards neuropsychological assessments⁹, and a sense of insecurity and discomfort was observed in those who received a clinical diagnosis of dementia, in fact the waiting period from the referral to diagnostic assessment in itself was considered stressful¹⁵.

A systematic review by Watt and Crowe highlights a paucity of research into patient perceptions and experiences of neuropsychological assessments⁶. Moreover, little is known about the experience and perspectives of older adults when they undertake neuropsychological assessments in India. This paper reports a study which aimed to gain insights into the lived experience (opinion about the test, emotional state before, during and after the test) of undergoing neuropsychological assessment among community living older adults. The study reported here was nested within the recruitment phase of an international research programme exploring Cognitive Stimulation Therapy (CST-International) as a treatment for dementia (CST) in Mysore, South India¹⁶.

Methods

Ethical considerations

Ethical approval was obtained from the Ethics Committee at the Foundation for Research and Advocacy in Mental Health (FRAME) Mysore and SCARF Chennai (Letter dated 28/11/17), and the Health Ministry Screening Committee (HMSC) of the Indian Council of Medical Research (ICMR) India (Indo-foreign/67/M/2018-NCD-1).

Study design

Study was conducted as part of three nation (India, Brazil, Tanzania) implementation research project called Cognitive Stimulation Therapy-International¹⁶. Mysore was one of the four centres in India and our team screened for potential participants from a range of community settings like memory clinics, retirement residential communities, assisted living settings or old age homes for recruitment. Persons diagnosed with Dementia were offered CST-International, while those without dementia were recruited for narrative interviews that were conducted between May-June 2020.

Inclusion criteria

Individuals were eligible to participate in the study if they had undergone neuropsychological assessment with culturally adapted Addenbrokes Cognitive Assessment- cognitive subscale (ADASCOG)¹⁷ by one of the trained research assistants in CST International study¹⁶. The ADAS-Cog consists of 11 tasks: word recall, naming objects and fingers, following commands, constructional praxis, ideational praxis, orientation, word recognition, remembering test directions, spoken language, comprehension and word-finding difficulty. The test was administered to screen elderly people living in the community for dementia and recruit them for CST International study. Diagnosis of dementia was determined by further evaluation by a Psychiatrist (BDU/MK). Participants with dementia were informed about CST and other treatments available. Individuals without dementia were approached for narrative interviews until we reached data saturation.

Sample

We used purposive sampling, and fifteen eligible individuals who had undergone dementia screening were approached face to face at their residence and told about the study and invited to participate in the study. We ensured that the participants understood that participation was voluntary and they were given an option to opt in or opt out. Study participants were already engaged by members of the CST-International team. Those potentially eligible for this nested study were contacted and provided with written information (in Kannada) about the objectives and methods of the study including data handling procedures. Participants were contacted after a week and if they were willing, they were recruited after obtaining a separate fully informed written consent form for specifically for participating in this project in addition to consent obtained for CST-International study. They were informed that the data

would be de-identified and personal identifiers would not be disclosed to anyone outside the research team. All outputs from this study would not have any information that would allow for identification of participants. Of the fifteen potential participants who were eligible, we interviewed eleven of them until we reached data saturation level. [Table 1](#) shows participant details.

Data collection

Data were collected via audio recording of face-to-face semi-structured interviews (in Kannada language) that were conducted in private (at participants' residence) without the presence of any other persons. For the interview guide, see [Extended data](#)¹⁸.

Participant interviews, each lasting for around 30–40 minutes followed the semi structured interview guide which aimed to capture and construct meaning from their experience. The interviewer (BDU) was a male psychiatrist (with MD) and research fellow at Foundation for Research and Advocacy in Mental health (FRAMe, Mysuru). He was formally trained and supervised in qualitative research methods by MK and SJ. BDU had an established relationship with participants as part of the ongoing research project at the time and they knew the interviewer's personal goals and reason for conducting this research. The interviewer asked the respondents to describe their lived experience of undergoing the neuropsychological assessment with minimal prompting while making some field notes. No repeat interviews were conducted as part of this study. All interviews were transcribed and translated to English by the interviewer (BDU). All recordings and transcriptions were re-examined by two researchers (MK and MC) for accuracy and any disputes resolved by consensus. Additionally, the transcripts were offered to the participants for

comment or correction. However, there was no felt need by the participants to peruse the transcripts of their interviews.

Qualitative analysis procedure

The transcripts were analysed manually utilising Interpretative Phenomenological Analysis (IPA) to develop key themes. IPA aims to explore how participants make sense of their personal and social world and has social cognition as its central analytic focus¹⁹. The method recognises that people struggle to express what they are thinking and feeling and the researcher often has to interpret people's mental and emotional state from what they say^{20,21}. A two-stage double hermeneutic process was employed: the participant trying to make sense of their world, whilst the researcher tried to make sense of the participant making sense of their own world²². Data coding at the first level was done by BDU, PRS.

IPA was conducted by investigators (BDU, JB, MK and SJ) revisiting the transcripts for accuracy and consistency raising data trustworthiness. MK and SJ have previously adapted the IPA analyses framework for studies from a similar setting²³. A set of subordinate themes emerged through the content analyses of coded data from which three superordinate themes were derived. These superordinate (or key) themes along with our findings were fed back to the participants and feedback received, which allowed for further validation.

Results

We interviewed 11 individuals aged between 64 and 88 years (see [Table 1](#)). All participants had completed at least 10 years of schooling, with 4 having higher education. To maintain anonymity participants were assigned an alphanumeric code.

During the interviews, participants spoke about how they felt before, during and after taking the neuropsychological test, when data was analysed three superordinate themes each with a set of subordinate themes emerged (see [Figure 1](#)). It is important to acknowledge that themes overlap therefore should not be viewed as being mutually exclusive; this is especially relevant to "test content" and "test process", and the opportunities testing presented in terms of evaluating and improving memory ability, reinforcing sense of self and interacting with others.

The following section describes each of the superordinate themes with a sample of quotes from participants' interviews. The full transcripts can be found under [Underlying data](#)¹⁸.

Experience related to outcomes

Given all participants had previously scored well on the test, the test outcome emerged as an important factor in not only reassuring them they did not have dementia, thus indicating cognitive health, but in facilitating participants' sense of self. A sense of achievement from "passing" the test was identified, which was important in bolstering self-esteem and reinforcing a sense of self. The test itself also provided participants

Table 1. Characteristics of the study participants.

Participant	Age	Gender
P1	64	Female
P2	70	Female
P3	68	Female
P4	89	Female
P5	72	Female
P6	64	Female
P7	71	Male
P8	80	Male
P9	81	Male
P10	85	Male
P11	70	Male



Figure 1. Super and sub ordinate themes.

with a metric to use when self-assessing their memory going forward.

Indicator of cognitive health. Most participants identified their performance as indicator of good cognitive health. It may also be that participants felt relief at performing well and demonstrating to themselves and others that they had retained their cognitive abilities. Here a participant talks about “feeling normal”:

“I feel that I answered most of the questions and I feel I am normal.”(P11)

Another participant highlighted that she wanted her family to know she passed the test:

“I am very happy with this test...Because all the test gone through, I came out in flying colours like that (P5)

Participants’ accounts suggested that a positive outcome from the testing was reassurance their cognitive ability was as would be expected.

“Because of the test we know where we are? Whether my memory is ok at this age? That means whether my mind is active, it shows my grasping power, my concentration power” (P5)

“I am feeling good after the test. It has given me more confidence that I am ok at this age” (P5)

A measure for self-evaluation. Participants were of the opinion that the test helped them assess their own performance and get fair ideas of their cognitive ability demonstrating participants had a subjective awareness of their performance and would evaluate their performance by themselves moving forwards:

“I can just gauge myself after your question that how much I can remember”. (P11)

However, the test offered more than simply being able to assess one’s ability, Participant 9 felt the test made him aware of his own capabilities and that he is able to do more than he previously realised:

“...writing letter, pasting stamp on the cover, folding the letter and putting in cover, all these made me happy. Because we go to others and ask them for help to write a letter to friends or relatives. Now we know by ourselves that I can write letter without asking others.”(P9)

It may be that, as well as assessing cognitive ability, the test facilitates individuals recognising their capabilities, which may in turn promote independence and reduced reliance on others.

Impact on sense of self. Many participants considered test performance an extension of self and mirroring their individuality. Indeed, test performance was seen to have both positive and negative impact of sense of self and self-esteem. As an example, Participant 11 spoke directly about both his self-image and interactions with others:

“it reflects my own image, how I can interact with a person if some things are told to me or when I am questioned...it reflects my own image, how mentally strong I am and how much I can remember” (P11)

While test performance was a positive influence for P11, the converse was seen for Participant 6 who felt she had underperformed on the test and failed to answer questions she actually knew:

“I felt I did not answer some known things. Also, now in the exam I did not know some answers actually, I feel myself a dull person.” (P6)

Another participant viewed the test outcome as more than an indication of dementia status and was concerned poor

performance would affect how others viewed him and damage his reputation:

"I was worried about the test. What all would be asked in the test? Till now I have a good name. What if I am caught making some mistake? Will they question me? Any problem will happen with incorrect answers I was worried but in the end it was an easy test."(P10)

Impact on self is a symptom manifesting as dementia progresses. So it is interesting that individuals with no diagnosis of dementia would indicate cognitive testing per se may affect self. This is clearly an unintended consequence of testing but one which should be considered when preparing individuals for such a test. The act of testing and positive or negative score consequences requires careful clinician explanation and clarification.

Experience related to content

Participants were tested using the culturally adapted Addenbrookes Cognitive Assessment- cognitive subscale (ADASCOG)¹⁷. It was reassuring that participants indicated the test content was appropriate and they had not experienced any content related difficulties.

Facilitated reminiscence. Employing test items as cues, some participants recollected cherished memories from distant past which appeared to have translated their experience of the test into a more positive experience. It however did not appear to revoke disturbing memories from earlier lives. P7 remembered his childhood memory of drawing and found this task fascinating:

"...drawing we did when we were young, once again we remembered. Now again I did drawing. That is why those are interesting" (P7)

Another participant recalled a conversation with his grandchildren while taking the test and hence found it engrossing. However, conversely this might have made him miss his grandchildren:

"Felt like I had a conversation with my grandchildren. Loneliness became less, it all helped" (P9)

The letter writing task again proved to be popular with participants, the following participant voiced pleasure at the opportunity to write a letter to his daughter. He also remembered that it had been a very long time since he had written anything and was happy to do it after a long time:

"I felt for a long time I had not written and I was also happy in writing a letter to my daughter, that I am here and I am coming to Bombay" (P11)

Acceptance and Cultural appropriateness. Participants were asked whether there was any part of the test they disliked or found difficult and if they could suggest any changes that could be made. All expressed ease in taking the test and many felt it was quite simple.

"...you cannot make the test further easier. Maps, match box etc are already easy." (P9)

"The way you are conducting the test was extremely good, I didn't find anything that has to be changed or added."(P5)

Given that the participants scored high enough not to meet criteria for diagnosis of dementia, it is unsurprising they found the test easy; however no problems were expressed with the content suggesting acceptability of the assessment by the participants and its cultural appropriateness.

Experience related to process

Means for engagement. Some participants indicated the test provided them an opportunity to interact and spend time with another person (psychologist). Indeed, there was evidence from participants' accounts was that the test helped them to overcome loneliness and they enjoyed the time with the psychologist:

"Overall I am happy with the test, I spent time with her, with those questions, so I am happy. Because some time some people come to my room, the loneliness goes. She came I spent 20- 30 minutes with me. Somebody was there with me, I felt very happy, and I felt good" (P5)

"it makes me happy that I got to interact with a person and I could remember some things well in the test" (P11)

One participant highlighted the quality of the interaction, relating it to meeting with family:

"It helped to pass time. Felt like I had a conversation with my grandchildren. Loneliness became less, it all helped" (P9)

Participants' noting the importance of interacting with the test administrator in terms of alleviating loneliness is another unexpected outcome from the testing. The quality of the interaction was also highlighted, which suggests clinicians should carefully consider who should administer the tests and brief them on the meaning the interaction may have for participants.

Indifferent to challenges. Considering the results of the test may have led to participant being diagnosed with dementia it was interesting that many did not voice any apprehension about taking the test. This response was common regarding not being concerned about the test

"No worry, No anxiety, nothing" (P5)

The following participant expressed trust in the clinicians which appeared to avert anxiety:

Interviewer – "OK before the test you had any worry, tension?"

P9 – “No, not anything like that, these are normal, I did not have any worry or tension about the test before taking it. I knew that you would not show anything that makes me afraid or uncomfortable”.

Rather than expressing fear regarding the test, participants took a pragmatic approach considering it to be just another test and performed with a mind-set that ‘if a test has to be taken then one cannot be emotional about it’. Indeed, there was almost emotional indifference with the neuropsychological test being viewed as simply a diagnostic tool which had to be endured to know more about one’s health, irrespective of whether you like it or not:

“it is nothing to do with likable, pleasant, good. If I have to get my blood test, I have to get it done because I have to see my blood reacting inside my body. If it is something that must be done it has to be done. If you are hungry you must eat food, similarly you must know your body, whether it is bad, unpleasant or good it has to be done. Or should be done” (P2)

This participant also believed that one need not give emotional value to the test, including the outcome:

“no question of liking because I am capable of answering, no question of liking. It must be accepted the test shows my weakness if I am unable to answer. No question of liking. It must be accepted as my fault if I can’t answer.”(P10)

Novelty. Most participants were new to conversational and interactive quality of the neuropsychological assessments. P1 told us that they hadn’t come across such a test and it was a learning experience. This suggests a cultural lack of exposure to neuropsychological assessments and the perception that medical tests include only blood tests and scans:

“We did not know about the test and we came to know about it. It was interesting.” (P1)

The following participant compared neuropsychological assessment with other routine tests e.g. blood sugar, weight, BP, he had undergone and considered the experience pleasant:

“Felt satisfied. Till now nobody did like this, college students and someone else come to do tests, but nobody did like this” (P9)

P10 said he enjoyed the test as it was new to him and he compared it to his experience of first semester of engineering, when he learnt new words and concepts:

“I am enjoying. It’s all new to me. The subject is new. Recollecting those words it’s like my engineering first semester.” (P10)

Moreover, he cherished the letter writing task as it helped him break the monotony of talking to his son over phone and he got a chance to pen his views on paper:

“I am happy on the contrary. I was happy to write a letter to my son. That I appreciate. I always spoke with him on phone. After writing letter to my son I am happy to have made an opportunity to express my views.” (P10)

Benefits of testing. Some participants identified a beneficial role of the testing process and found this an aid to improve their own memory and mental abilities. P3 believed the test could cause improvement in brain health and memory and said he would recommend the beneficial effect of the test to others:

“It’s good. I will tell them there will be brain improvement. Participate in the test and knowledge will improve” (P3)

P9 suggested the test has benefit in practical day to day activities. For example, by helping him remember the date day and year:

“Identifying things like date, day, year. These will help. While writing the cheque I remembered the date. So that helped to remember the date. It’s useful that way” (P9)

Data suggested the experience of the test was positive in terms of content and the testing process. Testing also presented opportunities for participants to identify and practice their cognitive abilities, as well as presenting them with a method of self-assessing cognition in the future. Furthermore, study findings also suggest factors clinicians should consider when preparing individuals for neuropsychological testing and when delivering the test. This includes the value attributed to testing scores and wider conclusions drawn from those scores need careful clinical detailing.

Discussion

To the best of our knowledge this is the first qualitative study in India or any LMIC setting reporting older adults’ experience of diagnostic neuropsychological assessments. Data was captured via one-to-one interviews and three superordinate themes emerged during our analysis; participants’ experience of the content, process and outcomes of the neuropsychological assessment. We discuss our findings in relation to extant knowledge and explore issues clinicians should consider when conducting neuropsychological assessments in LMIC settings.

Overall, participants voiced comfort in the test process and reported an overall positive experience which is consistent with previous literature from HICs²⁴⁻²⁶. Participants appreciated the way the test was conducted and did not experience any discomfort or worry during the test, reporting that the test was quite easy, simple and acceptable. This provides some evidence that the test items in the ADAS COG were educationally and culturally fair, and acceptable to all study participants. This finding supports and extends our findings related to the cultural appropriateness of this test that was adapted by our research group.

Most participants considered neuropsychological assessment as any other physical medical test and remained neutral in their feelings toward the process, considering the assessment as medical investigation to evaluate memory and mental agility in later life. The experience of study participants varied from some considering these ‘procedural’ to others finding the content of the neuropsychological assessments and the process as ‘engaging’ ‘entertaining’ and ‘challenging’. This is in contrast to findings from other studies from HICs where a wide range of emotions like pleasure, frustration, anxiety, nervousness, and confusion were experienced by participants undergoing neuropsychological assessment^{24,26}. This may also be a consequence of limited awareness about dementia and its possible implications on quality of life among our study participants and in general among the aging population in India¹.

Foran *et al.* (2016) and Westervelt *et al.* (2007) suggest the clinician’s respect and listening skills, awareness of individuals’ context and taking time to explain the process and offer feedback are valued by patients^{26,27}. Consistent with this, our participants appreciated the warmth and respectful attitude with which the test was conducted. In our study the assessments not only served diagnostic purpose but were facilitators of reminiscence and allowed active engagement with the research team. Indeed, participant feedback suggested they welcomed the opportunity the assessment presented to engage with another person and the company of the psychologist helped them tackle or identify loneliness. This may be explained by the possible prevalence of a sense of loneliness, boredom and yearning for human interaction among older adults residing in a community living setting away from their families. There was also evidence that some participants recalled their childhood and conversations with their loved ones. It was interesting that no participants recalled any negative events from their past. This necessitates clinicians who administer the tests to be mindful of the potential emotional value and challenges presented to older adults while undergoing these tests for the first time in their lives; this may also be culturally influenced.

Many participants considered the test performance as a self-evaluation tool to assess their memory and wellbeing and appraised their own performance which generated strong emotive feelings and influenced their identity. A good test performance evoked confidence, comfort and gave a relief that their mental ability is good and they are healthy. Krohne *et al.* (2011) found that a confirmation of cognitive deficits resulted in difficult emotions and a negative impact on self-identity²⁸. In our study no participants had a diagnosis of dementia however there was evidence some considered poor test performance as a weakness or fault which could impact self. Unsurprisingly, participants were grateful for confirmation of their retained ability with ageing. Some felt anxious before undergoing testing; however this anxiety was about performing well, protecting from shame and preserving reputation, rather than being diagnosed with dementia or any other potential unwanted outcome. This reinforces the need to be clear regarding the purpose and outcomes of testing. The very word ‘testing’ may also impact on pre-test anxiety levels.

Participants welcomed the team contacting them and providing opportunity for assessment, suggesting that in resource limited settings there is an urgent need for building capacity to conduct such assessments by non-specialists through task shifting to strengthen health systems.

Some participants felt that the test may have beneficial effect on memory and felt that it had the potential to improve their “brain health”. This shows that the pre-test briefing was not adequate regarding the purpose and utility of the test and the cognitive stimulating effect of the test content. This highlights the need for providing greater information clarity related to the purpose, process and possible outcomes of neuropsychological assessment to older adults prior to assessment. This may alleviate anxiety and uncertainty, but could promote effective engagement and optimal performance.

Strengths and limitations

To the best of our knowledge, this is the first attempt to explore the emotional experience of undergoing a neuropsychological test by elderly people from India with a qualitative approach using Interpretative Phenomenological Analysis (IPA). It is an attempt at hearing those voices that are not typically heard. This would help in a better understanding of distinctions and commonalities in thoughts, feelings and perceptions of neuropsychological tests in India compared to other cultures. Two independent researchers verified the transcripts for accuracy and validated the themes developed. Interviews were conducted in the local language. We employed a culturally adapted instrument for neuropsychological assessment that was validated for use in the study setting by our research group. The diagnosis of dementia (as an exclusion criterion) was ascertained by a trained senior psychiatrist.

The study has certain limitations. This study investigated individuals from one city in South India (Mysore) in a non-clinical setting and in those with higher levels of attained education compared to others of similar age in Mysore. Due to these reasons results are not readily generalizable to other community contexts or cultures. Translation is an interpretive act and though the translations were verified by researchers for accuracy, it is still possible that at times meaning may have been lost in the translation process. Study findings should be interpreted in the context of these specific methodological shortcomings. As the participants were only those who did not have dementia, which means they had performed reasonably well in the test, and this may have influenced their perceptions and experience of neuropsychological assessments.

Implications for clinical practice and future research

This study highlights the need for a thorough pre-assessment briefing for equipping participants with adequate information related to the neuropsychological assessment: its indication, length, contents, possible outcomes, medical implications of those outcomes and possible therapeutic options if diagnosed with lower cognitive function. This would help the participant in preparing better for the test. Additionally, exploring any

fears, doubts or prejudices held by the client could be advantageous. It is advisable that psychologists or other health care workers are aware of neuropsychological tests and that it is not considered as just another technical procedure.

We recommend similar studies in the clinical populations to gain additional insights into their experiences of going through cognitive function testing. Future studies could examine the impact knowledge and awareness of dementia, cognitive testing outcomes related to dementia populations, as these may influence an individual's attitude, experience and reaction towards future neuropsychological assessments.

Conclusions

Findings from similar studies in HICs, where older adults were 'fearful' of the possibility of being diagnosed with dementia following a neuropsychological assessment, were not observed in this study²⁴. A possible explanation could be lack of awareness about dementia or Alzheimer's disease among our study participants, and in general among older adults in LMICs. It is possible for such observations among those with a concern about decline in their memory or cognitive abilities, example among those MCI or early dementia that were excluded in this study.

Data availability

Underlying data

Figshare: "**Older adults' experience of neuropsychological assessments for dementia screening in South India: a qualitative study**". DOI [10.6084/m9.figshare.23741541](https://doi.org/10.6084/m9.figshare.23741541)¹⁸

This project contains the following underlying data:

- Interview transcript-final.docx

Extended data

Figshare: "**Older adults' experience of neuropsychological assessments for dementia screening in South India: a qualitative study**". DOI [10.6084/m9.figshare.23741541](https://doi.org/10.6084/m9.figshare.23741541)¹⁸

This project contains the following extended data:

- Interview guide.docx

Data are available under the terms of the [Creative Commons Zero "No rights reserved" data waiver](https://creativecommons.org/licenses/by/4.0/) (CC0 1.0 Public domain dedication).

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