BACKGROUND

• Becoming culturally competent healthcare providers depends on the ability of practitioners to acquire knowledge, awareness, and skills related to other cultures.1,2
• It is essential to consider geopolitical factors that may influence health and health-seeking behaviors.
• As of 2015, there were 47 million immigrants living in the U.S., representing 14.4% of the U.S. population2 (see Fig. 1 and 2).
• In FY 2016, nearly 85,000 refugees were admitted to the U.S., decreasing in FY 2017 to 54,000.4
• Previous research has shown that immigrants in the United States show less trust of healthcare providers and are less likely to seek medical care than their native-born peers.5,6

When care is sought, they likely have to experience significant barriers to effective care, including lack of providers who speak their language and failure of practitioners to integrate cultural beliefs into treatment plans.

The literature has documented that these barriers result in delays obtaining accurate diagnoses and treatment.2

This is complicated by the presence of geopolitical issues: immigration status, war/conflict in the patient’s country of origin, and/or human rights violations.

Awareness of the impact of these life experiences not only has the potential to deepen our understanding of our patients, but results in a more holistic, accurate, and culturally competent conceptualization of their physical and mental health needs.

OBJECTIVE

The current study will use the case of an Urdu-speaking, Pakistani national to illustrate one culturally-competent approach to the assessment of neurobehavioral changes in the context of complex geopolitical circumstances.

CHALLENGES

• There is a lack of culturally appropriate measures and normative data for foreign-born patients, which limits the interpretation of test data.
• Stigma regarding help seeking, particularly for mental health concerns and cognitive disorders.

CASE ILLUSTRATION: URDU SPEAKING PATIENT

• A 63 year old Pakistani female was referred for neuropsychological evaluation due to complaints of changes in her cognition after undergoing surgery in the 1980s with use of chloroform as the anesthetic.
• She was born and raised in Pakistan during a time of instability and spoke Urdu as her native language, though she learned conversational English later in life. She had increased difficulty speaking and understanding English since the 1980’s.
• She has lived in the United States for nearly 20 years.
• She and her family reported longstanding depression with psychotic hospitalization 4-5 times throughout her life. During times of worsening mood, she becomes increasingly paranoid, delusional, and unresponsive.

Further complicating the picture: she is seeking citizenship and would like to be granted exemptions from the English and civics test portion of naturalization, due to cognitive impairment.

She was tested in her native language with the use of an interpreter, in an effort to provide culturally and linguistically appropriate care.

Her testing was consistent with Mild Neurocognitive Disorder and also suggested additional disability due to depression rather than a remote history of chloroform exposure.

Education was provided regarding mental health and its potential impact on cognition and functional status.

This case highlights the need to consider psychosocial factors and geopolitical factors when evaluating patients and making diagnostic and disability determinations.

CONCLUSIONS & FUTURE DIRECTIONS

• People born outside the U.S. make up a sizeable percentage of the U.S. population and clinicians are likely to see them as patients.
• Our current helping styles may not be sufficient and we need to include linguistically and culturally appropriate practices.
• This case example illustrates the need to consider geopolitical factors when evaluating patients in an effort to provide excellent care.
• In the future, training regarding immigration and geopolitical factors should be implemented at the organizational level.

REFERENCES