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Asian Communities of Pakistani Origin

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Asian Communities of Pakistani Origin

Sanam J. Lalani, Farah Hameed, and Louise F. Wheeler

Section I: Background Information

Terminology and Perspective

People from Pakistan are referred to as Pakistanis, Asians/South Asians, Pakistani American/Canadian, etc. People from this region in South Asia (i.e., Afghanistan, Bhutan, Maldives, Nepal, Sri Lanka, India, Bangladesh, and Pakistan) are broadly referred to as “Desi,” meaning from this land. This is a colloquial term used by other South Asians to refer to people of their region when outside of their native land. The first author’s (SJL) preferred terminology for people from Pakistan is Pakistani or, if broadly from the region is South Asian and/or Desi.

I (SJL) am a Pakistani American who came to the United States (US) at age nine years as a bilingual Urdu and English-speaking immigrant. I (SJL) was raised in the American South and trained on the West Coast of the United States, where I am currently a practicing neuropsychologist in a private outpatient setting.

Geography

Pakistan is located in South Asia and borders India to the East, Afghanistan, and Iran to the West, the Arabian Sea to the South, and China to the Northwest. Pakistan is four times the size of the United Kingdom, with a population of over 216.5 million in 2019. It includes the most youth in the world; the majority of the population in Pakistan is under the age of 30. It is the fifth most populated country after China, India, United States, and Indonesia. The capital of Pakistan is Islamabad, with a population of 1 million people.

History

The history of Pakistan begins with the glory of the Muslim kingdom dating back to the 700s. By the 1400s, competition for global dominance and wealth led to colonization and myriad cultures and religions lived peacefully in the Indian subcontinent for centuries. More recently, following the British colonization of India from 1858 to 1947, the minority Muslim population won its independence and separated (known as Partition) itself into a democratic and predominantly Muslim nation of The Islamic Republic of Pakistan on August 14, 1947. Initially, Pakistan consisted of West and East Pakistan, that later became Bangladesh in 1971. The process of Partition displaced 10–12 million people along religious lines, creating a disordered and violent refugee crisis. The history of this traumatic event has led to a complicated and distrusting relationship between

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India and Pakistan. Although the result of the shifting borders has led to many commonalities between the cultures, it is important to note that the religious identity of people from India and Pakistan are generally distinct. In addition, the complex geographical history has also resulted in multiple disputed territories. For example, control of the Jammu and Kashmir region remains under dispute with India occupying Jammu and Pakistan occupying the Kashmir region.

People

I (SJL) was born in Karachi, Pakistan, in the 1980s and raised there for the first nine years of my life. The city of Karachi contains more than 15.7 million people and is projected to be the third-largest city in the world by 2050. Karachi consists of 18 towns (i.e., suburbs) surrounding the city and many diverse boroughs within the city.

I grew up in an intergenerational home in a middle-class borough. Some of my earliest memories are of playing with my neighbors. I can recall the drive to visit our family who lived by the sea and can still remember the striking Spanish tiles decorating the roads along the drive. My cousins and I would run around inside the spacious home and play in the singular air-conditioned room. When playing outside, the smell of jasmine floated through the gardens. We also visited family in the lower socio-economic boroughs; I recall playing on the unpaved roads as motorbikes whizzed past and street vendors and animals meandered about.

In the late 1980s, while under Martial law, I snuck out of the gates of our apartment complex to visit a friend down the street. Although I was young, I knew enough to hide behind parked vehicles and avoid detection by the passing military armored trucks. Suffice it to say, the family of my friend was horrified by the risk I took to visit. Luckily, our community took care of one another, and my parents were notified immediately. It is the diversity, the sense of community, and the feeling of belonging in the face of hardship that I admire most about the Pakistani people.

Immigration and Relocation

The first phase of immigration from Pakistan to the West occurred before Pakistan was independent. This wave of immigration included young men from British India (the province of Punjab) who settled predominantly in California. Following the 1965 US Immigration and Naturalization Act, Pakistani immigrants were highly educated and affluent professionals entering on employment-based visas. Immigration in the 1980s included family sponsorship. In the 1990s, immigration included the US Diversity Program (also known as the “lottery”), a program created to increase immigration from underrepresented minority groups within the United States.

The Diversity Program is notably different from the prior immigration patterns of other cultures that had a financial selection bias in that it allowed Pakistani immigrants without higher education or financial stability to move to the United States. Therefore, exploring each patient’s immigration history may allow for a richer understanding of their current circumstances.

The current make up of Pakistanis in the United States is 2% of the total Asian population (~1 million) and the seventh largest immigrant population. As such, Pakistanis no longer qualify for the Diversity “lottery” Program and it is difficult to achieve residency in the United States. By 2015, 67% of American Pakistanis were foreign born, with varying naturalization and residency statuses, and many (approximately 35%) lived in multigenerational households that predominantly spoke English in the home. While Pakistanis live in all 50 states, areas of concentration exist in the Northeast (New York City; Washington DC), the South including Texas...
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(Houston, Dallas) and Georgia (Atlanta), the Midwest (Chicagoland area), and California on the West Coast.8

There are many reasons for immigration. My family left Pakistan in 1990 in pursuit of sociopolitical safety and financial stability. The presence of a preexisting Pakistani community eased our transition, but it was still a stressful experience. For this reason, assessing a person’s immigration history including the presence of immigration-related trauma, changes in socio-economic status, English language fluency, and level of acculturation to the dominant culture, could help contextualize the patient’s concerns.

Language and Communication

Urdu is the national language of Pakistan and is the primary medium of communication throughout the country. However, only 8% of the local population speaks Urdu as their first language.9 Pakistan is culturally divided into four provinces, each with their own provincial language: Punjabi is spoken in Punjab and is the most widely spoken language in the country, Sindhi is spoken in Sindh, Pashto is spoken in Khyber Pakhtunkhwa (formerly Northwest Frontier Province), and Balochi is spoken in Balochistan.10 Gilgit-Baltistan, located in the Northeast part of the Khyber Pakhtunkhwa province, has semi-provincial status in Pakistan and has been proposed to become the fifth Pakistani province. There are several local languages spoken in this region, and Shina and Urdu are the official languages.

Spoken Urdu is similar to Hindi (a language spoken in India), but Urdu characters are based in Arabic—as such, Urdu is written from right to left. Due to the colonial history of Pakistan, government documentation is in English and Urdu. Moreover, many well-respected and private academic institutions provide English instruction. Therefore, many Pakistanis have some level of English proficiency. In America, 64% of American Pakistanis have been in the United States for over ten years and 72% speak English to some degree in home.11 Unfortunately, there are few formal measures available to determine English proficiency in Urdu speakers. Therefore, understanding a patient’s level of acculturation may be a useful proxy. For example, inquiring about the language of academic instruction, the number of years lived in the English-speaking country, languages spoken at home, work, or in social situations, and how English was acquired (formally or informally) may all be helpful considerations.12 In the event an Urdu interpreter is necessary but unavailable, a Hindi-speaking interpreter may be helpful.

Outside of speaking English, effective communication requires an understanding of the meaning and context behind the patient’s words and is necessary to build rapport, elicit accurate information, deliver effective feedback, and increase the chances that the patient will implement the recommendations made. See the following case example.

An elder Pakistani woman presented to her cardiologist. Distressed, she relayed to the physician that her chest hurt, she experienced heart palpitations, and felt as if she could not breathe. The physician, taking the patient at her word, ordered a cardiac work up which showed minor abnormalities and prescribed the patient medication to improve her heart function. The patient reported that thereafter, she presumed she had heart problems and her medical record reflected the same. Years later, she presented to the emergency department distressed and reported similar symptoms (e.g., palpitations, shortness of breath). During this visit, a culturally sensitive physician obtained a detailed medical and social history from both the patient and a family member who was present. The patient was subsequently diagnosed with social anxiety and the appropriate treatment recommendations were explained to the patient and her family caregiver. In this example, the physician was able to contextualize all
of the data to fully appreciate that the reported symptoms as somatic complaints, confirmed by ruling out medical comorbidities, and begin appropriate treatments.

Similar to other South Asian communities, Pakistani communication generally tends to be polite and indirect to avoid conflict. Direct eye contact is less common and reserved for personal relationships; therefore, lack of eye contact should be considered in context. Conflict avoidant language is common and includes responses such as “Inshahallah” which means “god willing” when too polite to reject a recommendation, or “what can you do?” when unsure/confused about something. Rather than asking a clarifying question, they opt to “save face” and avoid confrontation. The complementary nonverbal gesture for non-committal responses has been described elsewhere in this text as a “head shake/wobble.” A mix between a nod “yes” and a nod “no,” the head shake is an ambiguous gesture that reflects acknowledgment but does not always reflect the agreement. Therefore, if there is a question around the patient’s understanding, the provider is encouraged to probe comprehension with open-ended questions. Direct communication, on the other hand, is reserved for close relationships and, in particular, for men or younger people who are considered to be more “Westernized.”

A few general considerations that may be helpful include showing respect for elders regardless of the situation; therefore, the eldest in the room should be addressed first or the elder may require deference during a family conference/feedback session regardless of their level of involvement. Getting buy-in will likely go a long way in compliance. Also, doctors are highly revered by Pakistani people, and therefore patients and family members may not directly express any concerns, which could lead to non-compliance. When Pakistani patients in England were provided the reasoning for a prescription rather than just being told to take the medication, compliance improved.13 Lastly, haggling is commonplace in Pakistani culture and may need to be addressed, particularly in outpatient or out-of-pocket settings. Similar discussions around time management may also be necessary. While the perception of time in Western cultures is linear and limited, Desi cultures interpret time as cyclical and endless, and therefore patients may arrive late to scheduled appointments, following “Desi standard time.” The neuropsychologist may choose to send appointment reminders to ensure timeliness.

Socio-Economic Status, Education, and Literacy

Vast socio-economic disparities exist across the provinces that are worse in rural areas and have widened over time.14 These socio-economic disparities contribute to inequity in access to and quality of education in Pakistan, in particular for girls in rural areas who are unlikely to attend school.

The Pakistani education system consists of elementary (grades 1–5), middle (6–8), and secondary education, which is divided into lower secondary (9–10) and higher secondary (11–12). It was common to complete one’s education at grade 10 (not 12); thus, clarification may be warranted. Secondary education can be followed by vocational or technical education (1.5–2 years) or with traditional higher education (bachelor’s, master’s, or doctorate level degrees). Traditional higher education degrees were previously awarded earlier relative to international standards but this has been updated.2 Given the cultural values of norm adherence, respect for authority, and a sense of community, Pakistani education tends to require rote learning vs. critical thinking ability.

The Pakistan literacy rate is ranked 113 out of 120 countries but can be as high as 75% in some urban cities, similar to neighboring Asian countries. In contrast, rural areas have literacy rates as low as 9%.15 Education disparities include the language of instruction. Public education may be offered in a local language, while private education may include either English, the local languages, or a combination thereof. The quality of instruction also varies, from the qualifications of the teacher to the classroom itself. Children educated in rural areas may be taught in a room
without furniture, textbooks, or writing tools, while children in affluent areas may have well-qualified teachers, air-conditioned classrooms, desks, and access to Western textbooks. Education is commonly pursued for financial security and this privilege is largely reserved for boys who will later provide for their families. For those who were unable to pursue an education, it may be prudent to assess work history as a proxy for literacy. Educational attainment by Pakistani Americans is similar to other Asian Americans in the United States. However, relative to all Americans, Pakistanis are more likely to obtain bachelor’s and advanced graduate degrees.  

Religion and Views on Mental Health

About 97% of Pakistanis are Muslims (people who practice Islam). The majority of Muslims in Pakistan are Sunni (76%), and the remainder are Shia. Christians, Hindus, Sikhs, Zoroastrians, and Baha’i make up the remaining 3%. Islam is a monotheistic religion that follows Abrahamic traditions. Muslims traditionally pray five times per day, and Friday is considered the holy day. Common religious customs include abstaining from pork and alcohol and giving to charity. Ramadan, a holy month, is celebrated by daily fasting (i.e., abstaining from food and water), beginning at dawn until sunset. In addition to teaching obedience and discipline, fasting develops empathy toward the suffering of others. The end of the month is celebrated with a festival called Eid-ul-Fitr.

Religion plays an important role in psychiatric beliefs in the Muslim community. In Islam, homosexuality and suicide are traditionally considered a sin. However, individual interpretation of the scriptures varies. Rather than make assumptions, the clinician may respectfully ask the patient’s preferences. Related influences include the consideration of religious oppression or persecution in treating religious minorities. And discussing the impact of 9/11 on the patient may also be relevant. The semester of the 9/11 attack, I was a student at a public university. The sharp increase in on-campus crimes against all brown-skinned students, Muslims, and non-Muslims alike led me to take that year off for fear of my safety. These instances of violence against Muslims persist and inquiring about potential hate crimes may be important.

Spirituality also plays a role in psychiatric beliefs. When experiencing a hardship, a patient may believe “god willed it” and it is their responsibility to “bear the burden” rather than seek refuge in treatments. Therefore, events such as seizures may be explained away spiritually. A culturally normative explanation includes the involvement of a “djinn” (a supernatural being). Additionally, chronic illnesses may turn family members into primary caregivers, and as a result, a patient may not present to their physician until symptoms have progressed. The increased level of severity and related limitations in treatment could confirm the cultural belief that Western medicine is unhelpful. Thus, exploring family stressors for early detection and psychoeducation could play an important role in de-stigmatization and clinical care.

Common medical treatments may include homeopathy or ayurvedic treatments rather than Western medicine (allopathy) because conventional medicine is not consistently available. This results in limited resources, poor medical sophistication, and poor compliance. It is common for Pakistanis to not dispose of unused medications for fear of losing access and this can lead to off-label use of medications. Similarly, over-the-counter medicines, such as acetaminophen, can be misused (e.g., taken as a portion of the recommended dose) and/or referred to as a panacea, presumably referring to a placebo response. Notably, prescribed medications are typically accessible over-the-counter in Pakistan, making this a more affordable option for persons living abroad.

Regarding mental health, Desis may not directly refer to depression or anxiety; rather, concerns with mood may present physically described as frustration, fatigue, unease, pain in the mind/headache, chest pain, heart palpitations, or shortness of breath, without insight into the broader relationship between these experiences and low mood. Discussing the symptoms, rather than naming
Values and Customs

The collectivistic nature of Pakistani culture is reflected in its values and customs. Pakistanis value their faith and show honor and respect for their family and their community. Thus, decision making involves considerations beyond the self and includes the effect on the family and broader community. On the other hand, awareness of the patient’s values can aid the clinician in validating the patient’s interdependent sense of self with their family. The clinician should be cautious in sharing individualistic values to prevent any rupture in rapport.

Common customs reflecting Pakistani values begin with the initial greeting. One will always greet the elders in the room first. While men greet one another physically (e.g., hug), a common greeting can include a handshake or a simple right hand placed over the heart. Men and women may not be comfortable making physical contact (including a handshake) with the opposite sex. Opposite-sex providers should ask permission before physical contact. Customs such as arranged marriages and multigenerational households continue to exist; however, love marriages are increasingly valued, and it is becoming less common to live in the same household as the groom’s family. That said, these cultural practices can lead to intergenerational conflict, as well as internal conflict, as one attempts to reconcile traditional and progressive values.

Acculturation and Systemic Barriers

Acculturation in the context of neuropsychology is defined as “the similarity of a client’s culture and experiences to, and adoption of, mainstream culture.” The level of acculturation has previously been shown to have a direct impact on neuropsychological test performance as these tests are developed to measure Western constructs and values. Objective measures to quantify the level of acculturation exist, but few are specific to the Desi culture in the United States. The good news is that level of acculturation can be estimated with a clinical interview. Birman and Simon suggest that one aspect of acculturation is language proficiency. It is notable that children may pick up the dominant language faster than an adult immigrant and integrate it more fully than the adult counterpart. Another method may be to determine to what degree one identifies with their American versus Pakistani identity. Considerations of shifts in behavior such as grocery shopping at an American grocery store or watching English-language television could also be helpful.

While there are cultural barriers preventing appropriate recognition and treatment of psychiatric disorders, the respect Pakistanis feel toward physicians who treat “biological” conditions can be leveraged. As neuropsychologists, we are uniquely qualified to be the bridge between psychology and medicine. One way I (SJL) like to implement this into practice is by rephrasing the patient’s presenting concerns into language reflecting brain-behavior relationships.

Health Status

Cardiovascular disease is a significant health concern in the Pakistani population. Relative to other ethnicities in the United States, there is a higher prevalence of risk factors for cardiovascular disease such as obesity, type II diabetes, hypertension, and dyslipidemia, which results in higher...
rates of myocardial infarction and stroke. While South Asians make up approximately 25% of the world’s population, they make up 60% of the world’s cardiovascular cases (masalastudy.org). Exploring the effects of health on cognition will be important in the Pakistani population.

Approaches to Neuropsychological or Psychological Evaluations

A detailed and culturally sensitive interview is necessary to identify the underlying cognitive and/or psychosocial causes. However, some cultures may feel the process is intrusive and taking time at the start to explain the purpose of the assessment and highlighting the differences between neuropsychology and medicine could be helpful. Reiterating a focus on confidentiality could also reassure the patient that we value their privacy and create a safe space. For example, a young adult may be accompanied by a parent. If the young adult engages in recreational drug use, alcohol consumption, or has a significant other outside of marriage, they may not feel comfortable sharing that information in the presence of a family member. The ECLECTIC framework is a helpful tool to keep in mind during all interactions with our patients, but it is particularly useful during the clinical interview.

For those patients with low English fluency, the evaluation may require an interpreter. Interpreters themselves can have an impact on testing and should be utilized carefully for cognitive assessments. Family members should not be interpreters. In working with interpreters, I (SJL) have found taking time prior to the start of the evaluation to acquaint the interpreter has been helpful. The interpreter receives a copy of the forms and is encouraged to take notes. Emphasis is placed on standardization so there is no change in meaning or cognitive load of the test items.

Prior to the start of testing, I consider the cultural and linguistic appropriateness of the measures I have selected. Because there are few cognitive measures translated in Urdu and many lack appropriate normative data for Pakistani populations, it is important to accurately gauge the patient’s level of acculturation and English proficiency whether administering in English or with an interpreter. In addition, it is also important to consider familiarity with basic test taking, comfort with the testing environment, and familiarity with paper/pencil versus computer-based tests to data collection is valid. Finally, it is important to identify these limitations in the report. In my experience, reporting my thought processes around test selection and data interpretation has been instrumental in assisting other providers with understanding my conclusions and recommendations.

During the feedback session, patients may expect “prescriptions” for the next steps. This desire to follow doctor’s orders may be moderated by the patient’s cultural/spiritual beliefs. A sensitive touch may be helpful when delivering a new diagnosis. For example, if diagnosing a family member with Alzheimer’s disease, it may be important to specifically outline each family member’s role and identify concrete treatment goals. Without such psychoeducation, it may be easier for the family to “leave it up to god.”

Regarding specific recommendations, warm hand-offs are advised when possible. For example, if the evaluation requires a referral, the clinician may find it helpful to enter the referral or make the initial phone call for the patient to increase the likelihood of a follow-up. A discussion may be necessary with the patient and/or their family to address the stigma associated with treatment for neuropsychological disorders.

Section II: Case Study — “Racing Heart, Racing Mind”

The patient presented in this case study was seen for a presurgical workup. His information was de-identified and shared with the authors for use as a case example. Potential identifying information was changed to protect the patient’s identity.
Relevant Demographics

Mr. Khan was a 62-year-old, right-handed, bilingual (Punjabi primary/native; English secondary) Pakistani male. He immigrated to the northeast region of the United States in the 1980s and has resided there for 24 years. His early education was completed in Pakistan in English and Punjabi; he earned an associate’s degree in the United States. He has been gainfully employed and is involved in his community. He was diagnosed with Parkinson’s disease (PD) for 11 years and presented for a presurgical evaluation for consideration of deep brain stimulation (DBS) surgery.

Presenting Concerns

Mr. Khan’s initial symptoms were typical for PD, and he was successful with Sinemet for ten years. Unfortunately, the disease continued to progress, and he lost his job this year (approximately ten years after being diagnosed). He continues to experience PD-related symptoms. He also endorsed recent occasional shortness of breath and fast/irregular heartbeat. He endorsed difficulties falling asleep, stating his mind wanders and he cannot control his thoughts. He denied other physical or sensory concerns. He denied depression, anxiety, or compulsive behaviors but endorsed occasional low mood, particularly when thinking about his recent job loss and how he may be perceived by his community. He understood the risks and benefits involved with DBS surgery. He reported being independent in all activities of basic and instrumental daily living with the exception of driving, which he stopped three years prior to the evaluation.

Health History

Prior medical history was remarkable for fainting twice over many years and rare postural hypotension. Cardiovascular risk factors included diabetes and mildly elevated blood pressure, which were well controlled. Family history was unremarkable for Parkinsonism or neurodegenerative disorder. Psychiatric history was denied.

Social History

Mr. Khan was a married man with two adult children who lived independently. He did not consume alcohol and rarely smoked cigarettes. His primary role in the community was as the fundraiser at the local mosque.

Behavioral Observations

Mr. Khan arrived alone and was appropriately dressed for the appointment. He primarily spoke English and occasionally conversed in Punjabi. Motor movements were consistent with PD. He was alert and oriented to person, place, time, and situation. No sensory concerns were reported or observed. His comprehension was intact based on his responses during the evaluation. His speech was accented and fluent, with no concerns observed. Speech content was topic specific. His mood was neutral, with a mildly anxious affect. He demonstrated a restricted range of facial expressions. He denied any current hallucination, delusions, suicidal, or homicidal ideations. Overall, Mr. Khan was cooperative, engaged, and appeared to put forth a good effort. Therefore,
the attained scores were believed to be an accurate reflection of his current neurocognitive functioning.

**Test and Norm Selection**

Language dominance was assessed using a semantic fluency measure and obtaining a detailed linguistic history. Results reflected English-language dominance (Animal Naming, Punjabi = 9 Raw vs. Animal Naming, English = 17 Raw). As such, given the widespread availability of English measures and his understanding of the English language, English language-based tests were used. Instructions were translated into Punjabi by a Punjabi-speaking neuropsychologist, as needed. Unfortunately, there were no ideal normative comparisons available, and because these tests are normed on native English speakers that are educated in American schools in English, some scores may have underestimated his true abilities. However, every effort was made to interpret the results within the patient’s linguistic context.

The test battery included a comprehensive neuropsychological battery typically used for pre-DBS evaluations and included emotional functioning.

**Test Results and Impressions**

Abbreviated test results and impressions are presented below.

Mr. Khan's performance was intact on a task assessing broad cognitive functioning and he performed in the average range for his age on premorbid estimations of intellectual functioning. Most notably, his performance on tasks assessing language reflected an impoverished English lexicon rather than problems with language, per se. In that context, his performance on the remainder of the neuropsychological battery reflected a pattern consistent with PD. Mr. Khan did not meet criteria for dementia. From a neuropsychological perspective, Mr. Khan was a viable candidate for DBS surgery.

Although his responses on measures of emotional functioning did not reach clinical significance, in our conversation, we were able to connect reports of recent chest pain and difficulty breathing to the negative thoughts related to the recent job loss. His wife was invited to the feedback session and psychoeducation was provided to teach them how to monitor changes to his mood or levels of anxiety. They were provided resources both within and outside of their community to help improve his current mood state and prevent further deterioration.

Notably, he appeared more open to the discussion around mood when a biological link with PD was presented as a potential etiology. As his comfort increased, so did his wife’s and she became more involved in the discussion. She noted he was quieter and less physically active but had thought it was best not to comment in order to not upset him further. She had no idea how concerned he had been about the community’s reaction to his job loss. She was able to provide examples in the moment that provided an alternative perspective and challenge his negative thoughts. As a result, he had a more balanced perspective. A plan was made to include more pleasant activities in his day and use positive reinforcement when engaged in the community. Had his wife not been present, neither party would have developed insight into the observed changes in mood. Instead, both parties left feeling hopeful and empowered.

In summary, Mr. Khan received culturally sensitive care. His linguistic and educational background were considered to contextualize his neuropsychological functioning and prevent over-pathologizing. Cultural awareness allowed early detection of depressed mood. Finally, the strategic inclusion of a family member in the feedback session allowed recommendations to be
made within the patient’s cultural context and improve outcomes and compliance with medical recommendations.

Section III: Lessons Learned

- Pakistan is a country rich in history and diversity that is highlighted by the provinces and their respective languages. We hope the information presented in this chapter serves as a primer on Pakistani culture. We also hope to convey the importance of assessing each Pakistani patient as a unique individual with their own belief systems.
- Pakistani immigration patterns are varied, and each immigrant has a unique story that deserves exploration to receive culturally sensitive care.
- Urdu is the official language of Pakistan, but only a minority of Pakistanis speak it as their first language. However, due to a colonial past and potential immigration patterns, English is an important part of Pakistani culture.
- Assessing the level of acculturation and English language proficiency is important. Helpful questions to understand the level of acculturation and language proficiency include asking the number of years they have lived in the English-speaking country, which languages are used frequently, and how English was acquired?
- Effective communication requires an understanding of the meaning behind the patient’s words and can aid in building rapport, eliciting accurate information, delivering effective feedback, and increasing recommendation compliance.
- Pakistanis respect medical providers and may avoid asking for clarity. Clinicians should gauge understanding of the information provided.
- If an interpreter is necessary and an Urdu-speaking interpreter is unavailable, a Hindi-speaking interpreter may also be helpful.
- Clinicians should clearly communicate expectations regarding clinic policies as the approach to time varies across cultures.
- Based on varying levels of education and experience with test taking, Desi individuals might not be familiar with the testing environment and may need additional guidance to become more comfortable with the process.
- Religion plays an important role in a Pakistani person’s perception of mental health. It is important to be mindful of these beliefs so as to not under/over pathologize and make culturally appropriate recommendations.
- Cultural factors often impact symptom presentation (e.g., presenting with somatic concerns related to mental health difficulties that do not fit within the dominant culture’s expectations) and adherence to treatment recommendations. Understanding their experience is influenced by their family, the community, and their faith will help clinicians to provide individualized recommendations.
- In the neuropsychological report, a cultural considerations section that outlines the decision making around test selection, data interpretation, and recommendations may be helpful. This information could help current and future providers to fully appreciate the patient’s cultural context.

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