EPV0355

Cultural Diversity and Mental Health Care: A Case Study

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Introduction: In today's world of global migration and cultural diversity, mental health care grapples with persistent challenges. Despite efforts to promote cultural competency and person-centred approaches, it's vital to delve into the issues surrounding cultural differences and linguistic diversity in mental health care. This exploration highlights the complexities where culture, language, and healthcare intersect (Brisset et al., 2014; Desai et al., 2021).
Objectives: Our aim is to analyse cultural and linguistic barriers in mental health care for migrants and assess their impact on access and quality of care.
Methods: Literature review, drawing from sources such as PubMed, ResearchGate, and Google Scholar. This review will be framed around the case of a 34-year-old man from Bangladesh, who has been residing in Lisbon for a year. His clinical presentation includes depressive symptoms, disorganized behaviour, and psychotic manifestations, such as persecutory delusions. He does not speak Portuguese or English, thereby limiting his access to essential mental health treatment services. Through this review, we intend to elucidate the intricate dynamics surrounding cultural and linguistic barriers in mental health care.
Results: Migrants from diverse backgrounds face many challenges, including the loss of homes, livelihoods, and family, often leading to mental health issues like depression, anxiety, and post-traumatic stress disorder. Two primary challenges include adapting to a new life and experiencing discrimination and marginalization (Amri et al., 2013; Satinsky et al., 2019). Social stigma and mistrust hinder access to mental health services. Limited culturally competent services widen the gap between mental health needs and help-seeking attitudes. Language barriers significantly contribute to disparities in access to services (Amri et al., 2013). Additionally, mental health care providers' organizational culture often prioritizes 'ideal' patients who are native speakers, favouring individual-oriented treatment over community-focused care (Desai et al., 2021).
To address these barriers effectively, it is crucial to employ specific strategies. The Multi-Phase Model of Psychotherapy, Social Justice, and Human Rights (MPM) equips mental health counsellors to better serve immigrant communities while addressing social stigma. This comprehensive framework comprises five phases of intervention: psychoeducation, culturally responsive service delivery, cultural orientation, collaboration with local healers, and connecting patients to essential resources (Amri et al., 2013). Additionally, practitioners should receive training in effective collaboration with interpreters to provide multilingual healthcare (Brisset et al., 2014).
Conclusions: Addressing cultural and linguistic barriers in mental health care is vital. The Multi-Phase Model of Psychotherapy offers a promising approach, while collaboration with interpreters remains essential.

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Dissociative Identity Disorder from a Palestinian Perspective: A Case Report

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Introduction: Dissociative Identity Disorder (DID) is the presence of two or more distinct personality states within an individual. It is a rare dissociative disorder where usually self-non-integration arises as a response to significant stress. As is the case for many other psychiatric disorders, the diagnosis and management of DID is highly dependent on cultural variables and contexts.
Objectives: To present a case of DID in Palestine in which the diagnosis was dependent on noticing minor changes in the patient's dialect at different times. To highlight the importance of understanding each patient's environment, values, and culture when assessing DID to avoid under- or over-diagnoses.
Methods: A case report in which we present a case of a 17-year-old Palestinian girl who suffered from three months of general fatigue, restlessness, poor coordination, and peripheral numbness. She was seen by several doctors who excluded organic causes and several spiritual healers without benefit. This caused severe deterioration of social and academic functioning. The family noticed a change in her articulation and memory issues, so they presented her to a psychiatrist. Data was collected by interviewing the patient and her family weekly for a month. The psychiatrist noted that the patient has subtle differences in accent, and directed the family to record any change in tone of voice or articulation. The patient was found to have three different accents on top of her native one, representing a total of four personalities with no memory integrity among them. She was started on Escitalopram (gradually increased) and Alprazolam (gradually decreased).
Results: The psychiatrist detected the theme of being "stuck" throughout the personalities, each in its own way, according to the context of their roots. It was revealed that the patient is engaged to a man she doesn't approve of and has "no way out" due to the social and familial significance of this relationship. Family counseling and trauma-informed psychoeducation were done, where the patient's choice was reaffirmed. This led to significant improvement in terms of mood, identity integration, and social functioning with complete resolution of split personalities in just short of one-and-a-half months.
Conclusions: This case report asserts the importance of cultural understanding and sensitivity when assessing psychiatric patients. Symptoms, triggers, psychotherapy, and psychoeducation have a universal baseline, yet are highly culturally-dependent. Through this case study, we emphasize the importance of translating universal criteria into context-specific practices.

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