

Recurring Vivid Dreams in an Older Hmong Man With Complex Trauma Experience and Cognitive Impairment

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ABSTRACT

Introduction: Health care workers need to consider the culture and ethnic preferences prevalent in the Hmong community in order to provide optimal care. We describe an older Hmong man to illustrate the challenges faced and competencies needed by primary care.

Case Presentation: An 80-year-old non-English speaking Hmong man with diabetes, nerve sheath tumor, and hypertension presented to the outpatient clinic with his grandson complaining of sleep problems. He had had 2 vivid recurring dreams during the previous few months. Memory assessment was significant for dementia.

Discussion: This case addresses the complexity in taking care of a non-English speaking Hmong older man who has memory loss, trauma in adulthood, multiple caregivers, and sleep problems.

Conclusions: A careful history from patient and family to get to know their cultural preferences and attitudes was helpful. Identification of the primary caregiver was critical in providing care.

INTRODUCTION

Wisconsin has the third largest Hmong community (N=49,420) in the United States with California being first and Minnesota second, according to 2010 US Census data.¹ This is a 190% increase in the Hmong population in Wisconsin from 1990 to 2010. Approximately half of the Hmong residents are foreign born and many came to the United States as refugees. Health care workers need to consider the culture and ethnic preferences prevalent in the Hmong community in order to provide optimal care. We describe an older Hmong man to illustrate the challenges faced and competencies needed by primary care. As the primary care team, we had the following questions: (1) How do we address cul-

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tural and language aspects in this case? (2) What is the role of trauma during adulthood on late life dementia? and (3) How does input from caregivers affect our care?

CASE PRESENTATION

An 82-year-old non-English speaking Hmong man with diabetes, nerve sheath tumor, and hypertension presented to the outpatient clinic with his grandson complaining of sleep problems. He had had 2 vivid recurring dreams during the previous few months, one of which reflected his military combat experience as a young man in Laos 40 years previously, the other a dream of happy resettlement in his homeland. He

was not able to give more information due to memory loss.

The patient arrived in America as a refugee in the 1980s, together with his wife and 3 children. Prior to coming to America, he lived in a refugee camp for several years in Thailand after fleeing Laos, where he was a soldier, in the 1970s. He described being involved in direct combat during the war in Southeast Asia. At the time he presented to the clinic, he was living with his wife, son, daughter-in-law, and grandsons.

During this visit it was noted that he was not taking his anti-hypertensive medication or melatonin. Screens for posttraumatic stress disorder (PTSD) and depression were negative. Mini-Mental State Examination² score was 12/28, consistent with cognitive impairment. At a prior visit, an animal fluency test³ had been administered (5 in 1 minute) and the Mini-Cog⁴ (1/3 recall, 0/2 clock drawing) scores were consistent with cognitive impairment. The animal fluency test is performed by asking patients to say as many animals as possible in 1 minute (normal is > 14 animals). The Mini-Cog is a “3-minute” screening tool that consists of a short-term recall and clock drawing test. Further testing is recommended for abnormal scoring. However, the patient was nonliterate in either English or Hmong with only 2 years of schooling in Laos. His grandson’s perception was that the patient didn’t have

any problems with memory. However, the patient was seen multiple times in the clinic, each time with a different family member who had different perspectives regarding his health. His daughter acknowledged observing his decline in cognition and function. She also noted that he was often depressed.

DISCUSSION

We describe an 82-year-old Hmong older man who was exposed to combat-related trauma and severe social upheaval 40 years earlier who now has sleep and memory problems and is nonadherent to his medicines. We held an interdisciplinary team meeting to consider several challenges faced in the care of a non-English speaking patient with dementia who has multiple caregivers.

First, cultural and language barriers can interfere with elicitation and interpretation of the information needed for accurate diagnosis, and the accuracy of cognitive and PTSD screens are poorly studied in Hmong patients. Dreams hold deep meaning in Hmong culture and memory loss may be considered a normal part of aging,⁵ making it difficult to see either as symptoms of a medical condition; reluctance to accept western medical treatment might be a reason for his non-adherence to medication.⁶ Hmong cultural practices commonly lead to denial of behavioral symptoms and delay medical attention until traditional healing practices fail, if then.¹

Second, similar symptoms may be caused by different conditions. There is an association between a history of traumatic experiences and cognitive impairment. Many older Hmong in America have experienced cumulative trauma in adulthood, including displacement, life in refugee camps, or war.⁷ In US combat veterans, the convergence of environmental stressors, physical illness, and age-related neurodegeneration may contribute to late life emergence of PTSD.⁸ In US veterans, the prevalence and incidence of dementia in patients with PTSD is twice that of veterans without PTSD.⁹ Trauma reenactment is common in aging veterans with dementia.¹⁰ In patients with previously well-controlled PTSD, emergence of cognitive disorders may worsen PTSD symptoms.¹¹ PTSD screen could have been false negative due to cultural or language reasons. A possible reason could be the presence of a family member in the room causing the patient to not express his real feelings. Another well-known factor in a small community is that the medical interpreter is socially connected to the patient, leading to lack of privacy. However, overall we considered this patient to have experienced cumulative trauma during adulthood.

Third, the organization of family caregiving may critically influence what and how information is conveyed to clinicians. "Distributed" patterns of caregiving are common in many cultural groups; the person attending medical appointments may not be the best-informed regarding crucial aspects of the patient's health status and functioning, or may be reluctant to disclose information that might seem disrespectful to an elder.¹² We would have appreciated the wife's input in the patient's sleep problems because

she was in the home with him all the time. The patient's wife, whose input might have helped clarify the nature of his sleep complaints, never accompanied him to clinic because of her frail condition. The patient was brought to the clinic by various family members who were involved in different aspects of his care, such as providing transportation or accompanying him. There was a lack of objectivity in the history depending on who accompanied him even though the medical interpreter was used every time. On further questioning, it was noted that one of his two daughters visited him daily and helped him with all cares. Once we understood that his daughter was his primary family caregiver at home, we arranged for her to come with him to the clinic. She acknowledged observing his decline in cognition and function. She also noted that he was often depressed. With the help of the medical interpreter, the patient voiced that he did not want to take antidepressants.

CONCLUSIONS

This case report highlights the challenges faced by a primary care geriatrician in the care of a Hmong American patient complaining of sleep problems. A careful history from patient and family to come up with a plan of care was important.

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