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Investigating the Mechanisms through which Racialization Impacts Dementia Prevalence and Burden in Ethnic Minorites

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Abstract

K **:** Dementia; Social policy; Clinical policy; Social determinants of health; Dementia prevention; Ethnic minorities in dementia

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e modern geriatric healthcare problem lies within the increasing rates of dementia. In fact, groups of older adults that are 80 years or older, dementia is just as prevalent as heart failure, leading to a national average of 6.8% across Canada. To further fuel the re, in the next 13 years, the prevalence of dementia in Canada is expected to increase by 104%.

Despite the national Canadian average, it is surprising to note that dementia prevalence rates are higher in areas with greater ethnic heterogeneity as compared to areas with more homogenous communities. Within these culturally diverse societies, it is ethnic minorities that bear the brunt of high dementia prevalence [1].

Putting biological and genetic factors aside in both Canada and the United States, it's important to note that both countries stem from racially abusive backgrounds, particularly towards ethnic minorities [1]. While older racial attitudes have been subsidized, the prevalence of systemic racism remains present, especially at the heart of healthcare services [1]. is pattern is consistent with dementia prevalence rates as well across North American society.

While systemic racism and the racialization of ethnic minorities impacts dementia prevalence rates, there is a clear gap in understanding the mechanisms through which these results are observed. is review article seeks to identify the means through which racialization increases dementia prevalence and burden amongst ethnic minorities in North American societies, and derive evidence based public policy, medical practice, and healthcare system solutions to mitigate these impacts.

To accomplish this task, this paper will utilize the following evaluating framework to look at research studies through the three perspectives shown below:

1. Access to Care and Healthcare Systems Experiences
2. Income and Socioeconomic Status
3. Systemic Oppression and Social Hierarches

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is review was conducted using the PubMed Public Health Database. A 2 step screening process was utilized, the title and the abstract of papers. In the searches within the database, the results per page setting were set to 10 results per page. Only the rst two pages of every search were examined to ensure the utmost relevance to the terms inputted.

I C	E C
Written in English	Other language
Study must be newer than 2000	Study is older than 2000
Discusses dementia and racialization with respect to the evaluating framework. 1. Access to Care and Healthcare Systems Experiences 2. Income and Wealth 3.Mental Health, Cognitive & Suppression impacts – Systemic Oppression and social hierarchies	Does not discuss the topic with respect to the framework.

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Research should be limited to North American societies (Canada and the United States)	Research is outside Canada or United States
Racialized Groups include people of African descent (African-Americans/ Canadians), Asian	Racialized groups do not belong to the aforementioned categories
Minorities (Chinese, Japanese, Korean, Vietnamese), and South East Asians	

1: Inclusion and exclusion criteria

e inclusion and exclusion criteria, shown in (**1**), were developed to determine eligible literature sources.

D i i n

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**D i n . i i : ere is a gross misdiagnosis of dementia in ethnic minorities because the frameworks used to diagnose dementia are not structured to accommodate the ethnic versatilities present within dementia symptomology [1]. For example, in dementia patients, people of Caucasian descent are more likely to display neuropsychological symptoms, whereas South East Asians are more likely to be co-morbid with Parkinson's and Lewy Body's Disease. In fact, analysis of clinical vignettes supports signi cant di erences between the manifestation dementia symptoms between races. As racialization is a social concept as opposed to a biological one, the cultural and social practices of individuals across ethnicities have been found to result in di erent symptomatologies of dementia. However, the diagnosis criteria in dementia that's commonly utilized by practitioners, fails to account for this cultural diversity, resulting in higher rates of misdiagnosis among ethnic minorities, such as African or Asian Americans. To overcome this barrier, it is critical for health management, health informatics and health data organizations such as the Canadian Institute for Health Information or the Canadian Institute of Health Research to amplify health data collection endeavours on the dementia symptomatic diversity amongst ethnic minorities. is would require a greater level of funding and research endeavours into data collection for the diagnosis of dementia in ethnic minorities across an array of providers, particularly including primary

levels of LDL cholesterol and hypertension, which also makes them the leading ethnic cohort in the diagnosis of vascular dementia [7]. Unfortunately, many African American communities lack access to

e ects for long term dementia care [13].

**: While common medical evidence illustrates that cognitive decline initiates around the age of 25, ethnic minorities are at a relative disadvantage even in the uterus [14]. Social hierarchies, perpetuated by racist and capitalist beliefs lead ethnic minorities who are o en immigrants and socioeconomically "lower" than their counterparts to feel inferior [14]. e result of these manifests even in pregnancy where the behaviours and feelings of parents can have epigenetic consequences that increase the size of the amygdala and cortisol levels [14]. is is highly apparent in African American populations born in the Southern states of America, where those whose families lived in the racist regions for longer were found to have a greater level of fear, stress and social inadequacy, further coupled with higher rates of mild cognitive decline in middle age, as well as inferior cognitive performance from childhood [14]. It's of the utmost importance, therefore, for health policy makers to incorporate social data such as ethnicity, lived experiences, socioeconomic status and ancestral social conditions in geriatric care planning [14]. Embedding social network supports as a gateway to mitigating the impacts of these social hierarches is an illustratively powerful tool to slow down the cognitive aging process and empower ethnic minority groups to improve mental health conditions [14].

**: ere is a lack of access particularly towards mental healthcare [15]. is is partially because of cultural norms and stigmas associated with mental health, as well as an insu cient diagnostic criteria that fails to acknowledge the diverse symptomology of mental health in ethnic minorities [15]. In fact, 33% of practitioners report feelings of ambiguity when determining a diagnosis for an ethnic minority member with a mental health disorder [15]. As a result, ethnic minorities o en experience unaddressed mental health disorders, which continue to compound and worsen [7]. ese conditions are o en exacerbated by poor socioeconomic conditions, familial concerns as well as social hierarches that trigger feelings of inferiority [7]. Subsequently, the presence of these conditions increases the rate of cognitive decline, and helps damage synaptic connections, increasing the likelihood and severity of dementia [7]. To alleviate these risk factors, policy makers are encouraged to conduct ethnicity based research on the prevalence and types of mental health diseases in each ethnic population to collect ethnicity speci c data on mental health needs [7]. is information can be leveraged to develop accurate diagnostic criteria that can aid practitioners (particularly general practitioners) in identifying at risk patients [7]. As borne out by the experiences of mental health clinics in First Nations reserves in Alaska, enhancing research on ethnicity speci c mental health needs, as well as evidence based treatment practices can aid practitioners in delivering timely mental healthcare to minimize dementia growth [7].

**: Many of the mental health impacts faced by ethnic minorities are caused by immigration, e ects of which can still be prevalent in rst and second generations. In particular, the loss of language, traditions, cultural practices as well as norms due to assimilation into a new society is shown to break down emotional connections, having harmful impacts on the brain's emotional domain.

is has the e ect of resulting in higher rates of anxiety, depression, obsessive compulsive disorders, and other protein plaque based neurological conditions that can serve as precursors to the development of dementia. It is important for community level practitioners to leverage social supports such as social support workers, community health centers as well as religious mediums to help at risk patients maintain emotional connections to their heritage [16]. On a broader scale, research encourages the development of new community health centres targeted towards middle aged and older adults that include ethnicity based programming to help preserve cognitive function [16].

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While all older adults are increasingly likely to su er from dementia, ethnic minorities are not only more likely to get the disease, but also experience advanced and more debilitating versions of it. e range of healthcare in access, medical inequity and medical racism, coupled with deteriorating socioeconomic environments as well as social hierarches further worsens the conditions for ethnic minorities as they age. Policy reforms through more medical education, culturally sensitive care, more broadened data collection, as well as ethnicity and community led dementia prevention/treatment initiatives can help combat many risk factors faced by ethnic minorities.

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1. Anderson NB, Bulatao RA, Cohen B (2004) Critical perspectives on racial and ethnic di erences in health in late life.
2. Kenning C, Daker-White G, Blakemore A, Panagioti M, Waheed W (2017) Barriers and facilitators in accessing dementia care by ethnic minority groups: A meta-synthesis of qualitative studies. BMC Psychiatry 17(1): 316.
3.

aging health 32(7): 817–829.

12. Ya e K, Falvey C, Harris TB, Newman A, Satter eld S, et al. (2013) E ect of socioeconomic disparities on incidence of dementia among biracial older adults: Prospective study. Bmj 347: f7051.

13.

16. Ili e S, Manthorpe J (2004) e debate on ethnicity and dementia: From category fallacy to person-centred care? Aging Ment Health 8(4): 283-292.