COMMENTARY

Barriers to Care for Hispanic Adults With ADHD

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CME Objective

After studying this article, you should be able to:

- Identify ways in which a primarily English-speaking physician can more effectively identify and manage Hispanic patients with ADHD

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Hispanic Americans now make up the largest minority group in the United States.[1] Hispanics in the United States come from several different regions of Latin America, including Central and South America, the Caribbean Islands, and Mexico.[2] Mexicans are the most prevalent Hispanic group in the United States, with the highest concentrations in California and Texas.[2] With differing countries of origin, English proficiency, education levels, economic status, and professional backgrounds, Hispanics comprise an incredibly diverse subsection of American culture.

When treating a Hispanic patient, clinicians must remember that the patient's culture encompasses more than language or ethnic group membership.[3] Language and dialect vary naturally between regions. Moreover, racial and ethnic groups are heterogeneous and vary widely in traditions, values, beliefs, and even neighborhood characteristics. For instance, the culture of Cubans living in Miami can vary greatly depending on whether they live in high- or low-income communities. Generalizations cannot be made that apply to all members of any cultural group.

However, one commonality exists between subgroups of Hispanic Americans: they are often underserved in the mental health system, despite a prevalence of mental illness similar to that of the white population.[4] One diagnosis often overlooked in adults is attention-deficit/hyperactivity disorder (ADHD), which may cause substantial functional impairment in areas such as work performance and relationships.[5] To improve care for mental health conditions such as ADHD, clinicians must understand the cultural, economic, and diagnostic barriers that can hinder their Hispanic patients from receiving care and obtaining an accurate diagnosis.

CULTURAL BARRIERS

Country of origin can create potential barriers related to migratory status, language proficiency, and educational attainment. For example, Puerto Ricans in the United States have the largest numbers of native-born citizens (individuals born in Puerto Rico are US citizens) and the largest percentage of English proficiency, whereas Central Americans have the highest rates of noncitizenship and the poorest English proficiency.[6] Compared with other Hispanic groups, Central Americans and Mexicans also have the lowest levels of educational attainment.[6]

Hispanic people may not be familiar enough with certain mental illnesses to recognize a problem. For example, depression may be mistaken for nervousness, fatigue, or a physical problem.[7] A history of trauma may also affect those who come from a region or country with a recent history of violent conflict, further complicating symptoms. Beyond this potential confusion, many Hispanic adults may fail to seek treatment because of a general lack of knowledge about mental illness, particularly ADHD.[3]

Language Barriers

Language barriers are a significant obstacle to treatment, functioning along both cultural and institutional lines. Among

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The teleconference was chaired by **Anthony L. Rostain, MD**, Department of Psychiatry and Pediatrics and the Adult Developmental Disorders Section, University of Pennsylvania Perelman School of Medicine, Philadelphia. The faculty were **Yamalis Diaz, PhD**, Department of Child and Adolescent Psychiatry, New York University School of Medicine, New York; and **Juan Pedraza, MD**, Department of Psychiatry, Mount Sinai School of Medicine, New York, New York.

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Spanish-speaking people in the United States, about one-fourth do not speak English well or at all.[8] Patients with poor English proficiency will experience difficulty describing their symptoms or answering interview or assessment questions. In addition, many assessment interviews and instruments were developed in English for use with children. Even once they have been translated into Spanish, the criteria in these assessments may no longer be valid when used with adults.[9] The translation may be too literal or may use terms that do not make sense across cultural groups. For example, the ADHD symptom of acting as if "driven by a motor" does not translate well and therefore may not make sense to a Hispanic patient.

Another barrier is the shortage of mental health providers, especially Hispanic professionals who could bridge cultural and language barriers.[10] Translators are sometimes used to overcome language barriers, but problems still arise when translators simply translate what a clinician or patient says without considering context or meaning, leading to clinicians who do not fully understand the patient's reported symptoms or patients who do not understand the clinician's questions or explanations. Translators who are adequately trained in medical diseases may not be trained in mental health disorders. However, professional interpreters have been shown to improve the quality of health care for patients with limited English proficiency.[11] If formal translation services are not available, adult patients may use their children or other family members as interpreters, but this can also lead to mistranslation and can limit the ability of clinicians to gather important information. Similarly, because of a lack of translated educational materials about ADHD, clinicians often cannot provide information for patients to read, meaning that all treatment options must be discussed verbally, again potentially and literally getting lost in translation.

Cultural Attitudes

ADHD is largely understood within a cultural and social context, and that context has been found to influence whether an individual seeks treatment.[12] Cultural attitudes can keep Hispanics from seeking treatment. Acculturation level has been found to affect how Hispanic individuals perceive ADHD symptoms, particularly impulsivity and hyperactivity.[13] Many have a reluctance to divulge personal problems that they believe should be kept private or within the family.[10] Reliance on extended family, community, traditional healers, or religious leaders is common for Hispanic individuals who are undergoing a mental health crisis.[7]

Hispanic individuals sometimes fail to seek treatment because of general mistrust of or negative attitudes toward mental health providers. These patients place great value on a positive relationship or rapport with health care providers[14] and do not want to feel like they are just another patient. Until this rapport is established, Hispanic patients may refrain from asking questions and may not appear fully engaged in the assessment and treatment process. They may even pretend to understand and agree with the clinician's recommendations, when they actually have many questions and concerns.

Another obstacle is the stigma associated with mental illness.[7] Anyone, particularly a Hispanic patient, may fear being labeled as "crazy."[15] Negative views and misperceptions of psychotropic drugs are also common, such as the idea that these drugs are ineffective or addictive, or that the use of these drugs is indicative of severe mental illness.

Hispanics may also fear or distrust providers or doubt the benefits of treatment.[4] These cultural issues and attitudes deter Hispanics from seeking mental health care. In addition, many Hispanics, particularly if

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Clinical Points

- Clinicians must be aware that Hispanic patients in the United States seek treatment at much lower rates than their white counterparts.
- Translators and Spanish-language resources can help clinicians overcome language barriers with their adult Hispanic patients.
- Sensitivity toward deeply held cultural attitudes will help establish rapport and increase treatment success among Hispanic patients.
- Assessment questions should be tailored according to the patient's background and beliefs about mental illnesses and treatment.

they have immigrated illegally, may be reluctant to interact with the health care system for fear of deportation.

ECONOMIC BARRIERS

Beyond the cultural barriers to equal mental health treatment for Hispanic patients, economic barriers also exist. One such disparity is overall economic status. In the United States, poverty rates in 2012 were 25.6% for the Hispanic population and 9.7% for the white population.[16] In rural areas, the 2012 poverty rate was 29.2% for Hispanic people, compared with 13.5% for white people.[17]

Poor economic status influences another disparity, which is a lack of health insurance coverage. As of 2012, nearly one-third of Hispanics lacked health insurance, putting them in the top category of uninsured Americans versus white, black, and Asian people.[18] Without comprehensive health care coverage, including mental health treatment, Hispanic people are less likely to seek care for mental illnesses. Data from the National Center for Children in Poverty revealed that 88% of Latino children have unmet mental health needs,[19] which means that only about 1 in 9 children in Hispanic households are receiving the treatment they need. For patients without insurance, free or low-cost insurance options or voucher programs might be available, although use may be limited due to other factors, such as the language barrier.

DIAGNOSTIC BARRIERS

Adults with ADHD are generally expected to have low academic and occupational attainment, have a history of failed relationships or divorce, have a history of traffic violations or legal difficulties, and/or have a high incidence of substance abuse and comorbid disorders.[5,20] Although these characteristics are common in adults with ADHD, they may not accurately reflect Hispanic adults with ADHD. ADHD presentation can vary greatly depending on the patient's history and family background.[21] Clinicians, therefore, must be alert for varied ways that ADHD may manifest in Hispanic patients.

When conducting an interview, clinicians need to keep several factors in mind that may be unique to Hispanic patients with ADHD. The economic and political situation in the patient's country of origin may have exposed the patient to armed conflict or extremely depressed economic conditions, which may create a history of trauma and associated disorders.[22] Immigration may also have been a traumatic experience, bringing its own impact on symptom presentation and potential comorbidities. Because of the likelihood for a history of trauma associated with conditions in a patient's native country or the process of emigrating,[22] clinicians should always assess for comorbidities. For example, individuals who experienced discrimination or forced assimilation in their country of origin may fear the legal system or the loss of their culture.[22]

A diagnosis of ADHD in any patient is rendered using a clinical interview and various rating scales.[23] Self-report scales commonly used to assess for ADHD in adults include the Brown Attention-Deficit Disorder Scale, the Conners Adult ADHD Scale, and the Adult Self Report Scale V1.1.[24] Although these scales have been tested in adult populations,[24] they may not be effective in Hispanic populations. Beyond issues of translation or English proficiency, these scales may use assessments that do not accurately reflect conceptions of ADHD symptoms and disabilities that are common in Hispanic cultures. For example, Gerdes and colleagues[9] administered a Spanish version of the Disruptive Behavior Disorders rating scale to Latino mothers to assess for ADHD in their children. That study found that the hyperactive/impulsive subscale was not culturally appropriate. Although focused on children and not adults, the study illustrates the importance of considering cultural background when using rating scales with a Hispanic patient.

With Hispanic patients, semistructured clinician-administered interviews, such as the Adult ADHD Clinical Diagnostic Scale (ACDS),[25] that address both childhood and adult symptoms may be the best option, but clinicians must carefully discuss the questions and ratings with the patient and be aware that patients may underreport their symptoms or impairment. Clinicians must also be considerate of the patient's background. For example, the ACDS includes the question, "Was your desk or locker at school a mess?" This question would not be appropriate for an individual who has been working since early childhood or who was unable to attend school because of economic difficulties. Thus, when asking questions related to childhood experiences, the clinician must always keep in mind the conditions in which the patient grew up. For questions related to adult symptoms and functioning, consideration of the current demands that the patient is likely experiencing is also important when evaluating responses to question such as, "Do you have trouble with detailed work?" These considerations are important when using any type of assessment scale with Hispanic patients.

CONCLUSION

Barriers to mental health care for Hispanic patients are great but not insurmountable. Taking them into account is a critical consideration for clinicians serving the largest racial

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and ethnic minority in the United States. Language, cultural, and economic barriers must be considered and addressed to better serve this population. Clinicians should be sensitive to patients' English proficiency and cultural background when asking assessment questions. Frequent follow-up visits are effective for assessing progress and building rapport, which is particularly important to Hispanic patients. Increasing this rapport improves communication, resulting in more effective treatment. Correcting health disparities for Hispanic people requires time and effort, but clinicians who provide culturally sensitive mental health care and education will be part of the solution.

Disclosure of off-label usage: Dr Rostain has determined that, to the best of his knowledge, no investigational information about pharmaceutical agents that is outside US Food and Drug Administration–approved labeling has been presented in this activity.

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Posttest

To obtain credit, go to PSYCHIATRIST.COM (Keyword: January) to take this Posttest and complete the Evaluation.

1. Mr A, a 20-year-old US immigrant from Mexico, says his community college counselor suggested that he might have attention-deficit/hyperactivity disorder (ADHD). He became an American citizen 2 years ago, and he has health insurance under the Affordable Care Act. Mr A's English proficiency appears to be strong. He says he mistrusts an ADHD diagnosis but thinks highly enough of his counselor to make an appointment. What would be the best first step to take with Mr A?

a. Tell him his concerns are unfounded; many college students take prescription medication for ADHD

b. Try to build rapport by asking him about his background in Mexico, his goals in college, and his knowledge of ADHD, and why he mistrusts the diagnosis

c. Administer the Adult Self Report Scale V1.1 and discuss his symptoms

d. Discourage him from taking on too many responsibilities because they could cause additional stress or mood disorders

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