Recognition of Psychiatric Symptoms and Conditions in Latino Patients

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LESSONS LEARNED AT THE INTERFACE OF MEDICINE AND PSYCHIATRY

The Psychiatric Consultation Service at Massachusetts General Hospital sees medical and surgical inpatients with comorbid psychiatric symptoms and conditions. Such consultations require the integration of medical and psychiatric knowledge. During their twice-weekly rounds, Dr Stern and other members of the Consultation Service discuss the diagnosis and management of conditions confronted. These discussions have given rise to rounds reports that will prove useful for clinicians practicing at the interface of medicine and psychiatry.

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Have you ever wondered whether psychiatric symptoms manifest differently in Latino patients? Have you puzzled over the best method to screen for psychiatric problems in Latino patients? If so, then the following case vignette and discussion should serve to elucidate some of the issues faced by physicians who care for Latino patients.

CASE VIGNETTE

Ms A, a 31-year-old woman who recently immigrated to the United States from Mexico, went to the emergency department with complaints of constipation and diffuse abdominal pain that had persisted for 5 months. Ms A spoke little English; however, the evaluating emergency medicine resident (Resident 1) had a working knowledge of medical Spanish and felt comfortable taking her history. His interview revealed that Ms A was a single mother of 3 children who worked in the food service industry but was uninsured. Her workup (complete blood count, electrolytes, glucose, blood urea nitrogen, creatinine, liver function tests, urinalysis, pregnancy test, and abdominal computed tomography scan) revealed no organic cause for her complaints. Following dietary counseling, Ms A was discharged to her home with instructions to follow up at her local clinic or to return to the emergency department if her symptoms worsened.

One month later, Ms A returned to the emergency department with persistent abdominal discomfort, constipation, and severe headaches. This time, Resident 2 interviewed Ms A with the help of a telephone-facilitated interpreter. After asking about her personal life, Resident 2 elicited a more detailed psychiatric history. Ms A reported that over the past 6 months her appetite had decreased and that she had been sleeping poorly. She had recently been evicted from her apartment for not making rent payments. She felt extremely isolated and was sad for most of the day, every day. She also endorsed feelings of guilt. She attributed this to not seeing her children as often as she would have liked, as she worked evenings as a cook in her employer's home. She denied having symptoms of mania. Ms A felt helpless and acknowledged having thoughts of suicide (with a specific plan).

As with her previous emergency department visit, the medical workup was unremarkable. Ms A was admitted to the inpatient psychiatry unit with a diagnosis of major depressive disorder based on *DSM-IV* criteria (ie, anhedonia, depressed mood, decreased appetite, insomnia, fatigue, and trouble concentrating) and was started on a selective serotonin reuptake inhibitor.

While on the inpatient unit, Resident 2 arranged for a language-concordant social worker and an English-speaking staff psychiatrist for medication management. Since her hospital discharge several months ago, Ms A has continued to meet with her social worker every 2 weeks, and she has not returned to the emergency department.

HOW COMMON ARE PSYCHIATRIC ILLNESSES IN LATINO PATIENTS?

As many as 1 in 3 Latinos living in the United States is diagnosed with psychiatric illness (eg, major depressive disorder, an anxiety disorder, or

Clinical Points

- Latinos are less likely than other ethnic groups to seek follow-up care for any medical malady; they have significantly fewer visits with specialists than their white counterparts, and they report having fewer physician visits overall.
- Accurate assessment of language proficiency and appropriate use of interpreters improve the quality of medical care, reduce the rate of medical errors, and increase patient satisfaction. Fortunately, there are several easy-to-administer short-form questionnaires and simple inquiries that clinicians can make to assess English proficiency.
- Appropriate use of interpreters is especially important in the psychiatric context wherein most symptoms are self-reported, making solicitation and comprehension of symptoms dependent upon language concordance.

substance abuse) during his or her lifetime.[1] While the reasons for this rate are complex, the incidence of mental illness among Latinos varies with the time spent in the United States, reflecting the "Latino paradox" (ie, lower rates of mental illness are documented in those who are newly immigrated, while lifetime rates of mental illness rise as time spent in the United States increases).[1] The corresponding rate for a nationally representative sample of English speakers is 40.6% (but the sample was assessed for certain disorders, including bipolar I and II disorder, as well as "impulse control disorders" not examined within the Latino cohort).[2]

Whether these rates reflect underdetection in newly immigrated Latinos is uncertain. In particular, Mexican Americans born in the United States show a significantly higher rate of suicidal ideation than do Mexican Americans born in their native country (13.0% versus 4.5%), after adjusting for age and gender.[2] In addition, ethnic subgroups of Latinos report different rates of depressive symptoms.[1] For instance, the lifetime prevalence of psychiatric disorders among Puerto Rican immigrants is higher (by 27%) than it is for Mexicans.

Age also affects the development of mental health problems; Latinos ≥ 65 years of age are twice as likely to experience depression[3] as are whites of a similar age, while Latino adolescents are more likely than adolescents of other ethnic groups to have depression.[4,5] In addition, Latina women are more likely to develop postpartum depression than are white women.[6–8] Gender differences in rates of psychiatric history vary by ethnicity and by disorder. According to the National Latino and Asian American Study,[9] women show marginally higher rates of lifetime and past-year psychiatric diagnoses (30.2% vs 28.1% and 17.4% vs 13.47%, respectively). Generally, women show higher rates of depressive and anxiety disorders, while men have an increased likelihood of developing substance use disorders. Among ethnic subgroups, Cuban immigrants display the greatest gender disparity; women were 21% more likely to meet criteria for a lifetime psychiatric history than were men. This rate contrasts with Mexican women, who exhibited a 6% increased risk. Latino subethnicities grouped into a remaining category showed no difference in the rates between men and women.[1,9,10] Another study cited higher Center for Epidemiological Studies Depression Scale scores among immigrant Mexican women compared to their male counterparts.[11]

WHY DO LATINOS DEVELOP PSYCHIATRIC PROBLEMS?

While Latinos in the United States develop psychiatric symptoms for disparate reasons, problems with acculturation (the process by which new immigrants acquire language and adopt the customs of the dominant society) are often at play. Acculturative stress (ie, the "unlearning" of native culturally-based behaviors and the adoption of American culture)[12] can be categorized into economic, legal, social, and language stressors. Economic stressors (eg, having trouble finding and maintaining employment) can hinder access to health insurance and health care and result in discontinuous care. Unstable housing can contribute to inconsistent access to health care. Legal concerns (eg, the fear of being discovered as an illegal immigrant) and the complexity of the naturalization process are also stressful.

Social stresses often accompany the adoption of the English language and are a by-product of learning about, and assimilating to, American culture; changes in gender roles for couples and changes in social roles (among parents and children) often develop. For example, Latino adolescents exhibit higher rates of depression than do their white counterparts.[13] Those individuals with limited English proficiency can feel marginalized, and newly immigrated families may feel segregated from the rest of society. Geriatric Latino patients often report feeling isolated from younger family members who are out of the home (and attending schools or work). Intrafamilial marginalization also interferes with a sense of community among the elderly.[14] In addition, intergenerational conflicts between parents and assimilating children can impede psychological adjustment. Language difficulties exacerbate almost all of the above factors, making Latinos more vulnerable to psychological problems,[15,16] and interfere with the reporting of psychiatric symptoms and the assessment of psychiatric illness.

HOW CAN ONE SCREEN LATINOS FOR PSYCHIATRIC ILLNESS?

Effective communication facilitates accurate assessments. Unfortunately, patients with limited English proficiency are at significantly higher risk of experiencing medical errors.[17–22] Lower levels of English proficiency have an

adverse impact on a patient's comprehension of medical situations and medication use.[23] Conversely, access to language-concordant physicians increases understanding and adherence.[24] Although language-concordant providers are not available for every clinical encounter, interpreters can be obtained (whether in person or via telephone).

To evaluate a Latino patient's level of English proficiency, clinicians can ask several questions, such as, What language do you (usually) speak at home? What brought you in today? and Can you please describe your daily routine? The patient's responses to these questions should be assessed for clarity and understanding. If the clinician finds himself or herself repeating the questions in different ways to facilitate patient comprehension, an interpreter may be needed. Answers that do not require a binary response (yes/no), or a brief response, may prove more valuable in this assessment of language skills. Qualitative responses allow one to judge how effectively the patient can articulate his or her thoughts in English and understand the question asked. Asking the English-proficient patient which language he or she thinks in may also be useful. Questions can be modified to take into account the interests and concerns of the patient. When the level of English proficiency is questionable, it is safer for the clinician to engage the services of an interpreter.[25,26] As the severity of psychopathology increases, assessment of English proficiency can become problematic. Furthermore, it is important to remember that patients presenting for medical care, especially to an emergency department, are generally ill. Stress associated with illness can hinder the ability of a patient with limited English proficiency to communicate in English. A patient's affect can also be altered by the process of speaking and understanding a second language.[27]

It is not entirely clear as to which interpreter modality is "best," but patient satisfaction surveys suggest that patients prefer language-concordant providers, face-to-face interpreters, and telephone interpreters (in that order). While Resident 1 may have viewed himself as a language-concordant provider, his communication with the patient may not have been ideal. Language fluency is context dependent[28] and requires a high level of oral understanding and oral expression; therefore, one must be trained in medical Spanish, and beyond that, specifically trained in mood-related vocabulary and in psychiatric interviewing.

A 2004 survey administered to a national sample of US house officers found that more than half of the respondents reported having had no instruction on how to assess patient literacy.[29] Roughly one-third (35%) of respondents reported little or no instruction on how to deliver care via an interpreter. Perhaps Resident 1 felt uncomfortable using an interpreter. Maybe he felt overconfident in his level of fluency (false fluency and other errors made by untrained interpreters are significantly more likely to have clinical consequences).[19] Regardless of the reason, Resident 1 failed to call for an interpreter in a situation wherein it was warranted. These issues may be ameliorated by enhancing the education of house officers on how to appropriately and effectively utilize interpreters. In addition, objectively assessing one's own level of fluency in Spanish can help predict whether an interpreter will be required during clinical interactions.

The validated Language Experience and Proficiency Questionnaire (which takes about 15 minutes to complete) yields a language proficiency rating that can be used to gauge speaking ability.[30] Assessment of adequate proficiency does not discount elements (including one's vocal intonation and volume, facial expressions, and conveyance of genuine concern) central to clinical interviewing and to patient interactions. Clinician language can modulate the assessment of symptom severity as well. One 1998 study showed that bilingual clinicians were more likely to rate symptoms as more severe, followed by Spanish-speaking clinicians, and then English-speaking clinicians.[31] Therefore, both language of assessment and the interviewer's cultural orientation can impact assessment of mental illness.[31]

The use of interpreters is crucial to psychiatric assessment. It is also mandated by law. Title IV of the Civil Rights Act of 1964 (www2.ed.gov/programs/equitycenters/civilrightsact.doc) stated that appropriate language services must be provided to patients with limited English proficiency. Interpreters can help to establish expectations before the clinical encounter and interpreter-clinician teams can facilitate translation of nonverbal communications. Since expression of mental illness may differ between whites and Latinos and among Latino ethnic subgroups, knowledge of culture and behavior is crucial. For instance, it is common for Latinos to express *empacho* or gastrointestinal distress in response to emotional disturbance. It is likely that Ms A's constipation and diffuse abdominal pain conferred *empacho*. Latinos experience the mind and body as a unified whole and therefore can have difficulty separating somatic concerns from psychological ones (a condition known as *nondualism*).[32] Ms A most likely showed symptoms of *empacho*, with abdominal distension, headache, dry mouth, diarrhea, vomiting, and a reduced appetite.[17] Cultural competence (including language competence, nonverbal communication, and knowledge of cultural values and customs) on the part of her provider may have changed the initial assessment.

Colloquialisms are common within the Spanish language: *fatiga* means shortness of breath, whereas *sofocada* means fatigue. Two related terms are *susto*, which refers to chronic depression or anxiety and is sometimes secondary to a traumatic experience, and *ataque de nervios*, a somatic response comprised of anxious, dissociative, and depressive symptoms. The word *triste* literally means sad and can also describe depressive symptoms. Nonverbal communication can be equally important; for instance, Latinos take offense to being beckoned with the index finger. Even if clinicians are unaware of the cultural differences between these groups, recognizing that there is indeed a difference is a step in the right direction.

Awareness of values (such as the emphasis on alternative medicine and herbal remedies) can also ease communication. Latinos are highly likely to seek alternative forms of health

Table 1. Diagnostic Tools for Physicians Assessing Psychopathology in the Primary Care Setting

Diagnostic Tool	Population	Utility	Approximate Test Duration (min)/ No. of Items
Spanish version of Patient Health Questionnaire	General hospital inpatients; N = 1,003[39]	88% overall accuracy, 87% sensitivity, 88% specificity	3/9–12
Hospital Anxiety and Depression Scale	General medical outpatients; N = 385[41]		3/14 (7 items for each subscale)
Depression subscale		80% overall accuracy, 72% sensitivity, 87% specificity	
Anxiety subscale		83% overall accuracy, 80% sensitivity, 85% specificity	
Edinburgh Postnatal Depression Scale	Women (Spanish mothers) attending a routine postnatal checkup; N = 1,201[42]	Numbers refer to subscale for combined major-minor depression, 63.2% positive predictive value, 97.7% negative predictive value, 79% sensitivity, 95.5% specificity	3/10
Mood Disorder Questionnaire for screening bipolar II	Spanish-speaking patients with past major depressive episode (single or recurrent), not previously known as bipolar; N = 87[43]	72.7% sensitivity, 82.9% specificity	3/13

care that serve adjunctive roles complementing Western care, as opposed to replacing them. Some terms to be familiar with that pertain to alternative medicine include *yerberos* (or herbalists), *curanderos* (folk medicine healers), *espiritistas* (spiritualists), and *sobadores* (masseuses).[32] Not all Latino populations react in the same manner; cultural values and customs differ among Latino subethnicities. Of note, Latinos of Mexican background are the fastest growing segment of the US population, projected to comprise the largest Latino constituency in new census data.[33]

The appropriate use of interpreters can lead to fewer errors in communication and can improve clinical outcomes as well as increase patient satisfaction.[19] Increasing the comfort of the population with limited English proficiency in the primary care setting improves service utilization and increases the use of preventive care. Appropriate use of interpreters may ultimately decrease health care costs.

It is especially important to note how interpreters influence the patient-provider interaction. Inadequately trained interpreters may unintentionally misconstrue a patient account through the omission of important details, normalization of pathological behavior, or insertion of information not provided by the patient.

Numerous studies discourage the use of family members and friends as interpreters because they can interfere with patient disclosure and the accurate reporting of symptoms.[19,25,34,35] As the level of psychopathology increases, the chances that an untrained interpreter may be detrimental to the clinical encounter increases.

WHEN IS THE BEST TIME TO SCREEN A PATIENT FOR PSYCHIATRIC ILLNESS?

Screening is best accomplished after a clinician has established some rapport with a patient. Even when a language barrier exists, rapport can be built through listening to the answers of the questions provided above. With Latinos, nonverbal communication often sets the tone for the encounter. Facing the patient and making eye contact indicate that appropriate attention is being paid to the patient and to his or her problem.

As Latinos use primary care services more than mental health and specialty services,[32,36] mental health screening in primary care settings can reach more Latino individuals who are at risk, can provide continuity of care, and can decrease the stigma associated with receiving mental health care.[32] In fact, Latinos are significantly more likely than whites to seek mental health care in the primary care context. For instance, studies document the utilization rate of primary care as more than double that of mental health care among Mexican Americans already identified as experiencing mental illness.[36]

The prevalence of psychiatric symptoms in primary care clinics depends on the nature of the disorder being assessed and the patient's subethnicity. Posttraumatic stress disorder occurs at rates between 10% and 30% within populations accessing primary care, but literature indicates that this rate may be higher among Latinos.[37,38] Research shows that Latinos with limited English proficiency have lower rates of physician usage as compared to their English-proficient counterparts, but appointment compliance rates are comparable.[39]

Some useful screening tools include the Spanish-validated 36-item Medical Outcomes Study Short-Form Health Survey,[40] the Patient Health Questionnaire,[41] and the 12-item General Health Questionnaire,[42] each of which have been validated within Spanish-speaking populations. Other diagnostic tools are also readily available for the assessment of psychopathology in the primary care context (Table 1).[40–45] The patient's reading level must also be considered when using such tools. The results of such tools can be transcribed and evaluated easily by non–Spanish-speaking clinicians. More complicated clinical interviews (eg, the Structured Clinical Interview for *DSM-IV* diagnoses[46]) require the use of clinically prepared fluent speakers.

Unfortunately, many of our diagnostic tools fail to account for colloquial differences in language or for divergent cultural values. Increasing physicians' cultural competence (eg, involving an awareness of cultural values, knowledge

of the dynamics of cultural differences, the development of cultural knowledge, and adaptation of clinical practices to the patients' context) can compensate for these inadequacies.

WHAT ARE THE CONSEQUENCES OF DETECTING PSYCHIATRIC ILLNESS?

A patient cannot be treated for a mental illness that goes undetected. Identification of psychiatric disorders has the immediate impact of engaging more individuals in a system meant to monitor and track illness. This monitoring in turn provides a more accurate basis for epidemiologic studies (by augmenting measurements of incidence and prevalence of illness within populations).

Early detection of mental illness and timely referral to mental health specialists can increase behavioral compliance and medication adherence. Detection can decrease risk factors for systemic conditions and contribute to health maintenance. Lower costs result from patients not "recycling" through the health care systems due to undetected illness.[47]

DO LATINOS MANIFEST PSYCHIATRIC SYMPTOMS DIFFERENTLY THAN THOSE IN OTHER ETHNIC GROUPS?

Latinos are less likely to report psychological concerns, tending to emphasize physical (eg, headache, gastrointestinal upset) rather than psychiatric (eg, depression and anxiety) symptoms, in large part as a consequence of stigma. Such differences heighten the role of primary care physicians in the administration and management of mental health.

CONCLUSIONS

Latinos are less likely than other ethnic groups to seek follow-up care for any medical malady, they have significantly fewer visits with specialists than their white counterparts, and they report having fewer physician visits overall. Nonetheless, patients like Ms A commonly present to emergency departments and to urgent care clinics in metropolitan areas. By employing some of the skills mentioned above, the primary care physician will be able to make the clinical interaction as comfortable as possible so that patients will feel more at ease when seeking services in the future and will thereby receive appropriate care. Through recognition of the need for linguistic support, familiarity with cultural norms, and adaptations to clinical assessments, the provider can feel better equipped to treat patients with limited English proficiency in varying cultural backgrounds.

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