Acculturation and Cultural Concepts of Distress in Hispanic and Latino Communities

National Hispanic and Latino MHTTC
September 20, 2019

Roberto Lewis-Fernández, M.D.
Professor of Clinical Psychiatry
Columbia University
Director, NYS Center of Excellence for Cultural Competence
and Hispanic Treatment Program
Co-Director, Anxiety Disorders Clinic
New York State Psychiatric Institute

Outline

• Community characteristics of Hispanics/Latinos in the US
• Prevalence of mental health conditions
• Impact of acculturation
• Role of cultural concepts of distress
• Disparities in treatment utilization and engagement
• Conclusions

COMMUNITY CHARACTERISTICS
US Latino population, 2017

- 57 million
- 18.1% of US population
- 33.5% foreign-born

- Up to age 17: 25.2%
- 5.6% foreign-born

- Age 18 and older: 16.0%
- 46.3% foreign-born

Source: U.S. Census Bureau, 2017

US Latinos by country of origin


US society composition is changing rapidly

Projected Distribution of the US Population by Racial/Ethnic Group, 2015 to 2060

Source: 2014 National Population Projections
West to east migration trend

![Map showing west to east migration trend](image)

**Latino Population as a Percentage of Total Population by State**
- 25.0 or more
- 12.5 to 24.9
- 6.0 to 12.4
- Less than 6.0

**Latinos were 15.8% of US population in 2009**

**Highest % growth in the South**

Other community characteristics

**Latinos vs. whites: 2017 census**

- **Low income**
  - Poverty level: 19.4% vs. 6.1%
- **Low education**
  - No HS diploma by age 25: 31.3% vs. 7.1%
- **Importance of Spanish**
  - Only speak English: 27.9% vs. 94.4%
- **High un-insurance and under-insurance**
  - Uninsured: 17.8% vs. 7.8%

PREVALENCE OF MENTAL HEALTH CONDITIONS
Mental Illness Distribution by Race/Ethnicity, United States, 2015-2016

Source: Substance Abuse and Mental Health Services Administration (SAMHSA)'s restricted online data analysis system (RDAS) Survey: National Survey on Drug Use and Health: 2-Year R-DAS (2015 to 2016), //rdas.samhsa.gov/#/survey/NSDUH-2015-2016-RD02YR/rosstab/?

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Any Mental Illness</th>
<th>Serious Mental Illness</th>
<th>Major Depressive Episode</th>
<th>Suicidal Ideation</th>
<th>Co-occurring Mental Illness</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>19.6</td>
<td>4.7</td>
<td>7.5</td>
<td>5.7</td>
<td>3.3</td>
</tr>
<tr>
<td>Black</td>
<td>21.7</td>
<td>5.6</td>
<td>9.3</td>
<td>6.2</td>
<td>3.5</td>
</tr>
<tr>
<td>American Indians/Alaska Natives</td>
<td>15.1</td>
<td>3.2</td>
<td>5.8</td>
<td>2.8</td>
<td>2.8</td>
</tr>
<tr>
<td>Hispanic</td>
<td>11.8</td>
<td>1.6</td>
<td>3.9</td>
<td>2.5</td>
<td>1.4</td>
</tr>
<tr>
<td>Asian</td>
<td>14.4</td>
<td>3.5</td>
<td>5.5</td>
<td>3.1</td>
<td>3.1</td>
</tr>
<tr>
<td>Other</td>
<td>14.7</td>
<td>2.6</td>
<td>4.1</td>
<td>2.4</td>
<td>2.4</td>
</tr>
</tbody>
</table>


<table>
<thead>
<tr>
<th>Subgroup</th>
<th>Any Depressive Disorder</th>
<th>Any Anxiety Disorder</th>
<th>PTSD</th>
<th>Any Substance Disorder</th>
<th>Any Disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td>White, not Latino</td>
<td>22.6</td>
<td>15.6</td>
<td>6.8</td>
<td>13.8</td>
<td>37.4</td>
</tr>
<tr>
<td>Latino US-born</td>
<td>21.7</td>
<td>14.8</td>
<td>11.3</td>
<td>9.5</td>
<td>32.5</td>
</tr>
<tr>
<td>Latino immigrant</td>
<td>19.8</td>
<td>15.9</td>
<td>9.5</td>
<td>10.4</td>
<td>32.8</td>
</tr>
</tbody>
</table>

Lifetime Prevalence of Psychiatric Disorders by Latino Subgroup in the US


<table>
<thead>
<tr>
<th>Subgroup</th>
<th>Any Depressive Disorder</th>
<th>Any Anxiety Disorder</th>
<th>PTSD</th>
<th>Any Substance Disorder</th>
<th>Any Disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td>Puerto Rican</td>
<td>21.7</td>
<td>16.7</td>
<td>7.7</td>
<td>14.4</td>
<td>39.4</td>
</tr>
<tr>
<td>Cuban</td>
<td>25.7</td>
<td>20.4</td>
<td>11.4</td>
<td>15.6</td>
<td>40.4</td>
</tr>
<tr>
<td>Mexican</td>
<td>15.9</td>
<td>15.8</td>
<td>9.8</td>
<td>14.4</td>
<td>31.2</td>
</tr>
<tr>
<td>Other</td>
<td>15.3</td>
<td>15.6</td>
<td>9.5</td>
<td>13.8</td>
<td>32.2</td>
</tr>
</tbody>
</table>
IMPACT OF ACCULTURATION

Psychopathology increases with acculturation

Greater acculturation in Latinos is associated with higher prevalence of:

- Mood/anxiety disorders
- Suicidal ideation and attempts
- Substance use disorders
- Psychotic-like symptoms
- Ataque de nervios

Effect of acculturation increases linearly for most Latino subgroups
Odds of Depression/Anxiety among Mexican Americans, by Acculturation Level

Lewis-Fernández et al., *Psychol Med*, 2016

NESARC

Odds of Depression/Anxiety among Puerto Ricans, by Acculturation Level

Lewis-Fernández et al., *Psychol Med*, 2016

NESARC

But not for Puerto Ricans
Something special about Puerto Ricans

- No evidence of acculturation effect on mood/anxiety disorders
- Higher LT prevalence of any psychiatric disorder than other Latinos
- Higher rates of suicidal ideation and attempts than other Latinos
- Effect of acculturative stress on internalizing symptoms and antisocial behaviors even in Puerto Rico

So any explanation for effect of acculturation must:
- Explain why effect increases linearly
- Be consistent with Latino subgroup variation

Possible explanations

- Loss of protective cultural factors
  - Family cohesion and support, ethnic pride, spiritual practices to cope with adversity, resignación (acceptance/resignation)
- Cumulative adverse experiences
  - Discrimination, acculturative stress, substance abuse, marital disruption
- Relative deprivation
- Frustrated status
- Ethnic density
- Sending country prevalence of disorder
Clinical implications

- Focus on the meaning of the acculturation index in each person and subgroup, as it may differ
- Likely candidates of adverse effect:
  - Acculturative stress
  - Intergenerational conflict
  - Demoralization
  - Marital disruption
  - Racial-ethnic discrimination
  - Loss of family cohesion & support, ethnic pride, adaptive accommodation, and spiritually oriented coping
- Clarify and reinforce adaptive acculturation pathways found
- Psychotherapies tailored to maladaptive acculturative coping (e.g., intergenerational family disputes)
- Preventive strategies w/ at-risk Latino youth (e.g., school-based)

ROLE OF CULTURAL CONCEPTS OF DISTRESS

Diagnoses & cultural concepts

Source: Peter Guarnaccia, PhD
**DSM-5 & Caribbean cultural concepts**

- Major Depression: Ataques de nervios
- GAD: Altered perceptions
- PTSD: Suffer from nerves
- Panic Disorder: Be sick with nerves
- Schizophrenia: Be loco
- Other specified dissociative disorder: Have facultades
- Conversion disorder: Suffer from a demon
- Borderline Personality Disorder: Be nervous since childhood

**Uses of cultural concepts**

- Avoid misdiagnosis
- Obtain useful clinical information
- Improve clinical rapport and engagement
- Improve therapeutic efficacy
- Guide clinical research
- Clarify the cultural epidemiology

**Most frequent symptoms of 1st ataque (N=77)**

<table>
<thead>
<tr>
<th>Panic-like symptoms</th>
<th>Dissociative symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Became nervous</td>
<td>Surroundings seem unreal</td>
</tr>
<tr>
<td>Trembled a lot</td>
<td>Body felt unreal</td>
</tr>
<tr>
<td>Palpitations</td>
<td>Lost consciousness</td>
</tr>
<tr>
<td>Chest pressure</td>
<td>Period of amnesia</td>
</tr>
<tr>
<td>Felt like was suffocating</td>
<td></td>
</tr>
<tr>
<td>Heat in chest</td>
<td></td>
</tr>
<tr>
<td>Afraid of going crazy</td>
<td></td>
</tr>
<tr>
<td>Afraid of dying</td>
<td></td>
</tr>
<tr>
<td>Dizzy</td>
<td></td>
</tr>
<tr>
<td><strong>Loss of control</strong></td>
<td><strong>Anger and aggression</strong></td>
</tr>
<tr>
<td>Became hysterical</td>
<td>Feel angry</td>
</tr>
<tr>
<td>Lost/afraid of losing control</td>
<td>Broke things</td>
</tr>
<tr>
<td>Screamed a lot of control</td>
<td></td>
</tr>
</tbody>
</table>

**Dissociative symptoms**

- Surroundings seem unreal: 53%
- Body felt unreal: 42%
- Lost consciousness: 35%
- Period of amnesia: 29%

**Anger and aggression**

- Feel angry: 52%
- Broke things: 26%

**Suicidality symptoms**

- Suicide thoughts: 20%
- Suicide attempt: 14%

**Other symptoms**

- Cried/attacks of crying: 88%
- Fainted: 43%

*(Guarnaccia et al, CMP, 1996)*


**Lifetime prevalence of ataque de nervios**

- Psychiatric samples of Puerto Ricans
  - Massachusetts (N=89): 55.1%
  - Puerto Rico (N=97): 51.5%

- Community studies of Latinos
  - Puerto Rico (N=912): 13.8%
  - US (N=2,554): 5.4% – 10.9%

Guarnaccia et al., JNMD, 1993; Lewis-Fernández, Guarnaccia et al, Perspectives in Crisis Care Psychiatry, 2005; Guarnaccia, Lewis-Fernández et al., IJP, 2008

---

**Ataque as independent outcome marker**

Adjusted OR’s (95% CI) of ataque vs. no ataque:

- MH-related disability: 2.25 (1.5-3.4)
- Suicidal ideation: 2.4 (1.5-3.7)
- Outpatient MH care: 2.2 (1.3-3.8)

Adjusted for age, gender, education, income, marital status, psychiatric disorders, chronic medical conditions, traumatic exposure, ethnic origin, time in US, language, use of religion for MH problems

NLAAN, N=2,554

Lewis-Fernández et al., JNMD, 2008

---

**Altered perceptions and impairment in NYC primary care clinic** (N=1,005)

- Percent:
  - Poop Emotion: 2%
  - Work Loss: 25%
  - Parent-Child Distress: 10%
  - Marital Distress: 25%

- Suicidal ideation: 20% vs. 3.7%; AOR=3.4

Olfson, Lewis-Fernández et al., Am J Psychiat 2002
Altered perceptions as independent outcome marker

Adjusted OR’s (95% CI) of altered perceptions vs. no altered perceptions:

- MH-related disability: 1.8 (1.2-2.7)
- Suicidal ideation: 2.3 (1.5-3.6)
- Outpatient MH care: 1.7 (1.1-2.6)

Adjusted for age, gender, education, income, marital status, psychiatric disorders, chronic medical conditions, traumatic exposure, ethnic origin, use of English, language, use of religion for MH problems.

Lewis-Fernández et al., JNMD, 2009

NLAAS; N=2,554

DISPARITIES IN TREATMENT UTILIZATION AND ENGAGEMENT

Disparities = differences except due to clinical need & appropriateness & patient preferences (IOM)

Clinical Need & Appropriateness, Patient Preferences
Healthcare Systems & Legal/Regulatory Systems, Insurance
Discrimination: Bias, Stereotyping, & Uncertainty

Institute of Medicine, Unequal Treatment, 2002
Mental Health Treatment Utilization by Race/Ethnicity, United States, 2015-2016

Aspects of engagement

- Engagement incorporates various stages of health care including:
  - Initiation of care
  - Participation in health care visits
  - Adherence to treatment
    - E.g., medication taking, CBT homework
  - Retention

Limited engagement is the rule

- All R/E groups, including NL Whites, have low engagement
- Engagement tends to be lowest in underserved minorities
  - Lower acceptability of mental health care (e.g., higher stigma)
  - Lower initiation of care once ill
  - Lower continuity of care
  - Lower visit participation
  - Lower medication adherence
  - Lower retention
- Occurs in context of poorer access to and quality of care for these groups


Cooper et al., Med Care, 2003; Fosu et al., Med Care, 2002; Harman et al., Psychiatr Serv, 2004; Miranda & Cooper, Gen Intern Med, 2004; Olfson et al., Am J Psychiatry, 2006
Odds Ratio of AD retention over 30 days (N=829)

Adjusting for age, sex, & pretreatment MH status

Olfson et al., Am J Psychiatry, 2006

Cultural concepts of distress

48-year old Dominican woman
- Stopped AD at wk 6 after substantial improvement of MDD
- AD “very necessary” to “control too much liquid in brain that causes the depression”, but patient is “nervous since childhood” and has ataques de nervios (attacks of nerves)
- Therefore relapse is inevitable, and ongoing AD is useless and harmful, causing “effects on other organs”
- Had stopped AD in past and expects will need to restart AD in future once her MDD relapses

Disparities in access to & quality of care

- Depressed racial/ethnic minorities are less likely than majority whites to:
  - Have access to care
  - Be identified as being depressed
  - Be engaged in participatory communication
  - Receive
    - Equal assessment time
    - Guideline-concordant care, in terms of dose, duration, and number of visits

Borowsky et al., JSSH, 2000; Yang et al., Am J Prev Med, 2001; Miranda et al., Epidemiol Rev, 2003; Olfson et al., JGIP, 2009; Alegría et al., Health Affairs, 2016; Aggarwal et al., Patient Educ Couns, 2016; Lewis-Fernández et al., J Clin Psych, 2018
Barriers to engagement: The usual suspects

- Organization
  - Service fragmentation
  - Reimbursement policies
  - Clinic schedule
  - Low continuity of care
  - Long wait lists for appointments

- Provider
  - Turnover
  - Limited training
  - Multiple demands
  - Limited resources
  - Time constraints

- Patient
  - Lack of medical insurance
  - High medical cost
  - Comorbid substance use disorder
  - Competing demands
  - Transportation, child care
  - Low motivation/Avolition
  - Lack of family/social support

These barriers are just the tip of the iceberg

- Patient
  - Lack of medical insurance
  - High medical cost
  - Comorbid substance use disorder, etc.
  - Stigma
  - Alternate views of illness

- Organization
  - Service fragmentation
  - Reimbursement policies, etc.
  - Guideline-dissonant care
  - Lack of appropriate language services
  - Limited workforce diversity
  - Mismatch of treatment and expectations of patient and social network

Barriers: Beyond the usual suspects
Cultural/structural competence & engagement

- Delivery of mental health care should be consistent with health expectations, values, and social context of consumers
- Structural barriers to care must be overcome to increase engagement

CSC engagement strategy levels

- Patient
  - DECIDE
- Provider
  - Multifamily Group Intervention
  - Motivational Pharmacotherapy
  - Cultural Formulation Interview
- Organizational
  - Cultural Consultation Service
- Community
  - Community Partners in Care

Provider level
CC Engagement: Provider level

Motivational Pharmacotherapy

- Manualized pharmacotherapy + Motivational Interviewing (MI), with cultural adaptations
- Non-engagement conceptualized as ambivalence
- Incorporates MI spirit, goals, and techniques
- MI spirit in MPT:
  - Empathic, non-confrontational
  - Developing discrepancy
  - Rolling with resistance
  - Working with patient’s strengths, building self-efficacy
  - Patient and clinician as equal experts


Providing AD information – Usual care

Patient: I have now been taking these medications for almost 10 days and I still don’t feel any different.

Clinician: Sure, it’s important to understand that these medication typically take a few weeks until they begin to work. [Educating]

Courtesy of Alejandro Interian, PhD

Providing AD information – MI-consistent

Patient: I have now been taking these medications for almost 10 days and I still don’t feel any different.

Clinician: You’re not happy about this. You’ve gone through the trouble of meeting with us, filling your prescription, and taking your medication, and at this point, you really want to feel better. [Empathy]

Courtesy of Alejandro Interian, PhD
**MPT: Evoking change talk**

**Values & Goals Card Sort**
- 34 values and goals listed on cards
- Asked to select three most important
- Briefly explore each value and goal

“How have your values and goals been affected by your depression?”

Offer a summary of the patient’s description of how the depression has affected their life values and goals

<table>
<thead>
<tr>
<th>Taking care of my family</th>
<th>Devotion to God</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal hygiene</td>
<td>Raise my children well</td>
</tr>
<tr>
<td>Being energetic</td>
<td>Good health</td>
</tr>
<tr>
<td>Be popular</td>
<td>Enjoying life</td>
</tr>
<tr>
<td>Help family in my country</td>
<td>Being well-educated</td>
</tr>
</tbody>
</table>

Balán, Moyers & Lewis-Fernández, Psychiatry, 2013

---

**MPT: Evoking change talk**

Patient: I have now been taking these medications for almost 10 days and I still don’t feel any different.

Clinician: You’re not happy about this. You’ve gone through the trouble of meeting with us, filling your prescription, and taking your medication, and at this point, you really want to feel better. [Empathy; reflection to evoke change talk]

Patient: Yes, I definitely want to feel better. I hate feeling like this. [Change talk]

Clinician: This depression you are going through is really making a difference in your life. [Empathy, developing discrepancy]

Patient: I know, I’ve had enough, I’m ready for a change. [Change talk]

Courtesy of Alejandro Interian, PhD

---

**Cultural adaptations in MPT**

- Elicit patient’s cultural understandings of illness
- Use patient’s own illness terms
- Negotiate “expert” role and power differential
- Lists of concerns about AD’s derived from qualitative data
  - Use in negotiating AD onset, choice, dosing, timing of doses
- Confidence-building exercise tailored to low-income migrants
- Tailor course of ADT to expectations about nervios
  - Stepped care, minimum dose, minimum duration

Balán, Moyers & Lewis-Fernández, Psychiatry, 2013
Concerns about ADT among Latinos

- Stigmatization of ADT
- Disparaging views about ADT
- Notions about medications that conflict with ADT
- Folk ideas about ADT, including when/how to take
- Concerns about adverse effects of ADT
- Fear of dependence and addiction

Vargas et al., Transcultural Psychiatry, 2015

Retention in MPT

Lewis-Fernández et al., Psychiatry, 2013

Impact of MPT on patient engagement

39-year old Dominican woman

- Nearly discontinued ADT for MDD at week 3, one week after increase to sertraline 50mg/d
- Mild tremor indicated “my nervios are becoming uncontrolled”
- Side effect related to fear of progressive loss of motor and behavioral control, resulting in family chaos
- Negotiation of medical and cultural views led to clarification of side effect and medication switch to venlafaxine XR
- Patient completed 12-week ADT trial
**CSC Engagement: Provider level**

**DSM-5 Cultural Formulation Interview**

- Systematic set of interviews to guide cultural assessment during evaluation/treatment planning with any consumer by any provider in any care setting
- CECC NYSPI led its development and inclusion in DSM-5
- Three components:
  - Patient
  - Core CFI
  - Supplementary Modules (use as adjunct or in-depth cultural assessment tool)


---

**Goals of CFI**

- Elicit patient’s story, listen to person’s perspective
- Clarify meaning of illness or predicament
- Learn and use patient’s vocabulary
- Increase rapport and trust, enhance alliance
- Obtain information to align treatment with patient’s expectations
- Evidence caring
- Expand what counts as evidence in assessment
- Help empower patient


---

**What is culture?**

- Culture as process of meaning making
- Linked to participation in multiple social groups
- Culture has always been mixed or creolized
- Risks of thinking of culture as static group characteristics
- Must engage person to elicit cultural views

Fish don’t know they are in water
**DSM-5 Definition of Culture**

Values, orientations, knowledge, and practices that individuals use to understand their experiences.

Aspects of a person’s background, experience, and social contexts that may affect his or her perspective.

The influence of family, friends, and other community members (the individual’s social network) on the individual’s illness experience.

---

**Core CFI Domains & Questions**

**Cultural Definition of Problem**
- Definition of Problem
  - Own definition
  - How describe to social network
  - Most troubling aspect

**Cultural Perceptions of Cause, Context, and Support**
- Causes
  - Cause of problem
  - Cause per social network
  - Stressors and supports
  - How environment is stressful
  - Role of cultural identity
  - Key aspect of background or identity
  - Effect on problem
  - Other concerns re cultural identity

**Cultural Factors Affecting Coping and Help Seeking**
- Self-coping
  - Methods of self-coping
  - Paste help seeking
- Help seeking from diverse sources
- Barriers
- Barriers to obtaining help

**Current Help Seeking**
- Preferences
- Most useful help at this time
- Other help suggested by social network
- Clinician-Patient Relationship
- Concerns about misunderstanding affecting care

---

**Results of CFI Field Trial**

Interview duration p=0.004

CFI duration p=0.001

- Lewis-Fernández et al, Br J Psychiatry, 2017
Goal: To foster person-centered, culturally competent, recovery-oriented treatment planning by offering practitioners cutting-edge interactive online training on effective use of CFI

In partnership with: Center for Practice Innovations (CPI) at NYSPI/Columbia University, experts in online training

CFI Online Training Module

Key features:
- 55-minute training session
- Available online through CPI web platform
- “Action Planners” to support implementation in real-life program settings

http://nyculturalcompetence.org/cfionlinemodule/

Conclusions

- Intra-Latino variations in risk of mental health problems
- Lower service access than non-Latino whites
- Value of understanding impact of acculturation and cultural concepts of distress
- Cultural and structural aspects of care affect engagement
- Established engagement strategies must be enhanced with cultural/structural competence (CSC) approaches
- Promising CSC interventions being developed at patient, provider, organizational, and community levels
- Partnership among all stakeholders is essential for success

roberto.lewis@nyspi.columbia.edu
CFI Online Training Module

http://nyculturalcompetence.org/cfionlinemodule/