The American Journal of Psychiatry and the APA Committee of Residents and Fellows

Residents' Journal

December 2008: Volume 3, Issue 12

The Residents' Journal

Contents

The following is an interview with Arthur Kleinman, M.D., on "Cultural Anthropology and Global Mental Health," conducted by Anna Yusim, M.D. Dr. Kleinman is the Esther and Sidney Rabb Professor and former Department Chair of Harvard University's Department of Anthropology. Dr. Kleinman is also Professor and former Department Chair of Harvard Medical School's Department of Social Medicine. As one of the international community's leading medical anthropologists, Dr. Kleinman directed the 2001 World Mental Health Report. Dr. Yusim is a third-year Adult Psychiatry Resident at NYU and one of the Deputy Editors for the Residents' Journal.

Dr. Yusim: You chose to pursue a career that combines medicine and anthropology at a time when these two fields were considered disparate entities. How did you make this decision?

Dr. Kleinman: After completing my internal medicine internship at Yale during the Vietnam War, I became a Clinical Fellow at the NIH Institute of Allergy and Infectious Diseases. Thus, I began my medical career studying not psychiatric disease but leprosy and tuberculosis. Because my wife knew Chinese, I was sent as a public health service officer to the Navy medical research unit in Taiwan, where I was immediately impressed with the stigma associated with infectious diseases. In looking at stigma, it was impossible to realize how large a role history and culture played in determining which diseases were stigmatized, which carried less stigma, and which were even in some way "glamorous" to have, like tuberculosis, which at the time was thought of as deepening people's sensibilities and thus bringing them closer to the romantic notion of ineffability and the transitory nature of life. After that experience, I went to Harvard and studied anthropology because I wanted a systematic way to understand the social consequences of illness. I chose to study psychiatry because it was the most humanistic of the medical disciplines and, by focusing on the anxiety/depression associated with medical disorders, would enable me to combine anthropology with a medical specialty.

Dr. Yusim: In your career, you basically defined the entire field of medical anthropology. How did you go about doing this, and what are some of the fundamental tenets of this field?

Dr. Kleinman: The medical and academic world was very different when I trained. In the middle of my residency, I was awarded a wonderful fellowship that allowed me to spend part of my time during my residency on research and writing and after my residency ended to go back to the field (Taiwan) for 1 year. This really supported my intellectual life. In the middle of all this, I published four articles and wrote my first book, which ended up defining my career. One article was on the central role of meanings in medicine. The second was an attempt to lay out a model for comparing healthcare systems around the world. The third compared the different forms of medical care around the world, like biomedical care and religious and folk sorts of healing. The fourth article was related to the history of public health in China. Then I wrote my first book, *Patients and Healers in the Context of Culture*. It basically says that public health has it entirely wrong. If you really want to know what healthcare in society is like, you need to begin with the individuals who are sick. You need to examine the decisions they make, the ideas they have, and the ways in which they choose to navigate the different arenas of healthcare. In one of my empirical studies, I showed that around 75% of illness episodes in China never left the family network. People never went to any doctor or folk healer at all. This was an area even anthropology was not studying. This book took off and defined the entire field of medical anthropology. I had the phenomenon—that is different from most people—of having my greatest influence at the start of my career. Part of that was because there was a wave of interest gathering in this area, and somebody had to define it.

Dr. Yusim: A topic about which you have written extensively is the pathologizing of normal human experience. I was really struck by your quote in your book, *What Really Matters:*

Living a Moral Life Amidst Uncertainty and Danger. You wrote, "Perhaps the most devastating example of human values is the process of medicalization through which ordinary unhappiness and normal bereavement have been transformed into clinical depression, existential angst turned into anxiety disorders, and the moral consequences of political violence recast as post-traumatic stress disorder. That is, suffering is redefined as mental illness and treated by professional experts, typically with medication."

Dr. Kleinman: I have become taken with the idea that at this moment in global psychiatry, there are many societies that have done absolutely nothing for the clinically mentally ill. At the same time, there is a counter movement seen in some of the most globalized market settings, but also in China and India, of overmedicalizing social problems. I've become quite interested in the overmedicalization of normal sadness and whether this is useful to do. For instance, why should you have a normal bereavement when you could take medications and not feel bereaved at all? My feeling is that there is something dangerous from a social perspective in doing that. So a paradox occurs in countries like China and India, where in rural and small cities, there is absolutely no attention paid to the mentally ill. In China, 90% of people with serious and persistent mental illness are never diagnosed or treated. In contrast, in big cities like Beijing and Shanghai, you see the overmedicalization of normal sadness. If you come into a clinic with a loss of any sort, you will be offered antidepressants. This results in the remaking of the normal into the abnormal.

Dr. Yusim: You have devoted a substantial portion of your career to international mental health, which is only recently becoming recognized as one of the global health priorities. What do you think is accountable for this change?

Dr. Kleinman: With Vikram Patel and Bernardo Saraceno, I wrote a paper on the ethical reasons as to why mental health should be incorporated into the world's global health priorities. In the paper, we clearly state that it is not a problem of insufficient evidence that global mental health is indeed important. There is plenty of evidence to support that mental health matters and affects all spheres of life all over the world. So now we begin to question why there is moral commitment to the treatment of illnesses like HIV/AIDS and not to mental illness? Part of my answer is that I think that basically psychiatry has failed its patients—not so much in the United States and Western Europe, but certainly in the developing world. And since most of the resources are in the United States and Western Europe, we have actually failed the developing world.

For many years, psychiatry was not viewed like the other medical disciplines in the sphere of global health. Ophthalmologists, for example, were welcomed in the global health arena to help fight illnesses with a high global prevalence, like trachoma and river blindness. Obstetricians and gynecologists were equally welcomed because of the enormous interest in reducing perinatal mortality and STDs. But psychiatry was still being treated as if our set of problems did not quite belong in the global health agenda.

And then some remarkable things happened. First, we had the 2001 World Mental Health Report, which I released to Boutros Boutros-Ghali at the U.N. Summit in the late 1990s. Then we had the World Global Burden of Disease Report, which said that mental health problems like depression account for 14% of the total global burden of disease. Mental health was finally beginning to be recognized as a global health priority.

Dr. Yusim: In the sphere of global mental health, what is the ethical obligation of the developed world to the developing world, and how can this ethical obligation be met?

Dr. Kleinman: In meeting our ethical obligations to the developing world, we need to begin to think globally. No cancer expert or heart disease expert would regard the United States or Europe as the entire world. They're looking at Japanese and Chinese work, encouraging it, looking at how cancer and heart disease differ worldwide. In contrast, psychiatrists have been extraordinary in their unidimensionality of understanding mental illness in American terms. I will never forget how in around the year 2000, when I was Vice Chair of the APA's Committee on Global Mental Health, we had a meeting with the world's foremost global mental health experts at the annual APA conference. This meeting attracted about 100 people in a room that could have held over 500. Next door there was a meeting on a very American issue that had over 500 people, and the room was overflowing. Some of my colleagues from all over the world were astonished that there was so little interest among American psychiatrists in global mental health. Having said that, I teach undergraduates as well as medical students, and there is the equivalent of a moral movement right now among young students who feel deeply passionate about issues of human rights, social justice, and global health. I think they are going to change the way that medical schools and hospitals begin to think about this.

Dr. Yusim: What advice do you have for residents seeking to pursue a career in global mental health or cross-cultural psychiatry?

Dr. Kleinman: You have to be willing to be uncertain about your future because there is no set career path in this discipline. One way to go about this is to parallel an M.D. with an M.P.H., which is like a union card to do international work. Most people in global health have an M.P.H. or social science degree, like anthropology, sociology, or economics. If you want to do global mental health, it is important to do your training at an institution where global health is strong. Then you need to be able to carve out a specialty within global health focused on psychiatry or mental health issues. Another way to do global mental health is through the cultural psychiatry perspective. There are certain institutions with programs focused specifically on cultural psychiatry, like UCLA and UCSD. One way or the other, you have to look hard for ways that will allow you to make the life you want.

Anthropological Views on the Globalization of PTSD

Yavar Moghimi, M.D.

Department of Psychiatry and Behavioral Sciences, George Washington University

Since the establishment of clinical criteria for diagnosing posttraumatic stress disorder (PTSD), there has been an exponential increase in the number of published studies on trauma (1). What began as the cause of psychiatrists advocating for mental healthcare for trauma-exposed veterans returning home from the Vietnam War quickly expanded to also include victims of torture, natural catastrophes, serious accidents, assault, rape, and other forms of violence. The symptoms of PTSD have even been expanded to include the animal kingdom.

For example, some elephants that have been assaulted by poachers are now being diagnosed and treated using techniques similar to those used to treat humans (2). Clearly since its inception, the diagnosis of PTSD has become a prominent model for discussing and understanding trauma-related stress. In the international arena, researchers and humanitarian agencies working in postconflict societies have embraced the diagnosis and made it a priority in the facilitation of development and relief work.

Numerous epidemiological studies of war-torn societies have shown that survivors of conflict demonstrate various symptoms, some of which correlate with the symptom clusters of PTSD, although some symptoms might not. In Afghanistan, survivors of conflict have reported common complaints of a type of nervous anger, referred to as "asabi," as well as a mental sensation of internal pressure, called "fishar-e-bala" (3). The findings from a survey conducted among Salvadoran female refugees revealed that some women experienced sensations of intense heat in their bodies, referred to as "calorias" (4). In Sri Lanka, the most common complaints among survivors of conflict or natural disaster were the loss or disturbance of one's role in the group (5).

The variety of symptoms individuals demonstrate in response to traumatic events begs the question of whether PTSD should be examined as a universal syndrome or as culturally specific syndromes of trauma-related stress (6). How we elect to answer this question will have great implications in our treatment of the debilitating symptoms of trauma. Treatment of PTSD in the Western world is based on psychosocial, pharmacological, and cognitive behavioral interventions at the individual level (7). This contrasts sharply with more collectivistic cultures that may place more emphasis on healing through a social context, focusing on familial, sociocultural, and religious activities. Some have raised concerns that labeling an experience with Western psychiatric terminology unduly influences how people should suffer and heal (8). Another concern regarding treating PTSD by focusing exclusively on traumatic symptoms is that other mental health problems or socioeconomic issues might be overlooked, which, in some non-Western cultures, are actually deemed more important. In treating only the traumatic symptoms of the disorder, we tend to focus more on past events, when, in a continuously deprived environment, an individual may be more preoccupied with his or her current life conditions as well as the trauma of daily living (9).

In 1977, Arthur Kleinman, M.D., psychiatrist and anthropologist, coined the term "category fallacy" (10) to describe the application of Western psychiatric diagnosis within a cultural context in which it is not relevant, although the symptoms could be found and measured. This fallacy, as described by Dr. Kleinman, lies in not taking into account how symptoms are understood and experienced among individuals in non-Western societies and whether they carry the same level of salience in these cultures as they do in Western society. This can be found in some internationally conducted research on trauma when the emphasis has been to look for symptoms without assessing the meaning and effects these symptoms actually have on the individuals in a particular society.

PTSD is, without question, a debilitating form of traumatic stress. It is a real and important illness but one that should not be defined by global humanitarians in a naïve and reductionistic way. For the field of psychiatry to truly play a role in the relief of trauma-related stress in the international arena, there must be an appreciation of the nuanced ways people and societies have learned to recover the pieces of their lives in the face of tragedy. To achieve this, novel research programs and interventions that manage to meld local priorities with clinical perspectives have been developed. Most of these programs are pluralistic in their approach, relying on culturally accepted idioms of healing in concert with Western psychiatric understanding. Instead of assuming pathological effects and focusing on the victimization resulting from surviving trauma, these programs highlight resilience and positive coping skills for healing at individual and community levels (11). An example of such a project is one that was conducted by the international Transcultural Psychiatric Organization (a non governmental organization) with Bhutanese refugees in Nepal. The project was established to integrate the efforts of public health workers, psychologists, psychiatrists, and anthropologists. Prior to any epidemiological research being conducted among individuals in the refugee camp, narrative studies identifying local idioms of distress were performed, and group discussions were held regarding the social problems of the camp, knowledge of available help, traditional healers, and positive and negative coping strategies. This program showed that the refugees did endorse PTSD symptoms as well as symptoms from a range of other psychiatric disorders, but these symptoms were interpreted using local explanatory models, without inserting Western concepts of trauma into the local culture.

The future of culturally based interventions for individuals suffering from traumatic stress requires collaboration between disciplines that can contribute varied understanding to this arena (12). The merger of quantitative and qualitative methodologies with microlevel interpretations of personal experience in the context of macrolevel sociopolitical forces will provide a holistic view of how individuals make sense of their world when lives and communities are destroyed (13).

References

1. McHugh P, Treismann G: PTSD: a problematic diagnostic criteria. J Anx Disord 2006; 21:211-222
2. Bradshaw GA, Schore AN, Brown JL, Poole JH, Moss CJ: Elephant breakdown. Nature 2005; 433: 807
3. Miller KE, Omidian PA, Quraishy AS, Quraishy N, Nasiry MN: The Afghan Symptom Checklist: a culturally grounded approach to mental health assessment in a conflict zone. Am J Orthopsychiatry 2006; 76:423–433
4. Aron A, Corne S, Fursland A, Zelwer B: The gender specific terror of El Salvador and Guatemala: PTSD in Central American refugee women. Wom Stud Inter Forum 1991; 14: 37–34
5. Fernando G: Interventions for survivors of the tsunami disaster: report from Sri Lanka. J Trauma Stress 2005; 18: 267-268
6. Miller KE, Kulkarni M, Kushner H: Beyond trauma-focused psychiatric epidemiology: bridging research and practice with war-affected populations. Am J Orthopsychiatry 2006; 76:409-422
7. Foa E, Rothbaum R: Treating the Trauma of Rape: Cognitive Behavioral Therapy for PTSD. New York, Guilford Press, 1998
8. Breslau J: Cultures of trauma: anthropological views of postraumatic stress disorders. Inter Health Cult Med Psychiatr 2004; 28:113-126
9. Pedersen D: Political violence, ethnic conflict, and contemporary wars: broad implications for health and social well-being. Soc Sci Med 2002; 55:175-190
10. Kleinman A: Depression, somatization and the new cross-cultural psychiatry. Soc Sci Med 1997; 11:3-10
11. De Jong J: Deconstructing critiques on the internationalization of PTSD. Cult Med Psychiatry 2005; 29: 361-370
12. Kienzler H: Debating war trauma and post-traumatic stress disorder (PTSD) in an interdisciplinary area. Soc Sci Med 2008; 67: 218-237
13. Kleinman A: Writing at the Margins: Discourse Between Anthropology and Medicine. Berkeley, Calif, University of California Press, 1995, pp 314

Incarceration and Well-Being: The Multiple Bodies of the Incarcerated

Justin Sanders, M.D.
Department of Family and Social Medicine, Montefiore Medical Center

Anthropological research has often been focused on the cultural "other" from exotic locals, providing narratives that are academically enriching but of potentially little value to medical practitioners at home. In contrast, medical anthropologists are increasingly adept at turning their critical lens on groups within their own societies, and in doing so have identified historical and contemporary inequalities in the provisions of medical care, particularly as these provisions relate to hierarchies of power. Medical anthropologists have observed human phenomena and developed theoretical frameworks that have particular bearing on public health. The present article applies one specific anthropological framework to the problems posed by incarceration in relation to the health and well-being of incarcerated individuals and their families. This framework, which clarifies the contexts in which incarcerated patients struggle to maintain health, is potentially useful to those who provide medical care to this population.

Medical anthropologists Nancy Scheper-Hughes and Margaret Lock (1) proposed an analytical framework in response to what they felt was the failure of the field to categorize and define the body and its subsequent susceptibility to the "biological fallacy and related assumptions that are paradigmatic to biomedicine" (1). The three bodies of an individual's awareness and experience are the body-self (or embodied body), the social body, and the body politic. In the present article, these three bodies are discussed in relation to the effects of incarceration on the health of some individuals.

The Embodied Body

The embodied body is that experienced by each individual. It is the locus of bodily function and problems that might lead one to seek medical care. Healthcare providers prescribe medications and recommend healthy behaviors to treat this body. Western biomedicine ("medicine") upholds the Cartesian dichotomy of body and mind, and medicine duly upholds a division between physical health and mental health. Worth noting is the contrast that this model presents to the more holistic conceptions of the body held by many other cultural groups (e.g., the complimentary duality of the Chinese yin/yang cosmology [1]).

Incarceration has profound effects on an individual's health. Individuals who are incarcerated suffer disproportionately from infectious and chronic diseases as well as mental illness. Regarding infectious disease, incarcerated individuals have higher rates of HIV/AIDS, hepatitis B and C, latent tuberculosis, and sexually transmitted diseases when compared with individuals who are not incarcerated (2, 3). For example, seroprevalence of hepatitis C among incarcerated men and women has been found to be as high as 41%. Furthermore, some have estimated that of the more than 4.5 million individuals infected with hepatitis C in the United States, approximately 30%-70% have served time in a correctional facility (3). Additionally, it has been projected that incarcerated individuals also carry a greater burden of asthma, diabetes, and hypertension, which require regular monitoring and consistent care and can be negatively affected by poor oral care (3, 4). The excess burden of mental health disorders among incarcerated men and women has been demonstrated over time by statistical findings pertaining to aggregated institutionalization. In 2000, the aggregated rate of individuals incarcerated in U.S. mental hospitals, psychiatric institutions, and state and federal prisons was nearly the same as it was in 1955 (>600 per 100,000 individuals over age 15), despite a drop in the mental hospitalization rate from nearly 500 per 100,000 individuals to <50 per 100,000 individuals (5). Although men and women who are imprisoned are legally entitled to medical care, there have been criticisms of both the poor quality (6, 7) and availability of certain types of care (8). These issues are compounded by conditions of overcrowding and longer prison sentences (9).

The Social Body

Scheper-Hughes and Lock describe the social body as a "natural symbol for thinking about relationships among nature, society, and culture" (1, p. 6). Anthropologists have long discussed ethnomedical systems in which social relations contribute significantly to individual health and illness. Scheper-Hughes and Lock point out that "the body is seen as a unitary, integrated aspect of self and social relations…dependent on, and vulnerable to, the feelings, wishes, and actions of others, including spirits and dead ancestors" (1, p. 21). Scheper-Hughes and Lock also note that modern biomedicine has been criticized as viewing social relations as "partitioned, segmented, and situational—generally as discontinuous with health or sickness" (1, p. 6). Data analyzing the effects of incarceration on families demonstrate that imprisonment influences the social body. Studies have reported that the children of incarcerated men and women have higher rates of developmental delay, learning difficulties, and mental health problems, including behavioral problems, teenage pregnancy, and substance abuse (2, 9, 10). Incarceration can lead to the breakdown of families through divorce and loss of housing and employment (2). The inability of an individual to provide for his or her family may compound mental health issues and lead to disorders such as depression and anxiety.

The Body Politic

The body politic is affected by power structures that shape the behavior and well-being of groups and individuals. Scheper-Hughes and Lock describe the body politic as "the regulation, surveillance, and control of bodies in reproduction and sexuality, in work and in leisure, in sickness and other forms of deviance and human difference" (1, pp. 7-8). Moreover, Foucault (11) described various mechanisms of enforcement, among them the medical gaze, which exists as part of a paradigmatic "bio-power," which involves "numerous and diverse techniques for achieving the subjugation of bodies and the control of populations" (12, p. 140). Government policies and enforcement may subjugate populations in potentially unintended ways. The war on drugs, for example, has significantly and disproportionately affected African American men, particularly regarding the rate and duration of sentences (2). The proportion of incarcerated minorities reflects economic and educational disparities in society as a whole (2). Federal and state laws and any discriminatory enforcement of these laws, which may implicitly encode racism or classism, could possibly be considered a form of structural violence. Iguchi et al. (13) point out that these laws and enforcement practices "exacerbate the impact of health disparities already evident in the community and clearly have an adverse effect on the health and well being of the offender, the family of the offender, and the community at large" (13, p. 50).

Conclusion

The causal relationship between the relatively poor health of incarcerated individuals and their families, as well as incarceration itself, has been

an intense subject of debate. A calculus of blame that impugns the incarcerated themselves is likely to be simplistic, if not also discriminatory. Medical anthropologists frequently highlight culturally determined illnesses and responses to disease. Differential rates of incarceration among nations (which is particularly high in the United States [14]) suggest that incarceration is a culturally determined response to social ills. Medical providers must consider imprisonment to be both a risk factor for certain health problems and a type of morbidity. It is not enough to consider the individuated body when caring for an individual who has been affected by incarceration. As providers, we must also consider the social and political bodies that affect the mental and physical health of individuals who might also be affected by certain events that may have nothing to do with biological disease.

References

1. Scheper-Hughes N, Lock M: The mindful body: a prolegomenon to future work in medical anthropology. Med Anthr Quart 1987; 1: 6-41
2. Williams N: Where are the Men? The Impact of Incarceration and Reentry on African American Men and Their Children and Families. Atlanta, GA, Community Voices. August 1, 2006 http://www.communityvoices.org/Resources.aspx
3. National Commission on Correctional Health Care: The Health Status of Soon-To-Be-Released Inmates. Chicago, NCCHC, 2002 http://www.ncchc.org/pubs/pubs_stbr.html (accessed Oct 2008)
4. Williams N: Prison health and the health of the public: ties that bind. J Correct Healt Care 2007; 13:80-92
5. Harcourt B: From the asylum to the prison: rethinking the incarceration revolution. Tex Law Rev 2006; 84:1751-1786
6. Cohen R: Testimony of Robert L. Cohen, M.D., submitted to the Commission on Safety and Abuse in America's Prisons, July 20, 2005 http://www.prisoncommission.org/statements/cohen_robert.pdf. (accessed Oct 2008)
7. Berkman A: Engaged in life: Alan Berkman on prison health care, in The New Abolitionists: (Neo) Slave Narratives and Contemporary Prison Writings. Edited by James J. New York, SUNY Press, 2005
8. Soler M: Health issues for adolescents in the justice system. J Adolesc Health 2002; 31:321-333
9. Simmons C: Children of Incarcerated Parents. Sacramento, CA, California Research Bureau, 2000;
10. Mumola C: Incarcerated Parents and Their Children. Washington, DC, U.S. Department of Justice (NCJ 182335), 2000 http://www.ojp.usdoj.gov/bjs/pub/pdf/iptc.pdf (accessed Oct 2008)
11. Foucault M: The Birth of the Clinic: An Archaeology of Medical Perception. New York, Vintage, 1994
12. Foucault M: The Will To Knowledge: The History of Sexuality, Part 1. London, Penguin, 1998
13. Iguchi M, Bell J, Ramchand RN, Fain T: How the criminal system racial disparities may translate into health disparities. J Healt Care Poor Underser 2005; 16(4 suppl B):48-56
14. Chaddock G: U.S. Notches World's Highest Incarceration Rate. Christian Science Monitor, August 18, 2003. http://www.csmonitor.com/2003/0818/p02s01-usju.html (accessed Oct 2008)

The Effects of Immigrant Status on Mental Healthcare in Latino Communities

Flavio Casoy

Brown University

Recently, in my longitudinal clinic for Spanish and Portuguese speaking patients, I saw a woman with a long history of depression who came to the clinic for treatment because her only surviving son, whom she had been supporting in Central America by working legally in the United States, had been detained by Immigrations and Customs Enforcement agents while trying to enter into the United States without proper documentation. After years apart, their plan had been to eventually live together. When the mother came to the clinic, her son had been detained for 7 months in different Immigrations and Customs Enforcement facilities, but none of these facilities had been close enough for her to visit him. She was distraught and felt intense anxiety about her son's safety, health, and future and whether she would ever see or speak to him again. This episode gave me pause and made me think about the particular effects that immigrant status has on Latinos and their communities as well as the role of mental health professionals as advocates and voices for this extremely vulnerable population.

Latinos constitute 14% of the U.S. population, approximately 41.3 million people (1). Among these, there are an estimated 7.5 million undocumented men, women, and children, and more than 300,000 undocumented immigrants arrive in the United States each year (1, 2).

In general, Latinos face high barriers to healthcare. For example, lack of health insurance prevents many Latinos from accessing quality and affordable care. Additionally, they are more likely than Caucasians and African Americans to be uninsured. In 2004, uninsured rates were 32.7% for this population, while the rates for Caucasians and African Americans were 11.3% and 19.7%, respectively (1). Furthermore, immigrants and U.S.-born Latinos who have limited proficiency in English face additional barriers. These individuals have greater difficulty communicating their problems to healthcare providers as well as a more difficult time understanding providers' instructions (1).

As a result of less access to healthcare and lower quality care, Latinos are at higher risk for major complications from chronic and infectious diseases. Further, Latinos with mental illness underuse mental health services and are considered a high-risk group for depression, anxiety, and substance abuse disorders. The underuse of mental health services is especially prevalent in communities with a greater proportion of immigrants. Among Latinos with mental disorders, fewer than one out of 11 seek services from specialized mental health providers, and fewer than one out of 20 receive services. Additionally, fewer than one out of 10 receive mental health service from a general healthcare provider (1, 3).

In an endeavor to better understand the circumstances surrounding the lives of undocumented immigrants, Cavazos-Rehg et al. (2) attempted to assess the use of mental health services among Latino immigrants. In their survey of 143 participants, 39% indicated that they did not visit social or government agencies for fear of deportation. Respondents who reported fear of deportation also reported feeling vulnerable and showed more negative emotions, particularly anger and stress. In such cases, documentation status not only created an additional barrier for the undocumented individual in accessing mental health services, but it also increased risk factors for psychological distress.

Despite having reduced access to care and quality of care, Latinos need comprehensive and sensitive mental healthcare. In one study conducted in Fresno, California, U.S.-born Mexican Americans and Mexican immigrants demonstrated nearly double the rate of mental illness relative to Caucasians. These mental health problems appear to worsen the longer immigrants reside in the United States and are generally greater among U.S.-born Latinos. In another study, Mexican Americans who were born in the United States were twice as likely to report mental illness when compared with individuals who emigrated from Mexico to the United States. There are many possible explanations as to why U.S.-born Latinos and Latino immigrants with longer residency periods are at increased risk for mental illness when compared with immigrants who have recently arrived into the country. These explanations include a lack of community support, discrimination and minority status, and chronic lack of services (1).

Of particular importance to mental health providers is the widespread violence experienced by immigrants in their country of origin. In one study conducted in Los Angeles, Eisenman et al. (4) found that out of 512 Latino immigrants, 281 (55%) reported being subjected to political violence in their country of origin. Among these, 8% reported torture; 15% had witnessed violence committed against their family members; 27% reported forced disappearance of family members; 26% had witnessed mass violence; 32% reported surviving attacks with bombs or heavy weapons; 5% reported witnessing rape or execution; and 3% reported being raped. Participants who reported experiencing political violence had more mental health problems than those who had not experienced violence, and they had greater incidence of both depression and PTSD. Alarmingly, of the 267 participants who reported experiencing political violence and who also had one or more prior visits to a mental health professional in the previous year, only seven ever told their provider about the history of violence experienced, and none reported being asked by their provider about any experiences of political violence (4).

In the absence of a comprehensive immigration policy, what is our role as healthcare providers in caring for the immigrant population, which is a significant segment of the U.S. population? In order to ensure that all individuals in our society have access to quality care, we must aim toward increasing the diversity of the physician workforce so that it reflects the rest of society. This can be achieved by actively recruiting greater numbers of Latinos into the medical field. In 2004, only 7% of medical school students were Hispanic, and only 1,000 medical school graduates (6.3%) were Hispanic (5). In addition to increasing the number of Latino healthcare professionals, it is critical to expand the use of professional translators who are specifically trained to work in mental health settings in order to overcome linguistic barriers to quality care. Finally, to ensure better mental health outcomes for the entire U.S. population—not just the Latino population—mental health providers must be at the forefront of the effort to expand access to quality mental health services. It is only with a determined commitment to system-wide reform that we can ensure the care that all of our patients deserve.

References

1. Britt Rios-Ellis PD: Critical Disparities in Latino Mental Health: Transforming Research Into Action. Washington, DC, National Council of La Raza, Institute for Hispanic Health, 2005
2. Cavazos-Rehg PA, Zayas LH, Spitznagel EL: Legal status, emotional well-being and subjective health status of Latino immigrants. J Nat Med Assoc 2007; 99:1126
3. Aguilera A, López SR: Community determinants of Latinos' use of mental health services. Psychiatr Serv 2007; 59:408
4. Eisenman DP, Gelberg L, Liu H, Shairo MF: Mental health and health-related quality of life among adult Latino primary care patients living in the United States with previous exposure to political violence. JAMA 2003; 290:627-634
5. Association of American Medical Colleges: Minorities in Medical Education: Facts and Figures. Washington, DC, AAMC, 2005

Flavio Casoy is a fourth-year medical student going into psychiatry.

Committee of Residents and Fellows

The Committee of Residents and Fellows (CORF) is a permanent standing committee of APA. The Committee is composed of seven psychiatry residents, each representing one of the seven geographic areas into which APA divides the United States and Canada. Additionally, representatives from APA's three fellowship programs participate as active members. Each member is nominated by his/her residency training program and serves a 3-year term.

Since 1971, the Committee has represented

resident opinions and issues within the Association and has established effective and meaningful liaisons with many components of APA, as well as with many other organizations that are involved in training and the profession.

Area 1
Teo-Carlo Straun, M.D.
University of Massachusetts
c.s08873@gmail.com

Area 2
Stacey Yearwood, M.D.
The Zucker Hillside Hospital
smylein05@yahoo.com

Area 3
Jessica Kettel, M.D., Ph.D.
University of Pittsburgh
ketteljc@upmc.edu

Area 4, Chair
Molly McVoy, M.D.
University Hospitals-Case Medical Center
molly.mcvoy@uhhospitals.org

Area 5
Sarah Johnson, M.D.
University of Louisville
sbjohn01@gwise.lo
uisville.edu

Area 6
Shirley Liu, M.D.
University of Massachusetts
shirley.liu@umassmemorial.org

Area 7
Rachel Davis, M.D.
University of Colorado
rachel.davis@UCHSC.edu

Liaison from ACOM
Joshua Sonkiss, M.D.
University of Utah
joshua.sonkiss@hsc.utah.edu

Mentor
Paul O'Leary, M.D.
University of Alabama
pjoleary@uab.edu

APA Minority Fellow
Icelini Garcia-Sosa, M.D.
SUNY Downstate Medical Center
icelini@hotmail.com

APA/Bristol-Myers Squibb Fellow
Sharon Kohnen, M.D.
Univer
sity of Pittsburgh
kohnens@upmc.edu

Are you getting the full story? In addition to this online edition of the Residents' Journal, there is an e-mail portion delivered each month. This month's e-mail highlights trauma and recovery in high-risk populations and sleep disturbance and depression.

Looking for a Job? Search the **APA Job Bank** to find your ideal position.