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In This Issue



This issue of the *Residents' Journal* focuses on disparities in mental health care. Ijeoma Chukwu, M.D., M.P.H., provides an overview of factors that influence mental health disparities, including attitudes toward mental illness, among racial and ethnic minorities. In a perspective, Amilcar A. Tirado, M.D., M.B.A., discusses the difficulties of recruiting Latinos in clinical research trials. Neeral Sheth, D.O., offers commentary on the high prevalence of suicidality among LGBT youths and roles that schools can play in reducing suicide in this population. Last, Kenneth Osiezagha, M.D., Sarbani Maitra, M.D., Siva Subramanyam VaraPrasad Avula, M.D., and Yetunde Olagbemi, M.D., present data, including predisposing factors, pertaining to the overdiagnosis of schizophrenia in African Americans.

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Disparities in Mental Health

Ijeoma Chukwu, M.D., M.P.H.

The number of racial and ethnic minorities in the United States has been on the rise in the last two decades according to data from the U.S. Census Bureau (1). Despite this trend, health disparities among racial and ethnic minorities continue to exist. Currently, a disproportionate number of the mentally ill from minority groups receive inadequate psychiatric care. This statistic is not a reflection of greater severity of illness or prevalence of disease but rather of poorer quality of care (2). Several factors have been proposed to contribute to the disparities in mental health among ethnic and racial minorities in the United States, including distrust of physicians, lack of access to care, clinician bias, and attitudes toward mental illness.

The literature suggests that distrust of clinicians, particularly in the African American community, prevents many individuals from seeking medical and psychiatric care. Historically, the relationship between African Americans and their physicians has been influenced by the controversial Tuskegee syphilis experiment, which led many African Americans to lose faith and trust in clinicians. Although there have been some efforts to repair the physician-patient relationship in this population, distrust toward physicians continues to exist (3).

Lack of access to psychiatric care among minorities is another factor that perpetuates disparities in mental health. Racial

and ethnic minorities disproportionately represent the population of underinsured and uninsured in the United States. Thus, for many, financial limitations present a significant barrier to accessing psychiatric care. This problem is further compounded by the fact that these individuals tend to reside in lower socioeconomic status neighborhoods where mental health resources are very often limited. As a result, psychiatric diagnoses and treatment for the mentally ill in these communities is frequently delayed, which leads to poorer outcomes (2, 3).

Studies have shown that clinician bias may also play a role in existing mental health disparities. A study by DeCoux Hampton (4) demonstrated that even when standardized diagnostic tools are used to aid in the diagnosis of psychiatric disorders, clinicians tend to rely more on their own judgment in making a diagnosis. The result is that minorities are more frequently misdiagnosed and inappropriately treated compared with their white counterparts (4, 5).

Negative attitudes and perceptions of mental illness among minority populations can largely affect the utilization of mental health services. For instance, among African Americans, mental illness carries a stigma that reflects a perception of the mentally ill as “weak-minded” individuals, as some studies have indicated. These perceptions may significantly impede the desire of those with mental illness and their families in seeking mental health treatment (3).

Given the rate of growth of minority populations in the United States, the need to recognize and address racial and ethnic disparities in mental health is greater than ever. While there have been promising, recent efforts to reduce disparities in mental health, there are still significant strides to be made.

Dr. Chukwu is a second-year resident in the Department of Psychiatry and Human Behavior, University of California, Irvine Medical Center, Orange, Calif.

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Difficulties of Recruiting Latinos Into Clinical Trials

Amilcar A. Tirado, M.D., M.B.A.

As a psychiatry intern at Lincoln Medical and Mental Health Center, I am encouraged to increase our research and scholarly activities. Prior to starting residency, I worked as a clinical research coordinator, managing clinical trials in diabetes and hypertension at Columbia University. While at this institution, I found that it was challenging to enlist underrepresented minorities into these clinical trials. This made me contemplate the contributing factors that made recruiting these groups, and Latinos in particular, such a challenge.

Extrapolating from my own experience in clinical research, the following are some major, broad areas I believe have a negative impact on the ability to recruit and retain Latinos in clinical research: a language barrier between potential participants and clinical research study staff (1–5); prospective participants not having a clear understanding of what a particular study is about (its goal[s]) or of how it may potentially help them and others (2); not being aware that a particular study exists, since many times methods and formats for advertising a study are not geared toward recruitment of Latinos (3, 4); family, friends, and/or a primary care physician discouraging participation in clinical research (6); cultural barriers with clinical research; research study staff not having the cultural competency to be sensitive to the needs of Latinos, beyond speaking Spanish (2, 3); overly verbose and complex language used in documents, documents not available in Spanish, and documents not clearly explained (2, 7); concerns related to immigration/deportation; a fear of losing acquired rights as a result of consent to participate in a clinical research study (2); and fear of misunderstanding commitment to study participation (2).

To expand on some of the aforementioned points, the cultural perception of clinical research in the Latino community is still developing. Many Latinos come from

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countries where the socio-economic conditions are poor, with limited education (1, 2). Common misconceptions include being treated as a “guinea pig,” which is not exclusive to the Hispanic community in the United States but is also a common misconception everywhere (7). A classic example of an engrained distrust for clinical research is exhibited with the Tuskegee syphilis experiment (2, 7).

Language barriers play a critical role in Latinos not participating in clinical research (1–5). The ability of staff involved in clinical research to communicate effectively with a prospective participant can significantly affect the success of the study. If patients cannot understand the clinical research process or have their questions and concerns answered, they will be less inclined to participate (1, 2).

These issues represent only a handful of the challenges encountered in engaging Latinos with clinical research, and they are applicable to other groups that have been historically difficult to recruit and retain in studies (5, 7). For psychiatric clinical research, the points outlined above must be considered in order to resolve the concerns and preconceived notions patients, or their loved ones, may have about mental health (2).

Dr. Tirado is a first-year resident in the Department of Psychiatry, Lincoln Medical and Mental Health Center, Bronx, N.Y.

A January 2014 article published in Psychiatric Services examined factors associated with service use for mental health conditions among Latino and Asian non-U.S. citizens residing in the United States.

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LGBT Suicide Prevention Must Start in Our Schools

Neeral Sheth, D.O.

Despite recent advances for LGBT (lesbian, gay, bisexual, and transgender) Americans, an indisputable disparity in mental health exists in this population. Unfortunately, the most vulnerable of this stigmatized group are adolescents who have just begun to develop their identities. Suicide is the leading cause of death among LGBT adolescents, and recent studies have reported that suicidality is twice as prevalent among LGBT youths compared with their heterosexual peers (1). While more research is needed in this area, this population has been difficult to study because many LGBT adolescents subconsciously employ denial, repression, and reactive formation to prevent ego-dystonic desires from surfacing (2).

In recent times, the media has spotlighted countless victims of suicide among LGBT youths, such as 13-year-old Asher Brown, who was regularly assaulted and mocked by peers imitating gay sexual acts. In another instance, teenager Chloe Lacey struggled to fulfill societal expectations while embracing her transgender identity. Her efforts led to intolerable levels of depression and ultimately resulted in her suicide. Anti-bullying campaigns, such as the It Gets Better project, are widespread in the media, but as Chloe's story points out, bullying is not the only factor at play. The "minority stress theory," which illustrates why there may be higher rates of mental illness in minority populations, reflects the experience of LGBT youths (3). When applied to this particular population, the theory identifies prejudices, expectations of rejection, hiding, concealing, and internalized homophobia as psychosocial obstacles that LGBT adolescents encounter and endure (3). These chronic, socially based, and unique

Family connectedness, adult caring, and school safety have been associated with decreased suicidality.

stressors significantly increase risk for developing serious mental illnesses.

As suicide rates continue to trend upward, research has begun to identify protective factors for LGBT youths. Family connectedness, adult caring, and school safety have been associated with decreased suicidality (4). It appears that the presence of peers who are experiencing the same struggles, a "social convey," counters isolation and suicidality among LGBT teens. A recent study found that in schools with established gay-straight alliances, not only was suicidal behavior reduced in homosexual and bisexual students, but it was also decreased among other students who attended those schools (5). The study suggests that an established sexual minority presence may create an environment of tolerance throughout an entire institution. Reports have also suggested that the inclusion of LGBT topics in school curriculums may normalize LGBT experiences and increase empathy from heterosexual peers. Unfortunately, current political hurdles make this strategy unfeasible in many districts.

Nonetheless, given the alarming rates of suicidality among LGBT teens, it is imperative that suicide prevention efforts be

implemented in our schools. Adolescents may not know who to turn to in crisis situations, and mental health providers may not be consulted in time to prevent fatal events. There has been little research on preventive psychoeducation as a tool for suicide prevention in LGBT adolescents, yet this approach could be integral in preventing disastrous outcomes. Antibullying policies, LGBT-inclusive policies, and gay-straight alliances have shown promise; however, there is still a need for more effective strategies to save the lives of our LGBT youths.

Dr. Sheth is a third-year resident in the Department of Psychiatry, Rush University Medical Center, Chicago.

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Overdiagnosis of Schizophrenia in African Americans

Kenneth Osiezagha, M.D.

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Schizophrenia affects approximately 3 million people in the United States. Individuals with this illness often experience hallucinations, delusions, disorganized speech, disorganized behavior, and decreased emotional expression. African American patients tend to be overdiagnosed with schizophrenia and underdiagnosed with mood disorders (e.g., depression and bipolar disorder) compared with non-Hispanic white patients (1). African Americans are diagnosed with schizophrenia 4–5 times more frequently than non-Hispanic whites (2). The frequency of this diagnosis in this population is seen in juvenile, Veterans Administration, and public and private facilities that use DSM criteria. Between 1970 and 1986, the percentage of African Americans hospitalized with schizophrenia increased from 33% to 50% (3). In their study, Trierweiler et al. (3) found that the diagnosis of schizophrenia in African Americans was 10%–40% higher than the diagnosis in whites. In a study of over 1,600 patients representing all age groups, Schwartz and Feisthamel (4) found that 27% of African American participants received a diagnosis of schizophrenia compared with only 17% of white participants. Additionally, African Americans diagnosed with schizophrenia were 13 times more likely to experience forced hospital admission and longer hospitalizations than African Americans without a schizophrenia diagnosis. Additionally, through the use of a binomial effect size display (used to exemplify the magnitude of race/ethnicity as a factor in the overdiagnosis of schizophrenia), it was found that for every 1,000 clients, 107 were diagnosed on the basis of ethnicity.

There appears to be a relationship between ethnicity and first-rank symptoms (hallucinations, thought disorders, and delusions) in patients diagnosed with psychosis and schizophrenia (1). Researchers now believe that a misdiagnosis

of schizophrenia often occurs as a result of clinician bias, when in fact the patient may be showing signs and symptoms of hypomania (5). Once diagnosed with schizophrenia, African Americans are more likely than whites with the same diagnosis to be hospitalized and to receive higher doses of antipsychotics (6). According to the findings of Lawson et al. (7), overdiagnosis of schizophrenia in African Americans is widespread.

Predisposing Factors

Clinicians can misinterpret and misdiagnose patients whose cognitive style, norms of emotional expression, and social behavior are different from their own, unless the clinician is culturally sensitive to diverse expressions (8). For example, clinicians may misinterpret a client's deferential avoidance of direct eye contact as a sign of withdrawal or paranoia or as a flattened affect if they are unaware of cultural norms among groups other than their own. African American patients, compared with white patients, are more often diagnosed with severe psychotic disorders in clinical settings (7). The lack of cultural awareness of African American systems can lead to misinterpretation of the communication patterns in this population (1).

There are five subtypes of schizophrenia: catatonic, disorganized, paranoid, residual, and undifferentiated. According to DSM-5, schizophrenia is characterized by delusions, hallucinations, disorganized speech, grossly disorganized or catatonic behavior, and negative symptoms (9). Some research has suggested that African Americans experience hallucinations at a higher rate than whites (10); however, this alone warrants further investigation during mental status examinations. Some diagnostic criteria are misinterpreted by clinicians during mental status examinations, which could lead to false diagnosis of schizophrenia.

Frequently, African Americans present with hallucinations as a symptom of depression (depression with psychotic features), and this can be misinterpreted as schizophrenia (11).

Another consideration is spirituality, which is highly valued in the African American culture. Through “open dialogue with God,” or through discussions involving religious themes, African Americans are sometimes labeled delusional by a clinician who lacks understanding of the depth of religiosity in this population. In their study, Strakowski et al. (12) found that 20% of African Americans were diagnosed with schizophrenia after interviews with clinicians compared with only 7% of whites. Auditory hallucinations in particular were documented more frequently in African Americans than in whites. Increased attention to cultural variation has indicated that what is considered to be a hallucination in one culture may be accepted as normal in another (13). For example, among many African Americans, “seeing” or being “visited” by angels or a recently deceased person is not unusual, and African American women are more likely than white women to attribute mental illness to supernatural causes (13). Therefore, labeling an experience as a pathological symptom can be a subtle process for the clinician with a different cultural or ethnic background from that of the patient. Indeed, cultural variations and nuances may also occur within the diverse subpopulations of a single racial, ethnic, or cultural group. Often, clinicians' training, skills, and views tend to reflect their own social and cultural influences, at the risk of minimizing those of other cultural groups.

The presence of delusions is another criterion that is readily subject to misinterpretation. Because of a history of negative interactions with the dominant society and institutions in the United States, African Americans more often

are likely to present in a suspicious and guarded manner in therapeutic environments, as well as in selected social situations or in their views toward certain overt behaviors (14). Without fully understanding this cultural background, a clinician may interpret a suspicious and guarded manner as evidence of paranoia or of persecutory delusions. Also of particular concern regarding this population is the expression of hostility and anger. For example, if an African American is an involuntary client, it is possible that he or she will react to the clinician in a hostile manner. Although this might well be the case with any involuntary client, regardless of race or ethnicity, it could possibly lead to the clinician's perception of exacerbated aggression (e.g., "angry black person") in African Americans and contribute to a misdiagnosis of schizophrenia (12).

The cultural beliefs and social stigma associated with schizophrenia among African Americans also may prevent their utilization of available mental health resources (15), may make them less truthful with clinicians, and may cause them to reject any sign of ongoing mental illness. The mistrust of physicians among many African Americans and the reluctance to disclose inner feelings to strangers of different races/ethnicities (sometimes referred to as "healthy paranoia") can worsen the psychiatric treatment situation. All of these factors influence the mental health status in this population.

According to U.S. Census Bureau data, the median income for African American families is considerably lower than that for non-Hispanic white families. African Americans are more likely to live in environments with high rates of crime and substance abuse (16). These socioeconomic conditions can lead to higher rates of depression, which may contribute to negative symptoms (i.e., flat affect) often attributed to this population (16). In fact, flat affect may be the single most misinterpreted sign of schizophrenia in African Americans. Trierweiler et al. (17) found that non-African American clinicians are more likely than African American clinicians to associate negative symptoms with schizophrenia in African American patients. Baker (16) cited a study in

which 34% of African American patients who were diagnosed with schizophrenia were re-diagnosed with affective disorders upon more rigorous evaluation.

Low socioeconomic status among African Americans was long believed to be behind the increased diagnosis of schizophrenia. Warner (18) suggested that since African Americans often live in environments with high poverty levels, they are more prone than others to the stresses of life. African American children who have witnessed violence in neighborhoods with high poverty have been shown to exhibit a variety of psychiatric symptoms (11). Overcrowded surroundings and financial burden associated with a greater number of dependents in the household increases stress, and this may play a role in increased diagnoses of schizophrenia (19). Low socioeconomic status also results in less access to mental health services. Hence, when a patient with these characteristics approaches a health care provider, he or she is likely already experiencing extreme distress, which often contributes to increased diagnoses of schizophrenia (15).

Bresnahan et al. (20) examined the role of socioeconomic factors in the overdiagnosis of schizophrenia and found that African Americans were three times more likely than whites to be diagnosed with schizophrenia. When the same study controlled for four different socioeconomic status indicators (i.e., maternal education, paternal occupation, total family income, and maternal married status), findings showed that African Americans were twice as likely as whites to be diagnosed with schizophrenia. In their study, Kpowsa et al. (19) found that increased unemployment also plays a role in the overdiagnosis of schizophrenia.

Conclusions

Avoiding overdiagnosis of schizophrenia requires a broad understanding of patients' cultural belief systems. Such an understanding is essential for proper diagnosis. Social workers and other health care workers should also be trained to be aware of schizophrenia disorders in African Americans. Such knowledge will help to eliminate misconceptions and

stigma associated with schizophrenia in this population. Clinicians also should be taught important cultural beliefs among patient populations to enhance their own cultural competency.

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The authors thank Rabn K. Bailey, M.D., William D. Richie, M.D., Shahid Ali, M.D., and Narviar Barker, Ph.D.

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Spirituality, Guilt, and the Therapeutic Relationship

Elizabeth Stevens, D.O.

TO THE EDITOR: Therapists' awareness of their own spiritual position is relevant when the goal is to better understand their patients' world perception. Spiritual awareness is crucial in the assessment of psychiatric status, life stressors, and coping strategies. In 1989, the APA Committee on Religion and Psychiatry stated that "it is useful for clinicians to obtain information on the religious or ideologic orientation and beliefs of their patients so that they may properly attend to them in the course of treatment" (1). Therapists' inquiries about spiritual beliefs facilitate empathy, thereby establishing a therapeutic relationship based on acceptance and trust. Spiritual assessments can also help clinicians differentiate spiritual struggles from psychopathology (2). Below are two cases that illustrate how spiritual struggles may interface with excessive guilt and depression.

Case One

A 21-year-old Caucasian man with suicide attempts at ages 13 and 18, following the death of his parents, presented with suicidal ideation and depression. After his father's death when he was 13, the patient developed depression, including insomnia, poor concentration and appetite, and suicidality. He "ran from God" and immersed himself in drugs, alcohol, and infidelity during adolescence to avoid the pain and anger from his loss and grief.

He endorsed extensive guilt over drug use and infidelity that were juxtaposed with a developmental history of his father's example as a "spiritual rock," which inspired him as a child to become a pastor. After 6 years of running from guilt, he joined the Army to become a chaplain. However, he was assigned a medic position and agonized over this setback. Not feeling that he was fulfilling "God's path" for his life produced intense guilt and impulsive suicidal behavior.

Case Two

A 39-year-old Caucasian man with worsening depression presented to the emergency department with 2 days of suicidal ideation, superimposed on 3 months of sleeplessness, lack of en-

ergy, poor concentration, and weight gain. He stated, "I felt like I was drowning and I deserved to keep drowning." His depression involved guilt from a previous divorce, separation from his 15- and 16-year-old daughters, and "failure" as a father. He lamented over his younger daughter's rejection of him and his "abandonment" of his family and God. He wanted to restore his faith, stating that he was "like the seeds that fell by the wayside and never took root." He was subsequently hospitalized for depression and suicidality.

Conclusions

Guilt, shame, and depression often cloud our patients' judgment and insight, perpetuate mental illness, and present challenges in establishing therapeutic relationships. These two cases highlight how important therapists' empathy and affirmation are when engaging patients who struggle with spiritual problems. By encouraging exploration of our patients' spiritual struggles, trust and forgiveness can be learned in the therapeutic relationship, which can facilitate psychological and spiritual healing.

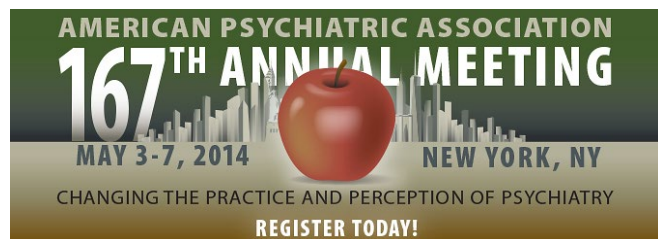
Dr. Stevens is a third-year resident in the Department of Psychiatry, University of Texas Health Science Center at San Antonio.

The author thanks Michael Darwes, M.D., Attending Physician, Department of Psychiatry, University of Texas Health Science Center at San Antonio.

Informed consent was obtained to interview both patients in the cases presented.

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TEST YOUR KNOWLEDGE

In preparation for the PRITE and ABPN Board examinations, test your knowledge with the following questions.
(answers will appear in the next issue)

This month's questions are courtesy of Vijeta Kushwaha, M.D., a second-year resident at Penn State Milton S. Hershey Medical Center, Hershey, Pa.

Question #1

Which of the following is true about autism spectrum disorder?

- A. Prevalence of Asperger's syndrome is higher than the prevalence of typical autism.
- B. Males with autism have more severe intellectual disability.
- C. Average male:female ratio is 1:4.
- D. The most frequently replicated neurochemical finding in autism spectrum disorder is decrease in peripheral levels of neurotransmitter serotonin.
- E. Structural MRI has shown overall increased brain size in autism.

Question #2

Which of the following is more likely to be associated with unipolar rather than bipolar depression?

- A. Depression with atypical features
- B. Depression with psychotic features
- C. Postpartum onset of depression
- D. Late age at onset of depression
- E. Presence of seasonal affective pattern

ANSWERS TO FEBRUARY QUESTIONS

Question #1

Answer: A. The three language variants are semantic, agrammatic/nonfluent, and logopenic.

Frontotemporal neurocognitive disorder is an uncommon cause of dementia (5% of cases) that has a shorter survival and faster decline course than Alzheimer's disease. Frontotemporal neurocognitive disorder can be divided into both behavioral and language variants. The language variant is further divided into semantic, agrammatic/nonfluent, and logopenic variants. The behavioral variant needs to only include three core symptoms.

Reference

1. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, 5th ed. Washington, DC, American Psychiatric Publishing, 2013, pp 614-618

Question #2

Answer: B. Major neurocognitive disorder with Lewy bodies

Lewy body neurocognitive disorder can frequently present with a fluctuant cognitive presentation alongside visual hallucinations. The presentation is less likely to represent Alzheimer's disease because visual hallucinations are uncommon. The lack of vascular risk factors in the patient's history reduces but does not eliminate the likelihood that the presentation is related to vascular causes. Frontotemporal neurocognitive disorders are not often associated with visual hallucinations or fluctuant cognitive symptoms.

Reference

1. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, 5th ed. Washington, DC, American Psychiatric Publishing, 2013, pp 618-621

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Submissions should include the following:

1. Two to three Board review-style questions with four to five answer choices.
 2. Answers should be complete and include detailed explanations with references from pertinent peer-reviewed journals, textbooks, or reference manuals.
- *Please direct all inquiries and submissions to Dr. Hsu: davidhsu222@gmail.com.

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