

# Future of Psychiatry, Cultural Competency, and Adolescent Medicine

## Introduction

Psychiatry is slowly gaining its importance and status among other specialties, such as pediatrics, cardiology, and dermatology, compared to two decades ago. The field of psychiatry started to become more developed since World Health Organization designated neuropsychiatric disorders as a part of non-communicable diseases. Along with the designation, the organization define mental health as “a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community” [1]. There are three mental health indicators that are designated by the Centers for Disease Control and Prevention: emotional, psychological, and social well-being [2].

Despite the emphasis on the importance of mental health and campaign on early diagnosis, the number of people with neuropsychiatric disorders is increasing on an annual basis. 2011 World Health Organization’s annual statistics has shown that approximately 14 percent of global burden has been attributed to neuropsychiatric disorders and these burdens occur due to “chronically disabling nature of depression and other common mental disorder, substance abuses, and psychosis” [3]. According to 2013 report from National Institute of Mental Health (Table 1), there are approximately 43.8 million adults (i.e.  $\geq 18$  years old) are suffering from any mental illnesses (AMI) [4]. A limitation of an annual report is that it does not necessarily reflect true statistics of neuropsychiatric disorders because there are people who have not been diagnosed or detected.

Children and adolescents are not exempt from increasing cases of psychiatric disorders. According to Mental Health Surveillance Among Children between the ages 3-17, the United States, 2005-2011. It estimates that 13-20 percent of children living in the U.S. and up to 1 out of 5 children between the ages of 3-17 are living with some kind of mental disorder. These childhood mental disorders range from depression, anxiety, autism spectrum disorders, bipolar disorder, schizophrenia, and Tourette Syndrome. Out of all AMI in children, Attention Deficit Hyperactivity Disorder (ADHD) is known to be the most prevalent childhood mental disorder [5]. Childhood psychiatric disorders is a public health concern and should be given more attention because any delays in intervention or diagnosis can have a significant impact on a child’s development experiences. Childhood and adolescent stages are when the individuals “learn of social and economic independence, development of identity, and the acquisition of skills needed to carry out adult relationships” [6].

In this perspective journal, it will discuss further on the limitations of diagnosing and treating mental disorders, a new study looking at Korean-American adolescents’ perception toward mental health, and the importance of clinician’s cultural competency.

## Perspective

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**Louis S Kim\***

*Department of Health Science, Brigham Young University, USA*

**\*Corresponding author:** Louis S Kim, Pediatric & Adolescent Neuropsychiatry Principal Investigator, B.S. (C) Public Health (Epidemiology), Brigham Young University, Provo, UT 84602, Tel: 801-830-0636; Email: Kim.hyunkyuu11@gmail.com

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## Impacts of delayed treatment

In the U.S, there are more than millions who are diagnosed and suffering from mental disorders, ranging from depression to schizophrenia. Due to financial difficulties, social stigma, and low mental health literacy, only half of millions, who have been diagnosed, are receiving treatments [7]. According to 2010 database from the National Institute of Mental Health (NIMH), there are approximately 7.9 million Americans suffering from either bipolar disorder or schizophrenia, and almost half of them are left untreated [8]. The consequences can be devastating for those who do not receive treatment, ranging from homelessness, drug abuse, incarceration, and suicide [8,9]. The delay in treatment and diagnosis has impacts on the community and national level as well, such as loss of economic productivity (Table 2).

## Diagnosing and Treating Psychiatric Disorders

Though it is gaining more attention and increased status, psychiatry poses some difficulties, especially on treatment options and diagnosis methods. One of the downsides of psychiatry is that there is no official diagnostic tool, such as MRI or blood metabolic panel, to diagnosis and monitor the progression of psychiatric illnesses. In the field of psychiatry, it requires a strong relationship between a clinician and a patient, an excellent clinical judgment, and good communication skills because a majority of diagnosis and monitoring are done orally.

As far as treatment plans for patients with psychiatric disorders, they can vary depending on the complexity and the severity of the disease. When a patient comes into the office and complains of loss of interest in his or her favorite activities, experience persistent low mood, and sleeping irregularity for more than three months, those are the signs of Major Depressive Disorder. Therefore, a psychiatrist would prescribe either on Bupropion, Serotonin Norepinephrine Reuptake Inhibitor (SNRI) or Selective serotonin reuptake inhibitor (SSRI) along with psychotherapy [8].

On the other hands, the treatment options can be either limited or difficult if a patient has a combination of three or more disorders. For example, if a clinician suspects his or her patients to have a combination of psychosis, schizophrenia, and anxiety, it would take more time and effort to find a right treatment regimen that works for the individual.

**Table 1:** Prevalence of any Mental Illnesses among the U.S. adults ≥18 years old (SAMHSA) [7].

Categories		Percent
<b>Overall</b>		18.5
<b>Sex</b>	Male	22.3
	Female	14.4
<b>Age Group</b>	18-25	19.4
	16-49	21.5
	50+	15.3
<b>Race</b>	Hispanic	16.9
	White	19.3
	Black	16.9
	Asian	16.9
	*Native Hawaiian/ Pacific Islander	14.4
	American Indians/ Alaska Native	26
	2 or more ethnicities	28.1

Prevalence of Any Mental Illness Among U.S. Adults ≥ 18 years old), 2013 Report (SAMHSA).

**Table 2:** Age-adjusted suicide rate by race/ ethnicity: CDC Data & Statistics Fatal Injury Report 2013 (n=41149) [9].

Year	White	Native Americans	Black	Asians/ Pacific Islanders	Hispanic
2001	11.7	10.5	5.5	5.3	5.7
2002	12	9.9	5.3	5.3	5.8
2003	11.8	9.5	5.2	5.6	5.6
2004	5.3	11.4	5.3	5.7	5.9
2005	12	10.6	5.2	5.1	5.6
2006	12.2	10.4	5	5.4	5.3
2007	12.6	10.1	4.9	5.8	6
2008	13	10.1	5.2	5.5	5.5
2009	13.2	10	5.1	5.9	5.8
2010	13.5	10.9	5.2	6.2	5.8
2011	13.9	10.6	5.3	5.8	5.7
2012	14.1	10.8	5.5	6.2	5.8
2013	14.2	11.7	5.4	5.8	5.7
Average Rate	12.30 (±2.3)	10.50 (±0.61)	5.23 (±0.17)	5.66 (±0.34)	5.71 (±0.20)

Age-Adjusted Suicide Rate By Race/ Ethnicity

What are some of the issues that a patient face during a psychiatric consultation? Two most difficult aspects of psychiatric consultation from a patient’s perspective are opening up to the clinician and finding appropriate words to describe and state one’s psychological state or emotions. On pediatric and adolescent population, they face greater challenges to describe their state of being because of lack of vocabulary or developmental ability. Most of the time, abnormal behavioral or psychological changes are often noticed by the caregivers.

### How Does Second Generation of Korean-American Adolescents Perceive Mental Disorder and Mental Health Literacy? (Table 3)

Looking at the percent of adults reporting poor mental health by race and ethnicities in the United States, Asian-Americans rank the lowest (Table 3). It can be interpreted by that Asian-Americans consider themselves mentally healthy and fit. There is a strong bias toward the national statistics because it is well known that Asian-Americans, including Korean-Americans, do not want to reveal mental health status because there is a strong stigma attached. Therefore, there could be a low number of reporting. For decades, there have been a significant number of studies on Korean immigrants, mental health service usage, and level of awareness. The majority of research studies concluded that regardless the number of years’ Korean immigrants live in the United States they are less likely to use the service. For more than decades, there has been a significant number of studies performed to examine the mental health literacy level of the first generation, Korean immigrants. Most of the studies have concluded that acculturation to the mainstream society, stigmas, and cultural and linguistic barriers barred the Korean immigrants from receiving appropriate medical care or increase their awareness of mental disorders.

Korean-Americans are considered to be a part of the minority groups in the United States. They are known as the model minority, which is “often regarded to achieve a higher degree of socioeconomic index success than the average population. The socioeconomic index success is measured by income, education, low crime rate, and high family stability” [11]. The adolescents excel in the areas of academic, extracurricular activities, and standardized testing, yet a model minority comes with costs. With the cultural and familial expectations to be excellent in all areas, they are exposed to a greater level of stress. Along with a high level of stress and pressure, the adolescents have a greater chance of developing anxiety and depression. Despite emotional disturbance, they keep to themselves and think that it will bring shame to their family members. Undiagnosed and untreated symptoms can lead to self-medicating or suicide. Excluding Alaskan and Native Americans, Korean-American adolescents suicide rate ranks 8th in the United States. If a suicide occurs starting from 14 years old age and goes all the up to 24 years old, due to non-treatment and delayed recognition of psychiatric disorder, 46 (± 3.32) years of potential life will be lost (Table 4).

**Table 3:** Percent of adults reporting poor mental health by race/ ethnicity in the U.S. [10].

Percent of Adults Reporting Poor Mental Health by Race/ Ethnicity in the U.S.	
Races	Percentage
White	33.7
Black	35.1
Hispanic/ Latino	34.3
Asian/ Pacific Islanders	29.1
American Indians/ Alaska Native	43.5
All adults	33.9 (±4.69)

**Table 4:** Years of potential life lost (YPLL) of Korean-American adolescents and young adults (Ages 14-24)\*\*.

Years of Potential Life Lost (YPLL) Of Korean-American Adolescents And Young Adults Due To Suicide (Ages 14-24)	
Ages	PYLL (*Reference Age: 65)
14	51
15	50
16	49
17	48
18	47
19	46
20	45
21	44
22	43
23	42
24	41
<b>Total YPLL</b>	506
<b>Average YPLL</b>	46 (± 3.32)

\*\*In this calculation of years of potential life lost (YPLL) of Korean-American adolescents, the age between 20-24 were included.

## Methodology

Though there have been many studies on the perception of psychiatric illnesses and awareness level on the first generation Korean immigrants in the U.S., there have not that many studies performed targeting specifically on the second generation of Korean-American adolescents. In August 2015, I recently conducted a study to understand the perception of 2nd generation Korean-American adolescents on psychiatric disorders and mental health literacy.

In August 2015, a study was conducted to examine the perception of mental disorders and mental health literacy level by using multiple testing methods: semi-constructed questionnaires, an open group discussion, and socioeconomic demography. The study focused more on semi-constructed questionnaires and an open group discussion because those provided more insights on how second generation Korean-American adolescents feel about such topics; these adolescents are the ones who will be leading the community. The participants (n=100), who are the ages between 15-19 years old, were recruited non-random basis in Los Angeles, CA. 20 participants out of 100 did not complete the survey questionnaires (i.e. semi-constructed questionnaires and socioeconomic demography). Among 80 participants, who completed the survey, 3 were willing to join the open discussion.

## Results

The results of both semi-constructed questionnaires and the open discussion interview helped greatly to understand the perceived views toward mental disorders, yet it also revealed that the perceptions are far more complex. The cultural stigmas that are attached with mental disorders make it difficult to openly talk about their feelings and concerns. These adolescents agreed with the fact that Korean-American community focuses heavily on well-being by living a healthy lifestyle and openly discuss more chronic diseases, such as diabetes. Despite its heavy emphasis on physical well-being, mental health is greatly neglected. One positive sign that opens a window for the opportunity to change the status of mental health is through religion. 95 percent of the participants (n=100) are considered and active in Christian denominations by attending church services. During the weekdays and Sundays, they participate in religious youth services and come in contact with youth leaders, who are also second generation Korean-Americans. Having the both cultures, Korean and American, these second generation Korean-American youth leaders do understand what needs to change in order to improve emotional, physical, psychological, and spiritual components of an individual. The youth leaders are opening up discussions to sensitive topics that have not been talked about with the first generation, such as LGBT rights and mental illnesses. Despite the frequent contacts and interactions, the adolescents feel that the leaders still do not have sufficient understanding and knowledge of mental health and disorders. Most important key finding that pertains to adolescent medicine and psychiatry is that adolescents feel that psychiatrists and primary care physicians (PCP) do not have sufficient understanding toward other cultures such as Asian values, or a lack of cultural competency. Therefore, there are more likely to go see Korean-American psychiatrists or primary care

physicians; it is not difficult to find the Korean-American board certified physicians in metropolitan cities, where a large number of Korean-Americans are residing.

## Cultural Competent Physicians and Adolescent Health

Cultural competency is “the application of cultural knowledge, behaviors, and interpersonal and clinical skills that enhance a provider’s effectiveness in managing patient care” [12,13]. The key components of cultural competency are attention to linguistic differences, cultural influences on attitudes, recognition of expressions of distress, and help seeking behaviors [14]. Most importantly, along with the key components, doctors should be aware of the social context in which an adolescent is growing up in. Healthcare professionals, who are not culturally competent in dealings with different cultures, are more likely to misinterpret cultural cues and possibly misdiagnose. As one of the findings, the adolescent said that they feel distant toward less culturally competent healthcare providers. It creates another barrier that prevents them from receiving appropriate care if needed. In metropolitan cities, like Los Angeles or New York, it is not difficult to find the Korean-American board certified physicians. On the other hand, there are Koreans who live in rural parts of the U.S. like Wyoming or South Dakota. The adolescents and individuals living in less populous states have more likelihood of becoming marginalized and faced with health inequity due to a lack of care providers who meet their needs. Oftentimes, individuals simply think that money is the main issue that causes health inequity and marginalization. However, under the context of social determinants of health, approximately 10% of the development of non-communicable diseases is attributed due to a lack of healthcare services. The crucial aspects of managing psychiatric disorders are early detection and intervention. If an early detection and intervention do not occur, it becomes more difficult to manage. In terms of adolescents, their normal physical, social, and psychological development would be interrupted (Figure 1).

## The Responsibilities of Today’s Physicians and Psychiatrists

The study revealed that cultural stigma and a lack of awareness are not the only reasons that prevent Korean-American adolescents from accessing mental health care services. Providing effective mental health services along with increasing mental health literacy can be difficult. Sometimes, it is normal to ask where should the intervention start and at some point, someone needs to break the barriers. As the results previously stated, cultural stigma and low mental health literacy are not the only factors that prevent both adolescents and adults from having access to mental health care service. The physicians’ cultural competency and clinical judgment can play a crucial role in removing barriers to some degree. Within the Asian-American community, including Korean-American, physical health is observed much better than mental health, which means status quo of someone with type 2 diabetes mellitus is better than an individual with depression. Additionally, the adolescents come into consultations with physical complaints, such as a headache, weight loss, and other symptoms. When he or she comes in, it would be highly valuable to check and inquire



about the individual's psychological and emotional states because mental disorders can be manifest as physical symptoms (i.e. somatization). By understanding the cultural background of an individual, physicians can better ask appropriate questions. Think about it, if adolescents or individuals feel uncomfortable talking

to doctors about sensitive issues, whom will they turn to receive help? Do we want to see these adolescents become unsuccessful, not live up to their own potentials, and fall into negative behaviors (e.g. substance abuse, suicide contemplation)? Let's keep in mind that they will be the ones who will contribute to the society.

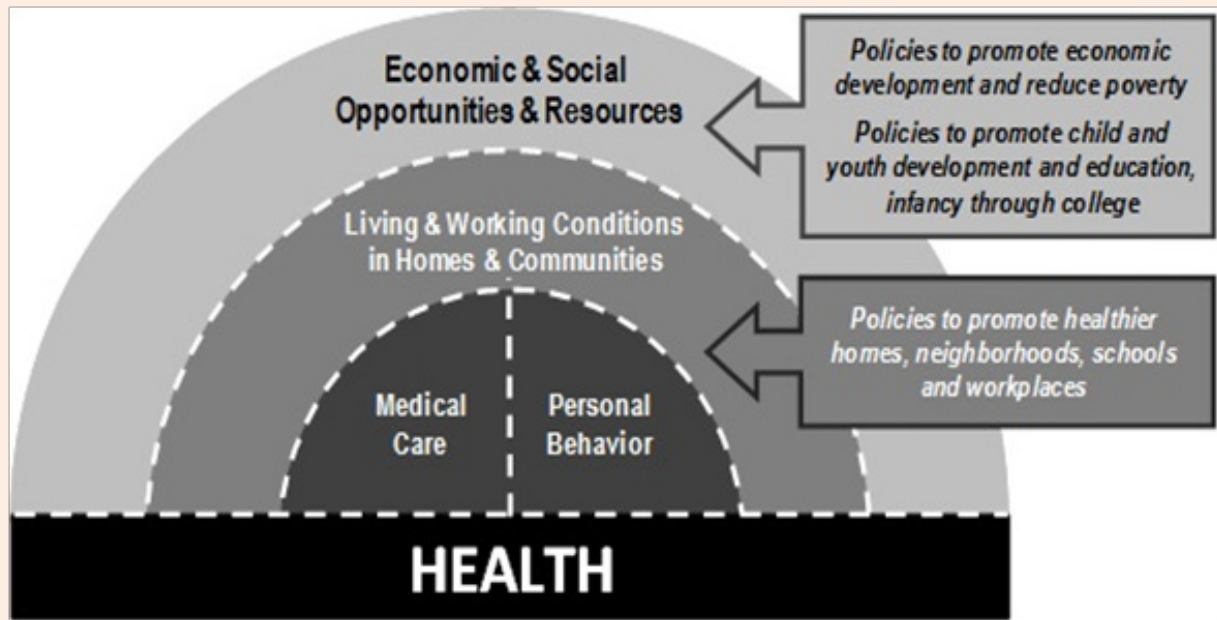


Figure 1: Social Determinant of Health [17].

### Questions for Think About

The research comes all back down to how can develop culturally competent physicians. It would be very difficult to teach medical students, residents, and board certified physicians on every single culture that exists in the United States; simply because there are so many cultures exist in this country. For the future research, there should be a greater emphasis on allowing medical students and residents become more exposed to behavioral medicine. Further research has to be done in order to figure out how many weeks or months that medical students and residents become exposed to behavioral medicine. A possible hypothesis is that more contacts that future doctors and doctors encounter through inpatient and outpatient settings, they could possibly gain greater knowledge. Also, it takes time and a true enthusiasm to become a culturally competent doctor because it won't happen overnight [15-17].

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