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Inside

EDITORIAL

Race and Psychiatry

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Throughout history, race and ethnicity have been powerful social constructs used to both unite individuals with a shared history, culture, and beliefs and also stigmatize these same groups of individuals due to their perceived physical, ideological, and social differences. The concept of race must be used cautiously, as the idea that "inhabitants of a geographical or political region belong to a certain 'culture' tends to ignore diversity and to suggest a homogeneity, which can unconsciously extend into the realm of biological similarities and differences" (1).

As physicians, we pride ourselves on providing uniformly equal, fair, and conscientious care to our patients, regardless of their skin color, religion, or social background. But even if we are trained in cultural competency, implicit bias still creeps in. For instance, a 2004 study showed that race was the demographic characteristic most associated with a diagnosis of schizophrenia: "Race appears to matter and still appears to adversely pervade the clinical encounter, whether consciously or not" (2). Examples abound: the Hispanic patient diagnosed with a paranoid delusion because of legitimate fears of gang retaliation or an African American patient misdiagnosed as psychotic rather than depressed due to "negative symptoms." It is a human inclination to see the world through the lens of our own lived experiences, but as psychiatrists we often demand more of ourselves. We attempt to suspend our inferences, assumptions, and judgments in order to truly hear and understand what our patients are saying.

Even if we are trained in cultural competency, implicit bias still creeps in.

Perhaps in response to some of these challenges, graduate medical education has increasingly emphasized cultural competency training. One message appears to be that while we strive to be color blind, we should remain color and culture conscious. For instance, a resident may be taught in cultural competency training that many Indian Americans are Hindu, and then he or she is taught the major tenets of Hinduism. This resident may then be asked to evaluate a South Asian patient on a busy night in the emergency room. The resident may, in his or her haste, assume certain facts about the patient given the patient's outward appearance and race. If the patient identifies as Hindu, the resident may assume he or she knows even more about the patient's background and experiences. Where then does the stereotyping begin and cultural competency end? When does inappropriate cultural bias and gross overgeneralization thwart honest attempts at providing culturally informed clinical care?

Some have suggested that cultural competency models as they exist are used more to end a conversation rather than start one; students may "materialize the models as a kind of substance or measurement (like hemoglobin, blood pressure, or X-rays)." Kleinman and Benson (3) further state that "the moment when the human experience of illness is recast into technical disease categories something crucial to experience is lost."

Despite these challenges, trainees should not be fearful or reticent in their attempts to deliver culturally competent care; however, cultural competency should not be a pretext for reckless stereotyping. Unfortunately, there are no shortcuts or quick categorizations that allow us to build a true therapeutic alliance and rapport with any individual patient. Obtaining general knowledge about ethnicities and cultures is simply one of many steps in providing truly "culturally informed" care. There is simply no substitute for listening, asking, and attempting to understand an individual patient's perception of race, ethnicity, and experiences within society.

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ARTICLE

Immigration and Risk of Psychiatric Disorders: A Review of Existing Literature

Julia Shekunov, M.D.

The United States has long been described as a melting pot of cultures, a country of immigrants. With over 41 million foreign-born U.S. residents—13% of the total population—the relationship between immigration and risk of psychiatric illness has significant public health implications (1). Historically, observations of socioeconomic disadvantage in immigrant groups shaped early theories causally linking immigration, stress, and mental illness. Multiple epidemiological studies over the past 30 years have provided evidence to the contrary for mood, anxiety, and substance use disorders, while demonstrating a different pattern for psychotic disorders.

PREVALENCE OF PSYCHIATRIC DISORDERS

Foreign-born Mexican Americans and Asian Americans have significantly higher lifetime prevalence rates of mood, anxiety, and substance use disorders than their U.S.-born counterparts. Rates of any drug use disorder are up to 8.3 times higher in U.S.-born Mexican Americans than in those who are Mexican-born (2–8). Asian immigrant women have lower lifetime rates of mood, anxiety, and substance use disorders, while Asian immigrant men have lower rates of only substance use disorders, compared to the U.S.-born population. English proficiency is strongly associated with lifetime depressive, anxiety, and substance use disorders but only in men, such that Asian men who speak English proficiently have lower lifetime and 12-month rates than non-proficient speakers (8). Risk is also lowest for foreign-born Asian Americans in the years before immigration and for immigrants who arrive in the United States after age 13. After arrival, risk rises to equal that of U.S.-born Asian Americans by 15 years, with the fastest pace of change for mood disorders (7). Immigrant Black Caribbean men have higher 12-month rates of mood and anxiety disorders than African American men, while Black Caribbean women have lower 12-month and lifetime rates of anxiety and substance use disorders than African American women. Rates also vary by ethnicity, such that Spanish Caribbean women have higher rates of mood and anxiety disorders compared to women from the English-speaking Caribbean, while Haitian men have lower rates of mood disorders compared to men from the English-speaking Caribbean. Generational status is associated with increased lifetime risk for all psychiatric disorders, such that lifetime prevalence rates for first-, second-, and third-generation immigrants are 19.3%, 35.27%, and 54.64%, respectively (9).

MIGRATION-RELATED FACTORS

Migration can be broadly described as occurring in three stages. The first, pre-migration, involves the decision and preparation to move. The second, migration, is the physical relocation of an individual or family. The third stage, post-migration, involves assimilation of the immigrant into a society. Assessment of risk for psychiatric illness in the immigrant population should evaluate an individual's experience in all three stages. Migration-related factors that may influence mental health outcomes in immigrant groups are summarized in Table 1 (10–13).

Pre-migration factors, including age, socioeconomic status, personality structure, and ability to cope with stress, among others, may be protective or could confer additional risk, as social roles and networks are disrupted during the migration process (10). Migration itself can be difficult, with poor traveling and living conditions and possible exposure to violence. Refugees are at significantly higher risk for psychiatric illness compared to the general population, with increased rates of depression, somatic complaints, and up to 10 times higher rates of post-traumatic stress disorder (10, 12). Culture shock and cultural bereavement may be additional vulnerability factors during migration, as individuals experience loss of language, social structures, and support, which can precipitate a grief reaction (13, 14). While grief can be a healthy response to a significant loss, it can also result in significant distress and functional impairment. Symptoms of bereavement should be recognized within a cultural context because culturally appropriate expressions of grief (such as hearing voices and seeing ghosts) may be misinterpreted when using Western diagnostic criteria.

Resettlement typically brings hope and optimism but also challenges, including isolation from social supports and difficulties resuming education or finding work. Housing may be inadequate and health care difficult to access. Immigrants are less likely to be referred to or seek out mental health treatment in particular. Appropriate services that are linguistically and culturally accessible can be challenging to find and to afford, and time away from work can be difficult to receive. Immigrants may wish to manage problems alone, worry that their concerns will not be understood in a cultural context, and fear stigmatization (10). Racism and discrimination are further obstacles to establishing

TABLE 1. Factors Related to Migration That May Impact Mental Health

Pre-Migration	Migration	Post-Migration
Age, developmental stage in children	Logistics of migration process (route, duration)	Stability of housing
Level of education	Group or single migration	Access to health care
Socioeconomic status	Exposure to violence	Availability of education and work
Linguistic capacity	Exposure to harsh living conditions	Social supports (ethnic density)
Reasons for immigration (voluntary or forced)	Nutrition	Exposure to racism and discrimination
Degree of preparation and control over migration	Separation of children from caregivers	Concern about family members left behind
Past psychiatric and family history	Uncertainty of outcome	Assimilation vs. separation from new culture
Personality structure	Culture shock	Acceptance by new culture
History of persecution or other trauma	Cultural bereavement	Discrepancy between expectations and achievement

a successful post-migration life. The significant culture change that immigration often brings can pose challenges in balancing assimilation or acculturation with maintaining cultural identity. Assimilation is defined as "a process by which cultural differences disappear as immigrant communities adapt to the majority or host culture and value system," which can be different from acculturation, defined as "the assimilation of cultural values, customs, beliefs and language by a minority group within a majority community [during which] both the immigrant and host cultures may change" (11, 15). In a study of Indian immigrants to the United States, better mental health was associated with a greater perception of acceptance by Americans and having a greater orientation toward and greater connection with U.S. culture (16).

SPECIAL CONSIDERATIONS

The finding of lower rates of mood, anxiety, and substance use disorders in immigrant groups compared to their U.S.-born counterparts is not universal. In addition to the differences seen in Black Caribbean immigrants, individuals from Cuba, Puerto Rico, and Western Europe do not significantly differ in their risk of mood or anxiety disorders compared to the U.S.-born population (17–19). The relationship between immigration and mental illness may be different in these groups for as yet unclear reasons. Alternatively, methodological differences or lack of statistical power associated with a small sample size may account for the lack of significance.

There is also strong evidence of a two- to three-fold increased risk of schizophrenia in immigrants to Eastern and Western Europe from the Caribbean, Africa, Asia, the Middle East, and Australia (20–23). This increased risk persists into the second generation, suggesting that migrant status is an important risk factor for psychotic disorders, one that approximates the risk associated with cannabis use, perinatal complications, or urbanicity (24). Furthermore, immigrants from countries where the majority of the population is black have significantly higher rates of psychosis, which not only persist but increase in the second generation (20–21). In the absence of increased rates of psychosis in source countries, this suggests that racism and discrimination may play a role in increasing risk for psychosis (14). Another contributing hypothesis is that of social defeat. The long-term experience of stress associated with social exclusion or having a subordinate position in society is theorized to result in sensitization of the mesolimbic dopamine system, increasing risk for psychotic disorders (20–22). There may also be a protective effect of social support in areas of higher ethnic density, which is supported by studies demonstrating relatively lower rates of schizophrenia in nonwhite ethnic minorities that represent larger proportions of the population (13, 20).

The selective migration hypothesis in which mentally healthier individuals are theorized to more likely make the decision to migrate and successfully navigate the immigration process may help explain the lower rates of mood, anxiety, and substance use disorders in immigrant groups compared to their

KEY POINTS/CLINICAL PEARLS

- The relationship between immigration and mental health has significant public health implications, and historically immigration status has been linked to increased mental illness.
- Immigrants to the United States generally have lower rates of mood, anxiety, and substance use disorders compared to the U.S.-born population, with increasing risk of psychiatric illness with longer duration of residence in the United States and generational status.
- Immigrant groups from across the world have higher rates of psychotic disorders compared to natives, with risk persisting into the second generation.
- Close consideration should be given to pre-migration, migration, and post-migration factors in a culturally competent assessment of first- or second-generation immigrant patients.

U.S.-born counterparts (5). However, this theory has been challenged not only by the increased rates of psychosis among immigrants but also by the finding of lower rates of psychiatric disorders in Asian countries (7). To further test this hypothesis, consistent methods assessing risk in immigrant populations and their countries of origin are needed.

The pattern of increasing risk of psychiatric illness with longer duration of residence in the United States speaks to the role of post-migration factors in this process, specifically acculturative stress (18). However, acculturation has also been associated with improved mental health in Indian immigrants (16). Additionally, we may expect older age at immigration to be associated with higher acculturative stress because these individuals have already established social networks and cultural identities, while immigrants arriving as children typically have an easier time learning English and establishing friendships at school (8). That younger age at immigration is associated with increased risk of mood and anxiety disorders suggests that the timing of exposure to American culture and developmental stage of the individual may be important.

CONCLUSIONS

Immigrants to the United States generally have lower rates of mood, anxiety, and substance disorders compared to the U.S.-born populations. Younger age at immigration is associated with increased risk of mood and anxiety disorders, while risk for substance use disorders is lower among immigrants regardless of age at immigration. Longer duration of residence in the United States and generational status are associated with increased risk of psychiatric illness. In contrast, immigrant groups from across the world have higher rates of psychotic disorders compared to natives, with risk persisting into the second generation. Multiple factors encompassing all three stages of migration—pre-migration, migration and post-migration—likely interact to influence mental health outcomes. Psychiatric assessment and treatment of patients who are first- or second-generation immigrants should include consideration of an immigrant's unique experience in all three stages in a culturally sensitive context.

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ARTICLE

Prevalence and Determinants of Psychiatric Disorders Among South Asians in America

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A substantial and growing body of research exists on Asian American mental health; however, less attention has been paid to mental health characteristics of South Asians in particular, defined as originating from India, Pakistan, Nepal, Sri Lanka, Bangladesh, Maldives, and Bhutan. This review synthesizes existing research on the prevalence of and determinants of psychiatric illness among South Asians in America. By doing so, we hope to educate resident physicians about this population's specific mental health challenges and to inspire targeted research into how to best meet their needs.

ASIAN AMERICANS AS A SINGLE RACIAL CATEGORY IN EPIDEMIOLOGICAL RESEARCH: HISTORY AND OVERVIEW

Initial research into the mental health of Asian Americans tended to treat them as a single category, without addressing different Asian subethnic groups. This was done largely to increase sample sizes (1). These studies tended to show that fewer Asians met criteria for psychiatric disorders than Caucasians and that fewer Asians sought psychiatric services (2, 3). It has also been found, however, that this practice of treating Asian Americans as a single population in psychiatric research studies obscures significant differences in the level of psychiatric disability between the multiple subethnic groups making up the Asian American whole (1).

The first nationwide American survey of mental health focusing specifically on minorities, including a range of Asian subethnic groups, was the National Latino and Asian American Survey (NLAAS) of 2002–2003 (4). It was largely funded by the National Institute of Mental Health under a mechanism for cooperative grants, along with the National Survey of American Lives, which was a survey of black Americans, and a replication of the National Comorbidity Study. These studies formed a cooperative agreement, the Collaborative Psychiatric Epidemiologic Studies (CPES), allowing the sharing of ideas, protocols, and measures. Following the NLAAS was the NLAAS II, a 3-year CPES initiative using NLAAS data to compare the prevalence of psychiatric disorders among Asian Americans, Latino Americans, and whites to localize disparities in mental health service provisions to these populations and to delineate differences in the patterns of use of mental health services (5).

PREVALENCE OF PSYCHIATRIC DISORDERS AMONG SOUTH ASIANS

Through examining NLAAS data, Masood et al. (6) found that compared to previously published NLAAS data on rates of psychiatric disorder among all Asian Americans, a smaller percentage of South Asians met criteria for psychiatric disorder (6). The lifetime prevalence of having ever met criteria for DSM-IV affective, anxiety, or substance abuse disorder was 20.8% in South Asians compared with 26.8% in all Asian Americans. For affective disorder, the prevalence was 2.7% in South Asians compared with 9.1% in all Asian Americans, while for anxiety disorder it was 5.3% in South Asians compared with 9.8% in all Asian Americans (6).

The National Epidemiologic Survey of Alcohol and Related Conditions (NESARC) of 2002, which surveyed Americans for alcohol use disorders and for comorbid mood and anxiety disorders, while not focused specifically on minorities, also provides information on rates of these disorders among South Asians. In the Lee et al. (7) study of NESARC data, the South Asian sample had a 24.5% lifetime rate of any DSM-IV mood, anxiety, or substance use disorder, while this rate was 36.4% among Southeast Asians and 22.5% in East Asians. Prevalence of mood disorder was 13.1% in South Asians, 16.9% in Southeast Asians, and 13.4% in East Asians, while prevalence of anxiety disorder was 11.4% in South Asians, 13.4% in Southeast Asians, and 11.4% in East Asians (7).

Similarly to the study by Masood et al. (6), the study by Lee et al. (7) shows that rates of psychiatric disorder among South Asians are toward the low end for Asian Americans. The Lee et al. study also points to the heterogeneity of different Asian groups, with East and South Asians reporting relatively similar rates of disorder, while Southeast Asians had rates that were significantly higher. Accordingly, we should also assume that there is likely to be heterogeneity within the South Asian sample itself, and there may be areas of commonalities between these Asian groups; for example, certain South Asians may share with certain Southeast or East Asians various factors, including religion, socioeconomic status, origin from rural society, and length of time since personal or familial immigration, not shared with other South Asians and that have effects on mental health.

DETERMINANTS OF MENTAL HEALTH AMONG SOUTH ASIANS

The study by Masood et al. (6) examined the predictors of psychiatric distress in South Asians, conducting multivariate

TABLE 1. Determinants of Mental Health Among South Asians in North America

Determinant (by Subpopulation)	Mental Health Outcome
South Asian American women	
Being born in the United States, as opposed to having immigrated	Statistically significant* increase in 30-day psychologic distress[a]
Low extended family support	Statistically significant* increase in 30-day psychologic distress[a]
South Asian American men	
Financial strain	Highly statistically significant** increase in 30-day psychologic distress[a]
Presence of family-cultural conflict	Statistically significant* increase in 30-day psychologic distress[a]
Low social position in South Asian community	Highly statistically significant** increase in 30-day psychologic distress[a]
High social position in American community	Highly statistically significant** increase in 30-day psychologic distress[a]
Canadian-born South Asians	
Unemployment	Statistically significant increased odds of having a mood disorder[b]
Physical inactivity	Statistically significant increased odds of having a mood disorder[b]
South Asian immigrants to Canada	
Female gender	Statistically significant increased odds of having a mood disorder[b]
Food insecurity	Statistically significant increased odds of having a mood disorder[b]
Poor physical health	Statistically significant increased odds of having a mood disorder and statistically significant increased odds of having an anxiety disorder[b]
Smoking	Statistically significant increased odds of having a mood disorder[b]
Having immigrated before 17 years of age	Statistically significant increased odds of having a mood disorder and statistically significant increased odds of having an anxiety disorder[b]

[a] For further details, see Masood et al. (6).
[b] For further details, see Islam et al. (8).
*p<0.05; **p<0.01.

regression analysis to see which factors had associations with an elevated score on the Kessler Psychological Distress Scale (also see Table 1). They found that these factors fell into three categories: those characteristic of the individual, those characteristic of the family, and those characteristic of the extrafamilial environment. Among a variety of factors examined, including demographic characteristics, financial situation, cohesiveness of family, and community position, the strongest predictor was found to be family cultural conflict, which describes conflict within the family over appropriation of traditional South Asian norms and values versus American ones. The only other significant predictor of distress was low social position within the South Asian community (6).

The authors completed additional analysis to assess the predictors of distress by gender (6). They found that among women, the most significant predictor was having low extended family support. Additionally, being born in the United States, as opposed to having immigrated, also predicted distress. For men, there were more varied predictors, with the most important being financial strain, family cultural conflict, lower social position in the South Asian community, and higher position in the American social community (6).

Data from the Canadian Community Health Survey (CHHS), an annual survey of various measures of health across Canada, also provides information on potential determinants of mental health

KEY POINTS/CLINICAL PEARLS

- Treating Asian Americans as a single category in psychiatric research obscures significant differences in prevalence of and risk factors for psychiatric illness, as well as in the level of psychiatric disability, between different Asian subethnic groups.
- South Asian Americans have a lower overall prevalence of meeting criteria for psychiatric disorders compared to the entire Asian American population; however, rates of subthreshold anxiety and affective symptoms are similar between South Asian Americans and Asian Americans at large.
- Barriers to mental health treatment in South Asian Americans include stigma attached to psychiatric diagnosis, as well as the belief that psychiatric symptoms are appropriate reactions to stress rather than diseases requiring professional treatment.
- Future research efforts should seek to develop culturally sensitive screening materials to elucidate psychological distress in South Asians that may not be detected by traditional Western screening tools and to expand existing knowledge on psychotic disorders in South Asian Americans.

among North American South Asians. Islam et al. (8) analyzed 2011 CHHS data to assess whether predictors of mood disorder differed among Canadian-born and immigrant South Asians and found that there were differences: among the Canadian-born population, unemployment and reduced physical activity predicted increased likelihood of mood disorder, while among immigrant South Asians, being female, experiencing food insecurity, poor physical health, smoking, and immigrating at less than 17 years of age predicted increased odds of mood disorder (also see Table 1). Although the study did not compare the rate of mood disorder between the immigrant and Canadian-born populations, what this study certainly suggests is that time of personal or familial immigration interacts with other factors and is an important determinant in and of itself to the risk of psychiatric illness among South Asians in North America. In working with South Asians, then, psychiatric providers should inquire about these individual and environmental/familial circumstances that we now know can have significant effects on psychologic health.

CHALLENGES TO DIAGNOSIS AND TREATMENT

The study by Masood et al. (6) found that while a lower percentage of South Asians met criteria for psychiatric disorder compared with all Asian Americans, the rates of subthreshold anxiety and affective disorders (i.e., meeting some but not all criteria required for diagnosis) were similar between the two groups. Additionally, they found that for South Asian women, meeting criteria for a DSM-IV diagnosis within the past year did not predict psychologic distress. This suggests that Western screening instruments for psychiatric disorder have less sensitivity in South Asians, which may be due to differences in reporting or because symptoms of psychiatric illness manifest differently in South Asians than in other ethnic groups (9, 10).

Furthermore, South Asians may experience psychiatric symptoms not as indicators of illness but as appropriate reactions to life stress, leading them to seek support of friends rather than consulting with mental health professionals (10). This is consistent with 2003 CCHS data showing that among South Asians who had experienced a recent major depressive episode, only 37.5% had used mental health services, while among whites experiencing recent depression, 46.2% had used services (11). Another factor potentially preventing South Asians from seeking professional treatment is stigma surrounding mental illness (12, 13).

SPECIAL CONSIDERATIONS

South Asians are more likely to have diabetes and atherosclerosis than are other ethnic groups in America (14, 15). Because many psychopharmacologic treatments cause metabolic side effects, this risk-benefit ratio should be considered carefully. Another biologic characteristic affecting psychiatric treatment is that members of the Vysya community of Southern India possess a higher than normal rate of pseudocholinesterase deficiency, a reduction in succinylcholine metabolism that impairs motor recovery from succinylcholine (16). Accordingly, members of this community who are ECT candidates could be administered an alternate, non-depolarizing muscle relaxant (17).

FUTURE DIRECTIONS

In order to improve detection, and ultimately to improve delivery of psychiatric services to this population, further research is needed toward the development of culturally sensitive screening tools, and investigating how to optimally deliver psychiatric care to a population in which mental illness is often regarded with shame or fear. Lastly, an area that would benefit from increased attention is rates of psychotic disorder and utilization of psychiatric services among South Asians with psychosis, who are likely to be a highly underserved group.

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CASE REPORT

Undocumented Immigrants in Psychiatric Wards

Mike Wei, Katherine Lubarsky, M.D., Bernadine Han, M.D.

Since the 1990s, more undocumented than documented immigrants have been arriving in the United States, with an additional 300,000–500,000 undocumented persons arriving each year (1, 2). While it is well known that Latino immigrants are relatively healthy upon arrival, they are paradoxically more likely to have poor health and low socioeconomic status after arrival. This can be attributed to language and cultural barriers, poverty, separation from family, stressors in the homeland prior to migration, discrimination and exploitation endured, lack of insurance, and decreased education (2, 3).

There are surprisingly little data on undocumented immigrants and the many health issues they face, despite their large and increasing presence. In particular, there are virtually no studies on the intersection of undocumented immigrants in the United States with the psychiatric world. Additionally, there are very little data about immigrant access to health services (1). While the health care system is meant to provide services regardless of criminal history and documentation status, in a study by Cavazos-Rehg et al. (2) involving 143 Latino immigrants in St. Louis, 39% feared seeking social services out of concern for deportation. In 2013, a research group led by Lovato demonstrated that one in eight undocumented Latino immigrants presenting to the emergency department fear discovery and deportation (4). Similarly, Bustamante et al. (5) showed that compared with documented immigrants from Mexico, undocumented immigrants from Mexico were 27% less likely to visit a doctor and 35% less likely to have a usual source of care.

In the face of an increasing undocumented population, it is critical for the hospital system to learn how to care for them. Unfortunately, on top of the difficulties undocumented immigrants face accessing the health care system, little legal oversight exists regarding hospital management of them. In sight of this, we present our care for an undocumented Honduran man with psychosis and provide a concise review of the available literature for managing undocumented psychiatric patients.

CASE

"Mr. A" is a 23-year-old monolingual, undocumented Honduran man who was brought by emergency medical services to NewYork-Presbyterian Hospital after he was found trying to break into a car without a shirt in the middle of winter. He was severely agitated, requiring restraints and intramuscular haloperidol, lorazepam, and diphenhydramine, after which he slept through the night. Psychiatry was consulted, and he was seen with a Spanish interpreter. The patient was a poor historian, often contradicting himself, making nonsensical statements, or simply not responding to questions.

On later evaluation, the patient was able to report his name and birthdate. He mentioned that he came to New York from Honduras with his brother 3 years ago. The night he came into the emergency department, he was "running as fast as possible to get world peace" by working with "everyone." He believed that he talked with God and also the devil, who told him to kill people, which he could not do because he was "here for peace." He was admitted to the inpatient psychiatric unit, where he received haloperidol (10 mg q.h.s.), valproic acid (500 mg q.a.m. and 1,000 mg q.h.s.), and a tapering clonazepam regimen, with improvement in his mood and psychotic symptoms, which allowed us to fill the gaps of his story.

The patient revealed that he had been in a depressive state for the 3 months preceding presentation and had many prior episodes consistent with major depression. His first episode was at age 12, leading to chronic marijuana use "to feel happier." One month prior to the depressive episode, his brother had been deported back to Honduras. The day of the incident, the patient went to the train station to find work elsewhere when he received a text and video from God on his phone instructing him to help the poor. The events following were unclear, but the patient believed it was God's order that he should break into the car. The day of the incident, he had five beers and a joint.

Disposition was complicated given the patient's lack of documentation. Because of the recent deportation of his brother, his desire to return, and his need for long-term outpatient psychiatric follow-up, we worked to help him return to Honduras. We attempted to secure identification by trying to contact the Honduran consulate, with multiple calls, a faxed letter, and a hand-delivered letter to the consulate. It took 10 days to receive an e-mail, and another 8 days before we secured a phone call. The consulate agreed to help the patient generate his ID and passport. Six weeks into the patient's admission, and after a hospital expenditure of $281,000, he was reunited with his family back in Honduras.

DISCUSSION

Our case of a Honduran man with psychosis highlights several important issues regarding undocumented immigrants struggling with psychiatric problems. Most of these patients need extensive care that hospitals lack the funds to provide. Repatriation back to

KEY POINTS/CLINICAL PEARLS

- There is a dearth of research available studying the psychiatric care of undocumented immigrants.
- Three laws guide the care of patients who come through the emergency department, independent of legal status: the Emergency Medical Treatment and Active Labor Act (EMTALA) stipulates that emergency rooms must stabilize all patients; Medicaid is legislated to reimburse emergency department costs; Medicare Conditions of Participation ensures that hospitals cannot discharge patients without an appropriate plan.
- Without clear laws governing the management of undocumented patients, hospitals have been repatriating patients without legal oversight.
- Laws governing repatriation are needed; without them undocumented patients may be vulnerable to abuse and unethical conduct.

the patient's home country with the assistance of consulate services is an option, though speed of response and coordination varies by the size of the consulate (6). In a similar case report by Vesga-López et al. (6) in 2009 about a Mexican patient, success was much quicker, attributed partly to the larger presence and increased staffing of the Mexican consulate (7). Severity plays an important role in determining disposition, with facilitated repatriation providing greater assurance of continued high-level care with more severely ill patients. For patients with milder symptoms, discharge to sliding-scale/free/low-income clinics may be more viable. Our patient fell in the middle of this spectrum, and his strong personal preference convinced the team to pursue repatriation.

The rise of undocumented immigrants has led to increasing health care costs, causing hospitals to strategize cost-containment measures (8). Overall, the United States health care system spends roughly $2 billion a year caring for undocumented immigrants. Three laws guide the care of severely ill or injured patients who come through the emergency department, independent of legal status. The Emergency Medical Treatment and Active Labor Act states that emergency rooms must stabilize all patients in emergency situations. Second, Medicaid is legislated to reimburse emergency department costs. Finally, the Medicare Conditions of Participation ensures that hospitals cannot discharge patients without an appropriate plan. Not only is the compensation grossly inadequate for hospitals caring for undocumented patients, no laws are set up to ensure even some level of compensation following discharge. With the confluence of reduced compensation and lack of governance, hospitals have been repatriating patients without legal oversight. This strategy will continue with the increasing number of undocumented patients. There is no current figure for the prevalence of repatriation, but it is a growing phenomenon. While repatriation is done to reduce overall costs, it is important to note that this process is quite expensive. Hospitals commonly spend $25,000 or more to send patients back via medically equipped planes (8).

Needless to say, laws governing repatriation are needed; without them, patients may be vulnerable to abuse and unethical conduct. Although not the case for our patient, hospitals may discharge patients without consent. While hospitals may not have the explicit right to repatriate patients, it is unclear what else hospitals should do. As such, hospitals navigate through legal and ethical gray areas that need clarification (8). As proposed by Cavazos-Rehg et al. (2), the government must either allow undocumented immigrants to become eligible for Medicaid or set up legal boundaries for repatriation.

Given the growing population and the rising cost of caring for undocumented immigrants, studies are crucial for hospitals to provide optimal care. What is clear is that given the vulnerable nature of this population, more needs to be done to meet their mental health needs.

Mr. Wei is a fourth-year medical student and Drs. Lubarsky and Han are third-year residents at Weill Cornell Medical College/New York-Presbyterian Hospital, New York.

The authors thank their mentors, Drs. Janna Gordon-Elliot and Jonathan Avery, for assistance with caring for the patient in this case report, as well as for their editorial assistance in the writing of this manuscript.

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COMMENTARY

Raising Mental Health Awareness by Utilizing Local Vietnamese Media Channels: A Residents-Initiated Community Outreach Project

Theresa Bui, D.O.

There are high rates of untreated psychiatric illnesses across all ethnic groups, especially in underserved minority communities such as the Vietnamese community (1). Vietnamese immigrated to the United States in multiple waves, and the earlier group of immigrants was older in age, exposed to more combat, and suffered more war-related traumas compared to the most recent group (2–4). However, even for the American-born Vietnamese youths, cultural differences, language barriers, gender roles, different rates of acculturation between family members, and changes in the family hierarchy are common factors that lead to interpersonal, as well as social, conflicts (1, 2, 4), putting the Vietnamese community as a whole at increased risk for psychiatric illnesses such as depression, post-traumatic stress disorder, adjustment disorders, somatization disorders, and anxiety disorders (2–4).

Even though many Vietnamese Americans meet criteria for psychiatric disorders, only few seek treatment due to stigmas that mental illness is a sign of weakness or the result of karma due to past wrongdoings by one's self or ancestors (2, 4). As a result, many people suffer without timely intervention, leading to rapid deterioration in functioning and poor quality of life (3). Even if they do seek treatment, they often face communication difficulties with treatment teams because of language barriers (3). These problems highlight both the need to educate the Vietnamese community on how to support people with mental illness and the need to reduce barriers for those seeking or receiving treatment.

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To decrease stigma and promote mental health awareness, a group of Vietnamese psychiatry residents and psychologists from three psychiatry residency programs in the Houston-Galveston area has initiated a community outreach project targeting specifically the Vietnamese community by utilizing local Vietnamese media channels. With the encouragement and support of the program directors, *Sức Khoẻ Tâm Thần* (Mental Health), a monthly live radio talk show on Saigon Houston 900 AM and weekly television talk show on Saigon Network Television channel 51.3, was started in July 2012 to educate the Vietnamese audience about common psychiatric conditions, encourage audience members to share their experiences with mental health issues, and provide resources such as referrals to community mental health clinics, as well as to local private psychiatrists and psychologists.

Since both media stations not only broadcast locally over the air but also live on the Internet, the messages of the program may reach far more than the 200,000 Vietnamese living in the Houston-Galveston and surrounding areas (5). Since the television station started to post all recorded programs, including *Sức Khoẻ Tâm Thần*, on YouTube approximately one year ago, the show has been receiving increasingly more questions, comments, and stories from across the nation, as well as from other countries, such as Vietnam, Germany, and Australia. The majority are referral requests (79%); 15% are questions on treatment; and 6% are negative comments against psychiatry. While these are only preliminary data, it suggests the willingness to seek help and the potential utility of more outreach programs to increase awareness and de-stigmatize mental health in a culturally sensitive fashion.

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HISTORY OF PSYCHIATRY

Addressing the Legacy of Racism in Psychiatric Training

Morgan Medlock, M.D., M.Div., Anna Weissman, M.D., Shane Shucheng Wong, M.D., Andrew D. Carlo, M.D.

The field of psychiatry developed at the time of colonialism and slavery when myths of racism were being integrated into European culture. By the end of the 19th century, it was accepted by many psychologists that members of the African race had smaller brains, as well as a more natural instinct for labor, and were "psychologically adolescent" compared to members of the European race (1). "Drapetomania" was the term used for the supposed mental illness that caused Africans to flee captivity (2).

In America, the Abolitionist and Civil Rights movements were met with mistrust and prejudice by mental health practitioners. African Americans, angry about their oppression, were labeled "schizophrenic," due to their supposed "pathological" reaction of emotional disharmony, hostility, and aggression (1). The over-diagnosis of schizophrenia among African Americans persists today, along with myriad other racial inequities in mental health practice (3).

This legacy of racism must be directly addressed within psychiatry if we are to move toward justice. Addressing racism within a formal didactic curriculum is an actionable challenge for the field.

While traditional medical education emphasizes mastery of cultural competencies, recent data demonstrate that racism education is paramount in changing implicit racial attitudes (4). The most effective racism education includes the following three domains: 1) formal curricula (defined as lectures and required assignments), 2) informal or "hidden" curricula (defined as informal organizational culture), and 3) interracial contact (defined simply as interaction of people from different racial backgrounds). Graduate and post-graduate education presents a critical window of opportunity for integrating this evidenced-based framework.

Addressing racism within a formal didactic curriculum is an actionable challenge for the field.

In response to these data, psychiatry residents at Massachusetts General Hospital have launched a novel resident-led curriculum that intentionally moves beyond cultural competency and addresses racism directly. The lecture series, embedded within the Division of Public and Community Psychiatry, addresses all of the proposed domains of racism education, using a three-tiered paradigm—institutional, interpersonal, and internalized racism—as its organizing framework (5). Lecture topics include the role of de facto racial segregation as a determinant of mental health access and outcomes, the social and mental health consequences of mass incarceration on communities, the effect of implicit bias and micro-aggressions on behavior and clinical decision making, and the patient experience of chronic oppression.

In a survey of PGY-3 residents completing didactic training on interpersonal racism and its impact on psychiatric practice, 100% identified racism as a topic that should remain in their didactics, felt the course was effectively taught, and believed that the resident speakers were ideal teachers. Peer-led curricula addressing racism in psychiatry may play a role in helping trainees identify their own biases and become better clinicians as well as advocates for systemic change in residency education. Racism education should be an integral part of psychiatric training.

The authors are third-year residents in the Department of Psychiatry, Massachusetts General Hospital, Boston.

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- Collaborate with others as necessary to develop innovative ideas.
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Selected candidate will be considered for a 2-year position, including advancement to Editor-in-Chief.

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- Collaborate with others as necessary to develop innovative ideas.
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Requirements

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- Must be a PGY-2, PGY-3, or PGY-4 resident in July 2016, or a fellow in an ACGME fellowship in July 2016
- Must be Must be in a U.S. residency program or fellowship

This is a 1-year position only, with no automatic advancement to the Deputy Editor or Senior Deputy Editor position in 2017. If the selected candidate is interested in serving as Deputy Editor or Senior Deputy Editor in 2017, he or she would need to formally apply for the position at that time.

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For all positions, applicants should e-mail a CV and personal statement of up to 750 words describing their a bit about who they, their reasons for applying, as well as any ideas for journal development to Katherine.Pier@mssm.edu . The deadline for applications is 4/15/2016.

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Here we highlight upcoming national opportunities for medical students and trainees to be recognized for their hard work, dedication, and scholarship.

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MARCH DEADLINES

Fellowship/Award and Deadline	Organization	Brief Description	Eligibility	Contact	Website
AACAP Pilot Research Award for Child Psychiatry Residents & Junior Faculty **Deadline: March 30, 2016**	AACAP	Offers $15,000 for child psychiatry residents and junior faculty who have an interest in beginning a career in child and adolescent psychiatry research. Recipients have the opportunity to submit a poster presentation on their research for AACAP's 64th Annual Meeting in Washington, DC, 2017. The award also includes the cost of attending the AACAP Annual meeting for 5 days.	Enrolled in a child psychiatry residency or fellowship or have a faculty appointment in an accredited medical school but no more than 2 years' experience following graduation from training Candidates must not have any previous significant, individual research funding in the field of child and adolescent mental health. AACAP member	Department of Research, Training, and Education at 202-587-9664 or research@aacap.org	http://www.aacap.org/AACAP/Awards/Resident_and_ECP_Awards/Pilot_Research_Award_Child_Psychiatry_Residents_Junior_Faculty.aspx
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