HIV Neuropsychiatry

Transcultural psychiatry in HIV-infected patients

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Grupo Clínico vinculado al CIBERSAM

Barcelona

UAB Universitat Autònoma de Barcelona

Vall d'Hebron Hospital

PROGRAMA DE PSIQUIATRÍA TRANSCULTURAL/PROSICS

PROSICS Barcelona

Transcultural Psychiatry Program


3.- Evolución del nº de extranjeros en España e incremento anual en % (INE)
6.000.000
5.000.000
4.000.000
3.000.000
2.000.000
1.000.000
0
60%
50%
40%
30%
20%
10%
0%
-10%
1996
1997
1998
1999
2000
2001
2002
2003
2004
2005
2006
2007
2008
2009
2010
2011
2012
Mujeres
Varones
Incremento
© Javier Sevillano

Imagen de los tripulantes de "La Elvira" a su llegada a Puerto de Guiripano, Venezuela, en Mayo 1949

Apresados en Venezuela 160 inmigrantes ilegales Canarios

Actas Luso-Esp. Neurol. Psiquiatr., 15, 4 (223-232), 1987

ALGUNOS ASPECTOS DEL TRATAMIENTO PSIQUIATRICO DE LOS EMIGRANTES ESPAÑOLES EN HOLANDA

Por

M. Kabela *

Health disparities

- Reports from the U.S. (Institute of Medicine 2002), the U.K. (Department of Health, 2003; Healthcare Commission, 2005), and Europe (Lindert et al., 2008) indicate that immigrants and ethnic minorities are subject to "disparities" in (mental)health treatment, access to care, and prognosis.
- Growing evidence indicates that these disparities are a function of immigration, cultural difference, and racial discrimination (Gregg & Saha, 2006).

DIFFICULTIES IN MANAGING CULTURALLY DIFFERENT PATIENTS

- **Entry into the system**
- **Understanding**
- **Evaluation**
- **Diagnosis**
- **Therapeutic management**
- **Social support**
- **Referral**

DIFFICULTIES IN MANAGING CULTURALLY DIFFERENT PATIENTS

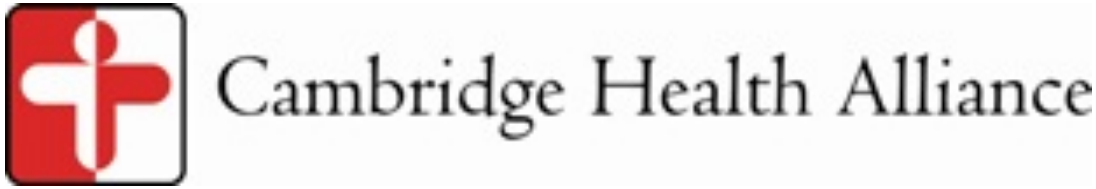
Barriers to acces:

- Stigma
- Relay on family support to contain the problems until they reach a critical point
- Lack of linguistically and culturally appropriate resources
- Concerns about the side effects of medication and drug therapy dominance
- Underdetection in primary care
- "Geographical" difficult access
- It handled the challenge of the complex health system and long waiting lists ...

ILRP

International Latino Research Partnership

National Institute on Drug Abuse grant R01 DA034952-A1



Results

Have you ever been tested for HIV?

HIV Test	Frequency	Percentage
NO	94	30
YES	221	70
Total	315	100

What were the results, if tested?

HIV results	Frequency	Percentage
Positive	5	2
Negative	213	96
Don’t know	3	1
Total	221	100

Results

Have you ever been tested for HIV? (By site)

HIV Test	Boston		Madrid		Barcelona		p-value	
	N	%	N	%	N	%		
NO	15	17%	43	42%	36	29%	0.001	
YES	74	83%	59	58%	88	71%		
Total	89		102		124			315

What were the results if tested? (By site)

HIV Results	Boston		Madrid		Barcelona		p-value	
	N	%	N	%	N	%		
Positive	0	0%	2	3%	3	3%	0.283	
Negative	72	97%	57	97%	84	95%		
Don't Know	2	3%		0%	1	1%		
Total	74		59		88			221

Results

HIV tested individuals only (n=221)

- Among all the *categorical covariates* that were compared between the tree sites, only “sense of belonging”, “greencard”, “non status refugee”, “trauma” and “alcohol/ drug use before sex” showed significant difference between Boston and the Spanish sites.

- The rest of *categorical covariates*: “gender”, “race” (White), “economic status”, “clinic type”, “MH needs”, “with HIV”, “HIV concern”, “unfaith sex”, “infrequent condom use”, “anal sex”, and “other risky behaviors” did not show significant difference between the sites

Results

HIV tested individuals only (n=221)

•Regarding the *continuous covariates*, a strong significant difference was found between Boston and the Spanish cities for “time in country” and the total score on the AUDIT scale. Ethnic identity showed a significant difference as well.

•The rest of continuous covariates that were compared between the three sites (“age”, “visits at home”, “discrimination”, “family conflict”, PHQ-9, GAD-7, PCL, DAST, and “benzodiazepines consumption”) showed no significant difference.

Results

		Boston		Madrid		Barcelona		
		n=74		n=59		n=88		
Categorical covariates								
Trauma	1	58	78%	56	95%	73	83%	0,027
“Greencard”	1	16	22%	22	37%	39	44%	0,009
Non status_refugee	1	9	12%	1	2%	2	2%	0,007
Sense of belonging	1	65	88%	34	58%	59	67%	0,000

The rest of categorical covariates (*gender, race, economic status, type of clinic, MH needs, with HIV, unfaith sex, HIV concern, infrequent condom use, anal sex, alcohol/ drugs before sex, other risky behaviors*) did not show significant differences.

Results

Continuous Covariates					
	Boston	Madrid	Pval (Boston vs Madrid)	Barcelona	Pval(Boston vs Barcelona)
Time in Country	23.18	10.68	0.00	11.13	0.00
Ethnic Identity	9.99	8.95	0.01	9.31	0.04
AUDIT	3.58	8.37	0.00	7.70	0.00

The rest of continuous covariates (*age, visits at home, discrimination, family conflict, PHQ-9, GAD-7, PCL, DAST, benzodiazepines consumption*) did not show significant differences.

Results: Factors of being tested for HIV (logit regression)

Dependent Variable				
	Demographics w/o imputation	Demographics w/imputation	demo+ sexual behavior w/ imputation	full model w/ imputation
Site				
Boston	referent		referent	referent
Madrid	-1.67***	-1.74***	-0.84*	-0.90*
Barcelona	-1.14*	-1.20**	-0.30	-0.40

Gender, race (white) or *living conditions* did not show significant differences through any of the four logit models implemented.

Results: Factors of being tested for HIV (logit regression)

	Demographics w/o imputation	Demographics w/imputation	Demo+ sexual behavior w/ imputation	Full model w/ imputation
Dependent Variable Clinical Type				
Primary care	referent		referent	referent
Mental health	0.35	0.43	-0.13	-0.29
Substance	1.50**	1.59**	1.10**	0.63
Discrimination_	0.33*	0.31*	0.28*	0.27*

Other factors that were analyzed, like *citizenship, time in country, ethnic identity, family conflict, visits at home, sense of belonging, MH needs, PHQ-9, GAD-7, PCL, DAST, AUDIT, benzodiazepines consumption* did not show significant differences through any of the four logit models implemented.

Results: Risky sexual behaviors as Predictors of being tested for HIV (logit regression)

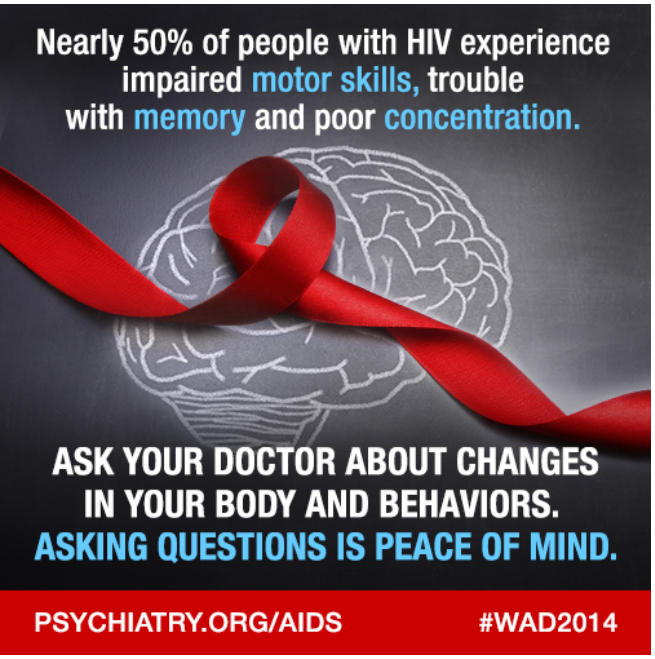
Dependent Variable:				
	Demographics w/ o imputation	Demographics w/ imputation	Demographics+ sexual behavior w/imputation	Full model w/ imputation
Risky sexual behavior				
With HIV			-0.21	-0.27
HIV concern			1.39***	1.34**
Unfaith sex			0.64	0.65
Infrequent condom use			1.32***	1.30***
Anal sex			-0.02	0.02
Alcohol/Drug before sex			0.22	0.08
Other behaviors			0.94	0.90

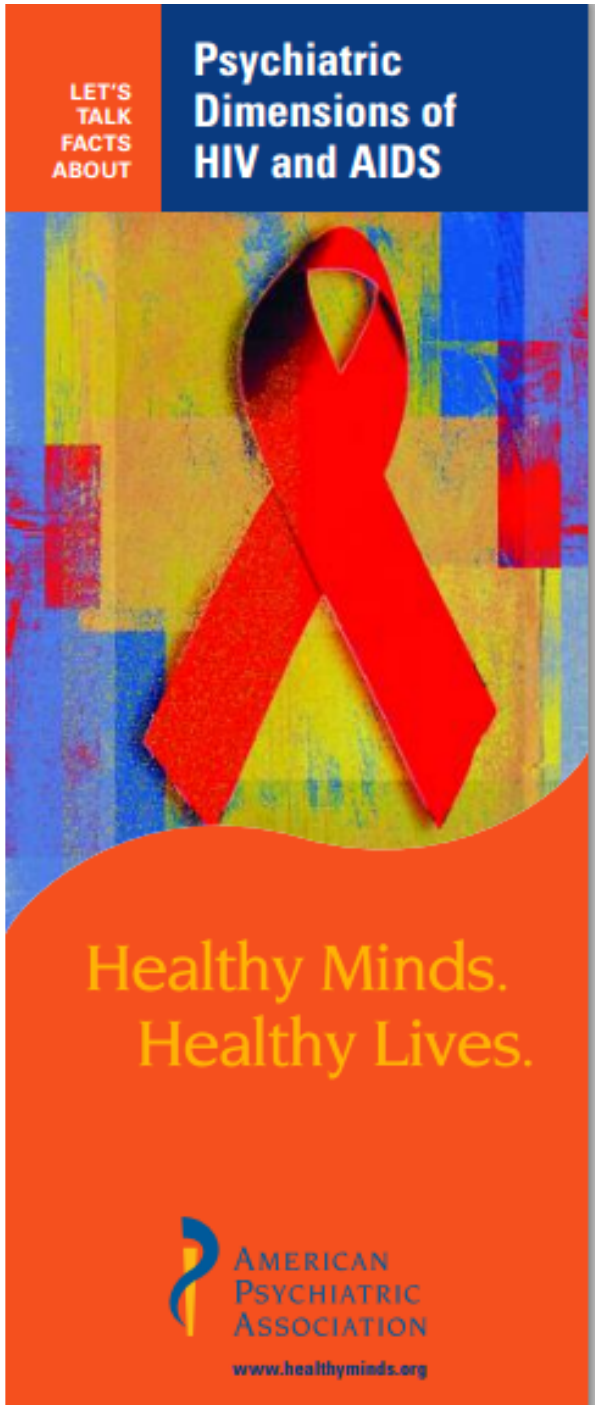
Conclusions

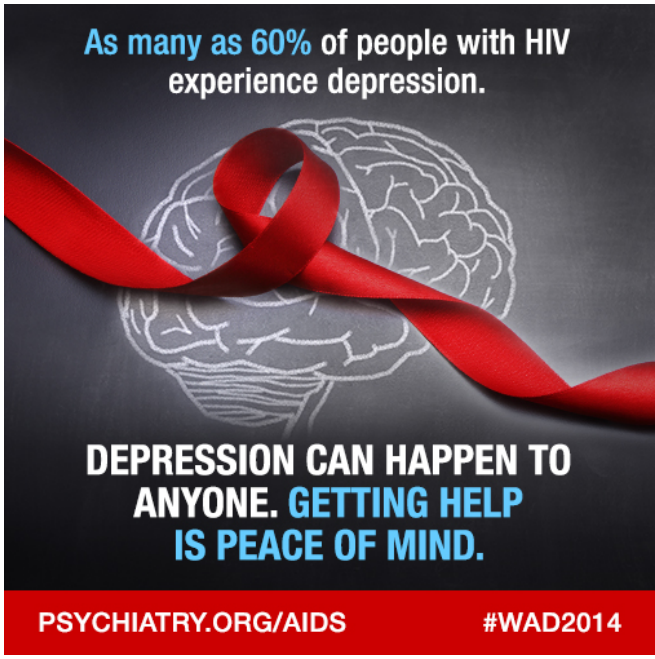
- The probability of being tested for HIV is significantly lower in Madrid and Barcelona than in Boston.
- Patients coming from drug clinics are more likely to have had the HIV test.
- The feeling of discrimination is positively correlated with having the test.
- In terms of sexual risk behaviors, those with "HIV concern" or an "infrequent condom use" have a significantly higher probability of having done an HIV test.

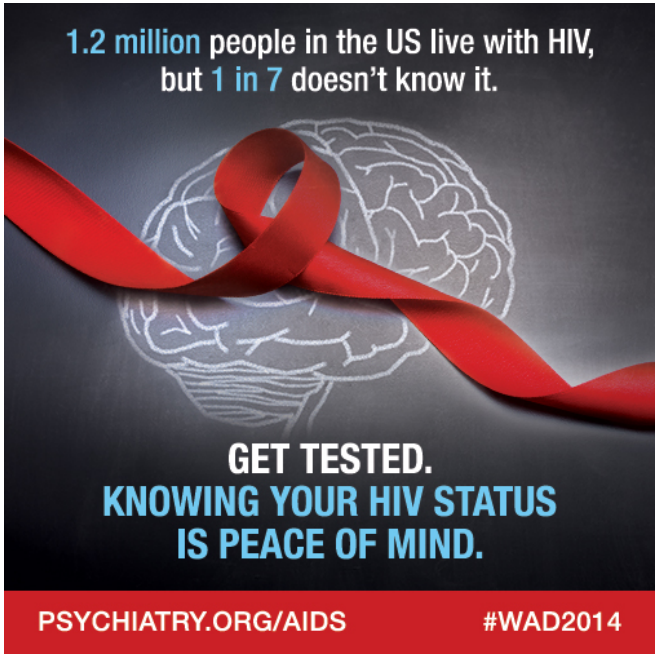
Huge heterogeneity when talking about ethnic minorities, immigrants…

The studies drawn from the literature over the past 20 years indicate that the differences in national health indicators show that racial and *ethnic minorities have worse outcomes for treatable and preventable diseases* (such as cardiovascular disease, diabetes, asthma, cancer or HIV / AIDS), *not only due to factors such as lower socioeconomic status, but also to differences in healthcare*


Nearly 50% of people with HIV experience impaired motor skills, trouble with memory and poor concentration.
ASK YOUR DOCTOR ABOUT CHANGES IN YOUR BODY AND BEHAVIORS.
ASKING QUESTIONS IS PEACE OF MIND.
PSYCHIATRY.ORG/AIDS
#WAD2014


LET'S TALK FACTS ABOUT
Psychiatric Dimensions of HIV and AIDS
Healthy Minds. Healthy Lives.
American Psychiatric Association
www.healthyminds.org


As many as 60% of people with HIV experience depression.
DEPRESSION CAN HAPPEN TO ANYONE. GETTING HELP IS PEACE OF MIND.
PSYCHIATRY.ORG/AIDS
#WAD2014


1.2 million people in the US live with HIV, but 1 in 7 doesn't know it.
GET TESTED.
KNOWING YOUR HIV STATUS IS PEACE OF MIND.
PSYCHIATRY.ORG/AIDS
#WAD2014

HIV MENTAL HEALTH TREATMENT ISSUES

HIV and Substance Use

A strong link between HIV and substance abuse.

Substance abuse has been associated with HIV/AIDS since the beginning of the pandemic. It is well known that sharing injection equipment is a leading cause of HIV transmission among those who inject drugs. But drug and alcohol use also put people at higher HIV risk by disinhibiting them and making it more likely they will engage in unprotected sex.

The National Institute on Drug Abuse (NIDA) reports that from 2005 to 2009, 64 percent of HIV+ people in the U.S. had used an illicit drug, but not intravenously; only 19 percent had never used an illicit drug. A 2009 study found one in four of those living with HIV reported alcohol or drug use at a level warranting treatment. Besides injection drugs, other substances associated with HIV risk include cocaine ("coke, crack"), amphetamines ("speed"), alcohol, inhaled nitrates ("poppers"), and "party" or "club" drugs, such as crystal methamphetamine (meth) or MDMA ("ecstasy").

NIDA further reports that drug abuse and addiction can worsen the progression of HIV and its consequences, especially in the brain. Animal studies have shown that stimulants can increase HIV viral replication. A human study found HIV caused greater neuronal injury and cognitive impairment in drug users than non-users.

How does substance abuse complicate HIV treatment?

Concurrent (or dual) diagnoses of HIV, substance use, and that between 70-90% had a psychiatric condition before being diagnosed with HIV. These patients also have high rates of prior suicidal behavior. The multifaceted symptoms of psychiatric conditions can sometimes mask the signs of substance abuse, and vice versa. When there is a comorbid psychiatric disorder, the treating physician should carefully prescribe medications, particularly those that tend to be habit-forming.

Medical complications are also a serious concern when treating an HIV+ patient who has a substance use disorder. A treating clinician must be aware of the risk of severe bacterial infections including tuberculosis, hepatitis C and sexually transmitted diseases.

How is substance abuse treated?

Effective treatment for substance abuse improves the quality of life for HIV+ patients, and reduces the spread of HIV infection. Substance abuse treatment can also make it more likely that patients will adhere to their HIV treatment.

Clincians need to screen all HIV+ patients for ongoing or recurrent drug and alcohol use and abuse. There are a variety of screening tools that can be used to identify these problems. Most important to a good history is for the clinician to use a nonjudgmental attitude in asking questions.

The main goal of substance abuse treatment is to reduce or

HIV MENTAL HEALTH TREATMENT ISSUES

HIV and Clinical Depression

Why is clinical depression a concern for those who are HIV +

Mood disorders, particularly depression, are the most common psychiatric complication associated with HIV disease. Although some studies suggest that depression is no more common among HIV+ people than in those at risk for HIV infection, a large meta-analysis of 10 studies found HIV+ people had twice the risk for depression than those who were at risk for HIV but were not actually infected.

One study estimated the lifetime prevalence of depressive disorders in HIV+ individuals to range as high as 22%, compared to lifetime estimates of 5% to 17% and current major depression diagnoses of only 3% to 10% in the general population.

Groups at heightened risk for HIV—African-American men and women, gay and bisexual men of all races—may have higher risk for depression, which may lead to increased risk behavior.

Depression can also be a consequence of HIV-induced brain injury or antiretroviral medication.

Who is at risk for depression?

HIV+ individuals who have not disclosed their seropositive

A number of HIV medications can also have side-effects that can cause depression and other psychological symptoms, as outlined in the table below.

HIV Medication	May trigger
Interleukin	Depression, disorientation, confusion and coma
Steroids	Mania or depression
Efavirenz (Sustiva)	Decreased concentration, depression, nervousness, nightmares
Stavudine (Zerit, d4T)	Depression or mania, asthenia
Zidovudine (Retrovir, AZT)	Mania, depression
Interferon	Neurasthenia fatigue syndrome, depression
Zalcitabine (Hivid)	Depression, cognitive impairment
Vinblastine	Depression, cognitive impairment

How can a clinician differentiate depression from other complications of HIV?

Symptoms of true clinical depression come in two categories: affective and somatic. **Affective symptoms** include depressed mood, loss of interest in normally pleasurable activities, feelings of guilt or worthlessness,

PSYCHIATRY

EXTREME CULTURAL RELATIVISM ⟷ **EXTREME UNIVERSALISM**

UNIVERSALISM: Mental disorders are essentially the same throughout the world.

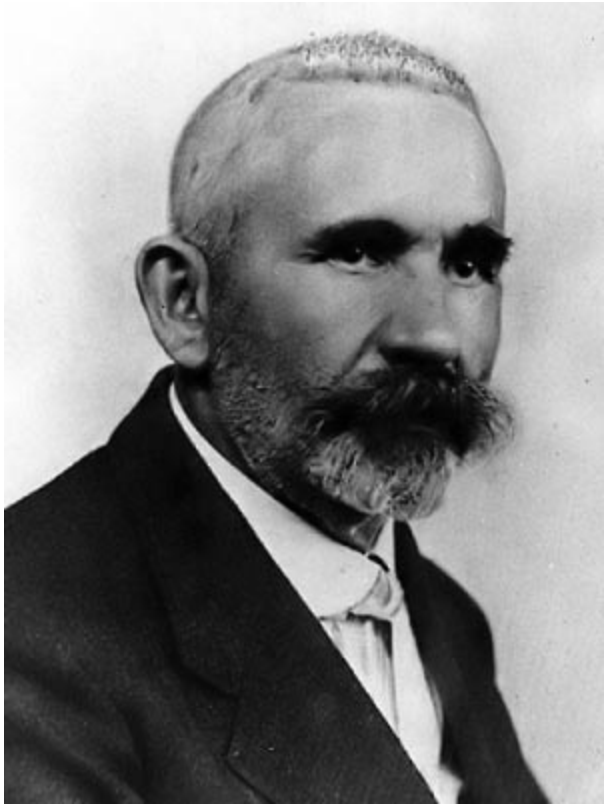
RELATIVISM: One is crazy in relation to a given society

Table 2.1 Prevalence of major psychiatric disorders in primary health care

Source: WHO Health report 2001

Cities	Current depression (%)	Generalized anxiety (%)	Alcohol dependence (%)	All mental disorders (according to CIDI[a]) (%)
Ankara, Turkey	11.6	0.9	1.0	16.4
Athens, Greece	6.4	14.9	1.0	19.2
Bangalore, India	9.1	8.5	1.4	22.4
Berlin, Germany	6.1	9.0	5.3	18.3
Groningen, Netherlands	15.9	6.4	3.4	23.9
Ibadan, Nigeria	4.2	2.9	0.4	9.5
Mainz, Germany	11.2	7.9	7.2	23.6
Manchester, UK	16.9	7.1	2.2	24.8
Nagasaki, Japan	2.6	5.0	3.7	9.4
Paris, France	13.7	11.9	4.3	26.3
Rio de Janeiro, Brazil	15.8	22.6	4.1	35.5
Santiago, Chile	29.5	18.7	2.5	52.5
Seattle, USA	6.3	2.1	1.5	11.9
Shanghai, China	4.0	1.9	1.1	7.3
Verona, Italy	4.7	3.7	0.5	9.8
Total	**10.4**	**7.9**	**2.7**	**24.0**

COMPARATIVE PSYCHIATRY… THE ORIGINS



EVOLUTION OF CULTURAL PSYCHIATRY

1. Comparative Psychiatry: CBS
2. Study of cultural diversity in multicultural populations, with a focus on the diagnosis of immigrants, refugees, specific ethnocultural groups ...: stress of migration and acculturation, ethnocultural aspects of trauma-related disorders.
3. Comprehensive analysis of the knowledge and psychiatric practice as a result of the interaction between social, cultural, historical, economic and political factors.

(TRANS) CULTURAL PSYCHIATRY

- (Definition shamelessly lifted from Wikipedia)
- **Cross-cultural psychiatry** or transcultural psychiatry is a branch of psychiatry concerned with the cultural and ethnic context of mental disorders and psychiatric services. It emerged as a coherent field from several strands of work, including surveys of the prevalence and form of disorders in different cultures or countries; the study of migrant populations and ethnic diversity within countries; and analysis of psychiatry itself as a cultural product.
- It is argued that a cultural perspective can help psychiatrists become aware of the hidden assumptions and limitations of current psychiatric theory and practice and can identify new approaches appropriate for treating the increasingly diverse populations seen in psychiatric services around the world.
- (Kirmayer & Minas, 2000; Kirmayer 2006)

CULTURAL PSYCHIATRY

Common Psychological substrate

Feelings / Common Sufferings

Different expression

Different interpretation

NEW CULTURAL PSYCHIATRY

- To what extent the medical symptom, diagnosis or psychiatric practice are a reflection of social, cultural and moral concerns.
- Get it over with duality biology vs. culture.
- Cultural biology: culture is a biological category.
- Biology is heavily influenced by genetics, environment, diet ...

EVOLUTION OF CULTURAL PSYCHIATRY

- Culture is dynamic and is inextricably linked to the social context of the patient.
- Exclusive ethnic minorities ??
- Inherently multidisciplinary:
  - Psychiatric epidemiology
  - Medical Anthropology
  - Cognitive and social psychology
  - Neurosciences
- Addressing the psychological processes not as a purely individual but include your speech into something social
- Critical view of the interaction of the structures of knowledge and power

(L.Kirmayer, H.Minas)

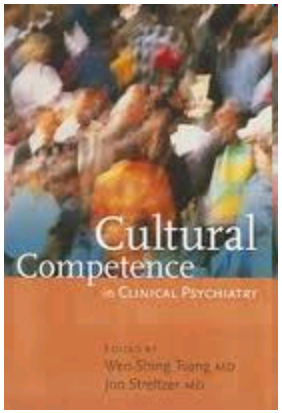
CHALLENGES OF MULTICULTURALISM IN MENTAL HEALTH CARE

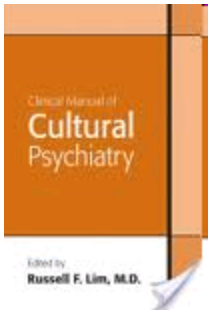
Current situation with immigrants:

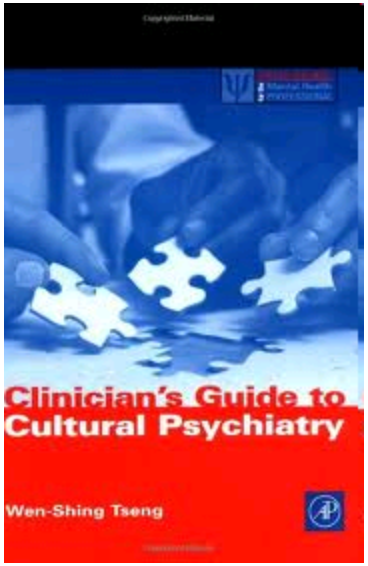
- **Underutilization of services**
- **High levels of discontinuity**
- **Poor adherence**
- **Poor results**
- **Misdiagnoses**
- **Inadequate treatment**

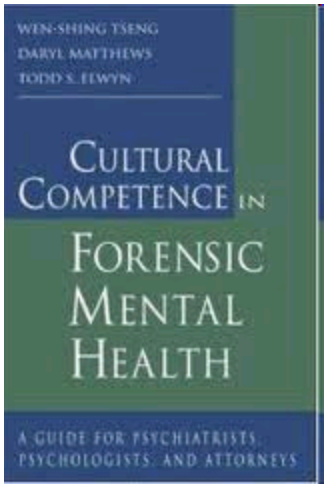
WHAT'S GOING ON?

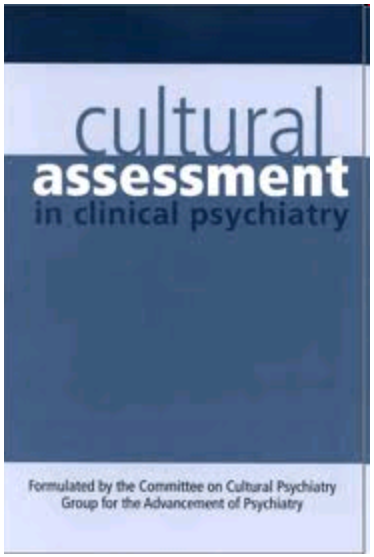
- *Do they get all all users a similar quality healthcare?*
- *Would not it be discriminating, unintentionally, to people who do not belong to the majority culture?*
- *Who is responsible for this: professionals, system failure or migrants?*
- *Are we aware of the importance of the relationship and quality of communication between health professionals and patients?*





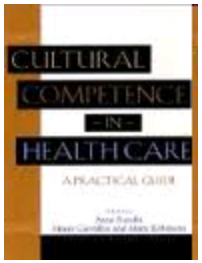




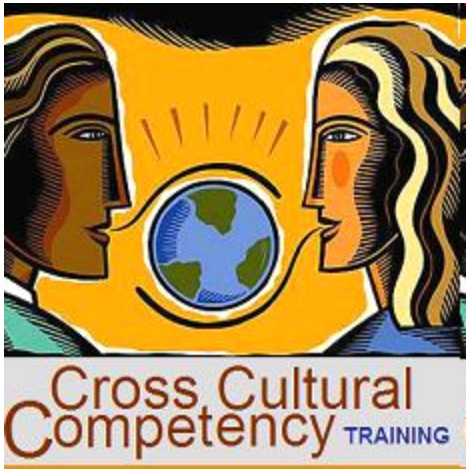


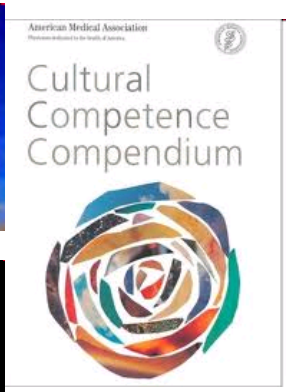
58 JUNE 2003 / PSYCHIATRIC TIMES

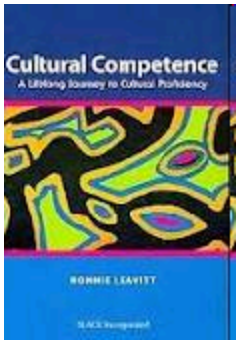
Cultural Competency Still Lacking in the Mental Health Community

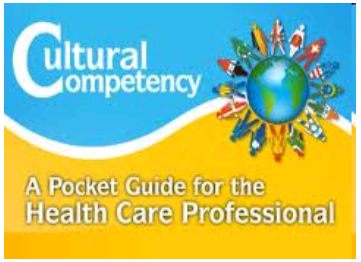

CULTURAL
COMPETENCE
IN
HEALTH CARE
A PRACTICAL GUIDE

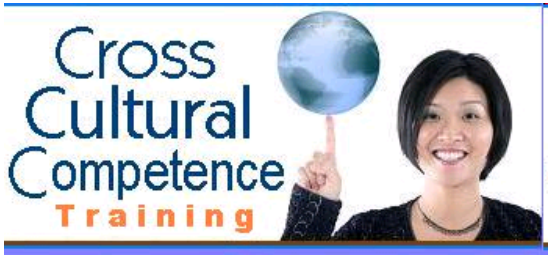

What's your level of cultural competence?


Cross Cultural
Competency
TRAINING

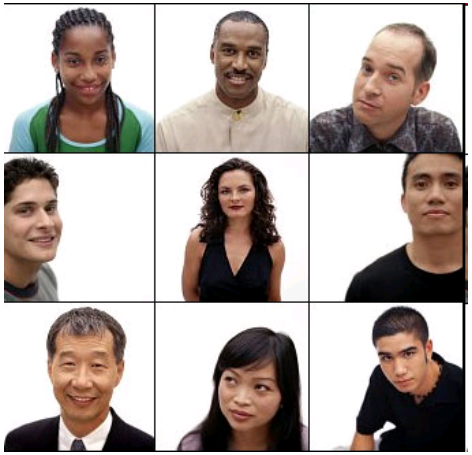

American Medical Association
Cultural
Competence
Compendium

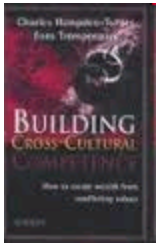

Cultural Competence
A Lifelong Journey to Cultural Proficiency
RONNIE LEAVITT


Cultural
Competency
A Pocket Guide for the
Health Care Professional


Cross
Cultural
Competence
Training

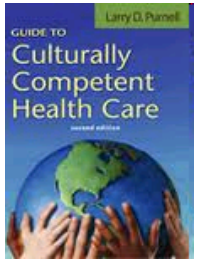

Cultural
Competence
in Health Care



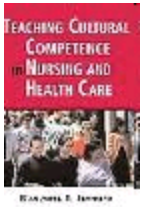

BUILDING
CROSS-CULTURAL


Cultural Competence
in Health Education
and Health Promotion


CULTURAL
COMPETENCE


Larry D. Purnell
GUIDE TO
Culturally
Competent
Health Care


COMMUNICATING
CULTURAL
COMPETENCE


TEACHING CULTURAL
COMPETENCE
IN NURSING AND
HEALTH CARE

CULTURAL COMPETENCE

Definitions

The ability to understand the cultural dynamics of patients and to react to each of these cultural aspects in a way that facilitates its development.

Ability to work effectively with all users, regardless of ethnic or cultural origins of these.

CLINICAL CULTURAL COMPETENCE

- Dimensions
  - **Knowledge (What To Know)**
  - **Skills (How to do…)**
  - **Attitudes (How to be…)**

CULTURAL COMPETENCE

- *Cognitive competence or knowledge*
  - What must a clinician know?
  - Does “cultural knowledge” help or hinder?
  - What sort of “cultural knowledge” is realistic? And useful?
- *Procedural competence, or skills*
  - Communication and the therapeutic relationship
  - Self exploration
  - Challenge prejudices
  - Relativize the hermeneutic circle
- *Emotional competence, or attitudes*
  - Willingness to challenge oneself
  - Accept uncertainty
  - Confront narcisism
  - Explore transference

KNOWLEDGE

- What must the clinician know in order to
  - Diagnose the patient?
  - Treat the patient?

KNOWLEDGE

- Cultural and social aspects
- Concept of problem
- Finding Help
- Living conditions
- Aspects related to immigration
- Explanatory models
- Meaning and Context
- "Idioms of distress"
- Notions of ethnopharmacology

CULTURE IN DSM-IV
CULTURAL FORMULATION

DSM-IV Cultural Formulation

A. Cultural Identity
- Cultural reference group(s)
- Language
- Cultural factors in development
- Involvement with culture of origin and host/majority culture

B. Cultural Explanations of Illness
- Idioms of distress and local illness categories
- Meaning and severity
- Causes and explanatory models
- Help-seeking experiences and plans

C. Cultural Factors Related to Psychosocial Environment and Levels of Functioning
- Social Stressors
- Social Supports
- Levels of functioning and disability

D. Cultural Elements of the Clinician-Patient Relationship
- Perceived similarities and differences

E. Overall Cultural Assessment
- Applying information to diagnosis and treatment

REVIEW OF CULTURAL FORMULATION

Limitations of DSM-IV	Changes in DSM-5
Poor use in clinical practice	Cultural Formulation Interview (CFI) 16 standarized questions in 4 sections
Limited guideline	Use at the beginning of the initial interview Applicable to all patients
Risk of stereotyping	Person-centered approach Collaborative, shared decision making

Cultural Formulation Interview (CFI)

Supplementary modules used to expand each CFI subtopic are noted in parentheses.

GUIDE TO INTERVIEWER	**INSTRUCTIONS TO THE INTERVIEWER ARE *ITALICIZED.***
The following questions aim to clarify key aspects of the presenting clinical problem from the point of view of the individual and other members of the individual's social network (i.e., family, friends, or others involved in current problem). This includes the problem's meaning, potential sources of help, and expectations for services.	*INTRODUCTION FOR THE INDIVIDUAL:* I would like to understand the problems that bring you here so that I can help you more effectively. I want to know about ***your*** experience and ideas. I will ask some questions about what is going on and how you are dealing with it. Please remember there are no right or wrong answers.

CULTURAL DEFINITION OF THE PROBLEM

Cultural Definition of the Problem

(Explanatory Model, Level of Functioning)

Elicit the individual's view of core problems and key concerns. *Focus on the individual's own way of understanding the problem.* *Use the term, expression, or brief description elicited in question 1 to identify the problem in subsequent questions (e.g., "your conflict with your son").*	1. What brings you here today? *IF INDIVIDUAL GIVES FEW DETAILS OR ONLY MENTIONS SYMPTOMS OR A MEDICAL DIAGNOSIS, PROBE:* People often understand their problems in their own way, which may be similar to or different from how doctors describe the problem. How would *you* describe your problem?
Ask how individual frames the problem for members of the social network.	2. Sometimes people have different ways of describing their problem to their family, friends, or others in their community. How would you describe your problem to them?
Focus on the aspects of the problem that matter most to the individual.	3. What troubles you most about your problem?

CULTURAL PERCEPTIONS OF CAUSE, CONTEXT, AND SUPPORT

Causes

(Explanatory Model, Social Network, Older Adults)

This question indicates the meaning of the condition for the individual, which may be relevant for clinical care. *Note that individuals may identify multiple causes, depending on the facet of the problem they are considering.*	4. Why do you think this is happening to you? What do you think are the causes of your [PROBLEM]? *PROMPT FURTHER IF REQUIRED:* Some people may explain their problem as the result of bad things that happen in their life, problems with others, a physical illness, a spiritual reason, or many other causes.
Focus on the views of members of the individual's social network. These may be diverse and vary from the individual's.	5. What do others in your family, your friends, or others in your community think is causing your [PROBLEM]?

Cultural Formulation Interview (CFI) *(continued)*

Supplementary modules used to expand each CFI subtopic are noted in parentheses.

GUIDE TO INTERVIEWER	**INSTRUCTIONS TO THE INTERVIEWER ARE *ITALICIZED.***

Stressors and Supports

(Social Network, Caregivers, Psychosocial Stressors, Religion and Spirituality, Immigrants and Refugees, Cultural Identity, Older Adults, Coping and Help Seeking)

Elicit information on the individual's life context, focusing on resources, social supports, and resilience. May also probe other supports (e.g., from coworkers, from participation in religion or spirituality).	6. Are there any kinds of support that make your [PROBLEM] better, such as support from family, friends, or others?
Focus on stressful aspects of the individual's environment. Can also probe, e.g., relationship problems, difficulties at work or school, or discrimination.	7. Are there any kinds of stresses that make your [PROBLEM] worse, such as difficulties with money, or family problems?

Role of Cultural Identity

(Cultural Identity, Psychosocial Stressors, Religion and Spirituality, Immigrants and Refugees, Older Adults, Children and Adolescents)

	Sometimes, aspects of people's background or identity can make their [PROBLEM] better or worse. By ***background*** or ***identity,*** I mean, for example, the communities you belong to, the languages you speak, where you or your family are from, your race or ethnic background, your gender or sexual orientation, or your faith or religion.
Ask the individual to reflect on the most salient elements of his or her cultural identity. Use this information to tailor questions 9–10 as needed.	8. For you, what are the most important aspects of your background or identity?
Elicit aspects of identity that make the problem better or worse. *Probe as needed (e.g., clinical worsening as a result of discrimination due to migration status, race/ethnicity, or sexual orientation).*	9. Are there any aspects of your background or identity that make a difference to your [PROBLEM]?
Probe as needed (e.g., migration-related problems; conflict across generations or due to gender roles).	10. Are there any aspects of your background or identity that are causing other concerns or difficulties for you?

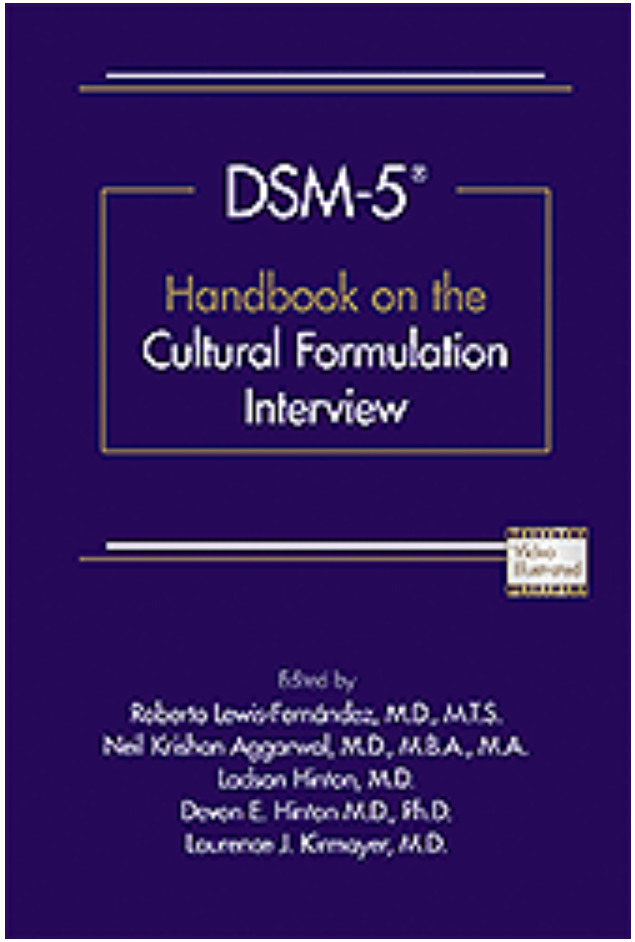
CULTURAL FACTORS AFFECTING SELF-COPING AND PAST HELP SEEKING

Self-Coping

(Coping and Help Seeking, Religion and Spirituality, Older Adults, Caregivers, Psychosocial Stressors)

Clarify self-coping for the problem.	11. Sometimes people have various ways of dealing with problems like [PROBLEM]. What have you done on your own to cope with your [PROBLEM]?

DSM-5 and CULTURE



Culture and Psychiatric Evaluation: Operationalizing Cultural Formulation for *DSM-5*

Roberto Lewis-Fernández, Neil Krishan Aggarwal, Sofie Bäärnhielm, Hans Rohlof, Laurence J. Kirmayer, Mitchell G. Weiss, Sushrut Jadhav, Ladson Hinton, Renato D. Alarcón, Dinesh Bhugra, Simon Groen, Rob van Dijk, Adil Qureshi, Francisco Collazos, Cécile Rousseau, Luis Caballero, Mar Ramos, and Francis Lu

The Outline for Cultural Formulation (OCF) introduced with *DSM-IV* provided a framework for clinicians to organize cultural information relevant to diagnostic assessment and treatment planning. However, use of the OCF has been inconsistent, raising questions about the need for guidance on implementation, training, and application in diverse settings. To address this need, *DSM-5* introduced a cultural formulation interview (CFI) that operationalizes the process of data collection for the OCF. The CFI includes patient and informant versions and 12 supplementary modules addressing specific domains of the OCF. This article summarizes the literature reviews and analyses of experience with the OCF conducted by the DSM-5 Cross-Cultural Issues Subgroup (DCCIS) that informed the development of the CFI. We review the history and contents of the *DSM-IV* OCF, its use in training programs, and previous attempts to render it operational through questionnaires, protocols, and semi-structured interview formats. Results of research based on the OCF are discussed. For each domain of the OCF, we summarize findings from the DCCIS that led to content revision and operationalization in the CFI. The conclusion discusses training and implementation issues essential to service delivery.

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DSM-5 and CULTURE

- "What evidence do we have that culture plays a role in diagnosis?“
- "For which diagnosis?“
- "What aspects of culture need to be integrated into the diagnostic assessment and why?“
- "Should certain criteria be excluded from specific disorders because they might not apply to certain ethnic groups?" "What evidence do we have that such is the case?“
- "What new studies need to be conducted to improve diagnosis for disparate ethnic groups?"

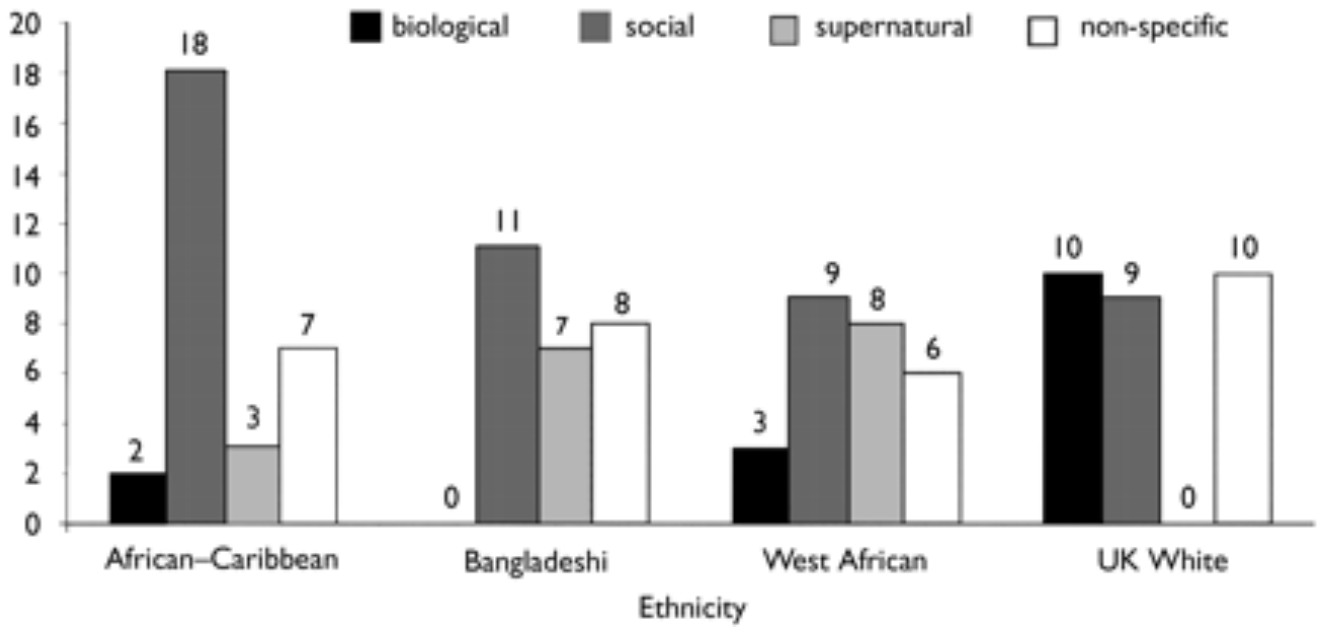
CULTURE in DSM-5

- The key point is making changes that strengthen the cultural validity of the diagnoses in practice.
- Inclusion of culture in the DSM-5
  - Section I: Introduction
  - Section II: Disorders
  - Section III: Cultural Formulation
  - Appendix: Glossary of Cultural Concepts of Distress

FACTORS THAT COMPLICATE THE DIFFERENTIAL DIAGNOSIS

- The diagnostic system is Eurocentric
- Symptom expression varies cross-culturally ("idioms of distress")
- The symptom presented by the patient does not fit well with the Western diagnostic system
- Symptom explanation varies across cultures ("explanatory models")

EXPLANATORY MODELS



BRITISH JOURNAL OF PSYCHIATRY (2004), 185, 25–30

Explanatory models of illness in schizophrenia: comparison of four ethnic groups

ROSEMARIE McCABE and STEFAN PRIEBE

HIV MENTAL HEALTH TREATMENT ISSUES

HIV and Cognitive Disorders

Still a problem for many HIV+ persons.

The brain is one of HIV's main targets. The virus most likely crosses the blood-brain barrier into the central nervous system (CNS) soon after infection. This means there are significant nerve and brain impacts in most HIV+ people and a wide range of clinical neurological symptoms. HIV-related clinical and neuropsychological disorders are more common in drug abusers than among other populations.

The clinical manifestations of CNS disorders in HIV disease include depression and all degrees of cognitive impairment. Neurocognitive disorders are most common in late-stage HIV disease (AIDS), unlike anxiety disorders (frequently seen just after HIV diagnosis) and depressive disorders (frequently seen when HIV-related symptoms appear).

HIV-Associated Neurocognitive Disorder (HAND) is still common even among individuals receiving highly active antiretroviral therapy (HAART). HAND risk is correlated with the nadir (low point) of CD4 cell count and an HIV viral load in the cerebrospinal fluid at least as high as plasma viral loads. Age, methamphetamine use, coinfection with hepatitis (A, B, or C), and a family history of dementia also increase an HIV+ person's risk for neurocognitive disorders.

HIV-Associated Dementia (HAD)

Before HAART was available, HIV-associated dementia was a common AIDS-related complication and cause of death. With HAART the incidence of HAD has fallen, although its prevalence has actually increased because HIV+ people are living longer. Even today, HAD affects 10 -20% of people living with HIV.

HAD's exact causes are unclear, although it corresponds most closely to inflammation in the brain rather than with viral load or HIV encephalitis. Neuroinflammation has long been recognized as a common pathological finding in HIV+ individuals and has been linked with CNS dysfunction.

Symptoms and signs of HAD include tremor, gait ataxia, loss of fine motor movement, mental slowing, forgetfulness, poor concentration, and behavioral abnormalities.

Risks for HAD include older age, decreased body mass, family history of dementia, and persistent physical symptoms of HIV infection. As many as 15% of those with advanced HIV disease (AIDS) are affected by HAD, severely impairing their daily functioning.

Potential cognitive changes from HAART medications

PSYCHOMETRICS ON IMMIGRANT POPULATION

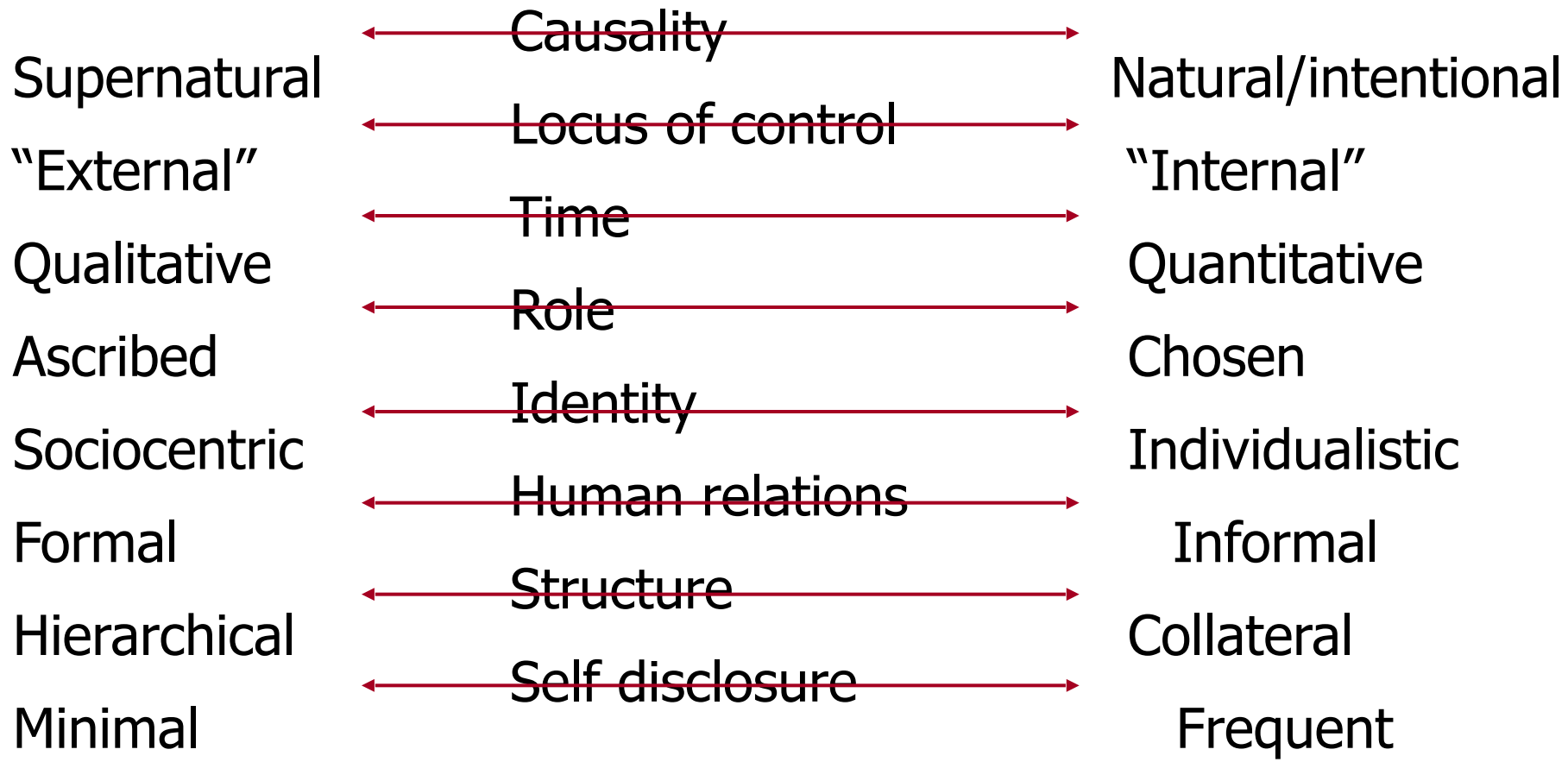
PSYCHOLOGICAL INSTRUMENTS

- Developed in the white and Euro-American population
- Validated in this same population
- Items are biased
- There is no tool "culture free "
- Need to validate (or develop) instruments for its use within different populations

PSYCHOMETRICS ON IMMIGRANT POPULATION

- CULTURAL BIAS:
  - Systematic and consistent statistical error, as opposed to random attributable, in the estimation of some psychological value as a result of belonging to a particular cultural group.
  - It is not synonymous with different overall test score.

CULTURAL VALUES



INVITED ARTICLE HIV/AIDS

Kenneth H. Mayer, Section Editor

Psychotropic Medications and HIV

Alex Thompson, Benjamin Silverman, Liz Dzeng, and Glenn Treisman

Department of Psychiatry and Behavioral Sciences, The Johns Hopkins University School of Medicine, Baltimore, Maryland

Patients with human immunodeficiency virus (HIV) infection and acquired immune deficiency syndrome have high rates of psychiatric illness. The effective management of these psychiatric conditions can improve a patient's quality of life and may improve antiretroviral adherence. Care providers for patients with HIV infection frequently encounter clinical situations in which psychotropic medications are needed or are being used. Those clinical situations require familiarity with the broad category of medications termed "psychotropic." That familiarity should include a basic understanding of indications, adverse effects, and drug interactions. In particular, it is very important to recognize the many potential interactions based on cytochrome P450 metabolism, which is common to many psychotropics, the protease inhibitors, and the nonnucleoside reverse-transcriptase inhibitors. In a brief review of the use of psychotropic medications in patients with HIV infection, we discuss indications, adverse effects, and drug interactions for commonly used antidepressants, mood stabilizers, anxiolytics, antipsychotics, psychostimulants, and drugs of abuse.

U.S. Food and Drug Administration
FDA Talk Paper

FDA Talk Papers are prepared by the Press Office to guide FDA personnel in responding with consistency and accuracy to questions from the public on subjects of current interest. Talk Papers are subject to change as more information becomes available.

T03-07
January 23, 2003

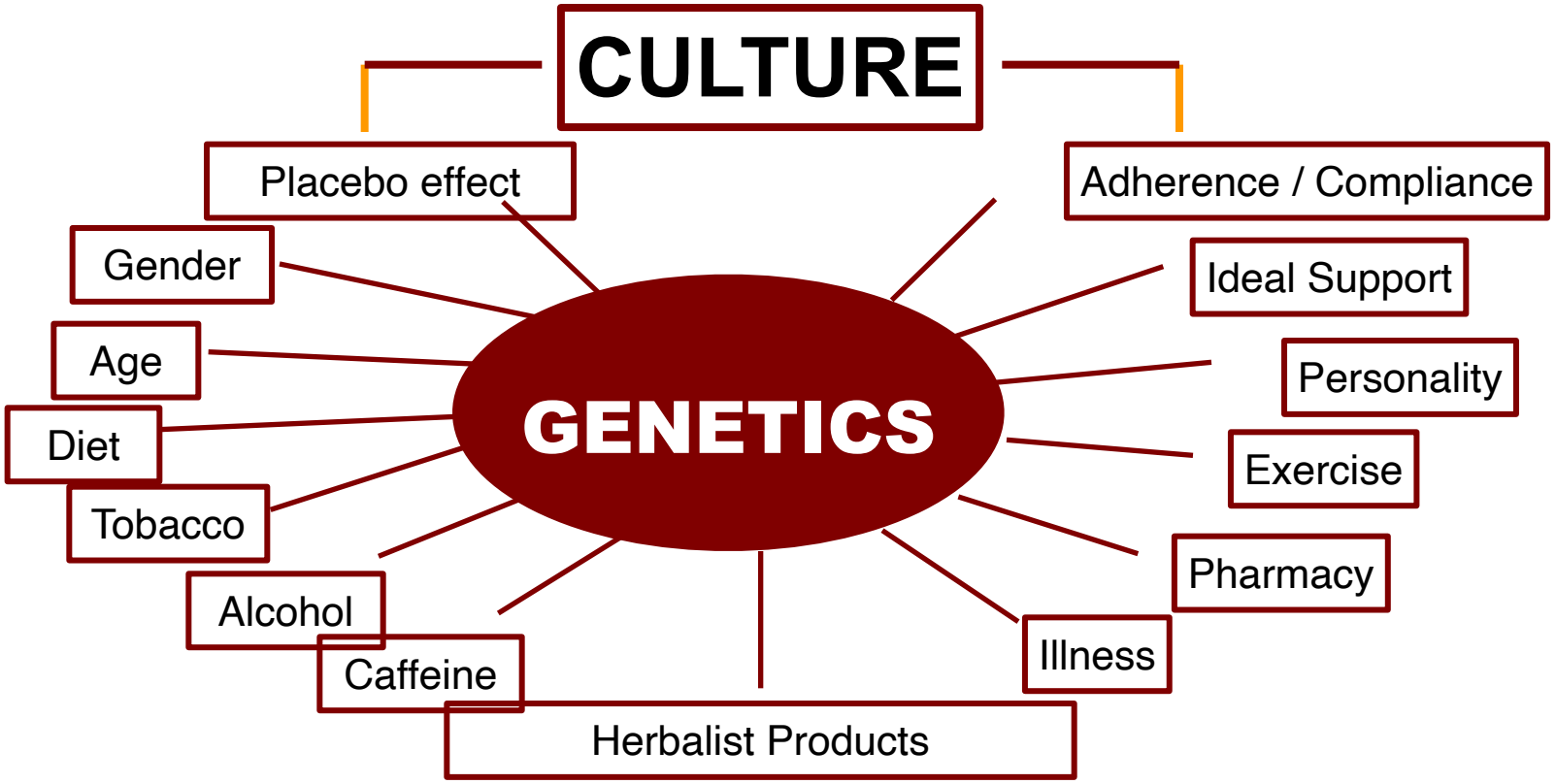
Media Inquiries: 301-827-6242
Consumer Inquiries: 888-INFO-FDA

FDA ISSUES GUIDANCE FOR COLLECTION OF RACE AND ETHNICITY DATA IN CLINICAL TRIALS FOR FDA REGULATED PRODUCTS

FDA has published a draft Guidance for Industry to recommend categories for collecting effectiveness and safety data during clinical trials for ethnic and racial demographic groups.

FDA regulations require drug sponsors to present an analysis of data according to age, gender and race. An analysis of modifications of dose or dosage intervals for specific groups is also required when manufacturers submit a new drug application for approval by FDA. To accomplish this, FDA recommends that the drug manufacturers use the OMB race and ethnicity categories during clinical

ETHNICITY, CULTURE AND PSYCOPHARMACOLOGY



ETHNOPSYCOPHARMACOLOGY

Environmental factors

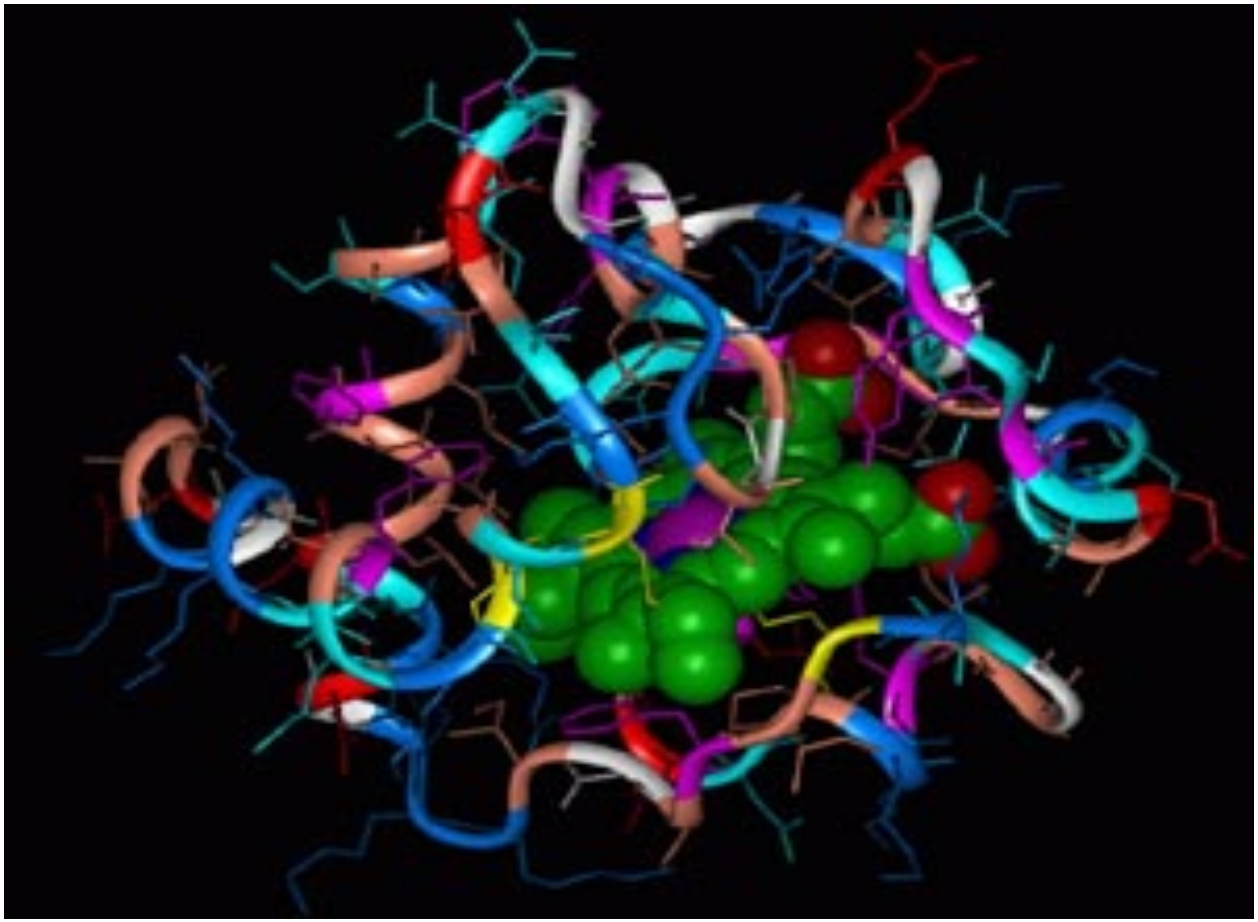
Cultural factors

Pharmacokinetic aspects

Pharmacodynamic aspects

Pharmacokinetic factors

CYP 450



Pharmacokinetic factors

CYP 450

- Adaptation to the environment
- Condition by the capacity of individiuals to metabolize pharmacological agents to different degrees due to different enzymatic properties.
- > 200 in nature.
- > 40 humans.
- 6 are responsible for > 90% of the oxidation of medicines in humans.
- Genetic variability.

ETNOPSYCHOPHARMACOLOGY

Tasa de Metabolización CYP4502D6

Tipo metabolizador	Tasa de metabolismo	Niveles plasmáticos del fármaco	Efectos clínicos
Ultralento	No	Tóxicos	Efectos secundarios
Lento	Lento	Altos	Efectos secundarios a dosis menores
Rápido	Normal	Normal	Respuesta normal
Ultrarrápido	Super rápido	Bajo o ausente	Ausencia de respuesta a dosis normales

Enzymatic inhibition CYP 450

	CYP 1A2	CYP 2C	CYP 2D6	CYP 3 A 3/4
FLUOXETINE		LIGHT	STRONG	MODERATE
FLUVOXAMINE	STRONG	LIGHT		STRONG
PAROXETINE			STRONG	
SERTRALINE		LIGHT	LIGHT	LIGHT
CITALOPRAM			LIGHT	
NEFAZODONE				STRONG
VENLAFAXINE		LIGHT	LIGHT	LIGHT
MIRTAZAPINE	LIGHT	LIGHT	LIGHT	
ESCITALOPRAM			LIGHT	

Treatment of depression

Optimal treatment:

- SSRIs that do not interact with CYP450

  (sertraline, citalopram, escitalopram)

- Mirtazapine
- Venlafaxine/Desvenlafaxine
- Duloxetine

ETNOPSYCHOPHARMACOLOGY
ATYPICAL ANTIPSYCHOTICS

Clozapine and Asian:

- Lower dose, same effect
- CYP - 1A2 an diet

Antipsychotics and Latinos:

- Lower dose
- Clinical impression, not evidenced

Antipsychotics and African:

- Higher sensitive to extrapyramidal effects
- Tardive Diskinesia
- Atypical antypsychotics indicated

Aripiprazole and Asian: higher levels if slow CYP2D6

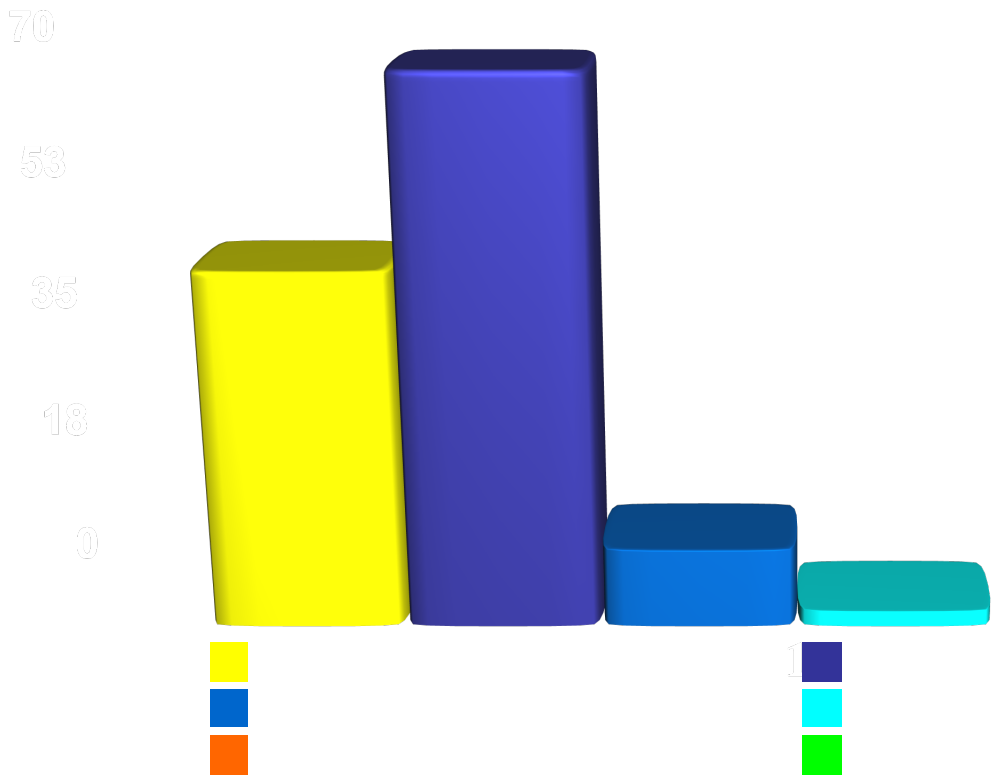
Advantages of paliperidone (59% excreted by kidney)

Option LAI

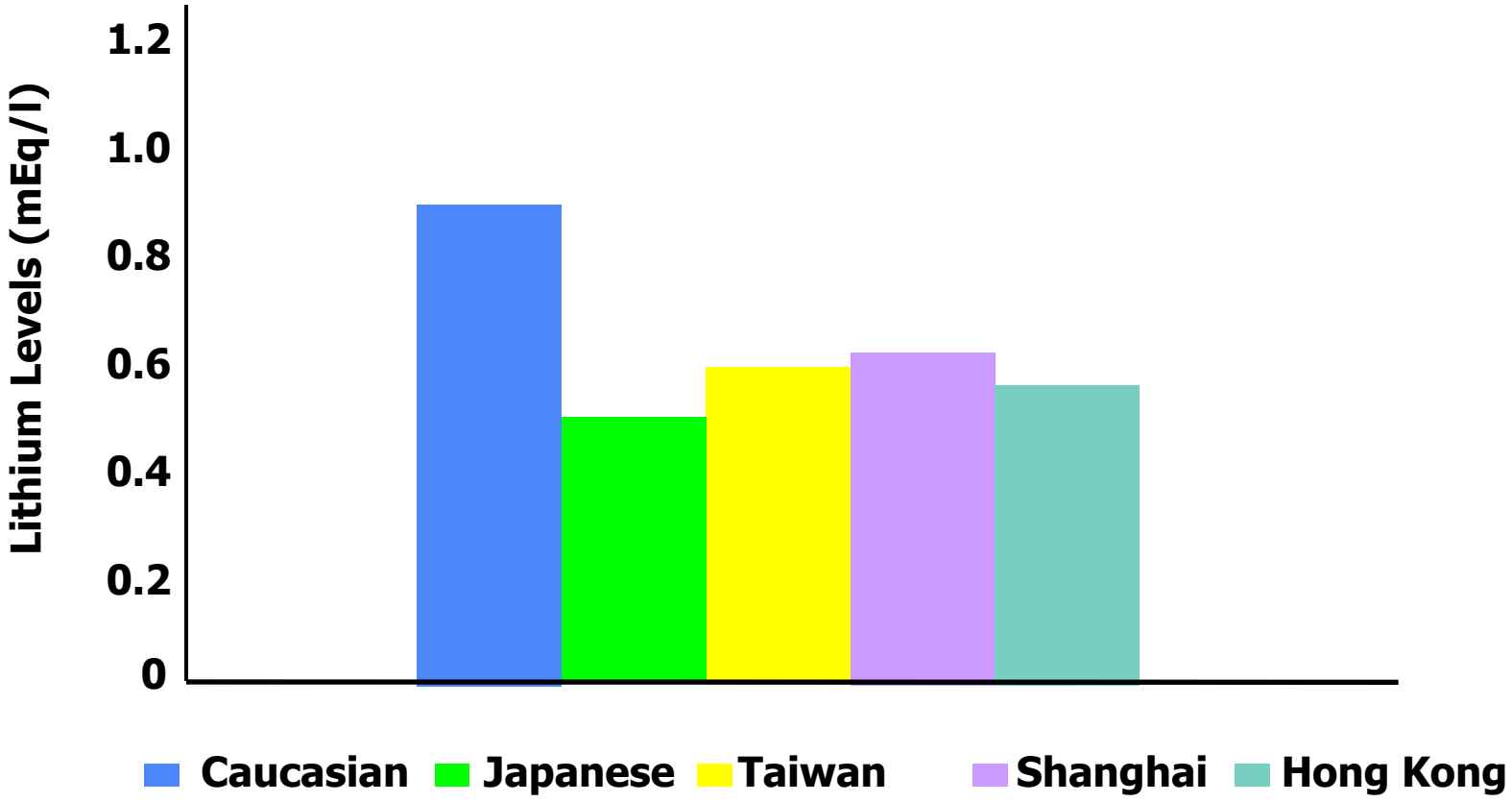
Ethnopsychopharmacology

Pharmacodynamic factors

PREVALENCIA DE LA DEFICIENCIA DE ALDH POR ETNIAS

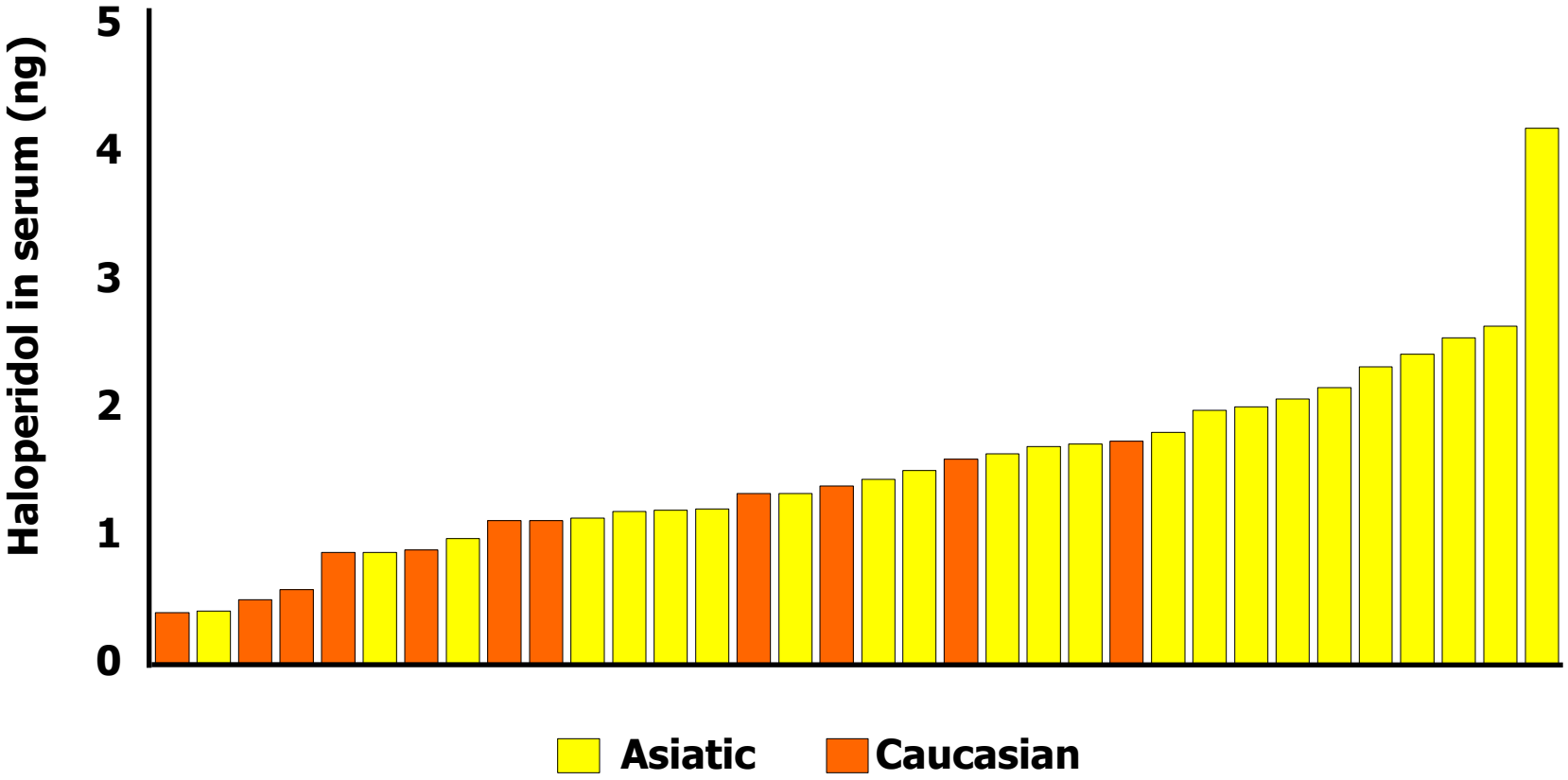


Therapeutic doses of lithium



Keh-Ming Lin, MD, MPH
Harbor-UCLA Research & Education Institute,
Torrance, CA

Maximum haloperidol concentration after administration of 0.5 mg (im)



Keh-Ming Lin, MD, MPH
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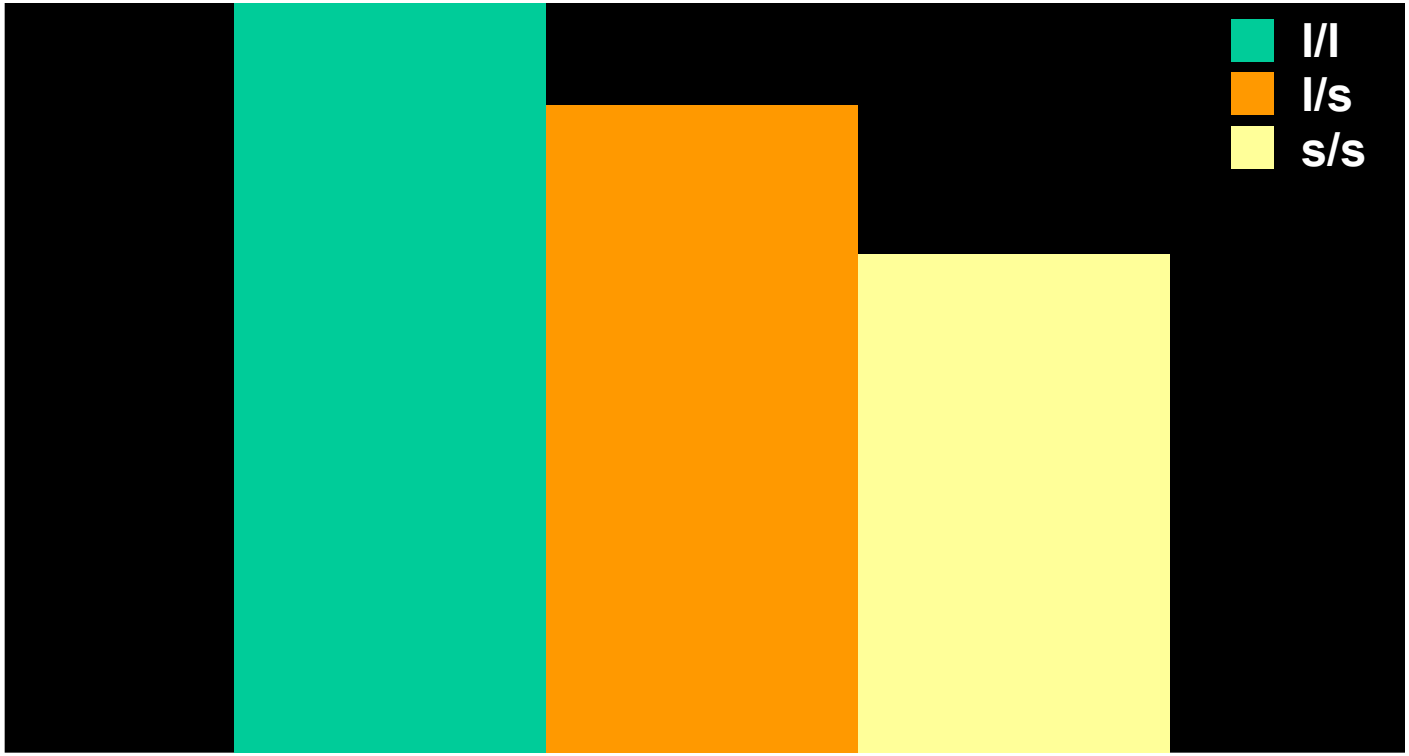
Serotonin transporter polymorphism: fluvoxamine response



l/l: long alleles homocygotes; **l/s**: heterocygotes; **s/s**:short alleles homocygotes

Effectiveness and Tolerability of Duloxetine in 2 Different Ethnic Samples

A Prospective Observational Cohort Study

SKILLS

THE INTERVIEW

- **Importance of initial contact.**
- **Respect.**
- **Use formal language.**
- **Avoid excessive familiarity.**
- **"Educate" the patient as to the limits.**
- **Personal revelations.**
- **Reciprocity.**

SKILLS

WORKING WITH A CULTURAL MEDIATOR

Previous encounter with the / the mediator / a

Interview Preparation

Take the needed time

Try to reduce your stress level

INTERCULTURAL COMMUNICATION

Listening and speaking skills

Interpretation of cultural codes

Respect for the patient

Awareness of the presence of prejudices

Adapt to the style of the patient

Create a comfortable space given the patient's needs

INTERCULTURAL COMMUNICATION

In any psychiatric interview, one listens not only to what is said but also to how it is said. We expect patients to get to the point, to speak directly, and express appropriate emotion.

Departure from the norms is a cause of concern

THE THERAPEUTIC RELATIONSHIP

The feelings and attitudes the therapist and patient have towards each other, and how they are expressed

Correlated with improvements in therapeutic outcome

Difference can complicate the alliance

THE THERAPEUTIC RELATIONSHIP

- Best predictor of therapy outcome[1]
- Explains more variance than therapeutic orientation[2]
- Explained 45% of the variance in effectiveness in a study in Puerto Rico[3]

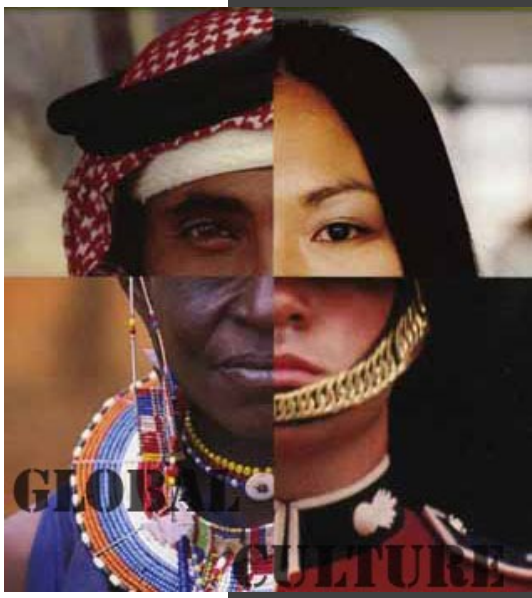
[1]Barber et al., 2001

[2]Martin et al., 2000

[3]Bernal et al., 1998

ATTITUDES and BELIEFS

Healthcare professionals should recognize that, as cultural beings, may have attitudes and beliefs that may have a negative influence on their perception or interaction with individuals who are ethnically and racially different from themselves.



ATTITUDES and BELIEFS

Cultural empathy and respect

Awareness of one's cultural location

Awareness of cultural prejudices

Awareness of cultural countertransference

Self-reflection and self-analysis: is this the reality or our interpretation? …?

ATTITUDES and BELIEFS

- ✓ **Understanding the role of culture on a patient requires the understanding of the role of culture on our own person**
- ✓ **Self-awareness as a cultural being**
- ✓ **Aware that, like any person, we experience the world through our own culture**

CULTURAL COMPETENCE

Are specialized services needed?

Is it a form of positive discrimination?

Cultural competence in specialized programs ("Centers of excellence in cultural competence"?)

or

Cultural competence in all centers

CCS Cultural Consultation Service

Transforming the culture of care

Center of Excellence for Cultural Competence

New York State Psychiatric Institute

Cultural Competency In Mental Health Programs

NYS Office of Mental Health

Nathan Kline Institute Center of Excellence in Culturally Competent Mental Health

CULTURAL HUMILITY

Cultural competency is an ideal

Cultural humility (Tervalon and Murray-Garcia, 1998) reminds us of our limitations

Sometimes a little knowledge can be dangerous

HIV Neuropsychiatry

Transcultural psychiatry in HIV-infected patients

Barcelona, 13 de Junio de 2015

Francisco Collazos

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Servicio de Psiquiatría

Hospital Universitari Vall d'Hebron

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