CULTURALLY SENSITIVE DEPRESSION ASSESSMENT IN CHINESE AMERICAN IMMIGRANTS

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SAN MATEO COUNTY BEHAVIORAL HEALTH AND RECOVERY SERVICES
DISCLOSURES

Presenter: ROSE WONG

Relevant Financial Relationship: NONE

Relevant Nonfinancial Relationship: NONE

Neither the presenter nor any immediate family members have any financial or non-financial relationship relevant to her participation in providing this CME activity of the San Mateo County of Behavioral Health and Recovery Services.
LEARNING OBJECTIVES

1. Describe the risk of depression and suicide in the Chinese American population vs. the general population.

2. List culture-specific symptoms of depression and typical immigration-related stressors that can trigger depression among Chinese American immigrants.

3. Outline at least one method for integrating culturally sensitive assessments for the Chinese immigrant population into general psychiatric practice.
PRE-TEST

1. Reported prevalence rates for depression and suicide among Chinese Americans:
   
   a) May be underestimated due to using translated, DSM-based assessment instruments.
   
   b) Are particularly alarming given the low level of use of mental health services.
   
   c) Suggest that clinicians should assess for suicidal ideation even when patients show very few or mild depression symptoms.
   
   d) All of the above.

Choose all that apply.
2. Culturally competent assessment of depression in Chinese American immigrants—*in addition to DSM-5 core symptoms*—should focus on the patient’s:

a) Somatic complaints

b) Negative thoughts about the self, the world and the future

c) Expressions of interpersonal and social difficulties

d) Expressions of fear and worry

e) All of the above

*Choose all that apply.*
## Adults: Suicide

<table>
<thead>
<tr>
<th></th>
<th>Chinese Am.</th>
<th>Asian Am.</th>
<th>General Pop.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suicide Ideation*</td>
<td>10.6%</td>
<td>8.8%</td>
<td>13.5%</td>
</tr>
<tr>
<td>Suicide Attempts*</td>
<td>3.2%</td>
<td>2.5%</td>
<td>4.6%</td>
</tr>
<tr>
<td>Suicide Deaths**</td>
<td>---</td>
<td>6.5</td>
<td>11.5</td>
</tr>
</tbody>
</table>

* Lifetime rates.  ** Per 100,000 people.

- Suicide was the 8th leading cause of death for API vs. 10th leading cause of death for Whites (2.0% vs. 1.5% of total deaths).

- U.S.-born Asian American women had higher lifetime rate of suicidal thoughts (15.9%) than the general population (13.5%).
## ADULTS: DEPRESSION

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Chinese Am.</th>
<th>Asian Am.</th>
<th>White Am.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major Depression*</td>
<td>6.9%</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Dysthymia*</td>
<td>5.2%</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Neurasthenia*</td>
<td>3.7%</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Any Affective Disorder*</td>
<td>---</td>
<td>9.1%</td>
<td>17.9%</td>
</tr>
</tbody>
</table>

* *Lifetime rates.*
ADULTS: CULTURAL FACTORS

- Lifetime rates of depressive disorder in Chinese Americans were much lower for:
  - Immigrants vs. U.S.-born (8.3% vs. 23.2%)  
  - Immigrated ≥ 18 yrs. vs. < 18 yrs. (7.1% vs. 18.0%)  

- Lifetime rate of suicidal ideation in Chinese Americans were much lower for:
  - Immigrants vs. U.S.-born (8.9% vs. 18.4%)  
  - Immigrated ≥ 18 yrs. vs. < 18 yrs. (6.6% vs. 17.5%)  

- Other immigration- and acculturation-related differences  
  - Immigrant women had much lower rates of depression than U.S.-born women.  
  - Men not proficient in English had much lower rates of depression than men proficient in English.
### YOUTH: SUICIDE

<table>
<thead>
<tr>
<th></th>
<th>API</th>
<th>White Americans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suicide Deaths Overall Rate*</td>
<td>3.98</td>
<td>7.11</td>
</tr>
<tr>
<td>Suicide Deaths M &amp; F Rates*</td>
<td>6.3 &amp; 2.4</td>
<td>12.2 &amp; 2.3</td>
</tr>
<tr>
<td>Suicide Death M:F Ratio</td>
<td>2.7:1</td>
<td>5.1:1</td>
</tr>
<tr>
<td>Suicide Attempts M &amp; F**</td>
<td>6.2% &amp; 12.5%</td>
<td>3.7% &amp; 7.9%</td>
</tr>
<tr>
<td>Suicide Ideation M &amp; F***</td>
<td>---</td>
<td>14.8% &amp; 23.7%</td>
</tr>
</tbody>
</table>

* Per 100,000 people. ** 12-month rates. *** Lifetime rates.

*Note.* Suicide emerges in high school and increases through young adulthood (e.g., 7.95 per 100,000 for 15-19 year-olds, 11.97 for 20-24 year-olds, and 13.80 for 25-40 year-olds nationally in 2001).
YOUTH: DEPRESSION

- Older Asian American teens had higher depressive symptoms, withdrawn behavior, and social problems than Caucasians.
- Asian American college students had higher levels of depressive symptoms than Caucasian counterparts.
- Asian American college students were more likely than White American students to have had suicidal thoughts and to have attempted suicide.
- API outpatients with depression were four times more likely to show suicidal behaviors than other diagnoses.
YOUTH: CULTURAL AND RISK FACTORS

- Family conflict
- Cultural conflict
- Harsh parental discipline
- Decreased expression
- Depression
- Peer rejection
- Model minority stereotype
- Recent immigration
- Non-U.S. born & older age at immigration, especially when under high parent-child conflict.
OLDER ADULTS: SUICIDE

- 6.5 per 100,000 suicide rate in Asian American women (ages 65-84)—highest among older adult women from all racial groups.

- 15% lifetime rate of suicide attempts in monolingual Chinese older adults in San Francisco.

- Suicide rates among Chinese in San Francisco increased as age increased, unlike for Whites.

- 57% of Asian American primary care patients experiencing significant psychological distress but not receiving mental health treatment reported suicide or death ideation, largest rate compared with other racial/ethnic groups.
OLDER ADULTS: DEPRESSION

- Community dwelling Asian Americans: 13%
- Community dwelling Asian Americans with chronic illnesses: 24%
- Chinese American primary care patients: 15.2% (mild to severe MDD) & 3.7% (moderate to severe MDD)
OLDER ADULTS: CULTURAL FACTORS

- Coped with stressors by ruminating rather than problem solving leading to stronger depression and suicidal ideation.

- Used alternative suicide methods: hanging, withholding medications, household poisoning, and using household possessions rather than gunshot and medication overdose.

- Attributed suicide attempts to ‘fear of being a burden’ (49%), ‘no hope’ (46%), severe physical illness (41%), ‘worthless’ (29%), family conflict (15%), neglect by family (14%), and income problems (13%).

- Asian Americans are “Hidden Ideators”, less likely to disclose suicidal ideation without probing.
ASIAN AMERICANS UNDER-USE MENTAL HEALTH SERVICES

- Lowest rates of mental health service use compared with all other populations.
- Highest disparities in receiving adequate care for depression compared with Whites.
- Higher rates of service use among U.S.-born than immigrants, with ≥ third-generation the highest.
- 68.7% with past-year depressive disorder did not access mental health treatment vs. 40.2% of Whites.
- 35.7% of suicide attempters never sought professional help.
EXPLANATIONS FOR LOW USE

- More Chinese Americans with self-perceived emotional problems sought help from human/social services and alternative services (acupuncturists, herbalists, etc.) than specialty mental health.

- Immigrants especially use relatively more human/social services and alternative services and general medical care than specialty mental health care.

- Immigrants tend not to attribute symptoms to a mental health condition and not to perceive a need for treatment.

- “Somatization” hypothesis & stigma.

- “Healthy immigrant” hypothesis.

- Provider and institutional factors.
Depressive and anxiety disorders are not necessarily a good indicator of suicidal risk in Asian Americans like they are for White Americans.

- Suicide attempters: 1 in 3 had neither disorder.

- Suicide ideators: 1 in 4 women vs. 1 in 20 men had a depressive disorder.

- Male suicide ideators: Co-occurring depressive and anxiety disorder is a good indicator.
CASE OF “MR. LI”

1. How does Mr. Li view or conceptualize his problem?

2. What are some ‘culture-specific’ symptoms expressed by Mr. Li?

3. What are some Chinese cultural values expressed by Mr. Li?

4. How does Mr. Li cope or deal with his problem?
Figure 1. Multidimensional depression construct: Three dimensions of distress and symptom groups.
HOW TO USE CADS-58

1. Do the items (symptom expressions) fall within the severity level you would predict?

2. Do patients tend to have a style of symptom presentation—such as emphasizing somatic complaints while minimizing emotional difficulties?

3. How can you use this 58-item list to aid your assessments?

4. Could some items be culturally biased such that two people with different levels of acculturation would endorse them differently?
ASSESSING BY DIMENSIONAL PROFILES
HOW TO USE CADS-9

1. How is CADS-9 different from PHQ-9?

2. Why are anxiety symptoms included in CADS-9?

3. What are some potential problems with PHQ-9 items for Chinese American immigrants?
ASSESSING FOR SUICIDALITY

◆ Whether patient answers 1, 2 or 3 regarding suicidal ideation, ask about ideation, plan and past attempts to assess whether suicide risk is high.

◆ If risk is present:
  
  ◆ Ask about precipitating events, stressors, family support, history of suicide and psychiatric treatment, and substance abuse.
  
  ◆ Turn the assessment session into a brief therapy session to resolve the risk.

◆ It is not difficult to get info. about suicide risk once you ask, but it is difficult to get patients to receive therapy or return to see you.
ASSESSING FOR SUICIDALITY

- Patients tend to think of suicide as a solution to their problems rather than the problem itself. They will go to ER for uncontrolled bleeding but not for suicidality.

- Provide empathy and hope.

- Remind them they didn’t wait so many years to come to America to kill themselves. They need to have faith that their situation will get better.

- Convey a caring and reassuring attitude. Some will appreciate that someone is finally willing to listen to their stressors.
ADULT STRESSORS

- Worry about family/future
- Pressures with caretaking or supporting family
- Conflict with children/spouse/in-laws
- Acculturation gap
- Lowered social status and insecure jobs
- Lack of social support and network
- Dealing with English language/American culture.
- ‘Interpersonal’ distress:
  - Hiding problems from others and avoiding criticism
  - Not as good as others
  - Feeling lack of respect from work/family
  - Feeling ashamed for not controlling emotions.
OLDER ADULT STRESSORS

- Isolation
- Living alone in SRO/public housing
- Loss of spouse/friends
- Health conditions
- Burdening one’s family
- Feeling useless
- Lack of contact/support from children
- Acculturation gap
- Language
TEEN STRESSORS

- Caretaking
- Translating
- Making parents unhappy
- Academic pressure from parents
- Seeing domestic violence
- Relationship breakups/conflict
- Living in small apartment/no privacy
- Dealing with two cultures/languages
- Identity issues
- Being bullied
- Conflict with parents
- Acculturation gap
- Needing independence
**HOW TO EXPLAIN DEPRESSION**

- It has mental and physical symptoms.
- Daily life stressors of immigrants can trigger depression.
- Depression is very common.
- Some have a genetic/family vulnerability.
- Feeling fear and shame is common.
- Being ‘crazy’ is an old-fashioned belief.
- Symptoms won’t necessarily go away by themselves.
- Depression can be effectively treated like other physical conditions.
- Talking about your problems can be helpful.
How To Explain Treatment

- Treatment is effective. It helps many people.
- Many types of treatment exist. You choose.
- Medications can manage the symptoms of depression.
- Don’t continue to suffer and let family, school, and work problems worsen!
- Don’t deny your problems.
- Help family and friends recognize depression and obtain professional evaluation and care!
- You have the responsibility and power to change your situation.
POST-TEST Q1

1. Reported prevalence rates for depression and suicide among Chinese Americans:

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   c) Suggest that clinicians should assess for suicidal ideation even when patients show very few or mild depression symptoms.

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Choose all that apply.
POST-TEST Q2

2. Culturally competent assessment of depression in Chinese American immigrants—*in addition to DSM-5 core symptoms*—should focus on the patient’s:

a) Somatic complaints

b) Negative thoughts about the self, the world and the future

c) Expressions of interpersonal and social difficulties

d) Expressions of fear and worry

e) All of the above

*Choose all that apply.*
3. Name one method for integrating culturally sensitive assessments for the Chinese immigrant population into your practice.
CONTACT INFORMATION

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REFERENCES


REFERENCES


San Francisco Bay Area Chinese Community Depression Education Project

三藩市灣區華人社區憂鬱症教育計劃

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Sunny Choi

Chinese Community Health Worker

Office of Diversity and Equity, Behavioral Health and Recovery Services

San Mateo County Health Department
MY ROLE

Educate

Partner

Advocate Connect
PARTNERING WITH YOU

- Outreach
- Referral
- Need Assessment
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