

In this article, we provide practical information on how to perform the initial assessment of an Asian American patient you suspect may have a behavioral health problem. In the article that follows, we show how these principles can be put into practice.

#### INTERVIEWING SKILLS

The following interviewing techniques, well described and put forth by Kates and Craven, have been modified for use with Asian American patients.

#### 1 Put your patient at ease

- Show your patient that you have a holistic view of health, which is familiar to Asian patients
- Acknowledge that patients and families often use many different types of interventions (eg, social, pastoral, alternative, Western) to improve symptoms
- Be willing to work with concerned families, and with their ideas of health and healthy behavior, in caring for your patient
- If the patient appears reluctant to discuss emotional issues, you may say, "You look tense or uncomfortable. Is this hard to talk about?" Acknowledging tension may help to ease it. A follow-up statement, targeted to a less insightful patient, can be, "We know that stress and emotional troubles affect physical health, and I believe that addressing these concerns can be helpful in making some of these symptoms decrease in intensity or go away."
- Maintain a respectful physical distance from the patient and do not be overly concerned about making eye contact

## Toolbox

# Initial behavioral health assessment of Asian Americans. Part 1. Key principles

Henry Chung, Pfizer, Inc., 235 East 42nd St., New York, NY 10017

Dustin Nguyen, NYU Downtown Hospital, 170 William St, New York, NY 10038-2649

Francesca Gany, New York University School of Medicine, 550 First Ave, New York, NY 10016-2002

Correspondence to: Dr Chung, hchung@pol.net

**Competing interests:** Henry Chung is Medical Director, Depression and Anxiety Disease Management Team, Pfizer, Inc. *West J Med* 2002;176:233-236

- To show respect and to avoid spreading germs to the physician, some older Asian patients cover their mouths when speaking. If this practice interferes with your assessment, gently let your patient know that you appreciate the polite gesture but discontinuing it would help you to understand their condition better
- Always use formal titles (Mr, Mrs, etc) when addressing adults unless they request that you do not

#### 2 Clarify your patient's goals

- Once the problems are assessed, discuss the goals of the visit and/or future visits to determine whether you and the patient agree about what needs to be done
- Ask about emotional or psychological concerns that you consider important.
   Even if they deny them initially, patients often make use of these connections later in the course of treatment

#### 3 Communicate clearly

- Use clear, supportive, and nonpejorative statements or questions to enhance the patient's ability to understand your diagnostic rationale and treatment plan
- Tell the patient, "Your symptoms could indicate a new heart problem, or they might mean you have a nervous condition; both could explain your symptoms. Let's do some simple but important tests for your heart first." Avoid statements such as, "You may have a heart condition that I must rule out or it might all be in your head."
- If you as a health care provider have continual difficulty discussing psychiatric is-

#### **Summary points**

- In the initial assessment, put your patient at ease, clarify your patient's goals in seeking help, and communicate concepts in simple and clear terms
- During history taking, ask about use of traditional medicines and pharmaceutical products
- Always screen for substance abuse or misuse and assess suicide risk
- Be aware that Asian patients with psychiatric disorders may exhibit "stoicism," denying sadness or depressed mood, or other psychiatric symptoms
- Maintain privacy by reassuring patients that what they discuss with you remains confidential
- Tailor explanations in a way that is appropriate to Asian culture; giving a bio-psychosocial explanation will resonate with the Asian "mind-body" view of illness

sues with Asian patients, you may need to assess your own biases or conceptions about treating mental disorders or treating these disorders in Asians. For example, perhaps the avoidance of discussing such issues is an attempt to avoid embarrassing or stigmatizing your patient. In fact, many patients are relieved when asked about them. Patients may present with a somatic complaint as a "ticket to admission" to a clinician's office, but they will avoid emotional complaints out of respect for the practitioner. Inquire sensitively about possible psychological issues and show comfort in doing so; otherwise, patients may sense your reluctance and deny symptoms

Always avoid using jargon. Even knowledgeable patients may differ in the mean-

www.ewjm.com Volume 176 September 2002 wjm 233

ing they apply to words such as "palpitations," which may be interpreted as anything from irregular heart rhythms to fast heart rate to chest pain

#### **TAKING THE HISTORY**

Elements of the basic history are shown in box 1. With Asian American patients, two specific cultural issues are important to remember.

First, although the patient and family are requesting symptom relief and expert consultation, they often have their own ideas about the etiology and treatment of the symptoms. For example, in many East and Southeast Asian patients, some psychiatric symptoms are thought to result from an imbalance between yin and yang, the complementary life forces. Many traditional treatments attempt to restore that balance instead of eradicating "disease." It is common for patients to have seen several traditional practitioners and to have tried acupuncture, several courses of herbal remedies, possibly qi-gong, and meditative exercises before trying antidepressants and other psychotropic medicines.

Second, some patients will have obtained pharmaceutical products from relatives and friends in their homelands that have helped others with similar symptoms. These include herbal pharmaceutical preparations, antipsychotic medication, benzodiazepines, and medicines that are not available in the United States.

Therefore, practitioners should ask patients nonjudgmentally about their use of alternative or traditional modes of therapy and of medicines obtained from their country of origin.

#### **MENTAL STATUS EXAMINATION**

Many Asian patients, particularly immigrants and older individuals, exhibit "stoicism" during this assessment. Many will deny feelings of sadness or depressed mood despite meeting many of the criteria for a person with a depressive disorder.

The examination involves assessing:

- Appearance and behavior
- Affect (the emotions you observe) and **mood** (emotions the patient reports)
- Communication patterns and processes (whether the patient is able to

## Box 1 Key elements in taking a history

Asian American primary care patients expect physicians to be confident in manner and knowledge. A thorough history should include:

- The present illness
- History of behavioral symptoms and in what situations they surfaced
- Treatment history, including response to traditional or alternative medicines, psychotropic medications, or psychotherapy/counseling
- · Family and social history
- Alcohol and substance abuse or misuse (see p 259)

discuss clearly several domains of daily life—at home, at work, with friends, etc)

Thoughts In particular, assess for unusual thoughts, perceptions, or experiences, such as hallucinations (hearing or seeing things) and delusions (organized paranoid or grandiose thoughts that have an extremely low probability of truth and are outside the patient's cultural norm). If the patient admits to having hallucinations, ask whether these might be ancestral figures and spirits and whether they have heard these voices in the past. Many

Asian cultures emphasize ancestral worship and filial piety, and some types of perceptual experiences may be a culturally appropriate adaptation to stress. If hallucinations occur in the absence of other psychotic symptoms, watchful waiting and periodic reassessment should be adequate

- Cognitive and intellectual functioning Are patients aware of their surroundings?
   Is short term and long-term memory impaired?
- Risk for self-harm and harm to others (see below)

#### Assessment of suicidal risk

Many practitioners have difficulty assessing suicide and homicide risk out of concern that:

- asking about suicidal or homicidal ideation increases the risk of the patient acting on these thoughts
- they will open a "Pandora's box," lengthening the visit from 20 minutes to an hour
- if the assessment shows that the patient is at risk for suicide, they will not have the knowledge or management skills to decrease that risk



Cultural importance of ancestral spirit worship must be considered when assessing perceptual experiences reported by patients

Amelia Baten

These concerns can be addressed by using a structured approach to assessing suicide risk (see box 2)

#### What factors increase suicide risk?

- History of self-harm
- · History of impulsiveness
- · Any current drug or alcohol use
- Severe depression with anxiety, or psychosis
- A sense of hopelessness
- Poor or little reliable social support

### Box 2 Assessing suicide risk in Asian patients: a structured approach

The following questions can be helpful:

- "Have you felt so bad or suffered so much that you have thought about harming yourself or someone else?"
- For Asian patients who are guarded or reluctant to answer, you can preface the question with a statement such as: "Many people with symptoms like yours who have not had much improvement or relief often have thoughts of giving up.
   Do you have these thoughts?"
- If the answer is yes to either of these questions, further exploration is essential. Follow up questions can include, "Do you have a plan for harming yourself?" and "Have you come close to acting on these thoughts?"
- If the answer is yes to either of these follow-up questions, an urgent psychiatric referral is advised
- If referral is difficult, consider the following:
  - Automatic referral to the emergency room may be seen by the patient as a rejection. If the patient is reliable, has social support, and can agree to a contract that will keep him or her safe, an approach that enlists the aid of the patient's family or friends may keep the patient safe until an appropriate referral can be made
  - Ask what factors, family members, friends, religious prohibitions, etc., might prevent the patient from carrying out the plan, and then reinforce these supports with phone calls and discussions until a referral can be made
  - If a successful referral is unlikely, a provider may have no choice but to refer the patient to emergency services

## PHYSICAL EXAMINATION AND INVESTIGATIONS

Taking a structured history and performing a thorough mental status examination confirm your role as an expert to the patient and give you the necessary clues to develop a working diagnosis and a treatment plan.

The physical examination and laboratory studies can be helpful if you suspect and want to rule out some common physical causes of fatigue, low energy, anxiety, and poor concentration, all common symptoms of depression. Laboratory testing may include a complete blood count to rule out anemia, blood chemistries and urinalysis to assess for the presence of diabetes or renal disease, B<sub>12</sub> and folate vitamin levels, and thyroid function tests. Other studies, such as electrocardiography, electroencephalography, and CT scanning of the brain, should be reserved for patients with clear indications of organic disease.

## PATIENT CONFIDENTIALITY AND FAMILY INVOLVEMENT

Many Asian patients are deeply concerned about the nature of chart documentation and the importance of privacy in discussions related to mental health conditions. At the same time, some patients ask that family members be involved in treatment planning. There are a few things you can do to reassure your patient:

- Tell the patient that all discussions with them are confidential
- Explain that, if the patient prefers, you can limit chart documentation to descriptions of symptoms and treatment but sparing in details of psychosocial difficulties
- Involve a family member whom the patient trusts to increase the therapeutic alliance between you and your patient. Always ask the patient for consent to do this, however, before approaching that individual. Also, reserve some time at each encounter with the patient to speak privately about any confidential matters

# TREATMENT PLANNING Reaching agreement on the nature of the problem

Once an assessment is completed, a mutual understanding about the nature of the prob-

lem and how it can be treated needs to be reached.

Asian patients may be particularly resistant to accepting a psychiatric diagnosis and are more comfortable when an organic or physical one is offered. Try to tailor your explanations so that a realistic treatment plan can be followed.

#### **Tailoring explanations**

If your patient has an explanation for symptoms, take your direction from the patient first. For example, a new immigrant may say that her symptoms are a result of work stress, that she is working a 7-day week, has had

#### Box 3 Explaining mental illness to Asian patients: the Chinatown Health Clinic experience

Asian American patients appreciate an explanation of depression and other psychiatric disorders as involving the brain and multiple organ systems

We explain that, because of psychological stress and genetic vulnerability, certain "brain chemicals" either increase in amount or are depleted. Because the brain has multiple two-way connections to organs, such as the gut, skin, and heart, some patients experience a high level of "stress" in these organs, even when they are not thinking of their troubles at that moment. Left untreated, the store of brain chemicals remains "out-of-balance" and gradually causes disruptions of sleep and appetite, nerve weakness, heart palpitations, etc.

Ways to restore balance include increasing rest, taking medications, having a healthier diet, engaging in light to moderate exercise under supervision, talking through problems, and developing different coping styles with their current problems.

This kind of explanation is culturally acceptable because it invokes the concept of *yin/yang* balance, avoids stigmatizing the patient with concerns of character and personal weakness, and offers hope through an array of treatments that can be individually tailored.

Finally, many patients will have vague, unexplained somatic symptoms without any apparent depressive or anxious affect. Some Asian patients will not necessarily present with the core symptoms of a depressive disorder, notably sadness or lack of pleasure in activities. Many perceive their problem to be medical, such as neurasthenia, "nerve weakness," or chronic fatigue syndrome (see p 257). We do not refute diagnostic terms known to the patient, as long as the diagnostic and treatment approach is not substantially different.

#### Box 4 Suggestions to providers of primary mental health care for Asian patients

- Maintain a strong biomedical identity. Explain to the patient how you have arrived at a
  diagnosis and the relevant tests performed to engender your patient's confidence and to
  improve his or her adherence to treatment
- Provide an explanation tailored to the patient's beliefs and educational level
- Outline what kind of medication to take, its mode of action, how slowly or quickly it works, and expected side effects
- Telling a patient that an antidepressant is a "sleeping pill" or that it "calms nerves" can
  backfire because antidepressants often do not relieve insomnia immediately. The patient may
  then lose confidence in the treatment and the provider
- Do not overtly or covertly "abandon" your patients when you make a referral to a mental health professional. Do not say, "I've done all I can, let me refer you to a mental health professional," or "it's all in your head."
- When you make this referral, explain to the patient that an expert with knowledge of "brain and body pathology," or an expert in helping with combined behavioral and body symptoms, will be the person to offer treatment. Reassure the patient that you will remain involved in the overall care
- Collaborate with mental health professionals. Ask for consent from your patient to share
  information with the mental health professional. Let that individual know that you intend to
  remain involved and that you would like to receive a consultation report. These actions set up
  the collaboration necessary for the optimal treatment of patients with recurrent or resistant
  disorders or with other medical problems
- Use any existing bilingual and bicultural community resources. These can be valuable for
  patients who have great social service needs or chronic and severe psychiatric conditions.
  Providing advocacy and access to specialty services is critical

little time for ancestor worship, and worries that bad luck may be responsible. You may support the patient's notion that work stress could be a precipitating or related factor. In addition, tell her you understand how important ancestor worship might be in this new environment and encourage her to find time for this activity. Emphasize, however, that regardless of the cause, the patient can benefit from treatment. This approach validates the patient's assessment and values but also sets up the expectation that treatment can help.

If possible, avoid defining the problem as an illness while developing alliances. For example, if a patient's symptoms can reasonably be attributed to a recent death, loss, or job change, try to help the patient understand the symptoms in that context. This approach decreases patient stigma. Even if patients require medication, this need can be explained as part of the process of healing, adjustment, and recovery from whatever life stresses they are experiencing.

If the patient's ability to function is impaired, an explanation of the diagnosis and its relationship to their symptoms is warranted. We have found that giving a bio-psychosocial explanation for mental illness (see box 3) is acceptable given the holistic view of health and illness held by many Asians.

## CONCLUSION: A PRIMARY CARE APPROACH TO TREATMENT

Primary care is an important setting for the mental health care of Asian patients. Primary care practitioners have the opportunity to provide high-quality, culturally sensitive care. In box 4, we summarize our suggestions for providing such care.

#### Reference

1 Kates N, Craven M. Managing Mental Health Problems: A Practical Guide For Primary Care. Seattle: Hogrefe and Huber; 1998.