Is this adolescent suicidal? Challenges in pediatric inpatient consultation-liaison

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How would you handle this case?

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Nine months after emigrating from Yemen, Ms. S, age 16, overdoses on pain medication. She denies having anxiety or stress, but says she previously attempted suicide by knife. Is she suicidal?

CASE Attempted suicide?

Ms. S, a 16-year-old Yemeni-American girl, is brought to the emergency department (ED) by her mother and brother after ingesting an overdose of painkillers and fainting. During the initial evaluation, Ms. S says she had in the past attempted suicide by knife. The medical team suspects that the current overdose is a suicide attempt, and they call the consultation-liaison (C-L) psychiatry/psychology team. Ms. S's brother strongly denies that his sister had previously attempted suicide, stating, "She's from a good family, and she is smart. She cannot feel that way." He also requests the name of the clinician who documented this information in the medical record.

During the consultation, Ms. S reports that the previous morning, she developed strong abdominal pain and discovered that she was menstruating for the first time. She explains that she did not understand what was happening to her and that no one had discussed menstruation with her before. Ms. S took her mother's opioid pain medication. Ms. S reports she took one pill, but when it did not immediately alleviate her pain, she ingested several more. After this, Ms. S says she went to play with her siblings, but gradually became dizzy and confused, and informed her sister and mother of this. The family was fasting in observance of Ramadan, and as they walked toward the mosque, Ms. S fainted, which prompted her family to bring her to the ED.

During the C-L consultation, Ms. S's brother, who speaks English, is present, as is her mother, who speaks only Arabic and thus needs a phone interpreter. As the C-L team asks Ms. S a question, it is translated to her mother, and then Ms. S's response is also translated, and then finally, the mother shares her own response. At times, her brother provides translation. Ms. S speaks in English, but often asks for the translation of words or questions.

Ms. S reports that she and her family emigrated from Yemen to the United States 9 months ago. Ms. S says that she enjoys school and is doing well academically. She denies experiencing any anxiety, worry, or stress related to her life in Yemen, her move to a new country, her parents' health, school, or other domains. Ms. S also denies any history of depressive episodes or previous suicidal ideation, intention, or attempt, which contradicts her endorsement of a previous sui-

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cide attempt to one clinician when she was initially evaluated.

Based on the information presented, what diagnoses would you consider?

a) major depressive disorder
b) adjustment disorder with depression
c) acute stress disorder
d) substance-related disorder
e) acculturation difficulty

The authors' observation

The C-L team determined that Ms. S did not meet criteria for major depressive disorder. She did not endorse current feelings of depression and denied anhedonia and other associated symptoms included in DSM-5 criteria for major depressive disorder or adjustment disorder with depressed mood (***Table 1***,[1] ***page 48***). Ms. S also denied having a history of depressive episodes or previous suicidal ideation, intention, or attempt, despite having said during the initial evaluation that she had a previous suicide attempt.

Although Ms. S and her family recently emigrated from Yemen, she did not report any symptoms consistent with an adjustment disorder with depression. Further, because she denied having any anxiety, worry, or stress related to her life in Yemen, her move to the United States, her parents' health, school, or any other domains, she did not meet criteria for posttraumatic stress disorder, acute stress disorder (***Table 2***,[1] ***page 49***), or an anxiety disorder. Similarly, there was no evidence of a substance use disorder.

Accurate case conceptualization and diagnosis is particularly crucial in C-L services, where there is an urgency for clinical decision-making after an initial evaluation without the luxury of amending conceptualization in follow-up sessions. Providing a diagnosis for which a patient does not fully or accurately meet the criteria can have deleterious effects. An inaccurate diagnosis for Ms. S would have unnecessarily added the perceived stigma of a mental disorder to her medical record. Additionally, misdiagnosing or pathologizing a natural process of acculturation could have led to inappropriate or even harmful treatment.

The C-L team evaluated alternative explanations for Ms. S's statements that suggested she was suicidal. First, they considered her mental status at the time she presented to the ED. An overdose of opioids alters mental status. Complicating reversal of opioid overdose is that some opioids have longer half-lives than naloxone, an opioid antagonist, so the individual can become reintoxicated. Similarly, some opioids are more potent and difficult to reverse.[2] An altered mental status may have limited Ms. S's ability to comprehend and answer questions accurately when she first presented to the ED.

Cultural factors and the clinical evaluation

Next, the C-L team considered Ms. S's clinical picture as it related to her cultural background. Cultural factors interact with the clinical evaluation in a complex manner, influencing the way patients approach the encounter, the symptoms they report, and the language they use to describe their experiences. While these variables are thoroughly evaluated during comprehensive psychological assessments, within the inpatient consultation service, the goal for pediatric C-L clinicians is to conduct a focused assessment to answer specific and critically important questions about a youth's psychological functioning. Thus, the fundamental challenge of inpatient consultation is to answer the referral question in a brief period and in a culturally informed manner, to appraise the referring medical team about the relevant clinical and cultural issues, with the goal of ethical and clinically sound decision-making.

The C-L team considered key cultural factors in its assessment of Ms. S (***Table 3***,[1] ***page 50***). Several issues were of concern.

Clinical Point

Accurate case conceptualization is particularly crucial in C-L services

Table 1

Criteria for major depressive disorder and adjustment disorder with depressed mood

Criteria
Major depressive disorder: ≥5 of the following symptoms
Depressed mood for most of the day, nearly every day
Diminished interest or pleasure
Weight loss or weight gain
Insomnia or hypersomnia
Psychomotor agitation or retardation
Fatigue or loss of energy
Feelings of worthlessness or inappropriate guilt
Diminished ability to think, concentrate, or indecisiveness
Recurrent thoughts of death
Adjustment disorder with depressed mood
Development of emotional symptoms in response to identified stressor
Marked distress in excess of expected or significant impairment in social/academic/occupational functions

Source: Adapted from reference 1

Clinical Point

Even with access to interpreters, many words and phrases lack direct translation

First, language is often cited as the top barrier to health care access by Arab Americans, even by those with competency in English.[3] Ms. S spoke English, but she often asked for the translation of words or questions, and her mother spoke only Arabic, and was assisted by a phone interpreter to communicate with the clinicians caring for her daughter. Conducting the interview with the phone interpreter added complexity to the interactions, interrupted the natural flow of the conversation, and was felt to hinder openness of disclosure.

Experts in culture argue that even with access to interpreters, many words and phrases lack direct translation, and their implicit meaning may be difficult to reveal. Additionally, at times more significance is placed on nonverbal cues and unspoken expectations.[4] This can create barriers to communication with clinicians, especially in the context of an inpatient psychiatric consultation, when thorough understanding of an adolescent and family often needs to occur in a single encounter, and clinicians may not appreciate the subtle nuances of nonverbal communication.

The language barrier also may have influenced Ms. S's initial endorsement of a previous suicide attempt by knife because the medical staff first interviewed Ms. S without an interpreter. For instance, many medical and psychosocial providers probe patients regarding suicidality with questions such as "Have you ever hurt yourself?" or "Have you ever tried to hurt yourself?" It is possible that in another language, an individual might interpret that question as, "Have you ever gotten hurt?" This interpretation completely alters the meaning of the question and eliminates intention or motivation to harm oneself. Language ambiguity and lack of shared cultural understanding may have influenced Ms. S's interpretation of and response to such questions. Ms. S and her family were perplexed by the C-L team's reference to the knife and continued to deny the incident.

Cultural attitudes to puberty

Cultures vary with respect to education of sensitive topics such as puberty. The medical providers assumed that Ms. S was informed about the onset of menses. Therefore, they could not consider the strong impact of such an event on an unsuspecting adolescent. Many adolescent girls in Yemen have poor health and lack menstruation-related knowledge, and many are "prescribed" medications by their mothers without contacting a physician.[5] Ms. S reported to the C-L team that no one from her family had discussed menstruation with her. She reported that since arriving at the hospital, nurses had educated her about menstruation, and that she was no longer afraid. She also noted that if she experienced such pain again, she would go to the hospital or "just deal with it."

Family identification and attitudes toward mental health

Ms. S's strong identification with her family and attitudes toward mental health may have limited what she chose to disclose regarding her experiences of loss related to leaving her country of origin, adjustment, and acculturation to the new environment, as well as feelings of sadness. Family has a central and critical role in Arab cultures. Commitment to a family's well-being and enhancement of honor and status is highly valued and encouraged.[4] Conversely, being concerned with individual needs may be a source of guilt and feelings of betraying the family.[6] Arab Americans tend not to discuss personal problems with people outside their extended family, including counselors and therapists, partly because of cultural stigma against mental illness[7,8] and partly because revealing family problems to strangers (ie, clinicians) may be considered a cultural taboo[9] and a threat to family honor.[10] Although Ms. S was interviewed privately when she first came to the ED and also during the psychiatric consultation, the stigma of psychiatric problems[11] and possible concerns about protecting her family's name may have influenced her readiness to reveal intimate information to "strangers."

Additionally, family statements that appeared to imply negative beliefs about mental health would have strongly deterred Ms. S from expressing any psychological concerns. For example, Ms. S's brother took offense when the C-L team said it was evaluating his sister because she had said she had previously attempted suicide.

The tenets of Islam may have provided a framework through which Ms. S interprets emotional concerns and may have defined her explanatory models of psychological stress. For instance, it is not uncommon among American Muslims to view mental health problems as rising from "loss of faith in God,"[9] and suicidal ideation may not be disclosed because suicide is forbidden in Islam.[12] Therefore, it might be particularly difficult to assess suicidal ideation in a patient who is Muslim, especially those who are less acculturated to Western culture.[13]

Directly asking Ms. S if she had thoughts of harming herself may have been too frightening or guilt-provoking for an adolescent with her background. Asking about passive expression of suicidal ideation would have been more culturally appropriate. For

Table 2

Criteria for acute stress disorder

Criteria
Exposure to actual or threatened death, serious injury, or sexual violation in ≥1 of the following ways: • Directly experiencing the traumatic event • Witnessing in person the event as it occurs to others • Learning the event occurred to close family members/friends • Experiencing repeated/extreme exposure to aversive details of the traumatic event
Presence of ≥9 of the following symptoms: Intrusion symptoms • Recurrent, involuntary, and intrusive distressing memories of the traumatic events • Recurrent distressing dreams • Dissociative reactions • Intense or prolonged psychological distress Negative mood • Persistent inability to experience positive emotions Dissociative symptoms • An altered sense of reality • Inability to remember an important aspect of the traumatic event Avoidance symptoms • Efforts to avoid distressing memories, thoughts, feelings associated with the traumatic event • Efforts to avoid external reminders that arouse distressing thoughts Arousal symptoms • Irritable behavior and angry outbursts • Hypervigilance • Exaggerated startle response • Problems with concentration • Sleep disturbance
Duration of disturbance 3 days to 1 month/ disturbance causes clinically significant distress/impaired functioning

Source: Adapted from reference 1

Clinical Point

Arab Americans tend not to discuss personal problems with people outside their extended family, partly because of cultural stigma toward mental illness

Table 3
Outline of cultural formulation

Cultural identity • Historical context • Language and nonverbal communication
Cultural explanations of illness • Expression of symptoms and severity
Cultural factors related to psychosocial environment • Social stressors • Supports • Role of religion
Cultural elements of the relationship between the individual and the clinician • Difficulty with language and communication • Difficulty eliciting symptoms or understanding cultural significance
Overall cultural assessment for diagnosis and care • Cultural considerations influencing diagnosis or treatment

Source: Adapted from reference 1

Clinical Point

Among Arab Americans, psychiatric symptoms often are expressed through somatization

example, asking, "Do you wish that God would let you die?"[12] may have elicited more meaningful clinical information about Ms. S's emotional state and possibly suicide risk.

Furthermore, Ms. S's identification of coping strategies (ie, "just deal with it") may have sounded limited to a Western clinician, but this may have been consistent with cultural norms of emotional expression of limiting complaints.[4] Also, among Arab Americans, psychiatric symptoms often are expressed through somatization.[7,14] Expressing psychological pain through physical symptoms appears protective against public stigma. Public image and opinion is important, and behaviors that would reflect well to others are dictated by the family. These attitudes, beliefs, and values likely impact how Ms. S presented her psychological concerns.

What treatment recommendations would you consider for Ms. S?

a) inpatient psychiatric admission
b) partial hospitalization
c) individual or family outpatient therapy
d) no treatment

The authors' observations

Although inpatient hospitalization was initially considered, it was not pursued due to denial of past and current suicidal ideation or suicide attempts, the lack of comorbidity, age-appropriate functioning, and a supportive family environment. Similarly, due to the absence of acute psychiatric symptoms, partial hospitalization was not pursued. The C-L team evaluated treatment options with extreme caution and sensitivity because recommending the wrong treatment option could have deleterious effects on Ms. S and her family's life. If inpatient hospitalization had been pursued, it could have likely caused the family unnecessary suffering and could have negatively affected familial relationships. Strong feelings of shame, betrayal, and guilt would be intensified, impairing the family's cohesion, removing environmental and family supports, and putting Ms. S at further risk of developing more severe symptoms of low mood.

Although there were significant concerns about making the wrong recommendation to the family, the C-L team's highest priority was Ms. S's safety. Despite cultural concerns, the team would have recommended hospitalization if Ms. S's clinical picture had warranted this decision.

OUTCOME Culturally-appropriate outpatient therapy

Due to the lack of substantial evidence of apparent risk for self-harm, the presence of a supportive family, and Ms. S's high academic performance and future orientation, the C-L team concludes that Ms. S's concerns were most likely the result of the challenges of acculturation related to the language barrier and a lack of health knowledge. However, the C-L team remains cautious that Ms. S may have minimized or denied her mental health concerns due to various cultural factors. The team recommends that Ms. S seek outpatient psychotherapy from a clinician who

Related Resources

- Adam B. Caring for Muslim patients: Understanding cultural and religious factors. Current Psychiatry. 2017;16(12):56-57.
- Nassar-McMillan SC, Hakim-Larson J. Counseling considerations among Arab Americans. Journal of Counseling & Development. 2003;81(2):150-159.
- Sue DW. Multidimensional facets of cultural competence. The Counseling Psychologist. 2001;29(6):790-821.

Drug Brand Name

Naloxone • Narcan

specializes in working with Arab American individuals and families in their native language. The C-L team communicates these conclusions to the medical team verbally and in writing.

The authors' observations

Cultural issues experienced during this consultation may not generalize to other Arab American adolescents and their families because there is diversity even within groups that share common cultural characteristics. Nevertheless, this case underscores the challenge of accurately assessing suicide risk, and making a differential diagnosis in the presence of complex cultural data and the dilemmas clinicians may encounter when attempting to answer important referral questions such as, "Is this adolescent suicidal and in need of psychiatric hospitalization?"

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Clinical Point

Culturally appropriate psychotherapy is key for patients experiencing difficulty with acculturation

Bottom Line

Cultural factors and attitudes toward mental health and language barriers may play a large role in how patients answer clinical questions. Cultural issues may add a level of intricacy not easily resolved within the restrictions of an inpatient setting, and this complexity may influence clinical judgment, recommendations, and possibly health outcomes. Culturally appropriate psychotherapy is key for patients experiencing difficulty with acculturation.