Mental Health in Hispanic/Latina/Latinx Women

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Introduction

Latinx people have become the largest minority group in the United States, making up about 17% of the population [1]. The heterogeneity of people who are Hispanic and Latinos, who are comprised of a variety of ethnic backgrounds such as Native American, African, and Spanish, makes identifying mental health needs a challenging but rewarding experience. The National Alliance on Mental Health reported that one in five Latinx people suffer from mental illness, making culturally competent outreach and treatment an urgent issue [2].

As part of the fastest growing and largest ethnic minority group, projections indicate that 128 million Latinos will reside in the United States by 2050 [1, 3]. Research on racial and ethnic disparities in healthcare access and utilization constantly identifies Latinos as one of the most disadvantaged ethnic groups. Using measures such as usual source of care, health insurance coverage, and the quality of care received, barriers for Latinas are readily identified [4]. However, an inclusive understanding of health and healthcare disparities must consider gender differences, given that health and illnesses are experienced differently by men and women. If demographic trends

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Table 14.1 Percentage of serious psychological distress among persons 18 years of age and over, by gender

Gender	Hispanic	Non-Hispanic White	Hispanic/Non-Hispanic White Ratio
Men	3.5	2.8	1.3
Women	5.5	4.8	1.1
Total	4.6	3.8	1.1

Source: CDC 2021. Summary Health Statistics: National Health Interview Survey: 2018. Table A-8. https://www.cdc.gov/nchs/nhis/shs/tables.htm

continue, it is suggested that Latinas will represent 25% of the total female population in the United States and make up 52% of the growing Latino population [5]. As a fast-growing demographic, it is important to address the challenges and barriers that may affect the quality of health and healthcare among Latina women. The terms Latino and Hispanic are used interchangeably in research to describe this fast-growing demographic [6]. Those who identify as Latino, Latina, or Latinx may consider themselves of Latin American ancestry (Central America, South America, or the Caribbean). Since the Spanish language is typically gendered, the term Latinx is used to eliminate a binary choice (male vs. female) that is limiting and excluding to trans individuals and others who identity as fluid or non-binary. Those who identify as Hispanic may be referring to ancestors from Spain or other Spanish-speaking [7].

Hispanic/Latina/Latinx Mental Health Data Related to Women in United States

Most of the current mental health studies combine minority groups—including Latina women—into a pool of research that generalizes their experience [8]. With the combination of ethnic groups, it is difficult to focus on one single population. A report at the US National Library of Medicine suggests that lifetime psychiatric disorder prevalence estimates were 28.1% for Hispanic men and 30.2% for Hispanic women. Increased rates of psychiatric disorders were observed among US-born, English-language-proficient, and third-generation Latinos [9]. The prevalence of serious mental illness is almost 70% greater in women than in men. Table 14.1 provides the percentage of serious psychological distress by gender.

Below is an overview of the most frequent psychiatric conditions affecting women in the United States.

Depression

Nadeem et al. [8] conducted a qualitative study with 15,383 participants who were low-income Latina and Black women, screened from Women Entering Care (WCE). They examined whether stigma was associated with seeking care or mental health treatment. Depression is a stigmatized illness, which makes it difficult for women to accept their condition and seek help. During the interviews, many were concerned about being characterized as "crazy," which decreased their disposition to employ

in mental health services. Nadeem et al. [8] revealed that Latina women with a mental health illness were less likely to want treatment because of the stigma. This research lacked a certain percent of different mental illnesses that were presented in the study, especially a few women who were diagnosed with depression. The forthcoming study identifies Mexican women's presenting problem, diagnosis, and treatment that have improved their well-being. Zayas [10] interviewed 148 Hispanic and African American women who assessed to have elevated depressive symptoms. The study found that Hispanic women had received less social support and support networks than African American women [11]. This finding is startling since family is an important element in the Hispanic culture; however, the study describes that Hispanic women had less social support due to having family in another country. In the qualitative study, 50–75% of women who had depressive symptoms went undiagnosed and untreated [11]. This study, research suggested physicians to be familiar with depressive symptoms, however, did not encourage Latina women with depressive symptoms to seek preventive mental healthcare [11].

In addition, the amount of depression in Latino women compared to Latin men is much higher—46% compared to 19.6%. However, the American Psychiatric Association's Office of Minority and National Affairs suggests that among Hispanics with a mental disorder, less than 1/11 contacts a mental health specialist, and less than 1/5 contacts a general healthcare provider.

Latinx women are twice as likely to develop depression as compared to Latinx men, white populations, or African American populations [12]. Research also indicates that employed Latinx women are more stressed than unemployed ones. Findings show that this could be due to the added responsibilities that come with being a mother and working multiple jobs. Another factor regarding employment includes the frustration and depression that arises from Latinx women being overqualified for the jobs they work, due to racial and gender discrimination. Latinas are typically paid just 57 cents for every dollar paid to white, non-Hispanic men [13]. This gap in pay—which typically amounts to a loss of $2409 every month, $28,911 every year, and $1,156,440 over a 40-year career—means that Latinas must work over 21 months to make as much as white, non-Hispanic white men were paid in just 12. In 2019, 15.2% of adult Latinas lived in poverty. That rate worsened to 16.8% in 2020 [14].

Because of Latinas' higher rates of unemployment and economic insecurity, when they return to the workforce, many Latinas will be willing to accept the first job offer they receive because they cannot afford to be out of work any longer; employers, in turn, may pay lower wages to employees who have been unemployed or out of the workforce for long stretches of time. And because Latinas face such a steep gender wage gap, they were less able to afford education or professional training during the pandemic that would have allowed them to advance or move into another field. All of this could translate to larger race and gender wage gaps for Latinas moving forward.

Mental health statistics show that Hispanic women in the United States experience depression at about twice the rate of Hispanic males and are at a higher risk for depression than Caucasian and African American women [15]. This is, partially, due to multiple social determinants of health that impact Hispanic women and their families. Social determinants of health (i.e., education, income, health status, and

acculturation) among Hispanic women may play a crucial role in the development or exacerbation of depression [16].

In the Latino culture, a woman's role is to informally maintain a strong foundation that keeps the family united. Meanwhile, the man role is to formally manage the family's basic needs [17].

Suicide

Suicidal behavior among Hispanic youth has been reported to be higher in comparison to non-Hispanic Black and White youth (Centers for Disease Control and Prevention, 2003, 2006; Substance Abuse and Mental Health Services Administration, 2003). Although data do not distinguish Latino youth by country of origin or heritage, Latino youth of both sexes have shown consistently higher rates of suicidal ideation, plans, and behavior than their non-Hispanic counterparts, except for the category of youth designated as "Other" (which includes Native American youth). Despite the higher than average reports of suicidal behavior among Hispanic youth, their actual rates of suicides are lower than those of non-Hispanic White and Native American adolescents, but higher than those of non-Hispanic Black youth [11].

Latin American culture is, traditionally, very family oriented but it retains firm gender divisions that celebrate achievements made by males while at the same time relegating women to roles of homemaking. Because these divisions run deep while at the same time families play such a strong part in the lives of Hispanics, young Latina girls feel guilt by not following their patriarchal demands. Or, if they decide to pursue their own ambitions regardless, they will create inner turmoil by following their dreams and going against family wishes [18].

In 2019, suicide was the second leading cause of death for Hispanics, ages 15 to 34 [19]. Suicide attempts for Hispanic girls, grades 9–12, were 30% higher than for non-Hispanic white girls in the same age group, in 2019 [19]. The high rates of suicidal behavior by teenage Hispanic females reported in large-scale surveys can be understood as a cultural phenomenon, a product of specific elements of the history, tradition, ideology, or social norms of a particular society, and that treatment interventions must take family and cultural factors into consideration [20]. A summary with the % of suicidal ideation among students who attempted suicide in grades 9–12 is noted in Table 14.2.

Table 14.2 Suicidal ideation (%) among students who attempted suicide in grades 9–12, 2018

	Hispanic	Non-Hispanic White	Hispanic/Non-Hispanic White Ratio
Men	5.5	6.4	0.9
Women	11.9	9.4	1.3
Total	8.9	7.9	1.1

Source: CDC 2021. High School Youth Risk Behavior Survey Data. [Accessed 04/21/2021]. https://nccd.cdc.gov/youthonline

Post-partum Depression (PPD)

Post-partum depression (PPD), a major depressive episode that occurs following delivery or within the first four weeks after delivery [21], is the leading medical complication among new mothers, and affects an estimated 12–19% of the general population of new mothers [22]. The prevalence of PPD in Latinas in the United States has been estimated at three to four times greater (30–43%) than the general population of new mothers [23]. A growing body of research suggests that psychosocial stressors are important risk factors for PPD [24]. There is evidence in the literature that prolonged exposure to stress is associated with hyperactivity of stress response systems, such as the hypothalamic-adrenal-pituitary (HPA) axis, which can become dysregulated over time, making it difficult for the individual to adapt to later stressors [25]. Dysregulation of the HPA axis has been implicated in the development of PPD [26]. However, the biological mechanisms by which psychosocial stressors are associated with an increased risk of PPD are poorly understood, particularly among immigrant and US-born Latinas who experience high rates of complex and long-lasting psychosocial stressors, because they are not well-represented in biomedical research and the multifaceted stressors they encounter throughout their life have not been examined [27].

While pregnant women everywhere are susceptible to PPD and other mental illnesses, the problem is greatest in developing countries, where WHO estimates that 20% of mothers experience post-partum depression. Latinas are part of the fastest growing minority group in the United States. In 2010, Latinas accounted for 24% of all births and immigrant Latinas accounted for 56% of births that year [28]. Despite the rapid growth of this population and high fertility rates among US- and foreign-born Latinas, there is limited information about the mental health of these women following delivery.

In a group of 116 Latinx immigrants, the prevalence of significant symptoms of PPD was 54.2% for the entire sample of 116 women. Nearly 66% of women who screened positive for symptoms of PPD scored above the listed cutoff score for suicidal thoughts [29]. PPD is exacerbated by poverty, migration, stress, and exposure to violence, according to research compiled by WHO. The organization emphasizes the need to integrate maternal mental health with general health guidelines, along with educating women about children's health and reproductive health. Latinas experience cultural and contextual contributors for PPD that should be assessed simultaneously along with biological factors, such as the HPA axis, that are affected by high levels of stress. This study has implications for clinical practice. Healthcare providers should routinely assess the presence, proximity, and degree of the contributors discussed here when evaluating immigrant and US-born post-partum Latinas for mood disorders. Similarly, health professionals should consider the potential effects of how a dysregulated HPA stress response might impact a woman's mood. In sum, it is vital that healthcare providers consider the broad range of cultural, contextual, and biological contributors to PPD noted here. [27].

Anxiety

The NIMH defines General Anxiety Disorder (GAD) as experiencing "excessive anxiety or worry" for most days over a period of 6 months. Other anxiety disorders include panic disorder, obsessive-compulsive disorder, social anxiety disorder (or social phobia), separation anxiety disorder, and phobia-related disorders (such as fear of flying, fear of heights, or fear of specific objects). While 19% of all adults in the US report having experienced anxiety disorder in the past year, the percentage is much higher for women than for men (23.4% vs. 14.3%).

Symptoms of anxiety disorder include the following: chronic irritability or nervousness, feelings of impending doom or disaster, racing heartbeat, hyperventilating, sweating, or trembling, weakness or tiredness, inability to concentrate, sleeplessness, stomach aches or other digestive problems.

Women are twice as likely as men to be impacted by Generalized Anxiety Disorder (GAD). The Anxiety and Depression Association of America (ADAA) reports that 6.8 million people in the United States are affected by GAD, although only 43% of them are being treated for the disorder. Women are also twice as likely as men to be diagnosed with panic disorder (PD), which affects six million US adults, and with specific phobias, which impact 19 million adults in the United States.

Post-traumatic Stress Disorders

Post-traumatic stress disorder (PTSD) is a serious and common mental illness with lifetime prevalence rates in the United States ranging from 3.4% to 17.7% [30], depending on sampling methods. Women are more likely to experience PTSD, and they wait much longer than men after symptoms arise to seek diagnosis and treatment. The Office of Women's Health at the U.S. Department of Health and Human Services reports that women wait an average of 4 years after the onset of PTSD symptoms before asking for help. Men, on the other hand, seek assistance an average of 1 year after PTSD symptoms arise. Sexual violence is the primary source of PTSD worldwide. Recovery Across Mental Health states that women have a higher rate of developing PTSD after a traumatic event: 20.4% for women, compared to 8.1% for men. According to the ADAA, 65% of male rape victims and 45.9% of women who are victims of rape will develop PTSD as a result [30].

Substance Abuse

The size of the Latina/Latino population in the United States and projections for its growth require that substance abuse researchers and treatment providers pay greater attention to the prevalence and treatment of drug and alcohol abuse among this group [31].

In general, Latinas are more likely than Latinos to abstain from using alcohol and illicit drugs and Latinas are less likely to drink heavily and become dependent on alcohol [9].

Substance abuse prevalence rates for Latinos/Latinas generally mirror those of the general US population; however, several indicators of assimilation to US culture as well as sociodemographic variables predict substance use and abuse among this group. Latinos/Latinas have poorer outcomes in substance abuse treatment programs. Yet there is little empirical evidence that explains the problems these individuals experience in treatment, and there are few studies on the use and effectiveness of mutual help groups among this population. New developments in the conceptualization and measurement of acculturation will lead to a greater understanding of the role of culture in the prevalence and treatment of substance-related problems [9].

Research from [9] provides some potential reasons for a higher rate of substance abuse in Hispanic females including a family history of substance abuse, mood and anxiety disorders, acculturation issues, unmarried, unemployment, exposure to traumatic events, and poverty [9].

Risk Factors for Mental Health Issues in Women

Studies suggest that the longer a Hispanic woman lives in the United States, the higher the risk for depressive symptoms, as there is an increased sense of loss in cultural values, norms, and family cohesion [16]. A key study into the social determinants of depression among Hispanic women suggests that when a Hispanic woman does not live with her partner, has an educational level of below high school, and has a fair or poor health, she has a significantly higher risk of developing depression [32]. Exposure to violence makes a woman three to four times more likely to be affected by depression. Researchers at WHO state that women who were exposed to sexual abuse as children, or to a violent partner as an adult, are diagnosed with depression at a much higher rate. The research also found that the severity and duration of the initial sexual or violent exposure impacts the severity of the resulting mental illness.

Women disproportionately experience the following risk factors for common mental disorders than men: 1) Women earn less than men; Hispanic/Latina/Latinx mental health data related to women in US risk factors for women who are full time workers earn about one-fourth less than male counterparts in a given year [33]; 2) the poverty rate for women aged 18 to 64 is 14.2% compared with 10.5% for men. For women aged 65 and older the poverty rate is 10.3%, while the poverty rate for men aged 65 and older is 7.0%; 3) victims of violence: About 1 in 3 women have experienced sexual violence, physical violence, and/or stalking by an intimate partner in their lifetime [34]; 4) an estimated 65% of caregivers are women. Female caregivers may spend as much as 50% Hispanic/Latina/Latinx mental health data related to women in US risk factors for more time providing care than male caregivers [7].

Insights for Clinicians

The presence of psychosocial stressors in many women's lives and its connection to depression and anxiety disorders warrants further research and evaluation for adequate social and financial supports. Follow up with proposed solutions when needed. Consider working with women in a collaborative care model, working together with a patient's primary care provider, and ancillary providers to deliver more holistic, comprehensive care. Be aware of biases that may come into play in the care of female patients, especially when there are symptoms with unique presentations.

Culture affected aspects of all the above themes, with birthplace sometimes modifying these effects. Regarding the physician–patient relationship, for instance, many women placed a high value on a caring social interaction whether they were born inside or outside the United States. Even so, birthplace (i.e., US born vs foreign born) seemed to influence some women's attitudes and preferences. Studies suggested that women who grew up in the United States differed from those born outside the United States in their emphases on aspects of the patient–physician relationship and communication. Some women born in the United States gave the impression that they regarded their doctor's role more as that of a paid professional, even though they still wished for a relationship characterized by warmth and compassion [35]. Women born outside the United States, however, tended to trust the doctor's medical training and automatically respect him or her as the authority in charge of their and their families' health. What they most desired from the relationship was the physician's ability to empathize with and understand them.

Conclusion and Future Needs

Hispanic/Latina/Latinx women, like other women have different needs for mental health services throughout their life. To respond to these needs it is necessary that during the training period of health professional's mental health as it relates to gender be included as a relevant aspect of their academic formation. With respect to the evaluation of health problems in women, several variables have been considered and emphasis has been placed on several psychosocial conditions that are common to most of Hispanic/Latinx. It is necessary to educate women, since the lack of education and poverty associated with cultural misconceptions maintains their poor life conditions, which in tum become psychosocial risk factors for mental disorders. Job conditions for Hispanic/Latinx women must improve, with access to social protection. Health services for women must integrate the mental health component in reproductive health services.

References

1. United States Census Bureau. Facts for features: hispanic heritage month 2017. Release Number CB17-FF.17 2017. https://www.census.gov/newsroom/facts-for-features/2017/hispanic-heritage.html
2. Moreno E. Latinos and mental health: current issues and a reason for hope. American Foundation for suicide Prevention. 2017. Retrieved from: https://afsp.org/latinos-mental-health-current-issues-reason-hope/

3. Valenzuela JM, McDowell T, Cencula L, Hoyt L, Mitchell MJ. Hazlo bien! A participatory needs assessment and recommendations for health promotion in growing Latino communities. Am J Health Promot. 2013 May-Jun;27(5):339–46.
4. Berdahl TA, Torres Stone RA. Examining Latino differences in mental healthcare use: the roles of acculturation and attitudes towards healthcare. Community Ment Health J. 2009 Oct;45(5):393–403.
5. Ramos B, Jurkowski J, Gonzalez B, Lawrence C. Latina women: health and healthcare disparities. Soc Work Public Health. 2010;25(3/4):258–71.
6. Jacobson L. The Hispanic dynamic: how will the rapidly growing Latino population affect politics and policy? State Legis. 2015;41(6):16.
7. SAMHSA. National survey on drug use and health 2016. 2015.
8. Nadeem E, Lange JM, Edge D, Fongwa M, Belin T, Miranda J. Does stigma keep poor young immigrant and US-born black and Latina women from seeking mental health care? Psychiatr Serv. 2007;58(12):1547–54.
9. Alvarez J, Jason LA, Olson BD, Ferrari JR, Davis MI. Substance abuse prevalence and treatment among Latinos and Latinas. J Ethn Subst Abus. 2007;6(2):115–41.
10. Zayas LH, Cunningham M, McKee MD, Jankowski KRB. Depression and negative life events among pregnant african-american and hispanic women. Women's Health Issues. 2002;12(1):16–22, ISSN 1049–3867. https://doi.org/10.1016/S1049-3867(01)00138-4.
11. Zayas LH, Pilat AM. Suicidal behavior in Latinas: explanatory cultural factors and implications for intervention. Suicide Life Threat Behav. 2008;38(3):334–42.
12. American Psychological Association, Latina Women Firsts. Ethnicity and health in America Series: Latina women's firsts in psychology. 2015. https://www.apa.org/pi/oema/resources/ethnicity-health/latino-heritage/women-firsts. Accessed 10/21/2021.
13. National Women's Law Center (NWLC) calculations using U.S. Census Bureau, Current Population Survey. Annual social and economic supplement. 2021. https://www.census.gov/data/tables/time-series/demo/income-poverty/cps-pinc/pinc-05.html
14. NWLC calculations using U.S. Census Bureau. Age and Sex of All People, Family Members and Unrelated Individuals. Table POV-01 in 2020 Current Population Survey and 2021 Current Population Survey. 2021, Sep 14. https://www.census.gov/data/tables/time-series/demo/income-poverty/cps-pov/pov-01.html
15. Shattell MM, Smith KM, Quinlan-Colwell A, Villalba JA. Factors contributing to depression in latinas of mexican origin residing in the United States: implications for nurses. J Am Psychiatr Nurses Assoc. 2008 Jun;14(3):193–204.
16. Lorenzo-Blanco EI, Cortina LM. Latino/a depression and smoking: an analysis through the lenses of culture, gender, and ethnicity. Am J Community Psychol. 2013 Jun;51(3–4):332–46.
17. Nuñez A, González P, Talavera GA, Sanchez-Johnsen L, Roesch SC, Davis SM, Gallo LC. Machismo, Marianismo, and negative cognitive-emotional factors: findings from the Hispanic community health study/study of Latinos sociocultural ancillary study. J Latina/O Psychol. 2016;4(4):202–17.
18. Landale NS, Oropesa RS, Bradatan C. Hispanic families in the United States: family structure and process in an era of family change. In: National Research Council (US) panel on Hispanics in the United States. In: Tienda M, Mitchell F, editors. Hispanics and the future of America, vol. 5. Washington (DC): National Academies Press (US); 2006. Available from: https://www.ncbi.nlm.nih.gov/books/NBK19902/.
19. CDC. National center for injury prevention and control. Web-based injury statistics query and reporting system (WISQARS). 2019. https://www.cdc.gov/injury/wisqars/index.html. Accessed 10/21/2021.
20. Nolle AP, Gulbas L, Kuhlberg JA, Zayas LH. Sacrifice for the sake of the family: expressions of familism by Latina teens in the context of suicide. Am J Orthopsychiatry. 2012;82(3):319–27.
21. American Psychiatric Association. Diagnostic and statistical manual of mental disorders (DSM-5®). American Psychiatric Pub. 2013.
22. Gavin NI, Gaynes BN, Lohr KN, Meltzer-Brody S, Gartlehner G, Swinson T. Perinatal depression: a systematic review of prevalence and incidence. Obstet Gynecol. 2005;106(5 Pt 1):1071–83.
23. Lucero NB, Beckstrand RL, Callister LC, Sanchez Birkhead AC. Prevalence of postpartum depression among Hispanic immigrant women. J Am Acad Nurse Pract. 2012;24(12):726–34.

24. Liu CH, Tronick E. Rates and predictors of postpartum depression by race and ethnicity: results from the 2004 to 2007 new York City PRAMS survey (pregnancy risk assessment monitoring system). Matern Child Health J. 2013;17(9):1599–610.
25. Juruena MF. Early-life stress and HPA axis trigger recurrent adulthood depression. Epilepsy Behav. 2014;38:148–59.
26. Jolley SN, Elmore S, Barnard KE, Carr DB. Dysregulation of the hypothalamic-pituitary-adrenal axis in postpartum depression. Biol Res Nurs. 2007;8(3):210–22.
27. Lara-Cinisomo S, Wisner KL, editors. Perinatal depression among Spanish- speaking and Latin American women: a global perspective on detection and treatment. New York, NY: Springer; 2013.
28. Livingston G, Cohn D. U.S. birth rate falls to a record low; decline is greatest among immigrants social and demographic trends. Pew Research Center. 2012;
29. Callister LC, Beckstrand R, Corbett C. Postpartum depression and help seeking behaviors in immigrant Hispanic women. J Obstet Gynecol Neonatal Nurs. 2011;40:S108.
30. Sibrava NJ, Bjornsson AS, Pérez Benítez ACI, Moitra E, Weisberg RB, Keller MB. Posttraumatic stress disorder in African American and Latinx adults: clinical course and the role of racial and ethnic discrimination. Am Psychol. 2019;74(1):101–16.
31. Delgado M. Cross-cutting themes and recommendations. In: Delgado M, editor. Latinos and alcohol use/abuse revisited. New York: Haworth; 2005. p. 205–12.
32. De Oliveira G, Cianelli R, Gattamorta K, Kowalski N, Peragallo N. Social determinants of depression among Hispanic women. J Am Psychiatr Nurses Assoc. 2017;23(1):28–36.
33. SAMHSA. Past year mental disorders among adults in the United States: results from the 2008–2012 mental health surveillance study. CBHSQ DATA Review. 2014. samhsa.gov/data/sites/default/files/NSDUH-DR-N2MentalDis-2014-1/Web/NSDUH-DR-N2MentalDis-2014.htm
34. American Psychiatric Association. Best practice highlights female patients. 2017. psychiatry.org/psychiatrists/cultural-competency/treating-diversepatient-populations/working-with-women-patients. Accessed 10/21/2021
35. Julliard K, Vivar J, Delgado C, Cruz E, Kabak J, Sabers H. What Latina patients don't tell their doctors: a qualitative study. Ann Fam Med. 2008;6(6):543–9.