

¡ No Soy Loco ! / I'm Not Crazy

Understanding The Stigma of Mental Illness in Latinos



A Guide

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Contextual Issues

The Latino Community in the United States: Demographics and Diversity

Latinos are the largest ethnic minority group in the United States. With a population of approximately 45 million, they now constitute 14% of the total U.S. population. By 2050, and probably before given their rapid increase through migration and internal growth, Latinos will account for 25% of the U.S. population. Several studies have found that between 40-60% of Latinos have limited English proficiency.

The Latino population is extremely diverse across a number of dimensions including country of origin, immigration status, language use, ethnic and racial background, religious and spiritual beliefs, and generation in the United States. Mexicans comprise the largest Latino group, accounting for 2/3 of all Latinos in the U.S. They also are the largest group of new immigrants to the United States. While Latinos of Mexican origin were once concentrated in the southwestern U.S., their populations have grown dramatically in all parts of the country. Between the 1990 and 2000 Census, their growth was most dramatic in the southeastern United States. Mexicans are extremely diverse in terms of immigration and generation. Some Latino individuals in states like Arizona and New Mexico trace their families back more than 10 generations in the same communities, before this region was part of the United States. Mexican immigrants primarily speak Spanish, but a growing number of newly arrived individuals speak a range of indigenous languages. Mexican cultures are a rich mix of Spanish and Indian heritages. Long-term Mexican residents of the U.S. have developed their own vibrant cultures, including the Hispano culture of the southwestern states and Chicano culture in California.

Puerto Ricans are the next largest group, accounting for 10 percent of the Latino population on the U.S. mainland. The Island of Puerto Rico is a commonwealth associated with the United States, and all Puerto Ricans have been U.S. citizens since 1917, regardless of whether they lived on the Island or on the mainland. Puerto Rican culture is a rich mix of African, Indian and Spanish cultures and shares a Caribbean culture with Cubans and Dominicans. As with Mexicans, Puerto Ricans born and raised on the mainland have developed a Nuyorican culture, which has been a rich source of music and poetry. While the largest Puerto Rican communities have been in New York City and the surrounding metropolitan area, newer Puerto Rican communities have been rapidly developing in Chicago, central Florida and Texas.

No other Latino group accounts for more than 5 percent of the total Latino population. Cubans, Dominicans and Salvadorans are the next largest groups of Latinos. Cubans are heavily concentrated in Miami, Florida and their numbers there have been growing

as aging Cubans from other parts of the U.S. move to Florida. Dominicans, the other large Caribbean group, are concentrated in the northeast, with Washington Heights in New York City rivaling Santo Domingo as a center of Dominican culture. Salvadorans and other Central American groups have been growing rapidly in many parts of the country such as Washington, DC and Los Angeles. Like Mexicans, Central American cultures mix indigenous and Spanish heritages.

Immigrants from South America have formed some of the fastest growing and most dynamic communities in several regions of the United States. Ecuadorian and Colombian communities have had some of the highest rates of growth in New York City, although their absolute numbers are still small. Immigrants from the Andean countries of Peru and Bolivia have significant populations who speak indigenous languages. Due to the economic and political turmoil in the Southern Cone, there are also significant populations of Argentines, Chileans, Paraguayans and Uruguayans, particularly in metropolitan centers.

Language

The language in which the patient speaks has an effect on the diagnosis and treatment of mental illness in Latinos. Language is a very culture-specific medium (Berry et al., 1992). Language influences emotional expression. In individuals who are fluent in more than one language, there is conflicting evidence as to which language (one's native or second language) most promotes or inhibits the display of emotion (Malgad et al, 1987;). Nonetheless, many researchers have concluded that people who are bilingual in English and Spanish express themselves differently in the two languages. Several studies have found that bilingual individuals tend to express more psychopathology and disclose more personal information when interviewed in Spanish, while remaining more emotionally withdrawn in English (Gutfreund, 1990; Marcos, 1976; Price & Cuellar, 1981). An individual who is highly acculturated to the American culture and highly fluent in English may express more emotion in English, compared to a less acculturated, less fluent individual. Spanish expressions, many with cultural meanings are frequently used in describing mental illness in Latinos.

Religion

The majority of Latinos in the United States identify themselves as Christian, with approximately 90% declaring themselves Catholic. Latino elders have been shown to become more active in religious activities as they age (Stolley & Koenig 1997). In addition to ascribing to religions such as Catholicism and Protestantism, *Curanderismo*, *Santeria*, and *Espiritismo* also may be included in the belief systems of some Latino subgroups.

Curanderismo is a diverse folk healing system practiced by many Mexican Americans, which includes beliefs originating from Greek humoral medicine, early Judeo-Christian healing traditions, the Moors, and Native American traditions. A main tenet of this belief system is that illness is caused by natural forces, supernatural forces, or a combination of the two. Examples of beliefs include *suerte* (luck), *susto* (soul or spirit loss resulting from a traumatic event), *mal de ojo* (the evil eye), *caida de la mollera* (fallen fontanel).

Healing practices may include physical and supernatural healings via *limpias* (spiritual cleansings), prayer, massage by *sobadores*, and herbal preparations (Luna 2003; Padilla et al 2001; Keegan 2000; Gafner & Duckett 1992). Healing is administered by *Curanderos*, who have a divine gift (*don*) for healing, (Applewhite 1995), *sobadores*, *yerberos*, and *espiritualistas* (Lopez, 2005).

Santeria is a religious system that blends African (Yoruba tribe) and Catholic beliefs, and is practiced by Cuban Americans and other Caribbean ethnic groups. It also may include elements of spiritualism and magic. Beliefs include that *oricha* saints (identities based on a combination of African deities and Catholic saints) may influence people on earth, *embruajamiento* (casting spells), and *mal ojo* (evil eye). Healing practices include *despojamientos* (expelling bad spirits), amulets, magic medicines, animal sacrifice, and care of blessed animals. *Santero* group beliefs and practices may vary, based on the needs of the group or the *Santero* priest (Baez & Hernandez 2001; Alonso & Jeffrey 1988; Suarez et al 1996).

Espiritismo is a spiritual belief system practiced by many Puerto Ricans in Puerto Rico and in the US. It includes beliefs in reincarnation and the power of mediums. Individuals are affected by fluids, which are spiritual emanations that surround the body. These fluids are derived from a combination of the individual's spirit, spirits of the deceased, and the spirits of others close to the individual. Mental and physical illnesses are the result of fluids either being sick or disturbed. Fluids may be negatively affected by karma (past actions influencing the present), religious negligence, *brujeria* (witchcraft), spirits, *mal ojo* (evil eye), and inexperienced mediums. Healing practices include prayer, group healings, house cleansings, personal cleansings with herbal baths, and possession trance (Harwood 1977; Richeport 1975, 1982, 1985 as cited by Hohmann et al 1990; Baez & Hernandez 2001)

Use of Herbal Medicines

Latinos often use herbal medicines. These include spearmint, chamomile, aloe vera, garlic, brook-mint, osha, lavender, ginger, ginseng, camphor, rue, anise, wormwood, orange leaves, sweet basil, oregano, peppermint and lime (Zeilmann et al., 2003; Rivera et al., 2002; Trotter, 1981), as well as marijuana tea (Pachter 1994). *Tila* (Linden flower) tea and Sarsaparilla may be used for nervous disorders (Pasquali 1994). Mercury (*Azogue*) may be used (Pachter 1994) by elders practicing *Espiritismo* or *Santeria*, as it is believed to provide good luck and protection from evil and the envy of others (Zayas & Ozuah, 1996).

Pathways to Care

Latinos are quite likely to seek the help of *curanderos* or clergy prior to seeking medical care for their illnesses. When they do seek help it is likely to be through primary care providers (Vega et al., 1999).

Mental Health Issues in the Latino Community

There have been several important studies of Latino mental health in recent years, including the Mexican American Prevalence and Services Survey (MAPSS) Study and the National Latino and Asian American Study. Some key issues that have emerged from these studies include:

- Overall, Latinos experience lower rates of most mental health disorders compared to the general U.S. population. For example, approximately 25% of European Americans met criteria for any depressive diagnosis in a large national study, whereas less than 20% of Latinos met criteria for depressive disorders in a parallel study. However, rates of depressive diagnoses were higher for Puerto Ricans and Cubans and lowest for Mexican immigrants. Similar patterns were found for anxiety and substance use diagnoses.
- Mexican immigrants have significantly lower rates of depression and substance use disorders compared with their U.S.-born counterparts. This phenomenon has been termed the *Latino Paradox*. While Mexican immigrants have lower socioeconomic status than U.S. born Mexican Americans, their mental health is better than those born in the U.S.
- Puerto Ricans on the U.S. mainland tend to have higher rates of mental disorders than other Latinos as well as Puerto Ricans in Puerto Rico. The Latino Paradox does not apply to Puerto Ricans.
- The Latino Paradox applies to Cubans and Latinos from Central and South America for substance use disorders, where immigrants from those countries have lower rates of substance use than their U.S. born counterparts.
- Latinos have lower rates of mental health services utilization than other ethnic groups, except for Asian Americans. Latino immigrants have especially low rates of mental health services use.
- Latina adolescents have the highest rate of suicidal ideation and attempts of any ethnic and gender group in this age category.

Psychotic Symptoms in Latinos

The assessment of psychosis in Latinos has been particularly problematic in mental health research. Important questions remain about the definition and meaning of phenomena consistent with psychotic symptoms among Latinos. .

- Latinos tend to report higher rates of phenomena consistent with psychotic symptoms than other ethnic groups in both clinical and epidemiological studies of mental health. Yet, in most studies of Latinos compared to other ethnic groups, the diagnoses of depressive disorders among Latinos far outnumber diagnoses of psychotic disorders.

- When examined more closely, the phenomena consistent with psychotic symptoms reported by Latinos do not seem to be indicative of psychotic disorders, although they do correlate with a greater prevalence of mental disorders.
- Symptoms such as “hearing your name called and no one is there” and “seeing shadows or glimpses or feeling presences that others do not feel” are quite common among various groups of Latinos. These kinds of phenomena consistent with psychotic symptoms appear on questionnaires about psychotic symptoms, and if they are not carefully probed, can lead to misdiagnoses. For example, in one community study in Puerto Rico, more than half of the respondents reported such experiences. Only 15% of those reporting the phenomena stated that they caused any psychological problems for them.
- Religious and spiritual experiences that are consistent with cultural identity can be misidentified as psychotic symptoms leading to misdiagnosis. For example, experiences of seeing saints and other religious figures or speaking with deceased relatives through spiritual practices are widespread in Latino cultures and represent valued experiences in many contexts.
- For cultural reasons such as religious/spiritual beliefs and practices, as well as for reasons that are not well understood, Latinos appear to be more prone to dissociative-type experiences, whether related to trauma or not.
- Clinicians need cultural knowledge and skills to assess the meaning and severity of these phenomena that are consistent with psychotic symptoms in Latinos. The DSM-IV-TR Outline for Cultural Formulation is a concise clinical tool to help understand the patient’s cultural identity, cultural expressions and explanations of illness, cultural stressors/supports, cultural elements of the clinician-patient relationship, which can aid both the differential diagnosis and treatment plan. (For more information, see the section on the Outline in the appendix of this guide).

The Concept of *Locura* in Latino Populations

According to the DSM-IV-TR Glossary of Culture-Bound Syndromes, *Locura* is “A term used by Latinos in the United States and Latin America to refer to a severe form of chronic psychosis. The condition is attributed to an inherited vulnerability, to the effect of multiple life difficulties, or to a combination of both factors. Symptoms exhibited by persons with *locura* include incoherence, agitation, auditory and visual hallucinations, inability to follow rules of social interaction, unpredictability, and possible violence.”

Latinos sometimes distinguish between *un loco tranquilo* and *un loco violento* (a quiet crazy person and a violent crazy person). The *loco violento* person is seen as totally out of control and is much more stigmatized. Once one is labeled as suffering from *locura*, it is very difficult to recover or to lose the label of *loco*. There is also a widespread belief

that if a person needs to take psychiatric medications, he or she must be suffering from *locura*. The contrast to suffering from *locura* is to suffer from *nervios*, which is seen as much more transitory and more the result of difficult life experiences, including the stresses and changes brought on by migration from Latin American countries to the United States.

Nervios is a common idiom of distress among Latinos. The term *nervios* may be used to refer to an individual's general state of vulnerability to stress and to a syndrome of symptoms triggered by stress. Symptoms of *nervios* include headaches, irritability, stomach disturbances, trembling, and dizziness. *Nervios* captures a spectrum, which can range from being sensitive to stress (*padecer de nervios*) to other presentations that may include adjustment, anxiety, depressive, dissociative, somatoform or psychotic disorders (APA 2005; Guarnaccia et al 2003).

Susto (fright) is a culture bound syndrome which includes psychological and somatic symptoms such as appetite disturbances, sleep disturbances, dreams, sadness, lack of motivation, feelings of low self worth or dirtiness, muscle aches and pains, headache, and stomach disturbances. This syndrome is attributed to a frightening event that causes one's soul to leave its body. Healings, such as those in *Curanderismo*, are focused on calling the soul back to the body and restoring body and spiritual balance. Other names for *susto* include *espanto*, *pasmo*, *perdida del alma* and *chibih* (Baer et al 2003; APA 2005).

Culture-Bound Syndromes:

"The term *culture-bound syndrome* denotes recurrent, locality-specific patterns of aberrant behavior and troubling experience that may or may not be linked to a particular DSM-IV diagnostic category. Many of these patterns are indigenously considered to be "illnesses," or at least afflictions, and most have local names... culture-bound syndromes are generally limited to specific societies or culture areas and are localized, folk, diagnostic categories that frame coherent meanings for certain repetitive, patterned, and troubling sets of experiences and observations."

Mental Health Stigma in the Latino Community

In 2001, the *Supplement to the Surgeon General's Report Mental Health: Culture, Race, and Ethnicity* called stigma the most pervasive problem preventing members of all racial and ethnic minority groups from seeking behavioral health care for mental disorders including substance use. Stigma is a particularly critical problem among members of Latino ethnic groups. Stigma often is very subtle in its presentation. The label of *locura* strongly shapes the stigma of mental illness in Latino communities.

Stigma is a complex phenomenon related to loss of status and disrupted identity. It is associated with labeling, negative stereotypes in the media and community, and lack of knowledge and awareness of mental illness. It can focus on visible or invisible

attributes, and be perpetuated through conscious or unconscious processes. It can emerge across systems, within a family, or in a community, or in biases that inadvertently emerge among service providers and are reinforced through anger, fear, or prejudice. For community members or patients who are members of the non-dominant culture and coping with mental health concerns, the cumulative impact of being labeled in multiple ways perceived as negative can be unexpected, far reaching and debilitating.

Latinos are more likely to somatize distress than Caucasians. Somatization and pre-occupation with somatic concerns among Hispanics have been widely described in the literature (Escobar 1995; Escobar et al., 1986;). Somatic symptoms are culturally sanctioned expressions for seeking and receiving care and treatment, and are reported by patients with and without Axis I diagnoses (Barrio et al., 2003; Weisman et al., 2000; Escobar et al., 1986). It is considered stigmatizing to express psychological distress explicitly, as this indicates mental illness. Thus for Hispanics, especially elderly Hispanic women, somatic symptoms may be manifestations of psychological distress (Angel & Guarnaccia, 1989).

Stigma surrounding mental illness, and lack of knowledge regarding mental health disorders and treatments, also may play a role in lower utilization of mental health services.

Several characteristics are associated with the stigma of mental illness in Latinos.

- **There is a negative cultural connotation associated with mental illness:** Culture shapes the expression, recognition, and social acceptance of psychiatric illness and problems. In many Latino cultures, mental illness is stigmatizing, especially if the person is labeled as *loco* and has to take medications to control his or her symptoms and behavior. Mental illness reflects poorly on the family and can influence social relations with family and friends, assessments of the suitability of an individual or his/her immediate relatives for marriage, and opportunities for education and employment. It is more acceptable to use idioms of distress that are somatic in nature rather than psychological, in particular the idiom of distress known as *nervios*.
- **Stigma is heightened by immigration and acculturation experiences:** Traditional Latino cultures greatly value family cohesion within well-structured roles. Migration often disorganizes families for the following reasons: some members may come to the U.S. first; marriages may break up over time; relatives who provide support may be left behind; and family dynamics may change as children acculturate more quickly than their parents. For many Latinos who immigrate to the United States, the stress of relocation increases as they encounter American society, with its emphasis on individual independence from the nuclear or extended family and often heightened experiences of discrimination from the wider community. Differences from the traditional cultural

values; language; and economic, social, professional and immigration status are among the many stressors migrants experience as they acculturate to the American host culture. These stressors can contribute to mental illness, substance use, and other conditions that may be a focus of clinical attention, such as problems with domestic violence or acculturation. Due to the stigma attached to mental illness, Latinos often are reluctant to seek help and treatment. Further, possible experiences of discrimination and prejudice in combination with these stressors may cause the person to feel marginalized; acknowledging mental illness may make the person feel even more devalued both intrapsychically and in the context of family and community.

The stigma of having a mental illness is one of the most significant obstacles preventing Latinos from seeking help. Some Latinos associate mental illness with loss of control, violence, and incurability that affect the patient and the whole family. Having a mental illness is also seen as a sign of personal weakness. Patients with mental illness symptoms fear being rejected by family members, as well as members of their community. Denial and concealment of mental illness, with the purpose of protecting the family reputation, are common. Overcoming stigma is difficult and challenging. Clinically, a biological explanation of mental illness may help to dispel part of the stigma, particularly when the patient and family understand that mental illness is related to biological neurotransmitter imbalances. However, it also may communicate the permanence of the illness and lead to greater hopelessness among family members. Close cooperation among social services, primary care providers, and mental health providers is very important in psychoeducation about the benefits of early evaluation and treatment of mental illness in Latino communities. Referrals to support groups where the family can connect with and get encouragement and information from others who experience similar stressors are very helpful in lessening the feelings of being an outcast.

- **Medication treatment heightens the stigma of mental illness among Latinos:**

Latinos tend to express preference for psychotherapeutic treatments, “talking cures,” for mental illness and are reluctant to take psychiatric medications. A significant concern about psychiatric medications is that they are incorrectly perceived as addictive. At the same time, many Latinos resist prescriptions because they feel others will view their illness as very severe and see them as *loco* if they need medications to control their symptoms and behavior. In addition, there is a stigma against “drug use” which links psychotropic medication use to illicit drug use. There is a strong feeling that people should be able to control their symptoms on their own, expressed in the phrase *hay que ponerse de su parte* (one has to do one’s part or make an effort to get better). Needing to take medications is seen as a sign of weakness or laziness and indicates that the person is not working hard enough to get well. If the person’s efforts to get better fail, there is a fear that the illness may be incurable and that the person has crossed over into *locura*.

Purpose of the DVD

The goal of *No Soy Loco/I'm Not Crazy: Understanding the Stigma of Mental Illness in Latinos*, is to demonstrate how Latino patients present their stigma of mental illness, and how skilled therapists manage it. The DVD is comprised of three vignettes of simulated Latino patients:

- A young man with schizophrenia
- A grandmother with bipolar disorder, whose son does not think she is well enough to care for her granddaughter
- A young woman who has been molested by her mother's boyfriend and previously misdiagnosed as having schizophrenia.

The vignettes are based on cases developed by the clinicians who appear in the DVD. The patients are actors; but the case material comes from real patients with whom the clinicians have worked. The cases have been altered to protect the identities of the patients involved.

Potential Uses and Target Audience:

No Soy Loco I'm Not Crazy: Understanding the Stigma of Mental Illness in Latinos originally was conceptualized as a continuing education program for physicians and others needing to meet continuing education requirements in cultural competence, especially those in mental health and primary care. There are many audiences for this DVD. They include psychiatry residents, medical students, social work students and practicing social workers, clinical and counseling psychologists, nurses and others working in the health care field, broadly defined. With appropriate facilitation, some of the vignettes also might be used to educate lay people. For example, the vignette about Carmen could be used, especially with adolescents, to raise awareness of sexual abuse by predators residing in the same household with the victim,

Learning Objectives

The overall learning objectives for *No Soy Loco/I'm Not Crazy: Understanding the Stigma of Mental Illness in Latinos* are:

1. To demonstrate how the stigma of mental illness in Latinos manifests in the individual, family, and community.
2. To demonstrate how therapists can empathize with the perspectives of mentally ill individuals and their families: the idioms of distress that individuals and families use to describe their illness; the impact of symptoms on family members' lives; and the diverse explanatory models and treatment pathways that individuals and families may use that may be different from those known to mental health providers.

3. To show how the mental health professional can work in partnership with individuals and families to negotiate and implement a treatment plan that is acceptable.

Several themes resonate through the three vignettes in this DVD. One is the meaning of severe mental illness in the Latino community and the culturally competent assessment of phenomena consistent with psychotic symptoms. Related to this is the stigma of psychosis leading to the cultural desire to avoid that label at all cost through the use of the idiom of distress of *Nervios*, which emerges as an alternative term that can be used by both family and clinician as a euphemism for psychosis and schizophrenia. Family relationships and the role of the family as caregiver and protector of vulnerable people are central issues in Latino culture and in these three cases. The role of religion both as a strong social support system for individuals and families with mental illness and as a source of distorted ideas for those with mental illness is an additional important theme in these cases.

While watching the vignettes, viewers should:

- Carefully observe how the clinician works with the socio-cultural issues embedded in each story.
- Pay particular attention to how the stigma of mental illness is managed as part of an overall culturally competent approach to assessment and treatment.

Vignette #1 Diego

Overview of the Case

Diego is an 18-year old Latino male who struggles to bring together the Latino and American aspects of his cultural identity. . Born in San Francisco, he is bilingual in English and Spanish. He is tightly linked to his extended family, particularly his mother's family who are from Nicaragua. His father's family was originally from Cuba. Diego's ethnic identity and acculturation as a second generation person help us to understand his cultural identity more completely. . Diego grew up and still lives in the Mission District of San Francisco, a large Latino barrio, or ethnic enclave, of the type found in many large U.S. cities.

Diego has had considerable experience with schizophrenia; his brother, who is 20 years older, has been explicitly diagnosed with schizophrenia and spent time in a state mental hospital. . Family members suspect that Diego's mother also suffers from schizophrenia. . Her first husband left the family in the care of his mother's parents because of her "bizarre symptoms" and disappeared. . Following the deaths of his grandparents Diego, his mother and his brother moved in with an aunt with whom they now live. .Both Diego and his relatives are torn between seeing his problems as related to mental illness or alcohol use or both.

Discussion Points

Diego's vignette illustrates the stigma of mental illness and taking psychiatric medications. It also highlights how extended Latino families maintain people in the community, even when they are quite ill. Both the stigma of mental illness and lack of knowledge about mental illness and its treatment prevent Latinos and their families from seeking help until symptoms become very serious.

The vignette also illustrates the importance of religion to Latino families. Diego's mother sees his attendance at church assemblies as having a calming effect on Diego. The clinician skillfully uses the hospital's pastoral counselor to meet with Diego.

Among Latino families, several family members may play key roles in caretaking.. In Diego's case, the clinician works with his mother and his aunt to enlist their help in medication adherence. The clinician also listens to Diego's aunt about his living situation and then negotiates a change with Diego's mother.

Cultural Formulation

Cultural Identity: Diego is a 19 year old second generation Latino male, who was born in San Francisco and lives in the Mission district. His father is Cuban and his mother is Nicaraguan. He is bilingual in Spanish and English and part of a large extended family. Diego is quite religious and his family is active in a church, which they attend twice a week. Diego's identity is tied to his family and the church.

Illness Expressions and Explanations of Illness: There is a wide divergence of opinion in the family about the nature of Diego's illness. There is a strong history of schizophrenia

in the family. Diego sees his problems as stemming from contamination with his mother's illness, an idea shared by his aunt who specifically wonders if he could have inherited schizophrenia from his mother. Diego also believes his mother took LSD while she was pregnant with him.. Secondary reports indicate that other family members see Diego's problems as possibly related to alcohol use.

His mother's symptom onset coincided with her husband, Diego's father, abandoning her and this may have contributed to the family's understanding and stigma with regard to mental illness. One culturally influenced explanatory model that the family uses to understand the decline in Jacinta's functioning, the voices and paranoia she had, is that because of an abusive relationship, she may have suffered a *susto*, or a severe fright, this has had persistent effects on her wellbeing. Diego initially explains some of his symptoms in terms of beliefs of being controlled by hostile external forces. During this same time when still fairly symptomatic he describes his symptoms being caused by someone giving his mother LSD when she was pregnant. After treatment for psychotic symptoms his explanatory model is that he was abandoning the family and was spending too much time with friends on the street drinking on the weekends. His aunt who is not a biological relative, being married to his mother Jacinta's brother, and being medically trained as a nurse, has a biological model that Diego and his brother Hector have a 'chemical imbalance' and sees medication adherence as the most critical part of treatment. She may not share the same stigma the family does around his mother's decline in function as there might be a fear in the family of stigma related to an inherited mental illness.

Cultural Factors related to Psychosocial Environment and Level of Functioning: Diego's mother and brother both suffer from serious mental illness. His mother receives disability payments and his brother has been diagnosed with schizophrenia and spent time in a state hospital.. Diego has a few friends who visited him in the hospital, but they are now away serving in the Peace Corps. Denial, shame and apprehension regarding family mental illness affect all of the family. Diego has a large family network. He and his mother see the role of the church as supportive and central in the family. A strong bond between a Latina mother and her son is not uncommon. Having grown up in a family without a father this may have been intensified, and he may have taken on a parentified role with his mother. In this context he served as a protector of his mother and brother who have suffered from symptoms of mental illness. He may fear a loss of this role with the onset of his symptoms and a fear of suffering from a similar disability to that of his brother. One could wonder about whether his brother's returning home from the state hospital was a stressful adjustment to his and his mother's relationship. His ethnic identity has been of a young Latino male in a predominantly Latino neighborhood of San Francisco. He describes that he has spent some time with his peer group drinking on the weekends and that he feels guilty with regard to his religious beliefs and his role within his family. Of note the police who brought him in felt that he was a well-known gang member in the neighborhood, but collateral from his family does not confirm this. This mischaracterization could influence treatment providers who are assessing his symptoms, engagement and prognosis. Although he lives in an extended family, including his Aunt Luz, he identifies more with his mother as a source of support, and she expresses this in part by guiding him in engaging in the church.

Cultural Elements of the Relationship between the Individual and Clinician: Diego and his mother are at first suspicious of the role of the psychiatrist as someone who is preventing his return home to the family. Their prior encounters with psychiatrists or physicians is not known, nor what their relationship was like when his older brother Hector was admitted to the hospital

Because the clinician was Latino and bilingual, he was able to communicate with Diego's mother in both Spanish and English. Both the clinician and patient were aware of his mother's mental illness, but Diego cautioned the clinician not to use the word 'schizophrenia' around his mother. This reflected differing family roles and the denial and stigma a diagnosis of schizophrenia carries. The clinician was willing and able to frame Diego's use of medications as helping his nervousness rather than controlling his psychotic symptoms.

Overall assessment: It was helpful for Diego to have a bilingual/bicultural clinician who could understand his experiences. The clinician worked with his strong bond with his family to create an alliance on treatment goals, particularly getting Diego to accept medications. He also used family members, particularly Aunt Luz, to gather information that was helpful in validating the diagnosis and formulating a treatment plan. He framed his taking his medications in terms of helping his family and controlling his nervousness. Psychoeducation would be valuable for all family members. The clinician worked with Diego's mother to be active and enlisted her help in explaining the need for Diego to take his medications. The clinician also worked with Diego regarding the stigma he felt about his brother's illness.

Diego and his mother view the importance of being able to engage in the family and religious life as the most important goal of treatment planning. Diego also is fearful of not being able to look for work in the future, which may have to do with his desire to help provide for his family. After the hospital stay Diego was able to engage his brother in a way that perhaps was quite different with his brother encouraging him to take his medications and this may have been more empowering for his brother. Offering him pastoral counseling, and using his brother's experience with medications to help alleviate the concerns about psychiatric treatment, as well as engaging Diego's mother in his treatment planning was an outcome of assessing the family structure and the cultural assessment of Diego's presentation.

Vignette #2 Mrs. Pedroso

Overview of the Case

Mrs. Pedroso is a 62 year old Cuban woman with bipolar disorder who has fantasies of being in love with her priest. She often has difficulty in the community and at church because she blesses strangers in the street as she passes them, gets into fights with people and interferes during church services. She believes she has special powers. These psychotic symptoms were episodic and only in the context of hypomania. She has been hospitalized several times for her symptoms. Mrs. Pedroso also has hypertension and diabetes, which are not well controlled because she refuses to see her PCP whom she accuses episodically of trying to poison her.

Mrs. Pedroso has minimal insight into her mental illness but she definitely perceives stigma associated with it because people shun her and sometimes call her the “crazy old lady”.

In this vignette, she is brought to the psychiatrist by her son who has threatened to have her re-hospitalized because of her behavior.

Discussion points:

The first key issue we see in this case is the power of the labels of *loco* and *locura* in the Latino community. Nothing can be more stigmatizing than these labels.

Mrs. Pedroso’s case illustrates the stigmatizing meanings of the category of *locura* and how *nervios* is contrasted with *locura* to make the individual’s experiences more normal.. This case also highlights the extent to which religious ideas and meanings shape mental illness problems for Latinos. The issue of being socially “out of control” is highlighted in this case. An elderly Latina is expected to behave with great decorum; her behavior clearly marks her in the community as someone with mental health symptoms.

Cultural Formulation:

Cultural Identity: Mrs. Pedroso is a 62 year old Cuban woman. She is very involved with her religion.

Cultural Expressions and Explanations of Illness: Mrs. Pedroso describes her problems as *nervios*, which she has had for a long time and which gets worse when she is under a lot of stress. Her son and others think she is suffering from *locura*, which is very insulting to her. Mrs. Pedroso’s preference for a treatment pathway that includes “natural remedies” as opposed to medications is quite widespread. Patients and families often consider psychiatric medications as too strong and dangerous if taken for too long; natural remedies are seen as gentler on the body. Psychiatric medications are particularly suspect because they are thought to be addictive and sometimes more like street drugs such as heroin and cocaine than other medications for physical illnesses. Dr. Resendez uses this cultural knowledge to reframe her medications as helping to

calm the patient's nervios. The clinician uses Mrs. Pedroso's cultural idiom. She also recognizes that this reframing may make the medications less upsetting to Mrs. Pedroso.

Cultural Factors related to Psychosocial Environment and Level of Functioning: Mrs. Pedroso's son is clearly involved with caring for his mother. At the same time, he becomes exasperated with her behavior. This is likely due in part to the public nature of her behavior in church and other places. Because of his acculturation to U.S. culture he does not expect to be as responsible for her as he would be if they were still in Cuba. While church often is a source of support for older Latinas, Mrs. Pedroso's behavior toward other members of her church and her infatuation with her priest make it less supportive.

Mrs. Pedroso highly values her role as caretaker for her granddaughter. One of the most upsetting and stigmatizing aspects of her illness is that her son will not let her take care of her granddaughter unless her mental disorder is under control

Cultural Elements of the Relationship between the Individual and Clinician: The provider in this case makes an important intervention by reframing Mrs. Pedroso's psychiatric medications as helping her with her nervios, rather than treating her locura. The clinician also supports Mrs. Pedroso's use of natural remedies, along with her psychiatric medications. and suggests that her patient also take her medications for hypertension and diabetes. She tries to reassure her patient that her PCP is not trying to poison her.

Overall assessment: Religious issues are very prominent in this case. Mrs. Pedroso's involvement with her church builds on culturally meaningful relationships, but they are taken to extremes that make them inappropriate here. Closeness and a confiding relationship with the priest are important, especially to older Latinas who may attend church regularly. However, feeling that your priest is in love with you is highly inappropriate and a sign of Mrs. Pedroso's mental disorder. Similarly blessing people is quite common in Latino culture. For example, when someone leaves the house it is normal to say *Que Dios te bendiga* (May God bless you). However it is not normative to approach strangers on the street to bless them.

This vignette illustrates the value of having a bilingual/bicultural clinician. The clinician is able to reframe the patient's illness using language and idioms that make the illness more acceptable. She skillfully suggests that the patient meet with her case manager and incorporates her into the treatment plan. She makes a strong effort to keep the patient's son engaged in the treatment process and offers the patient hope that if she adheres to the treatment regimen she may be able to take care of her granddaughter again.

Vignette # 3: Carmen and her Family

Overview of the Case:

Carmen is a 19 year old Mexican American female who was brought to the psychiatric emergency service of a public hospital by her family who said she was acting in a "bizarre manner...she was not sleeping and was walking on all fours in her room, barking like a dog when we said anything". The patient was placed on an involuntary commitment and admitted for a psychiatric evaluation.

Carmen had been diagnosed with schizophrenia at age 16, when she was hospitalized for the first time. She had had another brief hospitalization at age 18. The presentations for both hospitalizations had been "bizarre behavior" at home, getting into arguments with her mother and older sister, and smoking a "lot of pot" just before each hospitalization. She had taken psychiatric medication only for a few weeks after each hospitalization, and had functioned well, working on her GED and having a part time job at a local fast food restaurant. The patient was not on medication at the time of admission.

Carmen lived with her single mother, a dispatcher for a local furniture delivery, and a sister who was 3 years older. She had had very little interaction with her father since her parents divorced when she was 6 years old, but she apparently had been "devastated" by the divorce. The mother had taken up with a boyfriend when the patient was 10, and at age 12 the patient had accused the boyfriend of fondling her. This had been reported to the counselor at school who had made a Child Protective Services report and after an investigation, the boyfriend was told he could not live on the premises with the patient. The mother continued seeing the boyfriend though he did not live with them.

The patient was a healthy appearing 19 year old, though the way she dressed (casually and androgenously, with a red stocking cap she never took off) and the way she handled her body, with a certain awkwardness, hunched over, gave the impression of someone younger, who had grown tall before getting comfortable with her body. She initially presented as electively mute and in the first interview cried silently for about 20 minutes before answering any questions. The initial focus of the clinician's attention was trying to elicit any stressors that may have precipitated her decompensation and focus on "how are things at home" and "what's going on for you right now?" After a while she was able to say she lived with her sister and mother and they had been having "problems." She said her mother was pushing for her boyfriend to move back in, and she (the patient) had been saying she did not want him to. She then told the story of his previous abuse, the Child Protective Services involvement and the mother's continued disbelief. All this was told in a very tearful and bit by bit way, but she remained coherent and organized, and did not engage in any bizarre behaviors. She received no medications. A family meeting was proposed to "talk about these things in the open" and she agreed, anxiously. The family meeting was scheduled for several days later.

Discussion

In this family, which has a high level of acculturation, the stigma of the diagnosis of a mental disorder competes with the stigma of accepting a disclosure of sexual abuse, even when an investigation has ruled abuse likely. In the case of Maria, Carmen and Araceli's mother, the failure of her culturally prescribed role of protector of her daughters is another stigma, which seems to take priority over that of the mental disorder. The issue of sexual abuse comes up frequently in work with Latinas and their families. The risk for sexual abuse is greatly heightened by many of the changes wrought by migration. As we see in this family, the breakup of families is one key factor. The loss of a father, whose traditional cultural role is to protect the family's honor and to protect women in the family from other men, can have a negative impact. While the role of men in Latino culture – the role of the macho as provider and protector of the family as opposed to the stereotypical image of machismo – can be quite positive, there are also negative dimensions. An important source of protection is the broader social network. In their home countries, families often live nearby and monitor the safety of children generally and girls particularly. However, extended family often is lost in the migration process and cannot serve that protective role. Sexual abuse is viewed very negatively in Latino cultures and its rise in the U.S. is not a result of changing cultural values, but rather the breakdown of cultural supports and protections.

Cultural Formulation

Cultural Identity: This is a Mexican American family that has been in the U.S. for some time. The family has a relatively high level of acculturation; the mother had several years of college and had previously worked in a clerical capacity in a health care environment. Both daughters were born in the U.S. The divorce and lack of connection of the father represents a break in family ideals among Mexican American families.

Illness Expressions and Explanations of Illness: From Carmen's perspective, her illness was due to the stress of the conflict with her mother, on whom she was still dependent. Had the mother supported Carmen in pursuing therapy at age 16, it might have made it easier for the patient to be more direct in her communication with her mother as a young adult. While mental health professionals had previously diagnosed Carmen as having schizophrenia, her mother saw her as argumentative and disrespectful and engaging in bizarre behavior at times..

Cultural Factors related to Psychosocial Environment and Level of Functioning: Being raised by a single mother poses particular stresses for these young women. One challenge for Carmen and her sister was coping with the dating life of their young mother at the same time as they were going through their own sexual development. At the same time, their mother experienced cultural and personal conflict as a result of being unable to protect her daughters, and having used poor judgment in her choice of sexual partner.

Cultural Elements of the Relationship between Individual and Clinician: The positive attachment of the patient to the therapist, who was about the age of her mother and also Latina, speaks well for her hope that her own mother can step into the role of

protector again. It is also possible that seeing the therapist as someone powerful who could “speak truth” to her mother without harming or shaming her was a key therapeutic intervention.

Overall assessment: In this family with a high level of acculturation, the stigma of the diagnosis of a mental disorder competes with the stigma of accepting a disclosure of sexual abuse, even when an investigation has ruled such abuse likely. In this case the stigma of schizophrenia led the family to minimize the seriousness of the diagnosis and not be invested in follow up care. Once the abuse is accepted, the family is able to begin the process of coping with Carmen’s problems and seeing the real nature of her behavior. We must also consider that in a young woman with two hospitalizations, both preceded by inner turmoil and marijuana use, with an antecedent of sexual abuse, the differential diagnosis includes PTSD, adjustment disorder with disturbance of conduct and emotions, brief psychotic disorder or substance induced psychosis.

The stigma of mental illness in this case led the family to minimize the seriousness of the first hospitalization and not be invested in follow-up. Another unconscious contributor may have been the mother’s fear of having to deal with the accusations about the boyfriend again. The older sister’s firm assertion backing up her sister finally cracked the mother’s denial about her boyfriend’s behavior. Carmen was discharged from the hospital to the care of a clinic that offered family therapy along with the individual therapy. She was not taking any medications at the time of her diagnosis. The diagnosis of schizophrenia was revised.

Helpful Hints for Facilitators

The most important task of a facilitator is to maximize the learning experience for members of the group. With a DVD of this type, the facilitator's role will vary from coordinating the activity and moderating the discussion to running a structured didactic session. Whatever method and style is used, questions are included with each vignette that can be used to frame the discussion and maximize the learning experience. Their use is not required although we feel that they will help to enhance the learning experience.

Unless it has been covered elsewhere, the facilitator should talk a little bit about aspects of Latino culture to prevent stereotyping prior to viewing the DVD. Each vignette is introduced by the narrator, Peter. Guarnaccia, who points out some of the issues that viewers should look for as they watch the DVD. Facilitators should feel free to add to this list as they see fit. After each vignette has concluded, the facilitator should open the discussion with a lead question and then continue with other questions making certain to give everyone who wants to speak the opportunity to do so. At the conclusion of the discussion, the facilitator should reiterate the key points and briefly summarize the discussion as well as play Dr. Guarnaccia's brief concluding commentary.

The amount of time for discussion after playing each of the three vignettes may vary depending on how much time is available for teaching. For cross-cultural courses, if there is available time, case-based material could be introduced for further exploration of both the concepts and the cultures. This material can come from many sources ranging from patient vignettes of the learners and faculty to published cases illustrating the use of the DSM-IV-TR Outline for Cultural Formulation.

DSM-IV TR Outline for Cultural Formulation

The Surgeon General's report, *Mental Health: Culture, Race and Ethnicity* documented widespread mental health disparities for racial and ethnic minority groups and challenged the mental health professions to reduce those disparities through culturally competent clinical care, training, and research. The DSM-IV-TR Outline for Cultural Formulation (OCF) provides "a systematic method of considering and incorporating socio-cultural issues into the clinical formulation" (Lu, 2006). It is a comprehensive and inclusive diagnostic tool for the assessment and treatment of mind/body illness across cultural boundaries and diagnostic categories. It provides a structured methodology for teaching cultural competence and diversity skills to professionals across disciplines that include, but are not limited to, medicine, psychiatry, psychology, social work, and nursing. Despite understandable gaps in a clinician's knowledge about and exposure to diverse cultural groups, the OCF provides a multidimensional process to *contextualize* individual expressions of suffering (idioms of distress) and thus avoid misdiagnosing

culturally sanctioned behaviors as psychopathological symptoms (i.e., differential diagnosis) as well as help with the treatment plan.

The five components of the OCF are:

A. Cultural identity of the individual – This includes the individual's ethnic or cultural reference groups. For immigrants and ethnic minorities, note separately the degree of involvement with both the culture of origin and the host culture (where applicable). Also note language abilities, use and preferences (include multilingualism).

B. Cultural explanations of the individual's illness - The following may be identified: the predominant idioms of distress through which symptoms of the need for social support is communicated (e.g., “nerves”, possessing spirits. Somatic complaints, inexplicable misfortune), the meaning and perceived severity of the individual symptoms in relation to the norms of the cultural reference group, any local illness category used by the individual's family and community to identify the condition (see “Glossary of Culture-bound Syndromes...”).

C. Cultural factors related to psychosocial environment and levels of functioning- Note culturally relevant interpretations of social stressors, available social supports, and levels of functioning and disability. This would include stresses in the local social environment and the role of religion and kin networks in providing emotional, instrumental, and informational support.

D. Cultural elements of the relationship between the individual and the clinician - Indicate differences in culture and social status between the individual and the clinician and problems that these differences may cause in diagnosis and treatment (e.g., difficulty in communicating in the individual's first language, in eliciting symptoms or understanding their cultural significance, in negotiating an appropriate relationship or level of intimacy, in determining whether a behavior is normative or pathological).

E. Overall cultural assessment for differential diagnosis and treatment planning- The formulation concludes with a discussion of how cultural considerations specifically influence comprehensive diagnosis and care.

Facilitators can learn more about the OCF from the references provided below. In addition questions to stimulate discussion follow this discussion...

Published cases can be found in the journal *Culture, Medicine, and Psychiatry*; the book *Cultural Assessment in Clinical Psychiatry*, authored by the Group for the Advancement of Psychiatry and published in 2002 by the American Psychiatric Press, Inc (APPI).; and the book, *Clinical Manual of Cultural Psychiatry*, edited by Russell Lim and published by

(APPI) in 2006. The DVD *The Culture of Emotions* is a 58-minute program about the OCF with 23 multicultural experts commenting on it; it is distributed by Fanlight Productions and described at www.fanlight.com.

SUGGESTED DISCUSSION QUESTIONS

A. Cultural Identity

1. What are the cultural identity variables that patients may use to self-identify?
2. Within each cultural identity variable, such as ethnicity, to what extent does the term encompass homogeneous vs. heterogeneous phenomena?
3. How does the clinician come to know the individual's cultural identity? To what extent does this require discussion with the individual vs. simply observing the person?
4. How do the several cultural identity variables relate to one another to form more complex forms of cultural identity? For example, what is the degree of involvement with the culture of origin and the host culture?
5. Do Caucasians have a cultural identity?
6. What is the cultural identity of each viewer in the audience?
7. What is the importance and significance of understanding the individual's cultural identity? How might it help the clinician with understanding the other sections of the Outline?

B. Cultural Explanations of Illness

1. What are the idioms of distress that the patient presents?
2. How can it be determined if a particular phenomenon is related to the individual's culture vs. the individual's psychopathology?
3. When should a cultural consultation be requested?
4. How can stigma of mental illness affect the reporting of symptoms?
5. What are the Culture-Bound Syndromes discussed? Have viewers come across any in their work?

6. What explanations of illness are discussed in the program?
7. What treatment pathways are discussed in the program?
8. What is the significance of understanding the topics in this section? What difference might it make in the differential diagnosis and treatment planning?

C. Cultural Factors Related to the Psychosocial Environment and Levels of Functioning

1. What are the cultural stressors seen in this section of the program? How might they affect the onset and course of illness?
2. What are the cultural supports seen in this section of the program? How might they affect the onset and course of illness?
3. What supports/stressors are primarily intrapsychic vs. interpersonal vs. environmental?
4. How would the viewer assess the individual's religion/spirituality?
5. How would the viewer assess the individual's family/kin network?

D. Cultural Elements of the Relationship Between the Individual and the Clinician

1. How important is it to understand the clinician's own cultural identity?
2. What are the similarities in the cultural identity variables between the patient and clinician? What are the differences?
3. How is relationship (rapport, communication, transference, counter-transference, etc.) affected by similarities in the cultural identity variables between the patient and clinician? By the differences between them?
3. What transference phenomena influenced by culture have viewers experienced?
4. What counter-transference phenomena influenced by culture have viewers experienced?

E. Overall Cultural Assessment for Diagnosis and Care

1. Discuss how understanding of the four areas above aids in the process of constructing a differential diagnosis that incorporates cultural issues?
2. How can the clinician utilize the “Age, Gender and Cultural Features” sections of the narrative sections of the diagnostic categories in aiding the process of differential diagnosis?
3. How can the clinician utilize the “Other Conditions that May be a Focus of Clinical Attention” in aiding the process of differential diagnosis that include cultural issues?
4. What biological aspects of treatment planning are affected by cultural issues?
5. What psychological aspects of treatment planning are affected by cultural issues?
6. What sociocultural interventions may be useful for individuals and their families?
7. What religious and spiritual interventions may be useful for individuals and their families?

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