WHEN CULTURE IS CONSIDERED IN THE EVALUATION AND TREATMENT OF HISPANIC PATIENTS

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The purpose of this study is to identify a) when mental health practitioners consider cultural factors in their clinical practice with Hispanic patients and b) how practitioners know that certain problems and/or symptoms require cultural considerations.

Evaluations of thirty-five Hispanic patients by mental health clinicians were examined. Although therapists acknowledged considering cultural factors, it is not clear how they knew the problems or symptoms were cultural in nature. The possibility that clinicians may inappropriately apply different norms to their clinical work with Hispanic patients is considered.

Many authors have encouraged mental health clinicians to take culture into account when evaluating and treating Hispanic patients (e.g., Cuellar & Roberts, 1984; Levine & Padilla, 1980; Ruiz & Langrod, 1982). Culture refers to the shared beliefs, values, and practices of a given group of individuals usually from similar racial, ethnic, national, or religious backgrounds. If clinicians fail to consider these beliefs and customs, it is argued that patients will likely be misdiagnosed and given improper treatment.

Previous investigators have identified several symptoms or presenting problems that require particular consideration of cultural factors. Probably the most frequently cited symptom patterns are the folk disorders or symptom clusters believed to be caused by natural and/or supernatural factors (Comas-Díaz, 1981; Dominguez-Ybarra & Garrison, 1977). “Susto,” for example, is a folk illness characterized by depression, loss of appetite, decreased interest in personal hygiene, and restless sleep (Rubel, 1964). Psychotic symptoms, especially hallucinations, are other symptoms that have been noted to be significantly influenced by the Hispanic culture. Torrey (1972) suggests that hearing voices of a spiritual nature may represent a normative experience for some Mexican Americans due to their generally strong religious background. The presentation of somatic complaints as an expression of psychological distress (somatization) is a third symptom pattern thought to be culturally based. Madsen (1964) observed that Mexican Americans are likely to express their anxieties in the form of physical symptoms. Other investigators have also noted that Mexican-American mental health patients oftentimes present physical health concerns (Acosta, 1977; Fabrega et al., 1967; Ramirez-Boulette, 1975; Stoker et al., 1969; Yamamato & Acosta, 1982).

Although there seems to be a general consensus in the literature for clinicians to consider culture, there are no studies to indicate that mental health practitioners actually do so in evaluating Hispanic patients. At this time there are only case reports which point out that at least the authors considered cultural factors. For example, Cuellar et al. (1983) described a patient who was initially diagnosed as having schizophrenia. After considering linguistic and cultural factors they reported that a major affective disorder better fit the patient’s clinical picture. Of particular importance in this case was the clinicians’ interpretation of “marked regression and posturing.” Instead of interpreting these symptoms as representing catatonia, they interpreted them as representing somatization. The
(authors argued that such symptoms often accompany depressive disorders, particularly among rural low-income Mexican-American patients. (For other case reports see Comas-Diaz, 1981; Levine & Padilla, 1980; Smirnow & Bruhn, 1984.)

Case reports are helpful in that they point out the problems, symptoms, and/or disorders that particular therapists thought worthy of consideration of cultural factors in the evaluation and treatment of Hispanic mental health patients. They are limited, however, because they pertain only to the specific cases under study. As a result, our understanding of when clinicians consider culture is restricted to the presenting problems of these patients and the clinical judgments of their therapists. The extent to which other clinicians may consider the same cultural factors given the same problems is unclear.

In a recent study, López & Hernandez (1986) surveyed the extent to which licensed mental health clinicians in the state of California considered cultural factors in the evaluation of culturally diverse patients. Overall, the 118 respondents reported that they take culture into account for most of their culturally different patients. In addition, they supported the view that cultural factors influence the expression of psychopathology for some disorders. Respondents were also asked to describe a case for which they considered cultural factors in an evaluation, paying particular attention to how they knew cultural considerations were necessary. Thirty-five of the clients were identified as Hispanics, the racial/ethnic group with the largest number of cases. Although limited, this is the first evidence to suggest that taking into account cultural factors for Hispanic patients goes beyond isolated therapists with isolated cases.

The purpose of this article is to examine closely the Hispanic case descriptions to see if the clinicians’ report of their consideration of culture pertains to any specific groups of presenting problems, symptoms, or disorders. Of particular interest is the opportunity to compare the groups of problems that these therapists identified as requiring cultural consideration and the groups of problems that the literature has identified as requiring cultural consideration. Edited case illustrations representing each of the groups of problems will also be presented.

The second purpose is to examine how clinicians discover that a behavior, symptom, or disorder is culturally based. Although there appears to be a general consensus that practitioners should consider culture, the literature provides little guidance as to when therapists should and should not take culture into account. The literature appears to suggest that given the patient’s Hispanic background, as identified by mother tongue, skin pigmentation, or other characteristic, a clinician should expect particular cultural differences in the type of presenting problems (e.g., folk disorders) and the way in which psychological distress is expressed (e.g., somatization). Considering the great heterogeneity among Hispanics, it is likely that cultural factors should be taken into account for some Hispanics and not for others. There may be persons who identify themselves as Hispanic, but who do not adhere to Hispanic cultural mores. The application of different norms for such people would be inappropriate.

It would be of interest to know if mental health practitioners use other variables besides ethnic variables in considering culturally different norms. If clinicians apply culturally different norms on the basis of only the patient’s surname or ethnic identification, then they may be at risk to misapply such norms. If practitioners apply culturally distinct norms given a proper assessment of the patient’s beliefs and values, then they may be more likely to appropriately apply these norms. In order to assess what information was used in deciding to take cultural factors into account, the Hispanic case reports were coded according to whether or not the clinician noted how he or she knew the problem was culturally based.

**Methods**

**Respondents**

One hundred eighteen clinicians responded to the larger survey resulting in a 40.8% response rate. Of these respondents, 96 presented brief case summaries; 35 were Hispanic patients. The practitioners were from the three major mental health disciplines: 17 were MSW social workers, 12 were PhD psychologists, and 6 were psychiatrists. All were licensed in their respective fields. In terms of gender and ethnicity, 15 were females and 20 were males; 34 were considered Anglo-American while one was Mexican-American. As a group, these clinicians are quite experienced, having 15.9 years of postgraduate experience, and they are very much involved in clinical work, spending 72.5% of their professional time on clinical activities. In addition, more therapists reported seeing adults (n = 20) than both adults and children...
(n = 12) and children (n = 3).

Ethnic Descriptions of Hispanic Cases

Table 1 lists the ethnic descriptors used by the respondents in describing their cases. The majority of clients were identified as being of Mexican origin (Mexican, Mexican American, or Chicano). A generic label, Hispanic or Latino, was used for the second-largest group of patients. And for the remaining few cases, the specific United States territory or Latin American country of origin was noted.

Procedures

Three hundred mental health professionals practicing in California were randomly selected from the national directories of the three major professions: psychiatry (American Psychiatric Association, 1980), psychology (Council for the National Register of Health Service Providers in Psychology, 1980), and social work (National Association of Social Workers, 1976). One hundred professionals were chosen from each directory. The identified clinicians were mailed a two-page questionnaire with a stamped return envelope and a cover letter. The letter described the purpose of the survey as a) assessing the extent to which therapists consider cultural factors and b) qualitatively examining the process by which therapists may consider cultural factors.

The questionnaire contained three parts which respectively assessed a) clinicians’ attitudes toward culture in general, b) how they report taking culture into account, and c) clinicians’ personal and professional background. This report examines data from the latter two sections. To assess clinicians’ consideration of culture, respondents were instructed to a) describe a time when they took into account culture while evaluating and/or diagnosing a culturally diverse patient paying particular attention to how culture was taken into account, and b) to consider whether their evaluation or diagnosis would have been the same or different had they not considered culture. No definition of culture was provided in order that the respondent’s own perception and definition of culture could be examined. The personal and professional background section of the questionnaire requested information such as gender, ethnic origin, professional background, years of clinical experience, and licensure status. Following this, space was provided for them to comment about the study and to indicate whether they wanted a summary of the findings. Those who requested a summary were mailed one.

Eleven questionnaires were returned to the investigators because the potential respondent had moved and left no forwarding address. The response rate, therefore, was calculated in relation to 289 rather than 300 possible respondents. (See López & Hernandez, 1986, for a more detailed description of the procedures.)

Coding the Case Descriptions

After examining all the Hispanic cases, both authors developed categories of problems that pertained to more than one case. The following seven categories were developed: 1) marital/couple; 2) psychotic symptomatology; 3) nonpsychotic symptomatology of male adolescents; 4) family issues regarding hospitalization; 5) drinking problem; 6) marital and drinking problem; and 7) other. Both authors then rated each of the Hispanic cases according to the problem type best representing the case description. Given that this coding was used for descriptive purposes as opposed to testing specific hypotheses, any biases on the part of the authors were thought to have little effect on the ratings.

Results

Problem Types

For the ratings on the type of presenting problems, 86% interrater agreement (30 to 35 cases) was obtained. A kappa correlation coefficient which takes chance into account (Fleiss, 1981) was also calculated and found to be .82, indicating considerable agreement between the two raters. For the five discrepant ratings, the two raters discussed each of these ratings further and chose the rating most agreeable to both raters. Marital/couple problems were the most frequently mentioned problems (n = 15) among the
case descriptions. For three of the cases, there was a concomitant drinking problem. Examples of both types of cases are described below.

Marital/Couple Conflict with No Drinking Problem. Recently I saw a Hispanic couple in their mid 40s, who presented with marital difficulties. The wife wanted her husband to "try harder to understand" her feelings. He was dominant and she was submissive, but she explained that she was raised to take such a position in the marriage and that she was not complaining about this. He, on the other hand, was quiet and relatively nondisclosing, but it became apparent (and later confirmed by his wife) that he was raised to not reveal family or personal problems to anyone outside the family. If I had not considered culture I might have seen her as passive, or passive-dependent, and I might have seen him as perhaps passive-aggressive or maybe even paranoid.

Marital/Couple Conflict with Drinking Problem. A Mexican American woman is unhappy about husband's alcoholism. Nevertheless, she accepts his drinking in family and social situations, his absences from home, and their limited income. She is overly tolerant and accepting as compared to an Anglo. She expresses less anger and is aware of fewer options. If cultural factors had not been considered, the basic evaluation would have remained the same; however, the amount and kind of support provided would have probably been different.

The second most frequent type of presenting problem pertained to psychotic symptomatology. Six case reports referred to this type of problem. As evident in the example below, clinicians were generally concerned about differentiating between what was cultural and what was psychotic in nature.

A 15-year-old Mexican-American girl presented rather dramatic symptoms of depersonalization, social withdrawal, and questionable auditory hallucinations following some sexual experimentation with her boyfriend. Her parents were immigrants from rural Mexico with strict controls over their children's behavior. I believed that the cultural and familial background provided some rationale for understanding the symptoms as being less pathological than would otherwise have been the case. This assessment was borne out in the treatment (i.e., the young lady proved not to be suffering from a serious psychotic disorder). The patient upon presentation might have been evaluated as bordering on a psychotic break. In fact, both she and her family thought that she was "going crazy." Had cultural factors not been considered, both the evaluation and the treatment would have been different.

Nonpsychotic symptoms of male adolescents comprised the third most frequent problem type ($n = 4$). These problems were presented in the context of distinguishing between character disorders and culturally normative behavior of "streetwise" male adolescents.

With regard to a client from a Latino culture, my evaluation would necessarily need to include my sense of what kinds of framing occurred around specific experiences. The specific issue was a teenager in the family who was aggressive and domineering with peers, who needed to learn how to moderate his social interactions and who wanted support and redirection from his family. If cultural factors had not been considered, the aggressive, dominant, acting-out behavior would have been viewed as more pathological and manipulative and less a function of family press and street culture.

The fourth problem type pertained to issues dealing with the hospitalization of a Hispanic patient. These cases focused less on a specific aspect of psychopathology than on treatment-related issues regarding hospitalization. The fact that each of the three cases addressed very similar issues suggested that they deserved a separate category of their own.

A Mexican-American 16-year-old girl was diagnosed as acutely psychotic. Cultural issues for this case included the importance of all family members understanding the treatment, providing Spanish-speaking staff to work with the child who only spoke Spanish when psychotic, providing a clear strong authority figure, and encouraging the family to visit and bring special foods. The child responded well to medication. Her parents worked with us rather than undercutting or prematurely terminating treatment, as has happened with such children in the past.

A drinking problem was evident in five of the case reports; two pertained strictly to a drinking problem and as was already noted three included a drinking problem within the context of marital difficulties. One of the two strictly drinking problem cases follows.

An adult Chicano male, married and father of two children, was an alcoholic. Drinking helped this patient carry out the male role according to his perception of masculine behavior as the male head of household. Had cultural factors not been taken into account, it would have been difficult to understand the significance of his drinking.

The final category of problems, "Other," contained five cases. These included problems in anger control, assessment of intelligence, difficulties in father–daughter relationships, decisions regarding an unwanted pregnancy, and the relationship between a phobia and feelings toward parents.

How Clinicians Assessed Cultural Factors

Of the 35 case reports, only three included some mention of how the clinician knew that the problem was culturally based. The remaining 32 case reports contained no information regarding the rationale for considering cultural issues. Of the three cases which provided a rationale, therapists referred to different sources of information: a) the patient; b) the patient's family; and c) a consultation with a Spanish-speaking therapist. The following case report points out an advantage of consulting other resources in assessing the cul-
tural nature of a presenting problem.

A Mexican-American 16-year-old male was diagnosed as conduct-disordered. His secondary diagnosis was pedophilia. Two major issues for him were rejection by his mother and ambivalence toward females. I referred him to a Spanish-speaking therapist who confirmed the patient's sociopathic traits and deepseated hostility. The patient saw me as a weak female. I probably would have evaluated him to be the same even if I had not considered cultural factors, although I might have attributed more of the hostility to cultural factors without the opinion of the auxiliary therapist.

Discussion

An examination of the types of problems reported by clinicians in their case descriptions of Hispanic patients reveals that there is some agreement between what the sampled therapists and previous authors identify as culturally based problems. Marital/couple problems were most frequently reported as requiring cultural considerations. A theme that was evident in several cases was that of the authoritarian "macho" husband and the submissive wife. Clinicians reported that these marital roles were related to the expression of feelings, to dependency issues for the wife, and to the wife's acceptance of the husband's drinking, extramarital affairs, and even physical abuse. These observations are consistent with the literature indicating that Hispanics adhere to more restricted gender/marital roles than their Anglo counterparts (see Andrade, 1982, and Zinn, 1979, for a critique of this perspective).

Other problem areas identified by therapists that are consistent with the literature include psychotic symptomatology, drinking problems, conduct disorders, and family treatment issues. The present study found only one instance when a therapist considered cultural norms in the identification of auditory hallucinations; however, there were several occasions when therapists considered cultural factors in determining whether the observed behavior was culturally normative or indicative of psychosis. Drinking problems were also noted by five respondents as being culturally based, which is consistent with some research (cf. Madsen, 1964). Conduct disorders and gang-related behavior of male adolescents is another problem area noted by researchers (Erlanger, 1979) and clinicians as being culturally based. Finally, family-related problems in the hospitalization of a family member is most consistent with the literature focusing on the cultural importance of the Hispanic family, both from a clinical (Falicov & Karrer, 1980) and a nonclinical (Ramirez & Arce, 1981) perspective.

Of interest is that folk disorders and somatization, two purportedly prominent culturally related problems, were not at all cited by these practitioners. Some plausible explanations for this finding include: the identified cases did not comprise a random sample of all cases seen by these therapists therefore the reporting of symptoms and/or disorders may have been biased; respondents may not have had the expertise to identify these purportedly culturally based problems; and folk disorders and somatization are not highly prevalent among Hispanics primarily of Mexican origin using mental health services.

In considering the consistency between clinicians' and previous authors' notions of culturally based problems, it is important to indicate that empirical evidence to support the presumed cultural basis of any presenting problem is very limited. A look at the folk disorders research, for example, reveals adequate support for the existence of these culture-specific symptom patterns (Comas-Díaz, 1981; Madsen, 1961; Rubel, 1960) and the existence of folk-healing practices (Alegría et al., 1977; Harwood, 1977; Sandoval, 1977; Trotter & Chavira, 1981). However, systematic documentation of the extent to which Hispanics suffer from these disorders and the extent to which they seek professional care for these disorders is just beginning (e.g., Garrison, 1977). There is even less support for the cultural bases of the other behavior and/or symptoms. In fact, some investigators have questioned the empirical evidence supporting cultural interpretations of rigid marital roles (Cromwell & Ruiz, 1979; Zinn, 1980) and gang-related behavior (Morales, 1982).

The limited evidence for the cultural basis of most symptoms/behaviors can be attributed to a number of factors. First of all, there are few systematic investigations examining the relationship between culture and psychopathology among Hispanic Americans. Although the study of cross-cultural psychopathology has provided significant insights into the role of culture in the development and expression of psychopathology (Draguns, 1980), this literature is largely based on non-U.S. populations. Second, much of the available Hispanic research is based on early anthropological investigations of selected communities that are not representative of the varied Hispanic communities in the United States. For instance, some of the first research which offered a cultural explanation for Mexican Americans' drinking problems and somatization was based on observations.
collected in rural southwest Texas. A third reason for the meager evidence supporting "culturally based" symptoms or disorders is the limited designs used in studying cultural differences. Much of this research compares the symptomatology of an Hispanic group with some other ethnic group, usually Anglo-Americans. If differences are found, then the authors frequently conclude that they are due to cultural factors. A cultural explanation is plausible; however, this design does not rule out other explanations, such as the effect of minority group status (Butcher et al., 1983) and differences in the severity of the disorders between the two groups. Studies which measure the groups' cultural orientation and find group differences in cultural orientation and symptom expression are in a much stronger position to support a cultural hypothesis in explaining symptom differences (e.g., Mirowsky & Ross, 1984). Clearly much more research is needed before the cultural basis of Hispanic psychopathology can be identified.

Although the research literature is limited, culturally based problems, symptoms, or disorders exist. Given our knowledge of cross-cultural psychopathology in general, it is important to acknowledge that culture can significantly influence the development and expression of mental disorders. The recent research examining the ways in which the Amish express mania clearly points out how one's cultural background can influence symptom expression (Egeland et al., 1983). Therefore, it is likely that Hispanic culture influences the psychopathology of Hispanics in significant ways. However, at this time clinicians have few empirically based guidelines in considering how Hispanic culture is reflected in their clinical cases. Without these guidelines clinicians are apt to develop their own notions of how and when culture should be considered.

This then raises the question: Are therapists appropriately taking culture into account, or are they applying stereotypic notions which may not apply to their patients? Given that there are little data to identify true culturally based symptomatology, it is difficult to determine whether therapists are right or wrong in applying different cultural norms. At this point the investigator is limited to studying the basis on which they apply different norms. For the present study, clinicians were instructed to describe cultural aspects and how they considered them. Although this does not ask how they knew some behavior was culturally based, it does provide them with an opportunity to explain how they knew the behavior was cultural in nature. Only three clinicians provided this information. The meaning of this result is unclear. It may reflect the fact that practitioners were not instructed to describe how they knew the behavior was culturally based; those that did, did so on their own. Or, it could be attributed to presumed time constraints which restricted clinicians from elaborating further. Finally, clinicians may have only considered some salient cue like the color of the patient's skin, surnames, or accented speech as indications that the problem or symptoms were due to the patient's culture. Future research should address the important question of how clinicians decide that some behavior or symptom is cultural in nature. A comparison of clinicians with cultural expertise versus clinicians without such expertise might provide particular insight into how clinicians might best consider culture.

Given the limited sample of therapists and the even more limited sample of cases, we must be cautious in generalizing the results of this research. Furthermore, the survey methodology employed is susceptible to social desirability; clinicians may have reported only those cases which they believed they had properly evaluated for cultural factors. Nevertheless, the results indicate that clinicians do consider cultural factors in areas consistent with some of the literature on Hispanic culture and psychopathology. Further research should begin to address the very important question of the appropriateness of their consideration of culture. While it is important to take culture into account, it should be done carefully. Well-intentioned clinicians may be applying cultural notions that may or may not be appropriate for their specific patients.

References
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