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Curanderismo and the DSM-IV: Diagnostic and Treatment Implications for the Mexican American Client

by Martin L. Harris, Ph.D.
Southern California College

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Julian Samora Research Institute

Michigan State University • 112 Paolucci Building
East Lansing, MI 48824-1110
Phone (517) 432-1317 • Fax (517) 432-2221
Home Page: www.jsri.msu.edu

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Abstract: *When the Mexican American family's attempt to heal a troubled member fails, either by seeking out western medicine, psychotherapy, or the saints, curanderismo may be considered as a viable alternative form of intervention. However, opportunity for efficacious care may be thwarted by a psychologist/psychiatrist trying to "sell" their system of treatment and disease classification. Some challenges with traditional psychiatry and psychology are rooted in the nosological system used for assessment, diagnosis and treatment recommendations. Although the symptom profile for a culture-bound syndrome may mimic the clinical profile of a "standard" DSM disorder, the sequale of the disorder as well as the diagnostic, assessment and treatment protocol may differ significantly. The DSM-IV has made strides in terms of mentioning some cultural syndromes, however differential diagnosis, etiological considerations, and appropriate treatment protocols continue to be a challenging theme for mental health care providers. This paper seeks to overview some of the cultural stepping stones in the current classification system. Issues of family support, curanderismo, and differential diagnoses will also be discussed.*

About the Author: *Martin Harris*

Martin Harris, Ph.D., is Assistant Professor of Psychology at Southern California College. He received his Ph.D. in Clinical Psychology from Washington State University. He is the recipient of a fellowship from the American Psychological Association Minority Fellowship Program.

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Curanderismo and the DSM-IV: Diagnostic and Treatment Implications for the Mexican American Client

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The Julian Samora Research Institute is the Midwest's premier policy research and outreach center to the Hispanic community. The Institute's mission includes:

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Curanderismo and the DSM-IV: Diagnostic and Treatment Implications for the Mexican American Client

Basic Clinical and Research Questions

The participation in cross-cultural assessment, diagnosis and treatment intervention is a task that may seem intangible at times. In an attempt to provide a foundation for the understanding of the implications of cultural differences, Tharp (1991) suggests that theory and practice have converged on four basic research questions that must be considered in therapy and should be the focus of research. The first question provides a useful level of developmental analysis: what is the significance of the ethnogenisis for understanding and treating a client's present condition? The answer may be of significance when examining the higher prevalence of depression among African American inner-city youth, as compared to youth with different demographic composites. What is the causal agent for this increase in prevalence of depression? Is it a result of the cultural history of the ethnic group (i.e. oppression, discrimination, and minority status as a stressor), or is it a result of the cultural history of the youth himself or herself?

The next question Tharp asks is "How much weight should cultural psychosocial features be given?" If a Hispanic male drinks excessively and is abusive to his family, how much can we attribute behaviors such as this to culture and how much of it should we label psychopathology?

Tharp's third question is practice-oriented: How should therapy be applied to minority clients? Are there culturally specific and culturally unique treatments? Are there certain therapies that have been developed to work well with particular ethnic groups?

The final, and perhaps most controversial question raised by Tharp is: Are cultural members more effective in treating or investigating the treatment of members of their own culture? Many researchers on this topic have extremist views.

Tharp asks some insightful and thought provoking questions which are relevant to the challenges faced by psychologists who assess, diagnose and treat cultural clients, especially with regard to the utility and application of the Diagnostic and Statistical Manual of Mental Disorders Fourth Edition (1994) (DSM) with cultural clients. The DSM system fails to include many cultural disorders that have different etiological pathways. Subsequently research and treatment paradigms continue to be negatively affected, and "culture bound syndromes," unique phenomena that can pose challenges in assessment and treatment planning are not recognized. Being able to distinguish these etiological and cultural pathways to a disorder will allow the therapist and client to work together in recognizing the origins of the disorder, and subsequently facilitate treatment options.

Evidence of the need for cultural relevance in the delivery of mental health care is reflected in the very nature of concerns echoed by past and present researchers, mental health care providers and government agencies. However, the current assessment system is an impediment, rather than enhancement to improving the delivery of culturally sensitive care, as it too often serves as a conceptual starting point in the appropriation of treatment. In addition, the current system of disease classification is invalid, misunderstood and at times neglectful in recognizing cultural illnesses as unique syndromes. This chapter will serve to overview some of the progress and pitfalls the current diagnostic system has encountered in assessing Mexican American clients. In addition, issues of underutilization of mental health care services, family support, and alternative medicine, as well as an outline for cultural integration in psychotherapy, will be discussed.

The Epidemiological Paradox and the Underutilization of Psychological Services

Large-scale psychiatric studies have repeatedly indicated that oppression, racism, economic struggles, separation from family support, and other stressors are associated with a high incidence of mental illness. Paradoxically, however Mexican Americans tend not to utilize mental health care with the same frequency as other groups. Cuellar and Schnee (1987) state that, regarding the underutilization of services by Mexican Americans, "Perhaps no single issue in the mental health care field has generated so

much concern and raised more questions concerning care and treatment."

Regarding the underutilization of traditional services by Mexican Americans, research studies have fostered three central themes. One theory suggests that Mexican Americans may utilize alternative treatment modalities (Torrey 1986; Alegria, Guerra, Martinez, and Meyer 1977). This theory proposes that Mexican Americans inflicted with a mental illness will seek out a folk-oriented treatment such as those offered by *Curanderos* (Mexican American-Faith healers). A second explanation argues that the Mexican American family serves to buffer or neutralize psychological distress (Jaco 1959; Hoppe and Heller 1975; Becerra, Karno and Escobar 1982; Meadow 1982). A third theme suggests that traditional services are culturally incompatible with the mental health care needs of Mexican Americans. This theory identifies as obstacles and such elements as language, acculturation, and intracultural diversity issues (Yamamoto 1968; Burruel and Chavez 1974; Padilla 1975; Cuellar and Gonzalez 1983; Ramirez 1991).

Language and Acculturation

When discussing the theories as to why Mexican Americans underutilize services, cultural barriers influencing these patterns should be considered. These barriers include: language, acculturation, and intracultural diversity.

When a therapist is interviewing, assessing or appropriating treatment for Mexican American clients, the language barrier should be given special consideration. Among the Mexican people there is no one single encompassing culture which exemplifies all of its constituents. Errors relating to diagnoses can create problems both for the client in need of treatment and the therapist, who may be inappropriately providing services for an unwarranted diagnosis. Marcos and his colleagues (1979) noted that when patients were given critical psychiatric evaluations, the clinicians concluded that the patients who were interviewed in a non-dominant language, even when the interviews were conducted by professionals, were considered to have a greater degree of pathology than when the clients were interviewed in their own language.

Intra-cultural diversity and varying degrees of acculturation within the Mexican culture are factors that should also be considered when appraising mental health care. Traditional and atraditional Mexicans both need to be recognized as unique sub-groups. The Mexican culture, like other cultures, encompasses a continuous change of cultural, political, socioeconomic and familial ideologies. For example, generational differences among Mexican Americans may present a unique challenge for the transcultural psychotherapist.

La Familia (The Family)

The Mexican family has long been considered a valuable mental health resource alternative for members of the community suffering from psychological stress. Jaco concluded from studies conducted in Texas (1959) that the Mexican family provided considerable emotional support in mental health crises. When family members were considered to have some form of mental distress, the family would comfort and console the afflicted member, creating a natural and loving support system. Regarding the capacity for emotional support in a Mexican family, Hoppe and Heller (1975) state:

> *Family ties serve supportive and protective functions against risk of failure, economic loss, embarrassment, and vulnerability to criticism encountered in the broader society. Such ties serve as a buffer between the objec - tively alienated Mexican American and the Anglo middle-class society. (306)*

Becerra, Karno and Escobar (1982) concur that in the Mexican community "The natural support system, the family, has been viewed as one of the primary sources of sustaining the individual when he or she is experiencing emotional problems."

Origins of Mental Illness

According to Western culture, the origin of mental illness can be attributed to two main sources, psychological/psychiatric trauma, and organic causes that lead to the manifestation of a disease, for example, the dopamine theory to schizophrenia or the serotonin theories of depression. Within the Mexican culture, however, there are a multitude of causes for psychopathology and its related behavior. Torrey (1972) describes three etiological pathways:

1. Psychopathology that is influenced by natural causes. For example the *curandero* disorder *empacho* is usually caused by some food that has not digested properly.

2. Psychopathology that has been influenced by emotional causes. For example *susto,* which is often caused by a severe fright, or *Envidia,* which may be caused by a severe desire or jealousy.

3. Psychopathology that might be influenced by supernatural causes. For example those influenced by God as punishment for a particular behavior.

In attempting to explore the differences in *curanderismo* and psychiatry, one can begin with E.F. Torrey's *A Shared Worldview The Principle of Rumpelstiltskin*. In this important book, Torrey uses the story of Rumpelstiltskin to illustrate an important cultural assumption — that the therapist knows the right name to assign a disorder. But, according to Torrey, in order to know the proper name the therapist must share some of the patient's worldview concerning the disorder itself.

Torrey characterizes a shared worldview as a demonstrated awareness and an appreciation for the diversity of cultures, specifically the concept of a shared worldview between the therapist and patient. This concept implies that therapists will examine their own cultural perspective, and also familiarize with the cultures of patients.

Torrey recommends that therapists be flexible in their therapeutic approaches in order to develop a set of techniques that is consonant with the cultural belief system of their patients. Other cultures have alternative equivalents to psychotherapy, and although the means may differ, the fundamental ends of helping the patient feel better, remains the same.

El Curandero (The Healer)

When the Mexican family's attempt to heal the troubled member fails or becomes overwhelming, spiritually guided/therapeutic intervention may be an option. These faith healers are common in many Mexican communities, and often go by the name of *curandero* or *curandera.* This traditional and well respected folk healer may take the place of a psychiatrist, psychologist, or even general practitioner when ailments of the body and mind are regarded as too sacred for contemporary remedies.

In their study on *curanderismo,* Alegria and his colleagues (1977) interviewed several *curandero*s in order to explore the reasons people utilize these folk healers. On visiting one *curandero*s office (his home) — *el hospital invisible* (the invisible hospital) — they found a unique contrast to traditional practices in the *curandero*s practicing environment.

"The setting for the *curandero*s practice is invariably their homes. There is a waiting area as well as a room for private consultation… The curers all practice in the community they serve. In this respect they are completely integrated with their clients" (Algeria et. al. 1977). These researchers also describe the culturally relevant and appropriate nature of the *curanderos* relationships with their patients. In addition to sharing their clients' geographic location, the curers share patients' social/economic, class, background, language, and religion, as well as a system of disease classification.

Case Example: Esperanza

The following is an example of someone seeking out assistance of a *curandero*.

Esperanza is a 16-year-old Mexican female from the Yucatan peninsula. She is single, attractive, standing about five feet in height with a medium build. Her long black hair is woven into a single thick braid which she carries over her shoulder. Her family comes from a long history of Mayan Indians, and both her parents and maternal grandparents raised her. Her father is a *campesino* (fieldworker) and her mother stays at home. Esperanza is the youngest of 10 children (six brothers and four sisters). All of her siblings work in the fields. Esperanza went to public schools until about the fifth grade. At that point her parents decided that she had been educated enough, adding that "too much education would ruin her for a good man."

Esperanza, bright and energetic, longed to continue her education. She continued friendships with schoolmates, borrow their books, and spend hours reading discarded books from the library and bookshops. Esperanza wanted to experience more, but felt

that her life situation was doomed by history, racism, and by pressure from her traditional family. Esperanza had dreams for something besides the seemingly timeless cycle of life amongst the Mayan people.

In the Fall of her sixteenth year, she began to experience a host of problems: she would begin to feel that her heart was racing at tremendous speeds, she might lose consciousness, vomit profusely, or have considerable trouble breathing. At first her parents were not aware of these symptoms as Esperanza did not want to worry them with what she called "mild fainting spells." However, as the illness progressed and she began to have these attacks more frequently the family became alarmed. Esperanza's mother took her to a local clinic staffed with occasional medical personnel, nurses, and a priest. The clinical evaluation revealed no medical condition and referred the family to a psychologist in the city. The family, wanting to avoid the hint that there was something "crazy" going on with their daughter, chose to seek the advice, wisdom, and treatment of one of the towns *curandero*s, Don Wicho.

Don Wicho is a gentleman in his early seventies, with wrinkled hands and gray and white hair. His office is his backyard, with no books, waiting rooms, medicine, or magazines. He had one chair resting under a tree that looked older than Don Wicho himself. He also had one candle that he carried under his left arm, a rosary in his mouth, and a few olive branches in his right hand. Don Wicho sat Esperanza down, asking no questions, and began to pray and light his candle. He occasionally waved the branches over her face and body as she sat motionless in her chair, arms extended outward.

Upon completion of the "intervention" which took about 20 minutes, Don Wicho informed the parents that the situation involved a boy, and that she should consider marriage if the parents approved. On her next visit to Don Wicho (a day later) Esperanza confessed to the *Curandero* that she was pregnant and felt she could not tell her parents about the pregnancy, and was reluctant to admit to herself that she would have to continue her role in the Indian cycle of life. However, she added that she loved her boyfriend very much, and knew she must get married. Don Wicho prescribed some tea to help her with her nausea and told her to pray for her developing child and for her soon-to-be marriage. In addition, he provided a special healing intervention to assist in her plans to move away from her family and start her new home.

The symptoms and treatment for Esperanza were complicated by a host of medical, psychological, and cultural twists. Esperanza's belief in the healer aided her recovery.

Another *curandero* case history involves a 12-year-old boy named Lorenzo. Lorenzo, although born in Michoacan, Mexico, was sent to live with some relatives in the United States at the age of five**.**

Case Example: Lorenzo

Lorenzo was raised for the most part by his maternal aunt and uncle in a rural agricultural community in the Southwest United States. His aunt and uncle are first generation Mexicans who migrated to the United States illegally during the 1950's. Lorenzo was sent to live with this family because of his own parent's financial and emotional troubles. There were rumors that the family in Mexico was going to break up.

Lorenzo adjusted to his new environment and to the cultural norms of an American child as well. He was into video games, fast food, and sports. Everything seemed to be going well for him; he had many friends, both Mexican American and Anglo. He was very popular at school and was very close to his aunt and uncle. There were, however, occasional problems with his biological family which distressed him, but he continued to do well socially and academically.

All was well until he reached the summer before he was to begin junior high school. He was now 12 years old and began to worry about the next level of his education and the challenges therein. Would he be able to fit in, would the other students accept him, would he be able to compete academically? These worries began to transfer to worries about his aunt and uncle. He began to worry that they might reject him if he did not do well academically or socially. Would they be there for him, or would they abandon him? These worries eventually translated into nightmares of being left behind or abandoned by his aunt and uncle. He would wake up with night sweats, his heart racing, experiencing intense fear, and anxiety. During these episodes Lorenzo wished to be consoled and reassured by his *tios* that they would not leave him behind. These worries eventually began to affect

his sleep, social life, and mood. He became less interested in sports, his friends, and his appearance. The aunt, feeling she was untrained to help her nephew, called upon a local *curandera* to assist with the situation. Down the block from her home lived a locally-known faith healer: Angelita.

Angelita is a chubby sixty-ish woman with black and gray hair. She is soft-spoken and calm and came to the home to assess the situation. She was welcomed with *cafe con leche* (coffee and cream) and *pan dulce* (Mexican sweet bread). Angelita brought with her a special concoction of herbs, teas, and a rosary. She had Lorenzo dress down to his shorts and lie on the living room floor, crushed some leaves over his body, and began to pray with the rosary, calling on the saints and angels to protect the child and remove his fears. The treatment lasted about 15 minutes. Later, she prepared a special tea from crushed leaves she carried in a small plastic sandwich bag. She told the aunt to prepare this tea twice a day for Lorenzo until the bag was empty. Angelita was paid a small donation for her services. The boy's fears returned that night and continued for the next several days.

The aunt, worried about the child's well-being, consulted with a priest and a doctor who recommended she take the boy to a psychologist, which she reluctantly did. The psychologist began by having Lorenzo explain his fears, subsequently tracing them to the problems in Mexico with his biological family. After the course of about two months of visits, by exploring the origins of the child's fear, and reassuring him, the psychologist was able to successfully treat Lorenzo.

These cases illustrate the need for diverse and complex approaches to emotional crisis in the Mexican/Mexican American community which may include utilizing psychological or *curandero* treatment interventions, or both. Both adolescents were of Mexican ancestry and accustomed to the *curandero* tradition. Trust and belief in the power of the healer, the diagnostic system and treatment protocol are critical components to a viable intervention program.

The most common types of *curandero* diagnoses include *Mal De Ojo, Envidia, Susto, and Mal Puesto.* In table 1, I've discussed symptom profiles for each.

Table 1. Symptom Profiles for Commmon Curandero Syndromes

CURANDERO	SYNDROME
MALDE OJO *The Evil Eye*	One may interpret the behavior of a (The Evil Eye) look, glance, or stare of someone who is an enemy or a stranger as an attempt to inoculate someone with this illness. Headaches, crying, irritability, and restlessness are common symptoms, accompanied by stomach ailments.
ENVIDIA *Extreme Jealousy*	Envidia translates as a desire (Extreme Jealousy) or jealousy that results from an extreme anger toward,or a dislike or jealousy of another. Symptoms often mimic a number of anxiety syndromes, or may even resemble a more common illness such as a severe cold or fever.
SUSTO *Extreme Fright/Fear*	(ExtremeSusto is typically the result of Fright/Fear) a traumatic experience. In particular the symptoms of this disorder mimic those of Post-Traumatic Stress Disorder. These symptoms include feeling keyed up or on edge, fatigue, restlessness, a significant change in appetite, anhedonia, bodily complaints, withdrawal and other symptoms of depression
MALPUESTO *Hexing*	Hexes may be placed by somone (Hexing) who is familiar with witchcraft. Symptoms may include a host of somatic complaints and gastrointestinal problems. Paranoia and anxiety may be symptoms.

In addition to the differences in etiological pathways and symptom profiles of *curandero* versus western syndromes, treatment interventions also vary. Some of the common interventions used by *curandero*s include herbal tea treatments, which have long been used to treat a variety of maladies from the common cold to several types of cancer, as well as for psychological or emotional symptoms as anxiety is the most common form of mental illness not only among Mexican Americans, but in the world. (Hough et al. 1987). *Curanderos* have developed a myriad of herbal treatment options to cover the variety of anxiety type disorders, particularly significant is the fact that the following table illustrates some common *curandero* syndromes as well as the Western disorders they may mimic. In addition, common treatment interventions are illustrated in Table 2.

Table 2. Common Treatment Interventions

Curandero Syndrome	*Curandero Treatment*	*Similar Western Syndrome*	*Western Treatment*
Nervios	Herbal Tea Spiritual Healing	Generalized Anxiety	Medication Psychotherapy
Ataque De Nervios	Herbal Tea Spiritual Healing	Panic Attack Disorder	Medication Psychotherapy
Empacho	Herbal Tea Spiritual Healing Abdominal Massage	Stomach Ailment	Medication Diet Exercise
Mal Puesto	Spiritual Healing	Paranoia	Medication Psychotherapy
Susto	Spiritual Healing Herbal Tea	Panic Attack Phobic Disorder Extreme Fear	Medication Psychotherapy
Mal De Ojo	Spiritual Healing	Paranoia	Medication Psychotherapy
Tos	Herbal Tea Spiritual Healing	Cold Cough	Medication

Cultural Stepping Stones and the DSM

With respect to cultural issues, the DSM has been lacking. There is no mention of culture-bound issues until the 1987 DSM-III-R which states:

> *Culture specific symptoms of distress may create difficulties in the use of the DSM-III-R because a psychopathology is unique to that culture or because the DSM-III-R is not based on extensive research with non-West - ern populations.*

Table 3. Culture Specific Issues in DSM-IV

Anxiety Disorder	*Specific Cultural Issues*
Panic Disorder	Found in EPA studies worldwide Culture bound syndromes may be related
Agoraphobia	Some cultures restrict women in public
Specific Phobia	Varies with culture and ethnicity
Obsessive Compulsive Disorder	Cultural rituals not necessarily OCD
Post Traumatic Stress Disorder	Immigrants from war-torn countries
Generalized Anxiety Disorder	Cultural variations in expression of anxiety
Social Phobia	Presentation or impairment may differ

The DSM-IV (1994) took a positive step by incorporating four small sections to its edition. These additions include cautionary statements, culture specific issues, (Table 3) an outline for cultural formulation, and a glossary of culture bound syndromes.

Although these sections contributed more to cultural issues than all other editions combined, each section is extremely limited, non-specific, and may in fact do more harm than good. Specifically, the psychologist who may have expertise in culture-bound syndromes, differential diagnoses of cultural disorders and cultural formulations would more than likely disregard all of these additions. On the other hand, psychologists with limited cultural experience or training who use the DSM-IV as their primary assessment tool may do more harm than good by diagnosing and treating a client based solely on this criteria.

It is important to outline each new "cultural" section of the DSM-IV in order to exemplify the potential dilemmas.

Section 1. Cultural and Ethnic Considerations: Located in the introduction of the DSM-IV this section includes a series of cautionary statements regarding how challenging it may be to work with clients from different cultures. This section includes approximately one page of text to discuss the new "three types of information regarding cultural considerations." Within the content of this single page it also mentions that psychopathology can be misdiagnosed cross-culturally.

Section 2. Culturally Specific Variations: Discussion of cultural variations within the symptom profile of disorders. This by far was the least effective of the new additions. Most of the "specific cultural issues" included in the profiles were non-specific with no breadth, depth, or culture specificity. Within Table 3 is an outline and summation of the anxiety spectrum of disorders as included in the DSM-IV for illustration.

Section 3. Outline for Cultural Formulation: Located in Appendix-I, this section is also less than effective. The cultural formulation outlines five important steps that need be taken when making an assessment with a client of a different culture. These include:

Step 1. Note the cultural identity of the individual, acculturation, language use and assimilation.

Step 2. Note client's explanation and cultural explanation with regard to symptoms and treatment.

Step 3. Note cultural stressors, social support, and level of functioning and disability.

Step 4. Note differences in culture/social status between client and clinician and possible problems in diagnoses and treatment.

Step 5. The formulation concludes with a discussion of how cultural considerations specifically influence a comprehensive program of diagnoses and care.

Table 4. DSM-IV: Outline for Cultural Formulation

Step	*Assessment Issue*	*Significance Stated*	*Clearly Measurable*
I	Cultural Identity	No	No
I	Acculturation	No	No
I	Language	No	No
I	Assimilation	No	No
II	Worldview	No	No
III	Cultural Stressors	No	No
III	Social Support	No	No
III	Functioning	No	No
IV	S.E.S. Disparity	No	No
V	Formulation	No	No

Table 5. Mexican Based Culture Bound Syndromes Within the DSM-IV

CULTURAL SYNDROME	COMPARABLE SYNDROMES	DIFFERENTIAL DIAGNOSIS
Ataque de Nervios	Panic Disorder	None
Bilis	None	None
Mal De Ojo	None	None
Nervios	Adjustment, Anxiety, Depressive, Dissociative, Somatoform, Psychotic Disorders	None
Susto	Depression, PTSD	None

This section lists some very important steps, but offers no mention of how to carry them out, how to gauge their utility, how to conduct differential diagnosis, or how to recognize the impact on a treatment protocol. Once again, psychologists with experience in working cross-culturally would most likely ignore this section and defer to more reliable methods.

Within Table 4 is a summary of the shortcomings of the "cultural formulation" section of the DSM-IV.

Section 4. Glossary of Culture-Bound Syndromes in the DSM-IV: This section includes a glossary of 25 culture-bound syndromes. The glossary only sparsely defines the disorders, providing little to no mention of how to differentially diagnose from standard clinical syndromes. In Table 5 are five culture-bound syndromes of Mexican origin. This table illustrates some of the problems that may arise in assessment, differential diagnosis and treatment implementation.

The DSM has yet to recognize cultural disorders as clear syndromes, which meet criteria for a clinical profile. Cultural disorders such as *Mal Puesto, Empacho, Susto and Mal De Ojo* oftentimes mimic symptoms of Western mental illness. Making an appropriate assessment and differential diagnosis is crucial for providing treatment.

Assessment Model

The following paradigm (Table 6) is presented as a culturally sensitive approach to working with cultural clients, especially clients who might hold differing cultural beliefs regarding both the origin of mental illness, and what kind of intervention is appropriate.

Of the 3-part model essential for cross cultural intervention, Component I, encourages sensitivity toward the client's culture, language, empowerment issues, and belief systems. This includes being sensitive to the many stages of acculturation and intracultural diversity which exist within the Mexican culture.

Language is another issue that needs special attention, as it can be an obvious barrier for communication both for the client as well as for the therapist. Problems that may arise as a result of the inter-lan-

guage barriers include issues of assessment, diagnosis and treatment. Intra-language barriers may also create special problems. Mexican Americans sometimes create a secondary composite language used with family, friends, or in daily communications with society. These may include, *mocho* (Mixed-English and Spanish) or variations therein.

This model is a framework for approaching, assessing and treating the Mexican patient. It involves exploring the reasons and motives behind wanting to work with this population. It also requires one to respect the worldview of the patient one is treating, and to factor this worldview into assessment and treatment approaches.

Table 6. A Paradigm for the Assessement and Treatment Approaches with the Mexican American Client

I. *Understanding, and Respect for Client's:*		II. *Self Analysis of Racial:*		III. *Promotion of:*	
A)	Culture/Acculturation	A)	Motives	A)	Traditional Psychotherapy
B)	Language	B)	Tendencies	B)	Culturally Integrative Approach, Including use of *Curanderismo*
C)	Empowerement	C)	Biases		
D)	Belief System	D)	Predjudices		

Understanding a client's perception of his or her own degree of empowerment is another fundamental element for the therapist working with Mexican Americans. Understanding the client's personal degree of conflict with the majority culture may help orient the direction and approach to treatment.

The fourth issue comprising Component I is essential for all psychologists: it involves understanding the level of discordance in belief systems between the therapist and client. For example to what extent does the client's understanding of mental illness, mental health, and the provider of care, differ from that of the therapist.

Component II represents one of the most important steps in modifying traditional treatment. It involves therapists' self-analysis regarding their motives in doing therapy with the client, as well as their feelings about working with people of color, in order to uncover and recognize any prejudices, biases, or tendencies. Dealing with the etiology and maintenance of these feelings is difficult and personal, but also crucial for honest communication.

Finally, Component III suggests the promotion of traditional psychology/psychological care as a viable treatment (alternative). This component is valid only in the presence and effective implementation of the other components of the model. If possible and appropriate, the traditional approach may include therapeutic approaches and techniques which integrate the client's cultural/psychological treatment system.

Summary and Conclusion

Past research has attempted to understand and explain the reasons and motives behind the underutilization patterns in the field of psychology exhibited by Mexicans. These theories have suggested that Mexicans may have less need for traditional psychotherapy, or that this group may make use of alternative treatments. Torrey (1986), Alegria et al. (1977), and others found significant use of *curanderos* among Mexicans. Family buffers have also been considered as a viable explanation for why Mexicans do not seek traditional forms of psychological care.

Differences in perceiving psychopathology have also been considered as a possible explanation regarding the underutilization phenomenon. This theory suggests that Mexicans may have a different worldview with respect to perceiving psychological disorders and psychological care.

Models for providing care should also include the three components of the model included. Those include a sensitivity and respect for the clients culture and belief system, an analysis of the therapists own motives and racial biases, coupled with a promotion of traditional or cultural integrative treatments.

Identifying and understanding the cultural differences that exist among the Mexican people may offer more concrete evidence to support a change in the delivery of services to this group. More importantly, understanding these issues may offer Mexican Americans treatment options/approaches that are more commensurate with their needs.

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