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Deconstructing Cultural Aspects of Mental Health Care in Hispanic/Latinx People

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Abstract

In the United States, 18.9% of the population identifies as Hispanic or Latin. The culture of these communities is as diverse, heterogenous, and rich as the history of this population. Culture shapes the perception of symptoms and psychiatric disorders. To provide culturally sensitive care, it is relevant to understand the history of these communities in the US, recognize cultural humility, and acknowledge aspects and values (eg, culturally bound syndromes, familism, paternalism, stigma of mental illness, machismo, immigration) inherent to the cultural experience and unique barriers to care. Incorporating these aspects into clinical practice is essential for positive outcomes. The purpose of this article is to give a brief historical context, encourage cultural humility, and describe cultural aspects that are essential when providing culturally sensitive care to the Hispanic and Latinx community in the US.

First, it is necessary to clarify the terminology used in this article. What does Hispanic or Latin/a/o/e/x mean? In the United States, Hispanic and Latin are terms that commonly refer to people who—either themselves or their ancestors—come from other parts of the American continent. In general, most of the vast territory currently divided into multiple republics was historically colonized by Spain, Portugal, and to a lesser extent France. Hispania was the term used by the Romans to designate the Iberian Peninsula that entails Spain and Portugal. Th erefore, the term Hispanic America was used to differentiate Spanish and Portuguese America from Anglo America.[1] The French instead preferred the term Latin America, which included territories colonized by them, such as Haiti and Guayana.

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Today, some cultural studies scholars have made the criticizable argument that *Latin* refers to people who identify themselves as coming from the geographical area below the Rio Grande and *Hispanic* refers to people who identify themselves with their Spanish origins or the Spanish language. Th is argument lacks theoretical foundation and has added confusion to the terminology used. Moreover, it has led to the vilification of the term Hispanic by some people who have considered the term as European and therefore less preferred. Nonetheless, one must not forget that both Latin and Hispanic are European terms. In addition, the term Latin America should not include only the area below the Rio Grande. French Canada is, technically speaking, Latin America too. Traditionally, Latino or Latina, the Spanish word for Latin, includes all the Latin American people. The terms Latinx or Latine have been recently proposed in an attempt to avoid specifying gender.[2]

A HISPANIC HISTORY OF THE UNITED STATES TERRITORY

Hispanic/Latinx history in the current US territory goes back to the first encounters between Europeans and Indigenous people of the so-called New Continent. More than 100 years before the Mayflower arrived in Plymouth, Juan Ponce de León became the first European to arrive on the coast of Florida in 1513. In 1565, Pedro Menéndez de Avilés founded Saint Augustine, the oldest continuously inhabited European-established settlement in the US. In 1598, Juan de Oñate established the first settlement in today's New Mexico. In 1680, Spanish Franciscan missions expanded from El Paso to East Texas leading to the foundation of San Antonio in 1718. The presidio of San Diego was founded in 1769, and another Franciscan missionary, Junípero Serra, is credited with founding 21 missions between San Diego and San Francisco. The Caminos Reales or Royal Roads connected these missions to the rest of the Southern Hispanic territories.[3]

At the beginning of colonization, the Spanish crown was not concerned with race. Instead, the idea of spreading Catholicism dominated the thought of the time. Th erefore, natives were regularly baptized, leading to frequent mixing between Spaniards and natives regardless of their social classes and formation of the mixed ethnic group that characterizes Hispanic/Latin Americans today.[1]

According to the thought of the time, Christian people could not be enslaved. Th erefore, natives who embraced Catholicism were technically protected. However, contrary to what the Catholic monarchs mandated, it was common to avoid Christianization of indigenous people in order to enslave them. With the efforts of Fray Bartolome de las Casas, all indigenous people became legally subjects of the Spanish crown, protected from slavery, in 1515.[4] Th ese new laws protected the natives but resulted in an increased slavery trade from Africa to America that lasted for centuries. Under Spanish rule, African slaves had more rights than in the English colonies. For instance, they were allowed to marry, own property, or buy their own freedom. Interracial marriage was tolerated, and free Blacks could not be discriminated against as soon as they embraced Catholicism. As such, it became common for African slaves to escape from British colonies to Florida in search of freedom and a better life. The first settlement of freed slaves in current US territory was Fort Mose in Hispanic Florida.[5]

Following independence from the British crown, the US commenced its expansion by buying Louisiana in 1803 and Florida in 1819. With the conquest of the West, the US militia and army encountered and fought several Native American tribes that had partially assimilated the Hispanic culture and tradition and lived in Pueblos (ie, towns). Th ese people, now called Native Americans, had embraced Catholicism, had Spanish names, spoke Spanish, and had learned from Hispanic people to use guns and horses. Many (eg, Apaches, Navajo, Yaquis, Hopi) had also learned agriculture techniques from the Jesuits. The state of Texas declared independence from Mexico in 1836 and became annexed to the US in 1845. Following the US-Mexican war in 1848, Mexico ceded nearly half its territory including the present-day states of California, Nevada, Arizona, New Mexico, Colorado, Nevada, Utah, Oklahoma, Kansas, and Wyoming. Th us, nearly half of current US territory has a Hispanic ancestry.[6]

The fourth immigration wave in the US started in 1965 and accepted an increasing number of people coming from Latin America. Today 18.9% of the people in the US identify as Hispanic or Latin. In addition, Spanish is the second most spoken language and the first learned language in the US.[7]

CULTURAL HUMILITY IN HISPANIC/LATINX MENTAL HEALTH

Culture shapes how people define health and illness, understand symptoms and psychiatric disorders, and address treatment. Research has shown that clinicians able to understand the patient's culture are perceived to provide higher quality care.[8] Hence, cultural competency has become popular as "the ability of systems to provide care to patients with diverse values, beliefs and behaviors, including tailoring delivery to meet patients' social, cultural, and linguistic needs."[9] At the clinical level, however, this term has been criticized for stereotyping, generalizing (eg, cultural heterogeneity within the Latinx population is often overlooked and oversimplified), ignoring power dynamics, and increasing pressure on clinicians to take on certain attitudes and behaviors to be seen as nondiscriminatory.

To address this, there has been a transition from a knowledge-acquisition approach to a self-reflection and relationship-building approach, known as cultural humility. Th is approach allows clinicians to express respect and does not assume mastery of a patient's cultural experience.[10] It normalizes and strengthens the process of not knowing, inquiring about the patient's needs, and adjusting to their cultural values (eg, preference for paternalism in physician-patient interactions; involving family units in care conversations and support).

In addition to embracing this self-reflection, providing culturally sensitive care for Hispanic patients requires the acknowledgement of aspects and values that are inherent to their culture and represent unique (organizational and structural) barriers to care—such as language hurdles, wealth disparities, and federal and state policies for immigrant communities.

EPISTEMOLOGICAL ISSUES WITH CULTURALLY BOUND SYNDROMES

With the arrival of immigrants from Latin America to the US, several so-called culturally bound syndromes emerged in psychiatric literature. Phenomenologically speaking, these syndromes are diffi cult to reliably discern from any other psychiatric disorder; therefore,

they lack enough nosological foundation. Culturally bound syndromes are now considered cultural expressions of psychological distress or, at times, simply a concept developed from a direct translation from Spanish into English. For example, “ataque de nervios” was defined in the *Diagnostic and Statistical Manual of Mental Disorder*, fourth edition, as uncontrolled screaming or crying, dissociation, and the sensation of heat rising to chest and head, specific to a group of immigrants in New York.[7] Its equivalent in the English language would be “nervous breakdown,” which is another nonspecific expression of distress. “Mal de ojo” has also been described as a culturally bound syndrome in Hispanic people. However, it is actually the translation of “evil eye” or the belief that a spell can be imposed on a person, an idea rooted in most Mediterranean cultures and mentioned in the Bible. “Nervios” is a term generally used for anxiety, which has a direct translation in English as “nerves.” Interpretation of these terms has varied geographically and with time. As such, culturally bound syndromes are not consistent, reliable, or generalizable.

DIFFERENTIATING CULTURAL ASPECTS OF HISPANIC/LATINX COMMUNITIES

One element that has been largely implicated in positive health outcomes for Hispanics is familismo (familism). Familism refers to the value Hispanics place in family, manifesting the strong allegiance and attachment this ethnicity has toward their primary network of support.[11] The central role of family should be considered in multiple aspects of Hispanic patient care, including decision making, counseling, treatment selection, and communication.

Another relevant factor is the physician-patient relationship style, which is influenced by the value of respeto (respect). Respect is manifested in several domains: obedience to authority, deference, decorum, and public behavior. Naturally, because physicians represent a figure of high authority for many Hispanic people, their relationship would be vertical, and the patient’s communication style will be paternalistic. While a paternalistic relationship can be detrimental to autonomy, it has been shown that for this population it could be a protective factor and enhance positive outcomes. Th erefore, a balance that protects the autonomy of the patient but also incorporates respect should be implemented.[12]

Mental illness stigma is present in many communities. For Hispanic people, mental illness is viewed as a sign of weakness or as having religious connotations (ie, punishment, lack of faith, unholy practices). Awareness of these connotations is important because they not only impact access to care and help-seeking behaviors but also psychoeducation.

Machismo is another sociocultural aspect that plays a role in Hispanic mental health. Machismo refers to ideologies and values that promote manliness/hypermasculinity and promotes certain expectations and behaviors in Hispanic men. Machismo negatively impacts the willingness of Hispanic men to seek mental health care. Men are not expected to display emotions and show vulnerabilities, challenging their ability to display or regulate emotions, influencing the family environment, and limiting coping mechanisms.[13] Importantly, the dominance expected in Hispanic men’s behaviors plays a role in gender-associated disparities, domestic violence, and distress in LGBTQIA+ and gender-diverse persons.

While being respectful of cultural values, clinicians must overcome attitudes that have a negative impact in mental health and society.

CHALLENGES FACED BY THE HISPANIC/LATINX COMMUNITY

Hispanic/Latinx communities face unique challenges when compared with US-born, non-Hispanic communities. First-generation immigrants are exposed to specific stressors related to the immigration process, including the sometimes-forced decision to migrate from war- or drug-related violence.[14] Migrants are often exposed to violence, harsh living conditions, and family separation during the migration process.[15]

The post-migration stage is also notable for distinctive challenges. Hispanic immigrants strive to maintain cultural legacies, while attempting to assimilate within the host country, leading to complex acculturation factors.[16] Th ese factors often persist in second-generation immigrants.[17] Highly acculturated immigrants are more socially integrated into the host country; however, greater acculturation can result in the loss of protective traditional cultural values and potentially the loss of family structure. Familism, a core value shared by Hispanic communities, suffers some degradation in successive generations post-migration.[18]

Hispanic communities experience occupational disadvantages as well. Th ey are less likely to graduate from high school and have lower incomes when compared to US-born, non-Hispanic communities.[16] Language barriers not only limit occupational opportunities for Hispanic individuals, but also prevent them from accessing health care services.[19] Th is is particularly relevant in mental health services, where stigma in Hispanic populations is an additional barrier to service access. Successful assimilation in the first and second generations would entail embracing positive Anglo-American values while retaining positive Latin American values, which will only strengthen Hispanic individuals' ability to thrive in this already multicultural society in the US.[20,21]

MANAGEMENT OF HISPANIC/LATINX AMERICANS WITH MENTAL ILLNESS

Only after one has considered the roles immigration status, familismo, machismo, acculturation, education, stigma, and financial status play in clinical presentation can one identify the best approach to serving Hispanic/Latinx Americans. Th ey are a diverse group, hailing from many countries with varying degrees of acculturation. Compared with non-Hispanic White patients, Latinx patients in general have a higher degree of family involvement and treatment goals that are centered on functioning within specific relationships.

Psychoeducation can be a critical piece in managing mental illness as it can combat stigma and shame, improve health literacy, and possibly shift the focus from illness being a moral failing, weakness, or punishment from God to understanding it as an illness.[2,3] Because of the importance of family and community, interventions that focus on connectedness can empower families to face the illness with less shame and more unity, as well as mitigate symptoms. For example, Síndrome de Ulises, in reference to Homer's *Odyssey*, is a syndrome characterized by chronic stress, mood and anxiety symptoms, and somatic

symptoms occurring in migrants. The most effective strategy to mitigate this syndrome is to increase social connection.

Additionally, Hispanic patients are more likely to be hesitant to take medications due to social implications (eg, concern that taking medication correlates to severity of illness, occupational concerns, lack of trust in the safety and efficacy of the treatment). All in all, providing education and engaging in nonpharmacologic interventions, in addition to pharmacotherapy, will increase the probability of treatment success and symptom reduction.[5]

MENTAL HEALTH CARE USE AMONG HISPANIC/LATINX AMERICANS

Despite the significant mental health burden in this population,[22] Latinx use mental health services at a rate two to four times lower than their White counterparts.[23] Key problems exacerbating the access-to-care gap are lack of trust in providers and the health care system, lack of evidence-based and culturally competent practices in their native language, and the dominant mental-health specialist delivery model decontextualized from community needs.[20]

To adapt to the needs of this culturally diverse group, a shift toward cross-system and highly contextualized interventions is needed. To improve prevention, detection, and early treatment, leveraging community-based participatory principles to establish community partnerships has been key in developing interventions that expand outreach. Borrowing from decades of global mental health research, one of the strategies has been task sharing (eg, training non-mental health specialists who have greater community exposure and thus opportunities to aid at-risk populations, to deliver interventions). Community health workers and nurse care managers can effectively deliver interventions in the community.[24]

Based on similar principles, collaborative care models for depression have been shown to improve quality of care and treatment outcomes in primary care settings. Using adaptation frameworks, specialized collaborative-care clinics serving Latinx patients, have been successfully implemented,[25] demonstrating great promise and again anchoring on nontraditional models of mental health delivery. Finally, for patients who need a higher level of specialty care or for whom community resources have failed, Hispanic/Latinx psychiatry clinics have begun to appear throughout the US. Embedded in larger hospitals or community sites, these are valuable resources to fill a care gap with the knowledge of highly skilled professionals who can deliver culturally sensitive care in Spanish.

Coupled with more policies and global initiatives that bolster capacity and a pipeline of a culturally diverse workforce, scaling up these strategies is a way forward in providing better mental health care to Hispanic Americans.

THE LEGACY OF INDIGENOUS MEDICINE FROM LATIN AMERICA IN PSYCHIATRY

Psychedelic compounds are among the most ancient medicines known to humankind, and they have played an integral role in the religious and cultural foundation of indigenous societies. These substances have been used to treat physical and mental illnesses, as well as to alleviate spiritual suffering. Indigenous healing practices in Latin America have a vast history.[26] For example, psilocybin-containing mushrooms were once deemed as blasphemy by the Spanish Inquisition of the Aztec Empire due to their resemblance to the Christian Eucharist.[27] However, mind-altering substances (eg, psilocybin, 3,4-methylenedioxy-methamphetamine, ketamine) are now expanding the boundaries of modern-day psychiatry.[28] The psychedelic renaissance and potential medical application of hallucinogenic substances were indirectly spearheaded by indigenous medicine originated in Latin America. Psilocybin-containing mushrooms were traditionally used throughout cultures in Mexico and Guatemala. In fact, it was through anthropological studies of the Mazatec culture in Mexico that worldwide attention was brought to Maria Sabina, a curandera from the 20th century that used psychedelic substances for healing purposes.[29] Furthermore, ayahuasca, a blend of monoamine oxidase inhibitor and N, N-dimethyltryptamine used by Amazonian cultures, did not come to the attention of the Western world until the mid-1800s. While the use of ayahuasca in these cultures is broad, it is now being used to address psychological and spiritual matters. Additionally, tryptamine-derivative snuffs have been used by societies throughout the Andes mountains for medical, religious, and social purposes.

Altogether, the legacy of indigenous medicine in Latin America has had a significant impact on the field of psychiatry and has contributed to the development of more holistic and integrative approaches to mental health treatment. It is important to learn from other cultures the practice of healing. To realize the maximal potential of these psychedelic compounds, we must continue to learn and maintain a symbiotic relationship with cultures in Latin America, and beyond, that have used these substances for centuries.

CONCLUSION

The United States territory is marked by its Hispanic history. The Hispanic/Latinx community has grown to nearly 20% of the US population; however, the Hispanic/Latinx community continues to be at a disadvantage related to mental health care. Cultural humility, education, and better access to resources will be key in resolving inequalities among Hispanic/Latinx people.

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