Behavioral Medicine REVIEW

Telma Moreira, MS, Daphne C. Hernandez, PhD, MSEd, Claudia W. Scott, MS, RD, LD, CDE, Rosenda Murillo, PhD, Elizabeth M. Vaughan, DO, MPH, and Craig A. Johnston, PhD

Susto, Coraje, y Fatalismo: Cultural-Bound Beliefs and the Treatment of Diabetes Among Socioeconomically Disadvantaged Hispanics

Abstract: *Hispanics are disparately affected by diabetes. Treating socioeconomically disadvantaged Hispanics is challenging due to economic and cultural barriers. Health care providers must understand that cultural beliefs about medicine and disease may have an impact on how diabetes treatment is viewed. Concepts such as* susto *(fright),* coraje *(anger), and* fatalismo *(fatalism) are common cultural beliefs. If these beliefs are not well understood by the health care provider, recommendations for treatment are likely to be discarded. To dismantle cultural barriers between the patient and the health care provider, there are several strategies that a health care provider can implement. For instance, a health care provider must develop trust with the patient. The health care provider could also engage a family member or* promotora *or* promotor *(community health worker) in the conversation. Furthermore, if the cultural barriers are significant, the patient may be best served by receiving treatment from someone with a better understanding of his or her background. Thus, a referral may be appropriate.*

Keywords: anger; fatalism; fright; referral; religion

Diabetes affects a total of 30 million adults and prediabetes affects an additional 84 million individuals.[1] Medical expenditures associated with diabetes were $176 billion in 2012, and that number does not take into consideration cost associated with reduced earnings and productivity.[2] For that reason, lifestyle modifications that include physical exercise, diet, and diabetes self-management have been proposed to assist people make long-term behavior change as discussed in the current issue by Galaviz et al.[3]

Hispanics are disparately affected by diabetes with a prevalence rate of 12% compared with 7% in non-Hispanic whites.[1] Preventing and treating diabetes among Hispanics, especially among those who are low income, is challenging in part due to the fact that 1 in 5 Hispanics lack health insurance, which is double the rate than the general

Hispanics are disparately affected by diabetes with a prevalence rate of 12% compared with 7% in non-Hispanic whites.

DOI: 10.1177/1559827617736506. From the Department of Health and Human Performance (TM, DCH, CWS, CAJ) and Department of Psychological Health and Learning Sciences (RM), University of Houston, Houston, Texas; and Department of Medicine, Baylor College of Medicine, Houston, Texas (EMV). Address correspondence to: Craig A. Johnston, PhD, Department of Health and Human Performance, University of Houston, Houston, TX 77204; e-mail: cajohn25@central.uh.edu.

population.[4] The lack of access and availability of health care, along with significant language barriers, prevents many Hispanics from receiving timely and adequate health care.

Behavior change strategies can be applied to prevent diabetes in high-risk populations. In order to increase the likelihood that these interventions can have a meaningful impact among socioeconomically disadvantaged Hispanics, cultural beliefs about medicine and disease that may be deeply rooted in people's lives should be understood. For example, concepts such as *susto* (fright), *coraje* (anger), and *fatalismo* (fatalism) are common cultural beliefs cited that can affect how the causality and treatment of diabetes are viewed.[5] While it is important to note these cultural beliefs are common among some socioeconomically disadvantaged Hispanics, caution should be taken when grouping individuals together under a term such as Hispanics. Hispanic is a label used to group individuals whose ethnic backgrounds are from Spanish-speaking countries but are in fact a heterogeneous group that vary in their cultural beliefs in relation with disease. The purpose of this article is to provide a brief overview of some beliefs that could affect treatment outcomes among socioeconomically disadvantaged Hispanics taking into consideration the importance of health care providers to attend to the individual patient. By attending to the individual patient, rather than treating Hispanics as a homogeneous group, erroneous assumptions in treatment can be reduced.[6]

Emotional Causation

Several emotions are believed to cause diabetes among Hispanics.[7] *Susto* (fright) is defined as a condition of intense emotion felt after experiencing a traumatic event, such as a car accident or the death of a child that—according to tradition—makes the soul leave the body.[8] After experiencing *susto*, it may take from days to years for symptoms of diabetes to develop. For example, individuals of Mexican decent living in rural Washington State thought that *susto* could be caused by family fights, the use of drugs, or by the spirit of the deceased. Reported cold sweats, vomiting, and diarrhea are among the symptoms. In rural Guatemala, some individuals have been shown to believe that being exposed to air drafts could precipitate *susto*, and mentioned headaches and sweating among the symptoms. *Susto* can be healed by praying, taking herbs, visiting a *curandero* (folk healer), drinking holy water with herbs, or talking with a psychologist.[9,10] Not only are the treatments for *susto* varied, different groups do not view treatment for this the same. In one study, the only group that believed that *susto* could be healed by itself were Mexicans living in South Texas. Others believe that *susto* could be prevented by being calm, or overweight, and that the young and strong individuals are less affected.[11] To further complicate this issue, *susto* is viewed differently based on location (South Texas, Mexico, and Guatemala), and some evidence suggests that this belief may begin to disappear once in contact with a different culture.

Coraje is also mentioned as causative of diabetes.[12] *Coraje* is defined as the emotion resulting from long-term experience of social struggles or "moral indignation."[13] Being usually angry or experiencing family violence make the person feel *coraje*, which may in turn cause diabetes. Whether physical, verbal, or emotional, interpersonal abuse has also been viewed by patients as a causal factor in the development of diabetes, both in men and women.[13]

Fatalism

Fatalismo (fatalism or the belief that things happen because it is people's fate) has been related to the origin and outcomes of diabetes in 2 different ways.[11] Researchers have predominantly seen religious beliefs related to fatalism (as a form of punishment for past sins).[14] At the same time, many Hispanics use religion as a form of support that assists them to endure the disease. This may not only be a cultural belief but also grounded in life circumstances. Real economic barriers suffered by the most undeserved individuals (eg, lack of health insurance, financial burden of treating diabetes) may leave people with the sense that there is not much they can do, even if they do not believe that their lives are shaped by fate.[15]

Treatment Considerations

A better understanding of underlying beliefs can help the health care professional in many ways. Without understanding some of the issues that may be viewed as instrumental in the development of disease, recommendations for treatment are likely to be discarded. Additionally, some patients may never discuss these core issues without a prompt. For example, in one study, participants only referred to *susto* or *coraje* when they were specifically asked.[16] When the patients have strong cultural beliefs, there are several strategies that a provider can use to break the cultural barrier.

Developing Trust

Of utmost importance is the establishment of a relationship of trust with patients, especially when cultural differences may act as a barrier.[17] Patients have shown higher preferences for providers who are warm, empathetic, and listen with genuine interest. Individuals not only value the medical information they receive but also the emotional characteristics of the provider.[16] Directly asking about the cultural beliefs of the Hispanic patient opens the possibility of talking about stressful experiences and emotional aspects of the patient's life that could act as a barrier for the prevention and treatment of diabetes.[16] The time spent in such a conversation is likely to increase the patients' trust in the health care provider, improving their readiness for behavior change.

Promotores and Family Members

Additional strategies that can be used to break the cultural barrier between patients and health care providers

include inviting a family member, engaging bilingual and bicultural *promotora* or *promotor* (community health worker), or involving a peer coach. Involving a family member is important, not only because *familismo* is a Hispanic cultural trait that promotes family ties but because lack of support from the family has been reported as a barrier for successful self-management.[18] A study by Sorkin et al[19] showed that an intervention including obese women who attended with an obese or overweight daughter had greater weight loss and better adherence to healthy eating patterns than in the group of obese women who attended alone. Peer coaches may assist in behavior change by role modeling and providing both information and emotional support.[20,21] These coaches do not need to be experts to be effective either. For example, coaches with a lower sense of self-efficacy have been shown to help their assigned clients more than those with higher self-efficacy, probably due to feeling more empathy.[21]

Referral

Typically, the concept of referring a patient to another provider is associated with feelings of failure as a health care provider. The purpose of referring to another care provider does not imply that one does not have the skills required to appropriately treat a condition. In some cases, a referral is appropriate because of a poor "match" between the health care provider and the patient. As discussed, some patients will have belief structures that make it difficult for the clinician to fully understand the core issues that are related to the disease or disorder being treated. In these cases, the patient may be best served by receiving treatment from someone with a better understanding of his or her background. Health care professionals should regularly assess key barriers to treatment. If it is determined that the patient–health care provider match is not a good one, a referral may be appropriate.

Summary and Conclusions

A health disparity is clearly seen in that Hispanics have higher rates of diabetes than non-Hispanic whites. The treatment of diabetes in some socioeconomically disadvantaged Hispanics may be improved by including cultural beliefs about the disease. Specifically, strong emotions in the form of *susto* and *coraje* may be viewed as causative factors in the development of diabetes, while *fatalism* may deter individuals from diabetes management. Health care providers should be ready to assess for these beliefs and incorporate them into treatment. Additionally, other supports in the form of family members or peer coaches may help bridge any cultural gaps that exist between the patient and the health care provider. In cases where the provider-patient match is affecting treatment, a referral to a health care provider with a better understanding of the cultural belief system may be considered.

Authors' Note

This work was completed in collaboration with the University of Houston Dietetic Internship Program.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: This work has been supported with federal funds from the National Institutes of Health/National Institute of Diabetes, Digestive, and Kidney Disorders. Federal Award Identification Number (FAIN) K23DK110341 to the fifth author.

Ethical Approval

Not applicable, because this article does not contain any studies with human or animal subjects.

Informed Consent

Not applicable, because this article does not contain any studies with human or animal subjects.

Trial Registration

Not applicable, because this article does not contain any clinical trials. AJLM

References

1. Centers for Disease Control and Prevention. National diabetes statistics report. https://www.cdc.gov/diabetes/data/statistics/statistics-report.html. Accessed August 10, 2017.
2. American Diabetes Association. Economic costs of diabetes in the US in 2012. *Diabetes Care*. 2013;36:1033-1046.
3. Galaviz KI, Narayan KMV, Lobelo F, Weber MB. Lifestyle and the prevention of type 2 diabetes: a status report [published online November 24, 2015]. *Am J Lifestyle Med*. doi:10.1177/1559827615619159.
4. Center for Disease Control and Prevention. Health of Hispanic or Latino population. https://www.cdc.gov/nchs/fastats/hispanic-health.htm. Accessed September 16, 2017.
5. Caban A, Walker EA. A systematic review of research on culturally relevant issues for Hispanics with diabetes. *Diabetes Educ*. 2006;32:584-595.
6. González HM, Vega WA, Rodríguez MA, Tarraf W, Sribney WM. Diabetes awareness and knowledge among Latinos: does a usual source of healthcare matter? *J Gen Intern Med*. 2009;24(suppl 3):528-533.
7. Santos SJ, Hurtado-Ortiz MT, Sneed CD. Illness beliefs regarding the causes of diabetes among Latino college students. *Hisp J Behav Sci*. 2009;31:395-412.
8. Cabassa LJ, Hansen MC, Palinkas LA, Ell K. Azúcar y nervios: explanatory models and treatment experiences of Hispanics with diabetes and depression. *Soc Sci Med*. 2008;66:2413-2424.
9. Coronado GD, Thompson B, Tejeda S, Godina R. Attitudes and beliefs among Mexican Americans about type 2 diabetes. *J Health Care Poor Underserved*. 2004;15:576-588.
10. Weller SC, Baer RD, de Alba Garcia JG, et al. Regional variation in Latino descriptions of susto. *Cult Med Psychiatry*. 2002;26:449-472.
11. Hatcher E, Whittemore R. Hispanic adults' beliefs about type 2 diabetes: clinical implications. *J Am Acad Nurse Pract*. 2007;19:536-545.
12. Leganger A, Kraft P, Roysamb E. Perceived self-efficacy in health behaviour research: conceptualisation,

measurement, and correlates. *Psychol Health*. 2000;15:51-69.

13. Mendenhall E, Fernandez A, Adler N, Jacobs EA. Susto, coraje, and abuse: depression and beliefs about diabetes. *Cult Med Psychiatry*. 2012;36:480-492.
14. Giacinto RE, Castañeda SF, Perez RL, et al. Diabetes cultural beliefs and traditional medicine use among health center patients in Oaxaca, Mexico. *J Immigr Minor Health*. 2016;18:1413-1422.
15. de Los Monteros KE, Gallo LC. Fatalism and cardio-metabolic dysfunction in Mexican-American women. *Int J Behav Med*. 2013;20:487-494.
16. Concha JB, Mayer SD, Mezuk BR, Avula D. Diabetes causation beliefs among Spanish-speaking patients. *Diabetes Educ*. 2016;42:116-125.
17. Shelley BM, Sussman AL, Williams RL, Segal AR, Crabtree BF; Rios Net Clinicians. "They don't ask me so I don't tell them": patient-clinician communication about traditional, complementary, and alternative medicine. *Ann Fam Med*. 2009;7:139-147.
18. Hu J, Amirehsani K, Wallace DC, Letvak S. Perceptions of barriers in managing diabetes: perspectives of Hispanic immigrant patients and family members. *Diabetes Educ*. 2013;39:494-503.
19. Sorkin DH, Mavandadi S, Rook KS, et al. Dyadic collaboration in shared health behavior change: the effects of a randomized trial to test a lifestyle intervention for high-risk Latinas. *Health Psychol*. 2014;33:566-575.
20. Goldman ML, Ghorob A, Eyre SL, Bodenheimer T. How do peer coaches improve diabetes care for low-income patients? A qualitative analysis. *Diabetes Educ*. 2013;39:800-810.
21. Rogers EA, Hessler DM, Bodenheimer TS, Ghorob A, Vittinghoff E, Thom DH. Diabetes peer coaching: do "better patients" make better coaches? *Diabetes Educ*. 2014;40:107-115.