Published in final edited form as:

Cult Med Psychiatry. 2008 March ; 32(1): 102–121. doi:10.1007/s11013-007-9072-0.

Cultural Formulation with Attention to Language and Cultural Dynamics in a Mexican Psychiatric Patient Treated in San Diego, USA

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CULTURAL FORMULATION OF PSYCHIATRIC DIAGNOSIS

CLINICAL HISTORY

Patient identification—Ms. C. is a 53-year-old heterosexual, Catholic, divorced Mexican woman, mother of three adult children, one of whom was killed by a drunk driver ten years prior to this treatment episode. She has a sixth grade education and has worked in several different occupations throughout her life, but has been unable to hold a job since her son's death. She uses a hearing aid for a moderate-to-severe hearing impairment but has no other active medical problems. Currently, she lives with her daughter and receives financial support from her surviving son and a government disability pension. Ms. C. migrated legally to the United States at 19 years of age after marrying a U.S. citizen of Mexican descent who she knew since her childhood. Her English vocabulary is very limited, but as she has always lived in a predominantly Latino neighborhood near the U.S.-Mexico border in southern San Diego county, she has been able to cope. She returns to her home town, a small rural community near Guadalajara, Mexico, every two or three years to visit family for a few weeks. She feels she has never fully adapted to life in the U.S.; “nunca me he acostumbrado, es como que no soy ni de aquí, ni de allá, pero a la vez me siento de aquí y de allá...[I have never become used to it, it is like I not from here or from there, but I also feel from here and from there.]”

History of present illness—Ms. C. transferred to our clinic at the suggestion of her previous psychiatrist (English-speaking, non-Latino Caucasian) to start counseling and socialization services, but delayed coming to our clinic for 6 months. Prior to this treatment episode, she had been receiving treatment for a diagnosis of depressive disorder with psychotic symptoms and past records indicated a history of medication non-adherence. She stated that “Las medicinas me sirven mucho, las tomo hasta que me curan y las dejo de tomarlas cuando me siento bien porque ya no las necesito mas... [Medicines help me a lot, I take them until they cure me and stop taking them when I feel well and don't need them any more.]”

Ms. C. reported starting outpatient treatment at least ten times in the past 22 years. However, this was the first time that her assessment and subsequent treatment (individual and group therapy and medication management) had been with Spanish-speaking clinicians. About three weeks prior to coming to treatment, she started having headaches, backaches, poor appetite and felt “*fatigada, angustiada y abrumada...* [fatigued, anguished, and overwhelmed.]” She denied any significant acute psychosocial stressors at this time, but reported that she had

received an ultimatum from her family to seek treatment or be forced to move out. This had been the second time her family had urged her to seek treatment, and it made her feel both angry and useless, “*ahora que no trabajo me quieren tirar como basura...* [I am useless, and now that I don’t work, they want to throw me out like garbage.]”

During the first appointment, she was noticeably depressed and endorsed feelings of hopelessness, anhedonia, fatigue, and chronic suicidal ideation. She expressed thoughts of death, “*morir sería bello y lleno de paz, por fin descansar...* [to die would be beautiful and full of peace, I would finally rest.]” However, she denied active plans or intent to commit suicide, “*de ninguna manera sería capaz de lastimarme y sería un pecado quitarme la vida y lastimar de esa manera a mi familia...* [there is no way I would be capable of hurting myself, it would be a sin to take my life and hurt my family in that manner.]” She was seen by a crisis counselor to further explore suicidal risk, and it was determined that referral to a crisis home or hospital was not indicated at this time.

Psychiatric history and previous treatment—Information was obtained from the patient, her family, and past treatment records. Ms. C.’s first documented depressive episode was after her divorce at age 31. At that time, she was treated at the regional outpatient county-funded mental health center by an English-speaking psychiatrist who prescribed amitriptyline (an older antidepressant). After six weeks, she decided to discontinue the medication because it caused sedation, constipation, and dizziness. She remembered that her mood improved and she did not return for her follow-up appointment; “*me sentí excelente, con energía, sin tristezas, con esperanza, como que algo en mi me había curado y la medicina me hacía sentir mas mal...* [I felt excellent, with energy, without sadness and with hope, like something in me had cured me and that the medicine made me feel worse.]” She had a history of fluctuating moods prior to her divorce, but claimed that she had never experienced a severe depressive episode. She found a job at a tortilla factory and was able to support her family, and resumed what she called her “normal life.” Her mood continued to fluctuate, but she was able to maintain her job and care for her children for about 6 years.

At age 37 she had a suicide attempt by impulsively ingesting a combination of alcohol and six to eight over-the-counter sleeping pills following a failed reconciliation with her ex-husband. The record noted that she “seemed dejected, maintained minimal eye contact and endorsed feelings of hopelessness.” Her cognition was described as intact and her speech was clear. Her insight and judgment were reported as impaired. The evaluating clinician labeled it a “suicide gesture” and she was sent to a crisis home for a three-day stay. Her provocative dress style, history of mood swings, and the impulsive nature of the suicide attempt could have reflected more than a unipolar depression, but this was not investigated.

After discharge, she was referred to an outpatient clinic for follow-up treatment. The initial interview at the clinic was conducted in English with the assistance of an interpreter. Her chief complaint was noted as: “*de nuevo estoy deprimida...* [I’m depressed again.]” Her symptoms were described in the chart as “worsening back pains and headaches, depression, and pervasive sense of hopelessness.” Ms. C.’s attendance at her outpatient clinic appointments was erratic. She started and stopped treatment four times. Each time, she was assigned to a different English-speaking clinician. She recalled that there was an interpreter available about one of every three or four sessions. On those times where no interpreter was available, communication was extremely limited. “*Tratabamos de hablar pero ni el hablaba español ni yo inglés; el se desesperaba pronto y solo escribía la receta y me la entregaba...* [We tried to talk, but he did not speak Spanish, and I did not speak English; he would become exasperated quickly, and he just wrote the prescription and handed it to me.]” Such poor communication resulted in hurried interactions with very little information exchange with a possible negative impact on the care of this patient.

Between the ages of 37 and 43, Ms. C's treatment included several sessions of individual counseling, also with English-speaking clinicians, sometimes with the assistance of interpreters. During this time she continued to complain primarily of depression and was prescribed several different antidepressant medications. Regardless of the success, she always stopped taking them, "*a veces se me curaba con la medicina y a veces con el tiempo...* [sometimes I would be cured by the medicine and some times with time.]" At age 43, she was hospitalized for depression after the death of her oldest son. Her mood fluctuated often and she experienced recurrent thoughts of death, but no further suicide attempts. Thinking of her family, and especially of her children, helped her deal with these thoughts, "*nunca había visto la muerte de tan cerca, entendí que no le podía hacer daño de esa manera a mis hijos y mi familia...* [I had never seen death come so close, I understood then that I couldn't hurt my children and my family in that manner.]"

She continued her irregular pattern of treatment until age 51, when her family gave her the first ultimatum to enter treatment. She felt this was an imposition but agreed to start treatment with the previous psychiatrist, a private doctor, who in turn referred her to this clinic.

Treatment records indicated that she had been treated for the past two years with fluoxetine (a newer antidepressant) to target her depressive symptoms, and risperidone (a newer antipsychotic) at bedtime to target "voices." The depressive symptoms were endorsed and evident at the initial assessment. However, the patient was surprised when asked about the auditory hallucinations or "voices" that were noted in her previous psychiatrist's progress notes. "*No estoy loca, solo he estado mal de los nervios un poco depresiva...* [I'm not crazy, I only have been ill of nerves, a little depressed.]" Ms. C. considered that hearing voices was a symptom of a condition she referred to as "*estar loca*" [to be crazy], which she considered both severe pathology and shameful. She preferred to use the term "*enferma de los nervios*" [ill of nerves]. Ms. C. assured us that she had never heard voices. Confusion over the words "noises" and "voices" could have accounted for this treatment decision. Ms. C. claimed she remembered being asked by her previous psychiatrist in English if she "heard noises." At the time, she had started to hear buzzing sounds and crackles and was referred by her family physician for a hearing test. This test diagnosed a moderate to severe bilateral hearing loss, for which she was fitted with hearing aids that seemed to help eliminate the noises. This word confusion seemed a reasonable explanation for the prescription of risperidone when it was discussed with the patient. As the patient was adamant about not having a history auditory hallucinations, and as there were no active psychotic symptoms endorsed at this time, the recommendation to stop the risperidone was made.

Social and developmental history—Ms. C.'s personal history revealed that she was born and raised in a small rural town near Guadalajara, Mexico, where she was the oldest of seven sisters. As the oldest daughter, she was forced to help her mother with the daily house work, cooking, and caring for her younger sisters. She described her childhood and teen years as "*sola, sin amigas, hacienda quehacer y cuidando a mis hermanas...* [lonely, without friend, and always doing chores and caring for my sisters.]" She had very few memories of her mother but described her as "*triste, amargada y enojona que me hacia hacer todo el quehacer...* [somber, bitter, and angry, who made me do all the house work.]" She remembered her father as a hard-working farmer who was very strict and protective of his seven daughters. She reported that "*como yo era la mayor me llevaba al campo y me enseñó a trabajar pero a mis hermanitas nunca las llevó* [since I was the oldest, he would take me and teach me to work in the fields but he never took my little sisters.]" Although her parents were very strict and demanding, she denied neglect, mistreatment, or ever being physically or sexually abused. No history of drug or alcohol abuse was reported.

Her father died when she was 19 years of age. A distant cousin 10 years her senior, who had moved to the United States several years before returned to town for the funeral and asked her to marry him. She was torn about leaving her mother and sisters. “No recuerdo la verdadera razón, creo que decidí sin pensarlo, no me acuerdo por qué, solo quería salir de donde estaba... [I don’t remember the real reason, I think I decided without even thinking about it, I don’t remember why, I just wanted to leave where I was.]” She agreed to marry and moved with him to a small border community in San Diego, California near the U.S.-Mexico border. They had three children in 12 years of marriage. She reported the causes of the divorced as “su tomadera, sus majaderías y mis altas y bajas de depression, tanto llorar, mis manías de irme a manejar, y trabajar de más ó no hacer nada en la casa... [his drinking, his nastiness, and my highs and lows of depression, crying too much, my driving manias, and doing too much or nothing around the house.]” She had hints of impulsive decision-making, mood instability, and increased goal directed activities, such as driving, during this stage of her life, but mood disorder beyond depression was not investigated in other treatment episodes.

When Ms. C. was 43 years of age, her oldest son died tragically in a car accident at age 23. This led to her second and most recent psychiatric hospitalization. “Cuando murió me sentía muy mal físicamente y emocionalmente me sentía muerta y me preguntaba por que no me morí yo, me enojaba con todos y no quería ver a nadie. Estaba enojada con Dios, le gritaba preguntándole que si me estaba castigando por haber abandonado a mis hermanas. Hay veces que todavía me siento así. También sentía como que lo veía entre la gente y tenía pesadillas de su muerte. No pude manejar por un tiempo y todavía no puedo pasar manejando por donde fue el choque... [when he died, I felt really bad physically, and emotionally I felt dead; I asked myself why it wasn’t me who died, I would get mad with everybody, I did not want to see anyone. I was mad at God, I yelled at Him asking if He was punishing me for having abandoned my sisters. There are still times I feel that way. I also thought I saw him in crowds and had nightmares of his death. I could not drive for some time, and I still can’t drive by the place where the crash took place.]” She displayed symptoms of PTSD due to her son’s death that, according to records, were never investigated; specifically, intrusive thoughts, nightmares, emotional and psychological reactivity, recollections of the trauma, and initial avoidance of driving and persistent avoidance of the crash scene.

Two children survive; a son, 31 and a daughter, 29. Ms. C. lives with her daughter and her family. Her son supplements her disability pension of \$250/month. She has limited reading and writing skills in Spanish. Over the past ten years, she has made several attempts to work, but has been unable to hold a job for longer than a few weeks. “algunas veces dejo de ir a trabajar por que me deprimó mucho, otras me corren porque dejo de hacer el trabajo, no me importa nada y no me puedo concentrar, o me quiero ir lejos, perder, y me voy a manejar. Luego, cuando me quedo sin trabajo siento que ya no sirvo y que mi familia me quiere tirar como basura... [sometimes I stop going to work because I get too depressed, other times they fire me because I stop doing my work, nothing matters to me and I can’t concentrate, like I want to go far away, get lost, so I go driving. Then, when I’m without work I feel useless and that my family wants to throw me out like garbage.]” Her daughter told us that Ms. C. had been unemployed during these ten years because of mood swings and erratic behavior. Her daughter also reported that Ms. C. rarely took her medicine as directed because she would quickly get well, “ella decía que se sentía curada y que ya no necesitaba la medicina... [she would say that she felt cured and that she did not need the medication anymore.]”

With regard to social support, Ms. C.’s social network is limited to her son and daughter and their families. The few people she currently socializes with are Spanish-speaking Mexican women from her church’s prayer group and from the clinic’s socialization program. She recalled that since childhood she had difficulty interacting with others. She had been removed from school after 6th grade to care for her sisters. “De todas maneras no podía aprender y nunca

tenía tiempo para hacer tareas porque estaba muy ocupada y necesitaban que estuviera en la casa... [I couldn't learn or I couldn't do homework because I was always too busy and they needed me around the house.]”

Family history—Ms. C. reported that her father experienced extreme mood swings, “pasaba de alegre a triste de un momento a otro, o pasabas varios días deprimido; todos pensamos que se dejó morir, se puso triste y dejó de comer, no se cuidó y nunca fue a que lo atendieran ... [he went from happy to sad in a moment, or spent several days very depressed; everybody thought that he let himself die, he got sad and stopped eating, he did not take care of himself and never went to get treated.]” Her mother was described as somber and always sad, and like her father, never sought or received psychiatric treatment. She described that her paternal grandmother had episodes with elation and high energy during which she slept very little and told the family she was destined to be the town savior, but then would go for months without problems. She also reported that a paternal great-aunt had episodes lasting a few days where she would become “ill of nerves.” She was very young and did not know if they had ever been diagnosed or received treatment. When asked about the term *nervios*, she stated: When asked about the term *nervios*, she stated: “nosotros decíamos que mi abuela y mi tía estaban enfermas de los nervios porque no siempre estaban mal. Por eso pensábamos que no era lo que decía la gente, ya ve como hablan, decían que estaban locas, pero a mi me decían que era lo mismo, que los locos no se curan; además, daba harta pena que pensarán eso...[we used to say that my grandmother and great aunt were ill of nerves because they were not always bad. That is why we thought that it was not what people talked about, you know people talk, they would say that they were crazy, but I was told that it is not the same, that being crazy cannot be cured; also, we were very ashamed that they would think that.]” When the relationship of *nervios* and anatomical nerves was explored with her, she stated that “no sabía de esas cosas, yo pensaba que era de problemas emocionales, usted sabe, de la mente... [I didn't know, I thought it was only emotional problems, you know, the mind.]” Her deceased son had been diagnosed with, and received treatment for, depression and alcohol dependence. He had been in recovery for a year when his car was hit head-on and he was killed by a drunk driver. After his death, she had been convinced that she and her deceased son “*sacamos todo lo malo de la familia...*[inherited all that was bad in the family.]” She was also sure that “*Dios se lo llevó para que no sufriera como yo ...*[God had taken him so he wouldn't suffer like her.]”

Course and outcome—The information in this case study came primarily from Ms. C., who directly provided information in Spanish, and was corroborated by review of past records. Collateral information was also obtained from her son and daughter. This information was collected during the initial psychosocial assessment, the screening appointments for individual and group counseling, and the psychopharmacology and nursing evaluations. In addition, clinic staff were asked to comment about their observations of the patient's interactions with staff and peers. The case was initially discussed in treatment-team meetings, and an admission diagnosis of major depressive disorder; recurrent, unspecified was given on Axis I and “diagnosis deferred” on Axis II. She was invited to attend eight one-hour weekly sessions of individual counseling (of which she only attended three as she felt more comfortable in a group setting). She was also assigned to a two-hour long, weekly, staff-led women's depression group in Spanish; she also became active in on-going peer-led socialization activities at the clinic (which met for three hours, three times per week). She usually participated in an average of 8 hours of combined services per week, mostly socialization activities.

With regard to medication management, she was continued on fluoxetine 20 mg daily and trazadone (mainly as a sedative) 150 mg at bedtime. Progress notes from the medication management visits noted that she continued to report active symptoms of depression, feeling “*desanimada, triste, como que no sirvo para nada...*[discouraged, sad, like I am good for nothing.]” During this time, the dose of fluoxetine was increased from 20 mg to 80 mg in the

first six months, and consideration was given to switching or augmenting the antidepressant medication because of “poor response.” On one occasion, Ms. C. asked to meet with the clinic nurse because she had something to discuss and was embarrassed to talk to the doctor about it. She brought a bag full of medication to the appointment with the nurse. Some of the medications in the bag had prescription dates of up to five years old and most of the medication prescribed during this treatment trial. She reported that this time she had not taken the medicine because she had been confused about the instructions from the beginning, and that she had been embarrassed and ashamed to admit this to the doctor because “*No quiero decepcionarlo o hacerlo enojar...* [I don’t want to disappoint him or make him upset.]” She had not understood the risperidone taper instructions and had just stopped taking the medications. She added, “*si hubiera sabido que es medicina muy fuerte, que me la dio el otro doctor porque pensó que estaba loca, menos me lo hubiera tomado, yo no estoy loca...* [if I had known that this is strong medicine, that the other doctor gave it to me because he thought I was crazy I would not have taken it, I am not crazy.]” Her long history of non-adherence surfaced. On review of the medication management appointments during this and past treatment episodes, it was determined that she usually was asked standard questions regarding current status of her depressive symptoms, if she had had enough medication for the month, if the medication caused any discomfort or side effects. To these questions she responded that she had enough medication for the month (because she had not taken her medication), that she did not have any side effects (because she had not taken her medication), and that she still was depressed (because she had not taken her medication). As a result of this pattern of questioning during this treatment episode, the dose of fluoxetine had been gradually increased to 80 mg. She never admitted that she had not taken the medication out of embarrassment and shame. She claimed that this had also happened with her past doctors, but she never trusted them enough to admit her confusion.

She also reported to the nurse that during the first few weeks of treatment at this clinic, she had only reported the depressive symptoms to the doctor because “*era lo único que me preguntaban...* [that was all I was asked.]” The patient was accompanied on her next medication appointment by the nurse, and the confusion was clarified. The medication was modified accordingly, and only fluoxetine 20 mg per day was continued. Given the patient’s past history of overdose and her chronic suicidal ideation, the medication was sent for destruction to the University hospital pharmacy. At the combined meeting with the psychiatrist and nurse, she stated that she thought that she was ill of nerves and because her illness was episodic, she thought that medication treatment was supposed to be episodic. “*Como me viene y se me quita yo creí que era como mi abuela ó como otros males, como un dolor de cabeza o un resfriado por ejemplo, que se quita con medicina unos días de medicina y ya...* [since it comes and goes away I thought it was like my grandmother’s or like other maladies, like a headache or a common cold for example, that it goes away with medicine and that’s it.]”

Over the next few weeks she claimed adherence to medication, yet her symptoms were characterized by fluctuating energy levels and mood swings. Three months after her joint appointment with the nurse and the doctor, Ms. C. told the psychiatrist that she had “started to have the driving manias again.” When probed about this, she admitted to periods with increased energy, restlessness, and racing thoughts. She would go on unplanned car trips, driving at fast speeds between cities in southern California and northern Mexico for total round-trip distances of over 400 miles. She had felt that sleep was “unnecessary,” and would spend all night sewing or cooking. She referred to the high-energy periods as her “secret mental channel, like a movie going fast-forward.” She had tried telling a previous doctor about these symptoms but he had not understood her explanation., “*yo le traté de decir pero no me entendió, así que mejor ya no dije nada para que no me quitaran mi canal secreto...* [I tried to tell him but he did not understand me, so I didn’t say anything after that so he would not take secret channel away.]”

These symptoms were discussed with the treatment team and her past records were reviewed and it was found that she had described periods of increased activity. Other symptoms noticed by the staff during the case review included the cause for her divorce and the reason for the family ultimatum of treatment. She admitted that she had not reported all her periods of increased activity because it seemed normal to her. Her motivation for treatment had been to get her depressive symptoms under control and wait for the upswing in mood, energy and activity that usually followed her depression. Her family was contacted and invited to a family meeting. They corroborated that she had periods of increased productivity that lasted for several days to several weeks; “ella dormía muy poco y hablaba tan rápido que era difícil entenderle. Unas veces se salía vestida muy reveladora y descalza, también caminaba muy lejos. Nos hablaba por celular si se le acababa el dinero para la gasolina, pero otras no sabíamos de ella y nos angustiamos porque se ponía en peligro. Es cuando le pedimos que buscara tratamiento... [she would sleep very little and would talk so fast that it was difficult to understand her. Sometimes she would leave scantily dressed and barefoot, she also walked very far. She would call us on her cell phone if she ran out of money for gasoline, but sometimes we did not know of her and we would worry because she would put herself in danger. This is when we demand that she seek treatment.]” During these periods, she would sew clothing garments or prepare several dozen tamales overnight, “nosotros le ayudábamos a preparar los ingredientes y hacía varias docenas de tamales en menos de doce horas...[we would help her prepare the ingredients and she would make several dozen tamales in less than 12 hours.]” The family thought it was a good thing because it kept her active and productive, and everybody benefited financially from the sale of the clothing garments or tamales. The family attributed these periods to “*descompensación nerviosa*” [nervous decompensation], that when it was extreme, they could not handle her at home. When the meaning of this term was explored, they reported that they felt she suffered from an “illness of nerves”. They also felt that it was more acceptable to the rest of the family, friends and neighbors that were not tolerant of her mental illness. “Sabemos que tiene una enfermedad mental, pero nos dá pena y no queremos que la rechacen los vecinos... [We know she has a mental illness, but we are embarrassed and don’t want her to be rejected by the neighbors.]”

Based on the review of the information given by Ms. C. in Spanish at the initial assessment, during her ongoing involvement in group therapy, monthly medication visits, and by further review of past records and collateral information from family members, the staff concluded that Ms. C.’s symptoms and behaviors were consistent with a diagnosis of bipolar disorder, type I. There was a significant family history of mood symptoms and possibly untreated mood disorders. It was evident in the retrospective records review that she had a long history of mood swings with impulsive, erratic behavior with periods of escalating mood that reached psychosis and full-blown mania, but escaped psychiatric hospitalization.

Ms. C. was started on divalproex sodium (a mood stabilizer) and titrated up to a daily dose of 1,500 mg that yielded a blood level of 0.53 mcg/mL. A change of her antidepressant medication was recommended to avoid the risk of induction of mania with fluoxetine, but she declined because she considered it to be the only medication that had helped her in the past. Given her history of stopping the medication, the patient met with the nurse for several consecutive weeks to fill her pillbox until she was able to do it on her own. She was also asked regularly and clearly by the nurse and the physician about her medication adherence. She was asked to describe the pills, how she took them, and how she felt when she took them. Also, the laboratory exams that resulted in detectable and therapeutic blood divalproex sodium levels were considered a proxy for medication adherence. Over the next few weeks, she continued her prompt attendance and claimed adherence with her medication. Her family noticed significant improvement and, at her last appointment, she claimed that she felt energetic, that her thoughts were clear, and she could “de nuevo percibo y disfruto el aroma del aire y veo los colores y

tengo recuerdos felices...[once again perceive and enjoy the aroma of air, and see the colors, and have happy memories.]”

Ms. C. has continued to be stable for over 3 years. She has since relocated to the Los Angeles, California area with her daughter when her son-in-law. At last contact, she continued to be adherent with medication and participation in a socialization program.

Diagnostic formulation

Axis I	Bipolar I Disorder, Most Recent Episode Depressed, Moderate without full inter-episode recovery.
Axis II	Post-traumatic Stress Disorder, chronic (following bereavement)
Axis III	No diagnosis.
Axis IV	Moderate-to-severe bilateral sensorineural hearing loss.
	Distrustful of past treatment experiences.
	Language difficulty in host country.
	Social isolation.
	Unemployment and financial strain.
Axis V	Highest past year GAF = 75
	Current GAF = 50

Differential diagnosis—Prior to the current treatment trial, Ms. C.’s diagnosis during her repeated contacts with mental health clinicians was major depression. This was not surprising, as she had exclusively endorsed symptoms of depressive nature. After a failed attempt to describe her mood swings, impulsivity and increased energy to one doctor, she decided to withhold this information for fear of having “her special channel” taken away. In addition, her English language limitations made it more difficult to communicate this information that she considered intimate and sensitive. The list of diagnoses she collected throughout her previous treatment trials included the following: adjustment disorder with depressed mood, dysthymic disorder, and major depressive disorder with and without psychotic symptoms. However, once a history of mania was ascertained, unipolar depression was eliminated as a diagnostic possibility.

Differential diagnoses considered by our treatment team included: Bipolar II Disorder, Cyclothymic Disorder, Schizoaffective Disorder, and substance-induced disorders.

All types of disorders in the bipolar spectrum were considered. However, a consensus was reached among the treatment team members for a diagnosis of Bipolar I Disorder. The severity of symptoms was judged to correspond to that of mania, and the mood disturbance had been severe and had caused both occupational and social impairment. She attributed her divorce, in part, to her mood swings and erratic behavior, she had been unable to maintain employment for the past ten years, and her family had given her an ultimatum to seek treatment or live elsewhere. This eliminated Bipolar II as a diagnostic consideration. Cyclothymic Disorder was eliminated because both the episodes with both high and low moods were considered by the treatment team severe enough to meet both manic and major depressive proportions. Likewise, the patient had never experienced a period of psychosis in the absence of alterations in mood, which eliminated the possibility of Schizoaffective Disorder. Last, the patient had no history of abuse or misuse of alcohol or any other substance, including any herbal or holistic remedies.

CULTURAL FORMULATION

Cultural Identity

1. Cultural reference group—Ms. C. came from a region that has almost been absorbed by the greater metropolitan Guadalajara area, which in her time had been a rural farming community with traditional and conservative Mexican customs. She claims that even after 34

years in the U.S., she does not feel at home. Although she has maintained customs and traditions learned during her upbringing, she has also participated in activities that have allowed her to live according to life in this country. Her ethnic and national self identity is that of a Mexican woman. She is Catholic by religion, and her Mexican regional identity is “*mujer Tapatía*” [Tapatía woman] (a term used in México that refers to her place of origin in or near the Guadalajara, Mexico area.) She identifies herself as heterosexual, and her peer group includes a few Spanish-speaking Mexican women from her Church and from the clinic’s socialization program. She has ambivalent feelings about her migration to the U.S. She alternates between a sense of liberation (“*tenia que salir de donde estaba...*[I had to leave where I was]”) and a sense of abandonment of her younger sisters (“*Dios me quitó a mi hijo como castigo por haber abandonado a mis hermanas...*[God took my son away as punishment for abandoning my sisters.]”)

2. Language—Ms. C.’s primary language is Spanish. After more than 30 years in the San Diego area she has a limited English vocabulary, which she estimates to be about 100 words. Her limited English literacy had not been a problem for her, as she had always lived in predominantly Latino neighborhoods and had either worked with Spanish-speaking employers. With regard to treatment, she had needed the help of interpreters. The fact that the clinicians and staff at our clinic spoke Spanish had been important in the development of trust in this treatment episode. On one occasion, she specifically pointed out her comfort level with the psychiatrist and nurse due to the language and she also identified with the clinicians who had visited Guadalajara (her home state). This helped the patient bond with the psychiatrist and the clinicians, and is congruent with what Fernandez, et al.. (2004) reported as better quality of patient-provider interpersonal relationship when the providers have a higher degree of language ability and cultural knowledge. Further, failure to account for language limitations may lead to erroneous conclusions about the patient’s impairment level. This may translate into improved treatment participation, as the patient develops a higher degree of confidence in their ability to manage their own treatment (Jeste, et al 2005).

The lack of bilingual clinicians or interpreters on staff at previous treatment facilities was a troublesome systematic defect. In addition to the problems of communication, it placed an unfair and unrealistic burden and responsibility on the patient and may have led to misdiagnosis of her condition and to potentially risky side effects associated with the antipsychotic medication.

3. Cultural factors in development—Several key social and interpersonal cultural influences and scripts influenced Ms. C.’s development. Traditional Mexican culture has a predominant sociocentric organization, with an interdependent (kinship) quality that emphasizes the group over the individual (Alarcon, 1995). In contrast to the emphasis on individualism in American culture, *Familismo* dictates that the family is one of the most powerful influences on behavior (Sabogal, Marin, Otero-Sabogal, Marin, & Perez-Stable 1987). Moreover, gender roles are well defined and dictate many of the interactions, and determine much of the balance of power in traditional Mexican culture (Diaz-Guerrero, 1999). Other important aspects of her development were the patient’s role and status within the family structure and the development of her social skills.

Ms. C. was the oldest of seven daughters in her immediate family. She had been given the roles and responsibilities usually reserved for the elder male in addition to the role of the elder female in a traditional Mexican rural family. She had been the only daughter taught to work on the farm, and told that she was responsible for the farm in her father’s absence. She was also made responsible for helping her mother with the house chores and in raising her sisters, and was not allowed to continue beyond the sixth grade because “*necesitaban que estuviera en la casa* [they needed me around the house.]” After her divorce, she again was responsible for

both roles, as a single parent raising three children in the U.S. and helping her mother and sisters back in Mexico with remittances of money whenever possible. She viewed herself as a self-sacrificing mother. This is consistent with the script of *Abnegación*, considered a sociocultural personality trait of Mexican women by Diaz Guerrero (1999), who describes *abnegacion* [abnegation] as being most prevalent among women, and strongest among mothers. At the same time, she saw herself as a productive provider and protector of the family, more consistent with a traditionally male role.

Ms. C. also displayed the cultural elements of *Simpatía*, *Personalismo* and *Obediencia* in her interactions with the family and her physicians. In social relationships among Mexicans, a major social script is *Simpatía* (Diaz-Guerrero, 1999), to be *simpático* is to be a good person. *Simpatía* is displayed by behaviors such as courtesy, graciousness, attentiveness, obedience, and cheerfulness. It is driven by a desire for smooth functioning of interpersonal relationships, and avoidance of conflict (Diaz-Guerrero, 1999). This need to avoid conflict may have surfaced in her meeting with the nurse when she disclosed medication non-adherence (“no quería decepcionarlo ni que se enojara conmigo, quería caerle bien...[I didn’t want to disappoint him or make him upset at me, I wanted him to like me.]”) and may have also helped her comply with the family’s ultimatum to seek treatment or go live elsewhere. “*Caerle bien*” [to be liked] and *simpatía* was more important than obedience. Here she did not interpret her not taking medications as non-adherence with treatment, because she did not consider her illness to have a chronic and recurrent nature. The concept of *Personalismo*, (Gloria & Peregoy, 1996) emphasizes restricting interactions to trusted others, and collaboration instead of competition. Ms. C. was able to develop trust with her clinicians in this treatment episode primarily due to the language similarities. Also, she may have able to develop trust in her peers and continue participation in the socialization group because they all spoke Spanish, and she knew a couple of them from her Church. Self-affirmation and assertiveness are discouraged in rural areas and provinces of Central and Southern Mexico, whereas *Obediencia/afiliativa* (obedience/selflessness) is encouraged. These personality traits are considered important, and associated with decreased anxiety if the individual is able to be obedient and complacent with his or her parents (Diaz-Guerrero, 1999). Ms. C. may have been trying to display *obediencia* toward the doctor’s treatment recommendations but her own conception of having a self-limiting and episodic illness predominated, and she discontinued her medications. Her not having told the doctor immediately may have been a manifestation of *simpatía*, or need to avoid conflict or out of fear of upsetting the doctor. It was not until she identified an individual whom she could trust, the nurse, that the *Personalismo* allowed her to disclose her confusion over the medication. Conversely, she may have stopped the medication as she had a strong sense of independence and self-determination that allowed her to successfully raise her children as a single mother in the U.S. This combined with the language problems, the adverse affects of medications, and her conceptualization of illness may have combined to influence her decision to stop the medication.

4. Involvement with culture of origin—After 34 years of living in the U.S., Ms. C. continued to be connected with her culture of origin, and had limited contact with persons from the host culture in San Diego, CA. She identified herself as “*Tapatia*” and maintained close ties with her relatives in her hometown. She tried to visit them periodically and helped her mother and sisters financially. Her social network in San Diego consisted primarily of her family and a few friends, exclusively Spanish-speaking Latina women from her church and the clinic. She exclusively listened to and watched Spanish-only radio and television stations and her main hobby was watching *Telenovelas*, Spanish-language soap operas. She claimed that she had raised her children as “*Mexicanos*” and discouraged most manifestations of American culture when they were growing up. For example, during Christmas-time they hosted “*Posadas*,” (traditional Mexican festivities that take place from December 16th to the 24th and consist of a procession by a group of people carrying a doll statuette representing the Christ

Child and singing Christmas carols) and observed the “*Día de Reyes*” on January sixth (a Christian festivity that reenacts Magi’s visit to bring gifts to the infant baby Jesus during which good little girls and boys receive gifts on January 6, the Day of the Kings).

5. Involvement with host culture—Ms. C.’s involvement with the host culture was very limited. She had learned only “survival English” and had always lived in a predominantly Hispanic neighborhood in San Diego. She had little interaction with her non-Hispanic neighbors. Despite her continued attachment to her culture of origin, she had been able to successfully incorporate some aspects of life in California.

In summary, although lacking a full bilingual ability, Ms. C.’s cultural identity can be defined as bicultural. Despite having a collectivist orientation, she also displayed a degree of individualism. This is, in fact, how acculturation is viewed currently, as a dynamic process; not a unidirectional change. She mentioned in one interview that her family in Mexico criticized her, “me dicen que para unas cosas todavía soy muy a la Mexicana y que para otras soy medio agingada [for some things they say I am very Mexican, and that for others I am very Americanized.]” Although she maintained a hierarchical structure at home, she participated in sharing of power and family authority. This example of cultural-duality was one of several “dual-role” experiences for Ms. C. She had been the child-adult, a sister-surrogate mother to her siblings; she had to learn both household and farming chores to the satisfaction of both parents; and she had been a submissive wife-bread winner to support her children while married. Her self-identified cultural reference group was as Mexicana, Tapatia, but she clearly demonstrated an understanding of the culture in the U.S., at least to the extent by which she could identify things she did not choose to allow herself or her children to be involved in. With regard to language, she was observed to have a somewhat greater degree of fluency than she would admit. Lastly, with regard to her involvement in her culture of origin and the host culture, she demonstrated ability to, within limits, be accepted and live life in both cultures.

Cultural Explanations of the Illness

1. Predominant idioms of distress and local illness categories—Ms. C.’s reference to her grandmother and Great-aunt were “*enfermas de los nervios*” and her initial reaction of having a history of hearing voices revealed a level of discomfort with the use of the terms *loca* [crazy] and *enferma mental* [mentally ill]. *Locura* was a severe manifestation of mental illness, where *enfermedad de los nervios* was a more acceptable and less severe in nature. The patient had not linked the term *nervios* to anatomical nerves, she explained that to her it was used to refer to emotional problems. In brief, the patient and the family shared a conception of *enfermedad de los nervios* as a predisposition for manic symptoms and *descompensación nerviosa* as a severe form of *nervios*, the actual acute manic episode. It was at the level of *descompensación* that the family considered her symptoms severe, and was unable to manage or coexist with her. She was ambivalent about taking medication and would often discontinue them when she felt better. She was not convinced that she needed to be on regular medication. Her view of her illness was that it was an episodic illness, curable and with a short course of medication. This is additional evidence of system failure in which the responsibility and blame were entirely shifted to the patient. She probably had not been given information in the past about her illness in a way that she could understand the need for continuing to take her medication. Poor quality of patient education continued even in the early phase of this treatment episode, despite language compatibility. The patient and the family had also attempted to decrease the stigma associated with mental illness by referring to the manic episodes as nervous decompensation. It appears that the patient and the family used a stigma-reduction strategy of referring to an illness using terms that are less threatening to them and their social group, to afford the ill person an opportunity for continued participation in the family and social groups (Jenkins, 1988).

2. Meaning of severity of symptoms in relation to cultural norms—For Ms. C. and her family, the symptoms that led to her spending long hours sewing or cooking were not of major concern as she was viewed as productive. On the other hand, more severe symptoms, probably manic-level activation, were seen as “*descompensación*,” a severe form of “*nervios*” because the family could no longer handle her at home. During episodes of hypomania, the family saw her happy to be working, and felt she provided an example of hard work to the grandchildren. Furthermore, they interpreted her stopping the medication as a sign of improvement. Neither the patient nor the family expressed an understanding of the chronicity of her illness and the need for continued treatment with medications.

3. Perceived causes and explanatory models—It appears that the Ms. C. had a very pragmatic view of her illness based on a quasi-medical model with a hint of divine punishment. Both the patient and the family reported to the treatment team their view of her “illness of nerves” and the acute episodes as “nervous decompensations”. Thus, to them this was an episodic illness that needed short courses of medication that would “cure” her, as such it was compared to simple headaches that subside after taking medication. Ms. C. also provided a somewhat philosophical and religious interpretation of her son’s mental health struggles, and viewed it as inheriting of all what was bad with her family and felt that her son died so he would not suffer in the same way she had been suffering. She also shared with the clinic staff a somewhat fatalistic view of her illness as a punishment from God for all the bad things in her family and a fear of punishment for having abandoned her sisters when she left her hometown to marry and emigrate to the U.S.

4. Help-seeking experiences and plans—She usually resisted seeking help until some major circumstance forced her to start treatment (e.g., emergency crisis home admission after her suicide attempt and family pressure). During this treatment episode, she informed the treatment team of her conceptualization of the mild symptom phase as “illness of nerves” and the severe manic and depressive episodes as “nervous decompensations”. The patient and her family stated that they had used these labels out of fear of the stigma attached to mental illness. This is in accordance with the idea of normalization of mental illness by using the term “*nervios*” among some Mexican-Americans for whom the concept of *nervios* is a way of helping patients and families deal with the stigma of mental illness (Jenkins, 1988; Lopez & Guarnaccia, 2000). The treatment team was able to reframe these views and started to synchronize the explanatory models. This may have allowed the patient and the family to begin to understand the chronic nature of bipolar disorder and the need for ongoing medication adherence and, in turn, improve her adherence to medication.

When she had sought treatment in the past, the differences in explanatory models in addition to the problems from language barriers and other systemic problems might have caused her to become discouraged and abandon treatment. She had never remained at one clinic long enough to develop a trusting relationship with any clinician. The impersonal style of the physicians and other clinicians had been very uncomfortable for her.

Cultural Factors Related to Psychosocial Environment and Levels of Functioning

1. Social stressors—After her divorce, Ms C. continued supporting her mother and sisters, in addition to having sole responsibility for supporting and raising her own three children. She accomplished this without being fluent in English. During the severe “nervous decompensations” she felt unable to fulfill her obligations to the family, and interpreted the ultimatums to seek treatment as a betrayal by the family, as she had unconditionally sacrificed for them. In recent times, her inability to maintain employment made her feel “useless”.

The death of her son was clearly a major stressor that she was still unable to talk about without a great deal of distress. His mental illness and addiction compounded by his death produced severe symptoms in Ms. C., compatible with PTSD that had not been identified in the past. Seen over the course of her life, the patient also had other significant stressors. Leaving her family in Mexico to get married was another stressor that resulted in feelings of guilt. She felt like she had abandoned her sisters. Her move to the U.S., the language difficulties, problems of acculturation, marital difficulties, including her husband's alcoholism and everything that brought with it, also caused significant stress in her life.

2. Social supports—The main source of support was Ms. C.'s family in San Diego and Mexico, and a few Spanish-speaking women from her church prayer group. She also had some casual relationships with people from the socialization component of the clinic, but had little interaction with them outside of this setting. This made the group and socialization activities acceptable to her and may have allowed her to maintain good attendance and expand her support network. She kept some regular contact with her relatives in her hometown. In the past, she had visited them every few years and spent extended amounts of time with them. Over the past ten year, however, this had been less frequent due to her inability to work. She attended church regularly. Other than the support from the prayer group, she did not seek support from any other local cultural or community organization.

3. Level of functioning and disability—Prior to this treatment episode, the patient viewed her "nervous decompensations" as requiring short-term treatment with medication to "cure" her symptoms. Although she was receiving government disability benefits, the family and the patient herself did not consider her condition as a disability as she continued to be productive making clothing garments and tamales.

The treatment team identified moderate to severe impairment during her acute depressive and manic episodes. While the family and patient's views of mental illness were respected, the clinicians discussed the perceived benefits and the negative consequences of depression and mania with them, including loss of jobs and loss of family status were contrasted with her current status. Ms. C.'s level of functioning improved rapidly. Her relationship with her son and daughter improved noticeably, and she felt she had regained the place and status she felt she deserved within the family structure. Her grandchildren started calling her "*mama grande*" [a variation of grandmother]. She saw a benefit of treatment compliance, as now her family sought her advice and guidance "*ahora que estoy bien me piden consejos...*[now that I am well, they ask for my advice.]"

4. Cultural elements of the clinician-patient relationship—This case was plagued with system problems and organizational failures that hindered the patient's care throughout the years. In some cases, the responsibility to overcome some of these deficits was placed on the patient, who was expected to navigate through them and remain compliant and non-critical. She did the latter but not the former. From the outset, language limitations and non-adherence masked and diverted attention from one of the fundamental problems, the conceptual difference in the explanatory models of illness of the patient and the clinicians. She had no concept of chronicity of illness. The failure to recognize and explore her belief in *enfermedad de los nervios* and the assumption that she would follow recommended treatments led to frustration in the part of the psychiatrists and other clinicians who had worked with her.

System problems and organizational failures also characterized this case. From the long waiting list, lack of interpreters, inadequate patient education, brief medication appointment, and shortage of services that required patients to change providers, she faced complications that made it difficult to have optimal treatment outcomes. Instead of culturally sensitive psychiatry, she encountered the prevailing culture of psychiatry in particular and culture of healthcare in

general, with attempts to shift more and more responsibilities to patients. Community psychiatry has become a casualty of the economy. Shrinking funding streams, narrowing of treatment scope, and a shortage of minority mental health professionals have produced an overloaded, overworked, and under-funded mental health system that often fails patients. Unfortunately, the patients that bear the brunt are usually the poorest segment of the population, many of them from ethnic minorities, for whom community-based services are the only option for treatment.

Several cultural elements were present in the clinician-patient relationship. First, in Ms. C.'s case was the issue of respect, which is very important in Mexican culture and is culturally mandated for authority figures or older individuals. Traditionally the priest, the teacher, the physician, and the community leaders are awarded roles of power and influence. To maintain a harmonious relationship, culturally sanctioned behaviors practically mandate deference and passive obedience of them. The need to be charming or win people over, and to maintain *respeto* [respect] becomes important (Lopez & Carrillo, 2001; Diaz-Guerrero, 1999). This was implied by Ms. C. in her meeting with the nurse. In a way, she felt that if she spoke up and informed the doctor that she had not understood the instructions, she would offend or disappoint him and that he would be angry at her. She needed the support of the nurse to disclose the information to the doctor in the next appointment. The ambivalence surfaced as her sense of self-reliance gave her the will to challenge these beliefs and stop the medication, and then gave her the strength to confront the authority figure over the medication issues.

A second cultural element was the involvement of the family in treatment. One or more family members had accompanied her to most appointments, and were usually available to provide collateral information. This is common among Mexican-American patients (Lopez & Carrillo, 2001—pp 114-115; Diaz-Guerrero, 1999—pp135-145). At our clinic, we have noticed that the family usually comes with the patient to the appointment. In a pilot study at this clinic we found that the majority of patients are supported by, or under the care of, a family member, and that family members are willing participants in the treatment of their loved one (Patterson, et al 2005). The "clinician-patient" relationship is expected to become the "treatment team-family" relationship with the physician being the most imposing and intimidating figure of all because of his or her assigned cultural role of authority. As discussed above, the patient many times uses persons other than the physician to disclose information that may be sensitive, embarrassing, or may be considered as disrupting the relationship with the physician.

The third cultural issue is *Familismo*, the importance of family to the individual. The family is considered one of the most powerful systems influencing behavior within Mexican culture. Acknowledging and engaging the family early on in treatment is culturally expected, and failure to do so may influence outcome in a negative way. McCabe (2002) found that family in general, and parents in particular, influence retention in treatment among Mexican-American persons. Specifically, she found that education, perceived barriers to treatment, and client-therapist match were predictors of treatment abandonment. Furthermore, family is helpful in negotiation of the treatment approach, and supportive of adherence to treatment. Families play a central part in the Mexican culture, and their role in the management and treatment of psychiatric disorders cannot be overemphasized. Whenever possible, family members should be included in treatment plans to ensure that accurate histories are obtained, and that family members support treatment plans and aid patients in adhering to treatment recommendations.

A fourth cultural element is one of "*formalidad*" (formality). *Formalidad* is another value kept in high regard in Mexican culture (Diaz-Guerrero, 1999—pp135-145). It is protective against "*vergüenza*" (shame) and "*culpa*" (guilt), and contributory to "*respeto*" (respect) and "*simpatía*" (pleasing or friendliness). A component of *formalidad* is a special "language of respect" that reflects the hierarchical nature of relationships in Mexican society and helps

identify an appropriate level of closeness in relationships (De Mente, 1996). The casual informality of American-style personal interaction can be uncomfortable for Mexicans who use respect language and are accustomed to the formal and hierarchical relationships (Diaz-Guerrero, 1999—pp135-145). Lack of sensitivity and mishandling of these cultural concepts and language can lead to a loss of this automatic respect and detract from the therapeutic alliance.

Finally, with regard to cultural gender roles, Ms. C. had a complex set of roles that did not fit the Latino stereotype. Her role shifted over time, influenced by the course of her illness and life events during that led to changing levels of ability, obligations and responsibilities. She was adaptable and resourceful. She never ceased to attempt to regain that status and worked at home, at times being very productive. She self-identified proudly as heterosexual *Tapatía* woman. However, she felt conflicted and fluctuated between viewing herself as a self-sacrificing mother and a strong, reliable provider. For example, she felt she had succeeded in forming her children in the Mexican tradition [“*a la mexicana*”] because her daughter was a homemaker and her son supported her financially. At the same time, she wanted to be able to return to work and provide an example of strength and responsibility to her grandchildren.

5. Overall cultural assessment—In this case, there were several different factors that contributed to the initial inaccurate diagnoses and inappropriate treatments of Ms. C.’s bipolar disorder. Language was a problem, but the deeper miscommunication was an even larger problem. She said that she had informed her psychiatrist of her manic symptoms, but was not understood because she used Spanish expressions and idioms. She only received treatment for depressive symptoms because they created the most visible distress. Later, the brevity of the follow-up visits was not conducive to establishing trust and rapport. In addition, Ms. C. felt uncomfortable with the distant and informal style of interaction. Conversely, she felt disrespected when a psychiatrist attempted to speak Spanish and used the informal *tu* (vs. the formal *usted*). Interactions were brief, distant, and informal, in contrast to her sense of *personalismo* and need for formality. *Vergüenza*, *respeto*, and *simpatía* interfered with the development of an effective therapeutic relationship. Ms. C. had been embarrassed to disclose that she had not understood the instructions for the medication. She felt it would have been disrespectful on her part to contradict or disappoint the doctor, and she felt this would somehow disrupt the smooth relationship with the clinic. In opposition to this cultural deference, she relied on her sense of self-reliance to decide to stop her medication. In addition, the financial gains for her and the family during her manic phases could lead to future non-adherence to medications. Ms. C. was then seen as a case of chronic treatment non-adherence. She, in turn, lost interest in treatment as she interpreted the physician’s detached and directive style as disinterest in her well-being, and treatment interruptions were due, in part, to a lack of personal connection with the treating physician. When treatment began with a Hispanic team that was able to work within the appropriate cultural roles, she allowed herself to disclose her symptoms, resulting in reformulation of the diagnosis and start of mood-stabilizing treatment. The patient stated a comfort level she had not experienced before and was able to develop a positive connection with the treatment center resulted in greater adherence with treatment.

In summary, the patient’s expressed ambivalence of feelings of belonging and alienation in both cultures depicted in this case presentation gives us a taste of the bicultural, and marginally bilingual, patient. This is a common occurrence in many U.S. border cities and in medical practices in multicultural neighborhoods in many U.S. urban areas. It is a phenomenon that is important for clinicians to recognize and learn to better enable them to provide competent services. Beyond cultural competence, this case exemplifies the dynamic nature of culture and acculturation in real life.

Acknowledgements

This work was supported, in part, by the National Institute of Mental Health grants MH080002 and by the Department of Veterans Affairs.

REFERENCES

- Alarcon RD. Culture and psychiatric diagnosis. Impact on DSM-IV and ICD-10. *The Psychiatric Clinics of North America* 1995;18:449–465. [PubMed: 8545261]
- De Mente, B. NTC's Dictionary of Mexican Cultural Code Words. NTC Publishing Group; Chicago: 1996.
- Díaz-Guerrero, R. *Psicología del mexicano: Descubrimiento de la etnopsicología*. Editorial Trillas; Mexico, D.F.: 1999.
- Fernandez A, Schillinger D, Grumbach K, Rosenthal A, Stewart AL, Wang F, Pérez-Stable. Physician Language Ability and Cultural Competence: An exploratory study of communication with Spanish-speaking patients. *Journal of General Internal Medicine* 2004;19:167–174. [PubMed: 15009796]
- Gloria AM, Peregrory JJ. Counseling Latino alcohol and other substance users/abusers. *Journal of Substance Abuse Treatment* 1996;12:119–126. [PubMed: 8880669]
- Jenkins JH. Conceptions of Schizophrenia as a Problem of Nerves: a Cross-Cultural Comparison of Mexican-American and Anglo-Americans. *Society Science and Medicine* 1988;26:1233–1243.
- Jeste ND, Moore DJ, Goldman SR, Bucardo JB, Davila-Fraga W, Golshan S, Jeste DV, Patterson TL. Predictors of Everyday Functioning among Older Mexican Americans vs. Anglo-Americans with Schizophrenia. *Journal of Clinical Psychiatry* 2005;66:1304–1311. [PubMed: 16259545]
- López SR, Guarnaccia JJ. Cultural psychopathology: uncovering the social world of mental illness. *Annual Review of Psychology* 2000;51:571–598.
- López, AG.; Carrillo, E. *The Latino Psychiatric Patient: Assessment and Treatment*. American Psychiatric Publishing, Inc.; Washington, DC: 2001.
- McCabe K. Factors that Predict Premature Termination Among Mexican-American Children in Outpatient Psychotherapy. *Journal of Child and Family Studies* 2002;11:347–359.
- Patterson T, Bucardo J, McKibbin C, Mausbach BT, Moore D, Barrio C, Goldman SR, Jeste DV. Development and Pilot Testing of a New Psychosocial Intervention for Older Latinos with Chronic Psychosis. *Schizophrenia Bulletin* 2005;31:922–930. [PubMed: 16037481]
- Sabogal F, Marin G, Otero-Sabogal R, Marin BV, Perez-Stable EJ. Hispanic familism and acculturation: What changes and what doesn't? *Hispanic Journal of Behavioral Sciences* 1987;9:397–412.