EDITOR'S NOTE

Cultural Currents presents clinical experience derived from the practices of clinicians caring for patients and families whose cultural backgrounds are outside of the mainstream of society. At times, those very clinicians will be in the position to provide rich insights afforded by their own unique cultural background. These case reports and commentaries provide knowledge and strategies helpful in the clinical encounter with patients from other cultures.

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The Cuban American With Depression in Primary Care

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Even beyond culture-bound syndromes, culture plays a role in the etiology and presentation of psychiatric conditions, notably depression and anxiety.[1,2] Cultural background may also play a role in a patient's attitude toward diagnosis and treatment. While there are specific culture-bound syndromes, in many American immigrants the influence of cultural background may be subtle but still powerful. It can influence perception of behavior, understanding of what is normal versus pathologic, types of presentation (often somatic) in the physician's office, and receptivity to diagnosis and therapeutic interventions.[3] In addition, culture and immigration often affect the family and community resources that a patient has to help cope with stress. These resources also can have a powerful influence on the acceptability of treatment.

By the late 1990s, Cuban Americans had become the third-largest minority Hispanic group in the United States.[4] Consequently, in cities with concentrations of such populations, Cuban-American patients will often be treated by a physician who shares their ethnocultural background. However, this similarity does not guarantee culturally knowledgeable interpretation of psychological symptoms and management of treatment. Those who live in areas with large, dense Cuban-American populations are likely to subscribe to a more traditional Cuban value system than those who have assimilated more fully into mainstream American culture. In this way, geography may influence value systems, lifestyles, and attitudes toward psychiatric issues.

Have you ever encountered a patient with whose culture you were unfamiliar? Have you ever thought that an understanding of this patient's culture would aid you in interpreting his or her presentation, drawing out relevant areas of the patient's psychosocial history, or managing treatment more effectively? What are some issues of psychological relevance within Cuban-American culture? This article, based on conversation with a Cuban-American primary care physician and a Cuban-American psychiatrist, aims to identify unique cultural characteristics that may inform recognition, diagnosis, and treatment of Cuban Americans with depression in primary care.

CASE PRESENTATION: MS. A

A Cuban-American primary care provider who treats many Cuban-American patients in her practice described Ms. A, a 58-year-old Cuban-American woman who complained of fatigue. Ms. A had been seeing this physician for the past 15 years; in addition to treating Ms. A, this physician treated Ms. A's husband and daughter. Ms. A's last physical examination had been approximately 3 to 4 months earlier and had revealed no remarkable conditions. She was a generally healthy woman who took no daily medications except calcium and vitamin D supplements.

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She worked at a full-time job outside the home and reported noticing some recent problems with concentration, memory lapses, and irritability at work. She lived with her extended family and cared for her mother, whose medical condition had recently worsened. Additionally, Ms. A's daughter frequently worked late, so Ms. A had been picking up her grandchildren after school and taking care of them a few days a week. Ms. A emphasized that until recently she had been able to balance these responsibilities but lately had lacked the energy and strength to handle them. Ms. A felt sad and cried at times for no specific reason. When asked, she reported that she no longer was interested in activities she used to enjoy, like window-shopping and going to the movies, and that she would most like to stay at home and in bed.

THE PRIMARY CARE PHYSICIAN'S PERSPECTIVE

Ms. A's immersion in family duties is not unusual. The cohesive extended family is strongly valued among Cuban Americans of all socioeconomic classes. Significantly, extended families often reside in one home, where children are likely to live until they marry. Therefore, Cuban-American women typically play several roles within the household. A Cuban-American woman may juggle daily the responsibilities of wife, mother, grandmother, and daughter, with resultant stress and role conflict. Despite occasional stressors, however, family ties and caregiving roles are likely to be sources of enjoyment for Cuban-American women.

In taking a psychosocial history, it may be fruitful to inquire not only into family dynamics but also into which religion, if any, is practiced. Cubans are traditionally Catholic, and Cuban culture has historically held that health of mind, body, and spirit are interconnected. In treating a Cuban-American patient for a disorder such as depression, it may be useful to conceptualize religious practice as adjunctive therapy. For example, the primary care provider treating Ms. A frequently gives her Cuban-American patients copies of the "Serenity Prayer" as a therapeutic companion to biomedical treatment.

Ms. A's primary care physician diagnosed her with major depressive disorder. Because of their long-standing professional relationship, the physician felt it appropriate to tell Ms. A that her depression was likely triggered or exacerbated by stress in her current lifestyle. She counseled Ms. A to find time for herself and to prioritize, among her many responsibilities, her own mental and physical well-being. The physician then explained that Ms. A was being prescribed a nonaddictive medication that would have to be taken every day to achieve remission. The patient was given controlled-release paroxetine 12.5 mg/day.

When she returned 6 weeks later, the patient was doing much better and was taking the medication at night because it made her feel a bit drowsy. Ms. A said she felt "about 80% better." Ms. A and her physician agreed to consult again in another 6 weeks and to keep the same dosage until then. The physician stressed that the goal of treatment is not simply improvement but wellness, which is marked not only by complete resolution of depressive symptoms but also by the ability to enjoy life again. Ms. A's treatment for depression in primary care was considered successful.

The rapport between primary care provider and patient can facilitate treatment of depression. Ms. A was comfortable describing her symptoms to a physician she knew and trusted. In turn, her physician felt comfortable providing treatment, in part because the major depressive disorder did not seem to have established a chronic course, to have become ingrained in Ms. A's behavior and relationships, or to be refractory to treatment.

The physician who treated Ms. A emphasized that it can be reassuring to patients to compare a first or early episode of depression in the primary care setting with any other treatable medical condition. Like hypertension, diabetes, or high blood cholesterol levels, depression may require long-term treatment. Once remission of symptoms is reached, the patient should be encouraged to evaluate whether he or she feels well, or simply better. The patient should be counseled that the goal of treatment is a return to premorbid mood and functioning and that, while antidepressant treatment does not solve the underlying problems that may contribute to a depressive episode, prompt and appropriate treatment can enable a depressed patient to better deal with those problems. At times, primary care providers may not identify and treat major depression as promptly as is ideal. Ms. A's physician, however, treated depression with some frequency. For example, when she knew that a patient would soon be dealing with the death of a terminally ill spouse, the physician prescribed an antidepressant after the first signs and symptoms appeared in order to help with the normal grieving period.

THE PSYCHIATRIST'S PERSPECTIVE

A psychiatrist with a large Cuban-American clientele agreed that an understanding of the patient's family life is important to any psychiatric evaluation. Because Cuban-American families are quite matriarchal, the female head-of-household takes the role of emotional provider and mediator across generations; thus, problems within the family can weigh heavily on her. For these reasons, a component of beneficial therapeutic counseling is helping the Cuban-American woman to recognize the importance of setting limits and establishing boundaries within the multigenerational household. Still, family is normally an important value system, and a loss of enjoyment in family gatherings or a desire to isolate oneself

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from the extended family may herald the onset of a depressive episode.

While family counseling can be helpful, male members of the family often are resistant to it. Indeed, the doctor treating a Cuban American for depression must look beyond the individual patient to consider family dynamics, including the patient's concerns about the views that the rest of the family will take toward the diagnosis. Family members may feel that the reputation of the family is in jeopardy. Especially in the lower socioeconomic classes where there may be little education about psychiatric illness, a woman with a male partner may be reluctant to even inform him of her disorder. In such instances, the female patient may find it helpful to identify a female ally within the family to assist and support her during the treatment process. Additionally, the clinician might offer to speak with the patient's partner or suggest that he accompany the patient when she returns for follow-up. To promote acceptance of a diagnosis of major depression, patient and family education should emphasize that in today's American society depression has different connotations and implications than it would have had, for example, 40 years ago for a family member in Cuba: depression is highly treatable, and prognosis is good.

Depressed patients who present to primary care often do so early in a depressive episode or in a first depressive episode, which may become chronic and recurring if not treated promptly and thoroughly. Consequently, the psychiatrist finds any distinction between situational and chronic depression to be unproductive. Major depression, regardless of the triggering factor, has a severely detrimental impact on the sufferer's life, especially if it persists or recurs. Long-term monitoring for recurrence of depression is an important aspect of the primary care of such patients. Monitoring is facilitated by the geographic permanence of many Cuban-American communities and by the nature of primary care, to which patients report relatively frequently and for a wide range of needs. Indeed, in a 1974 survey,[5] 75% of Cuban-American respondents stated that they would turn to the family doctor for help if someone in the family had a serious psychological problem. The primary care rapport uniquely positions physicians to provide patients and their families with prompt treatment for depression.

The psychiatrist pointed out that Cuban-American men tend to value an exaggerated masculinity—or *machismo*—that can make them reluctant to admit to having psychiatric symptoms. When diagnosing a Cuban-American man with a psychiatric condition, the clinician may find it expedient to emphasize that the patient's condition is not the result of weakness on his part. *Machismo* may also make Cuban-American men especially unlikely to report medication-induced sexual dysfunction. Thus, the clinician should make the patient aware of the risk for decreased libido, delayed ejaculation, and erectile dysfunction at initiation of psychotropic treatment and should inform the patient that this side effect is a treatable biological side effect that does not reflect on their masculinity. Some Cuban-American women, particularly those of older generations, also may be reluctant to acknowledge any sexual side effects, owing to conservative Catholic upbringing. Again, the clinician should initiate dialogue about sexual side effects.

Unique to Caribbean cultures, including that of Cuba, is the practice of Santeria. Santeria derives from the interface of African and Spanish cultures in Latin America, combining worship of African deities, or orishas, with variations on Catholicism. The rituals of Santeria address treatments for both physical and mental illnesses. *Santeros* (practitioners of Santeria) come from all socioeconomic backgrounds; however, it has been suggested that a lack of access to mental health services among the lower socioeconomic classes, along with stigma attached to psychiatric conditions, supports the use of Santeria in treating psychiatric illness.[6] *Santeros* rarely operate in conflict with biomedical treatments[7]; therefore, Santerian practice and psychotropic treatment need not be mutually exclusive.

The psychiatrist also mentioned secular folk remedies unrelated to Santeria that clinicians may encounter when treating Cuban-American patients. For instance, some Cuban-American women drink a traditional herbal remedy for anxiety and depression called *tilo*. It is not uncommon for patients to try to manage their symptoms with *tilo* before seeking professional treatment. Clinically, interactions between *tilo* and prescribed antidepressants have not been reported, so patients may continue using *tilo* while taking an antidepressant if they so choose.

In the primary care or psychiatric setting, correct diagnosis is crucial to proper treatment. A depressive episode in bipolar disorder (i.e., bipolar depression) may be virtually indistinguishable from an episode of major depression, regardless of ethnocultural background. Looking for indications of mania or hypomania in the patient's past—or future—can help avoid misdiagnosis. If the patient presenting with depression drinks alcohol, it is important to discern not only whether the depression is secondary to a substance use disorder but also whether alcohol is used to diminish or manage the symptoms of a hypomanic episode. Previous antidepressant use also should be probed. If the patient reports that he or she previously could not tolerate an antidepressant due to side effect anxiety or nervousness, further questioning is warranted. Treatment-induced insomnia and racing thoughts may indicate an antidepressant-induced hypomania, which is one of the key markers for undiagnosed bipolar disorder.

Bipolar disorder does not present differently among Cuban Americans than among other patients. However,

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it is important that the clinician realize that certain—namely, hyperverbal—styles of expression that may suggest hypomania in other populations are in fact normative to Cuban-American culture. Cuban Americans tend to speak quickly, loudly, and with animated gestures. Among Cuban-American patients, racing thoughts, lack of sleep, gradiosity, distractibility, and increased energy may be more reliable indicators of hypomania than apparent pressured speech. Further, Cuban men and women tend to be outgoing and expressive and often prefer a patient-doctor relationship notable for its familiarity. For instance, it is common for patients to address doctors by their first names in Cuban culture. Patients may expect to hug their doctors, and it is customary for patients to bring their doctors gifts at holidays. While borderline personality disorder occurs in the Cuban-American population as in any other population, understanding the culturally normative appropriateness of informal address, hugging, gift-giving, and similar familiarity in Cuban-American culture should help the physician differentiate between a healthy and an unhealthy motivation. Indeed, refusing such patient-initiated bonding behaviors might seriously disrupt the doctor-patient relationship.

OTHER ISSUES OF POTENTIAL RELEVANCE

Cuban Americans represent one of the few minority groups in the United States who are predominantly refugees rather than immigrants. Several identifiable waves of relocation from Cuba have occurred since the Communist revolution there.[8] Those who arrived in the United States in the early 1960s tended to be of the professional classes and as a group have since assimilated more thoroughly into mainstream American culture than later waves that included many from lower socioeconomic classes. Among these Cuban Americans, compared with later-arriving refugees, there is much less stigma associated with psychiatric illness. Later arrivals are more likely to view psychiatric illness as a character weakness that is shameful to the individual and the family. They may resist reporting symptoms or seeking treatment. Among the predominantly working-class refugees who came to the United States via the Mariel boat lift in 1980, some were intractable criminals and individuals with chronic mental illnesses who may have a low level of receptivity or access to care. When evaluating a Cuban-American patient, it can be helpful to determine which group of refugees he or she identifies with, as this may have an effect on the way the patient interprets diagnosis and treatment.

Cuban-American and other Hispanic patients may describe feelings of nervousness and somatic symptoms that sound like manifestations of an anxiety disorder but that may actually be signs of a depressive disorder with anxious features. *Nervios* in Latin American culture is a nonspecific term used to describe distress brought on by stressful life circumstances and characterized by somatic symptoms. A complaint of *nervios* may correspond to several psychiatric conditions, including depressive disorder, or may occur in patients with no specific disorder. Somatic symptoms of *nervios* include headache, stomachache, sleep disturbance, trembling, dizziness, and tingling sensations and may be accompanied by psychological symptoms such as anxiety, irritability, tearfulness, and attentional problems.[4] Attention should be paid that *nervios* is not confounded with an anxiety disorder and that benzodiazepines are not prescribed in cases in which a selective serotonin reuptake inhibitor would be more appropriate.

CONCLUSION

In treating Cuban Americans as well as patients from other cultures, the clinician is challenged to avoid applying his or her value system to patient behavior. Being not only culturally sensitive but also culturally knowledgable can assist the primary care physician in diagnosing and treating psychiatric disorders in patients with strong ties to other cultures. Family dynamics, religion, machismo, culturally normative physician-patient rapport, immigration history, and *nervios* are among the potentially relevant issues that may arise in treatment of a Cuban-American patient with depression.

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