# “¿Qué tiene?” Experiences of mental illness and perspectives from providers, patients, and caregivers in Mexico

By

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# Abstract

Understanding the cross-cultural variability of conceptions of mental illness is essential to diversify scholarly knowledge on traditionally Westernized conceptions of distress. Mexico is of particular scholarly interest given the historical, social, political, and academic exchanges between Mexico and the U.S., with an uptake in Westernized psychological practices that can be culturally incongruent with indigenous conceptions of self and mental health. This dissertation study sought to understand the mental illness experience from the perspective of Mexican patients, their caregivers, and psychiatric providers using the semi-structured DSM-5 Cultural Formulation Interview (CFI; APA, 2013). A total of 19 cases were collected, and using thematic analysis (Braun & Clarke, 2006) I report on the common themes related to how stakeholders described the mental illness experience, including the cause and treatment expectations. Patients and caregivers often identified interpersonal causes of distress, while providers described overall biopsychosocial components. Providers further described that increasing "illness consciousness," that is, a "scientific" and biomedical understanding of distress, could increase the adoption of a sick role and improve illness management (usually through psychiatric medication) and outcomes. Another prominent theme was related to the gendered expectations of women, often seen as self-sacrificing ("*mujeres abnegadas*"), in the cause and maintenance of mental and emotional distress, despite multiple experiences of gender-based trauma. Finally, the prominent role of family is discussed in providing treatment support through symptom management and help navigating mental health care systems. Overall, findings are discussed in the context of the Mexican mental health system and a globalized push toward "psychological modernization" (Duncan, 2017) through "*psicoeducación*" (psychoeducation) into Western-based conceptions at the expense of interpersonally-based explanatory models and treatment interventions.

# Chapter 1: Introduction

Psychotherapy –the practices aimed at treating and managing mental illness and emotional wellbeing– represents a relatively modern cultural practice created to respond to psychological and emotional distress (Frank & Frank, 1991; Wampold, 2001). Modern psychotherapy is embedded within a particular cultural movement that reflects a broader history of Western hegemony over psychological practices commonly developed by professionals of White European-origin for White European-origin populations. Hence, psychotherapy as it is commonly practiced in Western cultures is congruent with the values and belief systems of a dominant White European culture that reify a scientific approach to treatment through the conceptualization of mind as separate from the body, an emphasis on biological explanations of mental illness, a focus on treating the distressed individual, and a preference for treatment interventions (e.g. cognitive-behavioral therapy) that gain credibility through putatively rigorous, scientific methods (Frank & Frank, 1991; Wampold, 2001, 2007).

However, in an increasingly diverse global landscape, mental health practitioners have turned their attention to questions of the cross-cultural variability of conceptions of mental illness and the assumptions underlying current mental health treatment, particularly given the alarming mental health disparities documented among non-White populations in Western cultures (Surgeon General, 2001). Scholars have acknowledged the cultural embeddedness of psychotherapy and have attempted to develop interventions tailored for the different non-dominant populations by incorporating local cultures into theory and practice (Benish, Quintana & Wampold, 2011; Christopher, Wendt, Marecek & Goodman, 2014; Frank & Frank, 1991).

Culture has been broadly defined as the shared meaning systems employed by a population that include multiple factors such as language, religion and spirituality, rituals and customs, morals codified into legal systems, family structures, and life-cycle stages (APA, 2013). The Multicultural Counseling Competencies (MCC) movement established in the U.S. has encouraged mental health practitioners to develop cultural awareness, knowledge and skills for working with cultural minority populations (Sue, Arredondo, & McDavis, 1992). As a response to this movement, scholars have developed cultural adaptations to conventional treatment interventions that attempt to incorporate the values, beliefs, attitudes, and worldviews of racial and ethnic minorities (Benish, Quintana, & Wampold, 2011; Domenech Rodríguez, Baumann, & Schwartz, 2011; Huey, Tilley, Jones, & Smith, 2014). Nevertheless, most adaptations have been limited by their narrow and racialized conceptualization of culture as belonging only to non-White minority populations, and by their predominant focus on U.S. culture and psychotherapeutic care.

The Diagnostic and Statistical Manual of Mental Disorders (DSM) has incorporated culture into psychiatric and psychological assessment and treatment planning through the addition of the Cultural Formulation Interview (CFI) in a recent edition of this nosology (APA, 2013; Lewis-Fernández & Díaz, 2002), albeit as an appendix. According to the DSM-5 (APA, 2013), the term “cultural minority” is used to describe people who deviate from the Westernized norm (e.g., White, middle-class, heterosexual) and includes multiple types of culture beyond race and ethnicity (La Roche, Fuentes, & Hinton, 2015).

One notable feature of the CFI has been its attention to patients’ explanatory models of illness, that is, the causal inferences they make for a specific illness episode, which are often influenced by their social position and more general cultural frameworks in society (Kleinman, 1988a). Explanatory models of mental illness provide information on the patients’ beliefs regarding the cause, onset, course, and treatment expectations for their distress. Yet less attention has been given to how mental health providers' explanatory models of illness, informed by their specific training and education, as well as their own social positioning, are similar or different to those of patients and their caregivers. When there is patient concern or resistance toward psychotherapy, professionals frequently attribute these to bias, stigma, or lack of "psychological mindedness," with little attention to the interplay between patient and provider culture and the ways in which their explanatory models of illness may compete. Thus, understanding the explanatory models of mental illness of treatment providers, patients, and patients' caregivers can help reduce incompatibilities among patients and providers, promote collaborative working alliances, increase treatment acceptability, and improve overall treatment outcomes.

## 1.1. Statement of the Problem

It has become increasingly important for scholars to understand how people from non-Westernized cultures make sense of mental illness and emotional wellbeing and how cultural considerations might be incorporated in their treatment. Psychotherapy in Mexico provides an interesting subject for further inquiry into how culture and patients' explanatory models of mental illness are incorporated into clinical practice. Mexico is of particular scholarly interest given the large number of Mexican immigrants to the U.S. and the historical, social, political, and academic exchanges between Mexico and the U.S. Despite vast cultural differences, many treatments utilized by practitioners in Mexico apply Westernized psychological practices that are often culturally incongruent with indigenous conceptions of self, mental health, and treatment acceptability. Furthermore, Mexican psychotherapeutic practice often adopts U.S. and other Westernized psychological theories, as reflected in the adaptation of U.S.-developed nomenclatures and an ever-expanding hegemony of Westernized, science-driven, biomedical explanations of mental illness. Mexican cultural conceptions of self and illness reflect a pre-

Colombian heritage and integrative worldview that contrasts modern Westernized mind-body dualism (Vallejo Samudio, 2006). Still, some Mexican psychologists' have made efforts to understand the Mexican psyche embedded within this populations' specific cultural background and history (Díaz Guerrero, 1971), including indigenous forms of healing (Villaseñor Bayardo, 2008), although it is yet unclear whether these efforts have been translated into culturally-congruent practices. Understanding the explanatory models of mental illness held by Mexican mental health providers is important for understanding cultural concepts of mental distress, and for improving mental health care practices in both Mexico and for providers in the U.S. working with patients of Mexican origin.

The current study is focused on understanding the explanatory models of mental illness of Mexican mental health providers, patients, and their caregivers, and how these influence treatment expectations. Further research that supports local and cultural understandings of mental illness are essential in the development of culturally competent care and can inform strategies to redress disparities in utilization and efficacy of mental health services. Across forms of health care, improving the compatibility between providers and recipients of services are key to engaging patients collaboratively, eliciting cooperation from recipients, and allowing recipients to be active agents in their health.  These issues are even more important for mental health services in which the role of biological factors is more opaque, compared to medical treatment of physical disorders. Definitions of disorders influence what concerns providers and patients focus on, treatment plans, and subsequently the course of mental illness. Therefore, understanding local, cultural, and professional conceptions of distress is a starting point in increasing access to culturally competent treatment.

## 1.2. Purpose of the Study

The purpose of this qualitative study is to understand the explanatory models of mental illness of Mexican patients, their caregivers, and psychiatrists at an outpatient clinic in central Mexico. Explanatory models are defined in this study as how providers, patients, and their caregivers understand and describe the cause, onset, and treatment expectations of their specific mental illness. The author explored these stakeholders' perceptions of mental illness contextualized within a broader historical background of U.S. and Western hegemony over Mexican psychological theory and practice.

I am interested in how psychotherapeutic practices are culturally grounded as a way to increase access, acceptability, and feasibility of the mental health treatment provided to a largely disenfranchised community. Mexican mental health care is of particular interest to me as a I grew up and was trained as a psychologist in Mexico. This training provided insight into the ways in which psychological and psychiatric treatment in Mexico often fail to meet the needs of people from my own and similar low-income communities. As a counseling psychologist-in-training, I believe that understanding the cultural factors that influence psychotherapeutic practice is a way to move toward social justice by decreasing inequitable practices (Vera & Speight, 2003). To broaden the analysis of "culture" as beyond individual identity markers, I draw heavily on literature from the fields of medical anthropology and transcultural psychiatry.

## 1.3. Research Questions

The present study sought to explore the ways in which Mexican mental health care providers, patients, and their caregivers make sense of mental illness experiences, through the use of the DSM-5 Cultural Formulation Interview (CFI). Specifically, this study investigates how these stakeholders perceive the cause, onset, and treatment expectations for different forms of mental and emotional distress. The researcher used the CFI to elicit explanatory models of mental illness and treatment expectations. Finally, this study sought to understand the similarities and differences among the explanatory models of mental illness of Mexican providers, patients, and their caregivers.

# Chapter 2: Review of the Literature

## 2.1. Western Biomedical Model

Scientific medicine has its origins in Europe with Hippocrates and Galen who sought to understand and manipulate, through empirical and scientific methods, relationships between observable events and variables (Frank & Frank, 1991; Vallejo Samudio, 2006; Wampold, 2001). The scientific approach is based on the empirical demonstration of materialism, seeking to identify change at anatomic and physiological levels within patients (Wampold, 2007). A scientific approach to medicine emphasized observation, hypothesis testing, and a chronological cause and effect relationship (Wampold, 2001). Descartes continued the development of medical science by declaring a mind-body dualism that separated anatomy and physiology from metaphysical and psychological components (Wampold, 2001). Modern medical practice is based on scientific assumptions that promote a biomedical model of treatment.

The biomedical focus on organic malfunction currently dominates modern psychiatric and psychological clinical practice and research in Western healthcare (Logan & Hunt, 2014). Indeed, in Western culture, credibility is “couched in the language of science” (Frank & Frank, 1991; p. 58), and psychiatry, struggling to be accepted as a form of science, has emphasized the somatic and physiochemical causes of illness (Wampold, 2001). Therefore, scientifically valid treatments are amenable to biological explanatory systems, such as the treatment of depression with antidepressants (Wampold, 2007). Thus, medicine has cemented itself as the privileged profession against which psychotherapies and other forms of “mind cures” try to establish their legitimacy (Wampold, 2001).

Medical practice is focused on treating diseases, defined as the structural and functional abnormalities of bodily organs and systems (Kleinman, Eisenberg, & Good, 2006). However, an important distinction is made by Kleinman and colleagues (2006) between disease and illness. Disease focuses on biological and psychophysiological functioning, whereas illness is the personal, interpersonal, and cultural reactions to the disvalued changes in states of being that make up the disease (Kleinman et al., 2006). The conceptual distinction between disease and illness highlight the different approaches commonly emphasized by patients and mental health care providers where the former often focus on illness, and the latter on disease.

Current psychotherapeutic approaches are historically influenced by a medical model of mental illness. Sigmund Freud, a physician, was highly influential in the advent of modern psychological and psychiatric practice during the turn of the twentieth century when he provided a seminal theory on mental disorder and treatment through psychoanalysis and talk therapy (Wampold, 2001). However, psychodynamic forms of therapy went out of fashion for the sake of increasing psychotherapy’s scientific claims. From the 1920s onward, psychological treatments with behavioral components were proposed as more “scientific” because of their emphasis on investigating observable behavior while de-emphasizing “mentalistic constructs” (Wampold, 2001). These works were based on Pavlov’s classical conditioning theory, Joseph Wolpe’s systematic desensitization treatment, Skinner’s work on operant conditioning, and Beck’s cognitive-behavioral approach (Wampold, 2001). Research and practice on psychotherapy has sought to replicate the medical model (Wampold, 2001) demonstrated by a focus on evidence-based treatments established through randomized control trials (RCTs) and a predominance of psychotherapeutic approaches that are most amenable to the scientific method (i.e. cognitive-behavioral therapy; CBT). As Wampold (2001) asserts "specificity is the hallmark of Western medicine" (p. 78), therefore, medical procedures are valued inasmuch as they have carefully specified and documented working mechanisms on the body or brain.

### 2.1.1. The Diagnostic and Statistical Manual of Mental Disorders (DSM)

An emphasis on disease specificity highlights one of modern psychiatry's major goals: to develop a nosology that can be used across social and cultural contexts that can provide a common language for psychiatrists and psychologists to exchange knowledge about patients, technical approaches, and advance psychiatric science (Kirmayer, 2005). The American Psychiatric Association's Diagnostic and Statistical Manuals of Mental Disorders (DSMs) have been some of the most influential texts in psychiatric literature and a main reference in clinical practice devised to facilitate the description, classification, communication, and research on mental illness (La Roche et al., 2015). However, there has been ongoing debate regarding the "universality" of diagnostic categories across cultures (La Roche et al., 2015).

Critics of the DSM system have challenged its ethnocentrist foundation on Western American beliefs and practices that reify a biomedical model of disease (Alarcón, 2009). According to these critics, beliefs such as individualism, an emphasis on biology, and practices that promote standardization and quantitative means of knowing, limit the utility of the DSM across cultural groups, particularly when this nosology is used to diagnose cultural minorities within a Western society (Alarcón, 2009; La Roche et al., 2015). Furthermore, a Westernized approach has often incorporated culture as uniquely relevant for use with minority clients or in interactions between majority clinicians and minority clients (Lewis-Fernández & Díaz, 2002).

Psychiatrists often draw a rigid model of pathogenicity and pathoplasticity in which they presume biology determines the cause and structure of mental illness, and culture shapes or influences the expressions of mental disease (i.e. the "content" of the disorder) (Kleinman, 1988b). From an anthropological stance, distinct experiences of disease can display illness behavior with distinctive symptoms, patterns of help-seeking, and treatment responses. According to Kleinman (1988), these distinctive patterns express more about the disease than the underlying biological processes. Therefore, it is essential that we develop models in which biological and cultural processes dialectically interact.

However, culture is often viewed as a distraction from the project of developing a global and universal nosology (Kirmayer, 2005). Following a biomedical approach, the DSM-IV was based on a neo-Kraepelinian assumption of mental illnesses as discrete, distinguishable disorders that has not been supported by research. Although the current edition of the manual, the DSM-5, marks a greater movement toward a dimensional, rather than categorical, approach which acknowledges that disorders share symptoms, risk factors, and neural substrates that are virtually indistinguishable from each other (La Roche et al., 2015), its cultural embeddedness in Westernized values continues to be challenged.

Diagnostic systems explicitly guide clinical intervention, research, and policy domains. Implicitly, they help contain symptoms. For patients, they provide a way of re-constructing identity. The overall goal is problem identification and solution, making a list of signs and symptoms from patient's narrative that meets the criteria for a specific diagnosis (Kirmayer, 2005). While they may serve to explain symptoms, they differ in important ways from patients' personal narratives and biographical explanations of distress by mapping the client's personal story onto general clinical categories, based on the essentialist notion that diagnostic entities have crucial elements typified by a set of core features (Kirmayer, 2005).

How disorders are conceived by the profession has significant clinical, political, and economical ramifications. Thus, if disorders are defined biologically it prioritizes psychopharmacological treatments over social, economic, and psychological concerns, it minimizes the effects of systemic oppression (e.g., racism, gender inequality, colonization) over mental health, and it assumes symptoms inhabit individuals, further supporting individualistic interventions (La Roche et al., 2015). Attention to the historical, social, and contextual factors that make up an individual's cultural background and that influence mental illness presentation has increased interest in how mental health practitioners broadly incorporate culture into psychotherapeutic practice.

## 2.2. Attempts to integrate culture in psychological and psychiatric practice

### 2.2.1. Definitions of culture

The incorporation of culture in diagnosis, treatment, and intervention has been a concern throughout the history of psychiatric and psychotherapeutic care (DelVecchio Good & Hannah, 2015). Although the cultural assumptions of the medical model may be congruent with dominant populations, this model seems culturally incongruent for cultural minority populations. Consequently, the psychology profession has attempted to integrate culture into the research and practice recognizing that culture is a major determinant of social cognition, motivation and behavior (Morris, Chiu, & Liu, 2015).

Cultural frameworks influence the way we communicate and interact with others. Individualistic and collectivistic frameworks differ in style of communication, how individuals view themselves, perspectives on illness, and treatment goals (Logan & Hunt, 2014). People from individualistic cultural frameworks are more likely to view the self as stable, with internal traits, and separate from others. Hence, they may view illness as residing within themselves and symptom reduction as the main goal for treatment. In contrast, individuals from collectivistic frameworks may define the self by their social relationships and see themselves as connected to others. From this perspective, illness is understood as being outside of the self, and treatment is geared towards the return to an adaptive role or function. Consequently, cultural frameworks of both patient and clinician can have significant consequences on their ability to communicate effectively (Logan & Hunt, 2014).

Research has also found that different cultural frameworks influence how people understand and conceptualize folkbiological functioning, defined by ojalehto and Medin (2015) as the conceptions individuals hold on life and how animate beings function. For example, those from individualistic cultures (e.g., European American) tend to understand folkbiology in terms of similarities in taxonomy or classification, whereas people from indigenous cultures view the ecological relationships among biological phenomena (ojalehto & Medin, 2015). These distinctions have implications on understanding individuals' folkpsychology, that is, how they understand and conceptualize psychological functioning (ojalehto & Medin, 2015). Some cultures, such as collectivistic or indigenous ones, may emphasize psychological dysfunction as related to ecological issues.

The DSM-5 has defined culture as the "systems of knowledge, concepts, rules, and practices that are learned and transmitted across generations" (APA, 2013; p. 749). This definition includes multiple cultural factors such as language, religion and spirituality, rituals and customs, moral and legal systems, family structures, and life-cycle stages. Furthermore, the

DSM-5 acknowledges culture as an open and dynamic system that changes over time and interacts with individuals and groups that compose multiple cultures.

Incorporating culture in clinical practice can be challenging given its broad, complex, and heterogeneous definition (Alarcón, 2009). Definitions of culture fall into several broad categories—those focused on content, on social heritage and tradition, on rules or ways of doing and patterns of organization, psychological definitions related to adjustment and problem solving, and genetic definitions that view culture as a product or artifact (Cohen, 2009). Across these definitions, Cohen (2009) draws attention to consensus on several properties of culture: it emerges from the adaptive interaction of humans and their environment, it consists of shared elements, and is transmitted across time and generations. "Shared meanings" across individuals within a culture are a matter of degree; that is, the extent to which these meanings are shared (Winston & Maher, 2015). However, defining culture as specific shared values, beliefs, and practices can be troubling due to its emphasis on culture as residing within individuals (López & Guarnaccia, 2000).

Currently, culture in cross-cultural psychiatry and psychology is often reduced to demographic references of race, ethnicity, language, migrant status, or culture-bound syndromes (Alarcón, 2009). In the United States and other Westernized countries that have increasingly diverse populations, there is a tendency to equate culture with country of origin, or view or position racialized and ethnicized individuals as "other" compared to a majority White population (Carpenter-Song, Nordquest Schwallie, & Longhofer, 2007; Cohen, 2009). Race and ethnicity are often conflated, and many psychology and psychiatry training programs that endorse cultural competence associate cultural traits with specific racial and/or ethnic group memberships, disregarding the inherent cultural diversity within ethnic groups and other cultural dimensions that affect care, for example, social class and educational status (Christopher, Wendt, Marecek, & Goodman, 2014; DelVecchio Good & Hannah, 2015; Reyes Cruz & Sonn, 2011). Thus, culture continues to be understood as residing within an individual and attributed to people from non-majority sociopolitical groups --i.e., *not:* White, middle-class, educated, heterosexual, (Carpenter-Song, Nordquest Schwallie, & Longhofer, 2007).

In recent decades, psychiatrists and psychologists have developed frameworks that attempt to incorporate a more nuanced understanding of culture in theory and practice. This has implied an acknowledgement that culture is more than race and ethnicity and, as Cohen (2009) states, “all people are in fact multicultural” (p. 200). A multicultural approach to psychotherapy has the potential to integrate multiple facets of a person’s identity that make up their “culture” including race and ethnicity and, importantly, other “cultures” that tend to be overlooked, for example, socioeconomic status, geographic region they live in or come from, religion or spiritual beliefs, and educational experience.

Conflating culture with race or ethnicity is troubling, as conceiving certain disorders or symptoms as belonging to one “culture” or cultural group can lead to essentialist notions, stereotyping, and increased stigmatization of each group (Good, 1996; Gregg & Saha, 2006). Defining cultural boundaries can lead to inaccurately perceiving forces affecting many racial and ethnic minority populations (e.g. poverty, violence, racism) as “culture” (Gregg & Saha, 2006). Misuse and misperception of culture in mental health care can lead to reinforcement of biases and stereotypes (Gregg & Saha, 2006). Therefore, it is essential to stress that “culture” is not equivalent to poverty or discrimination, and conflating the two minimizes larger societal issues related to disadvantage and deprivation (Gregg & Saha, 2006).

Recent anthropological conceptualizations of culture emphasize cultural communities and identities as “variable, situational, dynamic, and embedded in struggles for power and control over resources” (DelVecchio Good & Hannah, 2015; p. 208). Culture is not static or outside of the observer; it is a product and process of social construction that provides information on how people live, interact, and make sense of their lives within specific historical, political, social, and economic contexts (Reyes Cruz & Sonn, 2011). In contrast, the term “cultural minority” is used in the DSM-5 to denote people who deviate from the White American norm (APA, 2014). Although this expanded conceptualization includes other types of cultural minorities beyond race and ethnicity (e.g., Muslim, poor, bisexual, transgender), “culture” is still largely based on identity markers (La Roche et al., 2015).

“Unpacking” culture continues to be crucial in the advancement of the study of culture and psychopathology (López & Guarnaccia, 2000). Researchers have moved beyond questioning which expressions of suffering are related to specific ethnocultural groups (e.g., Whites compared to communities of color), and instead are focusing on the values or belief orientations related to idioms of distress-- for example, how is depression related to a greater family orientation (*familismo*) in Latinx populations (López & Guarnaccia, 2000). Research continues to assess factors beyond value and belief orientations and uncover *what* about them improves experiences of distress (López & Guarnaccia, 2000).

There is a tension between universalist and culturally specific rhetoric in mental health policies and interventions (DelVecchio Good & Hannah, 2015). Though some policies promote training in cultural competence, the advancement of evidence-based practices within the mental health care system tend to assume psychological constructs are universally applicable (DelVecchio Good & Hannah, 2015). Thus, some have proposed a “more informed universalism" (Lewis-Fernández in DelVecchio Good & Hannah, 2015; p. 204) whereby practitioners incorporate information from psychodynamic, cultural, biological, and neuroscience and genetic approaches, to make sense of mental illness and design appropriate therapeutic interventions (DelVecchio Good & Hannah, 2015). Through a universalist framework, cultural factors and racial and ethnic differences in access to care and treatment outcomes are proposed as due to "universal aspects of mental illness" with individual factors (e.g., poverty) disproportionately present in certain groups (DelVecchio Good & Hannah, 2015). In contrast, DelVecchio Good & Hannah (2015) recommend mental health care professionals consider local contexts where cultural differences become significant to appreciate the diversity of experience among individuals in that cultural context. This approach suggests moving away from broad cultural categories that are often used to conceptualize culture (i.e., racial or ethnic status) to take a case-based or individualized approach where a broad spectrum of culturally-relevant factors are included in the conceptualization of a patient's presenting concern.

### 2.2.2. The Multicultural Counseling Competencies (MCC) movement

In 1992, Multicultural Counseling Competencies (MCCs) were established in the U.S. heralded as the "fourth force" in psychology (Sue, Arredondo, & McDavis, 1992). The MCC movement developed as a response within the counseling profession to societal change in the U.S. This movement was based on principles of social justice, inclusion, equity, and an essential need for cultural and contextual paradigms that reflected the lived experiences of a culturally diverse clientele (Arredondo, Tovar-Blank, & Parham, 2008). The rationale behind the need for multicultural counseling competencies was established given the body of research and literature that excluded the lived experiences of racial and ethnic minority populations, indicating decreased rates of therapeutic effectiveness in these populations (Sue et al., 1992). Further, Arredondo (1999) warned about the issues that arise from deficit-focused research models in counseling that concentrate on ethnic and racial minorities and perpetuate historical, political, and overall systemic forms of oppression.

According to multicultural counseling scholars (Arredondo & Arcienega, 2001; Pedersen, 2003; Sue et al., 1992) all counseling is multicultural or cross-cultural, and is influenced by sociopolitical and historical forces that shape counseling values, beliefs and practices based on biases and norms held within specific institutions and societies (Arredondo, 1999). Hence, fostering a culturally competent practice is paramount as "a culture-centered perspective protects us from inappropriately imposing our own culturally encapsulated self-reference criteria in the evaluation of others" (Pedersen, 2003; p. 33).

In their seminal work, Sue et al. (1992) provided a conceptual framework of the MCCs that included three levels of cross-cultural skills development and competency domains. MCC theorists proposed that provider's cultural encapsulation can be prevented by: a) increasing their awareness of culturally learned assumptions (Domain A: attitudes and beliefs), b) increasing their access to culturally relevant knowledge (Domain B: knowledge), and c) increasing their appropriate use of culturally sensitive skills (Domain C: skills) (Arredondo & Arcienega, 2001; Pedersen, 2003; Sue et al., 1992). MCC development is posited as a dynamic and continuous process, where learning and change happen in cognitive, affective, and behavioral modalities (Toporek & Reza, 2001). In a clinical setting, multicultural counseling competencies can be hypothesized to be a meta-therapeutic approach "wherein assessment processes and interventions are selected or modified on the basis of the cultural values and worldviews of the client" (Owen, Leach, Wampold, & Rodolfa, 2011; p.1).

The Guidelines for Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists (American Psychological Association, 2002) marked a step further in the implementation of MCCs by requiring the psychology profession to adopt these guidelines across APA-accredited training programs and attend to the needs of racially and ethnically diverse populations in the U.S. (Miville et al., 2008). Thus, a new generation of psychologists in the U.S. were required to incorporate a culturally sensitive approach in their research and clinical practice. Other Westernized countries with increasingly diverse populations have adopted similar multicultural counseling approaches. For example, in Canada, scholars have developed a conceptual "culture-infused counselling competence" model that integrates the attitudes, knowledge, and skills needed for multicultural counseling competencies (Collins, Arthur, & Wong-Wylie, 2010).

Despite the promotion of MCCs in psychotherapy, content analyses have shown a gap between MCC theory and empirical tests of effectiveness that guide training, assessment, research and practice (Arredondo, Rosen, Rice, Perez, & Tovar-Gamero, 2005; Worthington, Soth-McNett, & Moreno, 2007). Most articles in the literature have been exploratory and theoretical, with researchers recommending further empirical studies. Moreover, MCCs are under-referenced as a means to explain research findings, calling to question the operational definitions of MCC and their usefulness in theoretical development and empirical testing (Wendt, Gone, & Nagata, 2015; Worthington et al., 2007).

Much of the MCC literature has focused on how to maximize access to and use of psychotherapeutic treatments as well as treatment effectiveness for racial and ethnic minority clients, through training mental health care providers to become multiculturally competent. At a broad level, studies have demonstrated disparities in access, availability and utilization, showing that, compared to White clients, racial and ethnic minority clients receive less adequate care, have higher drop-out rates, and often report dissatisfaction with treatment and mistrust of clinicians (Wendt, Gone, & Nagata, 2015). At an individual level, the MCC literature has documented concerns in the therapeutic relationship including issues of racism and discriminatory practices among clinicians, and reports that ethnic and racial minorities are more often over-pathologized and over-diagnosed with psychotic disorders (Wendt et al., 2015).

It has been paramount to the MCC movement to understand the characteristics that make clinicians more culturally competent in their cross-cultural interactions. Many studies have focused on the therapists’ race and ethnicity as a possible factor contributing to multicultural competence. Studies have reported that therapists who identify as racial or ethnic minorities themselves have greater awareness and are often seen as more multiculturally competent compared to their White peers due to an increased involvement with communities of color, which allows them to culturally tailor treatment in more appropriate ways (Berger, Zane, & Hwang, 2014; Chao, Wei, Good, & Flores, 2011).

Researchers have also sought to determine the relationship between multicultural competencies and measures of psychotherapeutic processes and treatment outcomes. Tao and colleagues' (2015) meta-analysis found that client’s perceptions of therapists’ multicultural competence accounted for approximately 8.4% of the variance in psychotherapy outcomes including working alliance, client satisfaction, and depth of sessions. In a study on clients’ perceptions of their therapists’ multicultural competency, Owen and colleagues (2011) found that the degree to which clients perceived therapists as culturally competent was related to the therapeutic relationship or the personal beliefs they held about the therapist. Tao and colleagues (2015) have highlighted the importance of clinicians’ development of multicultural competence across clients, regardless of race and ethnicity. Hence, multicultural competency must integrate clients' intersecting cultural identities (e.g., religion, social class, sexual orientation).

The Task Force on Re-envisioning the Multicultural Guidelines for the 21st Century has recently published new multicultural guidelines that adopt an ecological approach (Clauss-Ehlers, Chiriboga, Hunter, Roysircar-Sodowsky, & Tummala-Narra, 2017). This approach emphasizes the role of intersecting identities and multiple layers of environmental influence (following Bronfenbrenner's ecological model) on the development of patients' personal identity and the dynamics that unfold within therapeutic encounters (Clauss-Ehlers et al., 2017). These guidelines are informed by multiple models of cultural competence including the American Psychiatric Association's Cultural Formulation Interview (APA, 2013), the American Counseling Association's Multicultural and Social Justice Counseling Competencies (Ratts, Singh, Nassar-McMillan, Butler & McCullough, 2016), and the Standards and Indicators for Cultural Competence in Social Work Practice (National Association of Social Workers, 2015).

A global issue with the MCC movement has been its translation to countries outside the U.S. and Western Europe. MCC training may be problematic because multicultural knowledge often emphasizes learning about certain minority groups according to U.S.-based sociodemographic factors (Smith & Ng, 2009). Furthermore, studies have shown that multicultural training is not related to multicultural knowledge (Chao et al., 2011). Thus, an emphasis on developing multicultural knowledge specific to certain groups are often irrelevant in other countries and cultures, and do not necessarily translate into multicultural competence.

Another challenge in the MCC movement has been its conceptualization as a "cross-cultural" approach. This conceptualization focuses on the interactions between providers and patients seen as "others"–their "otherness" often defined by their racial or ethnic identity. This narrow approach is clearly a product of where the theory has developed: an increasingly diversifying social landscape in the United States with a dominant White population. Although the MCC approach has been applied cross-nationally, it continues to be framed as exclusively relevant in cross-cultural work with ethnic and racial minorities. For example, in Spain, the MCC model has been found to be helpful for providing services with recent immigrants or ethnic minority populations (Burckhardt & Sánchez, 2006). However, research in countries such as Mexico (i.e., Ramírez Stege & Yarris, 2016) has shown a tendency for providers to minimize within-country cultural differences (e.g., "we are all Mexican" –an assumption that most Mexicans identify as being from mixed racial heritage or *mestizo*). Therefore, a cultural competence focus on race or ethnicity framed in North American terms is too narrow considering multiple influencing cultural factors such as gender roles, family values, rural or urban provenance, social class status, and educational experience. Although the MCC movement has sought to critique mainstream Western views on mental health care and has tried to advocate for a better integration of cultural aspects into care, it has not gone far enough in providing a framework through which clinicians reflect on the hegemonic philosophical and theoretical underpinnings of psychotherapy, and apply a cultural framework relevant to all clients, regardless of cultural minority statuses. There is a need to develop a cultural approach that goes beyond the sociopolitical reality of the U.S. toward a more globalized approach of cultural competency in psychotherapeutic practice.

This concern has prompted researchers to posit "cultural humility" as the missing link between a multicultural orientation and multiculturally-oriented clinical practice. According to Owen and colleagues (2014) a multicultural orientation includes: the therapists' cultural humility, an ability to integrate clients' cultural heritage into therapy, and comfortability engaging in discussions regarding the cultural aspects important to the patient. At an intrapersonal level, cultural humility is enacted by the therapist through openness to reflect on oneself as a cultural being, and willingness to consider the limitations they face in understanding others' culture, background and worldview (Hook & Watkins Jr., 2015). At an interpersonal level, culturally humble therapists demonstrate an "other-oriented stance" and incorporate the cultural background or identity of an individual or group into the therapeutic process (Hook & Watkins Jr., 2015). Thus, cultural humility incorporates multiple factors that influence the interactions between patients and providers. Culturally humble providers tend to show a genuine interest in the patient, are respectful of the patient's background and beliefs, are open to explore the patient's perspective, and reserve their assumptions of cultural knowledge of the "other" (Hook & Watkins Jr., 2015). In contrast with the MCC movement which fosters the development of core multicultural competencies, cultural humility assumes that providers can never be "experts" in understanding difference (Kools & Chimwaza, 2015). Renouncing a stance of "expertise" of an other's experience fosters continual self-reflection on the beliefs, values, and assumptions the provider contributes to the therapeutic interaction, and provides a foundation for the development of positive therapeutic alliances (Kools & Chimwaza, 2015).

In summary, the MCC movement has sought to counteract Western psychotherapy's cultural embeddedness through the development of core competencies in attitudes, knowledge, and skills specific to cultural groups and designed to decrease mental health disparities among minority populations. Nevertheless, there have been multiple challenges within this approach, namely, its lack of empirical testing and research on multiple cultural groups that reflect the movement's own cultural embeddedness as a U.S.-based theory and practice and perpetuates conceptualizations of "culture" as specific racial or ethnic groups. Despite some shortcomings, the MCC movement has highlighted important issues in clinical practice particularly related to the therapeutic relationship and the interaction between culturally different providers and patients. Recent iterations of cultural competence have highlighted the importance of cultural humility, provider self-reflection, and an "other-oriented" stance to develop a truly multiculturally competent psychotherapeutic practice.

### 2.2.3. Cultural adaptations

Mental health care providers have responded to the MCC movement's call for multiculturally-focused therapeutic interventions by developing cultural adaptations to treatment interventions. Culturally adapted, competent, responsive, sensitive, or tailored interventions are usually described as those which attempt to modify and improve treatment by adapting conventional psychotherapy that has been developed and tested on a majority White, middle-class, U.S. population, to fit the values, beliefs, attitudes, behaviors, contexts, and worldviews of ethnic and racial minorities (Benish et al., 2011; Domenech Rodríguez et al., 2011; Huey et al., 2014). Cultural adaptations include translation of treatment materials, incorporation of culture-specific interpersonal values (e.g., *respeto*, *familismo*, *simpatía*, religion, and spirituality), utilization of culturally-appropriate assessment, psychoeducation aimed at de-stigmatization of mental illness, and exploration of client's illness beliefs (Kalibatseva & Leong, 2014).

One way of classifying cultural adaptations is through top-down, bottom-up, or integrative approaches. The top-down approach involves culturally adapting an established treatment to a particular target group similar to "surface adaptations" (e.g. translating materials into another language). Bottom-up or "deep adaptations" are usually done in collaboration with potential recipients, and incorporates contextual factors (e.g., historical, political, cultural) that influence treatment. Integrative approaches use both top-down and bottom-up adaptations usually through a cultural adaptation framework (Kalibatseva & Leong, 2014).

The need to incorporate culture and adapt psychotherapeutic treatment and interventions is an acknowledgement that illness is a culturally shaped experience of distress that is manifested through mental, emotional, and somatic symptoms that reflect the patient's broad sociomoral notions of self and personhood, and their assumptions about the etiology, expected course of treatment, and social implications of their form of suffering (Benish, Quintana, & Wampold, 2011; Kirmayer, 2005; Kleinman et al., 2006). As the U.S.-based MCC movement has shown, the main motivator for the development of cultural competency models has been to decrease disparities in health and mental health among racial and ethnic minorities, and other populations at the sociocultural margins (Gregg & Saha, 2006). Yet, despite years of institutionalized efforts to incorporate and promote culturally sensitive and competent care in the U.S., policy studies such as Mental Health: Culture, Race and Ethnicity (Surgeon General, 2001) have reported persistent treatment disparities by culture, race, and ethnicity across psychiatric and medical specialties (DelVecchio Good & Hannah, 2015). Scholars have called for an increase in culturally competent providers and a need for culturally tailored evidence-based treatments as a way of decreasing mental health treatment disparities among cultural minorities who often struggle to access mental health care (Kohn-Wood & Hooper, 2014).

Cultural competence requires awareness of culture and how to apply that knowledge to diverse clients (Huey et al., 2014). Consequently, cultural competence movements such as the MCC have sought to educate health care providers and policymakers on issues of culture, culture-specific beliefs, and their impact on health (Gregg & Saha, 2006). Still, caution is warranted as culturally sensitive practice risks the "systematization of ethnic behavior as an array of psychologized symptoms" (Santiago-Irizarry, 1996; p. 3). An emphasis on culture may inadvertently place blame on a patient's culture for the presenting concern, and may obscure structural power imbalances embedded within institutions, patient-provider interactions, and the biomedical culture itself (Carpenter-Song et al., 2007). A main issue in the development of culturally adapted psychotherapeutic interventions has been how to transfer cultural competency knowledge into practice and develop concrete skills that can be applied with culturally diverse patients (Yasui, 2015).

Several authors have developed cultural adaptation frameworks to guide the adaptation of conventional interventions. A comprehensive evaluation of these frameworks is beyond the scope of this review, however, for a summary of cultural adaptation theories, the reader is referred to Ferrer-Wreder, Sundell, and Mansoory (2012). I will provide two examples of cultural adaptation frameworks that highlight common similarities in adaptation approaches. Hwang (2006) developed the Psychotherapy Adaptation and Modification Framework (PAMF) with six domains: 1) dynamic issues and cultural complexities, 2) orienting clients to psychotherapy and increasing mental health awareness, 3) understanding cultural beliefs about mental illness, its causes, and what are considered appropriate treatments, 4) improving the client-therapist relationship, 5) understanding cultural differences in the expression and communication of distress, and 6) addressing cultural issues specific to the population. Similarly, Bernal, Bonilla, and Bellido (1995) developed the Ecological Validity Model (EVM) following Bronfenbrenner's seminal work questioning the ecological validity –the degree of congruence between a person's experience of their environment and the researcher's assumptions of the properties of the environment– of psychotherapeutic theory and practice. These authors propose eight dimensions of an intervention and the culturally sensitive elements that should be considered in cultural adaptation: 1) language, 2) persons involved in the treatment (i.e. client-therapist relationship), 3) metaphors or symbols shared in the population, 4) content (i.e. cultural knowledge), 5) concepts that are consonant with the culture and context, 6) goals that align with positive and adaptive cultural values, 7) methods of treatment that are culturally appropriate, and 8) contextual factors affecting the individual (e.g. acculturative stress, migration, developmental stage, social supports). Relevant to the current study, these cultural adaptation frameworks share key commonalities in their attempt to adapt treatments: an emphasis on the client-therapist relationship, attention to contextual factors that affect presenting concerns and treatment, incorporation of local knowledge in treatment that is congruent to client's cultural values and beliefs, an understanding of culturally-specific expressions of distress, and development of culturally-appropriate treatment modalities that promote adaptive coping.

The Latinx population may be a popular target for cultural adaptations in the U.S. because it is the largest and fastest growing minority group in this country (U.S. Census Bureau, 2009). In a critical review on culturally sensitive treatments (CSTs) for depression, Kalibatseva and Leong (2014) reported a majority were behavioral or cognitive-behavioral, several were group treatments, and were targeted at ethnic minority and low SES women, particularly Latino and African American populations. Cultural adaptations specifically targeted at Latinx populations share general principles essential to the incorporation of culture in psychotherapeutic practice. Namely, cultural adaptations with Latinxs include an in-depth understanding of contextual factors that affect the client (e.g., acculturation, migration history, language proficiency), development of intervention strategies that are congruent with the client's practices, values and beliefs through the adaptation of mainstream psychological techniques (e.g., adapting CBT, incorporating spirituality in specific interventions), promotion of community and social connection through "cultural enrichment activities," and, to some extent, a negotiation between client and provider’s explanatory models of mental illness through psychoeducation (Anderson & Garcia, 2015; Domenech Rodríguez et al., 2011; Ford-Paz, Reinhard, Kuebbeler, Contreras, & Sánchez, 2015; Wood, Chiu, Hwang, Jacobs, & Ifekwunigwe, 2008). Cultural adaptations tend to pay special attention to incorporating community members with cultural knowledge to inform the treatment adaptation through community-based participatory research methods (Ford-Paz et al., 2015), and cultural adaptation specialists (Domenech Rodríguez et al., 2011).

Although multiple programs have been culturally adapted, very few articles document the cultural adaptation process or test the effectiveness of the interventions (Baumann et al., 2015). In one of the few randomized experimental trials on the feasibility and efficacy of a culturally adapted empirically supported model of parent training for Spanish-speaking Latinos, Martinez Jr and Eddy (2005) reported improved parenting practice, youth adjustment, and high satisfaction with treatment. These researchers reviewed the core components of the original intervention for cultural relevance and identified new culturally-specific content areas to incorporate. Subsequently, the intervention program was presented to Latino parent focus groups to define cultural validity, identify possible challenges, and discus program delivery. Finally, further revisions were made during and after the pilot administration of the intervention (Martinez Jr & Eddy, 2005). Valdez and colleagues (2017) have taken a similar approach to their cultural adaptation of a community-based family intervention for Latina mothers with depression. Their pilot study has demonstrated improved psychological functioning and increased family support and functioning (Valdez, Abegglen, & Hauser, 2013; Valdez, Padilla, Moore, & Magaña, 2013). D’Angelo and colleagues' (2009) adaptation of a prevention program, also targeted at low-income Latino families, included offering the intervention in both English and Spanish, incorporating contextual factors affecting Latino families in the U.S, using cultural metaphors, and taking a strengths-based approach. Overall, these studies demonstrate that cultural adaptations of treatments are effective, feasible, positively influence the therapeutic alliance, and are well-received by Latinx populations (D'Angelo et al., 2009; Martinez Jr & Eddy, 2005; Valdez, Padilla, et al., 2013).

Current cultural adaptations or culturally sensitive treatments have shown encouraging data regarding participant retention and effect sizes showed significant improvement in participants' symptoms (Kalibatseva & Leong, 2014). Indeed, in a review of outcome studies regarding Latinx's health, substance use and mental health, Jani, Ortiz, & Aranda (2008) reported most studies with positive outcomes incorporated some form of cultural adaptation to treatment. Recent meta-analyses support the use of culturally adapted interventions but are unclear about how cultural adaptation enhances treatment effects (Huey et al., 2014). Recently, scholars have pointed to the importance of adapting psychotherapy explanatory models to clients' specific cultural beliefs about illness. Through a meta-analysis and moderator analyses, Benish et al. (2011) found that the only moderating variable that was significant in culturally adapted interventions was myth adaptation. The "myth" or therapeutic rationale is the explanation provided for the development of a mental illness (Benish et al., 2011). Benish and colleagues (2011) reported that culturally adapted treatments that included myth adaptations congruent with patients' cultural beliefs showed greater effects on psychological functioning. This provides information about the importance of patients' illness experiences, and understanding their beliefs regarding etiology, course and consequence of illness, symptoms experienced, and what they consider acceptable treatment (Benish et al., 2011; Kleinman, 1988).

### 2.2.4. The Cultural Formulation Interview (DSM-5)

The DSM nosology has developed its own response to incorporating culture into psychiatric and psychological assessment and treatment planning through the addition of the Cultural Formulation Interview in the last edition of this manual. The Cultural Formulation model has been heralded as one of the main methods for implementing a “culturally valid approach to care” (Lewis-Fernández & Díaz, 2002), one of the most useful cultural proposals for the DSM (Kirmayer, 1998), and “the single most practical contribution anthropology has made to psychiatric practice” (Kleinman, 2001). The cultural formulation can increase provider’s cultural knowledge by training them to elicit culturally relevant clinical material and cultural perspectives from patients and their families (Lewis-Fernández & Díaz, 2002). Similar to the cultural adaptation process, the Cultural Formulation model seeks to understand and incorporate key factors of a patient’s cultural background into the therapeutic process.

The Outline of Cultural Formulation (OCF) was the precursor to the CFI, developed for the DSM-IV by the Group on Culture and Diagnosis of the National Institute of Mental Health (Lewis-Fernández, 2009). It was based on a “mini clinical ethnography” approach that emphasizes a humanizing approach to patients’ suffering (Lewis-Fernández & Díaz, 2002). The OCF is comprised of four main categories: cultural identity, cultural explanations of illness & help-seeking, cultural factors related to psychosocial environment and levels of functioning, and cultural elements of the patient-provider relationship (Mezzich, Caracci, Fabrega, & Kirmayer, 2009). The information obtained seeks to improve diagnostic validity and align clinicians’ recommendations with patient and family understandings of illness and help-seeking expectations, which impacts treatment satisfaction, adherence, and response (Lewis-Fernández, 2009). However, lack of guidelines and examples in the DSM-IV’s OCF had limited its clinical use and propelled scholars to develop a standard interview, the current DSM-5 Cultural Formulation Interview (CFI).

The American Psychiatric Association and the DSM-5 Cross-Cultural Issues Subgroup collaborated to develop, implement, and disseminate the Cultural Formulation Interview (CFI) (DeSilva, Aggarwal, & Lewis-Fernandez, 2015). The CFI includes sixteen open-ended questions designed to elucidate the impact of culture on key aspects of a patient's clinical presentation (American Psychiatric Association, 2013). The instrument is divided into thematic sections, with written instructions for providers to pose questions and prompt follow-up comments by patients. One notable feature of the CFI is that it asks clinical providers to elicit patients' explanatory models of illness, drawing on the foundational work of Arthur Kleinman, which articulates how illness and treatment are inherently cultural processes (Kleinman, 1988b). The cultural formulation category on perceived causes and explanatory models focuses on the patients' view on how illness "works" –its cause, the reason for its presentation now and in this particular way, how it affects the patient, what would happen if the patient did not seek treatment, and the likely outcomes given the treatments available (Lewis-Fernández & Díaz, 2002).

Previous studies have found that using the cultural formulation has had a significant impact on clinical practice. Adeponle, Thombs, Groleau, Jarvis, and Kirmayer (2012) found that over-diagnosis of psychosis was frequent in an ethnic minority and immigrant clinical population in Canada. After using the cultural formulation, 49% of patients were re-diagnosed with non-psychotic disorders (Adeponle et al., 2012). Ramírez Stege & Yarris (2017) found that the use of the CFI increased feelings of trust among patients and providers, increased providers' understanding of patients' sociocultural contexts and supports, and for some, changed patients' course of treatment. Other studies have also found the CFI to be helpful in establishing rapport with patients (Aggarwal, Nicasio, DeSilva, Boiler, & Lewis-Fernández, 2013). Finally, researchers have reported differences among the type of practitioner using the CFI, with psychologists finding the cultural formulation process more helpful than physicians (Kirmayer, Thombs, Jurcik, Jarvis, & Guzder, 2008).

Critiques of the CFI have focused on how its conceptualization perpetuates erroneous views of "culture" as specifically relevant to certain cultural groups. The CFI has been criticized for being separated in the DSM manual from standard clinical case formulation, seemingly suggesting it should be used mostly with cultural minorities rather than incorporating cultural formulation as a standard assessment for all patients (La Roche et al., 2015). Thus, scholars have recommended including the CFI and cultural aspects of care more systematically throughout the DSM text (La Roche et al., 2015).

Scholars have also documented challenges in the implementation of the CFI. For providers, the CFI interview guidelines may seem rigid (Aggarwal et al., 2013), it may over-burden practitioners by additional time needed to be incorporated in standard assessments (Aggarwal et al., 2013; Ramírez Stege & Yarris, 2017). Further, researchers have noted the conceptualization of culture in the CFI can be problematic (Ramírez Stege & Yarris, 2017). Nevertheless, its use in standard psychotherapeutic practice has been shown to have a significant influence on patient care, it may help decrease distance between how patients and their providers make sense of mental illness and provide information on appropriate treatment approaches. Therefore, scholars continue to recommend further research and use of the CFI as a main tool to incorporate culture globally in assessment and psychotherapeutic processes (La Roche et al., 2015; Lewis-Fernández & Díaz, 2002).

To summarize the literature review thus far, the overall call to incorporate culture into psychotherapeutic theory and practice has been met with several responses. The fields of psychology and psychiatry are increasingly aware of the limitations of advancing and implementing psychotherapeutic theory and interventions that have been developed for only a fragment of the population (e.g., American, White, middle-class, heterosexual). This awareness initiated the Multicultural Counseling Competencies (MCC) movement in the U.S., calling for an increased attention to developing core cultural competencies and culturally appropriate practices that address mental health disparities among racial and ethnic minority populations in this country. Through cultural adaptations of interventions, psychotherapists have sought to incorporate cultural factors in the treatment of diverse populations in the U.S. Similarly, the DSM-5 nosology has developed the Cultural Formulation Interview (CFI) to address key aspects of patients' cultural background that influence the assessment and treatment of diverse individuals with mental illness. More generally, the incorporation of culture into psychotherapeutic practice is an attempt to understand how patients conceptualize their mental illness and the factors that influence their course of treatment. Explanatory models of mental illness provide the foundation for discerning individuals' culturally specific beliefs about the cause and onset of their mental illness, the likely course, and the types of treatment they believe will help alleviate distress. Hence, explanatory models of illness will be discussed in the following section of this literature review.

## 2.3. Explanatory Models of Illness

Explanatory models are the causal conceptions that patients, families, and practitioners hold regarding a specific illness episode (Kleinman, 1988). They are held by individuals, fluctuate over time and experience, and are unlikely to be homogeneous even within one community as they reflect a persons' social position (Kleinman, 1988a; Kleinman, Eisenberg, & Good, 2006; Young, 1982). A person's moral values, beliefs, and psychological characteristics determine the different meanings they attach to an adverse or stressful event (Frank & Frank, 1991). Furthermore, explanations of disorders reflect the zeitgeist of society and are generated by patients and the healers that seek to provide reassurance about the curability of a particular form of distress (Wampold, 2001).

Kleinman (1988a; Kleinman et al., 1978) makes the distinction between disease, sickness, and illness. He describes disease as the problem, that is, the biological dysfunction or abnormality from a biomedical perspective. Sickness is the conceptualization of a disorder from a broad population and macrosocial perspective according to a person's social position. Finally, illness are the changes in social functioning and human experience of sickness. Whereas a disease focus is on curing, an illness focus is on healing, and sickness is "a process for socializing disease and illness" through which biological signs are converted into symptoms that are socially significant (Young, 1982).

The biomedical model emphasizes disease–how signs and symptoms conform to specific diagnosable disorders (Kleinman et al., 2006). Its major goal is curing rather than healing, fixing rather than managing psychosocial factors, and treating rather than the search for meaning (Kleinman et al., 2006). In contrast, patients tend to emphasize their illness experience; namely, they search for ways to manage their illness problems, and their explanatory models conform to popular beliefs and expectations regarding helpful illness interventions (Kleinman et al., 2006).

Illness experience includes categorizing and explaining, in lay terms, the forms of distress caused by pathophysiological processes. It is shaped by how we perceive, experience, and cope with it, based on our explanations of sickness that are "specific to the social positions we occupy and systems of meaning we employ" (Kleinman et al., 2006; p. 141). Cross-cultural research reveals multiple perspectives of distress–ways in which people experience, understand and describe it (Lewis-Fernández & Díaz, 2002). These different languages of experiences are deemed idioms of distress (Lewis-Fernández & Díaz, 2002). Idioms of distress "are socially and culturally resonant means of experiencing and expressing distress in local worlds" (Nichter, 2010; p. 405). These idioms communicate experiential states of distress from mildly stressful to deeper experiences of suffering. Idioms of distress are embedded in cultural and interpersonal expectations of others that can be adaptive–effectively expressing distress and coping needs, or maladaptive–indicating psychopathology that decreases individual and collective well-being (Nichter, 2010). Common examples include a tendency to somaticize or to express psychologize suffering through bodily functions (i.e., suffering as "nerves"), or a description of distress as "fate" or a "spiritual test" (Lewis-Fernández & Díaz, 2002).

Illness experiences are shaped by culture. Our understanding of illness and what treatments will be considered congruent are structured by our "local cultural orientations," described by Kleinman (1988) as the ways in which we learn to think and act in our life worlds that replicate the current social structure. The local cultural system provides the theoretical framework for the therapeutic rationale (i.e., myth or explanatory model), and the knowledge of what type of ritual or behavior will help alleviate an individual's distress and is sanctioned by the group (Kleinman, 1988). The credibility of the myth or therapeutic rationale depends on its association to the dominant worldview of a particular culture (Frank & Frank, 1991).

The conceptions of symptoms of illness are grounded in how people understand the body and self, embedded within broader (e.g., societal) and local (i.e., patient or provider) cultural assumptions (Kleinman, 1988; ojalehto & Medin, 2015). For example, Kleinman (1988) describes the North American cultural concern with “unblemished skin surface, deodorized, youthful bodies, sexualized body shapes and gestures” as a reflection of the dominant capitalist worldview that prioritizes the body and self related to valued commercialized expectations (p. 13). A tendency, for example, for Mexican community members to somaticize or express mental and emotional distress as embedded in the body reflects permeable boundaries between the mind and body that are specific to their cultural milieu.

Cultural conceptions of illness are also relevant to how providers understand disease and deliver healing. For example, ojalehto and Medin (2015) report that energy healers tend to integrate mental and physical causes of illness, whereas mainstream nurses disconnect mind and body causal paths. Differences among patient and providers’ conceptions of illness have been documented between Mexican immigrants and U.S. laypeople and medical providers, suggesting culture shapes understanding of illness (ojalehto & Medin, 2015). These will be further discussed in the next section.

Cultures have specific illness categories or syndromes according to their systems of how illnesses are explained (Lewis-Fernández & Díaz, 2002). Wampold (2007) classified three different explanatory systems of illness: biological, psychological, and supernatural. Each of these systems has underlying assumptions that lead to different expectations for treatment rituals. In the treatment of depression, for example, a biological explanatory system would assume dysfunction happens at a physiological level and the treatment recommendation would likely be some type of anti-depressant that intervenes at a neurotransmitter level. In contrast, a psychological system would use different therapeutic approaches (e.g. CBT, psychodynamic, humanistic) that differ in their explanations and treatment expectations from the biological illness model. Finally, supernatural, religious, or spiritual explanations require yet another type of treatment that vary widely according to the specific practice in question (Wampold, 2007). To understand the illness experience and treatment expectations it is important to include patients' judgments about what type of coping will be helpful in facing their distress and what are the practical problems in daily living that their distress creates (Kleinman, 1988a). For instance, patients who attribute the cause of their distress to physical agents (e.g., virus, bacteria) are more likely to seek physicians for care, whereas those who interpret their illness as a product of troubled interpersonal or spiritual relationships may seek some form of psychotherapy or supernatural healing, respectively (Frank & Frank, 1991).

Evidence suggests treatment efficacy is strengthened when therapist's and client's therapeutic goals are congruent, and the therapist uses metaphors and symbols that correspond to client's cultural worldview (Huey et al., 2014). As previously discussed, myth adaptations (i.e., therapeutic rationale or illness narratives) that include client's beliefs regarding etiology, course, symptoms, and appropriate treatment can improve treatment outcomes (Benish et al., 2011; Kleinman 1988; Wampold & Imel, 2015).

### 2.3.1. Patient-clinician communication

Patient-clinician interactions are transactions between explanatory models (Kleinman et al., 2006). Authors have noted that discrepancies among patients' and clinicians' explanatory models in therapeutic values, expectations, and goals can cause breakdowns in communication that can lead to patient noncompliance with treatment and dissatisfaction with care (Kleinman et al., 2006). The quality of patient-clinician communication influences patient outcomes, and is likely to diminish when there are cultural differences between patient and clinician (Logan & Hunt, 2014). In the many clinical encounters, two systems of knowledge collide: "clinicians are experts in biomedicine; patients are experts in their own experience of distress" (Carpenter-Song et al., 2007).

In the clinical encounter, assumptions made by clinicians and patients can transform and influence the course of a diagnostic interview (Katz & Alegría, 2009). Studies have shown a tendency for cross-cultural medical encounters to be shorter in duration, that clinicians and patients respond with less affect, and affective verbal language influences patient participation and satisfaction (Logan & Hunt, 2014). These barriers to effective treatment highlight the importance for clinicians to develop communication skills that help them navigate different cultural belief systems such as taking appropriate amount of time, expressing empathy and respect, active listening, and eliciting the patient's perspectives, which can help lay the foundations for effective therapeutic encounters and allow them to reconcile differences in belief systems (Logan & Hunt, 2014).

Clinical encounters are inherently situations of unequal power and authority in which physicians dominate, directing conversation, and limiting patients' ability to relate their illness experience (Kirmayer, 2005). Just by virtue of their professional training and educational attainment, psychotherapists possess higher social statuses than most of their patients (Frank & Frank, 1991). Furthermore, clinical encounters are embedded within larger sociocultural contexts including economic, health care, work, family, and community systems (Kirmayer, 2005). Therefore, it is unsurprising that discounting patients' cultural views of treatment can compromise adherence and engagement in the psychotherapeutic process (Lewis-Fernández & Díaz, 2002).

Alternatively, effective interactions among clients and clinicians reflect a special kind of engagement that is characterized by an empathic approach beyond the simple task of acquiring useful evaluation information, and facilitates a deepening level of commitment with an ‘other’ (Katz & Alegría, 2009). Through a reflective process, clinicians can shift their view of the client as a person rather than a member of a stereotyped group, therefore, allowing them to be ‘seen’ (Katz & Alegría, 2009). As proposed within the cultural humility literature, a clinicians’ move toward self-reflectivity can promote an analysis of themselves *in relation* to their patient (Hook & Watkins Jr., 2015; Katz & Alegría, 2009).

Nichter (2010) was interested in why stakeholders are invested in interpreting experiences of distress in particular ways. This author recognized that interpretations of distress were influenced by the social positions each stakeholder occupies. In addition to individual idioms of distress, Nichter (2010) focused on how others, such as families and communities, respond to displays of distress and how their feedback influenced experience and expression of distress. He argued that by looking at these interactions in context providers could determine whether a particular behavior maintains or interrupts problematic behaviors for a particular person or group.

According to Kleinman (1977), most societies have family-based care yet Western clinical research and practice has not addressed how to adequately include patient-family or family-practitioner interactions. Families are essential to the illness experience and clinicians would be wise to include family narratives in their clinical practice as they provide information on a patients’ coping resources (Kleinman, 1988). Patient and families’ illness experiences are shaped by the bodily, cognitive, and interpersonal aspects of the disease that inform symptom presentation, perceived etiology, appropriate treatment choices, and outcome expectations (Lewis-Fernández & Díaz, 2002). Kleinman (1988) urged clinicians to affirm patients’ experiences of illness and understand patients' explanatory models to arrive at the most acceptable, and likely helpful, therapeutic approach.

### 2.3.2. Explanatory models of mental illness of Latinx patients and their families

A psychotherapeutic procedure will be more or less effective given the socio-cultural context of the person seeking healing. In this sense, treatment acceptability will depend on the individual's cultural background and context, and the effectiveness of treatment may depend on whether the patient and the provider share customs and a cosmogony that allows them to set agreeable treatment goals and interventions (Vallejo Samudio, 2006). There has been little research on the explanatory models of mental illness in Mexican populations, however, research on Mexican Americans can provide some insight into the cultural views of mental illness and emotional distress in this population.

Studies on Mexican or Latinx migrants in the U.S. report patients emphasize the interaction between behavioral, emotional, and physical causes and treatments of illness, particularly stressing the social and contextual causes of distress (Cabassa, Lester, & Zayas, 2006; Martínez Pincay & Guarnaccia, 2006; Martinez Tyson, Castañeda, Porter, Quiroz, & Carrion, 2011; Maupin & Ross, 2012). Studies have shown large variability among how Mexican Americans (i.e., Letamendi et al. 2013) and Hispanics (i.e., Cabassa et al., 2006) express their anxiety or depression symptoms, despite commonly held beliefs that Hispanic and Latinx populations share idioms of distress such as "*ataque de nervios*." Participants described feeling "desperate" (*desesperado*; Letamendi et al., 2013) and "being in a labyrinth" of interpersonal and economic burdens (Cabassa et al., 2006) that impede their access to emotional support systems that aid coping. Traumatic experiences are also cited as a precipitant to mental illness among Mexican Americans, reporting physical causes, substance abuse, losses, personal relationships, and lack of support as contributing factors that cause mental distress (Barrera, Schulz, Rodriguez, Gonzalez, & Acosta, 2013). The few studies on Mexican patients' mental illness beliefs and causal attributions report similar findings to their U.S. counterparts, highlighting the importance of social and contextual factors in their illness narratives, for example, attributing psychotic symptoms to social factors (i.e., Gómez-de-Regil, 2014), or contextualizing distress within prevailing indigenous community values and practices (i.e., Eroza & Gordillo, 2008). Other studies in Mexican indigenous communities demonstrate emotional distress is embodied (i.e., "illnesses are mapped onto the body") similar to integrative indigenous views of mind, body, and soul (Cartwright, 2007).

Studies have noted differences and similarities among how patients and their mental health care providers make sense of mental and emotional distress. Several studies show that biomedical staff and mental health care providers tend to focus on biochemical or biological causes of mental illness or utilize a folk/disease dichotomy rather than focusing on the social and contextual factors causing distress (Martinez Tyson et al., 2011; Maupin & Ross, 2012). Nevertheless, Barrera and colleagues (2013) report that Mexican Americans attributed mental distress to genetic factors, chemical imbalances, and thoughts and emotions, which is consistent with the dominant biomedical and cognitive-behavioral conceptualizations of mental disorders in the U.S. Indeed, only one participant out of the 82 in that study mentioned supernatural forces (i.e., witchcraft or *brujería*) as causing mental distress (Barrera et al., 2013). Martínez Pincay and Guarnaccia, 2006 also reported Latinxs commonly describe depression in terms that mirror the list of symptoms found in the DSM classification. Therefore, it is yet unclear whether biomedical expertise (i.e., having a higher level of medical knowledge), more than culture, fosters differences among providers' and patients' causal attributions to mental distress.

A review of research into the explanatory models of mental illness of patients and their families confirms a general failure to integrate family members' explanatory models in patient care. This could reflect the hegemonic Western practice of mental health care that tends to exclude families in the treatment of identified patients (Lefley, 1985). This exclusion was accentuated when research on patients with schizophrenia focused on how family dynamics can contribute to course of illness (Lefley, 1985). However, not all cultures separate family from the treatment of mental illness, and non-Western countries often utilize families as main resources for patient care (Lefley, 1985). Thus, psychiatric and psychological practice can gain from studying families as distinct social subsystems and understanding how families' values and norms relate to those of the larger cultural group (Lefley, 1985).

Some studies have focused on families' perceived etiology of the mental illness of a family member. In one study in Africa (Ensink & Robertson, 1999), most families (80%) considered psychosocial factors as the etiological cause of mental illness, including indigenous causes (e.g., bewitchment, failure to hold specific rituals), religious causes, and fate. Only 7% of families considered mental illness to be due to physical factors (Ensink & Robertson, 1999). Similarly, in a study on Latino families of patients with schizophrenia, the majority of family members considered interpersonal problems and other external environmental stressors as the main cause of the disorder (Weisman, Gomes, & López, 2003).

Explanatory models of illness can also provide information on how families cope with a family member's mental illness. For example, many Latino families have implicated God in their causal attributions, and reported religion as a main source of support and comfort when coping with a relative's mental illness (Weisman et al., 2003). In a narrative analysis, Stern, Doolan, Staples, Szmukler, and Eisler, (1999) described how caregivers of individuals with schizophrenia make meaning of a psychotic episode, usually exemplified either as stories of restoration/reparation, or through chaotic or frozen narratives. These different conceptualizations of a psychotic episode have implications on coping and therapeutic outcomes, expressing either criticism or support of the family member experiencing psychotic episodes.

Studies on patients' causal attributions of mental illness also provide insight into acceptable treatment modalities. For example, in a Latinx sample, Vargas and colleagues (2015) noted patients believed "putting forth effort" (in Spanish, *poner de mi parte*) was going to be more helpful in treating depression than antidepressant medication. Cabassa and colleagues (2006) also report apprehension towards using antidepressants in a Hispanic sample, particularly as they viewed interpersonal and social factors to be the causes of their depression. For Latinxs, "unburdening oneself" (in Spanish, *desahogarse*) may be an important psychotherapeutic treatment expectation (Martínez Pincay & Guarnaccia, 2006a).

To establish congruence between providers and patients' explanatory models there seem to be two main approaches: provider adapts to patient or patient adapts to providers' explanatory models. To help patients understand the treatment, providers often propose "psychoeducation" as a benign socialization of clients into the hegemonic Westernized worldview of psychological practice (Wendt, Gone, & Nagata, 2015).  To illustrate, an intervention in India by Das and colleagues (2006) sought to change the explanatory models of relatives of people with schizophrenia to conform to biomedical explanations of illness. These researchers found their intervention reduced non-biomedical causal explanatory models in the relatives who completed the educational program. In this context, the providers recognized that incongruence existed, and that greater congruence was desirable—however, many did not recognize problems with potential incongruence in explanatory models or illness narratives.  Although there is some research on families' explanatory models of illness that allow clinicians to understand the need to integrate their perspective in clinical practice, to date, there is still a dearth of information on how providers', patients', and families' explanatory models of illness interact and influence treatment expectations.

Explanatory models of mental illness help providers understand the factors that influence how an individual makes sense of their distress. Whereas patients tend to emphasize the psychosocial aspects of mental illness, providers often focus on the biological -disease- processes that make up a mental disorder. The differences among providers', patients' and family members' explanatory models reflect their social positions and "cultures" influenced by a broader hegemonic biomedical approach to treating mental illness. Unfortunately, a lack of knowledge on how patients conceptualize their distress also impedes knowledge on culturally appropriate sources of coping and acceptable treatment approaches. Thus, U.S.-based psychologies have emphasized a need to incorporate culture in psychotherapeutic to address mental health disparities particularly among non-White populations. Yet, this concern has been scarcely addressed in developing countries where "culture" is less racialized (i.e., a comparison of White to ethnically diverse) and regarded as more homogeneous, despite vast cultural differences within these populations.

Mexican psychotherapy provides an interesting subject for further inquiry into how culture is incorporated into psychotherapeutic practice, particularly given the historical, social, political, and academic exchanges between the U.S. and Mexico. An understanding of how Mexican providers, patients, and their caregivers make sense of mental illness can provide insight into the needs of recent immigrants to the U.S. Additionally, a global perspective on the cultural factors that affect mental health care can inform broader global mental health agendas that seek to diminish health disparities, particularly in low- and middle-income countries. Next, I review the literature specific to Mexican psychotherapeutic practice and explanatory models of mental illness.

## 2.4. Healing Practice in Mexico

### 2.4.1. Psychotherapy and training in Mexico

According to Sanchez-Sosa (2007), psychotherapy in Mexico developed from two psychodynamic approaches: one identifying with psychoanalytical orthodoxy embodied by José L. González, Santiago Ramírez, and Luis Feder, and the other identifying with the sociocultural tradition of Erich Fromm propelled by Raúl González and Guillermo Dávila in the mid 1950s. Other foreign theoretical influences prevailed as from the 1950s onward many graduates from training programs in Mexico began to pursue master's and doctoral degrees in other countries, particularly in the U.S. that were highly influential in the field of psychology in Mexico (Portal, Suck, & Hinkle, 2010).

In many Mexican psychology training programs, syllabi and textbooks are brought in from the U.S., although the social and cultural landscapes of the U.S. and Mexico are very different based on socioeconomic development, social inequity, among other factors (Díaz-Loving, Reyes-Lagunes, & Díaz-Guerrero, 1995; Portal et al., 2010) The disconnection between theory and practice has been a major issue in the development of clinical psychologists in Mexico (Esparza Meza & Blum Grynberg, 2009), with Mexican psychologists often struggling to adapt U.S. educational and training materials to fit the social and cultural realities of the communities in which they work (Portal et al., 2010). Díaz-Loving, Reyes-Lagunes, and Díaz-Guerrero (1995) warned against the tendency of Mexican psychology to use ready-made technology and theories in applied psychology without methodological knowledge for evaluating the interventions.

Psychological practice in Mexico has been influenced by how psychotherapeutic training has historically developed in this country. Before the 1970s, medical doctors, philosophers, pedagogues, psychiatrists and psychoanalysts were teaching psychology in Mexico (Esparza Meza & Blum Grynberg, 2009). During the 1970s, psychologists were specialized in areas of clinical and organizational psychology, and they were mostly restricted to conducting psychological testing and diagnoses (Esparza Meza & Blum Grynberg, 2009). Because of this training focus, psychologists in Mexico used to be considered psychiatrist assistants, and viewed as second-class professionals –a phenomenon that continues to contribute to issues within the profession, and continues to be a main challenge in the professional development of clinical psychologists (Esparza Meza & Blum Grynberg, 2009). Today, most undergraduate psychology degrees in Mexico offer clinical and organizational psychology specialty tracks. These tracks reflect an assumption that students who graduate with a *Licenciatura* in Psychology, a bachelor's degree that is equivalent to a "licensure," will mostly practice as psychologists in clinical mental health settings or in organizational –work– settings. In Mexico, community psychology has evolved separately from social psychology; this latter degree is only offered at the largest state-run university in Mexico City, the Universidad Nacional Autónoma de México (UNAM; Palomino Garibay, 2012).

The field of social psychology in Mexico has historically advocated for a Mexican psychology through the work of Rogelio Díaz Guerrero. In 1971, Rogelio Díaz Guerrero made a call to the Iberoamerican psychology profession to remove the colonist shackles of European and Angloamerican psychologies, and develop local conceptions regarding the structure, functioning and specific characteristics of the personalities of Latin American people ("our people"– "*nuestros pueblos*"; p. 6) He made specific contrasts between the U.S. and Mexico, noting many economic, organizational, and historical differences that influence the development and practice of psychology in each of these countries, and called for the operationalization of concepts inspired by the cultural idiosyncrasy of Latin America (Díaz Guerrero, 1971). His legacy continued through the work of his son Rogelio Díaz-Loving, however, despite continued efforts to promote a Mexican ethnopsychology, to date, these have not translated to clinical interventions or psychotherapeutic practices applied uniformly across the Mexican mental health care system specific to an indigenous understanding of the Mexican psyche. This has been particularly salient in public health care settings where most of the population seeks care.

Following Díaz-Guerrero's call to the psychology profession, some psychologists in Mexico and the U.S. have continued to identify the specific psychological needs faced by the Mexican population. At a graduate level, new training paradigms have emerged in community and counseling psychology, although these programs are mostly offered in universities in Mexico City such as the Universidad Nacional Autónoma de México (UNAM) and the privately-run Universidad Iberoamericana. A current issue is how training paradigms help Mexican psychologists develop psychological interventions that reflect the cultural diversity in Mexico and respond to the challenges faced due to poverty and social inequity (Portal et al., 2010). Through an 11-year collaboration between the US and Mexico, the University of Scranton and Universidad Iberoamericana developed a bicultural master's degree program in community counseling (or psychological counseling–as it is referred to in Mexico) to respond to the needs of underprivileged populations in both countries (Portal et al., 2010). As it has been in the past, Mexican psychology is looking to their U.S. neighbor as a reference for their development.

### 2.4.2. Mental health care in Mexico

Recent epidemiological studies demonstrate the mental health needs of the Mexican population. A national Mexican survey in 1994 reported an overall mental disorder prevalence of 15 to 18% in the general population, with depression affecting approximately 5% of males and 10% of females (Portal et al., 2010). In Mexico, 75% of the population lives is “urban areas” as defined by having a total population of over 2,500 people (Borges et al., 2006). According to a national psychiatric epidemiological survey in urban populations, 28.6% of Mexicans will suffer some form of mental disorder during their lifetime, with a 12-month prevalence of 13.9%, and 30-day prevalence of 5.8% (Medina-Mora, Borges, Muñiz, Benjet, & Jaimes, 2003). In other words, 1 in every 5 Mexicans will have some psychiatric disorder in their lifetime, almost 3 in every 20 during the last 12 months, and 1 in every 20 during the last 30 days (Medina-Mora et al., 2003). The most current assessment of mental health care in Mexico conducted in 2008 (IEMS-OMS, 2011) estimates that mental illness contributes 12% to the total burden of disease and is one of three leading causes of death among people between 15 and 35 years old.

The national psychiatric epidemiological survey reported schizophrenia, depression, obsessive-compulsive disorders, and alcoholism as the most disabling psychiatric disorders in Mexico (Medina-Mora et al., 2003). In an analysis of mental health service use among non-institutionalized individuals in Mexican urban centers, Borges and colleagues (2006) found the following 12-month frequencies of disorders: anxiety 6.8%; affective 4.8%; substance use 2.5%; any of these three 11.6%. These findings are similar to the national epidemiological survey which reported anxiety was the most frequent disorder (14.3%) followed by substance use (9.2%), and affective disorders (9.1%; Medina-Mora et al., 2003). This survey also reported regional differences with a higher prevalence in the central-west regions of Mexico (i.e., Aguascalientes, Jalisco, Colima, Guanajuato, and Michoacán; Medina-Mora et al., 2003). These differences are likely attributed to an increase in substance abuse disorders in the central-west (15.2% region-wide average compared to the 9.2% national average; Medina-Mora et al., 2003).

Despite the strong need for mental health care, there is a dearth of access to these services and mental health care in Mexico has been deemed an issue of social justice and equity (IEMS-OMS, 2011). Of the total health budget, only 2% is allocated to mental health, of which 80% is assigned to the operation of psychiatric hospitals (IEMS-OMS, 2011). Mexico has fallen behind global movements of deinstitutionalization and is still in the process of replacing the large mental hospitals and asylums that characterized previous eras of mental health care. Consequently, community-based services are lacking (IEMS-OMS, 2011). Rather than promoting community mental health programs and outpatient services, the Mexican mental health care system is currently endorsing medical primary care as the main source of support for people with mental illness, seemingly advocating an exclusively biomedical approach to mental health treatment (Berenzon Gorn, Saavedra Solano, Medina-Mora Icaza, Aparicio Basaurí, & Galván Reyes, 2013; IEMS-OMS, 2011). Indeed, in 2008 only 12% of psychiatrists and 34% of psychologists in Mexico reported participating in training on psychosocial interventions (IEMS-OMS, 2011). This raises further concerns about how mental health treatment is culturally tailored to the Mexican population.

In Mexico, there is a lack of access to mental health services (IEMS-OMS, 2011), lack of human resources specialized in mental health treatment (Knaul et al., 2012), and overall underutilization of mental health services (Borges et al., 2006). Borges and colleagues (2006) reported that fewer than 1 in 5 people with any psychiatric disorder received treatment in the last 12 months, and other researchers have indicated that only 10% of people with mental disorders in Mexico receive adequate care (Portal et al., 2010). This is contrasted with the U.S., where 40.9% of people with a mental disorder receive some treatment within 12 months, more than two times higher than in Mexico.

***Lack of access to mental health services.*** Mexico has four main health care systems: three public and one private. Two of the public, federally and state-funded systems are for individuals who are employed and their families: IMSS- Mexican Social Security Institute (http://www.imss.gob.mx/) and ISSTE- Institute of Security and Social Services for Government Employees (https://www.gob.mx/issste). Both are additionally funded through monthly amounts retained from employees' salaries and have a nationwide network of hospitals and outpatient clinics. The third public system, *Seguro Popular*, is mostly state-run, administered under the Ministry of Health, and covers the health care needs of those who are unemployed or those who would not be covered under any other system. The private health care system is generally comprised of hospitals, medical offices, and outpatient clinics funded by charities, corporations, or groups of physicians who have agreements with insurance companies (Sanchez-Sosa, 2007).

In Mexico, access to health care is a constitutional right (Laurell, 2010b). However, under several neoliberal reforms beginning in 1983, this right has been modified, changed, and conditioned in ways that restrict Mexican citizens' current access to health care (Homedes & Ugalde, 2009; Laurell, 2010b; Tamez González & Valle Arcos, 2005). The health care system went from being largely federally administered to an increasingly de-centralized system (Homedes & Ugalde, 2009). The health reforms in Mexico were enacted to expand the private sector of medical care, claiming this expansion would increase equity in health care provision (Tamez González & Valle Arcos, 2005). These reforms provided increased responsibility to individual states, with federal funding apportioned based on each state's economic condition

(Homedes & Ugalde, 2009). Researchers posited, however, that the reforms would be followed by increased stratification in the population based on their payment capacity (Tamez González & Valle Arcos, 2005).

Beginning 2004, *Seguro Popular* was instated across Mexico to ensure all citizens had access to universal health care, as recognized by the Mexican Constitution (Homedes & Ugalde, 2009; Knaul et al., 2012). Any Mexican who is not covered under employment-based insurance (i.e., IMSS or ISSTE) can apply for *Seguro Popular*. This insurance is voluntary and was developed in response to a lack of social protection against the financial burden of disease for the most marginalized of the Mexican population (i.e., impoverished, unemployed and uninsured; Frenk, 2006). According to Knaul and colleagues (2012), Mexicans are able to access *Seguro Popular* regardless of health status, pre-existing conditions, and socioeconomic status, which would eliminate the risk of inequitable enrollment. To enroll in *Seguro Popular,* families contribute 4-5% of their annual income, however, most families have been exempt from payment because this was too high a cost (Laurell, 2010a).

Since its inception, a main focus in the successful implementation of *Seguro Popular* has been to increase access to health care among the Mexican population. According to some researchers, *Seguro Popular* has been successful in significantly reducing and nearly eliminating out-of-pocket costs for psychiatric care after patients are connected to services (Frenk, 2006; Knaul et al., 2012). However, concerns about the quality of health care have continued, and described as “a moving target” due to issues in enrollment and access to services (Knaul et al., 2012). In theory, states receive funding for *Seguro Popular* based on enrollment numbers, health needs, and performance (Knaul et al., 2012). But in practice, states have the same fixed rates to support families enrolled in *Seguro Popular*, which contributes to discriminatory and inequitable care for the poorest states of the country (Laurell, 2010b). That is, the increase in access to care has not been equally met with a reduction in health inequity nor increased quality and efficiency of health care services (Homedes & Ugalde, 2009). For example, a recent study conducted in a remote rural area in the state of Chiapas indicated that Mexicans were less likely to seek medical care from government clinics compared to private services due to long waits, convenience, pride, bureaucratic issues, and infrastructure deficiencies (Molina & Palazuelos, 2014). Mexicans in Chiapas also had significant issues trusting providers due to previous experiences of discriminatory or condescending attitudes, gender-based power dynamics, and discrepancies among how providers and patients understand and treat health and illness (Molina & Palazuelos, 2014). Patients in this context were described by local health providers as "people of low culture," evidencing classist attitudes toward those they served whom they often treated paternalistically and expected unquestioning obedience, compliance, and respect (Molina & Palazuelos, 2014).

*Seguro Popular* is a reflection of a broader political philosophy seeking to decentralize the power and responsibility of the government over health care, and increase the participation of the private sector (Laurell, 2010a; Tamez González & Valle Arcos, 2005). Another component of this approach is an emphasis on a purportedly scientific approach to measure and promote outcomes of "evidence-based public health policies" and "evidence-based medicine" (Laurell, 2010a). A main concern in how evidence is collected is that the same institutions that finance these health insurance initiatives are often developing the research that provides evidence for its success (Laurell, 2010a). In Mexico, Julio Frenk (cited here, 2006) commissioned and paid Harvard University and the National Public Health Institute (NPHI) to evaluate the effectiveness of *Seguro Popular*, resulting in five articles prominently published in *The Lancet* allegedly demonstrating the success of the program (Laurell, 2007, 2010b).

A next step in ensuring high quality treatment is to monitor patient outcomes across systems of care. Monitoring, assessing, and evidence gathering will be essential in understanding the gaps of care in this system (Knaul et al., 2012). The Mexican Health Secretary has a national system of health quality indicators (INDICAS: *Sistema Nacional de Indicadores de Calidad en Salud; Secretaría de Salud,* 2018). This system is a mechanism to register and monitor the quality of health services and to collect data to compare medical units across the country (Secretaría de Salud, 2018). At the federal level, local medical units are asked to register and submit online the results of various outcome measures including surveys provided to users, review of clinical records, and registers across medical units (Secretaría de Salud, 2018). This information is expected to be analyzed by committees comprised of professionals, an "*aval ciudadano*" or "citizen guarantee," and other local representatives. Their analysis informs actions and implementation plans with the purpose of improving local medical services (Secretaría de Salud, 2018). This "citizenship representation" on the committee was confirmed by Dr. F., a Mexican colleague who was a psychiatry resident at the study site in 2014 and has worked within the system of *Seguro Popular* since 2010. He reported that most hospitals have a special committee that oversees treatment quality titled the Committee of Patient Quality and Security (*Comité de Calidad y Seguridad del Paciente*; COCASEP). Although one account, Dr. F. described concerns about the implementation of larger government efforts that monitor the quality of services within the health care system:

| | |
|---|---|
| "*Los indicadores que manejan son manipulados todo el tiempo, no son confiables, y solo se hacen con fines políticos…no hay ninguna estrategia o programa a gran escala que lo lleve, si alguien lo hace, quizá sean investigaciones internas, pero no* | "the indicators [for outcomes] that they work with are manipulated all the time, are not reliable, and are only done with a political end… there is no strategy or broader scale program that carries it, and if someone does, it's maybe internal |

> *miden por ejemplo el impacto de los tratamientos… lo que hacen es supuestamente realizar encuestas (manipuladas) en las que le preguntan a la gente por el trato que ha recibido, el tiempo de espera para la atención, las condiciones de la infraestructura en salud...los miembros del consejo este suelen ser casi siempre directivos pero no siempre...también existe una figura llamada "aval ciudadano", una persona de la comunidad que en teoría debe de servir de enlace entre los usuarios y la institución y que debiera de revisar que la información no sea manipulada"*

> investigations, but they do not measure, for example, the impact of treatments… what they do is supposedly conduct surveys (manipulated) where they ask people about the treatment they have received, the treatment wait time, the condition of the health infrastructure… the members of the council are almost always directors but not always… there's also a person called the "citizen guarantee," a person from the community that in theory should serve as a liaison between the users and the institution and that should review that the information is not manipulated."

(Dr. F, personal communication cited with permission, February 9, 2018).

***Lack of human resources for mental health treatment.*** Lack of human resources specialized in the treatment of mental illness has been an additional barrier to providing quality mental health care in Mexico (Knaul et al., 2012). Portal and colleagues (2010) reported that 60% of psychological counselors report working in the private sector, compared to 20% in public, and 20% in non-profit sectors, respectively. Therefore, most psychological counselors in Mexico are likely providing services to a small percentage of the population that can afford out-of-pocket costs. Psychologists working in health care facilities in Mexico are not common and mostly provide psychological testing (Sanchez-Sosa, 2007). As of 2008, rates of mental health care practitioners per 100,000 people in Mexico were as follows: 1.6 psychiatrists, 1 psychologist, and 0.53 social workers (IEMS-OMS, 2011). These numbers are troubling when compared to countries like the U.S. with reported ratios of 7.79 psychiatrists, 29.03 psychologists, and 17.93 social workers per 100,000 people (World Health Organization, 2011).

Following WHO guidelines, Mexico has tried to move into a continuum level of care from providing community-level treatment at outpatient clinics to providing specialty services in psychiatric hospitals (Lara Muñoz, Fouilloux, Arévalo Ramírez, & Santiago Ventura, 2011). Yet there is currently dearth of psychiatrists operating at community-based levels of care where most of the interventions are targeted closer to the communities served rather than accessing specialized hospitals or treatment facilities (Lara Muñoz et al., 2011). Because of the shortage of psychiatrists in lower levels of care, primary care providers are being trained to respond to mental health concerns (Berenzon Gorn, Saavedra Solano, Medina-Mora Icaza, Aparicio Basaurí, & Galván Reyes, 2013). However, this approach has been inefficient in Mexico, with a growing need for direct integration of mental health services across different levels of care that include general physicians and psychologists, and view community-based care as fundamental in the provision of psychiatric treatment (Lara Muñoz et al., 2011).

Psychiatrists in Mexico are often providing the majority of treatment for mental or emotional distress within the larger Mexican health care system. A recent study conducted in 2015 estimated a total of 4,393 psychiatrists in Mexico (Heinze, Chapa, & Carmona-Huerta, 2016). Unfortunately, a vast number (42.09%) of these psychiatrists are located in Mexico City (Heinze et al., 2016). A major barrier to increase the general number of psychiatrists to treat the Mexican population is that only 134 to 150 (around 2%) of psychiatric residency slots are offered to the approximately 898-982 of medical residents applying for specialty training in psychiatry as their first choice (Heinze et al., 2016). According to the study conducted by Heinze and colleagues (2016), of the doctors who become psychiatrists, only 51.17% are ever certified by the Mexican Psychiatric Council (*Consejo Mexicano de Psiquiatría*; CMP), only 19.39% were currently certified, and less than half of all psychiatrists in Mexico (48.82%) were registered under the Mexican Psychiatric Association (*Asociación Psiquiátrica Mexicana;* APM). Despite the shortage of psychiatrists, these professionals are often the main source of support for treatment of persistent mental illness experiences.

***Underutilization of specialized mental health treatment.*** People with mental and emotional distress are less likely to seek specialized treatment in Mexico. According to the World Health Organization report in Mexico, the first point of entry to care for people with mental illness is usually general medicine, with approximately 50% of people receiving care in hospital settings (IEMS-OMS, 2011). Unfortunately, mental disorders in primary care settings are often inadequately treated or assessed, and frequently not referred to mental health specialists (Medina-Mora et al., 2003).

A major proportion of the Mexican population may seek alternative mental health treatment rather than specialized care. A study by Borges and colleagues (2006) in Mexico reported that the sector with the largest mean number of visits was the complementary-alternative medicine sector (44.7 visits), followed by other mental health care (5.9 visits), the general medical sector (3.5 visits), and the psychiatrist sector (2.8 visits; Borges et al., 2006). Mexicans experiencing mental distress seem far less likely to seek specialized psychiatric or psychological care and far more likely to utilize alternative healing approaches. This study provides some information on alternative types of mental health services Mexicans are utilizing however, there is a dearth of research on community-based treatments available.

An additional barrier in seeking mental health services in Mexico have been discrepancies between how mental health care providers and their patients conceptualize mental illness. While patients define mental illness based on the everyday problems that represent sources of stress (e.g., work related, conflict with children or partner, deaths or disease in the family, financial burdens, etc.), the services offered are based on psychiatric diagnoses (Medina-Mora et al., 2003). Consequently, the lack of agreement among the population’s felt needs and the services offered make treatment entry challenging (Medina-Mora et al., 2003). Studies in an urban Mexican population (e.g., Medina-Mora et al., 1992) found that people with emotional distress generally sought medical treatment as a secondary resource, asking for help within their immediate social network (54% asked family members or friends and 10% of priests or ministers), and then self-medicating (reported by 15%).

Mexican mental health practitioners need to consider how to integrate religious and spiritual aspects into the psychotherapeutic process as these are generally sources of strength and resilience among the Mexican population (Portal et al., 2010). Berenzon (in Medina-Mora, 2003) reported a high rate of use of alternative medicine as a complement to modern conventional medicine. In Latin-America, an estimated 50% of the population uses traditional medicine to treat disease, mostly by people who suffer chronic illness or as health prevention methods (Berenzon-Gorn, Ito-Sugiyama, & Vargas-Guadarrama, 2006). In a study on the treatment outcomes of eight patients with mostly adjustment or affective disorders under the care of *curanderos*, Zacharias, (2006) reported that six cases had complete recovery, and two had partial improvement, including a woman with schizophrenia. Some reasons why people resort to traditional medicine are: finding medical theories simplistic, incomplete or inadequate; ease of access and moderated cost of services; curiosity arising from anecdotes and testimony of family and friends who have sought traditional medicine before; belief that they will receive more cordial treatment with an allopathic provider; and wanting to be more involved in treatment and decision-making (Berenzon-Gorn et al., 2006). Patients' report of greater improvement with folk healers may be due to an emphasis on "explanation" or healing myth, greater concordance between the explanatory systems of the healer and the patient, and smaller social class differences between healer and patient (Benish et al., 2011; Kleinman et al., 2006). For example, according to Santiago-Irizarry (1996), Hispanic patients being treated in the U.S. reported that being able to discuss their alternate religious and spiritual beliefs, such as *santería* and *espiritismo*, can help them adopt medication.

Some of the major challenges of the Mexican mental health care system in the next few decades will be to train mental health care professionals, strengthen mental health promotion and prevention programs, improve rehabilitation and reinsertion programs, and strengthen and promote the interaction of therapists from other medical services, including those in allopathic and traditional Mexican medicine and alternative treatments (IEMS-OMS, 2011). Understanding how Mexicans make sense of their mental illness concerns and their treatment expectations will be a first step in understanding the type of services the mental health sector should be providing.

### 2.4.3. Indigenous healing in Mexico

Mexican cultures reflect a rich interaction between pre-Colombian ethnic groups and European–mostly Spanish–colonization history that have resulted in a variety of ethnicities, languages, values, and traditions that, mixed with globalization, make up current Mexican families and communities (Sanchez-Sosa, 2007). Thus, conceptions of Mexican culture include cultural heritage in addition to a variety of factors such as educational histories, income, and residence (i.e., proximity to urban areas) (Sanchez-Sosa, 2007). Given the history of colonization and cultural exchange, indigenous medicine and healing must be addressed to understand the broader picture of mental health care in Mexico.

Indigenous medicine, when used as a synonym for traditional medicine, becomes a confusing term because the latter alludes to allopathic conceptions and medical practices that are not validated by Western academic psychology (Vallejo Samudio, 2006). In this category there are Eastern medical practices such as acupuncture, and alternative medical practices like homeopathy. Therefore, it is important to define indigenous medicine (in Spanish, *medicina* *indígena*) as the medicine that develops conceptions, processes, and healing practices that are native to the American continent and have been practiced throughout millennia by American indigenous people (Vallejo Samudio, 2006).

"Mental health" from a non-Western perspective implies a relationship between the subject and their surrounding socio-cultural context (Vallejo Samudio, 2006). In indigenous medicine, people are viewed through an integrative framework as physical, social, and cultural beings (Vallejo Samudio, 2006). Therefore, indigenous medicine treats the social being who becomes ill, in a specific context (Vallejo Samudio, 2006).

Indigenous medicine has its epistemological basis in its indigenous cosmogony and cosmology. This particular epistemological framework is less accessible for questioning and study by Western knowledge as it might easily incur in reductionisms and schematizations characteristic of positivistic Western science. In indigenous medicine practice, healing interventions for the body and soul are the same; the treatment will depend on the habits and customs of each cultural ethnicity (Vallejo Samudio, 2006). Healers are often individuals who have a "divine gift" (*don*) for healing and use natural and supernatural interventions (Applewhite, 1996).

Mexican culture is strongly influenced by its pre-Colombian civilizations, mostly from the dominant Aztec (nahua or mexica) and Mayan groups, although various Mexican regions were historically populated by multiple ethnic groups including toltecas (mostly in the states of Mexico, Hidalgo, Morelos, Tlaxcala and Puebla), olmecas (mostly in the states of Tabasco and Veracruz), and chichimecas (mostly in the central states of Mexico, including Querétaro, Jalisco, Coahuila and San Luis Potosí) (Villaseñor Bayardo, 2008). At the arrival of Hernán Cortés, the Spanish conquistador, the Aztec empire was the most influential and covered three important cities under the rule of Moctezuma: Texcoco, Tlacopán, and Tenochtitlán, which currently surround the modern Mexican capitol, Mexico City (Villaseñor Bayardo, 2008).

The nahua worldview was dominant at the time of Spanish conquest. They denoted mental illness as *cuatlahuelíloc* or *yollotlahuelíloc* (Villaseñor Bayardo, 2008). *Cuatlahuelíloc* came from the word *cuaitl* referring to the superior part of the head, and *yollotlahuelíloc* referred to the heart (in nahua, *yollotl*), both postulated as centers of reasoning and human consciousness (Villaseñor Bayardo, 2008). According to their worldview, mental illness was caused by organic dysfunction located in the head and the heart. However, the body was not conceived as separate from spirit nor the individual separate from society: the cosmos and [wo]man was a whole. The head was particularly important as it was believed to be the center of communication between the individual, society, and the cosmos. Further, nahuas made a distinction between "good diseases" inflicted by the gods, and "bad diseases" caused by dark magic, although both could be equally disturbing. To the nahua people, disease etiology was explained as a transgression of social principles, therefore it was essential to cure disease not only for the sake of the individual but for the community as a whole. Consequently, pre-Colombian medicine acted as a regulator of social control (Villaseñor Bayardo, 2008).

Current Mexican indigenous medicine reflects its Aztec and pre-Colombian heritage. People seeking indigenous forms of healing request help from "*brujos*" (witch doctors) and "*curanderos*" (medicine men), who use various healing techniques (Applewhite, 1996; Vallejo Samudio, 2006). Traditional healers are classified according to the technique they use and include herbalists (*yerberos*), bone and muscle therapists (*hueseros* and *sobadores*), and midwives (*parteras*), in addition to specialized *curandero* practitioners (Applewhite, 1996). *Curanderismo* has its literal origin in the Spanish word "*curar*" – to heal. Because of its indigenous roots, *curanderismo* was highly persecuted during the Catholic inquisition and has had a history of rejection within Mexican society particularly among privileged classes (Zacharias, 2006).

Similar to the nahua worldview, Mexican *curanderos* conceptualize health and illness as manifesting through three interconnected and interactive dimensions: "spirit" (*espíritu*), "soul" (*alma*), and "body" (*cuerpo*; Zacharias, 2006). Disease is conceptualized through the patient's integration and perception of their body and their interpretation or the meaning they make about their problem (Berenzon-Gorn et al., 2006). Thus, diagnosis and treatment is easily tailored to how each patient names and lives their illness (Berenzon-Gorn et al., 2006).

Traditional healers in Mexico are still widely sought. In a Mexico City sample (Berenzon-Gorn et al., 2006), traditional healers reported that the main reason people seek their care is due to issues related to everyday life such as problems in romantic relationships, family problems, work-related issues, and economic and legal difficulties. According to the healers, these issues mainly impact individual's emotional wellbeing, exhibiting symptoms of depression. A second reason people seek treatment from traditional healers is due to stress, tension, and "*nervios*" (anxiety). These issues are often associated with emotional problems (e.g. fear, feeling pressure) and physiological symptoms (e.g., fatigue, headaches, stomachaches, high blood pressure, muscle tensions and feeling nerves are not aligned, and feeling weak or broken). A third motive for seeking traditional healing is due to spiritual problems, defined by healers as diseases related to the soul or spirit, such as hate, resentment, ambition, jealousy, and loss of soul. Loss of soul can happen in multiple ways: through accidents, a fright (*susto*), and a surprise, among others. If a person loses their soul, they are no longer in control as the soul is conceptualized as the leading element of the human being. This belief has been passed down from mixture of Mesoamerican and Christian tradition and beliefs that a person has one soul and it is the vital force of their being (Berenzon-Gorn et al., 2006). Therefore, spiritual problems can only be cured by the person affected by this illness and *curanderos* (medicine men) function as "mirrors" to help the patient recognize the origin of their mood problem. Hence, traditional healing in Mexico today is used for multiple psychosocial concerns that incorporate indigenous conceptualizations of self and illness as integrated with body, spirit and soul.

Mexican mental health care seekers may feel more comfortable seeking mental health services from traditional healers who honor indigenous integrative views of mind, body, and soul rather than seeking services from Western medicine and biomedical explanations of mental illness that make a distinction between mind and body (Berenzon-Gorn et al., 2006). Additionally, *curanderos* de-emphasize pathology, and focus on therapeutic activities that aim to prevent mental illness (Zacharias, 2006). The message from indigenous to Western medicine is explicit and clear: it is not possible to understand human suffering without taking into account the sociocultural and environmental context where the person develops (Vallejo Samudio, 2006).

# Chapter 3: Methodology

## 3.1. Philosophical Assumptions

The current qualitative study adopted a social constructivist approach to understand how patients', caregivers', and providers' experiences of mental illness in Mexico are socially and historically constructed within a hegemonic Western model of mental health treatment (Creswell, 2007). Broadly, this research stems from an interest in how to incorporate local culture into therapeutic encounters (i.e., psychiatric and other mental health services).

## 3.2. Strategy of Inquiry

The study adopted a hermeneutic phenomenological strategy of inquiry (Wojnar & Swanson, 2007) to understand the meaning of mental illness experiences of patients, their caregivers, and providers. This approach will describe the meaning of a common lived experience (i.e., mental illness) from different perspectives to find a "universal essence" of that experience, accounting for the historical, political, and social structures underlying that experience (Creswell, 2007; Moustakas, 1994). The phenomenon studied were the explanatory models of mental illness –how patients, caregivers, and providers explain the cause, onset, and treatment expectations of mental illness.

A hermeneutic phenomenological approach emphasizes the role of the researcher as structuring and interpreting the experiences (Moustakas, 1994). The ideal is not objectivity but to historically, politically, and socially contextualize the authentic experiences of providers, patients, and caregivers (Guba & Lincoln; Koch, 1995). As a Mexican and American psychologist who has been trained and has worked with patients in Mexico, and is currently being trained in the U.S., I purposefully utilized my cultural and contextual knowledge to make my interpretations. A phenomenological approach allows for an intentional incorporation of the researcher as it views them as "mediating" the different meanings of a phenomenon through their interpretations (Creswell, 1997).

### 3.3. Study Setting & Design

The current study was conducted in an outpatient clinic located in a regional, public, psychiatric hospital in one of the largest metropolitan cities in Mexico: Puebla –situated two hours away from Mexico City in the state of Puebla. Because the outpatient clinic is state-run, many patients seeking services at this site are not only from the city of Puebla but also from remote locations in municipalities across the state of Puebla, and beyond (the hospital's catchment area is vast).

The city of Puebla is the fifth largest in Mexico by population (INEGI, 2012). According to the 2010 population census, the city of Puebla has a little over 1.5 million inhabitants, representing almost 27% of the total population of the state (INEGI, 2011). Fifty-five percent of the citizens, more men than women, are economically active (INEGI, 2011). In the city of Puebla, the majority of the population (50%) has basic education (*educación básica*), or preschool to 9th grade; 20% have a high school education; and almost 30% have some college or university education (INEGI, 2011). In contrast, the state of Puebla's educational average is 8th grade. Seventy-two percent of the state of Puebla's population lives in urban settings, and 28% in rural ones, below the national urbanization average of 78% compared to 22%, respectively (INEGI, 2012). Very few people in the city of Puebla (less than 50 in total) report speaking indigenous languages; those who do, speak náhuatl or totonaco (INEGI, 2011). However, the overall average of indigenous speaking population in the state of Puebla is 11 for every 100 people, much higher than Mexico's national average of 6 for every 100 (INEGI, 2015).

The study clinic is staffed by approximately 25 residents in psychiatry and 40 attending psychiatrists, with two to three psychologists. Residents in psychiatry have come from multiple sites across Mexico and provide services at the clinic throughout their four to five years of medical specialization. Attending residents are more established in the city of Puebla and vary widely in the amount of time they spend at the site. Because the clinic serves patients from the city and rural areas, patients represent a wide range of socioeconomic backgrounds, educational attainment, and life experiences. All patients receiving services at the clinic were enrolled in Mexico's public insurance program, *Seguro Popular*, which provides full coverage for psychiatric visits and prescribed medication (https://www.gob.mx/salud/seguropopular). Usually, once diagnosed and stabilized, patients are treated through monthly visits where providers check on patients' symptoms, illness course, and medication adherence. Caregivers were included in this study because we had noted in previous research endeavors (i.e., Ramírez Stege & Yarris, 2017) that most patients were accompanied by a family member to their mental health care appointments. Caregivers were often described as an important support in mental health treatment (Ramírez Stege & Yarris, 2017).

All participants (i.e., patients, caregivers, and providers) were interviewed asking about their experiences with mental illness. Interviews were conducted in Spanish by myself, my site principal investigator Dr. Kristin Yarris who is a medical anthropologist, and two undergraduate student research assistants as part of the University of Southern California's NIMH-funded Latino Mental Health Research Training program (https://dornsife.usc.edu/latino-mental-health/). Data collection was conducted from May to August of 2016. Due to the collaboration between researchers, IRB approval was provided by the University of Wisconsin-Madison and the local clinic IRB in Puebla. Data analysis was conducted in the U.S. from May 2017 to January 2018.

### 3.4. Instruments & Procedures

Participants seeking mental health services (hereafter "Patients") were recruited at the outpatient clinic. For inclusion in the study, Patients provided oral consent to have a family member who accompanied them to the appointment (hereafter "Caregiver") and a Mental Health Provider (hereafter "Provider") participate in the study and discuss their perceptions of the target participant's experiences with mental illness. Caregivers had attended the mental health appointment without previous knowledge of this study and regardless of participation. Caregivers and Providers were also asked to provide oral consent to participate in the study.

After recruitment and consent processes, the researchers conducted three sets of interviews in private offices at the outpatient clinic: 1) Interview of Patient; 2) Interview of Caregiver of Patient; and 3) Interview of Provider of Patient. The interview protocol also included demographic questions at the beginning of the interviews for all participants (Appendix G). Patient and Caregiver interviews lasted approximately one hour. Provider interviews were shorter and lasted approximately 30 minutes. Immediately following the interviews, researchers took field notes systematically that included observations, impressions, and perceptions of participants' responses and interactions.

All interviews were audio-recorded. All interviews were subsequently transcribed in Spanish in the U.S. by myself and undergraduate research scholars at the University of Wisconsin-Madison. Given my higher mastery of the local language, I did a final review of all the transcribed interviews to ensure the fidelity of the transcriptions. Thus, the data corpus (i.e., all data collected; Braun & Clarke, 2006) included demographic information, Patient interviews, Caregiver interviews, Provider interviews, and researcher field notes.

For the Participant and Caregiver interviews, the researchers used the semi-structured DSM-5 Cultural Formulation Interview as a basis for the interview protocol (CFI; APA, 2013). The CFI attempts to counterweight the more euro-centric foundation of the DSM classification system through the incorporation of specific questions to elicit the explanatory models of mental illness from patient and caregiver perspectives –how patients and caregivers understand the cause, onset, course, and treatment of a mental illness influenced by their cultural experiences and identities. Specifically, it asks the interviewee questions regarding how they make meaning of their distress that are derived from the explanatory models of illness literature (Lewis-Fernández & Díaz, 2002). The first two sections of the patient and caregiver versions of the CFI, (i.e., questions 1 through 7) are aimed at understanding the definition, cause, context, and supports related to the main presenting mental health concern (Appendices A & C- CFI English patient and informant versions, respectively, APA, 2013; Appendices B & D- CFI Spanish patient and informant versions, respectively; APA, 2014). Questions 14 and 15 of the CFI ask about the types of support patients and caregivers believe would be helpful (i.e. treatment expectations). I developed an additional semi-structured interview protocol to ask similar questions of Providers regarding their explanatory models of mental illness and how they make sense of patients' cause, onset, and course of illness and possible treatment interventions (Appendices E & F). Interview questions were not confined to the CFI questions and interviewers asked probe and follow-up questions as relevant to the study's research questions.

Audio-recorded interviews were transported by the research team to the research team's office, located outside the outpatient clinic. Once there, all participant data was de-identified using pseudonyms. The laptops where the recordings were temporarily uploaded and stored were password-protected. Audio-recordings were deleted from the recorder upon being uploaded to the computer. All audio-recordings were uploaded to a UW-Box folder and deleted from the laptops for long-term storage.

### 3.5. Participants

To provide multiple perspectives on mental illness, participants included providers, patients and their caregivers that were recruited through purposeful sampling (Marshall, 1996). Patients and Caregivers were recruited at the outpatient clinic during their standard clinic visits through the use of flyers widely distributed to all people present at the lobby at any given time of recruitment. Therefore, potential participants were not targeted directly. To ensure confidentiality was maintained, the recruitment flyers stated that potential participants could approach front desk personnel who then directed them to the researchers' office. The researchers' offices were located through one private corridor, therefore, other individuals seeking mental health services could not infer an individual was a participant in the study as they were coming in and out of the corridor where all mental health provider offices were located (i.e., psychiatrists, psychologists, nurses). The researcher office was also a private individual office.

Patients seeking mental health services who meet the following inclusion criteria were included in the study: a) aged 18 years or older; b) had a diagnosis of any mental health disorder; c) were able to express themselves coherently (i.e., without intrusion of active psychotic or manic symptoms); d) were patients at the psychiatric outpatient clinic; e) were accompanied by a Caregiver who was also willing to participate in the study; f) agreed to be interviewed and audio-recorded; and g) provided informed consent.

Caregivers were recruited through the Patients and included in the study if they meet the following inclusion criteria: a) aged 18 years or older; b) had a family member with a mental illness; c) were able to express themselves coherently; d) agreed to be interviewed and audio-recorded; and e) provided informed consent.

Providers included psychiatrists, psychiatry residents, and psychologists who met the following inclusion criteria: a) worked at the outpatient clinic of the hospital; b) treated/attended patients with any mental health disorder; c) agreed to be interviewed and audio-recorded; and d) provided informed consent. Only psychiatry residents consented to participate in this study.

Researchers read through a consent script to obtain oral consent. Researchers encouraged the participants to ask questions regarding the study and asked participants questions to assess understanding. These steps ensured that valid consent was obtained. Researchers clarified that all information shared during interviews would remain confidential unless the participant disclosed risk of harm to self or others. Researchers informed participants that if they disclosed risk of harm, researchers would inform the attending psychiatrist to ensure their safety and the safety of others. All participants were also assured that they could withdraw participation at any time before, during, or after participation, and that participation or withdrawal of participation would have no influence on their treatment. Finally, Providers were explicitly asked to not disclose specific Patient diagnoses or medical record information, in compliance with U.S.-based regulations. Providers were only asked demographic information about themselves and the interview questions previously described. All participants were compensated $100 MXN (approximately $5 USD at the time of the study) at the end of their interviews. Participants who were unable to understand the informed consent procedure, unable to answer the questions contained in the interviews, or who did not meet inclusion criteria were excluded from the study.

The research team recruited a total of 51 participants: 24 patients, 23 caregivers, and 4 providers (all psychiatrists). Of these participants, a total of 19 cases gathered were "complete cases" that included patient, caregiver, and provider interviews (Table 1). For patients, ages ranged from 18 to 83 years old (M = 42.63, SD = 19.50), with 11 men and 8 women participants. Patient mental distress included symptoms related to depression (6), schizophrenia or psychosis (5), obsessive-compulsive disorder (3), anxiety (2), substance abuse disorder (2), and bipolar disorder (1). Patients had been engaging in their current psychiatric treatment from 2 months to 53 years. One patient had a bachelor's degree (*Licenciatura*), 4 had some university experience, 5 high school, 2 middle school, 4 grade school, and 3 were unknown. Five patients reported they were currently students. Employment for other patients included four skilled laborers (e.g., painters, construction), three business owners, two homemakers, one gym instructor, one security guard, and a photographer. Two patients reported being unemployed. Patients were also asked how far away they lived from the site where data was collected. Distance from the psychiatric outpatient hospital ranged from 20 minutes to 5 hours (M = 87.63 minutes, SD = 60.22), however, most patients (13/19) lived within 40 minutes and 1.5 hours away.

Table 1

*Patient and Caregiver Demographic Information*

| Case no. | | Pseudonym | Age | Gender | Diagnosis* | Time in Treatment | Distance from site | Education | Employment |
|---|---|---|---|---|---|---|---|---|---|
| 3 | Patient | Eduardo | 55 | M | Schizophrenia | 9 months | 45 minutes | Some university | Mechanic |
| | Caregiver | Daniel (twin brother) | 55 | M | | | | NA | Engineer |
| 4 | Patient | Alejandra | 43 | W | Depression | 7 months | 1 hour | NA | Business owner |
| | Caregiver | Luisa (daughter) | 25 | W | | | | Some university | Student |
| 5 | Patient | Alberto | 54 | M | Obsessive-compulsive | 2 months | 1.75 hours | NA | Construction worker |
| | Caregiver | Melinda (daughter) | 19 | W | | | | NA | Business owner |
| 6 | Patient | Olga | 27 | W | Anxiety | 10 months | 1.75 hours | High school | Housemaid |
| | Caregiver | Angelina (mother) | 42 | W | | | | NA | Homemaker |
| 7 | Patient | Caila | 54 | W | Depression | 7 years | 1.2 hours | Grade school | Homemaker |
| | Caregiver | Mario (husband) | 52 | M | | | | Grade school | Welder |
| 8 | Patient | Alicia | 29 | W | Obsessive-compulsive | 1 year | 1.5 hours | Some university | Salesperson |
| | Caregiver | Celeste (mother) | 67 | W | | | | Grade school | Salesperson |
| 9 | Patient | Ricardo | 45 | M | Schizophrenia | 11 years | 1 hour | High school | Photographer |
| | Caregiver | Cecilia (partner) | 47 | W | | | | High school | Janitor |
| 10 | Patient | Emiliano | 27 | M | Schizophrenia | 4 years | 2 hours | Some university | Student |
| | Caregiver | Edith (mother) | 44 | W | | | | Some university | Cook |
| 11 | Patient | María | 70 | W | Depression | 4 months | 1 hour | Grade school | Homemaker |
| | Caregiver | Mariano (husband) | 73 | M | | | | High school | Retired |
| 12 | Patient | Verónica | 22 | W | Obsessive-compulsive | 2 years | 40 minutes | Some university | Student |
| | Caregiver | Jorge (father) | 58 | M | | | | University degree | Business owner |
| 13 | Patient | Lorenzo | 22 | M | Psychosis | 7 months | 1.5 hours | High school | Student |
| | Caregiver | Juan (father) | 66 | M | | | | Some university | Retired |
| 14 | Patient | Omar | 47 | M | Bipolar | 1 year | 1 hour | University degree | Business owner |
| | Caregiver | Marla (partner) | 46 | W | | | | Middle school | Salesperson |
| 15 | Patient | Juan | 60 | M | Substance abuse | 6 years | 40 minutes | NA | Security guard |
| | Caregiver | Margarita (sister-in-law) | 56 | W | | | | High school | Homemaker |
| 17 | Patient | César | 71 | M | Substance abuse | 30 years | 2 hours | Grade school | House painter |
| | Caregiver | Rosa (wife) | 71 | W | | | | Grade school | Homemaker |
| 19 | Patient | Miriam | 83 | W | Depression | 53 years | 1.5 hours | Grade school | Unemployed |
| | Caregiver | Ramón (son) | 58 | M | | | | High school | Skilled labor |
| 20 | Patient | Pedro | 18 | M | Schizophrenia | NA | 5 hours | High school | Student |
| | Caregiver | Martín (uncle) | 58 | M | | | | University degree | Engineer |
| 21 | Patient | Sara | 19 | W | Depression | 5 months | 20 minutes | High school | Student |
| | Caregiver | Mariana (mother) | 47 | W | | | | Technical college degree | High school administrator |
| 23 | Patient | Javier | 34 | M | Depression | 8 months | 2 hours | High school | Unemployed |
| | Caregiver | Blanca (sister) | 24 | W | | | | University degree | Business owner |
| 24 | Patient | Carmelo | 30 | M | Anxiety | 3.5 years | 40 minutes | High school | Gym instructor |
| | Caregiver | Cristóbal (father) | 64 | M | | | | Grade school | House painter |

*Note*. M = Man; W = Woman.

[a] Diagnoses were assigned by the researcher based on information gathered through case-related notes and interviews

Caregiver ages ranged from 19 to 73 years old (M = 51.16, SD = 15.53), with 11 women and 8 men. Caregivers included parents (7), partners or spouses (5), adult children (3), siblings (2), an uncle (1) and a sister-in-law (1). Caregivers tended to have higher educational attainment than patients. Three had a bachelor's degree (*Licenciatura*), 1 a technical college degree, 2 had some university experience, 2 high school, 4 middle school, 3 grade school, one caregiver reported taking classes as an adult, and 3 were unknown. All caregivers reported being currently employed or on retirement (2); one noted she was still a university student. Caregiver employment included two engineers, one high school administrator, four skilled laborers (e.g., painter, welder), three business owners, three homemakers, two salespeople, and one cook.

Providers were all psychiatric residents affiliated with a medical school at a local public university in Puebla, Mexico. Their ages were 26, 27, 29, and 30 years old (M = 28, SD = 1.82). Providers had between one month and two years of clinical practice in psychiatry and had all graduated with a bachelor's degree (*Licenciatura*) in medicine from various universities across central states of Mexico. Their places of origin were also from urban cities in central states of Mexico.

Currently in Puebla, there are a total of approximately 166 psychiatrists, which is a ratio of 2.69 psychiatrists for every 100,000 people (Heinze et al., 2016). This ratio was an increase from 2.34 in 2011 (Heinze et al., 2016). In this study, the research team and I were only able to recruit male psychiatrists which in some ways reflects the current gender disparity in the psychiatric field with only 34.6% of total female psychiatrists in Mexico (Heinze et al., 2016). This data provides some context on the low number of psychiatrists recruited in this study (*N* = 4). The psychiatric residents who participated were providing treatment to a majority of patients and represented the morning and afternoon rotations at the outpatient clinic. All attending psychiatrists declined to participate in the study.

### 3.5.1. Risks and Benefits

There were no direct benefits to participants. However, it was expected that this study could contribute to furthering our understanding of the experiences of mental illness from multiple perspectives. Additionally, this study provides insight on treatment expectations that have the potential to inform clinical practices and possibly improve future treatment of similar individuals seeking mental health services.

Interviews discussing mental illness experiences included topics that could potentially cause some discomfort or distress for Patients and their Caregivers. Although the topics covered in the Cultural Formulation Interview may cause some degree of distress, we believed the risks were minimal and somewhat unlikely to occur in using the CFI, which has been a standard interview protocol adopted by the profession to understand a mental illness experience. During data collection, no Patient or Caregiver disclosed discomfort or concern about their overall wellbeing, nor risk of harm to self or others. For Providers, there was no expected risk or discomfort in discussing their understanding of a patient's mental distress, and no concerns were disclosed to the research team.

Interviews were conducted at the Hospital Psiquiátrico Dr. Rafael Serrano, therefore, there was some potential risk of breaching Patient and Caregiver confidentiality. Nevertheless, the office setting at the Hospital Psiquiátrico Dr. Rafael Serrano helped maintain Patient and Caregiver confidentiality. Specifically, all mental health provider and researcher offices were accessed through the same private corridor. Therefore, Patient and Caregiver confidentiality was maintained from other individuals seeking mental health treatment at the same clinic. Because

Patients needed to consent to Provider's discussing their mental illness experiences, the researchers did not foresee issues of confidentiality of Patient or Caregiver participation in the study. Additionally, researchers clarified in the informed consent process that all information disclosed during the interviews would remain confidential and would not be shared among Providers, Patients, or Caregivers. Participants were also notified that confidentiality would only be broken if a participant disclosed potential risk of harm to self or others, in which case researchers would notify the attending psychiatrist to assist them.

### 3.6. Data Analysis

For this study I used an inductive thematic analysis to identify, analyze, and report latent themes across interviews and provide a rich description of the essence underlying Mexican providers, patients, and caregivers' mental illness experience given their particular sociocultural positions (Braun & Clarke, 2006). The inductive approach meant that the themes identified were strongly related to the data, trying to code emerging themes without fitting them in with a preconceived coding frame (Braun & Clarke, 2006). However, as discussed below, the research teams' assumptions based on theoretical knowledge and personal experience also informed the thematic analysis. Thematic analysis allows a researcher to identify multiple stakeholders' descriptions and have a broader understanding of their experiences through patterns of meaning found across the data gathered (Crowe, Inder, & Porter, 2015).

The data analysis team included myself, three undergraduate psychology students and six master's-level counseling psychology students who were bilingual and all but one identified as Latino (or bi-racial with part Latino), and one who was from a Caribbean country but had lived for an extended period in Mexico. All data analysis team members had UW-Madison Education and Social/Behavioral Science (ED/SBS) IRB Human Participants Research Training and had been approved to conduct data analysis for this study by the University of Wisconsin-Madison IRB. The research team was paired up to complete data analysis for consensus and fidelity purposes. The master's students were paired with each other, and the undergraduate students were each paired with me as they had less clinical experience and training. Each pair was assigned to code three cases that included Patient, Caregiver, and Provider interviews. The team conducted consensus coding on one complete case.

Following Braun and Clarke's (2006) steps for thematic analysis, the team first actively immersed themselves in the data set by repeated readings of the transcripts, searching for meanings and patterns, and developing a list of ideas about what in the data is relevant to this study's research questions. The team members were asked to keep in mind the research questions of this study as they reviewed each interview. These research questions included: 1) How does the Patient/Caregiver/Provider perceive the cause/onset of the mental illness experience? (i.e., What caused the problem? How/when did it start? Why?); and 2) What are the treatment expectations of the Patient/Caregiver/Provider? (i.e., What type of treatment would be helpful? Why?). Team members then developed a list of common meanings. Some team members in each pair were also familiar with the data corpus as they had helped with data transcription.

The second step in the thematic analysis was to produce initial codes from the data sets at a latent interpretive level, coding as many themes as possible. That is, identifying the underlying ideologies (e.g. ideas, assumptions, conceptualizations) that inform the semantic content of the data (Braun & Clarke, 2006). For example, a patient responded to the question: "*¿qué fue la causa de su depresión?*" // "what was the cause of your depression" by stating: "*¿qué fue la causa? <mm> este lo que pasa que yo tengo un esposo que a él le han gustado mucho las mujeres*" // "what was the cause? <mm> the thing is that I have a husband that has liked many women" (Patient 4, Alejandra –pseudonym). This was then coded as "CAUSE: Husband's infidelity." This code reflected underlying assumptions that might not be explicitly stated by the participants but could be interpreted as reflecting broader themes of "interpersonal conflict" discussed in the next step.

The research team as a whole coded one full case (Patient, Caregiver, and Provider interviews) before each research team pair began coding separately. Three full cases that included Patient, Caregiver, and Provider interviews were assigned to each pair for coding. There was a total of six coding pairs: three master's level students, and three undergraduate students paired with me. Pairs first individually coded each interview within one case. Then as a pair, they had to come to consensus on all the codes for each interview.

Third, the research team as a whole analyzed the codes of each interview by stakeholder (e.g., all Patients, all Caregivers, and all Providers) and considered how they might be combined into an overarching theme across cases. From the previous example, the first-level code "*adversidades familiares*" (family adversity) code was consolidated under the overarching theme: "Family issues." Then, I gathered and sorted in Excel sheets all first-level codes (e.g., "Husband's infidelity") by case and area of interest (i.e., cause and treatment expectations). That is, all codes relevant to the perspective on the cause of mental illness were put in columns next to each other by Patient, Caregiver, and Provider for each case. This allowed for an analysis of the overlap among stakeholders. Then, each case was sorted under the second-level overarching theme (e.g., "Family issues") which allowed for a visual representation of congruence among stakeholders. The first-level code and line number of the original data source were visually represented under each broader theme to provide easy accessibility. The first three steps of data analysis were conducted with the research team over 10 weeks from May to July 2017.

The fourth and fifth steps entailed revising, defining, and refining the initial themes. After an initial round of revision, I defined and refined the themes considering the essence of each one, and what aspect of the data that particular theme captured. For example, the first-level code for a cause, "*aguantar infidelidades*" (withstand cheating), was later consolidated under the second-level code "Gendered illness narratives." Another example related to treatment expectations was the first-level code of "*grupo de apoyo*" (support group) then established under the second-level code "Psychotherapeutic treatment." In this phase I organized the themes to develop a coherent and consistent account of the findings.

The final step in the thematic analysis I conducted independently, writing a narrative using extracts as examples of the main theme to convey a story regarding the data collected. In this narrative I developed an argument relevant to the study's research questions. Specifically, I asked the question "what is the essence of mental illness experience (either the cause or the treatment expectations) from this stakeholder's perspective?" and developed a narrative that reflected the main themes gathered from the perspective of patients, caregivers, and providers.

Finally, the discussion of the main findings includes my own interpretations informed by theory, my literature review, and my personal past experiences. I provide contextual information that I believe is necessary for the reader to understand the historical and sociopolitical context in which the data was gathered, as well as the role of the researcher in analyzing the data.

Any data set can have multiple interpretations (Crowe et al., 2015), therefore, it is important to provide avenues to determine credibility, transferability, and dependability of the interpretation (Guba & Lincoln, 1989; Koch, 2006). To enhance credibility, each research team pair was asked to record "subjectivity statements," 30-minute conversations describing how their experiences influence their relationship to the data and the coding process. After coding a case, each research team member was asked to write a case summary that answered the following questions: 1) How are patients, caregivers, and psychiatrists making sense of the cause of mental illness and treatment expectations in a similar and/or different way?; 2) What have you learned about what is happening in this case in terms of how each stakeholder describes the cause of mental illness and treatment expectations?; 3) What are some strengths and challenges faced by the stakeholders in this case? How are these influenced by the context? I reviewed the subjectivity statements and case summaries before our team meetings to inform our conversations when coming to consensus and deciding how codes might be classified under overarching themes. The subjectivity statements, including my own experience as a bi-national researcher are discussed in the following section. These reflections and the field notes I gathered during data collection, informed the narrative account and main discussion of the findings.

Transferability, the degree to which there are similarities between the context of the study and other contexts (Guba & Lincoln, 1989; Koch, 2006) was relevant in the degree to which this study provides insight into experiences of patients, caregivers, and providers in other Mexican contexts. For this, I provide information regarding the context of the specific study site for readers to assess the transferability to other contexts in Mexican clinical practice. I also provide contextual information about Mexican mental health care practice in general to further contextual local findings. Finally, the data analysis research team read my narrative account of the findings and provided feedback to determine the dependability of my interpretations (Guba & Lincoln, 1989; Koch, 2006).

## 3.7. Subjectivity Statements

### 3.7.1. The research team

The research team was asked to discuss the overall assumptions they had related to the data and possible findings they expected. These early reflections of who we were as researchers interacting with the data gathered helped frame our conversations as we came to consensus on coding interviews and developing emerging themes. In our team meetings, we relied on each other to maintain accountability, openly discuss our reactions to stakeholder stories, and ask each other for corroboration on the interpretations being made. Although we had many shared experiences, students also had unique perspectives that helped challenge possible areas of bias. Students broadly assumed that explanations of mental illness would be quite varied across stakeholders and cases. Next, I describe the main themes that emerged from students' subjectivity statements.

Students often identified as coming from bi-cultural backgrounds, having lived in a Latin American country or having Latino cultural heritage, and currently living in the U.S. Many also noted a low-income or working-class background which they believed provided some familiarity with the struggles faced by the patients and caregivers interviewed. Yet students also acknowledged the differences between growing up low-income in the U.S. versus Mexico, and the broader influence of their higher education experiences.

Many of the research team members had personal experiences with mental illness of a close family member. They identified that it had been a difficult process for their family members to seek mental health services because they did not believe in psychiatric or psychological treatment. These students conjectured that these family norms reflected a broader Latinx cultural norm related to the widespread stigma surrounding mental illness. According to the students, stigma often prevented people from seeking Western-based psychotherapeutic treatment. Thus, students assumed it may be difficult for the patients and caregivers of our sample to be disclosing of their mental illness experience in the interviews.

Students discussed their assumption that cultural gender roles, norms, and expectations such as *marianismo* and *machismo* could affect how stakeholders describe the mental illness experience. For example, some students noted the influence of a highly patriarchal culture and the prevalence of domestic violence, expecting women would be particularly victimized and may even blame themselves for gendered experiences of abuse.

Two research team members had unique experiences growing up in Latin American countries where they had witnessed or engaged in indigenous forms of healing. These students noted that indigenous healers were often more trusted by community members than other Western-based medical doctors. Indeed, based on their own experiences, most of the research team members believed there would be mistrust in medical providers that would influence whether patients and caregivers believed the psychotherapeutic intervention provided was helpful. Students also assumed that Western-based psychotherapy would be less prevalent in Mexico, and that patients and caregivers would likely resort to prayer and other forms of culturally-based healing (e.g., natural remedies).

Many research team members hypothesized that medication would be an important psychotherapeutic intervention. A graduate student acknowledged that in her experience, medication was a main intervention for mental health concerns in the South American countries where she had lived. When considering medication treatment in Mexico, some students noted that although most Mexicans may have some access to health care, the costs of medication may be prohibitive and cause distress due to the financial burden of this treatment. Regardless, students believed that medication would be a more accessible form of treatment than weekly counseling appointments. Another cultural assumption that emerged was the possible belief that needing medication could symbolize a lack of personal fortitude, that is, that a person is not "strong enough" or that if they put forth more effort (i.e., "*le echa ganas*"), they could overcome their affliction.

Finally, students described me as passionate, invested, and caring deeply about the experiences of the people interviewed because of my own personal and professional background in Puebla. Students believed that my cultural embeddedness could provide insight into the data gathered, however, they also described themselves as having a unique role in helping me confirm my analysis against potential personal biases. They believed my biracial and bicultural identity could be beneficial in my ability to integrate the emerging data, and compare and contrast cultural values and norms in Mexico and the U.S. They also wondered how I was perceived by the stakeholders I interviewed because I presented as an outsider from a U.S. institution and could pass as a White American.

### 3.7.2. Ramírez Stege subjectivity statement

My research endeavors are informed by my *inbetweening Cholugringa* Mexican and American identities as a border-crossing Latina (Cervantes-Soon, 2014). As a current doctoral student who is a feminist, U.S.-born and Mexican raised, able-bodied, biracial, White-passing, queer, cis-gender woman, raised in a low-income household yet currently living a middle-socioeconomic experience, I acknowledge multiple identities and privilege that shape how I interpreted and conveyed the data I gathered. Moreover, the town of Cholula in which I was raised and where I earned my bachelor's degree (*Licenciatura*) in psychology neighbors the city of Puebla where I gathered data. Thus, I have both personal and professional experiences that influenced my relationships with participants. For the sake of brevity, in my narrative I focus on how the intersections of social class or socioeconomic experience, provenance (rural vs. urban), nationality (U.S. and Mexican citizenship), racial and ethnic identity, and educational experience influence my research. However, as listed in my self-description, I acknowledge how other cultural identities (e.g. gender, sexual orientation, ability status) intersect, interact and make up who I am as a researcher (Cole, 2009).

Personally, during my formative years I was connected to lower income and rural cultures in my Mexican community. My father was the oldest of nine children who grew up in poverty. His generation was the first to own businesses in the Cholula marketplace, yet their income was limited due to the clientele they served: mostly agricultural workers from rural neighboring municipalities. These rural communities were also a source of social connection in my family as my parents, aunts, and uncles were often solicited as "*padrinos*" and "*madrinas*" (godparents) and invited to participate in diverse festivities. Locally, my connection to people from mostly rural and low-income experiences shifted through access to education. Abroad, I had access to other cultures through visits with my mother's White U.S. middle class Midwestern family.

Professionally, I have had access to educational opportunities that influence how I view professional practices in Mexico. Through scholarships, I had access to exclusively private schooling from primary school to my undergraduate degree. As a White-passing, "*Gringa*," native English speaker in Mexico, my educators and peers held stereotypes that I was from a similar middle to high socioeconomic experience that did not match my actual lived experience. Issues of power and identity have been evident throughout my life as people react and interact with who I am, revealing, as Cervantes-Soon (2014) phrased, the "continuous hemorrhaging of a history of colonization, imperialism, neoliberalism, and asymmetrical binational relationships between the U.S. and Mexico" (p. 98). I recognize my own colonization and oppression earlier in my professional career reflected in my desire to "bring back" theories from my educational experiences abroad in England and the U.S. that I considered "superior" and able to inform interventions in my clinical practice in Mexico.

When I tried to put hegemonic outsider theories into clinical practice at an inpatient psychiatric hospital in Puebla, I found they further distanced me from the people I was trying to serve. I vividly remember trying to explain to one of my female patients the cognitive behavioral model of anxiety I had excitedly imported from my psychopathology classes in Manchester, England. When I discussed how we could intervene with her thoughts which influenced her emotions and behaviors, she disagreed, stating that it was not her thoughts that were causing concerns but that she felt an "*angustia*" (distress) in her body that she simply could not shake off. Upon further reflection, I also recognized that the dominant CBT model was incongruent with my own conceptualization and experiences of holistic healing, which included affect-based interventions, as well as seeking local support from providers such as *hueseros* (bone doctors), or healing practices like prayer or *temazcales* (sweat lodges). As I was integrating this awareness, I asked for help and support from other mental health care providers at that site, inquiring whether I could observe group therapy provided by the attending psychologist or be supervised in my individual encounters with patients. The psychologist's response was that I would learn on my own through trial and error –she did not want me sitting in on her therapeutic encounters. These experiences left me feeling helpless and ineffective, and propelled me to seek further training.

Currently, I negotiate an insider and outsider perspective as a U.S.-based Mexican and American doctoral student and researcher. My experiences in both countries compel me to reflect on how mental health researchers in Mexico continue to develop an indigenous understanding of mental illness and emotional distress that serves a majority population in Mexico that is starkly different to the U.S., White, middle-class population for which conventional psychotherapy has been developed. My critical awareness (*concientización*; Freire, 1970) of systemic privilege compels me to seek power-sharing methods within multiple levels of my research experiences, acknowledging that my humanness and freedom is intimately tied to those who have been or continue to be oppressed. I believe research should include taking action as necessary in the struggle for liberation and hope my research agenda gives voice to underserved and underrepresented communities in Mexico where voices are often brutally silenced. I tend to privilege the voices of clients and caregivers as a more vulnerable population given the power dynamics of the therapeutic encounter. However, having practiced as a psychologist in Mexico, I also wonder how providers are oppressed through dominant ideologies, systemic pressures and constraints, and a dearth of alternatives.

# Chapter 4: Results

Throughout the presentation of the results, I provide quotes in the original Spanish transcription and my English translation to illustrate the themes discussed. In the transcription system adopted here, moments of overlapping speech, that is when speakers interrupt or talk over each other, is indicated by a bracket ([) to mark where the overlap begins. Words in brackets ([ ]) provide additional contextual information or are used to denote a change made by the transcriber to ensure confidentiality. Pauses in speech are noted as (P) or (LP) for long pauses. Hyphens indicate a speaker has cut their speech or self-interrupted. An interviewee's intonation was also captured, for example, the symbols < > are used to describe a slow stretch of talk. Transcriber's description of non-verbal utterances are denoted with double parentheses, for example, ((crying)). Finally, unintelligible utterances are denoted with a (xxx) or as (unintelligible). I use "IT" to indicate the "interviewer," "PX" for patient, "CR" for caregiver, and "PR" for provider.

## 4.1. Cause of mental and emotional distress

Explanatory models are the causal attributions about an illness episode (Kleinman, 1988). Biomedical and psychological etiological theories of mental distress have been vigorously debated. The physiological and psychodynamic causes are at times seen as competing with each other, with some researchers ardently advocating for a biomedical perspective (i.e., mental disorder as disease) that is considered more scientifically sound (Pérez Álvarez, 2009; Yonge, 1965). Other theorists have proposed an integrative, circular and transactional view on the etiology of distress (Yonge, 1965). Moreover, cultural factors can also have explanatory force, shaping how a seemingly "universal" illness is experienced and expressed (Lester, 2007).

In debating which is the 'true' cause of an event or illness, it is helpful to turn to Aristotle's "four causes" which he viewed as answering the question "Why?" about a certain occurrence (Hocutt, 1974). Aristotle believed that the question "Why?" could be answered "in many senses," mainly, four: *material* (what is it made of?), *efficient* (who made it? How did it come to be?), *formal* (what is its form? What is it?), and *final* or *teleological* (what is its purpose? Why does it exist?) causes (Hocutt, 1974; Pérez Álvarez, 2009). The classical Aristotelian example is the causes of a bronze statue with the material cause being the bronze, the efficient cause is the work and activity involved in melting and casting of the bronze, the formal cause being the form of the statue (e.g., taking the form of a human versus the form of a wall), and the desire to have a work of art is a final cause. Aristotle did not intend for the causes to be mutually exclusive, rather these four ways of knowing are considered central to understand the causal nature of a phenomena (Hocutt, 1974; Pérez Álvarez, 2009). My intention in raising Aristotle's framework is to counter the tendency to view mental disorders as having a cause, usually biomedical, and instead to indicate that there are different and multiple causes that influence a mental illness experience.

In the present study, psychiatrists often proposed *material* causes focused on the biological bases of the disorder (i.e., dysfunction of neurotransmitters) and *formal* causes or models of how a disorder may be organized (i.e., a biopsychosocial understanding of illness). Formal models to explain the "essence" of mental illness were often adopted from Western-based psychiatric medicine, such as the cognitive triad explanation provided by a cognitive behavioral approach. For example, provider Felipe prescribed cognitive behavioral therapy to increase patient's "illness consciousness" and adoption of the biomedical perspective. These results are consistent with previous research with U.S. psychiatrists (Hackethal et al., 2013), and findings by Hale (2017) who reported that psychiatrists trained at the outpatient clinic in Puebla endorsed a biopsychosocial understanding for the cause of patient's emotional distress.

The formal causes described by psychiatrists were attributional theories to understand psychological phenomena and prescribe a specific course of treatment (Killeen, 2001). As an example from this study, provider Martín's explanation of the origin of patient distress incorporated the theoretical model that underlying biological structures in the brain influenced emotional arousal that perpetuated distress. According to Martín, how a patient lives with the distress (in his words: "*cómo lo vive también la paciente*" // "how the patient lives with it") changed based on environmental and social factors. Despite this formal causal perspective, psychiatrists often focused primarily on one pathway of treatment, which may reveal their own description of the essence of a phenomenon (Hocutt, 1974) –a concern based on bio-medical processes treated with psychiatric medication. This focus on medical treatments of psychological disorders reflects a larger trend in modern psychiatry of treating disease and organic malfunction (Kleinman, Eisenberg, & Good, 2006; Logan & Hunt, 2014; Wampold, 2001, 2007).

In contrast, patients and caregivers often provided *efficient* causal explanations, which offered information on what initiated change (Killeen, 2001). For example, for patient Eduardo, "it was a family problem that led to everything else." Emiliano's mother Edith described a belief that his psychosis developed after his missionary experience where he came into contact with people who were different to him, was a target of aggression, and "saw the world for what it is" outside of the protection of the family home. For many women, multiple infidelities, tumultuous romantic relationships, and histories of abuse preceded their distress.

Providers, patients, and caregivers in this study described many different causal explanations for the experience of distress that were influenced by their own positionality and expectations. Congruent with the Aristotelian framework, these stakeholders may each provide one or more causal attributions. This does not imply that one explanation is incomplete if not all causal attributions are provided, the explanation only needs to explain the phenomenon to be helpful (Hocutt, 1974). Causal explanations provide information on where change begins, and different explanatory models would suggest specific pathways to treatment (Carpenter-Song, 2015; Kleinman, 1988; Pérez Álvarez, 2009). Thus, understanding these, at times, divergent perspectives may inform how providers, patients and caregivers decide on an appropriate treatment and healing process.

Clinical encounters and psychiatric diagnoses often involve an effort to develop a coherent descriptive narrative or causal account of the patient's distress (Kirmayer, 2000). According to Frank and Frank (1991), a component of all healing approaches is the provision of a rationale or myth that offers an acceptable explanation for the symptoms of distress. This rationale is described as a “myth” because it does not need to be “scientifically” proven or “true” –the potency of the explanation lies in an understanding that is consistent with the patient’s worldview about what the symptoms are, why they arose, and which treatment may be helpful (Wampold & Imel, 2015). This “myth” provides consistency, control over the interpretation of the narrative, and reinforces the ideology of its structure (Kirmayer, 2000). Previous research has described how mental health professionals may use culturally congruent terms to describe an illness experience, such as “*nervios*,” with patients and family members to increase rapport and decrease mental health-related stigma (Guarnaccia et al., 1992).

In this study, the causal myths or ‘theories’ provided to explain patients’ mental illness experience often converged on the role of interpersonal or efficient causes of distress. These were also influenced by the Mexican cultural milieu. Causal myths reflected broader cultural and social values and beliefs, and subsequent treatment expectations revealed the systems of care available in Mexico.

#### 4.1.1. Lack of Illness Consciousness

All psychiatrists (4/4) described the cause of patients’ mental distress as rooted in biopsychosocial components. That is, they acknowledged the multiple factors that may cause or influence the development of mental and emotional distress. Their responses likely reflected learned theoretical knowledge in their training as they all shared similar theoretical hypotheses that included an interaction between the biological, psychological, and social aspects of the illness experience. Martín (in his late 20s, with one month of psychiatry experience) characteristically described:

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| *“Bueno pues las causas son múltiples generalmente, se explican de tres maneras, biológica, psicológica y social. Biológica porque hay un sustrato anatómico y bioquímico, fisiológico en el cerebro que se altera. Psicológico porque pues (P) hay algún-hay situaciones emocionales que lo activan o que lo perpetúan o que tienen una relación directa con su padecimiento, el cómo lo viven. Y social porque pues influye el entorno eh académico, laboral, económico, familiar, em pues el-el que el padecimiento se produzca, el que cómo lo vive también la paciente”* | “Well, there are generally multiple causes, you explain in three ways, biological, psychological, and social. Biological because there is an anatomical, biochemical, and physiological substrate that is altered in the brain. Psychological because well (P) there are some-some emotional situations that activate or perpetuate or are directly related to their ailment, how they live with it. And social because well the eh academic, work, economic, family environment influence em well the-the that the illness develops, and also how the patient lives with it” |

(Martín, psychiatrist)

Diego (in his mid 20s, with a year and a half of psychiatry experience) described the role of stress, adaptation, and interpersonal coping in the development of mental illness. When describing patient Miriam (83 years old), he noted multiple factors, in addition to biological causes (i.e., an aging brain), that influenced the development of her depressive symptoms. These included the role of adapting to changing life circumstances and difficult interpersonal patterns between Miriam and her son:

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| *“IT: …¿Cuáles fueron las causas de su problema?* | “IT: …. What were the causes of her problem? |
| *PR: Pues yo estoy de acuerdo con el sentido que fueron las dos. Primero, primeramente, por la propia edad. No eh- no vamos a poder saber si haya tenido otra cosa ya en sus ochenta y tantos años. Tiene una atrofia importante. Ósea, su cerebro ya está pequeñito, entonces es un cerebro muy vulnerable. Y eso aunado a una relación ahí medio extraña o complicada con su hijo. Que no sale, o se hace. Y la única convivencia que tenía además de su hijo, que yo creo que ya ha de estar cansada ¿quién sabe? Era de la otra chica. La pierde, y bueno, le da-le dio su adaptativo. Y ese adaptativo se vio empeorado pues por el daño cerebral que tiene.* | PR: Well, I agree with the sense that it was both. First, firstly, her own age. No eh –we’re not going to be able to know if she had something else now that she’s eighty something years old. She has a significant atrophy. I mean, her brain is very small, so her brain is very vulnerable. That, summed with a sort of strange and complicated relationship with her son. That she doesn’t go out, or she’s faking. And the only socializing she had apart from the son, that I think she must be tired, who knows? Was that other girl. She loses her, and well, she gets her adaptive. And that adaptive was worse due to the brain damage she has. |
| *IT: ¿Qué es un adap-adap [* | IT: What is an adap-adap [ |
| *PR: [¿Adaptativo? Ah, pues, lo que nos cualquiera nos puede dar un adaptativo, por* | PR: [Adaptive? Ah, well, what anyone can get when you’re adapting, for example, I live |

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|---|---|
| *ejemplo, yo vivo en tal lado tanto tiempo y estoy acostumbrado a vivir ahí o lo que sea y salgo, pues en lo que me adapto. Si me dan síntomas ansiosos, síntomas depresivos, o los dos, pienso que fueron síntomas ansiosos, digo, depresivos, que se complicaron por su daño y no fueron adaptativos a lo mejor dieron a su, bueno, diagnóstico. Si."* | somewhere for so long and I'm used to living there or whatever and I go out, well, while I adapt. If I get anxious symptoms, depressive symptoms, or both, I think it was anxious symptoms, I mean, depressive, that were complicated due to her damage and they weren't adaptive, maybe they developed her, well, her diagnosis. Yes." |

(Diego, psychiatrist)

Providers often viewed patients' prognosis as influenced by their "illness consciousness," described as patients' recognition, comprehension, and acceptance of their disorder. Providers believed that patients' ability to adopt a sick role and "accept their illness" would lead to better illness management and improved outcomes. "Accepting" the illness meant understanding their symptoms were a "known" psychiatric disorder, such as depression. Provider Felipe (in his 30s, with two years of experience) described:

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| *"PR: Pues que es un padecimiento que muchas personas podemos llegar a tener, que puede ser por los rasgos de personalidad que tenemos, que lo importante pues es reconocerlos y aceptarlos. Y que eso no nos impide que hagamos algún- pues nuestra vida cotidiana. En el caso de ella pues ya sus síntomas son desencadenados por otro- otros factores, pero todo partimos de esta parte de la personalidad y pues aceptarlo eh que eso va ser que nos haga pues tener un buen pronóstico, que se vaya disminuyendo poco a poco los síntomas, y el objetivo ideal es que ella siga con su vida cotidiana, sin tratamiento. Y pues lo principal es el apoyo de terapia que ella va a recibir.* | "PR: well that it's an ailment that many people can come to have, that it can be due to personality traits that we have, and what's important is to recognize and accept it. And that doesn't impede our ability to do some –well, to have our day to day life. In her case, well her symptoms are a result of other –other factors, but we all start from this part of the personality and, well, accept it, eh, that that's going to lead to a good prognosis, that the symptoms will diminish little by little, and that the ideal objective is that she continue her day to day life, without treatment. And, well, the main thing is the support of therapy that she's going to receive |
| *IT: ¿De terapia?* | IT: Of therapy? |
| *PR: Mhmm, como terapia cognitivo conductual, mhm* | PR: Mhmm, like cognitive behavioral therapy, mhm" |

(Felipe, psychiatrist)

Adoption of the sick role is influenced by social, cultural, and personal factors (Segall, 1976). According to Parson's theory, adoption of the sick role often implies two main exemptions for patients (Segall, 1976). One, the patient is perceived as exempt from personal responsibility for their suffering when the illness is viewed as outside of their control. Two, patients are exempt from their normal social roles and obligations (Segall, 1976). Responsibilities and expectations normally performed as part of social roles are tailored to the new sick role (Pearce & Pickard, 2010). Adoption of the sick role also grants two main responsibilities for patients: to recognize that to be ill is undesirable, and to be motivated to cooperate with treatment to alleviate distress (Pearce & Pickard, 2010; Segall, 1976).

The "sick role" encourages a view of the ill person as a "passive victim of disease" and can diminish patients' agency and sense of responsibility as an active participant in treatment, particularly in the case of mental illness (Pearce & Pickard, 2010). Adoption of the sick role may be more difficult when the illness is related to psychological distress because the question of personal responsibility arises (Segall, 1976). For example, in the above quote, provider Felipe described the need for patients to "recognize and accept" their illness. When discussing how he might describe the mental illness experience to patients, Felipe expressed that it's like a disorder or ailment that anyone could have, and he stated: "*lo importante pues es reconocerlos y aceptarlos*" // "what's important is to recognize and accept it."

According to Felipe, "accepting" the diagnosis or psychiatric label as the causal myth could improve patients' prognosis. This causal myth was also congruent with the popularized cognitive behavioral approach which emphasizes the role of psychoeducation at the onset of psychotherapy to increase patients' myth adaptation. Indeed, provider Diego described that one of the first interventions delivered at the outpatient clinic was psychoeducation to help patients understand their disorder. Psychoeducation was also aimed at normalizing patients' illness experience and emphasizing that it could "happen to anyone." Although psychiatrists described a biopsychosocial causal model, they purposefully emphasized the biological aspects of the illness experience to encourage patients to adopt a sick role and reduce the stigma associated with patients' distress. In this excerpt, Diego stated how he would describe a patient's illness when they have schizophrenia:

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| *"PR: Primero diles que es una enfermedad- ah bueno les decimos trastorno porque enfermedad suena muy estigmatizante, entonces, que tienen un problema de salud y que no es de voluntad, echarle ganas, culpa de nadie, o algo místico, que es una enfermedad bien establecida que afecta a un órgano de su cuerpo como cualquier otra enfermedad que afecta cualquier otro órgano, que causa unos síntomas pero que todos modos sigue siendo un padecimiento del cuerpo.* | "PR: First, tell them that it's a disease –ah well, we tell them disorder because disease sounds too stigmatizing, so, that they have a health problem and that it's not their will, effort, anyone's fault, or something mystical, that's it's a well-established disease that affects an organ in their body just like any other disease that affects any other organ, that it causes some symptoms but that, regardless, is still an ailment of the body. |
| … | … |
| *IT:¿cómo describiría usted el problema de este paciente y pacientes similares a otra persona?* | IT: how would you describe this patient and similar patients' problem to other people? |
| *PR: La comunidad igual, bueno, con ellos es más psicoeducación pero hemos visto que no funciona como decirles qué es salud mental, entonces básicamente con que-si les hacemos saber saber que están enfermos ya es un avance significativo, esa es la meta, explicarles que están- que tienen una enfermedad, y enfocarnos en decirles que tienen algo en el cuerpo y que están enfermos. Ya más allá de la realidad de la enfermedad, a lo mejor en la primer consulta, como es el caso, pues no nos enfocamos tanto en los detalles."* | PR: To the community, the same, well, with them it's more psychoeducation but we've seen that it doesn't work to tell them what mental health is, so basically as long as we –if we make them know know that they are sick, that's a significant advance, that's the goal, to explain that they're – that they have a disease, and to focus on telling them that they have something in their body and that they're sick. After that, more than the reality of the disease, maybe in the first appointment, like in this case, then we don't focus as much on the details" |

(Diego, psychiatrist)

Providers in Mexico tried to acculturate patients into a biomedical understanding of their illness as outside of their control and unrelated to "will" or "effort." These biomedical explanations included the role of the brain and neurotransmitters in developing symptoms of mental and emotional distress. Providers described mental illness as similar to other physical concerns such as diabetes and provided the rationale that symptoms were often outside of their control and medication could help control and alleviate symptoms. However, understanding what patients do and do not have control over as part of their mental functioning may compel providers to re-empower patients to understand and face the consequences of their illness (Pearce & Pickard, 2010). Recovery then would depend in a larger part on the choices and actions taken by the sufferer who is encouraged to actively participate in treatment (Pearce & Pickard, 2010). However, as the above quote describes, providers in this study emphasized that psychoeducation could help patients "know that they are ill," which was viewed as a significant step forward in their recovery process.

Providers hypothesized that patient's ability to "understand" their disorder (ostensibly in biomedical terms) was related to their social class and educational attainment. For example, when discussing the cause of mental illness from the perspective of friends, family or other community members, provider Martín described:

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| *"Bueno, depende del estrato del nivel sociocultural. Por ejemplo, los pacientes con bajo nivel educativo pues llegan a pensar que es debido a cuestiones sobrenaturales, cuestiones pues de brujería o posesiones demoníacas. Si es una persona que tiene un nivel pues de estudios medio pues puede llegar a entender pues que se debe a cuestiones pues médicas y ya si es una persona pues que tenga un grado mayor de estudios pues si entiende-puede llegar a entender las causas este pues como científicamente de qué es lo que lo causa mhm"* | "Well, it depends on the sociocultural level. For example, patients with a low educational level, well, they can come to think that it's due to supernatural causes, stuff like witchcraft or demonic possession. If it's a person that has, well, mid-educational level, well, they can come to understand that it's due to medical causes and if it's someone that has a higher degree of education, well, they do understand –they can come to understand the causes, well, like scientifically of what is causing it mhm" |

Martín further noted:

| | |
|---|---|
| *"[el nivel de escolaridad] bueno influye en la capacidad de las personas para entender la situación porque realmente no es una –como dije, es una cuestión multifactorial y si me enfermo tengo que tener cierta preparación para entender los conceptos de cada una de las causas y pues el concepto mismo de enfermedad mental porque la explicación pues es compleja se necesita-necesita tenerse-pues sí, cierto nivel educativo para entenderlo. De manera muy básica pues se puede decir que están mal de la mente o que-que tienen problemas como pues a veces lo comentan como* | "[the level of educational attainment] well influences the capacity for people to understand the situation because it really isn't a –how did I say, it's a multifactorial issue and if I get ill I have to have certain education to understand the concepts for each of the causes and the concept itself of mental illness because the explanation well is complex and you need-need to have –well, yes, a certain educational level to understand it. In a very basic way well you can tell them that they're unwell in their mind or that –that they have problems like sometimes they call it like |

> *locura ¿no? Que es algo como muy básico que lo puedan entender, pero pues si el nivel educativo pues influye en que si son conceptos complejos, abstractos y difícilmente los van a entender"*
>
> madness, right? That's like something very basic that they could understand, but well yes, the educational level well does influence in that if they are complex, abstract concepts that are hardly understood by them"
>
> (Martín, psychiatrist)

The ability of patients to comply with the "sick role" may facilitate their access and utilization of mental health services as they may be willing to align with professional perspectives of distress and healing (Carpenter-Song et al., 2010). However, promoting the patient's adoption of the sick role could come at the cost of resigning their distress to biomedical models that view their brains as "broken" (Carpenter-Song et al., 2010). Further, a view of the patient as "incapacitated" and a heavy reliance on family to comply with treatment may fail to address the damaging interpersonal dynamics, often with close relatives, that were perceived as the cause of the patient's emotional distress.

In a rare example, Omar, a 47-year-old man with bipolar symptoms, reported the cause of his distress based on the biomedical explanation provided by his psychiatrist. Interestingly, he was the only patient with a university degree. When asked the cause of his distress, Omar stated:

> *"Como dicen los médicos, este, es una, un fallo en la, en la generación o recepción de químicos en el cerebro. Así, este, es un fallo que tenía que tocarle a alguien, y me tocó a mí. Así, no, no tengo… no tengo nada, ahora si, "ah que Dios me maldijo" que cosas así, no, nada de eso. Simplemente alguien le tenía que tocar, y pues me tocó a mí. Trato de tomarlo lo más light posible"*
>
> "As the doctors say, mmm, it's a, a failure in the generation or reception of chemicals in the brain. So, it's like a failure that had to happen to someone, and that someone was me. So, no, I don't have… I don't have anything, or to say "ah, God cursed me" or things like that, no, nothing like that. It's just that it had to happen to someone and it was me. I try to take it as lightly as possible"
>
> (Omar, 47)

Gender seemed to influence the perspective on the cause of mental and emotional distress among men and women in this study. For men, the cause was overwhelming described as biologically-based. Of the 11 men who participated in the study, most (5/11) were diagnosed with a psychotic disorder, followed by substance abuse (2/11), obsessive compulsive disorder (1/11), bipolar disorder (1/11), anxiety (1), and depression (1/11). Patients, Caregivers, and Providers often described these experiences of distress as a result of a physical condition (e.g., anxiety symptoms after a major surgery, convulsions, a brain injury), brain dysfunction ("chemical imbalance in the brain"), genetic or hereditary (e.g., as a result of a family history of mental illness). These results could be in part be explained by the larger number of psychotic disorders in the male sample. Indeed, in my field notes I wrote that psychiatrists seemed to ascribe more biological bases of the etiology of illnesses such as obsessive-compulsive disorder and psychosis. There were only two male cases in which stakeholders did not report any biologically-based etiology: a man diagnosed with anxiety (Carmelo), and another with depression (Javier).

### 4.1.2. *Mujeres abnegadas*: the causal myth of the self-sacrificing woman

Early on in the data collection process, provider Diego described the "common story" of the archetypal "*mujer abnegada*" (self-sacrificing woman), seen as a main cause of mental distress in many female patients diagnosed with anxiety or depression. In fact, Patients and Caregivers also frequently blamed women and mothers for the development of emotional distress. In multiple interviews, provider Diego offered the following explanation for these women's distress: enduring ("*aguantar*") adversity within the family system led to brain dysregulation that influenced women's ability to cope psychologically with adversity, subsequently changed their cellular physiology, which then led to the development of depressive symptoms. A version of this explanation was offered by the four psychiatrists interviewed for six of the eight women who participated in the study.

Across cases, a common theme was that *mujeres abnegadas* were expected to be silent, submissive, and suppress their thoughts and feelings. Provider Diego described *mujeres abnegadas* as being taught by society and their families to be self-sacrificing and to comply with expected gender roles of getting married and becoming a mother. Thus, these women's value was based on being wives and mothers. Diego reported that many of these women had led "unfavorable lives" in which they had been made to feel less than others, had low self-esteem, and had, in Diego's words: "come to believe their own central thoughts" that "they should feel bad, or better said, are underserving of feeling good." Diego stated:

> *"…aunque no hayan, aunque no hayan querido - y ya de alguna manera ellas se lo creen, pero aparte tienen que soportar a una pareja que a veces ellas no quieren <ah> o que la pareja las maltrata les-de todos los aspectos de la vida y su misma familia lo acepta, les dice que (P) es su cruz, así, lo tienes que asimilar, tienes que seguirlo soportando, mh-hm, entonces ella no tiene socialmente su voz y su voto es muy limitado y eso por supuesto le ocasiona mucho conflicto"*

> "… even if they didn't, they didn't want to -and in some way they believe it, but they also have to withstand a partner that they sometimes don't want <ah> or that the partner mistreats them -in all aspects of life and their own family accepts it, they tell them (P) it's your cross, like that, you have to assimilate, you have to continue withstanding, mh-hm, therefore socially she has no voice and her say in the matter is very limited and that of course causes a lot of conflict"
>
> (Provider Diego, 26)

In his description of the *mujer abnegada*, Diego conjures the Catholic metaphor of carrying a cross. In the Bible, when Jesus exhorts others to "bear the cross" with him, it can be interpreted as a willingness to demonstrate faith in Jesus to the death –an absolute surrender and devotion to Him. Diego uses the cross metaphor as a commonly understood analogy within a patriarchal and Catholic society. In using this analogy Diego implies that, like Jesus with his cross, women are expected to carry and withstand whatever challenges they may face, including possible threats to their personal dignity to demonstrate devotion toward (commonly) their male partners and general family. Mexican women are regularly assigned responsibility for the emotional support and nurturance of the family and expected to attend to others' needs before their own.

In Diego’s quote there is ambivalence about whether women have agency to stop or deter harmful interpersonal dynamics. Diego expresses that “even if they didn’t want to… in some way [women] believe it,” that is, believe that they must withstand abuse usually perpetrated by men in their lives. Interestingly, my field notes and the overall data corpus suggests that there is no reported male counterpart to the *mujer abnegada*. Namely, an explanation of harmful stereotypical dynamics perpetuated by men that could influence the development of mental and emotional distress. Thus, all stakeholders are complicit and implicated in creating the archetypal “*mujer abnegada*”: societal norms demand it, family members accept it, women themselves believe it, and the doctor just explains it.

***Cultura y tradición.*** Cultural context and Catholic values influenced the development and maintenance of the *mujer abnegada*. *Marianismo*, the expectation that women should be self-sacrificing in the image of the Virgin Mary, has been commonly described in Latino samples (Arredondo, Gallardo-Cooper, Delgado-Romero, & Zapata, 2014). Prominent Catholic values reflected in this study’s interviews include the belief in marriage as a sanctified lifelong union, a heteronormative perspective on sexual relationships, and an understanding that sex is performed with the intent to procreate. Catholic values have been prominent in Mexico since Spanish colonization and were propagated by the church as a means to control the development and maintenance of an “ideal” family unit based on the monogamous, permanent union of a man and a woman (Barajas, 2011; Singer, 2018).

In the case of Alejandra, she was a 43-year-old woman with depressive symptoms who had been currently seeking psychiatric treatment for seven months. She owned a *taquería* (taco restaurant) and was from a small town located an hour away. She reported that enduring her husband’s infidelity for years had caused her depression:

> *"Y-y cuando lo encontré adentro de mi casa con la persona me dijo que no dijera nada que no, no iba pasar nada y todo <y> y sacan a la muchacha de-y el, cómo no es de acá mi esposo, mi esposo es de Hidalgo, la fue a dejar a la terminal y él me dijo no digas nada y esto va a pasar y todo, y yo me confié que ya no iba pasar nada entonces este trabajaba muy -me guardé todo yo-no pasó nada, como siempre de palabra, no pasa nada y ya vamos a seguir echándole ganas y entonces me callé, no dije nada y todo pero después me lo fue haciendo y haciendo y no decía nada ósea lo hacía y no decía nada, me callaba, yo me creía fuerte y que aguantaba todo hasta que después ya hace 10 años este <mm> me la hizo con una propia trabajadora y luego lo perdoné, regresó a la casa, ahorita me lo volvió a hacer con otra trabajadora y ahorita fue más fuerte y ahorita ya caí en depresión ((solloza))"*

> "And-and when I found him in my home with another person he told me to not say anything, that no, that nothing would happen and all <and> and they took the girl out of- and because my husband is not from here, my husband is from Hidalgo, he took her to the terminal and he told me not to say anything and that this would pass and all, and I trusted that nothing else would happen so I worked very –I kept it all in I –nothing happened, and like always by word, nothing will happen and we'll continue making an effort so I shut up, I didn't say anything and all but later he kept doing it and doing it, and I didn't say anything, I mean, he did it and I didn't say anything, I kept it quiet, I thought I was strong and I could endure it all until later, 10 years later <mm> he did it with my own worker and I forgave him, he came home, and then he did it again with another worker and this time it was more severe and I fell into depression ((sobs))"
>
> (Alejandra, 43)

In this excerpt, Alejandra described being asked multiple times to be silent and to not express her emotions, presumably to maintain her marriage. Alejandra may have aspired to be the ideal self-sacrificing, understanding, hardworking wife -the quintessential *mujer abnegada* by Diego's description. She might have had the expectation that "if I am strong, I do not need to discuss how these affairs affect me." However, when she was no longer able to "be strong," she "fell into depression." Perhaps the depression reflected an inability to perform gender roles as expected and a cry for help that she was unable to withstand (*aguantar*) her suffering any longer. Alejandra's daughter Luisa (25 years old) noted that despite multiple affairs, her mother had continued her marital relationship in part due to the Catholic-based expectation that marriage is a lifelong commitment. Luisa stated: "*si te casas, es para toda la vida… lo que te haga, lo que no te haga…si te vas a casar bien, pero te tienes que pasar sus infidelidades, que si un golpe, si es borracho… entonces tienes que perdonar eso…*"// "if you get married, it's for life… what he does, what he doesn't do… if you're going to get married good, but you have to withstand his cheating, if he hits you, if he's a drunk… so you have to forgive that…" Alejandra described these expectations as rooted in their "culture and tradition," that, like Provider Diego described, expect women to assimilate to their difficult life circumstances and view forgiveness as a necessary virtue to continue withstanding these conditions.

Gender role expectations were often engrained in heterosexism, that is, the assumption that heterosexual relationships were the norm. Not surprisingly, heterosexist attitudes were harmful to women who felt attraction toward the same sex. In the case of Sara, who was a 19-year-old woman, she described her depression as caused by conflicts that arose with her mother when Sara began to express sexual attraction toward women. Sara's mother Mariana, a 47-year-old woman, believed the depression was the direct result of Sara's sexual orientation. Mariana described that when her daughter started coming out, she believed it was a "*capricho*" or whim, and that Sara was being unduly influenced by a female friend because: "*nosotros de antemano pues sabemos que las personas con diferentes preferencias a veces son muy insistentes y más en una mujer*" // "beforehand we know that people with different preferences sometimes are very insistent and more so when it's a woman." Mariana insisted to her daughter that she did not "truly" experience same-sex attraction, and described constant discussions with her that "made everything explode":

> *"Entonces yo siento que eso fue lo que hizo que explotara todo no se encontraba ya a sí misma. ¿Por qué? Porque yo le decía una cosa, ella le decía otra y llegó el momento hasta qué hubo un choque conmigo a pesar de que nos llevamos y nos conocemos, me dijo que no creía en mí, no confiaba, otras cosas que no."*

> "So, I feel that's what made everything explode, she couldn't find herself anymore. Why? Because I would say one thing, she would say another, and the time came where she even collided with me despite us getting along and knowing each other, she said she didn't believe in me, didn't trust me, and other things that no"
>
> (Mariana, mother, 47)

When discussing their sexuality, women were commonly asked to suppress their genuine feelings and told by more powerful others (e.g., husbands, fathers, mothers) how to conform their experience to the norm. This inevitably led to conflict as women’s psychiatric symptoms were at times perceived by others as a bid for attention or a rebellion against the family and social norms. Yet many of these women viewed their depression or anxiety as a result of reaching their limit of tolerance against abusive, harmful, and oppressive interpersonal relationships that dictated what their experience “should be,” with a dearth of alternative options.

Catholic values of chastity and the divine role of sexual intercourse for procreation also influenced views regarding women’s sexuality as it related to their mental illness experience. For example, Caila was a 54-year-old woman with depressive symptoms who had been in treatment for 7 to 8 years. Both her and her husband Mario (52 years old) stated that sexual concerns was an additional source of distress. Caila had a diminished sex drive that developed after a thyroid operation, possibly as a side effect of medication or related to depression. Despite years in treatment, this aspect of her illness experience, her sexuality, had not been adequately addressed. Caila described in her interview:

| | |
|---|---|
| *“PX: mire, una vez al psiquiatra de paga le pregunté porque a raíz de mi problema de la depresión este ya no quise tener relaciones con mi marido y mi marido este se enoja hasta ahora, hasta ahora ya tiene años y se enoja no es de que tú este que no, no, no, no <y> yo le he preguntaba al doctor, al psiquiatra, pero se fue el de paga, le preguntaba yo que ¿por qué? Él dijo que porque había medicamentos eh antidepresivos que inhibían el* | “PX: look, once I asked the private psychiatrist because from my problem with depression I no longer wanted to have sex with my husband, and my husband would get angry, even now, even now it’s been years and he gets angry, no that you don’t, no, no, no, no <and> I asked the doctor, the psychiatrist, but it was the private one, I asked him, why? He said that because the antidepressant medication could inhibit the |
| *AR: el deseo sexual* | AR: sex drive |
| *PX: aha, si y le digo y pues si doctor, pero mi marido este se enoja conmigo y dice ¿y para usted es muy importante eso? Me dio pena y le dije pues no* | PX: aha, yes, so I said, well yes doctor but my husband gets angry at me and he said, is this very important to you? And I felt ashamed so I said no |
| *AR: mh-hm* | AR: mh-hm |
| *PX: y ya este ya no me dijo nada, me apuntó mi receta y ya me fui, pero si es importante para mí* | PX: so, he didn’t say anything else, he wrote down my prescription and I left, but it was |

| | |
|---|---|
| *porque (P) yo pienso que, no sé, pienso que sí es importante porque este porque mi marido y yo no podemos estar como si fuéramos hermanos o algo* | important to me because (P) I think that, I don't know, I think that it is important because, because my husband and I can't be as if we're siblings or something |
| *AR: claro* | AR: of course |
| *PX: es lo que pienso, no sé* | PX: That's what I think, I don't know |
| *AR: claro* | AR: of course |
| *PX: a lo mejor estoy equivocada ya estamos grandes, yo le he dicho yo ya estamos grandes y él me dice, aunque fuera yo un ancianito a mí no se me van a quitar las ganas ¿no?"* | PX: maybe I'm wrong and we're too old, I've told him that we're too old, and he tells me that even if he was a little old man his desire would not go away, no?" |

(Caila, 54)

The above quote provides a glimpse into how gender dynamics influence the therapeutic encounter. Caila brought up her concern regarding a diminished sex drive in the context of wanting to please her husband. Thus, from the start, her own sexual wants and needs were subtly dismissed. When her male psychiatrist presumably tries to understand whether this is a concern that is important to her, not only her husband, Caila feels shamed. Having a pleasurable sex life may imply values outside the Catholic norm of having sex for procreation, and it may threaten Caila's ideal gender expectation that women should be pure and chaste. Consequently, although the psychiatrist's question may have had the intent to elicit her experience, the tone, delivery, and person of authority who asked it felt threatening, leading Caila to cease her questioning.

Through sobs, in a tearful and difficult exchange, Caila's husband Mario described how the lack of sexual intimacy had affected their relationship. Mario expressed that cultural and gender norms dictated that he should seek sexual pleasure with other people if he was dissatisfied in his marriage. However, Mario stated he longed for intimacy and connection with his wife and did not want to acquiesce to those culturally sanctioned norms. He reported attempts to be understanding and reassure Caila that "everything is going to be ok." In this next quote, the impact of Caila's rejection is palpable during his long pauses ("LP"), as Mario expresses his struggle to understand how to best support his wife:

| | |
|---|---|
| *"CR: pues la verdad yo la busco pero pues (LP) hay veces pues me rechaza dice no, no, pues no sé qué le pasa, digo, yo creo que ha de ser por-por la enfermedad que tiene pues yo pues hay veces pues ya no le ya no le insisto ya no (P) y pues desde que esto yo nunca la he engañado (LP) entonces digo ok voy a estar haciendo otras cosas, ósea engañarla no, ps yo se que ella es mi mujer y tengo que ahora si comprenderla (P) eso es lo que, si, doctora* | "CR: well, to be honest, I reach out to her but well (LP) she sometimes rejects me and says no, no, and I don't know what's going on with her, I mean, I think it has to do with her illness, well I sometimes I don't insist I don't insist anymore (P) and since this I have never cheated on her (LP) so I say ok, I will do other things, I mean cheat on her no, I know she is my wife and I need to understand her (P) that's what I know, yes doctor |
| *IT: ¿pero se ha sentido muy distanciado de ella?* | IT: but you've felt distanced from her? |
| *CR: si, si* | CR: yes, yes |
| *IT: ¿y por qué cree que le pasó a ella la depresión?* | IT: and why do you think the depression happened to her? |
| *CR: pues no sé que cómo habrá sido de su niñez o adolescencia, no sé la verdad, me platica unas cosas también, pero (P) yo la verdad pues (p) ya le digo pues ya va a pasar bien todo eso, ya, si"* | CR: well I don't know how her childhood or adolescence was, I truly don't know, she also tells me some things but (P) to be honest I (P) I tell her everything is going to be ok, that, yes" |

(Mario, husband, 52)

Unfortunately, Caila's current psychiatrist Provider Diego, completely missed her sexual concerns and did not discuss these as relevant to his clinical conceptualization. Diego reported Caila was another example of a *mujer abnegada* but based this description on Caila's concerns with her adult child who had problems with substance abuse. Caila's issues with her son were only briefly mentioned in my interview with her. It is possible that being a female interviewer, Caila felt she could disclose more of her life history and sexual concerns with me.

Surprisingly, Provider Diego did note in an interview related to another case (i.e., Patient María) that it was important to ask patients about their sexual history. He noted that these conversations were often difficult to have due to the gender dynamic between a female patient and male physician. Diego also stated these dynamics were even more salient when doctors were young (like him), and if the male partner or husband was present in the appointment. Diego reported that a sexual history is usually gathered during their first appointment at the outpatient clinic. However, it was unclear how doctors used that information and whether it influenced their clinical conceptualization. Diego stressed that it was of particular importance to discuss sexual history with female patients who had symptoms of depression or anxiety for long periods of their life, and stated: "*cuando son esposas abnegadas, a fuerza hay que preguntarla*" // "when they are self-sacrificing wives, we must forcibly ask [this question]." This statement casually implied the expectation that self-sacrificing women were vulnerable to experience gendered violence.

***Vidas adversas***. *Mujeres abnegadas* commonly shared experiences of physical, emotional, and sexual abuse, usually perpetrated by husbands or fathers. Additionally, they often experienced other life stressors that precipitated their symptoms of distress. These included the loss of a loved one, partner infidelity, medical conditions, and having the responsibility of maintaining their household. These women frequently described the need to "*aguantar"* or withstand, resist, and endure abuse. Verónica, a 22-year-old woman completing a degree in chemical engineering from a town 40 minutes away from the clinic noted plainly that growing up witnessing domestic violence caused her obsessive and compulsive symptoms:

| | |
|---|---|
| *"Yo siento que fue por la niñez que sufrí pues varios traumas familiares y todo eso y eso desencadenó el trastorno"* | "I feel like it was because I suffered a lot of family trauma in my childhood and all that, that led to the disorder" |

(Verónica, 22)

The previously discussed case of Caila was another example of a woman that Provider Diego described as having lived "*una vida adversa*" (an adverse life). Caila had experienced multiple incidents she described as traumatic ("*traumante*"), including physical abuse by her father, bullying in school due to her stuttering, an abortion earlier in life, and medical issues related to her thyroid gland in adulthood. She described these events laid the foundation for her current depressive symptoms yet viewed her abortion as the index trauma that caused her distress:

> *“IT: y la primera vez que le pasó o que empezó a sentir síntomas, ¿qué fue lo que cree que a lo mejor lo causó en ese momento?*
>
> *PX: aparte mire (P) a nadie yo le he dicho esto porque yo pienso que es algo muy mío pero este cuando yo era novia de mi marido salí embarazada pero me dio miedo por mi papá y mi hermano entonces yo provoqué un aborto y fue algo (P) para mí, algo traumante y eso no lo he procesado yo, siempre me está recordando, siempre-luego vino lo de la tiroides y lo tomé como, como que un castigo porque Diosito me estaba castigando pero luego ya cuando vine acá y empecé a hablar con los psiquiatras este (P) pues ellos dicen que pues no, que– incluso fui a este a la iglesia y me confesé y me dijo el padre que Diosito ya me había perdonado, que la que no se perdonaba era yo, entonces fueron muchas cosas, muchas cosas. Ahora yo pienso que ya pues ya lo superé porque ya no me acuerdo mucho, pienso yo que-pues yo ahora lo que pienso es que Diosito cuando me muera yo pues lo va a tomar en cuenta eso y pues (P) yo pienso que merezco un castigo y que Diosito me lo va a dar. Que a veces dicen que el castigo está aquí en la Tierra, que eso es mentira hasta que lleguemos con Dios, entonces yo lo veo de otra manera, yo pienso que esto lo que a mí me pasa es un castigo de Él, sí”*

> “IT: and the first time that this happened to you, that you began to feel symptoms, what do you think maybe caused that at that time?
>
> PX: besides, look (P) I haven’t told this to anyone because I think it’s something very mine but when I was my husband’s girlfriend I got pregnant and was scared because of my father and brother so I caused an abortion and it was something (P) to me, something traumatizing and that I haven’t processed, I am always remembering, always – then came the thyroid and I took that as a, like a punishment because God was punishing me but then when I came here and started talking to the psychiatrists (P) well they said that no, that –I even went to church and confessed, and the priest told me that God had forgiven me, that the one who had not forgiven was myself, so it was a lot of things, a lot of things. Now I think that I’ve overcome it because I don’t remember much, I think that I-well, now what I think is that when I die, God will take it into account and that (P) I think I deserve a punishment and that God will give it to me. They say that sometimes punishment is here on Earth, that it’s a lie that it’s when we get to God, so I see it differently, I think that all this that’s happening to me is a punishment from Him, yes”

(Caila, 54)

Like many *mujeres abnegadas*, Caila had learned to suppress her thoughts and feelings which could have exacerbated her trauma-related symptoms. In her pursuit to make meaning of her distress, Caila explained her symptoms as the result of a punishment from God, blaming herself for “making wrong decisions.” This explanation is also culturally congruent with her Catholic beliefs regarding the sanctity of marriage and abortion as a mortal sin. Consequently, having acted against the gender and cultural expectations, Caila believed she must now serve a life sentence of sorrow and misery.

In another case, María, a 70-year-old woman, had been prescribed benzodiazepines for her depressive symptoms for over 30 years by her primary care physician and only recently had sought psychiatric services four months prior. She had second grade educational attainment and identified as a homemaker. María expressed many challenging experiences in childhood. She had been abandoned by her mother at an early age who had left her under the care of an aunt. According to María, her aunt worked as a prostitute, had been physically abusive toward her, and eventually forced her into prostitution for her aunt's financial gain. She met her future husband at age 17 and married him a couple of months later to escape her aunt's household. Unfortunately, issues quickly arose in their marriage due to her husband's infidelity and alcohol abuse. Still, María described her depression as caused by yet another moment of distress, the unexpected loss of her then 12-year-old daughter who died in an accident:

> *"Mi niña se accidentó y este a partir de ahí eh para mí fue el acabose de la vida, todo, todo se eh después intenté suicidarme eh –me llevó, me tomé unas pastillas y mi esposo me llevó al centro de salud de [ciudad], me hicieron lavado y este, ¡no tengo ganas de vivir todavía! Aun así, no tengo, pero me siento, ya a partir de que he venido, he sentido conformidad, no he peleado, ya no peleo, pero antes eran pleitos, pero era lo mismo la agresividad del Alprazolam"*

> "My girl was in an accident and from then eh for me it was the end of life, everything, everything, eh, then I tried to kill myself eh – it took me, I took pills and my husband took me to the health center in [city], they pumped me and I still don't want to live! However, I don't have, but I feel, since I came here, I've felt acquiescent, I haven't fought, I don't fight anymore but before there were confrontations but it was because of the aggressiveness brought on by the Alprazolam [benzodiazepine]"

(María, 70)

After she experienced many traumatic events, María reached a breaking point where she lost the will to live. Mariano, María's 73-year-old husband, also viewed the cause of her illness as related to the traumatic loss of their child. He described seeking help from many different healers (e.g., priests, *curanderos* or folk healers), yet no one explained the cause of María's distress as due to the traumatic loss of their daughter. María's distress was treated through medication which presumably helped decrease some of her symptoms. However, the core issue of grief was never addressed. Now, after multiple failed suicide attempts and seeking different treatment avenues, María seemed resigned to living –although she did not have the will to live, she felt she could accept her current life circumstances.

Women's mental and emotional distress was often the result of tolerating multiple experiences of abuse and reaching the limit of what they could endure. Olga was a 27-year-old woman from a town approximately 2 hours away with anxiety and panic symptoms that had been in treatment for 10 months. She believed that her symptoms in part arose as a result of having too much responsibility as the oldest child to care for her younger siblings and enduring the fear of being beaten if her siblings misbehaved or if the household chores were not completed. Olga's parents were involved in politics and often very busy, therefore, she was burdened with the household responsibilities, as she described "*hasta que de plano ya no aguanté*" // "until I could not take it anymore."

Olga's mother, Angelina, corroborated in her interview that she had perpetrated physical abuse against Olga at a young age, and also believed this was the cause of her anxiety. Through tears, Angelina stated "*me remuerde la consciencia*"// "I have a heavy conscious" for the suffering she made her daughter endure, and the responsibility she had placed on her as the oldest of three siblings. She noted Olga was sensitive and had learned to not fight back: "*ella no decía nada, la golpeaba, pero no decía nada ((llorando))*"// "she didn't say anything, I would beat her but she didn't say anything ((crying))." Like the women previously discussed, Olga had been taught from an early age to submit to abuse. From these experiences, Angelina stated: "*Algo ahí hay, está traumada, ya desde chiquita*"// "There's something there, she's traumatized, since she was little."

Olga’s experience of abuse was influenced by the strict gendered expectations for both her and her mother within their household. Angelina described that her husband (Olga’s father) expected both women to maintain the home and serve the men of the family. Failure to meet these expectations would result in discussions between Angelina and her husband that increased Olga’s anxiety symptoms. Alternatively, Olga would suffer the consequences by being beaten by her mother. Angelina described her husband’s viewpoint on Olga’s mental health concerns:

> *“CR: Mm mi esposo dice, no pues, este dice, no pues es que tus hijas también este ps, no se enoja, dice, no lo saca lo que tiene, siempre está teniendo ahí dice, yo que tengo la culpa, me dice mi esposo, yo que tengo la culpa, no lo saca. Entonces nos echábamos la culpa, pero es que tú también, le digo, tú también siempre este te enojas, ajá sí, y este o no hemos hecho la comida, o no hemos lavado la ropa, siempre se enojaba mi hija ya se ponía así porque a veces yo ya no podía yo lavar cuando estaba enferma, cuando estaba grave mi hija, no podía yo lavar, no podía yo ni hacer comida. Porque estaba yo pendiente con ella. Entonces mi esposo se enojaba y ya mi hija como que los nervios, le daban los nervios, ¿no? Ya va a llegar mi papá. Tú no te preocupes mija, yo le voy a decir, yo le voy a platicar todo. No, porque siempre se va enojar. Y ahí empezaba a llorar.”*

> “CR: Mm my husband says, no well, he says, no that your daughters are also mmm, well, he gets angry, he says, she doesn’t express what she has, she’s always having there, he says that I’m at fault, my husband tells me, why am I to blame, she doesn’t express it. So, we would blame each other, no that you also, I would say, you are also always angry, aha, yes, or that, if we haven’t made dinner or washed the laundry, my daughter would always get mad and get like that because sometimes I couldn’t do the laundry when she was ill, when my daughter was severely ill, I couldn’t do laundry, I couldn’t even do meals. Because I had to be tending to her. So, my husband would get angry and my daughter’s nerves would, like she would get nervous, right? My dad is going to get here. Don’t worry, mija, I’ll tell him, I’ll talk to him about all of it. No, because he always gets mad. And then she’d begin to cry.”

(Angelina, mother, 42)

From Angelina’s report, her husband believed he had no responsibility or contribution to Olga’s concerns (i.e., “why am I to blame?”), rather, he blamed Olga for not expressing her emotions, specifically, anger. In this quote, Angelina lists some chores they were expected to complete (e.g. prepare meals, do laundry) to avoid her husband’s anger, and provides a glimpse of the fear Olga experienced at not having fulfilled these chores due to her psychiatric symptoms. For Olga, the weight of these responsibilities and the fear of retaliation may have fueled her anxiety yet the same symptoms impeded her from performing these responsibilities, creating a continuous cycle of distress. How could Olga express her anger at having to carry too heavy a load in her family when she deeply feared the consequences?

***Entre la espada y la pared.*** Although providers and caregivers reported the cultural embeddedness of the plight of *mujeres abnegadas*, these women were also often blamed for experiencing emotional or mental distress. Women were described in frequently contradictory ways. They were too dependent on others yet wanted too much independence. They were overly involved in family conflict yet did not express their emotions enough. They were victims of their circumstances yet invited abuse into their lives. *Mujeres abnegadas* have also learned to internalize these messages and often also blame themselves.

For example, Alejandra's daughter Luisa blamed her mother for having an unhealthy attachment toward her father despite reporting the gendered cultural expectations placed upon women in Mexico that lead to these dysfunctional relationships. In her words, Luisa described her parents' relationship as: "*una aferración que ella tiene hacia mi papá por ese amor enfermizo*"// "an attachment she has toward my dad for that sickly love." In fact, both women noted that part of Alejandra's depression was due to her "*dejadez*" or neglect of her needs, "allowing" her partner's infidelity, and not putting an end to it. Consequently, although they believed the trigger was the husband's infidelity, the responsibility for continued suffering rested on Alejandra.

In another example, Provider Felipe expressed that family dynamics likely contributed to the development of Olga's anxiety symptoms. However, he did not have specific information about her family concerns because he had not discussed these directly with his patient. Rather, Felipe hypothesized that Olga was too dependent on her mother, and believed this was the main factor that maintained her distress.

Providers and caregivers described that women's dependency and over-involvement in relationships could lead to mental and emotional distress. Mariano, María's husband, described one cause of his wife's depression was being overly involved in her children's problems. Both María and Mariano described strained relationships with their son due to a difficult daughter-in-law who borrowed money without paying it back, spread gossip about their daughter, and whom María viewed as overall disrespectful. Mariano stated:

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| *A veces ella se enferma porque le hace caso a los problemas de la nuera o de los hijos y eso no (P) o luego a veces hasta para un bien, oye mañana nos vamos a ir a tal parte y este pues nos vamos algo temprano ¿no? Nos invita alguno de mis hijos <o> nos vamos a ir temprano pues con eso ya no puede dormir* | Sometimes she gets ill because she's too involved in her daughter-in-law's problems or the children's and that no (P) or sometimes even for something good, hey, tomorrow we're going to this place and we need to leave early, right? One of the kids invites us <or> we're going to leave early, well with that she can't sleep anymore |

(Mariano, husband, 73)

An interesting example of blame placed on women for the cause of mental or emotional distress was another archetype discussed by provider Diego: the "*madre esquizofrenizante*" or schizoprenisizing mother. According to Diego, caregivers (particularly mothers) could have detrimental effects on their children early on in life that lead to the development of pre-morbid personalities that were presumably the cause of mental distress. Diego described the "schizophrenizing" aspect of these relationships as the mixed messages provided by caregivers that confuse children and make it difficult for them to have a firm sense of reality. This subsequently lead to the disorganized thinking pattern characteristic of psychosis. When asked more specifically on the theoretical underpinning of this archetype, Diego responded that these were "*como teorías psicodinámicas, que igual y ya no son tan vigentes, pero si se ven en la práctica*"// "like psychodynamic theories that may no longer be as current, but you do see them in practice." One case example was Pedro, an 18-year-old man diagnosed with psychosis. When discussing the cause of this patient's distress, Diego described:

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| *"IT: ¿Cree que alguna otra explicación además de la genética, algo social o contextual de este paciente?* | "IT: Do you think there's another explanation apart from genetics, something social or contextual for this patient? |
| *PR: Pues está en dos situaciones psicodinámica, por ejemplo, la madre esquizofrenizante y la personalidad, el desarrollo de la personalidad pre-mórbida bueno a lo largo de la vida es una explicación, yo en lo particular me voy a lo biológico, pero si es posible.* | PR: Well there are two psychodynamic situations, for example, the schizophrenisizing mother and the personality, the pre-morbid personality development really throughout life that's an explanation, me, in particular I focus on the biological, but it's possible |
| *IT: Creo que antes ya me habías explicado que es como una madre esquizofrenizante pero tal vez cuáles son unos ejemplos ¿no? de esos tipos de [* | IT: I think you had explained to me before what a schizophrenisizing mother was but maybe what are some examples, right? Of this type of [ |
| *PR: Pues aquí lo ridículo es que le dice- ¿mamá o papá? Es más, como la mamá que el papá, que le dan permiso de salir, pero a cada rato le preguntan a qué horas llegas, dónde estas, cómo estas, entonces como que le dicen que sí, pero con la actitud le dicen que no. O si te quiero, te acepto como eres pero me hubiera gustado que seas de otra manera o que seas de otra forma, entonces pues tiene un doble mensaje. Eso es como muy esquizofrenizante."* | PR: Well the ridiculous part here is that they say- mom or dad? In fact, it's as much the mother as the father that, they give him permission to go out, but they're constantly asking him when he's coming back, where are you, how are you, so, they like tell him yes but with their attitude say no. Or I do love you, I accept you as you are but I wish you would have been another way or be different, so he has a double message. It's like very schizophrenisizing." |

(Diego, psychiatrist)

There is a long history in psychoanalytic theory regarding the role of early attachment experiences in the development and maintenance of psychological dysfunction, particularly in psychotic symptoms. The role of parents, particularly mothers, in the pathogenesis of schizophrenia was studied by interpersonal psychoanalysts in the 1940s following Harry Stack Sullivan's Washington School of Psychiatry (Neill, 1990). Fromm-Reichmann (1948) suggested that individuals with schizophrenia exhibit regressive tendencies that defend against early hostile reactions toward the self, usually by important people in their childhood, that leads to withdrawal from others and the outside world. Thus, the term *schizophrenogenic mother* was used to denote two central concepts in the early development of psychotic pathology: maternal overprotection and maternal rejection (Neill, 1990). The schizophrenogenic mother was posited to influence the development of schizophrenia due to her attitude toward the infant (Neill, 1990). However, these theories were ultimately unsupported (Neill, 1990).

Although unsubstantiated by empirical evidence, the use of the term schizophrenogenic mother, "*madre esquizofrenizante,*" as described by provider Diego, is interesting as it implies agency, power, and influence of the mother (and women) over the development of mental illness (Neill, 1990). This historical view on the pathogenesis of schizophrenia is outdated yet the underlying assumptions of this theory continue to be viewed as relevant in clinical practice in Mexico. As Diego stated: "*…igual y ya no son tan vigentes, pero si se ven en la práctica*"// "…they may no longer be as current, but you do see them in practice." Consequently, gender roles may be an important factor influencing the perspectives on the origin, course, and treatment expectations for mental illness in Mexico.

Another example of the schizophrenizing mother was in the case of Eduardo, a 55-year-old man who had been in psychiatric treatment for over 30 years for psychotic-related symptoms that emerged in his early adulthood. He had been institutionalized multiple times in Mexico City and for brief periods in a psychiatric hospital located in a smaller town neighboring the city of Puebla. When this psychiatric hospital closed, he sought treatment at the current outpatient site, approximately 2 years ago. Eduardo's accompanying caregiver was Daniel, his twin brother. Both described Eduardo's early life experiences and his mother's rejection as precipitating factors to his mental illness. Their parents divorced when they were young, and their mother separated the children (the twin boys and two older daughters), stating she was unable to care take for all of them. However, only Eduardo was separated from the family of origin and made to live with his grandparents and an uncle. Eduardo noted his mother's rejection was a main contributor to the emergence of his distress and stated decisively: "*Fue un problema familiar lo que me llevó todo lo demás*" // "It was a family problem that lead to everything else."

Eduardo's twin brother, Daniel, agreed that difficult family dynamics and lack of resources caused Eduardo's psychotic symptoms. When Eduardo was separated from his family of origin, he became an "only child" in a wealthier and seemingly more stable home with his grandparents and uncle. However, when his grandmother died and his uncle married, Eduardo had difficulty adapting to the real loss of this grandmother and the felt loss of his uncle, both his primary attachment figures. Daniel noted that their sisters were given preferential treatment and both twin boys had less educational and financial opportunities throughout their lives.

When mothers were not explicitly blamed for their son's psychotic disorders, other women were often described as responsible for mental and emotional distress. For example, in the case of Ricardo, a 45-year-old man diagnosed with schizophrenia, both him and his partner Cecilia (47 years old) believed that a past problematic romantic relationship with a woman had caused his distress. Ricardo reported that the mother of this woman had performed witchcraft against him so he would become impotent and unable to have sexual relations with other women. Interestingly, in his lament he noted that he is not like other men who are "beaters and all":

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| *"AR: Y ¿por qué cree que esto le está pasando a usted? ¿Qué lo causó?* | "AR: And why do you think this is happening to you? What caused it? |
| *PX: Meterme con mujeres que no debía haberme metido. Yeste, no soy rico, no soy güero ni nada, ni tengo ojos azules, ¿verdad? Pero, no sé, por qué a mí. Hay personas que, que se portan más peores con sus parejas, golpeadores y todo y son felices de la vida, no les pasa nada y yo por una tontería todo lo que me ha pasado, se descompuso mi vida"* | PX: Getting involved with women I shouldn't have gotten involved with. And mmm, I'm not rich, I'm not White [blonde] or anything, I don't have blue eyes, right? But, I don't know, why me. There's people that, that are much worse to their partners, beaters and all, and they're happy as can be, nothing happens to them and for a stupid thing all this has happened to me, my life got derailed" |

(Ricardo, 45)

Unfortunately, Diego noted that for *mujeres abnegadas*, psychiatric support is often a last resort after trying multiple treatments. When discussing the case of María, Diego noted an almost cynical outlook regarding her prognosis, and of women similar to her:

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| *"PR: tardan en venir, fueron a todos lados, hicieron lo que – todo lo que hicieron, no les funcionó. Empeoraron, empeoraron, empeoraron ((risas)), van a seguir empeorando y al final pues el panorama no es muy bueno, en general* | "PR: they take a long time to come, they've gone everywhere, they've done –everything they've done hasn't worked. They've gotten worse, worse, worse ((laughs)), they'll keep getting worse and in the end the outlook is not very good, in general |
| *IT: Como que el último recurso fue venir aquí* | IT: Like the last resort was coming here |
| *PR: Ajá* | PR: Aha |
| *IT: ¿Y por qué crees que eso pasa? ¿De que este es como el último recurso?* | IT: And why do you think that happens? That this is like the last resort? |
| *PR: Ahhh bueno yo- de donde viene el primer recurso es siempre el curandero, el hierbero, el huesero o el – todo. Eso es lo- el primer paso invariablemente. Cuando fracasa, que siempre fracasa, pasan con el médico general y ya-"* | PR: Ahhh well I- where they come from the first resource is always the *curandero* [witch doctor], the *hierbero* [plant healer], the *huesero* [bone healer] or the –everything. That's the –the first step, invariably. When it fails, they go to the primary doctor and that's it-" |

(Diego, psychiatrist)

## 4.2. Treatment expectations

Most patients (18/19), all caregivers (19/19), and all psychiatrists (19/19) described psychiatric support, including medication, as helpful to alleviate distress. However, multiple barriers influenced patients' access to psychiatric treatment including lack of knowledge about psychiatric resources, inadequate treatment by primary care providers, type of insurance (i.e., whether it was government subsidized), and high out-of-pocket costs for medication and appointments with private doctors if uninsured. Furthermore, the outpatient clinic was often difficult for patients and family members to find due to its remote location. As presented in Table 1, patients traveled an average of 85.4 hours (approximately 1 hour and 25 minutes; SD = 60 minutes) to attend their psychiatric appointments.

Word-of-mouth, through friends, family or community members, was often the way patients and caregivers learned about the outpatient clinic. Further, patients learned they could enroll in the government subsidized insurance *Seguro Popular* to obtain this psychiatric treatment. As previously discussed, *Seguro Popular* is a "catch-all" insurance for people who would otherwise be uninsured in Mexico. Being able to attend psychiatric appointments and receive medication through the *Seguro Popular* was often the only way psychiatric services were affordable to patients. For example, Margarita, patient Juan's sister-in-law, noted that for some time Juan was not receiving psychiatric care due to the costs of treatment. Margarita reported that once Juan got Seguro Popular, he not only sought psychiatric services at this site, but also used psychiatric appointments for regular check-ups of other medical concerns such as hypertension.

Provider Martín agreed that *Seguro Popular* was a main support that helped increase access to biomedical treatment. When asked what helpful sources of support for patients would be, Martín stated: "*obviamente el apoyo del gobierno que pues le subsidia el medicamento, la consulta… con Seguro Popular*" // "obviously the government support that subsidizes the medication, the [psychiatric] appointment… with *Seguro Popular*." Provider Diego further noted that patients' ability to access medication within their communities, rather than having to go to the psychiatric outpatient hospital, would help increase medication compliance. Unfortunately, for a majority of patients, psychiatric support had been the only aide available to them to manage or treat their mental or emotional distress. In the following excerpt, Olga, a 27-year-old woman from a town approximately 2 hours away experiencing panic attacks, described a common narrative of how patients arrived at the psychiatric outpatient hospital for treatment:

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|---|---|
| *"PX: Es [psiquiatría] la única ayuda que he recibido* | "PX: This [psychiatry] is the only help I've received |

| | |
|---|---|
| *IT: Y ¿Cómo se-cómo la canalizaron para acá?* | IT: How were you referred here? |
| *PX: Lo que pasa es que cuando yo empecé recientemente no conocía aquí. Entonces íbamos con otros doctores, pero pasó como dos años y seguía yo igual, igual y entonces ya nos, nos hablaron de-de este hospital, dicen allá hay especialistas, y ya le dijeron a mi mamá, y le digo, pues vamos, y como dijeron que nada más ocupaban el Seguro Popular, y le digo a mi mamá, yo tengo de eso y ven, que a veces no alcanza el dinero y allá con especialista pagaba la consulta y luego este pues comprábamos el medicamento. Y entonces eso hizo que ya no fuera yo más. Ajá. Ya no iba mucho al médico y ya no tomaba mi tratamiento y volvía a empezar* | PX: The thing was that when I started recently, I did not know about this place. So we went to other doctors but then two years went by and I was the same, the same, so then they, they told us about this-this hospital, they say, there are specialists there, and then they told my mom, and I told her, well let's go, and they told me that they only took *Seguro Popular* [insurance], and so I told my mom, I have that and come, because sometimes the money isn't enough and with the specialists I was paying the appointment and then buying the medication. So that made me not go anymore. Aha. I wasn't going to the doctor much and not taking my treatment and I would start again |
| *IT: ¿A empezar a sentir la ansiedad?[* | IT: Start feeling the anxiety again?[ |
| *PX: [A empezarme a sentir así, otra vez y entonces ya vine aquí como lo platicaron, vine luego luego, y hasta ahorita. Sí"* | PX: [Start feeling that way, again and then I came here because I was told, I came right away and until now. Yes" |

(Olga, 27)

Provider Diego noted that most patients sought more accessible alternative supports (e.g., folk healers such as *curanderos* and *yerberos*) within their communities before seeking specialized medical treatment. Like Olga, when patients sought medical care, often the first line of response were primary care physicians, sometimes in the private sector, who were not trained in psychiatric treatment but may prescribe psychiatric medication to alleviate distress. Patients who did not experience improvement of their distress would subsequently be referred to specialized care either by the same doctor or by people in their social network. Sadly, referrals could take a long time depending on the referral source and the acuteness of patient symptoms.

Primary care physicians usually did not know how to appropriately treat patients with mental and emotional distress. In the example of patient María (70 years old with depressive symptoms), she had seen a primary care physician at least 30 years earlier who prescribed a benzodiazepine for her "anxiety" after the traumatic loss of her 12-year-old daughter. Although the benzodiazepine helped relieve some of the immediate symptoms she was experiencing after the loss, she later became addicted and suffered from both depression and withdrawal symptoms due to the medication dependence. Psychiatrist Diego discussed the issues of receiving psychiatric treatment by primary care physicians. When asked why they might prescribe, for example, a benzodiazepine for a prolonged amount of time, he reported:

> *"PR: pues de desconocimiento y cuando, o yo creo cuando, me imagino, pasaron ciertos años en los que ya-ya viene fulana por su benzodiacepina y ya pos al cliente lo que pidan. Entonces apatía de los médicos generales al primer contacto de donde vienen, desconocimiento, y a lo mejor tal vez se acostumbró "Ay, hoy salgo por mi receta, sigo sintiéndome igual, pero ahí sigo por eso"*

> "PR: well from ignorance and when, or I think when, I imagine, certain years passed in which – oh, oh, what's her name is coming for her benzodiazepine and well to the client what they ask for. So, the apathy of primary care doctors in their first encounter from where they come from, ignorance, and maybe she got used to it "Ay, today I go get my prescription, I feel the same, but I'm still in this"
>
> (Diego, psychiatrist)

When discussing this case, Provider Diego offered that primary care doctors' practice may reflect ignorance and complacency. Yet missing from this discussion was the likely economic gain private sector doctors incur through similar cases in which they stand to benefit from medicalizing patient's emotional distress. According to Diego, the over prescription of psychiatric medication puts patients at risk of becoming drug dependent, escalating the dosage when drug effects decrease or mixing with other substances (e.g., alcohol) for more potent effects, neurocognitive decline, and overall deterioration.

Psychiatrists often reported concern about medication management and compliance. They frequently reported that patients' illness would likely become chronic unless they used medication as prescribed. Diego reported that, unlike primary care physicians, psychiatrists normally prescribe medication for four weeks to up to two months. However, when discussing treatment expectations for patients, Diego provided the opposite perspective: that psychiatric treatment (i.e., medication) was usually "for life."

### 4.2.1. "Curing" chronic mental illness: the role of medication compliance

Medication was often perceived by psychiatrists, patients and caregivers as a lifelong treatment. For example, Carmelo was a 30-year-old man with anxiety symptoms from the city of Puebla. He was a gym instructor and had a high school degree. He believed the cause of his emotional distress was related to family problems and not having an appropriate outlet for his emotions. However, for treatment, he reported a belief in having to take medication for life. He noted that both medication and family support were essential in his illness management:

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|---|---|
| *"IT: Ok. Em ¿hay algún tipo de apoyo que mejore su desequilibrio, su angustia? Ya sea el apoyo de la familia, los amigos, u otras personas* | "IT: Ok. Em, is there any type of support that would improve your imbalance or anguish? It could be from family, friends, or other people |
| *PX: Mi apoyo (P) Después de mi familia. Mi familia fue la que sufrió más (P) y ahorita ya con esto, pues ya, ya saben que no ((risas)) no puedo vivir otra vez sin el medicamento y todo esto. Pero en sí, en sí, la familia fue la que me apoyó más"* | PX: My support (P) After my family's support. My family suffered the most (P) and now with this, well now, now they know that ((laughs)) that I can't live again without the medication and all this. But really it was my family who supported me the most" |

(Carmelo, 30)

Although Carmelo clearly stated a need for lifelong medication, both him and his treating psychiatrist Tomás, reported some ambivalence regarding the chronicity of his distress. Carmelo reported a history of suicidal thoughts and concern about killing himself. His father Cristóbal, the accompanying caregiver, reported that medication had improved these symptoms, but believed that Carmelo's recent engagement in psychological treatment had also been helpful. In contrast to Carmelo's statement, Provider Tomás noted that psychiatric treatment had not seemed helpful, stating: "*a pesar de que hemos trabajado como en el rapport, el siente que su avance no es muy- como que considerable y el siente como que eso no- no asiste y no le está ayudando*" // "although we have worked on developing like rapport, he feels like his progress has not been very -like considerable and he feels like that is not -not assisting and not helping him." Thus, although all stakeholders agreed that medication was helpful, there was an underlying concern that was not being treated in Carmelo's illness experience.

Psychiatrists, patients, and caregivers seemed to grapple with the question of whether mental distress was curable or characterological. My field notes suggested that knowing whether their illness experience was curable influenced how patients made meaning of their sense of self having experienced psychiatric symptoms. If patients believed their distress was chronic, they needed to find ways to integrate this new experience into their daily lives and identities.

Psychiatrists oscillated between describing medication as a treatment "for life" or as transient, to be taken for a couple of months until symptoms subsided and then again if symptoms reemerged. Yet Provider Diego reported multiple times that an important aspect of psychiatric support was helping patients understand that their illness *will* require medication "for life." This explanation was most frequently provided for patients with psychotic or obsessive-compulsive diagnoses. However, even in this excerpt from the interview discussing patient Sara, who exhibited depressive symptoms, when asked if Diego was worried about having different perspectives than his patient, he stated:

> *"A lo mejor en perspectivas (P) Pues que el tratamiento es de por vida y creo que no lo ha entendido (P) Entonces ahí hay que enfocarnos que va a necesitar una pastilla toda su vida [inaudible] Tiene que entender que tiene algo en su cerebro, ósea tiene un montón de cosas, pero psicológicas, pero si se puede modificar la parte biológica y que lo acepte, en su vida diaria, por ejemplo, no es simplemente "ah se me fue la medicina" pero porque - porque no entiende que es algo que necesita."*

> "Maybe from the perspectives (P) well, that the treatment is for life and I think she hasn't understood that (P) So, there we have to focus on needing the pill all her life [inaudible]. She has to understand she has something in her brain, I mean, she has a bunch of things, but psychological, but she can modify the biological part and accept it, in her daily life, for example, it's not just "ah, I forgot the medicine" but because-because she doesn't understand that it's something she needs."
>
> (Diego, psychiatrist)

Although psychiatrists often described mental and emotional distress as a biopsychosocial concern, they frequently focused their treatment efforts on the biological bases of the illness experience. In this excerpt, Diego stated that his patient “has a bunch of things, but psychological” and emphasized that the treatment he can provide can help “modify the biological part.” Diego’s concern is for his patients to “accept” the biological explanation for their distress and incorporate medication as prescribed in their daily routines.

An important aspect of psychiatric treatment “for life” was medication compliance. Psychiatrists were concerned that once patients would experience some relief, they would discontinue their medication regiment. Provider Diego described that psychiatrists could increase medication compliance by conforming to patients’ expectations within the therapeutic encounter. Diego noted that patients frequently expect psychiatrists to adopt an expert role as experienced in most other medical encounters. He reported the need to be “decisive” or, possibly, authoritarian in his interactions with some patients to promote medication adherence. In an excerpt related to patient Miriam, an 83-year-old woman with depressive symptoms, he described:

> *“Entonces cuando un doctor así, sobre todo las personas mayores que toda la vida han sido atendidos de esa forma pues tienes que ser <muy> decisivo. Tiene esto. Tómese esto. Si le digo, mire, mire, esto, o le recomiendo esto, no me va a creer, no se la va a tomar, y no me cree. Entonces, pues sí, a lo mejor no es lo ideal, que haya venido a decirme que tiene un problema, así y así, no iba a entender y sólo-y a lo mejor no se toma la medicina y no mejoraba. Entonces no me preocupo porque tomé una postura, tengo-porque tomé en cuenta que no me iba a entender”*

> “So, when a doctor like that, particularly with older people that they have been treated that way their whole life, well, you have to be <very> decisive. You have this. Take that. If I say, look, look, this, or I recommend that, she’s not going to believe me, she’s not going to take it, and she’s not going to believe me. So, well, yes, maybe it’s not ideal, that she came to tell me she has a problem, and this and that, she wasn’t going to understand and just –and maybe she doesn’t take the medicine and doesn’t improve. So, I don’t worry that I took this posture, I have to-because I took into account that she wasn’t going to understand me”

(Diego, psychiatrist)

Diego believed that taking an authoritarian stance would increase patients’ buy-in for treatment, conceivably through increasing the salience of the expert role. Patient characteristics such as generational status and age were important for Diego to determine which patients to use an authoritarian stance with. Diego noted that he also used “*regaños*” or scolding as a strategy with both patients and family members to increase medication compliance. Paradoxically, he scolded them to drive the point that medication should not be used or described to patients as punishment. He reported:

> *"Mmm, sí, siempre les regaño y les digo a los familiares, que no es por milagro, que los tratamientos no son castigos, y siempre ponerles ejemplos, que luego a través de que si haces esto o no haces el otro te vamos a tener que dar pastillas, o te vamos a llevar al hospital, y aclararles que venir a consulta no es un castigo, y a ver que los familiares también que dicen, como "ay y ahora que voy hacer?" Entonces, es como uno de los niños. Como un ejemplo, a los niños les dicen, si te portas mal, te voy a tener que inyectar, entonces hay que quitarles eso y decir, que es lo mismo, que no, no es un castigo"*

> "Mmm, yes, I always scold them and tell the family members, it's not by a miracle, that the treatments are not punishments, and always given them examples, that sometimes if you do this or you do the other, that we're going to have to give you the pills, or we're going to take you to the hospital, and to clarify that coming to the appointment is not a punishment, and then the family members also say, like "ay, and now how am I going to do it?" So, it's like one of the kids. As an example, to children you would say, if you're naughty, I'm going to have to give you the injection, so we have to take that away, and say that it's the same, that no, it's not a punishment"
>
> (Diego, psychiatrist)

Patients, caregivers, and psychiatrists reported that psychoeducation, that is, providing information on side effects of medication and how it relates to the diagnosis, was helpful to increase medication compliance. Psychoeducation was seen as helpful to increase patients' "illness consciousness" or understanding of their disorder. For example, when asked what type of support would be helpful at this time, Margarita, the sister-in-law of Juan, a 60-year-old man with substance abuse concerns, stated:

> *"¿Qué tipo de ayuda en este momento? Pues nos acaba de atender eh su (P) psiquiatra, nos mandó un medicamento, eh le explicó mucho también de su problema, de que no debe de tomar alcohol frecuentemente porque muchas veces ya no nos hace caso, y pues creo que es lo que se necesita. Tener consciencia médica"*

> "What type of support right now? Well, we just saw his eh (P) psychiatrist, he sent us a medication, eh he also explained a lot of his problem, that he shouldn't drink alcohol frequently because he often doesn't listen to us, and I think that's what he needs. To have medical insight [awareness of his concerns]"
>
> (Margarita, sister-in-law, 56)

Psychiatrists often believed medication could help manage patients' symptoms but that "curing" the underlying stressors that originated the distress would most likely be addressed through psychotherapy. Psychotherapy was seen as a helpful individual and family intervention to target the core stressors or factors that were influencing and/or maintaining distress. Provider Diego reported that psychotherapy could help patients answer the question “why did this happen to me?” Diego described:

| | |
|---|---|
| “*Ahorita el medicamento está deteniendo que avance la idea [suicida], pero no lo está curando entonces ¿para qué? Para que no empeore, el medicamento. Para que se componga, se cure, o se mejore, ahora sí que se mejore, pues la psicoterapia”* | “Right now, the medication is stopping the advancement of the [suicidal] idea but it’s not curing it so, for what? The medication is for her not the get worse. For her to get better, to get cured, or improve, really to improve, well, psychotherapy.” |

(Diego, psychiatrist)

### 4.2.2. *Desahogando penas*: the role of psychologically-based interventions

Although medication had been helpful, all psychiatrists (4/4), and a majority of patients (13/19) and caregivers (14/19) reported that psychological support had been or would be beneficial. From the patient and caregiver perspective, psychotherapy was mainly seen as effective in helping patients “talk through their problems.” Patients and caregivers described psychological support as going to “*pláticas*” or talks.

Patients and caregivers believed that “pláticas” could help “let out” (“*desahogar*”) emotions, stress, and help make sense of their illness experience. Blanca was the younger sister of Javier, a 34-year-old patient with depressive symptoms from a small town 2 hours away who had been in treatment for approximately eight months. Blanca noted that, in addition to Alcoholic Anonymous meetings, Javier had attended weekly therapy sessions at the *Desarrollo Integral de la Familia* (DIF), a federally-funded family-based integrated health system with local centers in larger communities:

| | |
|---|---|
| *“<Mm> pues, bueno (P) mm yo pienso que está yendo a reuniones de Alcohólicos Anónimos tres veces por semana entonces eso le ayuda, igual está yendo con una psicóloga del DIF, eso también le ayuda. Yo creo que (P) el desahogarse, el sacarlo de esta forma, le está ayudando a aceptarlo o afrontarlo con el tiempo”* | “<Mm> well, (P) mm I think that he’s going to the Alcoholic Anonymous reunions three times a week so that helps, he’s also going to a psychologist from the DIF, and that also helps. I think that (P) to unburden himself, letting it out in that way, that’s helping him accept or confront it with time” |

(Blanca, younger sister, 24)

Blanca and Javier reported that "letting out emotions" and "unburdening" helped Javier "accept" and "confront" his distress. Patient Javier noted a past history of bullying at school and in his family unit. Similar to his sister's account, Javier described that attending the Alcoholic Anonymous groups had allowed him to find a group of people who understood him and a place where he could "*sacar las cosas que me están afectando en este momento*" // "let out the things that are affecting me at this time."

"Letting out" their feelings, talking through and making sense of past events was especially helpful to patients who had experienced multiple traumatic events and losses in their lifetime. However, psychotherapeutic services geared toward processing complex trauma were often inaccessible to patients. María, the 70-year-old patient who had lost her daughter at an early age, stated:

| | |
|---|---|
| *"Sí, yo siempre tuve ganas de platicar así este desde la raíz porque como a nadie le he platicado porque pienso yo que a nadie le importa"* | "Yes, I always wanted to talk through everything from the root because I haven't talked about this with anyone because I think no one cares" |

(María, 70)

For patients who had been in psychiatric treatment for decades, there was less hope that they could benefit from psychotherapy. Psychotherapy was often described by psychiatrists through a cognitive behavioral therapy (CBT) lens. Congruent with the CBT approach, psychotherapists' main intervention were reported as challenging and restructuring maladaptive thoughts. Provider Diego discussed María, the patient who had been prescribed benzodiazepines for about three decades and in one point of his interview jokily stated that he would recommend psychotherapy *"y cambiar de esposo, pero eso no se lo vamos a decir"* // "and to change her husband, but we won't tell her that." For her treatment, Diego stressed the need for "a lot" of psychotherapy and described an almost resigned outlook about her ability to change or for her experience of distress to improve. Based on cognitive behavioral theory, Diego reported that it would be difficult to change María's maladaptive core beliefs because that would signify changing other interpersonal systems. Diego described:

> *"ahh en ella pues ya como, solo un milagro, casi casi pero pues psicoterapia, <mucha> psicoterapia, algo de antidepresivo que no va ser como la piedra angular. La idea pos va ser, es que ya cambiarles sus pensamientos centrales a estas alturas de la vida va ser como muy complicado y hasta cierto punto habrá que valorar que tan bien y tan mal haríamos. Porque si ya deja su marido, y ¿que va hacer? No sabe escribir, no sabe leer, no trabaja. ¿Quién la-quién la va a mantener? Pues ahorita, ya casi nadie."*

> "ahh in her well now like, just a miracle, almost, but well, psychotherapy, <a lot> of psychotherapy, some antidepressant but it's not going to be a staple. The idea is going to be, because now changing their central thoughts at this point of life is going to be complicated and to a certain extent we'll have to evaluate how much good or bad we would do. Because if she leaves her husband, what is she going to do? She doesn't know how to write, she doesn't know how to read, she doesn't work. Who-who is going to support her? Well right now, almost no one."

(Diego, psychiatrist)

Although "*pláticas*" could help build a coherent narrative around the illness experience, they were often summoned and used to increase patients' motivation to participate in the biomedical treatment available to them. Thus, there was a tension between the psychological needs of patients and the psychiatric services provided. For example, Daniel, Eduardo's twin brother, noted that Eduardo needed someone who would understand him and talk through his core issues. In my field notes, I noted that both Eduardo and Daniel seemed relieved to finally have someone to talk to about Eduardo's illness experience and Daniel's experience providing him support. Yet most interventions aimed at treating Eduardo's distress had centered on medication compliance. Daniel alluded that this approach to treatment was designed to maintain patients at a certain level of distress, constantly seeking medication treatment, rather than a recovery-oriented approach. When asked what helpful treatment for Eduardo would be, he reported:

> *"Hablar. Platicar, con personas pero que realmente lo quieran comprender y lo quieran ayudar. Porque, como le comentaba, tanto en el [Hospital Psiquiátrico de la Ciudad de México] como aquí en el [Hospital Psiquiátrico en Pueblo], recetarte y ponerte fuera de combate y eso no es ni sanarte ni nada, valga la expresión, es un signo de pesos, un signo de pesos con patas, la verdad, mantenerte, mantenerte, mantenerte. Porque habían medicamentos que ya existían y que se lo podían haber dado con anticipación y hubiésemos salido de la situación mucho antes."*
>
> "To talk. To chat with people who really want to understand him, who want to help him. Because, I was telling you, both at [Mexico City inpatient psychiatric hospital] and here in the [Small Town inpatient psychiatric hospital], prescribing and putting you out of action, that's not curing you or anything, so to speak, he's a sign of pesos, a sign of pesos with feet, truly, to sustain, sustain, and sustain you. Because there were already medications in existence that they could have given him before and we would have been out of this situation much earlier"
>
> (Daniel, twin, 55)

"*Pláticas*" were also described by patients as helpful to increase their illness management and motivation to treatment. For example, Alicia, a 29-year-old woman with obsessive-compulsive symptoms, noted that she wanted to go to *pláticas* to gain information "*de cómo sobrellevar esto porque la depresión sí es como algo muy feo"* // "how to endure this because the depression is something terrible." Others used psychotherapy as an opportunity to increase medication compliance. For example, patient Alicia's mother Celeste would frequently tell the psychologist that her daughter did not want to take the medication and asked that be a main focus of their psychotherapeutic appointment.

Patients and psychiatrists believed group psychotherapy could help patients gain new perspectives on their illness by sharing with other people who had similar concerns. Provider Tomás reported that group psychotherapy could provide needed perspective and understanding, an opportunity to connect with other patients, and to help patients feel "*que no está sola*" – "that [she's] not alone." Tomás also hoped group therapy interactions would increase patients' "illness consciousness" by hearing stories of other people with comparable symptoms.

Omar, a 47-year-old man with bipolar symptoms, reported that group therapy would be very helpful but unfortunately was unavailable in the community where he resided. Omar was from a city one hour away and had been seeking psychiatric services at the outpatient clinic for only two months. He had sought help with a Catholic priest who conducted 6 to 8 exorcism sessions. He then sought treatment with a *curandero* (folk healer) who did "*limpias*" (cleansings) but was unsure if that had been, in his words, "good or bad." He reported he had group psychotherapy when he was treated at a private inpatient psychiatric hospital near the Puebla city center. According to Omar, hearing about others' experiences and how they have managed their distress in these group therapy sessions would be useful in his healing process. Omar's partner Marla also described that attending psychiatry and psychology appointments had been helpful for him, particularly to discuss things that Omar felt he could not discuss with her or others within his social support network. Marla described:

> *Mmm, lo que le ayuda mucho es venir con su doctor. Ah, hubo este… en [Hospital Psiquiátrico Privado] hay psiquiatras, psicólogos que platicaban con él. Yo ya lo veía conmigo a visitarlo cuando iba, yo lo veía mucho mejor. Es que me decía "No es que les cuento cosas que a ti no te puedo contar." Así me decía. Y yo creo que ese era el atractivo, de venir a hablar con una persona que tiene esa preparación*
>
> Mmm, what helps a lot is coming here with his doctor. Ah, there was… in [Private Inpatient Psychiatric Hospital] there were psychiatrists, psychologists that would talk to him. I would see it when I would go visit, I would see him much better. He would say "No, it's that I can tell them things I can't tell you" That's what he'd say. And I think that was the attraction, to come to someone who has preparation, to talk"
>
> (Marla, partner, 46)

Omar's provider, Diego, also believed that psychotherapy would be helpful. However, when discussing his case, Diego reported he had not actively sought to connect his patient to psychologically-based services. Diego described that he "could not remember well what the main problem was" but there was some biologically based issue "in his brain" and Omar was "*bien controlado*" // "well controlled" at this time. In his discussion of Omar, Diego clearly champions the role of medication management in treating his distress. When asked further questions about psychotherapeutic treatment, Diego reported that couples therapy may be beneficial to improve the wife's understanding of Omar's illness experience because improving the partnership relationship would likely improve Omar's distress. Diego also reported that, in his experience, men rarely attended therapy. Therefore, Diego may have believed that, similar to other men, Omar would not benefit or engage in psychotherapy.

The disconnect between psychological and psychiatric treatment permeated the professional practice at this specific site. Psychiatrists reported having much more communication with social workers and nurses than with staff psychologists yet wanting greater communication with psychologists to improve clinical interventions. When I asked provider Diego about the relationship between psychiatrists and psychologists and the site, he described:

| | |
|---|---|
| *"IT: Y si alguien viene aquí al psicólogo, ¿ustedes platican como psicólgo-psiquiatra del tratamiento de esa persona?* | "IT: And if someone comes here to see a psychologist, do you talk like psychologist-psychiatrist about that person's treatment? |
| *PR: difícilmente, la verdad, difícilmente. Primero porque son distintos días entonces a lo mejor ella viene con el psicólogo fulano que está tal día, y a lo mejor yo me toca ese mismo día y a lo mejor coincidimos pero que nos acordemos de ese paciente va estar complicado (LP). Lo que si podemos hacer es ir a revisar nuestras notas. Nosotros entramos, a según yo, a hacer nuestras notas muy explícitas. Pero creo que los psicólogos por alguna situación, probablemente por tiempo, hacen sus notas muy genéricas, casi en todas es "se establece rapport, doy-hago directriz," y ya, es como la mayoría de las notas, bueno, tienen más cosas entonces a lo mejor, sí se da el caso, no es la regla, es más bien la excepción cuando tenemos alguna inquietud muy importante con algún paciente determinado, sí nos acercamos, primero presentar al paciente con el psicólogo, este es un paciente así, así, así, me gustaría-ojalá pudieran trabajar en esto, esto, esto, y ya, o les preguntamos, o ellos mismos nos los mandan cuando vienen a psicología, su cita de psicología, ah no pues encuentro que hay ideación suicida importante, por decir un ejemplo, nos lo dicen y si sí existe-antes existía el sistema de referencia aquí mismo y creo que estaba padre, creo que la regla-la idea es regresar a ese sistema (P) pero no se escucha mucho."* | PR: hardly, to be honest, hardly. First because it's different days so maybe she comes with whoever psychologist that's on that day, and maybe I have the same day, and maybe we coincide but it's going to be complicated for us to remember that patient (LP). What we can do is review our notes. We go in, I think, making our notes very explicit. But I think that the psychologists, for some reason, probably time, they make their notes very generic, almost all of them are "establish rapport, I give-provide directive," and that's it, it's like the majority of the notes, well, maybe they have more things, it can be the case, not the rule, it's more the exception when we have some important query with a specific patient, we can approach them, first present the patient to the psychologist, this is a patient like this, this, and this, I'd like –I hope you could work on that, that, that, and that's it, or we ask them, or they even send them when they go to psychology, to their psychological appointment, ah no, well, I find significant suicidal ideation, an example, so to speak, they tell us, and yes, yes, there's a-before there was a referral system right here and I thought it was cool, I think the rule –the idea is to go back to that system (P) but you don't hear about it a lot." |

(Diego, psychiatrist)

The different mental health providers seemed to practice independently, influenced by structural issues that affected patients' access and engagement in psychotherapy. Time seemed to be a main constraint for psychiatrists as they were expected to see patients for approximately 15 to 30 minutes. Psychiatrists often focused on assessing issues related to medication compliance including dosage and side effects, with little time to consider alternative treatment options and referral sources. Time also seemed to constrain psychologists as their notes were frequently described as vague and provided little to no information about patients' course of treatment. Therefore, even if psychiatrists had time to briefly review patients' charts, it is unlikely that psychotherapy notes would be helpful. Further, there was no specific referral protocol, therefore, it was unclear which, how and why patients were referred to psychological treatment. Finally, it seemed to be expected that each professional (i.e., nurses, psychiatrists, psychologists) worked independently, with little to no consultation.

Overall, psychiatrists noted many common challenges in accessing psychotherapy. These included inaccessibility to services within patients' communities (i.e., they had to travel to the outpatient clinic), frequency of appointments that were often spaced out months at a time because the few psychologists available were booked out, and psychologists utilizing interventions that were not research-based. Many providers described psychotherapy through a cognitive behavioral approach, although provider Martín noted that he did not believe in one psychological theory over another but rather in tailoring psychotherapeutic interventions to the individual and their presenting concern. Given all the challenges inherent in seeking psychotherapy, psychiatrists seemed to focus on their role of treating the biological bases of the illness experience, with little time to provide attention to the psychological and social aspects.

### 4.2.3. *La familia primero*: the role of family in psychiatric treatment

Psychiatrists (4/4), patients (15/19), and caregivers (15/19) described family and social support as a helpful interpersonally-based treatment. Indeed, for patients and caregivers, family support was described more frequently as a necessary treatment expectation than psychologically-based services. Family provided treatment support by managing day-to-day symptom changes, accessing mental health services, accompanying patients to psychiatric appointments, and supporting the economic costs of psychiatric care. Families also viewed themselves as providing a “moral” support. They helped distract the identified patient from their suffering, provided motivation to continue social engagement, and attempted to positively influence their family member’s mood. Often nuclear families described themselves as the patient’s sole source of support. For example, when asked the types of support that helped alleviate her distress, patient Olga, a 27-year-old woman with panic and anxiety symptoms, described:

> *“Ahorita, por ejemplo, primero están mis papás. Mi papá y mi mamá, ellos. Luego ah tengo, tengo unas amigas que también me han apoyado mucho y gracias a eso pues también ahí, voy recuperándome”*

> “Right now, for example, first I have my parents. My mom and dad, them. Then ah, I have, I have my friends who have also been very supportive and thanks to that I am on the path toward recovery”
>
> (Olga, 27)

Psychiatrists frequently recommended increased family support as part of patient’s treatment. For example, Olga’s mother Angelina stated that since the psychiatrist’s recommendation, she has tried to be her daughter’s main source of support, taking her to appointments, out for walks, and worrying with her when her symptoms get worse. Angelina reported that she had been more intentional and vocal about getting her daughter’s needs met despite her husband’s previous expectations that women in the household should not go out or have much social interaction. In fact, in many cases, family members assumed that lack of social engagement could further exacerbate patients' psychiatric symptoms. Angelina said: "*Sí, la estoy apoyando mucho a mi hija, sí. Siempre lo que ahí, ahora sí me pide esto yo me-nos salimos porque es lo que nos recomienda el doctor*" // "Yes, I am very supportive of my daugther, yes. Always what there is, really what she asks for and that I -we go out because that's what the doctor recommends." Provider Felipe noted that Angelina's involvement in Olga's treatment had been very helpful because often the mother had been the one to report on Olga's symptoms and provided an assessment of her improvement and progress in treatment.

Psychiatrists described that the family's ability to understand the patient's illness had a large influence on the illness course. Psychiatrists often used the relationship with a family member as an opportunity to gain further buy-in to treatment by "explaining" the disease (*enfermedad*), that is, providing the biomedical explanatory model. Psychiatrists hoped that through psychoeducation, family members could be more supportive and less rejecting or stigmatizing of the ill relative. Provider Tomás described that often their goal was for patients to "*no sientan el rechazo"* // "not feel rejected." According to provider Diego, increasing "*entendimiento*" or understanding of the mental illness in family members was helpful:

> *"El entendimiento por parte de la familia- si él mismo que entienda que puede vivir su vida de manera normal con el medicamento, pero de ahí fuera puede tener actividades personales, laborales, académicas, todo normal, pero seguro que no va a tener ninguna de esas por la carga que lleva, entonces si quitamos esas creencias falsas de su familia, entonces a lo mejor puede mejorar, bueno, no a lo mejor, seguramente mejorará su calidad de vida."*

> "The family's understanding –if he himself can understand that he can live his life normally with the medication, but from then on, he can do personal, work, academic activities, everything normal, but he is likely not going to do any of those things because of the load he carries, so if we dispel the family's false beliefs, then maybe he can improve, well, not maybe, his quality of life will surely improve."

(Diego, psychiatrist)

Patient Omar, who had symptoms related to bipolar disorder, also noted that his family needed help understanding his illness and how to best support him. He stated:

> *"PX: Ahora si, la familia te ayuda mucho. Muchas veces no saben exactamente cómo ayudarte. Tienen la buena intención de hacerlo, pero no… pues no tienen quizás la preparación, ¿verdad? Para hacerlo. Luego creen que, cuando estás, le digo porque ya pasó antes, cuando estás en la cama que no quieres pararte y ya tienes dos, tres, cuatro días, una semana, creen que con llegar y destaparte "Ya párese órele vámonos!" Así, creen que con eso, vas a salir adelante. Pues si te ayuda, ya cuando lo ves desde punto de vista cuando estas bien. Pues si dices bueno, pues si, pero en ese momento tienes ganas de brincar encima de ellos ((risas)) si…"*

> "PX: Really, the family helps you a lot. Often, they don't know exactly how to help you. They have the good intention to do it but no… well maybe they don't have the preparation, right? To do it. Sometimes they think that, when you're, I tell you because it's happened before, when you're in bed and you don't want to get up and it's been two, three, four days, a week, they think that just coming and uncovering you "Get up now, let's go!" Like that, they think that with that you're going to move on. And it does help, when you see it from the point of view when you're feeling ok. Then you say, ok, well yes, but in the moment, you want to jump on them ((laughs)) yes…"

(Omar, 47)

In the case of Pedro, an 18-year-old man with psychotic symptoms, his uncle Martín reported that it was important for him to be treated by family members and friends "*como si fuera una persona normal*" // "as if he was a normal person." This meant having similar role expectations so Pedro could feel like he was a useful member within the family and larger society, and to prevent further relapses. Martín believed that if the family treated Pedro as if he were ill, his relapses would increase. This was an interesting juxtaposition as psychiatrists encouraged patients to adopt a sick role yet adopting this role could further stigmatize the patient and alienate him from socially expected roles and activities.

At times families could be both the main source of stress and a major support. In various cases, providers described that improving relationships with family members and increasing social support would be a needed target for treatment intervention. Provider Martín described the influence of the family within Mexican culture and the tension between society's and the family's understanding of mental illness:

> *"pues el núcleo principal con el que mayormente conviven es con la familia entonces como por ejemplo en los países [inaudible] que también sufren discriminación pero si viven en un ambiente de apoyo en el que la familia, los*

> "well, the main core of who they mostly spend time with is with the family so like, for example, in countries [inaudible] that they also suffer discrimination but they live in a supportive environment in which the family, friends, are with

> *amigos, están con ellos y los apoyan pues hace que pues emocionalmente puedan sobrellevar su padecimiento eh independientemente de que la sociedad los discrimine pero pues en este caso la sociedad sí tiende a discriminar y estigmatizarlos y aparte en-en el núcleo familiar hay muchos conflictos debido a la enfermedad pues yo creo que-que ósea sí importa la sociedad, son los que les dan trabajo, los que los podrían integrar a que sean productivos pero el mayor desastre, bueno, en este tiempo que llevo aquí, pero que estudié antes, pues sí tiene que ver sobre todo con el entorno familiar"*

> them and support them well that makes that they can emotionally withstand their illness eh independently of whether society discriminates them but well, in this case, society does tend to discriminate and stigmatize, and also in-in- the family there are a lot of conflicts due to the disease but I think that-that, I mean, yes, society matters, it's who provides work, who could integrate them to be productive but the biggest disaster, well, in the time I've been here, but I studied before, well, it does have to do with the family environment"

(Martín, 27)

## Chapter 5: Discussion

### 5.1. Cultural factors in mental health treatment in Mexico

#### 5.1.1. A Shared Worldview? Cultural distance between patients and providers

A "shared worldview" is an important common factor in the development of a therapeutic relationship (Fischer et al., 1998; Wampold & Imel, 2015). A shared worldview is facilitated by the development of a plausible explanation or "myth" about the mental illness experience that is shared by the patient and clinician (Fischer et al., 1998; Frank & Frank, 1991; Wampold & Imel, 2015). The degree to which this worldview is shared can make a therapeutic relationship stronger or more difficult to establish. Torrey (in Fischer, 1998) proposed that "the very process of providing a label for a client's illness or distress is therapeutic" (p. 535).

Myths or therapeutic rationales can be shaped in multiple ways within the therapeutic encounter. Clinicians can conform to client expectations or clinicians can influence clients to reshape their expectations to conform to a shared client-clinician worldview (Fischer et al., 1998; Frank & Frank, 1991; Wampold & Imel, 2015). Having a shared worldview with the provider on the etiology of distress can increase the client's positive expectations that the prescribed treatment will relieve their distress (Wampold & Imel, 2015).

Psychoeducation or “mental health literacy” is often proposed as a means through which providers can socialize patients into the biomedical worldview of psychotherapeutic practice (Wendt, Gone, & Nagata, 2015; Robles-García, Fresán, Berlanga, & Martínez, 2013). Psychoeducation is targeted at reducing the gap between lay understandings and biomedical beliefs and knowledge of the symptoms related to mental illness (Robles-García et al., 2013). In my study, providers frequently discussed using psychoeducation (“*pscioeducación*”) to help patients “understand” and “accept” their disorder as biomedically based. *Psicoeducación* in other Mexican mental health care settings has been described as consciousness raising, promoting self-knowledge, and management and expression of emotions (Duncan, 2017). Research conducted with U.S.-based providers caring for Latinos also emphasized the need to provide *educación* to patients about mental illness (Hackethal et al., 2013). In Mexico, there are documented efforts to socialize the general population into understanding the biomedical explanations of symptoms related to mental disorders, particularly for early signs of psychosis (López et al., 2009).

An interesting dynamic may arise when psychiatrists believe they must provide *psicoeducación* for patients to understand their illness experience. “Understanding” in this interaction is unidirectional and meant to increase patient buy-in to biomedical treatment at the loss of their own interpersonally-based or efficient explanatory models. In this interaction, patients’ and providers’ causal explanations may be in competition with each other with providers trying to increase patients’ acceptance of the biomedical rationale, rather than negotiating a collaborative bio-psycho-social-cultural understanding of the patient’s illness experience. Patients may be derided for having a different understanding of their illness experience. When they demonstrate unwillingness to comply with providers’ worldview, psychiatrists may become more “decisive” or authoritarian, using “*regaños*” or scolding to gain patient compliance and increase medication adherence.

A “lack of understanding” (or an assumed lack of *ability* to understand) the illness experience was classified by providers in strata according to sociocultural background. Providers assumed that an ability to integrate a biomedical explanatory model was influenced by educational attainment and other social status markers such as employment, indigeneity, and a rural place of origin. Providers assumed that patients with lower educational attainment believed in mystical or supernatural causes of distress that generally reflected indigenous or pre-Colombian worldviews. In contrast, the biomedical causal explanations provided by psychiatrists were seen as “scientifically sound” but less accessible to the less educated population they served.

The cultural enactments in the Mexican therapeutic encounter reflected what Duncan (2017) described as “psychological modernization” –an effort to incorporate Westernized concepts of mental health and disparage culturally embedded (or indigenous) and beliefs and practices. Psychological modernization can displace explanatory models that include the self, the social, and the spirit, to center on more narrow conceptions of biomedical mental health (Duncan, 2017). However, most patients assume the coexistence of multiple explanatory models of distress that include spiritual, social, psychological, and biomedical attributions.

My findings are similar to research conducted with Latino immigrant populations that suggests that many do not view genes (i.e., solely biomedical explanations) as a main cause of mental illness (Caplan et al., 2013). In a study of Mexican patients diagnosed with schizophrenia, Gómez-de-Regil (2016) reported that most viewed society as the cause of their illness, followed by personological, family, and biological factors. Although patients do not commonly view the etiology of their illness as exclusively biomedical, they may only engage in psychiatric treatment based on biomedical premises (Gómez-de-Regil, 2016).

Providers believed that a focus on the biological determinants of disease could help de-stigmatize mental disorder by asserting that psychiatric symptoms were outside of a patient's control. Through psychoeducation, providers in this study emphasized mental distress was like most diseases: it could happen to anyone and it was the result of a physical malfunction, specifically, in the brain. However, results suggest that although patients incorporated biomedical perspectives on the cause of illness, it was to a lesser extent than what providers might expect through their psychoeducation efforts.

The stigma related to mental illness may still be present for patients despite a perception that the distress was outside of their control. Thus, it is unclear whether this explanation in fact lessens the impact of stigma on patients and family members. A study on the role of stigma in mental health care in Mexico reported that most (91%) participants with psychiatric disorders described feeling stigmatized due to their mental illness (Mora-Ríos & Bautista, 2014). Experiences of stigma included criticism, accusations, derision, and name calling (Mora-Ríos & Bautista, 2014). Patients reported that the most common sources of stigma were family and mental health professionals (Mora-Ríos & Bautista, 2014).

In this study, providers oscillated between the belief that medication would be lifelong or episodic. This belief was related to whether a certain illness expression was believed to be treatable (with temporary biomedical intervention), chronic (as with schizophrenia), or characterological (as the "*mujeres adversas*" described). In a previous study in Puebla, Mexican patients were encouraged to comply with medication to experience relief, and psychiatrists tried to reassure patients that medication would likely be temporary and not lifelong, with the exception of schizophrenia (Hale, 2017). However, the dangers of over-medicalizing emotional distress were evident through case examples that described the over prescription of psychiatric medication, such as benzodiazepines, that contributed to addiction and may increase mental distress.

Previous research suggests that Latino family members' expectations of curability are less consistent with a biomedical understanding of cure (i.e., the removal of a disorder). Rather, family members expected a cure  would attend to the social aspects related to the illness experience that affect both the individual and the family (Guarnaccia et al., 1992a). In a study conducted in Puebla, family members were also socialized into a biomedical view of mental and emotional distress (Hale, 2017). Psychiatrists encouraged families to understand that a patient's concern was chronic, with likelihood of relapse, and to dispel dichotomous thinking of someone as either "*loco*" (i.e., crazy) or healthy (i.e., cured) (Hale, 2017).

Although medication targeted the biomedical bases of illness, previous research at the study site in Puebla suggests providers also prescribed psychiatric medication to improve interpersonal difficulties within families. According to Hale (2017), medication treatment was prescribed to "help finesse the family dynamic and ensure a calmer climate in the home." In contrast, medication in my study was described as helping stop or manage psychiatric symptoms such as provider Diego's description that "*el medicamento está deteniendo que avance la idea [suicida], pero no lo está curando*" // "the medication is stopping the advancement of the [suicidal] idea but it's not curing it."

To "cure" suffering, providers believed patients needed more intensive psychological treatment. Hale (2017) also described that psychiatrists at this site often referred patients to psychotherapy for more "in-depth emotional and social work" to address the underlying interpersonal dynamics that exasperated or maintained distress. Unfortunately, none of the psychologists at the site consented to participate in this study, and little research has been done related to psychotherapy processes in Mexico.

Psychiatrists in our study were often the primary line of treatment for any mental or emotional distress. Patients may have experienced long periods of suffering, possibly sought treatment with local mental health providers such as *curanderos* but had not experienced relief until attending specialized psychiatric care. Caregivers often described their own suffering trying to respond to the mental health care needs of their loved ones, and access resources for patient care. However, the psychiatric treatment provided in the form of medication management may only be one portion of a larger need in mental health care.

### 5.1.2. Other cultural and social factors: the role of gender, emotional expression and family in the treatment of mental distress

Generally, research suggests that Latino patients and families tend to emphasize the social and contextual causes of distress (Cabassa, Lester, & Zayas, 2006; Martinez Tyson, Castañeda, Porter, Quiroz, & Carrion, 2011; Maupin & Ross, 2012; Weisman, Gomes, & López, 2003). For example, Latinos ascribe interpersonal and adverse everyday life factors as the main cause of depressive symptoms (Cabassa, Lester, & Zayas, 2006; Caplan et al., 2013; Martínez Pincay & Guarnaccia, 2006; Martinez Tyson, Arriola, & Corvin, 2016). These include fighting, infidelity, concerns about children and parenting, or substance use (Heilemann, Coffey-Love, & Frutos, 2004). These efficient causes are often interpersonally-based and highlight the role of illness as it relates to the breakdown in social functioning (Kleinman, 1988).

***Gender roles, norms and expectations.*** Findings in my study related to the role of gender in the causal attributions of illness are comparable to research conducted with Hispanic families in the U.S. Previous research reported that for Latina women, emotional concerns were more frequently attributed as the origin of mental illness, compared to men whose distress was seen as reflecting issues in their development or biologically-based concerns (Guarnaccia et al., 1992). These results mirror broader gender socialization and norms among Hispanic or Latino populations in which men are traditionally expected to be breadwinners and head of households, while women are responsible for emotional and family support (Guarnaccia et al., 1992). Accordingly, Mexican and Latina women may be considered essential in the emotional development of not only themselves but their families, imbuing power in the maintenance of mental wellness or the genesis of distress.

Gender norms and expectations in Mexico also contributed to harmful dynamics such as power-based interpersonal violence. In this study, women described harmful interpersonal relationships (e.g., infidelities, violence) and pathological attachments (e.g., “sickly love”) as main sources of distress. Research conducted in the neighboring state of Oaxaca reported that women believed gendered violence was “a normal aspect of life” (Duncan, 2015). Like the *mujeres abnegadas* in my study,  women in Oaxaca also believed it was a man’s right to abuse and neglect them, and that they had to withstand infidelities (Duncan, 2015). These shared beliefs point to the insidious nature of gendered violence in Mexico, often described by providers as a "ubiquitous 'cutural problem' too ingrained and ordinary" to affect women (Duncan, 2015; p. 203). Providers believe women are accustomed to living with violence and abuse, and that women may come to believe that they deserve this treatment.

The disguise of gender violence as cultural and “custom” in Mexico could make providers complicit with this norm by failing to assess and diagnose symptoms of distress as a direct response to trauma. In my study, women were never diagnosed with PTSD but rather with depression, anxiety or personality disorders. The normalization of gender violence may skew providers' perspective by blaming women who exhibit symptoms of distress for not being able to withstand ("*aguantar*") gendered norms, instead of focusing on the insidious and oppressive societal norms that contribute to the genesis of their concerns.

Diagnoses, myths, or therapeutic rationales provide information on how distress is culturally constructed. In the case of the *mujer abnegada,* diagnoses of depression or anxiety can risk minimizing the influence of past traumatic experiences that include harmful gender expectations and gendered violence. Although abuse, domestic violence, and overall trauma is strongly associated to symptoms of depression, providing a therapeutic rationale that explains distress as a result of trauma may have a greater therapeutic effect (Caplan et al., 2013; Duncan, 2015). In a study conducted in Oaxaca, women whose experience had been framed through a trauma lens experienced significant relief and decreased symptoms when compared to women diagnosed with depression and anxiety (Duncan, 2015). These women described that it was helpful to understand that their distress was not caused by their "way of being" (Duncan, 2015).

For Mexican providers to appropriately assess, adapt, and prescribe interventions, it is essential for them to understand the role of gender in the expression of distress and overall illness experience. Particularly, providers must recognize and address the normativity of gender violence to improve the mental health care of women (Duncan, 2015). Women who participated in this study seemed disproportionately affected by harmful interpersonal dynamics that were prescribed or adopted through rigid adherence to gender roles and expectations. With conscious awareness, mental health providers can help women challenge the belief that gender violence is normative (Duncan, 2015). Psychological treatment can then encourage women to express, make sense, and overcome past experiences of violence (Duncan, 2015). Providers' attention to these cultural factors could help de-pathologize patients, broaden their awareness of contextual forces that influence distress, and galvanize appropriate resources and supports. Furthermore, providers could be encouraged to understand how rigid gender norms are harmful to both men and women, how gender roles affect the therapeutic encounter, and have explicit discussions of sex, sexuality, and gender norms to help tailor interventions to this population.

***The role of "desahogo."*** A main finding from the present study was patients' and caregivers' belief in the need to "*desahogar*" or "let out" their emotions to experience relief. Mental illness attributions often influence what people believe to be necessary for their recovery process (Carpenter-Song, 2015). Classification and identification of mental distress has important clinical implications as it prioritizes some forms of treatment over others. "*Desahogo*" may have been particularly relevant for *mujeres abnegadas* who were often asked to silence their voices and dismiss their distress.

*Desahogo* could also be linked to Mayan and other Mesoamerican cultural beliefs about the need to use confession to alleviate illness (Pavón-Cuéllar, 2013). Mayan folk healers (*curanderos*) would interrogate the ill person and through their confession diagnose illnesses related to the spirit, soul and mind (Pavón-Cuéllar, 2013). Psychotherapeutic interventions were then aimed at changing the patient's emotional state, attitudes, and social behavior to reestablish social connections, particularly among family members (Pavón-Cuéllar, 2013). Mesoamerican psychology generally integrates mind and body and works to build back the patient's social role within the family and larger community (Pavón-Cuellar, 2013; Villaseñor Bayardo, 2008).

All psychiatrists and a majority of patients and caregivers suggested talk therapy ("*pláticas*") and "talking through problems" would be helpful to alleviate patient suffering. This belief shared by psychiatrists, patients, and caregivers represents one of the few topics in which there was wide agreement.  It may be that the cultural and medical worldviews converge on this form of treatment because there is a cultural tradition of '*pláticas,*' and empirical research supporting psychotherapy as beneficial. The purpose of psychotherapy is often to provide an outlet for patients to express, organize, and make meaning of their illness narrative in a way that provides coherence and healing to their experience of distress (Kirmayer, 2000). Developing narrative accounts of distress through talk therapy may help build a coherent identity and sense of self through how a person codifies and represents their experience (Kirmayer, 2000). Conversely, failing to emphasize the need to "talk through" contextual factors influencing distress may perpetuate patient suffering.

"*Desahogo*" has been previously described as a helpful treatment expectation in other Latino populations. In a study using a clinical vignette of a person with depression, Martinez Tyson and colleagues (2016) found that Latino participants often described the need to "*desahogar*" or talk through issues with family or friends. "*Desahogo*" could help patients express their emotions and activate social supports which are particularly salient in collectivistic cultures. Similar research with U.S.-based Latinos has also reported on the worth of "unburdening oneself" or "*desahogarse*" (Martínez Pincay & Guarnaccia, 2006). "*Desahogo*" is also consistent with some psychotherapeutic theories that integrate the expression of affect to alleviate psychological distress (Levenson, 2010; McCullough et al., 2003; Teyber & Teyber, 2017). Previous research in Oaxaca suggested that mental health practitioners envision their role as helping patients express their emotions fully, and dispel cultural, social, educational, familial, and other ideals to form their own individualized identities and transcend "cultural burdens" (*cargas culturales*) that contribute to maladaptive coping (Duncan, 2015; 2017).

My findings contrast those of Hale (2017) who described psychiatric treatment in Mexico as more “clinical” and “interpersonal,” compared to strictly focused on medication management. Hale (2017) stated that “referrals to psychotherapy were frequent and scheduled to coincide with [patient’s] psychiatric visits, reinforcing [the site’s] integrative system of care.” Yet psychiatrists in this study, at the same site, claimed there was little to no communication between psychologists and psychiatrists, and that psychotherapy was often unavailable. Despite psychiatrists’ belief that psychotherapy could be helpful or even “cure” emotional distress, they often prescribed this intervention with little hope for patient follow-up. In the current health care system, barriers to psychotherapy such as inaccessibility to services in local communities, appointments being spaced out months at a time, insufficient psychologists, and lack of locally-based psychotherapy research, made interventions seem foreign, unfeasible and unhelpful. Consequently, providers relied on behavioral tactics and the dominant biomedical cognitive behavioral psychotherapy model to encourage positive patient behavior.

Tailoring myths or therapeutic rationales to patient cosmogony can improve treatment outcomes by incorporating patients’ beliefs about the genesis and likely course of their illness experience (Benish, Quintana, & Wampold, 2011; Frank & Frank, 1991; Huey, Tilley, Jones, & Smith, 2014). Specifically, for Mexicans and Latinos it seems important to adopt treatment rationales that fit the broadly held belief in “*desahogo*” as a main source of relief from suffering. The role of emotional processing is congruent with all dominant psychotherapeutic theories, although somewhat de-emphasized in certain cognitive behavioral approaches. Further, the belief that mental and emotional distress is mainly caused by adverse interpersonal factors indicates a need to tailor treatment that builds back the social relationships that provide the strongest supports for patients (Martinez Tyson et al., 2016). Additional empirical research could ascertain the influence of having (or not) a shared worldview or causal myth on the quality of the therapeutic relationship amongst Mexican psychiatrists and patients.

***The role of family.*** *Familismo* is believed to be one of the most important cultural values among Latino populations (Sabogal, Marín, Otero-Sabogal, VanOss Marín, & Perez-Stable, 1987). This value includes strong attachment to family members in both the nuclear and extended family unit, with relationships that are characterized by loyalty, reciprocity, and solidarity (Calzada, Tamis-LeMonda, & Yoshikawa, 2013; Chavez-Korell, Benson-Flórez, Rendón, & Farías, 2014; Sabogal et al., 1987). The value of *familismo* has been linked to positive mental health among Latinos through the provision of networks of social support (Chavez-Korell et al., 2014; Guarnaccia, Parka, Deschamps, Milstein, & Argiles, 1992b), and is often described by Latinos as fundamental to the healing process (Elizabeth Carpenter-Song et al., 2010; D. Martinez Tyson et al., 2016; Santiago-Rivera et al., 2011).

The value of *familismo* was evident in this study as family members were described as the main source of support and were central in the therapeutic encounter. Yet, as in all cultures, there were costs and benefits associated with close familial ties, and a need to understand when and how interventions with family members are effective (Calzada et al., 2013). Previous findings with Latino caregivers suggest that family-level dynamics can significantly influence whether family support is helpful in mental health treatment (Marquez & Ramírez García, 2013). For example, in a study on older Latino adults, *familismo* was found to be negatively associated with depressive symptoms (Chavez-Korell et al., 2014), and the actual experience of mental illness can contribute to family breakdown (Hackethal et al., 2013).

Research on foreign-born Mexicans living in the U.S. suggests that increased levels of family support can decrease the risk of depression in this population (Almeida, Subramanian, Kawachi, & Molnar, 2011). Indeed, family support may be more influential than other sources of social support such as friends (Almeida et al., 2011). In fact, Almeida and colleagues (2011) found that foreign-born Mexicans believed that family should be the first source of support when experiencing depression. Family warmth may also serve as a protective factor and decrease the likelihood of subsequent hospitalizations among Mexican Americans with severe mental illness (López et al., 2004). Research with patients with severe mental illness also demonstrates that a higher frequency of family contact was associated with less relapse among Mexican Americans (López et al., 2004). However, the quality of family relationships could also negatively influence patients, for example, Guo, Li, Liu, and Sun (2015) found that family cohesion was a risk factor for depression, and family cultural conflict increased the occurrence of anxiety in Asian and Latino older adults in the U.S

A family-based therapeutic perspective and structuring family involvement to enlist family engagement in adaptive ways may help address patient suffering and provide support to family members involved in their care. Many culturally congruent psychological interventions for Latinos are aimed at treating the whole family unit (Garza & Watts, 2010; Valdez, Abegglen, & Hauser, 2013). In a more sociocentric society with collectivistic values, personhood is conceptualized in relationship to others and the group, and effective healing systems may be ones that affirm and repair the person's connection to others (Kirmayer, 2007; Logan & Hunt, 2014). In this study, enlisting family members' support could at times be detrimental to patient care and reenact the maladaptive patterns that underlie their symptoms. The providers, patients, and caregivers I interviewed described family at times as a source of stress, and at others as a source of support. Thus, further research needs to extend our understanding of *how* certain cultural values like *familismo* influence experiences of distress, and *what* interventions may improve them (Lopez & Guarnaccia, 2000).

In the U.S., Latino values such as *familismo* are often difficult to incorporate in the service provision of culturally diverse populations. For example, most systems of care do not readily incorporate family members into treatment due to broader cultural norms and legislation that views the patient as the sole agent for treatment. Interventions developed in more individualistic cultures may need to incorporate collectivistic values to be appropriately adapted to local cultures and be efficacious in other contexts. For example, the treatment model in Mexico naturally incorporates locally-based values that expect the inclusion of family in treatment. Family members are expected and invited to be a part of the psychiatric appointment, and frequently recruited to increase patients' compliance with treatment recommendations. Research conducted at the same site reported that at least half of patients who attend appointments at this hospital were accompanied by between one to five family members (Hale, 2017). Psychiatric appointments were often a moment for family members to also voice their concerns regarding patient behavior or non-compliance with treatment (Hale, 2017).

### 5.2. Globalization of psychiatric treatment

Mental health strategies across the world seek to identify targets to improve health disparities among all populations (Kirmayer & Pedersen, 2014). However, a tension continues between biomedicine and evidence-based practices largely developed in high-resource countries, and understanding culturally localized and community-based approaches to wellness (Kirmayer & Pedersen, 2014). The demand to expand evidence-based practices may increase the uptake of largely biomedical approaches such as medication management and behaviorally-based interventions, rather than conducting complex psychosocial interventions that respond to culturally-specific needs (Kirmayer & Pedersen, 2014). The neglect of cultural contexts in a global mental health agenda could negatively impact care by disregarding locally bound social constructions of distress, privileging attention to biological rather than contextual factors that influence mental illness and treatment outcomes, and ignoring indigenous systems of coping and care (Kirmayer & Pedersen, 2014).

Despite the expansion of psychopharmaceutical treatments to treat mental distress, the disorders they presume to remedy have continued to rise (Ecks, 2011). Carpenter-Song (2015) described a shift in modern medicine and psychiatric care from understanding the person-in-context (i.e., “how do you feel?”) to a focus on the bodily markers of disease (i.e., “where does it hurt?”). Modern psychiatrists across the world often focus on symptom suppression, management, and control (Carpenter-Song, 2015). Psychiatric treatment has reflected a larger capitalist venture in a globalized context driven by highly influential pharmaceutical companies to increase revenue for hugely profitable corporations (Ecks, 2011). In my study site, at least once a week pharmaceutical companies brought breakfast for the psychiatric residents and faculty during morning grand round presentations and provided samples of new or popularly prescribed drugs. Psychiatrists often kept these samples to dispose to patients when these drugs were unavailable through the hospital pharmacy.

Psychiatrists in Mexico reflect the larger dominant and globalized mental health agenda, including underlying assumptions that Western evidence-based treatments can be applied without adaptation across cultures and contexts because the underlying mechanisms of mental illness are biologically based and stable across cultural contexts (Kirmayer & Pedersen, 2014). Although psychiatrists had a biopsychosocial perspective on patient distress, they did not seem to integrate this in their treatment. Therefore, there is a broader need for these practitioners to adopt an "informed universalism," in which they integrate biological, psychodynamic, social, cultural, and neuroscientific approaches in the design and implementation of therapeutic interventions (DelVecchio Good & Hannah, 2015).

It is essential to understand the local and global forces that influence psychiatric practice in Mexico. Broadly, mental health agendas proposed by globally focused institutions such as the World Health Organization (WHO) affect local practice by developing policies and procedures, administrating funding, and providing access to resources. Global mental health has pushed to de-centralize care located in large inpatient institutions and promote comprehensive community-based treatment that is more accessible and cost-effective (World Health Organization, 2001). However, locally, Mexico has lagged behind global mental health objectives despite having a universal health care structure. Issues in current Mexican mental health care include a lack of funding for services, shortage of human resources to provide them, and inadequate programmatic structures to implement de-centralized care. Thus, providers in Mexico are constrained within the specific health care system in which they practice, and patients are constrained within the health care structures they can access.

In 2012, the World Health Organization (WHO) published the mhGAP intervention guide for mental, neurological and substance use disorders to be treated in non-specialized health settings. This guide seeks to reduce the gap in mental health care across the globe, particularly in middle- and low-income countries such as Mexico (WHO, 2012). This document provides general guidelines for practitioners to evaluate and decide on the best course of treatment based on a specific diagnosis (e.g., depression, psychosis) and common clinical "best practices" for treatment (WHO, 2012). Part of these efforts include the development of scalable mental health interventions to address the needs of communities who are affected by adversity and experience extreme stressors such as chronic poverty, trauma, gender-based violence, displacement, and more (WHO, 2017).

Scalable psychological interventions include brief evidenced-based cognitive behavioral therapy and interpersonal therapy treatments, self-help materials, and self-guided group programs (WHO, 2017). These interventions seek to increase accessibility of mental health care through the provision of interventions that do not necessitate a specialized provider (WHO, 2017). Thus, scaling up mental health interventions can address issues related to access by increasing the availability of treatment via non-specialized providers, though possibly compromising the quality of services provided (WHO, 2017). Randomized control trials are currently underway to test the effectiveness of these interventions across different populations around the globe (WHO, 2017).

### 5.2.1. A global psychology in Mexico

In Mexico, there is a continued need for local, community-based, psychotherapeutic care that attends to the interpersonal concerns in the lives of patients and their family members (Berenzon et al., 2013; Lara-Muñoz et al., 2010). Findings in this study suggest a lack of access to non-health sector services like counseling that may be a helpful alternative treatment. Indeed, previous reports in Mexico suggest there are higher rates of service use in specialty care such as psychiatrists and medical doctors (Borges et al., 2006). With 60% of psychologists in Mexico reportedly working in the private sector, it is not surprising there is a lack of psychological services for the most disenfranchised of the Mexican population (Portal, Suck, & Hinkle, 2010).

Psychosocial interventions not only attend to the issues this population often faces but also offers a cost-effective alternative to specialized care (Berenzon et al., 2013; Lara-Muñoz et al., 2010). The Mexican health care system could benefit from increasing financial support to community-based mental health care, and a more equitable distribution of resources among the population and at different levels of care (Berenzon et al., 2013). Efforts to increase psychosocial interventions could include WHO scalable interventions provided by social workers and trained community-based mental health promoters (*promotoras;* Waitzkin et al., 2011; WHO, 2017).

Psychosocial interventions could be community-based and integrated within the State Systems for the Integral Development of the Family (*Sistemas Estatales para el Desarrollo Integral de la Familia*; SNDIF). The SNDIF were established in 1977 to provide state-sponsored social security programs in Mexico that target health, mental health, food security and shelter (Bonilla, 2017). More specifically the SNDIF implements models of service to strengthen and address the needs of vulnerable or marginalized children, women, and families (Bonilla, 2017). The SNDIF is a decentralized system that operates at state and municipal levels with each having different monetary budgets (Bonilla, 2017). Consequently, service quality and access differ based on the region but are generally under-resourced across the country (Bonilla, 2017). Increasing availability of quality and cost-effective psychosocial interventions in local DIF offices could be a step toward scaling up mental health care yet is challenging to implement in a generally under-funded and ineffective health care system.

Finally, psychosocial services need to be appropriately evaluated for effectiveness to continue to inform public policy (Berenzon et al., 2013). Previous research conducted in Mexico suggests that a combination of psychiatric medication and brief psychotherapy is the most cost-effective intervention for depression (Lara-Muñoz et al., 2010). Indeed, stakeholders in this study frequently described the need for both medical and psychological treatment to effectively address patient's distress.  Brief psychotherapeutic services provided by social workers in Mexico have also been found to be moderately effective in the treatment of depression (Lara, Navarro, Rubí,

& Mondragón, 2003). Unfortunately, research related to other mental illness experiences in Mexico such as psychosis have only measured the cost-effectiveness of different psychiatric medication regimens (Palmer, Brunner, Ruíz-Flores, Paez-Agraz, & Revicki, 2002).

### 5.2.2. Implications for mental health provider training

Although not directly used in clinical practice, the use of the CFI in research suggests that it could have a significant impact by enhancing the clinical data gathered and the development of a therapeutic alliance. Patients and family members disclosed important aspects of the illness experience that they had occasionally not shared with their current provider. The anthropological approach of the CFI de-emphasizes the focus on symptoms that are associated with biomedical categories and highlights a holistic experience and its impact on conceptualization, rationale, coping and supports, and treatment expectations associated with mental distress (APA, 2014).

Recent studies on the influence of using the CFI in clinical practice report similar themes independently found in the present research. With regards to attributions of distress, CFI interviews with Spanish-speaking Latinos reported that disruptions in their interpersonal relationships, past traumatic experiences, and losses (through immigration or death) were major contributors to their distress (Díaz, Añez, Silva, Paris, & Davidson, 2017). Clinically, recent research indicates that using the CFI helps address stigma related to seeking mental health treatment, increase trust with providers, focus on restoring social ties, and provides an assessment of psychosocial needs and coping that includes other help seeking and supports such as spirituality (Díaz et al., 2017; Ramírez Stege & Yarris, 2017). The CFI helps providers focus on patients' perceptions and uncover their patient's subjective experience while appearing to build trust in the therapeutic alliance (Díaz et al., 2017; Ramírez Stege & Yarris, 2017).

Consequently, use of the CFI can enhance treatment by increasing diagnostic accuracy, patient engagement and satisfaction, and accurate treatment planning (Lewis-Fernández et al., 2017).

Findings from this study have direct implications for clinical training of Mexican psychiatrists. Psychiatrists could be taught and encouraged to adopt a cultural humility approach to integrate the multiple cultural factors (e.g., ethnicity, provenance, language, social class) that influence patients' presenting concerns (Owen et al., 2014). In some ways, psychiatrists in this study seemed to understand the multiple contextual and cultural factors that influenced their patients yet failed to integrate this information into their psychotherapeutic interventions. Although psychiatrists are often respectful and knowledgeable of patients' cultural background, they lack the tools to challenge some culturally embedded maladaptive patterns, and at times jumped to conclusions based on their own culturally embedded assumptions. Thus, integrating cultural humility and critical cultural awareness into psychiatrist training could promote effective psychotherapeutic practice through the promotion of active self-reflection and continual challenge of one's values, beliefs, and assumptions (Christopher et al., 2014; Kools & Chimwaza, 2015).

Adopting cultural humility may be a challenge for providers in Mexico due to cultural expectations in the doctor-patient interaction. Provider Diego described the importance of being "decisive" and "authoritarian," at times even scolding patients to promote medication adherence. However, previous research in Chiapas would suggest that lack of respect, authoritarianism, and classist attitudes may actually deter patients from seeking treatment (Molina & Palazuelos, 2014). These attitudes are contrary to a cultural humility approach that encourages provider humility, respect for patient's background and beliefs, exploration of patient's perspective, and reservation of assumptions based on patient's background (Hook & Watkins Jr., 2015). Mexican providers' assumption that there is a need to be authoritarian with certain patients may reflect more deeply embedded cultural dynamics rooted in high levels of educational, economic, and geographic inequity among the Mexican population. Further research could help elucidate how the negotiation of different power dynamics influences the quality of the therapeutic alliance.

Despite being from the same "culture," there were differing perspectives among Mexican psychiatrists, patients and family members as a result of their positionality. The cultural distance among stakeholders in this study supports the proposition that in fact all psychotherapeutic encounters are cultural, and that attention needs to be given to the various cultural factors that affect the therapeutic relationship (Arredondo & Arciniega, 2001; Cohen, 2009; Owen et al., 2011; Sue, Zane, Nagayama Hall, & Berger, 2009). In comparison to cross-cultural exchanges between U.S. Latinos and their providers, a major advantage for psychiatrists in Mexico is that by virtue of their shared cultural background, their professional training and title, they are assigned a social position that commands respect and may increase patient buy-in to psychiatric treatment. Nevertheless, the psychiatrists who participated in this study might have faced other challenges in the establishment of therapeutic rapport such as being stereotyped by patients and family members due to psychiatrists' age and level of training as psychiatric residents. The possible fear or discomfort related to stereotyping may contribute to psychiatrists' belief in needing to be more authoritative and commanding in their therapeutic encounters. These and other provider factors are important to consider in patient treatment as beliefs about therapists' effectiveness are tied to patient-held perceptions about the competence of their providers (Owen et al., 2011).

More broadly, a global mental health perspective could benefit from redefining cultural competency as *structural* competency, described by Metzl & Hansen (2014) as the trained ability to distinguish the financial, legal, political, and ethical systems, in addition to social aspects that influence health care and patient outcomes (Metzl & Hansen, 2014). Structural competency posits that inequitable health care and outcomes are related to harmful institutional actions and social conditions (Metzl & Hansen, 2014). This model advocates to train health practitioners to distinguish how clinical symptoms and diseases are shaped by larger social and structural systems such as health care delivery and treatment availability, services in rural and urban areas, and general laws and policies (Metzl & Hansen, 2014). These structures reenact the social world where patients and clinicians are embedded, including systems of privilege and oppression (Metz & Hansen, 2014). Although clinicians may not have control over larger structural issues, being aware of how these might influence a patient's expression of distress could help empathize with patient's feelings in the therapeutic encounter, and adequately address treatment expectations (Metzl & Hansen, 2014).

As discussed in the previous section, scaling up mental health services at community levels implies a need for non-specialized treatment. In Mexico, social workers and community members could be trained as *promotoras de salud* (health promoters) to conduct a basic mental health assessment and offer brief psychotherapeutic interventions (Lara et al., 2003). Similarly, primary care physicians could be trained in basic mental health assessment and treatment as a first point of contact for people within the community seeking care.

Supervision of clinical practice will be indispensable for the effective implementation of quality care across different types of mental health providers. Findings in my study suggest that providers are often practicing independently with little communication among psychiatrists, psychologists, nurses, and social workers. Integrating supervision for the provision of psychotherapeutic services could increase support for clinicians and help monitor the quality of services provided (Montiel, 2016).

## 5.3. Limitations

A main limitation of this study was that, although patients, caregivers, and providers were all interviewed, these sources only provide information on individual interactions held with the researchers, and thus, cannot be an analysis of how all these stakeholders actually interact. Therefore, although my analysis makes some inferences and hypotheses about how patients, caregivers, and providers interact, it is not a direct analysis of actual therapeutic interactions. Although some accounts within a case may differ according to what is reported by patients, caregivers, and providers, I believe these different perspectives added richness to the overall understanding of the illness experience.

Further limitations also relate to the nature of qualitative inquiry which is based on self-report and subjective experience. For instance, participants may be more or less reliable storytellers, and their accounts provide different perspective that have been weaved together throughout the presentation of results and the discussion of this document. Thus, it is important to contextualize as much as possible the narratives provided by these stakeholders as they relate to broader local (in Mexico) and global forces in mental health care. I believe further research that incorporates quantitative measures, for example, on the strength and quality of the therapeutic alliance over time, could provide helpful additional information to inform some of the conclusions provided in this discussion.

In contrast to previous studies (i.e., Berenzon-Gorn, Ito-Sugiyama, & Vargas-Guadarrama, 2006), the majority of patients interviewed did not describe seeking folk or traditional healing. This finding could reflect the design of the study. Patients interviewed had all accessed specialized psychiatric services, had attended the outpatient clinic at least once, and had likely decided psychiatric intervention and medication was an appropriate course of action as they continued to be engaged in treatment. Therefore, patients and family members who participated in this study are likely more acculturated into the biomedical treatment model. Nevertheless, treating illness in the body is also congruent with indigenous Mexican cosmogony (Vallejo Samudio, 2006), and most patients and family members also endorsed the need for a holistic approach to treating mental distress. Patients may have also been reticent to report on failed attempts to seek healing. Further community-based research may elucidate the role of indigenous or alternative medicine in local healing practices.

There are additional strengths and limitations of this research based on my own analysis and subjectivity. I provide a narrative of my experience as a Mexican and American researcher in the methodology section to further contextualize myself as a researcher and my relationship to the participants of this study and the data gathered. During my professional development in Mexico, I had challenging clinical experiences due to a lack of professional support, supervision, training, and resources to address patients' mental health concerns. These experiences invariably shape my analysis as I understand the culture of clinical practice in Mexico, and I am critical of the need for improvement and change. Thus, my analysis was also supported by a research team of Latinx master's counseling psychology and undergraduate psychology students who helped code and organize major themes. Their observations enriched the analysis as they also had insider and outsider perspectives on mental health care in Mexico. Further, as a counseling psychologist-in-training, my clinical perspective and relationship to patients' and caregivers' accounts are different than those of my participating providers who are trained as medical doctors and psychiatrists. Therefore, when possible, I relied on psychiatry colleagues in Mexico who have practiced and trained at the same or similar institutions as the study site to add or corroborate local contextual information.

## 5.4. Conclusions

It is imperative that we continue to develop effective psychotherapeutic approaches to treat culturally diverse populations. In Mexico, 1 in every 5 people in the general population will experience some psychiatric disorder in their lifetime (IEMS-OMS, 2011). With such high prevalence rates, we must search vigorously for ways to best address this population's needs. Results from this study provides essential information on how patients conceptualize their illness and their treatment expectations. I believe this information can be used to best meet the needs of this, and similar, populations. What this study seeks to highlight is that the adequate and effective treatment of the mental illness experience in Mexico will have to broadly incorporate the perspectives of patients and their family members, as well as the social and contextual dynamics at play in the therapeutic encounter. I sum myself to the efforts of many researchers who are trying to dispel the view that historical, social, and economic environments are marginal to the expression of mental distress when compared to biomedical determinants (Alarcón, 2009; Arredondo, 1999; Carpenter-Song, Nordquest Schwallie, & Longhofer, 2007; Christopher et al., 2014; DelVecchio Good & Hannah, 2015; Kirmayer & Pedersen, 2014; Kleinman, 1988b; López & Guarnaccia, 2000; ojalehto & Medin, 2015; Wampold, 2001).

In the year 2000, when I was 12 years old, the first McDonald's in my hometown of Cholula, Puebla was built only four blocks away from the archeological pyramid site (Image 1). For many, this signaled movement toward modernization in our community. For others, this symbolized the decay of our traditional values. Indeed, we were one example of the evolution and response to incessant global forces that infringe on local communities. This same year, my father left to work in the U.S. because of increasing debt in our marketplace store and a dearth of opportunities for economic advancement locally. My mother had to take on the fulltime responsibility of the store in addition to her job as a school teacher. With little time to prepare meals, she sometimes relied on fast food options to provide quick meals after school for me and my twin sister. But instead of going to the new McDonald's, we ordered our local "*comida corrida*" (fast food) from *fondas* or restaurant establishments that sold home cooked Mexican *guisados* by the liter that could feed our family for a third of the price of a McMeal. These *fondas* responded to the increasing need to have affordable eating options for working professionals and their families while maintaining the same level of food quality one might find in a home cooked meal.

I share this experience because I see the McDonald's fast food experience in Mexico as a metaphor to my work on understanding how we incorporate indigenous conceptualizations and culture in psychotherapeutic intervention and generate indigenous interventions. Similar to cultural adaptations of hegemonic, Western-based psychotherapeutic interventions, McDonald's in Mexico tries to tailor its product to the Mexican palate. They develop spicier versions of the McPollo and add guacamole, but it is still a McDonald's eating experience. This "fast food" does not respond to the needs of communities who do not have economic access to this food and who do not find it socially acceptable or feasible to access this experience. Yet through migration and globalizations, there is much Mexican-U.S. cultural exchange, and cultural adaptations may and do work for some acculturated Mexican or Latino populations in the U.S. My hope is that this research sheds some light on indigenous ways of knowing and moves us toward understanding how to respond locally to local needs. We live in a larger globalized society but need to understand how to effectively interact within our own cultural idiosyncrasies.

*Image 1*. "*Cuatro Caminos*" –view of Cholula Pyramid circa 2013.

## References

Adeponle, A. B., Thombs, B. D., Groleau, D., Jarvis, E., & Kirmayer, L. J. (2012). Using the cultural formulation to resolve uncertainty in diagnoses of psychosis among ethnoculturally diverse patients. *Psychiatric Services*, *63*(2), 147–153.

Aggarwal, N. K., Nicasio, A. V., DeSilva, R., Boiler, M., & Lewis-Fernández, R. (2013). Barriers to implementing the DSM-5 Cultural Formulation Interview: A qualitative study. *Culture, Medicine, and Psychiatry*, *37*(3), 505–533. https://doi.org/10.1007/s11013-013-9325-z

Alarcón, R. D. (2009). Culture, cultural factors and psychiatric diagnosis: review and projections. *World Psychiatry*, *8*(3), 131–139.

Almeida, J., Subramanian, S. V., Kawachi, I., & Molnar, B. E. (2011). Is blood thicker than water? Social support, depression and the modifying role of ethnicity/nativity status. *Journal of Epidemiology & Community Health*, *65*(1), 51–56. https://doi.org/10.1136/jech.2009.092213

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (Fifth Edition). Arlington, VA: American Psychiatric Association.

American Psychiatric Association (2014). Manual diagnóstico y estadístico de los trastornos mentales (DSM-5). 5ta edición. Arlington, VA: Asociación Americana de Psiquiatría.

American Psychological Association. (2002). Guidelines on multicultural education, training, research, practice, and organizational change for psychologists. *APA Policy*. Retrieved from http://dpi.wi.gov/sites/default/files/imce/crc/pdf/c2_multicul_gdln.pdf

Anderson, B. T., & Garcia, A. (2015). ‘Spirituality’and ‘cultural adaptation’ in a Latino mutual aid group for substance misuse and mental health. *British Journal of Psychiatry Bulletin*, *39*(4). Retrieved from https://escholarship.org/uc/item/66k2x5gc.pdf

Applewhite, S. L. (1996). Curanderismo: Demystifying the health beliefs and practices of elderly Mexican American. *Multicultural Issues in Social Work*, 455.

Arredondo, P. (1999). Multicultural counseling competencies as tools to address oppression and racism. *Journal of Counseling & Development*, *77*(1), 102–108.

Arredondo, P., & Arcienega, G. M. (2001). Strategies and techniques for counselor training based on the multicultural counseling competencies. *Journal of Multicultural Counseling & Development, 29*, 263-273.

Arredondo, P., Rosen, D. C., Rice, T., Perez, P., & Tovar-Gamero, Z. G. (2005). Multicultural counseling: A 10-year content analysis of the Journal of Counseling & Development. *Journal of Counseling and Development: JCD*, *83*(2), 155.

Arredondo, P., Tovar-Blank, Z. G., & Parham, T. A. (2008). Challenges and promises of becoming a culturally competent counselor in a sociopolitical era of change and empowerment. *Journal of Counseling & Development*, *86*(3), 261–268.

Barrera, I., Schulz, C. H., Rodriguez, S. A., Gonzalez, C. J., & Acosta, C. A. (2013). Mexican-American perceptions of the causes of mental distress. *Social Work in Mental Health*, *11*(3), 223–248. https://doi.org/10.1080/15332985.2013.774922

Baumann, A. A., Powell, B. J., Kohl, P. L., Tabak, R. G., Penalba, V., Proctor, E. K., … Cabassa, L. J. (2015). Cultural adaptation and implementation of evidence-based parent-training: A systematic review and critique of guiding evidence. *Children and Youth Services Review*, *53*, 113–120. https://doi.org/10.1016/j.childyouth.2015.03.025

Benish, S. G., Quintana, S., & Wampold, B. E. (2011). Culturally adapted psychotherapy and the legitimacy of myth: A direct-comparison meta-analysis. *Journal of Counseling Psychology*, *58*(3), 279–289. https://doi.org/10.1037/a0023626

Berenzon, S., Lara, M. A., Robles, R., & Medina-Mora, M. E. (2013). Depresión: estado del conocimiento y la necesidad de políticas públicas y planes de acción en México. *Salud Pública de México*, *55*(1), 74–80. doi: 10.1590/S0036-36342013000100011

Berenzon Gorn, S., Saavedra Solano, N., Medina-Mora Icaza, M. E., Aparicio Basaurí, V., & Galván Reyes, J. (2013). Evaluación del sistema de salud mental en México: ¿Hacia dónde encaminar la atención? *Rev Panam Salud Publica*, *33*(4), 253.

Berenzon-Gorn, S., Ito-Sugiyama, E., & Vargas-Guadarrama, L. A. (2006). Enfermedades y padeceres por los que se recurre a terapeutas tradicionales de la Ciudad de México. *Salud Publica de México*, *48*(1), 45–56.

Berger, L. K., Zane, N., & Hwang, W.-C. (2014). Therapist ethnicity and treatment orientation differences in multicultural counseling competencies. *Asian American Journal of Psychology*, *5*(1), 53–65. https://doi.org/10.1037/a0036178

Bonilla, E. B. (2017). La asistencia social en México. Una mirada desde el SNDIF. *Ánfora*, *24*(43), 189–212.

Borges, G., Medina-Mora, M. E., Wang, P. S., Lara, C., Patricia Berglund, M. B. A., & Walters, E. (2006). Treatment and adequacy of treatment of mental disorders among respondents to the Mexico National Comorbidity Survey. *The American Journal of Psychiatry*, *163*(8), 1371–1378.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Burckhardt, A. Q., & Sánchez, F. C. (2006). El modelo Americano de competencia cultural psicoterapéutica y su aplicabilidad en nuestro medio. *Papeles Del Psicólogo*, *27*(1), 50–57.

Cabassa, L. J., Lester, R., & Zayas, L. H. (2006). "It's Like Being in a Labyrinth:" Hispanic immigrants' perceptions of depression and attitudes toward treatments. *Journal of Immigrant and Minority Health*, *9*(1), 1–16. https://doi.org/10.1007/s10903-006-9010-1

Calzada, E. J., Tamis-LeMonda, C. S., & Yoshikawa, H. (2013). Familismo in Mexican and Dominican families from low-income, urban communities. *Journal of Family Issues*, *34*(12), 1696–1724.

Caplan, S., Escobar, J., Paris, M., Alvidrez, J., Dixon, J. K., Desai, M. M., Scahil, L. D., & Whittemore, R. (2013). Cultural influences on causal beliefs about depression among Latino immigrants. *Journal of Transcultural Nursing*, *24*(1), 68–77.

Carpenter-Song, E. (2015). Putting meaning into medicine: Why context matters in psychiatry. *Epidemiology and Psychiatric Sciences*, *24*(04), 292–295. https://doi.org/10.1017/S2045796015000475

Carpenter-Song, Elizabeth, Chu, E., Drake, R. E., Ritsema, M., Smith, B., & Alverson, H. (2010). Ethno-cultural variations in the experience and meaning of mental illness and treatment: Implications for access and utilization. *Transcultural Psychiatry*, *47*(2), 224–251. https://doi.org/10.1177/1363461510368906

Carpenter-Song, E. A., Nordquest Schwallie, M., & Longhofer, J. (2007). Cultural competence reexamined: Critique and directions for the future. *Psychiatric Services*, *58*(10), 1362–1365.

Cartwright, E. (2007). Bodily remembering: Memory, place, and understanding Latino folk illnesses among the Amuzgos Indians of Oaxaca, Mexico. *Culture, Medicine and Psychiatry*, *31*(4), 527–545. https://doi.org/10.1007/s11013-007-9063-1

Chao, R. C.-L., Wei, M., Good, G. E., & Flores, L. Y. (2011). Race/ethnicity, color-blind racial attitudes, and multicultural counseling competence: the moderating effects of multicultural counseling training. *Journal of Counseling Psychology*, *58*(1), 72.

Chavez-Korell, S., Benson-Flórez, G., Rendón, A. D., & Farías, R. (2014). Examining the relationships between physical functioning, ethnic identity, acculturation, familismo, and depressive symptoms for Latino older adults. *The Counseling Psychologist*, *42*(2), 255–277.

Christopher, J. C., Wendt, D. C., Marecek, J., & Goodman, D. M. (2014). Critical cultural awareness: Contributions to a globalizing psychology. *American Psychologist*, *69*(7), 645–655. https://doi.org/10.1037/a0036851

Clauss-Ehlers, C. S., Chiriboga, D. A., Hunter, S. J., Roysircar-Sodowsky, G., & Tummala-Narra, P. (2017). Multicultural guidelines: An ecological approach to context, identity, and intersectionality.

Cohen, A. B. (2009). Many forms of culture. *American Psychologist*, *64*(3), 194–204. https://doi.org/10.1037/a0015308

Collins, S., Arthur, N., & Wong-Wylie, G. (2010). Enhancing reflective practice in multicultural counseling through cultural auditing. *Journal of Counseling & Development*, *88*, 340–347.

Creswell, J. W. (2007). *Qualitative inquiry and research design: Choosing among five approaches* (2nd ed.). USA: Sage Publications, Inc.

Crowe, M., Inder, M., & Porter, R. (2015). Conducting qualitative research in mental health: Thematic and content analyses. *Australian and New Zealand Journal of Psychiatry*, 0004867415582053.

D'Angelo, E. J., Llerena-Quinn, R., Shapiro, R., Colon, F., Rodriguez, P., Gallagher, K., & Beardslee, W. R. (2009). Adaptation of the preventive intervention program for depression for use with predominantly low-income Latino families. *Family Process*, *48*(2), 269–291.

Das, S., Saravanan, B., Karunakaran, K. P., Manoranjitham, S., Ezhilarasu, P., & Jacob, K. S. (2006). Effect of a structured educational intervention on explanatory models of relatives of patients with schizophrenia. Randomised controlled trial. *The British Journal of Psychiatry*, *188*(3), 286–287.

DelVecchio Good, M.-J., & Hannah, S. D. (2015). "Shattering culture": perspectives on cultural competence and evidence-based practice in mental health services. *Transcultural Psychiatry*, *52*(2), 198–221. https://doi.org/10.1177/1363461514557348

DeSilva, R., Aggarwal, N. K., & Lewis-Fernandez, R. (2015). The DSM-5 cultural formulation interview and the evolution of cultural assessment in psychiatry. *Psychiatric Times*, *32*(6), 10–10.

Díaz, E., Añez, L. M., Silva, M., Paris, M., & Davidson, L. (2017). Using the Cultural Formulation Interview to build culturally sensitive services. *Psychiatric Services*, *68*(2), 112–114. https://doi.org/10.1176/appi.ps.201600440

Díaz Guerrero, R. (1971). La enseñanza de la investigación en psicología en lberoamérica: Un paradigma. *Revista Latinoamericana de Psicología*, *3*(1), 5–36.

Díaz-Loving, R., Reyes-Lagunes, I., & Díaz-Guerrero, R. (1995). Some cultural facilitators and deterrents for the development of psychology: The role of graduate research training. *International Journal of Psychology*, *30*(6), 681–692.

Domenech Rodríguez, M. M., Baumann, A. A., & Schwartz, A. L. (2011). Cultural adaptation of an evidence based intervention: From theory to practice in a Latino/a community context. *American Journal of Community Psychology*, *47*(1–2), 170–186. https://doi.org/10.1007/s10464-010-9371-4

Duncan, W. (2015). Gendered trauma and its effects: Domestic violence and PTSD in Oaxaca. In *Culture and PTSD: trauma in global and historical perspective* (pp. 202–239). Philadelphia: University of Pennsylvania Press.

Duncan, W. (2017). Psicoeducación in the land of magical thoughts: Culture and mental-health practice in a changing Oaxaca. *American Ethnologist*, *44*(1), 36–51. https://doi.org/10.1111/amet.12424

Ecks, S. (2011). Polyspherical pharmaceuticals. Global psychiatry, capitalism, and space. In *Pharmaceutical self: The global shaping of experience in an age of psychopharmacology*. (pp. 97–116). Santa Fe, New Mexico: School for Advanced Research Press.

Ensink, K., & Robertson, B. (1999). Patient and family experiences of psychiatric services and African indigenous healers. *Transcultural Psychiatry*, *36*(1), 23–43.

Eroza, E., & Gordillo, G. del C. Á. (2008). Narrativas del padecimiento" mental": arenas de debate en torno a prácticas sociales ya los valores que las sustentan entre los mayas tzotziles y tzeltales del sur de México. *Revista de Antropología Social*, (17), 377–410.

Esparza Meza, E. M., & Blum Grynberg, B. (2009). Evaluación del programa para optimizar la formación del psicólogo clínico. *Revista de La Educación Superior*, *38*(152), 97–112.

Fischer, A. R., Jome, L. M., & Atkinson, D. R. (1998). Reconceptualizing Multicultural Counseling: Universal healing conditions in a culturally specific context. *The Counseling Psychologist*, *26*(4), 525–588.

Ford-Paz, R. E., Reinhard, C., Kuebbeler, A., Contreras, R., & Sánchez, B. (2015). Culturally tailored depression/suicide prevention in Latino youth: Community perspectives. *The Journal of Behavioral Health Services & Research*, *42*(4), 519–533. https://doi.org/10.1007/s11414-013-9368-5

Frank, J. D., & Frank, J. (1991). *Persuasion and healing: A comparative study of psychotherapy* (6th ed.). Baltimore: Johns Hopkins University Press.

Freire, P. (1970). Pedagogy of the oppressed. New York: Herder and Herder.

Frenk, J. (2006). Bridging the divide: global lessons from evidence-based health policy in Mexico. *The Lancet*, *368*(9539), 954–961.

Fromm-Reichmann, F. (1948). Notes on the development of treatment of schizophrenics by psychoanalytic psychotherapy. *Psychiatry*, *11*(3), 263–273.

Garza, Y., & Watts, R. E. (2010). Filial therapy and Hispanic values: Common ground for culturally sensitive helping. *Journal of Counseling & Development*, *88*(1), 108–113.

Gómez-de-Regil, L. (2014). Causal attribution and illness Perception: A cross-sectional study in Mexican patients with psychosis. *The Scientific World Journal*, *2014*, 1–7. https://doi.org/10.1155/2014/969867

Good, B. J. (1996). Culture and DSM-IV: Diagnosis, knowledge and power. *Culture, Medicine and Psychiatry*, *20*(2), 127–132.

Gregg, J., & Saha, S. (2006). Losing culture on the way to competence: the use and misuse of culture in medical education. *Academic Medicine*, *81*(6), 542–547.

Guarnaccia, P. J., Parka, P., Deschamps, A., Milstein, G., & Argiles, N. (1992a). Si Dios quiere: Hispanic families' experiences of caring for a seriously mentally ill family member. *Culture, Medicine and Psychiatry*, *16*(2), 187–215.

Guo, M., Li, S., Liu, J., & Sun, F. (2015). Family relations, social connections, and mental health among Latino and Asian older adults. *Research on Aging*, *37*(2), 123–147. https://doi.org/10.1177/0164027514523298

Hackethal, V., Spiegel, S., Lewis-Fernández, R., Kealey, E., Salerno, A., & Finnerty, M. (2013). Towards a cultural adaptation of family psychoeducation: Findings from three Latino focus groups. *Community Mental Health Journal*, *49*(5), 587–598. https://doi.org/10.1007/s10597-012-9559-1

Hale, K. L. (2017). Family life and social medicine: Discourses and discontents surrounding Puebla's psychiatric care. *Culture, Medicine, and Psychiatry*, *41*(4), 499–540. https://doi.org/10.1007/s11013-017-9539-6

Heilemann, M. V., Coffey-Love, M., & Frutos, L. (2004). Perceived reasons for depression among low income women of Mexican descent. *Archives of Psychiatric Nursing*, *18*(5), 185–192. https://doi.org/10.1016/j.apnu.2004.07.006

Heinze, G., Chapa, G. del C., & Carmona-Huerta, J. (2016). Los especialistas en psiquiatría en México: año 2016. *Salud Mental*, *39*(2), 69–76. https://doi.org/10.17711/SM.0185-3325.2016.003

Hocutt, M. (1974). Aristotle's four becauses. *Philosophy*, *49*(190), 385–399.

Homedes, N., & Ugalde, A. (2009). Twenty-five years of convoluted health reforms in Mexico. *PLoS Medicine*, *6*(8), e1000124. https://doi.org/10.1371/journal.pmed.1000124

Hook, J. N., & Watkins Jr., C. E. (2015). Cultural humility: The cornerstone of positive contact with culturally different individuals and groups? *American Psychologist*, *70*(7), 661–662. https://doi.org/10.1037/0003-066X.52.5.569.b

Huey, S. J., Tilley, J. L., Jones, E. O., & Smith, C. A. (2014). The contribution of cultural competence to evidence-based care for ethnically diverse populations. *Annual Review of Clinical Psychology*, *10*(1), 305–338. https://doi.org/10.1146/annurev-clinpsy-032813-153729

IEMS-OMS. (2011). *Informe Sobre Sistema de Salud Mental en México*. México, D.F.: Secretaria de Salud Mexicana, Organización Panamericana de Salud, Organización Mundial de Salud.

Jani, J. S., Ortiz, L., & Aranda, M. P. (2008). Latino outcome studies in social work: A review of the literature. *Research on Social Work Practice*, *19*(2), 179–194. https://doi.org/10.1177/1049731508315974

Juan López, M., Durán Fontes, L. R., & Hernández Torres, F. (2012). *La calidad de la atención a la salud en México a través de sus instituciones: 12 años de experiencia*. Secretaría de Salud: D.F., México.

Kalibatseva, Z., & Leong, F. T. L. (2014). A critical review of culturally sensitive treatments for depression: Recommendations for intervention and research. *Psychological Services*, *11*(4), 433–450. https://doi.org/10.1037/a0036047

Katz, A. M., & Alegría, M. (2009). The clinical encounter as local moral world: Shifts of assumptions and transformation in relational context. *Social Science & Medicine*, *68*(7), 1238–1246. https://doi.org/10.1016/j.socscimed.2009.01.009

Killeen, P. R. (2001). The four causes of behavior. *Current Directions in Psychological Science*, *10*(4), 136–140.

Kirmayer, L. J. (1998). The Fate of Culture in DSM—IV. *Transcultural Psychiatry*, *35*, 3.

Kirmayer, L. J. (2000). Broken narratives: Clinical encounters and the poetics of illness experiences. In *Narrative and the cultural construction of illness and healing*. (pp. 153–180). Berkeley: University of California Press.

Kirmayer, L. J. (2005). Culture, Context and Experience in Psychiatric Diagnosis. *Psychopathology*, *38*(4), 192–196. https://doi.org/10.1159/000086090

Kirmayer, L. J. (2007). Psychotherapy and the Cultural Concept of the Person. *Transcultural Psychiatry*, *44*(2), 232–257. https://doi.org/10.1177/1363461506070794

Kirmayer, L. J., & Pedersen, D. (2014). Toward a new architecture for global mental health. *Transcultural Psychiatry*, *51*(6), 759–776. https://doi.org/10.1177/1363461514557202

Kirmayer, L. J., Thombs, B. D., Jurcik, T., Jarvis, G. E., & Guzder, J. (2008). Use of an expanded version of the DSM-IV Outline for Cultural Formulation on a cultural consultation service. *Psychiatric Services*, *59*(6).

Kleinman, A. (1988a). *Illness narratives. Suffering, healing and the human condition*. USA: Basic Books.

Kleinman, A. (1988b). *Rethinking Psychiatry. From cultural category to personal experience*. New York, N.Y.: The Free Press, A Division of Macmillan, Inc.

Kleinman, A. (2001). Why psychiatry and cultural anthropology still need each other. *Psychiatry*, *64*(1), 14–16.

Kleinman, A., Eisenberg, L., & Good, B. (2006). Culture, illness, and care: clinical lessons from anthropologic and cross-cultural research. *Annals of Internal Medicine*, *88*(2), 251–258.

Knaul, F. M., González-Pier, E., Gómez-Dantés, O., García-Junco, D., Arreola-Ornelas, H., Barraza-Lloréns, M., Sandoval, R., Caballero, F., Hernández-Avila, M., Mercedes, J., Kershenobich, D., Nigenda, G., Ruelas, E., Sepúlveda, J., Tapia, R., Soberón, G., Chertorivski, S. & Frenk, J. (2012). The quest for universal health coverage: achieving social protection for all in Mexico. *The Lancet*, *380*(9849), 1259–1279.

Kohn-Wood, L., & Hooper, L. (2014). Cultural competency, culturally tailored care, and the primary care setting: Possible solutions to reduce racial/ethnic disparities in mental health care. *Journal of Mental Health Counseling*, *36*(2), 173–188.

Kools, S., & Chimwaza, A. (2015). Cultural humility and working with marginalized populations in developing countries. *Global Health Promotion*, *22*(1), 52–59.

Lara, M. A., Navarro, C., Rubí, N. A., & Mondragón, L. (2003). Outcome results of two levels of intervention in low-income women with depressive symptoms. *American Journal of Orthopsychiatry*, *73*(1), 35–43. doi: 10.1037/0002-9432.73.1.35

Lara Muñoz, M. del C., Fouilloux, C., Arévalo Ramírez, M. del C., & Santiago Ventura, Y. (2011). ¿Cuántos somos? ¿Dónde estamos? ¿Dónde debemos estar? El papel del psiquiatra en México. Análisis preliminar. *Salud Mental*, *34*(6), 531–536.

Lara-Muñoz, M. C., Robles-García, R., Orozco, R., Real, T., Chisholm, D., & Medina-Mora, M. E. (2010). Estudio de costo-efectividad del tratamiento de la depresión en México. *Salud Mental, 33*(4), 301-308.

Laurell, A. C. (2007). Health system reform in Mexico: a critical review. *International Journal of Health Services*, *37*(3), 515–535.

Laurell, A. C. (2010a). An Overview of Latin American Health Policies and Debates. *Social Medicine*, *5*(1), 50–57.

Laurell, A. C. (2010b). El Seguro Popular... ¿Una garantía de acceso universal a la salud?, 177–190.

La Roche, M. J., Fuentes, M. A., & Hinton, D. (2015). A cultural examination of the DSM-5: Research and clinical implications for cultural minorities. *Professional Psychology: Research and Practice*, *46*(3), 183–189. https://doi.org/10.1037/a0039278

Lefley, H. P. (1985). Families of the mentally ill in cross-cultural perspective. *Psychosocial Rehabilitation Journal*, *8*(4), 57.

Letamendi, A. M., Ayers, C. R., Ruberg, J. L., Singley, D. B., Wilson, J., Chavira, D., … Wetherell, J. L. (2013). Illness conceptualizations among older rural Mexican-Americans with anxiety and depression. *Journal of Cross-Cultural Gerontology*, *28*(4), 421–433. https://doi.org/10.1007/s10823-013-9211-8

Levenson, H. (2010). *Brief Dynamic Therapy*. Washington D.C.: American Psychological Association.

Lewis-Fernández, R. (2009). Editorial: The Cultural Formulation. *Transcultural Psychiatry*, *46*(3), 379–382. https://doi.org/10.1177/1363461509342519

Lewis-Fernández, R., Aggarwal, N. K., Lam, P. C., Galfalvy, H., Weiss, M. G., Kirmayer, L. J., Paralikar, V., Deshpande, S. N., Díaz, E., Nicasio, A. V., Boiler, M., Alarcón, R. D., Rohlof, H., Groen, S., van Dijk, R. C. J., Jadhav, S., Sarmukaddam, S., Ndetei, D., Scalco, M. Z., Bassiri, K., Aguilar-Gaxiola, S., Ton, H., Westermeyer, K., & Vega-Dienstmaier, J. M. (2017). Feasibility, acceptability and clinical utility of the Cultural Formulation Interview: Mixed-methods results from the DSM-5 international field trial. *British Journal of Psychiatry*, *210*(04), 290–297. https://doi.org/10.1192/bjp.bp.116.193862

Lewis-Fernández, R., & Díaz, N. (2002). The Cultural Formulation: a method for assessing cultural factors affecting the clinical encounter. *Psychiatric Quarterly*, *73*(4), 271–295.

Logan, S., & Hunt, C. (2014). Considerations for clinicians when working cross-culturally: A review. *Cross-Cultural Communication*, *10*(5), 12–20.

López, S. R., & Guarnaccia, P. J. (2000). Cultural psychopathology: Uncovering the social world of mental illness. *Annual Review of Psychology*, *51*(1), 571–598.

López, S. R., Lara, M. del C., Kopelowicz, A., Solano, S., Foncerrada, H., & Aguilera, A. (2009). La CLAve to increase psychosis literacy of Spanish-speaking community residents and family caregivers. *Journal of Consulting and Clinical Psychology*, *77*(4), 763–774. https://doi.org/10.1037/a0016031

López, S. R., Nelson Hipke, K., Polo, A. J., Jenkins, J. H., Karno, M., Vaughn, C., & Snyder, K. S. (2004). Ethnicity, expressed emotion, attributions, and course of schizophrenia: Family warmth matters. *Journal of Abnormal Psychology*, *113*(3), 428–439. https://doi.org/10.1037/0021-843X.113.3.428

Marquez, J. A., & Ramírez García, J. I. (2011). Family caregivers' monitoring of medication usage: A qualitative study of Mexican-origin families with serious mental illness. *Culture, Medicine, and Psychiatry*, *35*(1), 63–82. https://doi.org/10.1007/s11013-010-9198-3

Marquez, J. A., & Ramírez García, J. I. (2013). Family caregivers' narratives of mental health treatment usage processes by their Latino adult relatives with serious and persistent mental illness. *Journal of Family Psychology*, *27*(3), 398–408. https://doi.org/10.1037/a0032868

Marshall, M. N. (1996). Sampling for qualitative research. *Family Practice*, *13*(6), 522–526.

Martinez Jr, C. R., & Eddy, J. M. (2005). Effects of culturally adapted parent management training on Latino youth behavioral health outcomes. *Journal of Consulting and Clinical Psychology*, *73*(5), 841.

Martínez Pincay, I. E., & Guarnaccia, P. J. (2006). "It's like going through an earthquake": Anthropological perspectives on depression among Latino immigrants. *Journal of Immigrant and Minority Health*, *9*(1), 17–28. https://doi.org/10.1007/s10903-006-9011-0

Martinez Tyson, D., Arriola, N. B., & Corvin, J. (2016). Perceptions of depression and access to mental health care among latino immigrants: looking beyond one size fits all. *Qualitative Health Research*, *26*(9), 1289–1302.

Martinez Tyson, D., Castañeda, H., Porter, M., Quiroz, M., & Carrion, I. (2011). More similar than different? Exploring cultural models of depression among Latino immigrants in Florida. *Depression Research and Treatment*, *2011*, 1–11. https://doi.org/10.1155/2011/564396

Maupin, J. N., & Ross, N. (2012). Expectations of similarity and cultural difference in conceptual models of illness: A comparison of medical staff and Mexican migrants. *Human Organization*, *71*(3), 306–316.

McCullough, L., Kuhn, N., Andrews, S., Kaplan, A., Wolf, J., & Lanza Hurley, C. (2003). *Treating Affect Phobia. A manual for short-term dynamic psychotherapy*. New York, N.Y.: Guilford Publications, Inc.

Medina-Mora, M. E., Borges, G., Muñiz, C. L., Benjet, C., & Jaimes, J. B. (2003). Resultados de la encuesta nacional de epidemiología psiquiátrica en México. *Salud Mental*, *26*(4), 1.

Medina-Mora, M. E., Rascon, M. L., Tapia, R., Mariño, M. C., Villatoro, J., Caraveo, J., Gomez, M. (1992). Trastornos emocionales en población urbana mexicana: Resultados de un Estudio Nacional. *Anales. Instituto Mexicano de Psiquiatría*. 48-55.

Metzl, J. M., & Hansen, H. (2014). Structural competency: Theorizing a new medical engagement with stigma and inequality. *Social Science & Medicine*, *103*, 126–133. https://doi.org/10.1016/j.socscimed.2013.06.032

Mezzich, J. E., Caracci, G., Fabrega, H., & Kirmayer, L. J. (2009). Cultural Formulation guidelines. *Transcultural Psychiatry*, *46*(3), 383–405. https://doi.org/10.1177/1363461509342942

Miville, M. L., Changming Duan, Nutt, R. L., Waehler, C. A., Suzuki, L., Pistole, M. C., Arredondo, P., Duffy, M., Mejia, B. X., & Corpus, M. (2008). Integrating practice guidelines into professional training: Implications for diversity competence. *The Counseling Psychologist*, *37*(4), 519–563. https://doi.org/10.1177/0011000008323651

Molina, R. L., & Palazuelos, D. (2014). Navigating and circumventing a fragmented health system: The patient's pathway in the Sierra Madre region of Chiapas, Mexico: Health care Navigation in Chiapas, Mexico. *Medical Anthropology Quarterly*, *28*(1), 23–43. https://doi.org/10.1111/maq.12071

Montiel, A. L. V. (2016). Counseling Supervision in Mexico: A Professional Activity under Progress. *Multidisciplinary Health Research, 1*(2), 4.

Mora-Ríos, J., & Bautista, N. (2014). Estigma estructural, género e interseccionalidad. Implicaciones en la atención a la salud mental. *Salud Mental*, *37*(4), 302. https://doi.org/10.17711/SM.0185-3325.2014.035

Morris, M. W., Chiu, C., & Liu, Z. (2015). Polycultural psychology. *Annual Review of Psychology*, *66*(1), 631–659. https://doi.org/10.1146/annurev-psych-010814-015001

National Association of Social Workers (2015). Standards and indicators for cultural competence in social work practice. Washington, DC: Author.

Neill, J. (1990). Whatever became of the schizophrenogenic mother? *American Journal of Pscyhotherapy*, *44*(4), 499–505.

Nichter, M. (2010). Idioms of distress revisited. *Culture, Medicine, and Psychiatry*, *34*(2), 401–416. https://doi.org/10.1007/s11013-010-9179-6

ojalehto, bethany l., & Medin, D. L. (2015). Perspectives on culture and concepts. *Annual Review of Psychology*, *66*(1), 249–275. https://doi.org/10.1146/annurev-psych-010814-015120

Owen, J., Jordan II, T. A., Turner, D., Davis, D. E., Hook, J. N., & Leach, M. M. (2014). Therapists' multicultural orientation: Client perceptions of cultural humility, spiritual/religious commitment, and therapy Outcomes, *42*(1), 91–98.

Owen, J., Leach, M. M., Wampold, B., & Rodolfa, E. (2011). Client and therapist variability in clients' perceptions of their therapists' multicultural competencies. *Journal of Counseling Psychology*, *58*(1), 1–9. https://doi.org/10.1037/a0021496

Palmer, C. S., Brunner, E., Ruíz-Flores, L. G., Paez-Agraz, F., & Revicki, D. A. (2002). A cost-effectiveness clinical decision analysis model for treatment of schizophrenia. *Archives of Medical Research*, *33*(6), 572–580. doi: 10.1016/S0188-4409(02)00409-5

Palomino Garibay, L. (2012). La psicología comunitaria: Una experiencia de vida. *Revista Electrónica de Psicología Iztacalca*, *15*(1), 263–281.

Pavón-Cuéllar, D. (2013). La psicología mesoamericana: ideas psicológicas, psicopatológicas y psicoterapéuticas en las culturas maya, purépecha y azteca. *Memorandum, 5,* 93-111.

Pearce, S., & Pickard, H. (2010). Finding the will to recover: philosophical perspectives on agency and the sick role. *Journal of Medical Ethics*, *36*(12), 831–833.

Pedersen, P. B. (2003). Increasing the cultural awareness, knowledge, and skills of culture-centered counselors. In F.D. Harper, & J. McFadden (Eds.), *Culture and counseling: new approaches* (31-46). USA: Pearson.

Pérez Álvarez, M. (2009). The four causes of behavior: Aristotle and Skinner. *International Journal of Psychology and Psychological Therapy*, *9*(1).

Portal, E. L., Suck, A. T., & Hinkle, J. S. (2010). Counseling in Mexico: History, current identity, and future trends. *Journal of Counseling & Development*, *88*(1), 33–37.

Ramírez Stege, A. M. & Yarris, K. (2017). Cultura in *La Clínica*: Evaluating the utility of the Cultural Formulation Interview (CFI) in a Mexican outpatient setting. *Transcultural Psychiatry, 54*(4) 466–487, doi: 10.1177/1363461517716051

Ratts, M. J., Singh, A. A., Nassar-McMillan, S., Butler, S. K., & McCullough, J. R. (2016). Multicultural and social justice counseling competencies: Guidelines for the counseling profession. Journal of Multicultural Counseling and Development, 44(1), 28–48.

Reyes Cruz, M., & Sonn, C. C. (2011). (De)colonizing culture in community Psychology: Reflections from critical social science. *American Journal of Community Psychology*, *47*(1–2), 203–214. https://doi.org/10.1007/s10464-010-9378-x

Robles-García, R., Fresán, A., Berlanga, C., & Martínez, N. (2013). Mental illness recognition and beliefs about adequate treatment of a patient with schizophrenia: Association with gender and perception of aggressiveness-dangerousness in a community sample of Mexico City. *International Journal of Social Psychiatry*, *59*(8), 811–818.

Sabogal, F., Marín, G., Otero-Sabogal, R., VanOss Marín, B., & Perez-Stable, E. J. (1987). Hispanic familism and acculturation: What changes and what doesn't? *Hispanic Journal of Behavioral Sciences*, *9*(4), 397–412.

Sanchez-Sosa, J. J. (2007). Psychotherapy in Mexico: Practice, training, and regulation. *Journal of Clinical Psychology*, *63*(8), 765–771. https://doi.org/10.1002/jclp.20391

Sandelowski, M., Voils, C. I., & Knafl, G. (2009). On quantitizing. *Journal of Mixed Methods Research*, *3*(3), 208–222. https://doi.org/10.1177/1558689809334210

Santiago-Irizarry, V. (1996). Culture as cure. *Cultural Anthropology*, *11*(1), 3–24.

Santiago-Rivera, A. L., Kanter, J. W., Busch, A. M., Rusch, L. C., Reyes, W., West, P., & Runge, M. (2011). Latino immigrants with depression: An initial examination of treatment issues at a community clinic. *Journal of Immigrant and Minority Health*, *13*(4), 772–779. https://doi.org/10.1007/s10903-010-9380-2

Secretaría de Salud (2018). *Sistema INDICAS*. Retrieved from: http://dgces.salud.gob.mx/INDICASII/index2.php

Segall, A. (1976). The sick role concept: Understanding illness behavior. *Journal of Health and Social Behavior*, *17*(2), 162. https://doi.org/10.2307/2136342

Smith, S. D., & Ng, K.-M. (2009). International counseling trainees' experiences and perceptions of their multicultural counseling training in the United States: A mixed method inquiry. *International Journal for the Advancement of Counselling*, *31*(4), 271–285. https://doi.org/10.1007/s10447-009-9083-3

Stern, S., Doolan, M., Staples, E., Szmukler, G. L., & Eisler, I. (1999). Disruption and reconstruction: Narrative insights into the experience of family members caring for a relative diagnosed with serious mental illness. *Family Process*, *38*(3), 353–369. https://doi.org/10.1111/j.1545-5300.1999.00353.x

Sue, S., Zane, N., Nagayama Hall, G. C., & Berger, L. K. (2009). The case for cultural competency in psychotherapeutic interventions. *Annual Review of Psychology*, *60*(1), 525–548. https://doi.org/10.1146/annurev.psych.60.110707.163651

Tamez González, S., & Valle Arcos, R. I. (2005). Desigualdad social y reforma neoliberal en salud. *Revista Mexicana de Sociología*, *67*(2), 321–356.

Tao, K. W., Owen, J., Pace, B. T., & Imel, Z. E. (2015). A meta-analysis of multicultural competencies and psychotherapy process and outcome. *Journal of Counseling Psychology*, *62*(3), 337–350. https://doi.org/10.1037/cou0000086

Teyber, E., & Teyber, F. (2017). *Interpersonal Process in therapy: An integrative model*. (Fifth). Boston, MA: Cengage Learning.

Toporek, R. L., & Reza, J.V. (2001). Context as a critical dimension of multicultural counseling: Articulating personal, professional and institutional competence. *Journal of Multicultural Counseling and Development, 29,* 13-30.

Valdez, C. R., Abegglen, J., & Hauser, C. T. (2013). Fortalezas Familiares program: Building sociocultural and family strengths in Latina women with depression and their Families. *Family Process*, *52*(3), 378–393. https://doi.org/10.1111/famp.12008

Valdez, C. R., Padilla, B., Moore, S. M., & Magaña, S. (2013). Feasibility, acceptability, and preliminary outcomes of the Fortalezas Familiares intervention for Latino families facing maternal depression. *Family Process*, *52*(3), 394–410. https://doi.org/10.1111/famp.12033

Valdez, C. R., Ramírez Stege, A., Martinez, E., D'Costa, S., & Chavez, T. (2017). A community-responsive adaptation to reach and engage Latino families affected by maternal depression. *Family Process*. https://doi.org/10.1111/famp.12310

Vallejo Samudio, Á. R. (2006). Medicina indígena y salud mental. *Acta Colombiana de Psicología*, *9*(2), 39–46.

Vargas, S. M., Cabassa, L. J., Nicasio, A., De La Cruz, A. A., Jackson, E., Rosario, M., Guarnaccia, P. J., & Lewis-Fernandez, R. (2015). Toward a cultural adaptation of pharmacotherapy: Latino views of depression and antidepressant therapy. *Transcultural Psychiatry*, *52*(2), 244–273. https://doi.org/10.1177/1363461515574159

Villaseñor Bayardo, S. J. (2008). *Apuntes para una etnopsiquiatría mexicana*. Guadalajara, Jalisco, México: Universidad de Guadalajara.

Waitzkin, H., Getrich, C., Heying, S., Rodríguez, L., Parmar, A., Willging, C., Yager, J., & Santos, R. (2011). *Promotoras* as mental health practitioners in primary care: A multi-method study of an intervention to address contextual sources of depression. *Journal of Community Health*, *36*(2), 316–331. https://doi.org/10.1007/s10900-010-9313-y

Wampold, B. E. (2001). Contextualizing psychotherapy as a healing practice: Culture, history, and methods. *Applied & Preventive Psychology*, *10*, 69–86.

Wampold, B. E. (2007). Psychotherapy: The humanistic (and effective) treatment. *American Psychologist*, 857–873.

Wampold, B. E., & Imel, Z. E. (2015). *The great psychotherapy debate. The evidence for what makes psychotherapy work*. (Second). New York, N.Y.: Routledge.

Weisman, A. G., Gomes, L. G., & López, S. R. (2003). Shifting blame away from ill relatives: Latino families' reactions to schizophrenia. *The Journal of Nervous and Mental Disease*, *191*(9), 574–581. https://doi.org/10.1097/01.nmd.0000087183.90174.a8

Wendt, D. C., Gone, J. P., & Nagata, D. K. (2015). Potentially harmful therapy and multicultural counseling bridging two disciplinary discourses. *The Counseling Psychologist*, *43*(3), 334–358.

Winston, C. N., & Maher, H. (2015). Beyond the confines of culture: Reflections of two non-American psychologists. *American Psychologist*, *70*(7), 659–660. https://doi.org/10.1037/a0038954

Wood, J. J., Chiu, A. W., Hwang, W.-C., Jacobs, J., & Ifekwunigwe, M. (2008). Adapting cognitive-behavioral therapy for Mexican American students with anxiety disorders: Recommendations for school psychologists. *School Psychology Quarterly*, *23*(4), 515–532. https://doi.org/10.1037/1045-3830.23.4.515

World Health Organization (2001). Mental health. A call for action by World Health Ministers. *Ministerial Roundtables 54th World Health Assembly*. Retrieved from: http://www.who.int/mental_health/media/en/249.pdf?ua=1

World Health Organization (2011). Mental Health Atlas 2011. United States of America. Retrieved from: http://www.who.int/mental_health/evidence/atlas/profiles/usa_mh_profile.pdf?ua=1

World Health Organization (2017). Scalable psychological interventions for people in communities affected by adversity: A new area of mental health and psychosocial work at WHO. Retrieved from: http://www.who.int/mental_health/management/scalable_psychological_interventions/en/

Worthington, R. L., Soth-McNett, A. M., & Moreno, M. V. (2007). Multicultural counseling competencies research: A 20-year content analysis. *Journal of Counseling Psychology*, *54*(4), 351–361. https://doi.org/10.1037/0022-0167.54.4.351

Yarris, K. E., & Ponting, C. (2017). *Moral matters: Schizophrenia and masculinity in Mexico*. Manuscript submitted for publication.

Yasui, M. (2015). The Cultural Ecogram: A tool for enhancing culturally anchored shared understanding in the treatment of ethnic minority families. *Journal of Ethnic And Cultural Diversity in Social Work*, *24*(2), 89–108. https://doi.org/10.1080/15313204.2014.991980

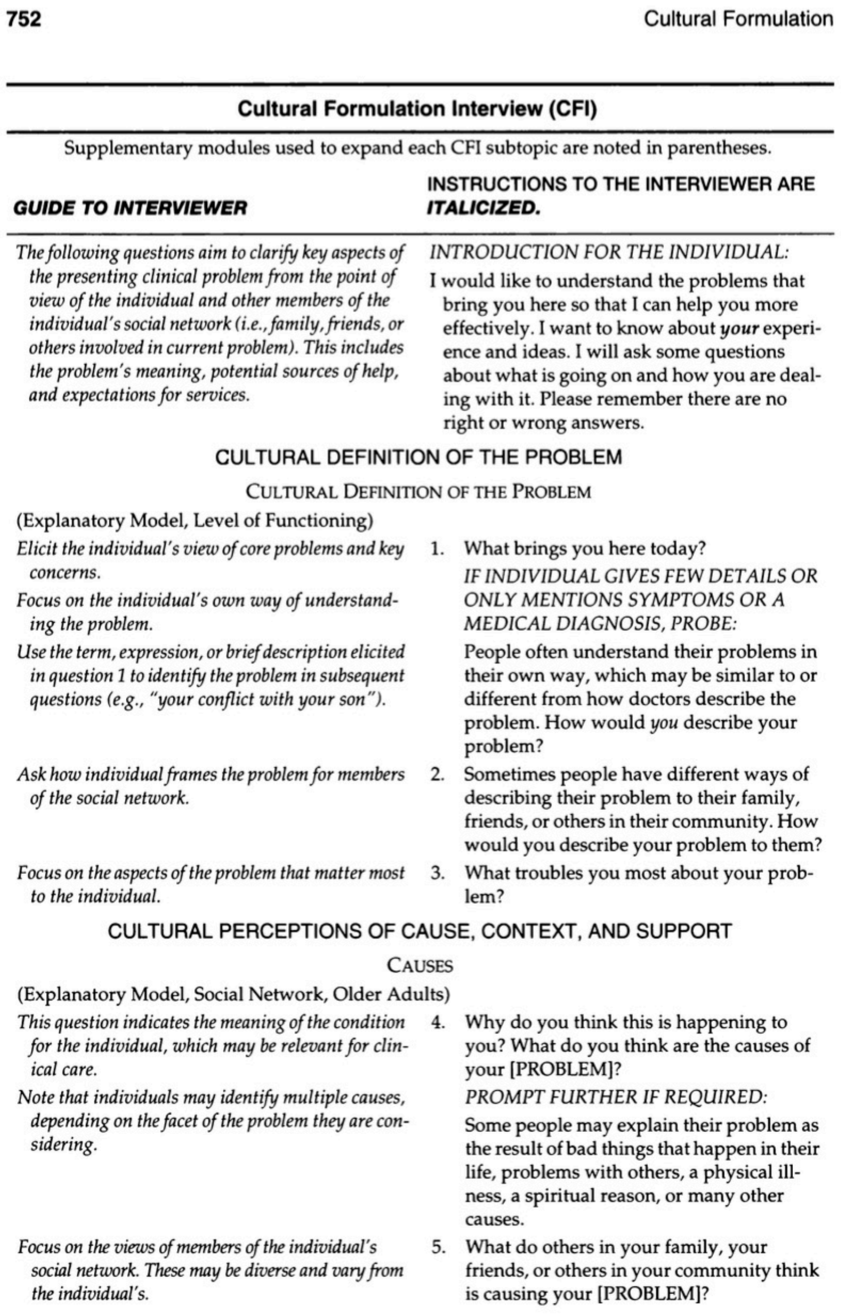
Yonge, K. A. (1965). Towards an integration of psychodynamic and physiological concepts. *Canadian Psychiatric Association Journal*, *10*(4), 236–243.

Young, A. (1982). The anthropologies of illness and sickness. *Annual Review of Anthropology*, *11*, 257–285.

Zacharias, S. (2006). Mexican *curanderismo* as ethnopsychotherapy: A qualitative study on treatment practices, effectiveness, and mechanisms of change. *International Journal of Disability, Development and Education*, *53*(4), 381–400. https://doi.org/10.1080/10349120601008522

# Appendix A

## CFI English patient version



### Cultural Formulation Interview (CFI)

Supplementary modules used to expand each CFI subtopic are noted in parentheses.

| ***GUIDE TO INTERVIEWER*** | **INSTRUCTIONS TO THE INTERVIEWER ARE *ITALICIZED.*** |
|---|---|
| *The following questions aim to clarify key aspects of the presenting clinical problem from the point of view of the individual and other members of the individual's social network (i.e., family, friends, or others involved in current problem). This includes the problem's meaning, potential sources of help, and expectations for services.* | *INTRODUCTION FOR THE INDIVIDUAL:*<br>I would like to understand the problems that bring you here so that I can help you more effectively. I want to know about ***your*** experience and ideas. I will ask some questions about what is going on and how you are dealing with it. Please remember there are no right or wrong answers. |

#### CULTURAL DEFINITION OF THE PROBLEM

##### CULTURAL DEFINITION OF THE PROBLEM

(Explanatory Model, Level of Functioning)

| | |
|---|---|
| *Elicit the individual's view of core problems and key concerns.*<br>*Focus on the individual's own way of understanding the problem.*<br>*Use the term, expression, or brief description elicited in question 1 to identify the problem in subsequent questions (e.g., "your conflict with your son").* | 1. What brings you here today?<br>*IF INDIVIDUAL GIVES FEW DETAILS OR ONLY MENTIONS SYMPTOMS OR A MEDICAL DIAGNOSIS, PROBE:*<br>People often understand their problems in their own way, which may be similar to or different from how doctors describe the problem. How would *you* describe your problem? |
| *Ask how individual frames the problem for members of the social network.* | 2. Sometimes people have different ways of describing their problem to their family, friends, or others in their community. How would you describe your problem to them? |
| *Focus on the aspects of the problem that matter most to the individual.* | 3. What troubles you most about your problem? |

#### CULTURAL PERCEPTIONS OF CAUSE, CONTEXT, AND SUPPORT

##### CAUSES

(Explanatory Model, Social Network, Older Adults)

| | |
|---|---|
| *This question indicates the meaning of the condition for the individual, which may be relevant for clinical care.*<br>*Note that individuals may identify multiple causes, depending on the facet of the problem they are considering.* | 4. Why do you think this is happening to you? What do you think are the causes of your [PROBLEM]?<br>*PROMPT FURTHER IF REQUIRED:*<br>Some people may explain their problem as the result of bad things that happen in their life, problems with others, a physical illness, a spiritual reason, or many other causes. |
| *Focus on the views of members of the individual's social network. These may be diverse and vary from the individual's.* | 5. What do others in your family, your friends, or others in your community think is causing your [PROBLEM]? |

### Cultural Formulation Interview (CFI) *(continued)*

Supplementary modules used to expand each CFI subtopic are noted in parentheses.

| ***GUIDE TO INTERVIEWER*** | **INSTRUCTIONS TO THE INTERVIEWER ARE *ITALICIZED.*** |
|---|---|
| STRESSORS AND SUPPORTS | |
| (Social Network, Caregivers, Psychosocial Stressors, Religion and Spirituality, Immigrants and Refugees, Cultural Identity, Older Adults, Coping and Help Seeking) | |
| *Elicit information on the individual's life context, focusing on resources, social supports, and resilience. May also probe other supports (e.g., from coworkers, from participation in religion or spirituality).* | 6. Are there any kinds of support that make your [PROBLEM] better, such as support from family, friends, or others? |
| *Focus on stressful aspects of the individual's environment. Can also probe, e.g., relationship problems, difficulties at work or school, or discrimination.* | 7. Are there any kinds of stresses that make your [PROBLEM] worse, such as difficulties with money, or family problems? |
| ROLE OF CULTURAL IDENTITY | |
| (Cultural Identity, Psychosocial Stressors, Religion and Spirituality, Immigrants and Refugees, Older Adults, Children and Adolescents) | |
| | Sometimes, aspects of people's background or identity can make their [PROBLEM] better or worse. By ***background*** or ***identity,*** I mean, for example, the communities you belong to, the languages you speak, where you or your family are from, your race or ethnic background, your gender or sexual orientation, or your faith or religion. |
| *Ask the individual to reflect on the most salient elements of his or her cultural identity. Use this information to tailor questions 9–10 as needed.* | 8. For you, what are the most important aspects of your background or identity? |
| *Elicit aspects of identity that make the problem better or worse.*<br>*Probe as needed (e.g., clinical worsening as a result of discrimination due to migration status, race/ethnicity, or sexual orientation).* | 9. Are there any aspects of your background or identity that make a difference to your [PROBLEM]? |
| *Probe as needed (e.g., migration-related problems; conflict across generations or due to gender roles).* | 10. Are there any aspects of your background or identity that are causing other concerns or difficulties for you? |
| **CULTURAL FACTORS AFFECTING SELF-COPING AND PAST HELP SEEKING** | |
| SELF-COPING | |
| (Coping and Help Seeking, Religion and Spirituality, Older Adults, Caregivers, Psychosocial Stressors) | |
| *Clarify self-coping for the problem.* | 11. Sometimes people have various ways of dealing with problems like [PROBLEM]. What have you done on your own to cope with your [PROBLEM]? |

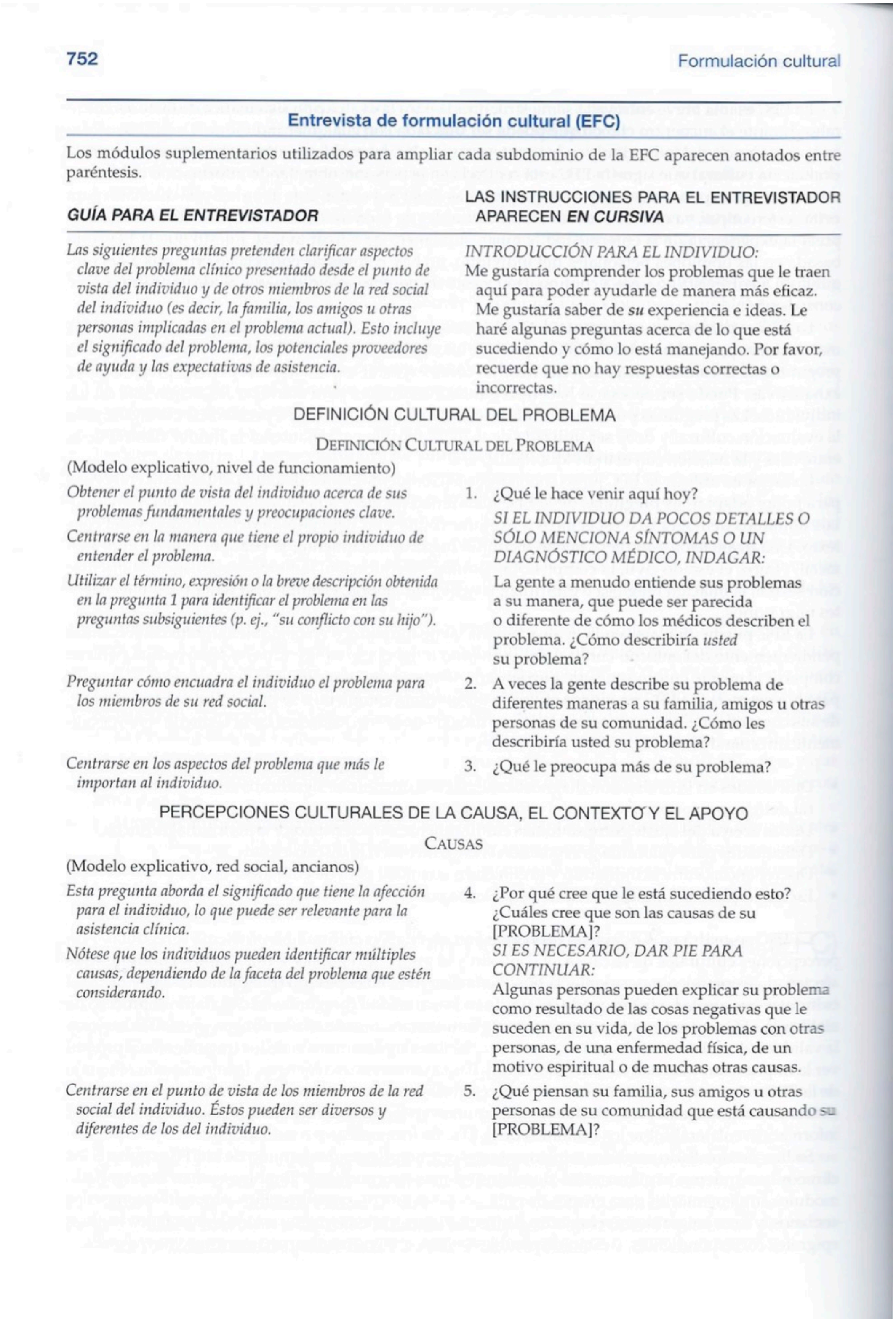
## Cultural Formulation Interview (CFI) *(continued)*

Supplementary modules used to expand each CFI subtopic are noted in parentheses.

| ***GUIDE TO INTERVIEWER*** | **INSTRUCTIONS TO THE INTERVIEWER ARE *ITALICIZED.*** |
|---|---|
| PAST HELP SEEKING | |
| (Coping and Help Seeking, Religion and Spirituality, Older Adults, Caregivers, Psychosocial Stressors, Immigrants and Refugees, Social Network, Clinician-Patient Relationship) | |
| *Elicit various sources of help (e.g., medical care, mental health treatment, support groups, work-based counseling, folk healing, religious or spiritual counseling, other forms of traditional or alternative healing).*<br>*Probe as needed (e.g., "What other sources of help have you used?").*<br>*Clarify the individual's experience and regard for previous help.* | 12. Often, people look for help from many different sources, including different kinds of doctors, helpers, or healers. In the past, what kinds of treatment, help, advice, or healing have you sought for your [PROBLEM]?<br>*PROBE IF DOES NOT DESCRIBE USEFULNESS OF HELP RECEIVED:*<br>What types of help or treatment were most useful? Not useful? |
| BARRIERS | |
| (Coping and Help Seeking, Religion and Spirituality, Older Adults, Psychosocial Stressors, Immigrants and Refugees, Social Network, Clinician-Patient Relationship) | |
| *Clarify the role of social barriers to help seeking, access to care, and problems engaging in previous treatment.*<br>*Probe details as needed (e.g., "What got in the way?").* | 13. Has anything prevented you from getting the help you need?<br>*PROBE AS NEEDED:*<br>For example, money, work or family commitments, stigma or discrimination, or lack of services that understand your language or background? |
| **CULTURAL FACTORS AFFECTING CURRENT HELP SEEKING** | |
| PREFERENCES | |
| (Social Network, Caregivers, Religion and Spirituality, Older Adults, Coping and Help Seeking) | |
| *Clarify individual's current perceived needs and expectations of help, broadly defined.* | Now let's talk some more about the help you need. |
| *Probe if individual lists only one source of help (e.g., "What other kinds of help would be useful to you at this time?").* | 14. What kinds of help do you think would be most useful to you at this time for your [PROBLEM]? |
| *Focus on the views of the social network regarding help seeking.* | 15. Are there other kinds of help that your family, friends, or other people have suggested would be helpful for you now? |
| CLINICIAN-PATIENT RELATIONSHIP | |
| (Clinician-Patient Relationship, Older Adults) | |
| *Elicit possible concerns about the clinic or the clinician-patient relationship, including perceived racism, language barriers, or cultural differences that may undermine goodwill, communication, or care delivery.*<br>*Probe details as needed (e.g., "In what way?").*<br>*Address possible barriers to care or concerns about the clinic and the clinician-patient relationship raised previously.* | Sometimes doctors and patients misunderstand each other because they come from different backgrounds or have different expectations.<br>16. Have you been concerned about this and is there anything that we can do to provide you with the care you need? |

# Appendix B

## CFI Spanish patient version



### Entrevista de formulación cultural (EFC)

Los módulos suplementarios utilizados para ampliar cada subdominio de la EFC aparecen anotados entre paréntesis.

| ***GUÍA PARA EL ENTREVISTADOR*** | LAS INSTRUCCIONES PARA EL ENTREVISTADOR APARECEN ***EN CURSIVA*** |
|---|---|
| *Las siguientes preguntas pretenden clarificar aspectos clave del problema clínico presentado desde el punto de vista del individuo y de otros miembros de la red social del individuo (es decir, la familia, los amigos u otras personas implicadas en el problema actual). Esto incluye el significado del problema, los potenciales proveedores de ayuda y las expectativas de asistencia.* | *INTRODUCCIÓN PARA EL INDIVIDUO:*<br>Me gustaría comprender los problemas que le traen aquí para poder ayudarle de manera más eficaz. Me gustaría saber de ***su*** experiencia e ideas. Le haré algunas preguntas acerca de lo que está sucediendo y cómo lo está manejando. Por favor, recuerde que no hay respuestas correctas o incorrectas. |

#### DEFINICIÓN CULTURAL DEL PROBLEMA

##### DEFINICIÓN CULTURAL DEL PROBLEMA

(Modelo explicativo, nivel de funcionamiento)

| | |
|---|---|
| *Obtener el punto de vista del individuo acerca de sus problemas fundamentales y preocupaciones clave.*<br>*Centrarse en la manera que tiene el propio individuo de entender el problema.*<br>*Utilizar el término, expresión o la breve descripción obtenida en la pregunta 1 para identificar el problema en las preguntas subsiguientes (p. ej., "su conflicto con su hijo").* | 1. ¿Qué le hace venir aquí hoy?<br>*SI EL INDIVIDUO DA POCOS DETALLES O SÓLO MENCIONA SÍNTOMAS O UN DIAGNÓSTICO MÉDICO, INDAGAR:*<br>La gente a menudo entiende sus problemas a su manera, que puede ser parecida o diferente de cómo los médicos describen el problema. ¿Cómo describiría *usted* su problema? |
| *Preguntar cómo encuadra el individuo el problema para los miembros de su red social.* | 2. A veces la gente describe su problema de diferentes maneras a su familia, amigos u otras personas de su comunidad. ¿Cómo les describiría usted su problema? |
| *Centrarse en los aspectos del problema que más le importan al individuo.* | 3. ¿Qué le preocupa más de su problema? |

#### PERCEPCIONES CULTURALES DE LA CAUSA, EL CONTEXTO Y EL APOYO

##### CAUSAS

(Modelo explicativo, red social, ancianos)

| | |
|---|---|
| *Esta pregunta aborda el significado que tiene la afección para el individuo, lo que puede ser relevante para la asistencia clínica.*<br>*Nótese que los individuos pueden identificar múltiples causas, dependiendo de la faceta del problema que estén considerando.* | 4. ¿Por qué cree que le está sucediendo esto? ¿Cuáles cree que son las causas de su [PROBLEMA]?<br>*SI ES NECESARIO, DAR PIE PARA CONTINUAR:*<br>Algunas personas pueden explicar su problema como resultado de las cosas negativas que le suceden en su vida, de los problemas con otras personas, de una enfermedad física, de un motivo espiritual o de muchas otras causas. |
| *Centrarse en el punto de vista de los miembros de la red social del individuo. Éstos pueden ser diversos y diferentes de los del individuo.* | 5. ¿Qué piensan su familia, sus amigos u otras personas de su comunidad que está causando su [PROBLEMA]? |

## Entrevista de formulación cultural (EFC) *(continuación)*

Los módulos suplementarios utilizados para ampliar cada subdominio de la EFC aparecen anotados entre paréntesis.

| ***GUÍA PARA EL ENTREVISTADOR*** | **LAS INSTRUCCIONES PARA EL ENTREVISTADOR APARECEN *EN CURSIVA*** |
|---|---|

### Factores de Estrés y de Apoyo

(Red social, cuidadores, factores de estrés psicosocial, religión y espiritualidad, inmigrantes y refugiados, identidad cultural, ancianos, afrontamiento y búsqueda de ayuda

| | |
|---|---|
| *Obtener información acerca del contexto vital del individuo, centrándose en los recursos, los apoyos sociales y la resiliencia. También se puede indagar acerca de otros apoyos (p. ej., de compañeros de trabajo, de la participación religiosa o espiritual).* | 6. ¿Hay algún tipo de apoyo que mejore su [PROBLEMA], como el apoyo de la familia, los amigos u otros? |
| *Centrarse en los aspectos estresantes del entorno del individuo. También se puede indagar acerca de, p. ej., los problemas de relación, las dificultades en el trabajo o el colegio, o la discriminación.* | 7. ¿Hay algún tipo de estrés que empeore su [PROBLEMA], como las dificultades económicas o los problemas familiares? |

### Papel de la Identidad Cultural

(Identidad cultural, factores de estrés psicosocial, religión y espiritualidad, inmigrantes y refugiados, ancianos, niños y adolescentes)

| | |
|---|---|
| | A veces hay aspectos del contexto o la identidad de las personas que pueden mejorar o empeorar su [PROBLEMA]. Por ***contexto*** o ***identidad*** me refiero, por ejemplo, a las comunidades a las que pertenece, los idiomas que habla, los lugares de los que proceden usted o su familia, su raza u origen étnico, su género u orientación sexual, o su fe o religión. |
| *Pedir al individuo que haga una reflexión sobre los elementos más destacados de su identidad cultural. Utilizar esta información para adaptar las preguntas 9-10 según sea necesario.* | 8. Para usted, ¿cuáles son los aspectos más importantes de su contexto o identidad? |
| *Obtener información acerca de aspectos de la identidad cultural que mejoran o empeoran el problema.*<br>*Indagar según sea necesario (p. ej., un empeoramiento clínico como resultado de la discriminación debida a la condición de inmigrante, la raza/etnia o la orientación sexual).* | 9. ¿Hay algún aspecto de su contexto o identidad que suponga una diferencia para su [PROBLEMA]? |
| *Indagar según sea necesario (p. ej., los problemas relacionados con la emigración, conflictos intergeneracionales o debidos a los roles de género).* | 10. ¿Hay algún aspecto de su contexto o identidad que le esté causando otras preocupaciones o dificultades? |

## FACTORES CULTURALES QUE AFECTAN AL AFRONTAMIENTO PERSONAL Y LA BÚSQUEDA DE AYUDA EN EL PASADO

### Afrontamiento Personal

(Afrontamiento y búsqueda de ayuda, religión y espiritualidad, ancianos, cuidadores, factores de estrés psicosocial)

| | |
|---|---|
| *Clarificar el afrontamiento personal del problema.* | 11. A veces las personas tienen maneras diferentes de afrontar los problemas como [PROBLEMA]. ¿Qué ha hecho usted por sí mismo para afrontar su [PROBLEMA]? |

## Entrevista de formulación cultural (EFC) *(continuación)*

Los módulos suplementarios utilizados para ampliar cada subdominio de la EFC aparecen anotados entre paréntesis.

### BÚSQUEDA DE AYUDA EN EL PASADO

(Afrontamiento y búsqueda de ayuda, religión y espiritualidad, ancianos, cuidadores, factores de estrés psicosocial, inmigrantes y refugiados, red social, relación clínico-paciente)

| ***GUÍA PARA EL ENTREVISTADOR*** | **LAS INSTRUCCIONES PARA EL ENTREVISTADOR APARECEN *EN CURSIVA*** |
|---|---|
| *Obtener información acerca de diferentes fuentes de ayuda (p. ej., asistencia médica, tratamiento de salud mental, grupos de apoyo, asesoramiento laboral, curandería, asesoramiento religioso o espiritual, otras formas de sanación tradicional o alternativa).* | 12. A menudo las personas buscan ayuda de muchas fuentes diferentes, incluyendo distintos tipos de médicos, asistentes o sanadores. En el pasado, ¿qué tipos de tratamiento, ayuda, consejos o sanaciones ha buscado para su [PROBLEMA]? |
| *Indagar según sea necesario (p. ej., "¿Qué otras fuentes de ayuda ha utilizado?").* | *SI NO DESCRIBE LA UTILIDAD DE LA AYUDA RECIBIDA, INDAGAR:* |
| *Clarificar la experiencia y opinión del individuo acerca de la ayuda previa.* | ¿Qué tipos de ayuda o tratamiento le resultaron más útiles? ¿Cuáles no resultaron útiles? |

### OBSTÁCULOS

(Afrontamiento y búsqueda de ayuda, religión y espiritualidad, ancianos, factores de estrés psicosocial, inmigrantes y refugiados, red social, relación clínico-paciente)

| | |
|---|---|
| *Clarificar el papel de las barreras sociales para buscar ayuda, acceder a la asistencia, y en los problemas para implicarse en tratamientos previos.* | 13. ¿Hay algo que haya evitado que obtenga la ayuda que necesita?<br>*INDAGAR SEGÚN SEA NECESARIO:* |
| *Indagar acerca de los detalles según sea necesario (p. ej., "¿Qué obstáculos encontró?").* | Por ejemplo, ¿el dinero, los compromisos laborales o familiares, el estigma o la discriminación, o la ausencia de servicios que comprendan su idioma o contexto? |

## FACTORES CULTURALES QUE AFECTAN A LA BÚSQUEDA DE AYUDA EN LA ACTUALIDAD

### PREFERENCIAS

(Red social, cuidadores, religión y espiritualidad, ancianos, afrontamiento y búsqueda de ayuda)

| | |
|---|---|
| *Clarificar las necesidades actuales percibidas por el individuo y sus expectativas de ayuda, en términos generales.* | Ahora hablemos un poco más sobre la ayuda que necesita. |
| *Si el individuo únicamente menciona una fuente de ayuda, seguir indagando (p. ej., "¿Qué otros tipos de ayuda le resultarían útiles en este momento?").* | 14. ¿Qué tipos de ayuda cree que le resultarían más útiles en este momento para su [PROBLEMA]? |
| *Centrarse en el punto de vista que tiene la red social en relación a la búsqueda de ayuda.* | 15. ¿Hay otros tipos de ayuda que su familia, amigos, u otras personas le han sugerido que le ayudarían en este momento? |

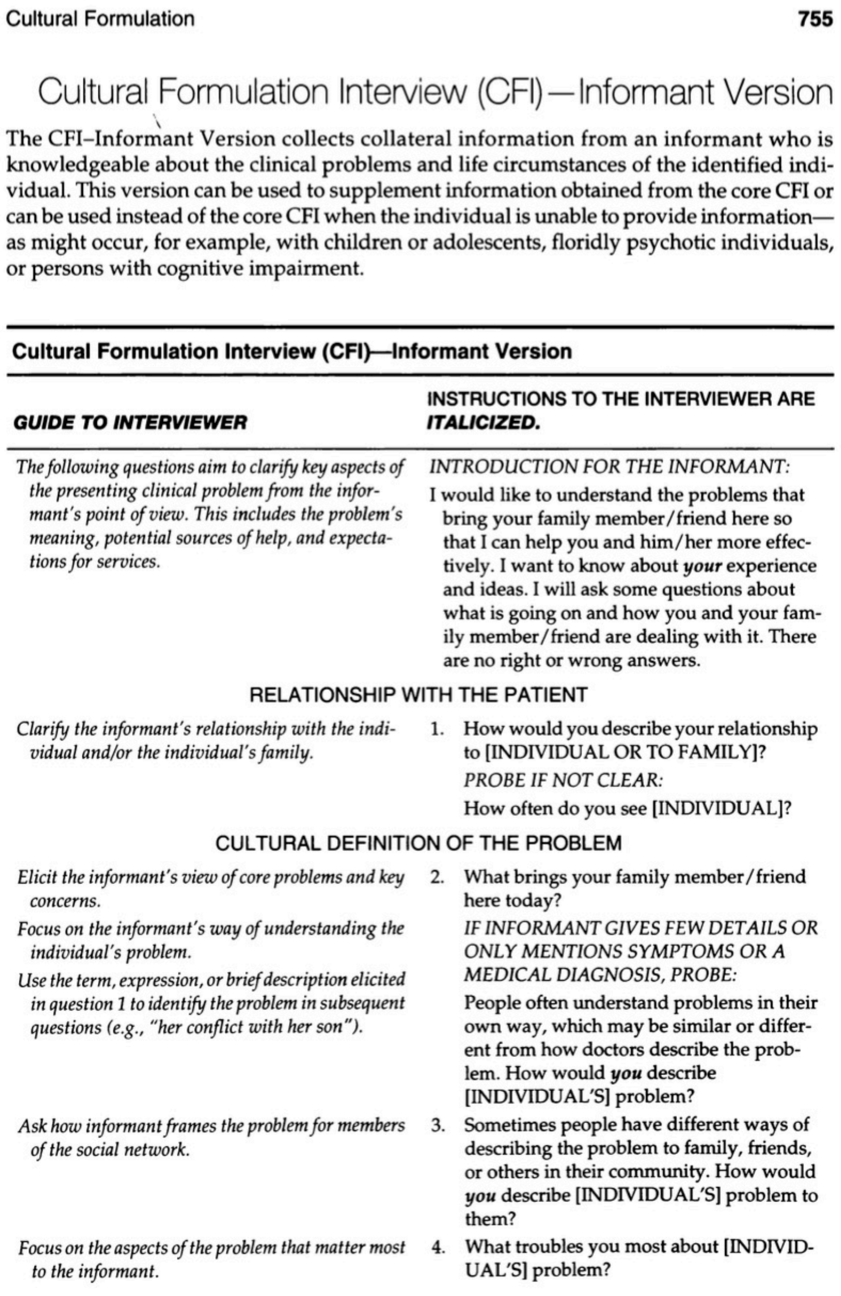
### RELACIÓN CLÍNICO-PACIENTE

(Relación clínico-paciente, ancianos)

| | |
|---|---|
| *Recoger las posibles preocupaciones acerca de la clínica o la relación clínico-paciente, incluyendo el racismo percibido, las barreras lingüísticas, o las diferencias culturales que pueden minar la buena voluntad, la comunicación o la provisión de asistencia.* | A veces los médicos y los pacientes no se entienden bien porque provienen de contextos diferentes o tienen expectativas distintas. |
| *Indagar acerca de los detalles según sea necesario (p. ej., "¿De qué manera?").* | 16. ¿Ha estado usted preocupado por esto, y hay algo que podamos hacer para proporcionarle la asistencia que necesita? |
| *Abordar las posibles barreras a la asistencia o las preocupaciones acerca de la clínica y la relación clínico-paciente que surgieron anteriormente).* | |

# Appendix C

## CFI English informant version



### Cultural Formulation Interview (CFI)—Informant Version

The CFI–Informant Version collects collateral information from an informant who is knowledgeable about the clinical problems and life circumstances of the identified individual. This version can be used to supplement information obtained from the core CFI or can be used instead of the core CFI when the individual is unable to provide information—as might occur, for example, with children or adolescents, floridly psychotic individuals, or persons with cognitive impairment.

**Cultural Formulation Interview (CFI)—Informant Version**

| ***GUIDE TO INTERVIEWER*** | **INSTRUCTIONS TO THE INTERVIEWER ARE *ITALICIZED.*** |
|---|---|
| *The following questions aim to clarify key aspects of the presenting clinical problem from the informant's point of view. This includes the problem's meaning, potential sources of help, and expectations for services.* | *INTRODUCTION FOR THE INFORMANT:*<br>I would like to understand the problems that bring your family member/friend here so that I can help you and him/her more effectively. I want to know about ***your*** experience and ideas. I will ask some questions about what is going on and how you and your family member/friend are dealing with it. There are no right or wrong answers. |
| **RELATIONSHIP WITH THE PATIENT** | |
| *Clarify the informant's relationship with the individual and/or the individual's family.* | 1. How would you describe your relationship to [INDIVIDUAL OR TO FAMILY]?<br>*PROBE IF NOT CLEAR:*<br>How often do you see [INDIVIDUAL]? |
| **CULTURAL DEFINITION OF THE PROBLEM** | |
| *Elicit the informant's view of core problems and key concerns.*<br>*Focus on the informant's way of understanding the individual's problem.*<br>*Use the term, expression, or brief description elicited in question 1 to identify the problem in subsequent questions (e.g., "her conflict with her son").* | 2. What brings your family member/friend here today?<br>*IF INFORMANT GIVES FEW DETAILS OR ONLY MENTIONS SYMPTOMS OR A MEDICAL DIAGNOSIS, PROBE:*<br>People often understand problems in their own way, which may be similar or different from how doctors describe the problem. How would ***you*** describe [INDIVIDUAL'S] problem? |
| *Ask how informant frames the problem for members of the social network.* | 3. Sometimes people have different ways of describing the problem to family, friends, or others in their community. How would ***you*** describe [INDIVIDUAL'S] problem to them? |
| *Focus on the aspects of the problem that matter most to the informant.* | 4. What troubles you most about [INDIVIDUAL'S] problem? |

## Cultural Formulation Interview (CFI)—Informant Version *(continued)*

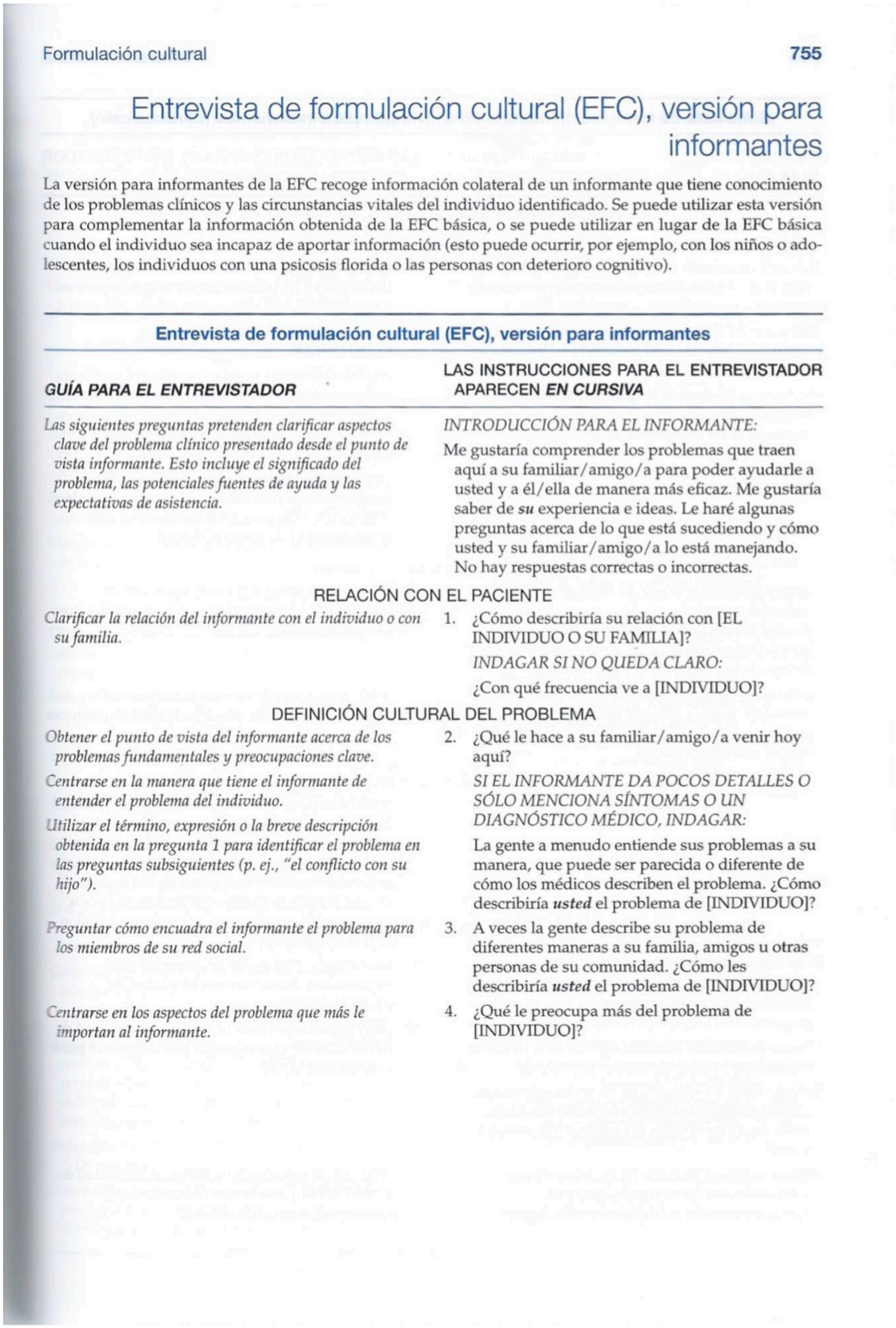
| ***GUIDE TO INTERVIEWER*** | **INSTRUCTIONS TO THE INTERVIEWER ARE *ITALICIZED.*** |
|---|---|
| **CULTURAL PERCEPTIONS OF CAUSE, CONTEXT, AND SUPPORT** | |
| **CAUSES** | |
| *This question indicates the meaning of the condition for the informant, which may be relevant for clinical care.* | 5. Why do you think this is happening to [INDIVIDUAL]? What do you think are the causes of his/her [PROBLEM]? |
| *Note that informants may identify multiple causes depending on the facet of the problem they are considering.* | *PROMPT FURTHER IF REQUIRED:*<br>Some people may explain the problem as the result of bad things that happen in their life, problems with others, a physical illness, a spiritual reason, or many other causes. |
| *Focus on the views of members of the individual's social network. These may be diverse and vary from the informant's.* | 6. What do others in [INDIVIDUAL'S] family, his/her friends, or others in the community think is causing [INDIVIDUAL'S] [PROBLEM]? |
| **STRESSORS AND SUPPORTS** | |
| *Elicit information on the individual's life context, focusing on resources, social supports, and resilience. May also probe other supports (e.g., from coworkers, from participation in religion or spirituality).* | 7. Are there any kinds of supports that make his/her [PROBLEM] better, such as from family, friends, or others? |
| *Focus on stressful aspects of the individual's environment. Can also probe, e.g., relationship problems, difficulties at work or school, or discrimination.* | 8. Are there any kinds of stresses that make his/her [PROBLEM] worse, such as difficulties with money, or family problems? |
| **ROLE OF CULTURAL IDENTITY** | |
| | Sometimes, aspects of people's background or identity can make the [PROBLEM] better or worse. By ***background*** or ***identity,*** I mean, for example, the communities you belong to, the languages you speak, where you or your family are from, your race or ethnic background, your gender or sexual orientation, and your faith or religion. |
| *Ask the informant to reflect on the most salient elements of the individual's cultural identity. Use this information to tailor questions 10–11 as needed.* | 9. For you, what are the most important aspects of [INDIVIDUAL'S] background or identity? |
| *Elicit aspects of identity that make the problem better or worse.*<br>*Probe as needed (e.g., clinical worsening as a result of discrimination due to migration status, race/ethnicity, or sexual orientation).* | 10. Are there any aspects of [INDIVIDUAL'S] background or identity that make a difference to his/her [PROBLEM]? |
| *Probe as needed (e.g., migration-related problems; conflict across generations or due to gender roles).* | 11. Are there any aspects of [INDIVIDUAL'S] background or identity that are causing other concerns or difficulties for him/her? |

### Cultural Formulation Interview (CFI)—Informant Version *(continued)*

| ***GUIDE TO INTERVIEWER*** | **INSTRUCTIONS TO THE INTERVIEWER ARE *ITALICIZED.*** |
|---|---|
| **CULTURAL FACTORS AFFECTING SELF-COPING AND PAST HELP SEEKING** | |
| SELF-COPING | |
| *Clarify individual's self-coping for the problem.* | 12. Sometimes people have various ways of dealing with problems like [PROBLEM]. What has [INDIVIDUAL] done on his/her own to cope with his/her [PROBLEM]? |
| PAST HELP SEEKING | |
| *Elicit various sources of help (e.g., medical care, mental health treatment, support groups, work-based counseling, folk healing, religious or spiritual counseling, other alternative healing).*<br>*Probe as needed (e.g., "What other sources of help has he/she used?").*<br>*Clarify the individual's experience and regard for previous help.* | 13. Often, people also look for help from many different sources, including different kinds of doctors, helpers, or healers. In the past, what kinds of treatment, help, advice, or healing has [INDIVIDUAL] sought for his/her [PROBLEM]?<br>*PROBE IF DOES NOT DESCRIBE USEFULNESS OF HELP RECEIVED:*<br>What types of help or treatment were most useful? Not useful? |
| BARRIERS | |
| *Clarify the role of social barriers to help-seeking, access to care, and problems engaging in previous treatment.* | 14. Has anything prevented [INDIVIDUAL] from getting the help he/she needs? |
| *Probe details as needed (e.g., "What got in the way?").* | *PROBE AS NEEDED:*<br>For example, money, work or family commitments, stigma or discrimination, or lack of services that understand his/her language or background? |
| **CULTURAL FACTORS AFFECTING CURRENT HELP SEEKING** | |
| PREFERENCES | |
| *Clarify individual's current perceived needs and expectations of help, broadly defined, from the point of view of the informant.*<br>*Probe if informant lists only one source of help (e.g., "What other kinds of help would be useful to [INDIVIDUAL] at this time?").* | Now let's talk about the help [INDIVIDUAL] needs.<br>15. What kinds of help would be most useful to him/her at this time for his/her [PROBLEM]? |
| *Focus on the views of the social network regarding help seeking.* | 16. Are there other kinds of help that [INDIVIDUAL'S] family, friends, or other people have suggested would be helpful for him/her now? |
| CLINICIAN-PATIENT RELATIONSHIP | |
| *Elicit possible concerns about the clinic or the clinician-patient relationship, including perceived racism, language barriers, or cultural differences that may undermine goodwill, communication, or care delivery.*<br>*Probe details as needed (e.g., "In what way?").*<br>*Address possible barriers to care or concerns about the clinic and the clinician-patient relationship raised previously.* | Sometimes doctors and patients misunderstand each other because they come from different backgrounds or have different expectations.<br>17. Have you been concerned about this, and is there anything that we can do to provide [INDIVIDUAL] with the care he/she needs? |

# Appendix D

## CFI Spanish informant version



# Entrevista de formulación cultural (EFC), versión para informantes

La versión para informantes de la EFC recoge información colateral de un informante que tiene conocimiento de los problemas clínicos y las circunstancias vitales del individuo identificado. Se puede utilizar esta versión para complementar la información obtenida de la EFC básica, o se puede utilizar en lugar de la EFC básica cuando el individuo sea incapaz de aportar información (esto puede ocurrir, por ejemplo, con los niños o adolescentes, los individuos con una psicosis florida o las personas con deterioro cognitivo).

### Entrevista de formulación cultural (EFC), versión para informantes

| ***GUÍA PARA EL ENTREVISTADOR*** | **LAS INSTRUCCIONES PARA EL ENTREVISTADOR APARECEN *EN CURSIVA*** |
|---|---|
| *Las siguientes preguntas pretenden clarificar aspectos clave del problema clínico presentado desde el punto de vista informante. Esto incluye el significado del problema, las potenciales fuentes de ayuda y las expectativas de asistencia.* | *INTRODUCCIÓN PARA EL INFORMANTE:*<br>Me gustaría comprender los problemas que traen aquí a su familiar/amigo/a para poder ayudarle a usted y a él/ella de manera más eficaz. Me gustaría saber de ***su*** experiencia e ideas. Le haré algunas preguntas acerca de lo que está sucediendo y cómo usted y su familiar/amigo/a lo está manejando. No hay respuestas correctas o incorrectas. |
| **RELACIÓN CON EL PACIENTE** | |
| *Clarificar la relación del informante con el individuo o con su familia.* | 1. ¿Cómo describiría su relación con [EL INDIVIDUO O SU FAMILIA]?<br>*INDAGAR SI NO QUEDA CLARO:*<br>¿Con qué frecuencia ve a [INDIVIDUO]? |
| **DEFINICIÓN CULTURAL DEL PROBLEMA** | |
| *Obtener el punto de vista del informante acerca de los problemas fundamentales y preocupaciones clave.*<br>*Centrarse en la manera que tiene el informante de entender el problema del individuo.*<br>*Utilizar el término, expresión o la breve descripción obtenida en la pregunta 1 para identificar el problema en las preguntas subsiguientes (p. ej., "el conflicto con su hijo").* | 2. ¿Qué le hace a su familiar/amigo/a venir hoy aquí?<br>*SI EL INFORMANTE DA POCOS DETALLES O SÓLO MENCIONA SÍNTOMAS O UN DIAGNÓSTICO MÉDICO, INDAGAR:*<br>La gente a menudo entiende sus problemas a su manera, que puede ser parecida o diferente de cómo los médicos describen el problema. ¿Cómo describiría ***usted*** el problema de [INDIVIDUO]? |
| *Preguntar cómo encuadra el informante el problema para los miembros de su red social.* | 3. A veces la gente describe su problema de diferentes maneras a su familia, amigos u otras personas de su comunidad. ¿Cómo les describiría ***usted*** el problema de [INDIVIDUO]? |
| *Centrarse en los aspectos del problema que más le importan al informante.* | 4. ¿Qué le preocupa más del problema de [INDIVIDUO]? |

## Entrevista de formulación cultural (EFC), versión para informantes *(continuación)*

| ***GUÍA PARA EL ENTREVISTADOR*** | LAS INSTRUCCIONES PARA EL ENTREVISTADOR APARECEN ***EN CURSIVA*** |
|---|---|
| PERCEPCIONES CULTURALES DE LA CAUSA, EL CONTEXTO Y EL APOYO | |
| CAUSAS | |
| *Esta pregunta aborda el significado que tiene la afección para el informante, lo que puede ser relevante para la asistencia clínica.* | 5. ¿Por qué cree que le está sucediendo esto a [INDIVIDUO]? ¿Cuáles cree que son las causas de su [PROBLEMA]? |
| *Nótese que los informantes pueden identificar múltiples causas, dependiendo de la faceta del problema que estén considerando.* | *SI ES NECESARIO, DAR PIE PARA CONTINUAR:* |
| *Centrarse en el punto de vista de los miembros de la red social del individuo. Éstos pueden ser diversos y diferentes de los del informante.* | Algunas personas pueden explicar el problema como resultado de las cosas negativas que suceden en su vida, los problemas con otras personas, una enfermedad física, un motivo espiritual o de muchas otras causas. |
| | 6. ¿Qué piensan otras personas de la familia, amigos u otros miembros de la comunidad de [INDIVIDUO] que está causando el [PROBLEMA] de [INDIVIDUO]? |
| FACTORES DE ESTRÉS Y DE APOYO | |
| *Obtener información acerca del contexto vital del individuo, centrándose en los recursos, los apoyos sociales y la resiliencia. También se puede indagar acerca de otros apoyos (p. ej., de compañeros de trabajo, de la participación religiosa o espiritual).* | 7. ¿Hay algún tipo de apoyo que mejore el [PROBLEMA], como el apoyo de la familia, los amigos u otros? |
| *Centrarse en los aspectos estresantes del entorno del individuo. También se puede indagar acerca de, p. ej., los problemas de relación, las dificultades en el trabajo o el colegio, o la discriminación.* | 8. ¿Hay algún tipo de estrés que empeore el [PROBLEMA], como las dificultades económicas o los problemas familiares? |
| PAPEL DE LA IDENTIDAD CULTURAL | |
| | A veces hay aspectos del contexto o la identidad de las personas que pueden mejorar o empeorar el [PROBLEMA]. Por ***contexto*** o ***identidad*** me refiero, por ejemplo, a las comunidades a las que pertenece, los idiomas que habla, los lugares de los que proceden usted o su familia, su raza u origen étnico, su género u orientación sexual, o su fe o religión. |
| *Pedir al informante que haga una reflexión sobre los elementos más destacados de la identidad cultural del individuo. Utilizar esta información para adaptar las preguntas 10-11 según sea necesario.* | 9. Para usted, ¿cuáles son los aspectos más importantes del contexto o identidad de [INDIVIDUO]? |
| *Obtener información acerca de aspectos de la identidad cultural que mejoran o empeoran el problema.*<br>*Indagar según sea necesario (p. ej., un empeoramiento clínico como resultado de la discriminación debida a la condición de inmigrante, la raza/etnia o la orientación sexual).* | 10. ¿Hay algún aspecto del contexto o identidad de [INDIVIDUO] que suponga una diferencia para su [PROBLEMA]? |
| *Indagar según sea necesario (p. ej., los problemas relacionados con la emigración, conflictos intergeneracionales o debidos a los roles de género).* | 11. ¿Hay algún aspecto del contexto o identidad de [INDIVIDUO] que le esté causando otras preocupaciones o dificultades? |

## Entrevista de formulación cultural (EFC), versión para informantes *(continuación)*

| ***GUÍA PARA EL ENTREVISTADOR*** | LAS INSTRUCCIONES PARA EL ENTREVISTADOR APARECEN ***EN CURSIVA*** |
|---|---|

### FACTORES CULTURALES QUE AFECTAN AL AFRONTAMIENTO PERSONAL Y LA BÚSQUEDA DE AYUDA EN EL PASADO

#### AFRONTAMIENTO PERSONAL

| | |
|---|---|
| *Clarificar el afrontamiento personal del problema que realiza* [INDIVIDUO]. | 12. A veces las personas tienen maneras diferentes de afrontar problemas como [PROBLEMA]. ¿Qué ha hecho [INDIVIDUO] por sí mismo para afrontar su [PROBLEMA]? |

#### BÚSQUEDA DE AYUDA EN EL PASADO

| | |
|---|---|
| *Obtener información acerca de las diferentes fuentes de ayuda (p. ej., asistencia médica, tratamiento de salud mental, grupos de apoyo, asesoramiento laboral, curandería, asesoramiento religioso o espiritual, otras formas de sanación tradicional o alternativa).*<br>*Indagar según sea necesario (p. ej., "¿Qué otras fuentes de ayuda ha utilizado?").*<br>*Clarificar la experiencia y la opinión del individuo acerca de la ayuda previa.* | 13. A menudo las personas buscan ayuda de muchas fuentes diferentes, incluyendo distintos tipos de médicos, asistentes o sanadores. En el pasado, ¿qué tipos de tratamiento, ayuda, consejos o sanaciones ha buscado [INDIVIDUO] para su [PROBLEMA]?<br>*SI NO DESCRIBE LA UTILIDAD DE LA AYUDA RECIBIDA, INDAGAR:*<br>¿Qué tipos de ayuda o tratamiento le resultaron más útiles? ¿Cuáles no resultaron útiles? |

#### OBSTÁCULOS

| | |
|---|---|
| *Clarificar el papel de las barreras sociales para buscar ayuda, acceder a la asistencia, y en los problemas para implicarse en tratamientos previos.*<br>*Indagar acerca de los detalles según sea necesario (p. ej., "¿Qué obstáculos encontró?").* | 14. ¿Hay algo que haya evitado que [INDIVIDUO] obtenga la ayuda que necesita?<br>*INDAGAR SEGÚN SEA NECESARIO:*<br>Por ejemplo, ¿el dinero, los compromisos laborales o familiares, el estigma o la discriminación, o la ausencia de servicios que comprendan su idioma o contexto? |

### FACTORES CULTURALES QUE AFECTAN A LA BÚSQUEDA DE AYUDA EN LA ACTUALIDAD

#### PREFERENCIAS

| | |
|---|---|
| *Clarificar las necesidades actuales percibidas por el individuo y sus expectativas de ayuda, en términos generales, desde el punto de vista del informante.*<br>*Si el informante únicamente menciona una fuente de ayuda, seguir indagando (p. ej., "¿Qué otros tipos de ayuda le resultarían útiles a* [INDIVIDUO] *en este momento?").*<br>*Centrarse en el punto de vista que tiene la red social en relación a la búsqueda de ayuda.* | Ahora hablemos un poco más sobre la ayuda que necesita [INDIVIDUO].<br>15. ¿Qué tipos de ayuda cree que le resultarían más útiles en este momento a [INDIVIDUO] para su [PROBLEMA]?<br>16. ¿Hay otros tipos de ayuda que la familia, amigos u otras personas le han sugerido a [INDIVIDUO] que le podrían ayudar en este momento? |

#### RELACIÓN CLÍNICO-PACIENTE

| | |
|---|---|
| *Recoger posibles preocupaciones acerca de la clínica o la relación clínico-paciente, incluyendo el racismo percibido, las barreras lingüísticas, o las diferencias culturales que pueden minar la buena voluntad, la comunicación o la provisión de asistencia.*<br>*Indagar acerca de los detalles según sea necesario (p. ej., "¿De qué manera?").*<br>*Abordar las posibles barreras a la asistencia o las preocupaciones acerca de la clínica y la relación clínico-paciente que surgieron anteriormente).* | A veces los médicos y los pacientes no se entienden bien porque provienen de contextos diferentes o tienen expectativas distintas.<br>17. ¿Ha estado usted preocupado por esto, y hay algo que podamos hacer para proporcionarle a [INDIVIDUO] la asistencia que necesita? |

# Appendix E

## CFI English provider version

### CULTURAL FORMULATION INTERVIEW PROVIDER VERSION

I would like to understand the problems that bring your patient here from ***your*** experience and ideas. I will ask you some questions about what is going with your patient and how you have or plan to deal with it. There are no right or wrong answers.

### RELATIONSHIP WITH THE PATIENT

1. How would you describe your relationship to [INDIVIDUAL]?
   How often do you see [INDIVIDUAL]?

### CULTURAL DEFINITION OF THE PROBLEM

2. What brings your patient here today?
   *PROBE:* How would you describe [INDIVIDUAL'S] problem?
3. Sometimes people have different ways of describing the problem to the patient, their families, friends or others in their community. How would you describe [INDIVIDUAL'S] problem to them?
4. What troubles you most about [INDIVIDUAL'S] problem?

### CULTURAL PERCEPTIONS OF CAUSE, CONTEXT, AND SUPPORT

#### CAUSES

5. Why do you think this is happening to [INDIVIDUAL]? What do you think are the causes of his/her [PROBLEM]?
   *PROMPT FURTHER IF REQUIRED:* If provider only gives biologically-based explanation, inquire about social/contextual factors
6. What do others in [INDIVIDUAL'S] family, his/her friends, or others in the community think is causing [INDIVIDUAL'S] [PROBLEM]?

#### STRESSORS AND SUPPORTS

7. Are there any kinds of support that make/could make his/her [PROBLEM] better, such as from family, friends, or others?
   *PROBE:* May also probe other supports (e.g. co-workers, religion, spirituality)
8. Are there any kinds of stresses that make/could make his/her [PROBLEM] worse, such as difficulties with money, or family problems?
   *PROBE*: Focus on stressful aspects of individual's environment, e.g., relationship problems, difficulties at work/school/in community, discrimination, acculturation.

#### ROLE OF CULTURAL IDENTITY

Sometimes, aspects of people's background or identity can make the [PROBLEM] better or worse. By background or identity, I mean, for example, the communities they belong to, the languages they speak, where they come from, their race or ethnic background, their gender or sexual orientation, their faith or religion.

9. For you, what are/could be the most important aspects of [INDIVIDUAL'S] background or identity?

10. Are there/could be any aspects of [INDIVIDUAL'S] background or identity that make a difference to his/her [PROBLEM]?
    *PROBE:* Are there/could be any aspects that make the problem better or worse?
11. Are there/could be any aspects of [INDIVIDUAL'S] background or identity that are causing/could cause other concerns or difficulties for him/her?

## CULTURAL FACTORS AFFECTING SELF-COPING AND PAST HELP SEEKING

### SELF-COPING

12. Sometimes people have various ways of dealing with problems like [PROBLEM]. Do you know what has [INDIVIDUAL] done on his/her own to cope with his/her [PROBLEM]?

### PAST HELP SEEKING

13. Often, people also look for help from many different sources, including different kinds of doctors, helpers, or healers. Do you know what kinds of treatment, help, advice, or healing [INDIVIDUAL] has sought for his/her [PROBLEM] in the past?
    *PROBE:* What types of help or treatment were most/could be most useful? Not useful?

### BARRIERS

14. Has anything prevented [INDIVIDUAL] from getting the help he/she needs?
    *PROBE:* For example, money, work, family commitments, stigma or discrimination, lack of services that understand his/her language or background?

## CULTURAL FACTORS AFFECTING CURRENT HELP SEEKING

### PREFERENCES

Now let's talk about the help [INDIVIDUAL] needs.

15. What kinds of help would be most useful to him/her at this time for his/her [PROBLEM]?
    *PROBE:* If provider only lists one source of help, ask: "Are there any other types of help that would be uselful?"
16. Do you know of any other kinds of help that [INDIVIDUAL'S] family, friends, or other people have suggested would be helpful for him/her now?

### CLINICIAN-PATIENT RELATIONSHIP

Sometimes doctors and patients misunderstand each other because they come from different backgrounds or have different expectations.

17. Have you been concerned about this? Have you had misunderstandings or difficulties communicating with [INDIVIDUAL]?

# Appendix F

## CFI Spanish provider version

## ENTREVISTA DE FORMULACIÓN CULTURAL VERSIÓN PROVEEDOR

Me gustaría comprender los problemas que traen aquí a su paciente desde su experiencia e ideas. Le haré algunas preguntas acerca de lo que está sucediendo y cómo usted lo está manejando o planea manejar. No hay respuestas correctas o incorrectas.

### RELACIÓN CON EL PACIENTE

1. ¿Cómo describiría su relación con [EL INDIVIDUO]?
   ¿Con qué frecuencia ve a [INDIVIDUO]?

### DEFINICIÓN CULTURAL DEL PROBLEMA

2. ¿Qué le hace a su paciente venir hoy aquí?
   *INDAGAR*: ¿Cómo describiría ***usted*** el problema de [INDIVIDUO]?
3. A veces la gente describe el problema de diferentes maneras al paciente, sus familias, amigos, u otros en su comunidad. ¿Cómo les describiría ***usted*** el problema de [INDIVIDUO]?
4. ¿Qué le preocupa más del problema de [INDIVIDUO]?

### PERCEPCIONES CULTURALES DE LA CAUSA, EL CONTEXTO Y EL APOYO

#### CAUSAS

5. ¿Por qué cree que le está sucediendo esto a [INDIVIDUO]? ¿Cuáles cree que son las causas de su [PROBLEMA]?
   *INDAGAR MÁS SI ES NECESARIO:*Si el proveedor sólo da una explicación biológica como causa de problema, pregunte acerca de los factores sociales/contextuales.
6. ¿Qué piensan otras personas de la familia, amigos, u otros miembros de la comunidad de [INDIVIDUO] que está causando el [PROBLEMA] de [INDIVIDUO]?

#### FACTORES DE ESTRÉS Y DE APOYO

7. ¿Hay algún tipo de apoyo que mejore o podría mejorar el [PROBLEMA], como el apoyo de la familia, los amigos u otros?
   *INDAGAR:* También se puede indagar acerca de otros apoyos (p. ej., de compañeros de trabajo, de la participación religiosa o espiritual).
8. ¿Hay algún tipo de estrés que empeore o podría empeorar el [PROBLEMA], como las dificultades económicas o los problemas familiares?
   *INDAGAR:* Céntrese en los aspectos estresantes del entorno del individuo, p. ej., los problemas de relación, las dificultades en el trabajo/colegio/comunidad, la discriminación, la aculturación.

#### PAPEL DE LA IDENTIDAD CULTURAL

A veces hay aspectos del contexto o la identidad de las personas que pueden mejorar o empeorar el [PROBLEMA]. Por contexto o identidad me refiero, por ejemplo, a las comunidades a las que pertenece, los idiomas que habla, los lugares de los que procede, su raza u origen étnico, su género u orientación sexual, o su fe o religión.

9. Para usted, ¿cuáles son/podrían ser los aspectos más importantes del contexto o identidad del [INDIVIDUO]?
10. ¿Hay/podría haber algún aspecto del contexto o identidad de [INDIVIDUO] que suponga/podría suponer una diferencia para su [PROBLEMA]?
    *INDAGAR*: ¿Hay/podría haber algún aspecto del problema que lo pueda/podría mejorar o empeorar?
11. ¿Hay algún aspecto del contexto o identidad de [INDIVIDUO] que le esté causando/podría causar otras preocupaciones o dificultades?

## FACTORES CULTURALES QUE AFECTAN AL AFRONTAMIENTO PERSONAL Y LA BÚSQUEDA DE AYUDA EN EL PASADO

### AFRONTAMIENTO PERSONAL

12. A veces las personas tienen maneras diferentes de afrontar problemas como [PROBLEMA]. ¿Sabe qué ha hecho [INDIVIDUO] por sí mismo para afrontar su [PROBLEMA]?

### BÚSQUEDA DE AYUDA EN EL PASADO

13. A menudo las personas buscan ayuda de muchas fuentes diferentes, incluyendo distintos tipos de médicos, asistentes o sanadores. En el pasado, ¿sabe qué tipos de tratamiento, ayuda, consejos o sanaciones ha buscado [INDIVIDUO] para su [PROBLEMA]?
    *INDAGAR:* ¿Qué tipos de ayuda o tratamiento le resultaron/podrían resultar más útiles? ¿Cuáles no resultaron/podrían resultar útiles?

### OBSTÁCULOS

14. ¿Hay algo que haya evitado que [INDIVIDUO] obtenga la ayuda que necesita?
    *INDAGAR:* Por ejemplo, ¿el dinero, los compromisos laborales o familiares, el estigma o la discriminación, o la ausencia de servicios que comprendan su idioma o contexto?

## FACTORES CULTURALES QUE AFECTAN LA BÚSQUEDA DE AYUDA EN LA ACTUALIDAD

### PREFERENCIAS

Ahora hablemos un poco más sobre la ayuda que necesita [INDIVIDUO].

15. ¿Qué tipos de ayuda cree que le resultarían más útiles en este momento a [INDIVIDUO] para su [PROBLEMA]?
    INDAGAR: Si el proveedor únicamente menciona una fuente de ayuda, pregunte: “¿Existen otros tipos de ayuda que podrían ser útiles?
16. ¿Sabe de otros tipos de ayuda que la familia, amigos u otras personas le han sugerido a [INDIVIDUO] que le podrían ayudar en este momento?

### RELACIÓN CLÍNICO-PACIENTE

A veces los médicos y los pacientes no se entienden bien porque provienen de contextos diferentes o tienen expectativas distintas.

17. ¿Esto le ha preocupado a usted? ¿Ha tenido algún malentendido o dificultades comunicándose con [INDIVIDUO]?

# Appendix G

## Demographic Information Pre-interviews

### Pre-interview Questionnaire Patient Version

1. How old are you?

2. Where do you live? How far is it to the hospital? How long does it take for you to get here? With whom do you live?

3. Who helps you take care of yourself?

4. Do you work/study?

5. How long have you been receiving outpatient treatment?

6. What is your psychiatric diagnosis?

7. When was your first contact (episode) with psychiatric services?

8. Can you tell me a bit more about what you remember about that episode?

9. Why did you come to treatment/your appointment today?

### Preguntas de Pre-entrevista Versión Paciente

1. ¿Cuántos años tienes?

2. ¿Dónde vives? ¿A qué distancia del hospital? ¿Cuánto tiempo tardas en llegar al hospital? ¿Con quién vives?

3. ¿Quién es el que más te apoya con tu auto-cuidado?

4. ¿Estudias o trabajas?

5. ¿Cuánto tiempo llevas recibiendo atención de consulta externa?

6. ¿Cuál es tu diagnóstico psiquiátrico?

7. ¿Cuándo fue tu primer episodio o contacto con servicios de psiquiatría?

8. Me puedes contar un poco más sobre lo que recuerdas de este episodio.

9. ¿Porqué viniste a tratamiento hoy?

## Pre-interview Questionnaire Caregiver Version

1. What is your relationship with the patient?

2. Are you the patient’s primary caregiver?

3. How long have you been caring/providing support for the patient?

4. Where do you live? How far is it to the hospital? How long does it take for you to get here? Do you live near the patient?

5. What is your occupation?

6. What is the patient’s psychiatric diagnosis?

7. When was their first contact (episode) with psychiatric services?

8. Can you tell me a bit more about what you remember about that episode?

9. Why did you come to treatment/your appointment today?

## Preguntas de Pre-entrevista Versión Cuidador

1. ¿Cuál es su relación con el paciente?

2. ¿Usted es el cuidador primario del paciente?

3. ¿Qué tanto tiempo ha estado cuidando/apoyando al paciente?

4. ¿Dónde vives? ¿A qué distancia del hospital? ¿Cuánto tiempo tardas en llegar al hospital? ¿Vive cerca del paciente? ¿Con quién vive?

5. ¿A qué se dedica?

6. ¿Cuál es el diagnóstico psiquiátrico del paciente?

7. ¿Cuándo fue el primer episodio o contacto con servicios de psiquiatría del paciente?

8. Me puede contar un poco más sobre lo que recuerda de este episodio.

9. ¿Porqué vino a la cita de hoy?

## Pre-interview Questionnaire Provider Version

1. How old are you?

2. Where are you from?

3. What is your academic training?

4. What is your medical specialty?

5. For how long have you been providing care to patients with [severe] mental disorders?

6. What is this patient's diagnosis and how long have you been treating him/her?

7. What is the purpose of the patient's appointment today?

## Preguntas de Pre-entrevista Versión Proveedor

1. ¿Cuántos años tienes?

2. ¿De dónde eres?

3. ¿Cuál es su formación académica?

4. ¿Qué especialidad médica tienes?

5. ¿Cuántos años has estado dando atención a pacientes con trastornos de salud mental [grave]?

6. ¿Cuál es el diagnóstico clínico de este paciente y por cuánto tiempo has dado atención a él/ella?

7. ¿Cuál fue el propósito de la cita de este paciente hoy?