

11

CULTURE AND LATINO ISSUES IN HEALTH PSYCHOLOGY

HECTOR BETANCOURT AND JOSÉ L. FUENTES

*Department of Psychology
Loma Linda University
Loma Linda, California*

Some of the main issues relevant to health psychology in the Latino population are not specific to health. These are issues relevant to the study of culture in human behavior in general, but they are particularly important in understanding health behavior in a multicultural society. First, some of the problems associated with the study of culture and ethnicity in mainstream American psychology must be considered. This is important in order to fully understand the limitations of the psychological knowledge on which health research, interventions, and policies are often based. Second, some characteristics of nondominant ethnic populations, such as intragroup diversity, socioeconomic status, and levels of acculturation, which are particularly important for Latinos in the United States, should be taken into consideration if interventions and policy decisions are to be successful.

In the first section of this chapter, we address some of the general aspects concerning the study of culture in mainstream psychology. We also address intragroup diversity in cultural background, socioeconomic status, and levels of acculturation, all of which are issues relevant to the study and practice of health psychology in general and of Latinos in particular. Then, we focus on some of the issues specific to health psychology in the Latino population. Due to space limitations, we cover only some areas, particularly those that serve to illustrate the kinds of health concerns relevant to this population as observed in the United States.

GENERAL CONSIDERATIONS

THE STUDY OF CULTURE AND ETHNICITY
IN PSYCHOLOGY

Mainstream American psychology has traditionally neglected the study of culture and cross-cultural psychology has been criticized for being rather segregated from mainstream psychology. In addition, cross-cultural research as well as the psychological study of ethnic minority issues have been criticized for neglecting theoretical and methodological developments (Betancourt & Lopez, 1993). This reality appears to be changing (Goldberger & Veroff, 1995; Peplau & Taylor, 1997). However, the current body of knowledge in psychology is still, to a large extent, ethnocentric. In many areas, the role that culture plays in understanding human behavior—including the fact that often psychological knowledge represents just one instance of how psychological processes determine behavior, within a particular cultural context—is often ignored. Hence, theories and principles seen as scientific, in fact, lack the universality that is expected of scientific laws.

This reality creates the likelihood that the knowledge on which culturally diverse health policies are based is founded, in fact, predominantly on studies of Anglo American subjects functioning within the context of an Anglo American culture. This knowledge is, to a great extent, produced by Anglo American scholars who have only lived in an Anglo American culture. Furthermore, they generally know little about other cultures and are mostly unaware of how their understanding of their subjects' behavior, as well as their own, may be, at least in part, a function of their own culture. From a scientific perspective, such knowledge, representing only one instance of psychological and behavioral functioning as observed within the context of one particular culture, ignoring the role of culture, would not be appropriate to explain health behavior issues in a multicultural society.

Within this context, it is important to note that developments in numerous areas, such as disease prevention and health promotion, are making it impossible for American psychologists to continue assuming universality when this knowledge is based on culture-specific research. Other advances, such as increased awareness of the changes in U.S. demographics, advancements in electronics and communications technology, and manifestations of a global economy, are among the factors that contribute to this new interest in a culturally diverse knowledge base. This could be the case particularly in areas such as health psychology, where psychologists may be as aware as public health professionals of the importance of culture to understanding health behavior and illness. In contrast to the "parochial" views that have characterized American psychologists, health professionals have long been dealing with the challenges of disease prevention and health promotion at the local and international levels. This has made cultural, economic, and human diversity at all levels more salient and difficult to ignore. This may serve to enhance awareness among psychologists concerning the importance of including culture in their research, theories, and interventions.

DIVERSITY OF THE LATINO POPULATION

Another aspect of general interest in the study of health issues in the Latino population is the diversity of groups included in this categorization, in terms of various aspects of their social, economic, and cultural background and reality. This within-group diversity appears to be something of which mainstream scholars and policymakers appear to have little awareness. Intragroup variations, such as those concerning culture, socioeconomic status, and access to health care and education, are often ignored in research and intervention in areas such as health promotion, education, and policymaking affecting nondominant ethnic groups. In fact, most of the demographic information often used, which has been obtained from sources such as the U.S. Federal Government, could be misleading, unless the limitations concerning within-group diversity are considered.

The study and practice of health psychology in a multicultural population necessitates the use of data concerning the intrinsic diversity of the population. The system of classification that has been employed in the United States when studying population trends is misleading in terms of the cultural characteristics not only of Latinos but also of other groups often considered homogeneous, such as Asian Americans.

In the case of Latinos, the term "Hispanic" is particularly misleading in that it is used to include people from all Spanish-speaking countries, irrespective of differences such as cultural values and beliefs, education, socioeconomic status, or level of acculturation. In fact, this is one of the inherent factors contributing to the erroneous impression of social and cultural homogeneity among Latinos of various backgrounds. The dominance of the Spanish language, which has led some to categorize all Latino Americans as "Hispanic," creates the erroneous impression that Latino people are generally homogeneous in regard to beliefs, practices, socioeconomic and educational status, and ethnic identity.

It seems that the term "Latino," more than "Hispanic," serves as a convenient reference to include all of the U.S. population that comes from the various regions and countries of Latin America. This also includes individuals whose ethnicity is rooted in the regions of the U.S. that were originally Latin American, such as California and Texas. Although Spanish is the native language for most Latino groups—which may still create the impression of homogeneity—awareness of the fact that Latinos come from many different Latin American countries and regions, which include different ethnicities, cultural traditions, socioeconomic backgrounds, and languages, make the diversity of this population more obvious. Moreover, since, from a health behavior perspective, culture and ethnicity—more than language—influence psychological processes and behavior, we propose that the use of the term "Latino" is more appropriate when addressing this population but especially in the context of psychological research and practice.

The facade homogeneity attributed to this population also ignores the fact that migrational patterns of Latinos in the United States have resulted in the forma-

tion of communities that are often overrepresented by one dominant subculture. For example, Mexican American immigrants have a strong presence in southern California and Texas, while in the greater Miami area, there is a larger contingency of Cuban American immigrants. New Jersey and New York, on the other hand, have strong contingents of Dominican and Puerto Rican immigrants.

To some extent, the concentration or dominance of one or another of the Latino groups in a particular region not only creates the impression of homogeneity at the federal but also at the state level. This impression of homogeneity at the regional level hides the diversity associated with the presence of other Latino subgroups in the same region. For instance, distinctive cultural, educational, and socioeconomic characteristics of Latinos from Puerto Rico, Cuba, Central, and South America might be ignored in the study of Latino health issues in California and the Southwest.

In regard to health data for Latinos, there are serious questions as to how valid the data are in representing the Latino populace. For example, it was not until the 1970s that the United States census separated the data from the Latino population from the data from those categorized as "White" (Hayes-Bautista, 1992). Consequently, discriminating data compiled prior to 1970 with reference to Latinos is not available. More current data from the National Center for Health Statistics (NCHS) has improved in that there is a stronger effort made to include other cultural categories under the term Hispanic. However, the problem remains that in order to apply statistical measures and analysis to this population, there is the underlying assumption that Hispanic is a valid, reliable, and measurable category in which the data are representative of all Latino groups and subcultures.

The implications of employing broad arbitrary classifications, based largely on linguistic or phenotypic characteristics, can have a profound effect on social, political, and health related policymaking decisions. Just as an example, a study conducted by Sorlie, Rogot, and Johnson (1992) found that while racial classification on death certificates and self-identification of a knowledgeable family member correlated highly (>98%) for Anglo and African Americans, discrepancies were observed in this classification with Asian, Pacific Islander, Latino, and Native Americans. If death certificates are used to report on cause of death, then it is likely that incidence rates for terminal illness, accidents, crime, and the like are inaccurate and nonrepresentative of some cultural groups, including Latinos.

ACCULTURATION

An important characteristic of the Latino and other groups experiencing a steady influx of new immigrants is the various levels and forms of acculturation observed within the corresponding population. Acculturation studies have been criticized for using indirect measures of level of acculturation instead of actually measuring the cultural variables of interest (see Betancourt & Lopez, 1993). However, if research includes the assessment of relevant cultural variables, such as health-related value orientations and beliefs, a better understanding of the cul-

tural processes that enhance or prevent positive health outcomes, such as adaptation and resiliency, may be possible (Zambrana, 1995). The study of such processes, including cultural variables and levels of acculturation, is one way in which the study of issues concerning the health behavior of Latinos (or other ethnic groups) can serve to advance the understanding of the role of culture and acculturation in health psychology in general.

In addition, the study of the process, forms, and levels of acculturation in groups such as Latinos may be as important in understanding health behavior and outcome as the direct study of cultural influences in health behavior and outcome. For example, Berry (1990) provides a model of classification that is based on varieties of acculturating groups rather than on phenotypic, linguistic, or geographic distinctions. Under this classification system, people are divided into five groups that are particularly relevant to the understanding of acculturation among Latinos and other nondominant ethnic groups in the United States. *Ethnic groups* refer to individuals who identify with and exhibit a common heritage in the second and/or subsequent generations after immigration. *Native peoples* refer to people who are indigenous (aboriginal) to the land and were present prior to settlement, in the case of North America, European settlement. In the case of the United States, this would include people of Native American Indian descent. In parts of Texas, New Mexico, Arizona, and California, some people of Mexican and Spanish descent could also be considered *native peoples*, given that they were present well over 100 years prior to Anglo colonization. *Immigrants* and *refugees* are similar in that they are both considered to be first-generation immigrants. However, immigrants are more likely to have emigrated from their country in quest of a better way of life. On the other hand, refugees may have emigrated due to persecution, political unrest, or other negative factor from within their own culture. Finally, the term *sojourners* applies to people who have emigrated but have a distinct purpose and or time period after which they intend to return to their country of origin.

The process of acculturation for groups such as Latinos can be complex and mediated by numerous factors, including circumstances and previous experiences as well as those encountered in the new society by groups and individuals. One example is found in mobility. As presented by Berry (1990), mobility refers to fluidity of contact with the new culture as well as the voluntariness of this contact (Berry, Kim, Minde, & Mok, 1987; Berry 1990). It is proposed that sojourners are individuals who are in temporary contact with the dominant culture and, thus, lack a permanent social support network. The net result of this contact is likely to be characterized by more health problems. Both immigrants and sojourners are more likely to be in voluntary contact with the dominant group. However, immigrants are more likely to establish a relatively more permanent contact with the dominant society, thus resulting in a stronger social support network, which may well mediate a reduction in acculturative stress. As such, this may account for a lower propensity to exhibit stress-related health problems.

One advantage to this classification system may be its tendency to be more inclusive and less exclusive in regard to ascribing membership to the dominant group. However, this categorical depiction is equally inadequate in generalizing health trends and subsequent needs both within and among all groups in question. At this point, the *construct* of acculturation can take on a significant role in understanding health and other population trends.

Regarding strategies or attitudes of acculturation, Berry, Poortinga, Segall, and Dasen (1992) provide a parsimonious structural framework from which to evaluate how an individual has accommodated to the dominant culture. This theory proposes four primary strategies: assimilation, integration, separation, and marginalization.

Strategies of acculturation present meaningful dynamics to the study of health and psychology in that they are likely to be more representative of the needs of individuals. However, it should be pointed out that individuals can routinely utilize multiple strategies of acculturation in different roles. That is, an individual may resort to a strategy of integration in her work and employment while remaining separate in her religious views.

SOCIOECONOMIC STATUS (SES)

Among the more profound limitations in addressing Latino health needs is the failure to control for socioeconomic status (SES) within the Latino cultures. While SES cannot account for poor health indicators on its own, numerous studies support the tenet that higher income and education—both measures of SES—are often associated with better health outcomes (Williams & Collins, 1995). One example of how SES may contribute to better health outcomes is found in the study by Wagner and Schatzkin (1994), who found that the mortality rate of women with breast cancer was significantly lower for women who reside in high SES counties as compared to women who reside in low SES counties.

General population trends suggest that Latinos, as a group, continue to be overrepresented in low SES statistics. From 1980 to 1996, the median household income increased by an average of 10.5% for “non-Latino White” and African American households, but Latino households saw a decline of 4% in median household income during this same period. Black and Latino households were more likely to be at or near poverty level, compared to non-Latino Whites and Asian Americans. In fact, African Americans and Latinos had a poverty rate that was 3.3 times higher than that of non-Hispanic Whites.

However, while accounting for socioeconomic status may indeed meet the standard of necessity, studies on the incidence of low birth weight strongly suggest that it lacks evidence for establishing sufficiency. For example, statistics have shown that women with low socioeconomic status tend to have a higher incidence rate for low birth weight (i.e., less than 2500 grams). Based on this evidence, it makes intuitive sense that Latinas would fall at risk for having infants with low birth weight. However, Fig. 11.1 shows that while Latinas as a whole

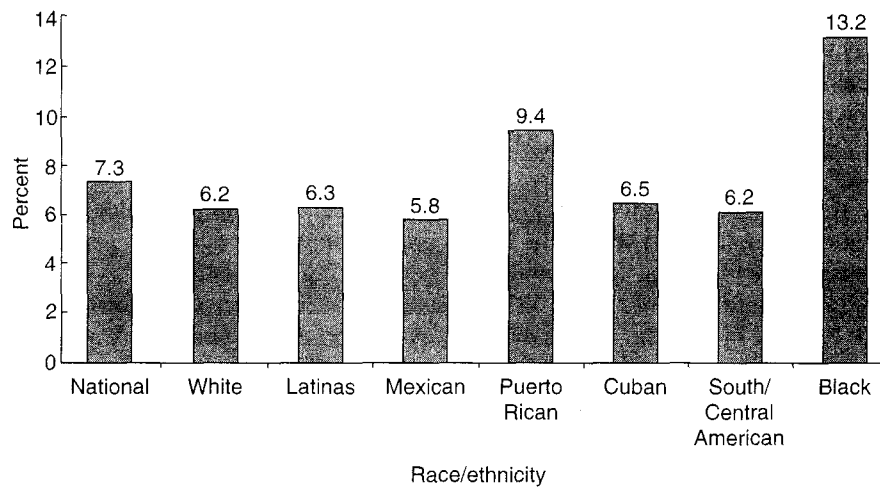


FIGURE 11.1 Percent of low birth weight.

generally have a low incidence rate for low birth weight, Mexican American women have the lowest incidence of low birth weight of any population group. This is ironic, especially when taking into consideration that the Mexican American women have similar SES to that of African American women. Also, this graphic shows that while Latinas average a good overall incidence rate for low birth weight, Puerto Rican American women have an incidence rate that is nearly 50% higher than the average for Latinas and nearly 29% higher than the national rate. This is second only to African American women, who have an incidence rate that is over 80% higher than the national rate.

SPECIFIC HEALTH PSYCHOLOGY ISSUES

In order to address health concerns of Latinos, it is important to consider the potential changes that Latinos experience. Health data has clearly suggested that across most health indicators, low socioeconomic status, among other variables, is associated with higher health risks. Latinos show patterns of health access to health care and mortality rates that differ from the overall population (Johnson et al., 1996). Consequently, it is important to consider the larger social environment and intragroup diversity of Latinos when studying health. For example, in the southern part of Florida, Cubans are heavily involved in the political process, including healthcare. However, not all Latino groups are equally involved or united in regional areas where they may be concentrated and, as such, require that specific attention be given to their health needs.

Perhaps some of the problem in the disparity of knowledge can be explained by an erroneous assumption of what is considered to be common knowledge. For

example, the belief that exercise is good for you may be understood and generally accepted; however, the definition of exercise lacks consensus. Someone educating Latinos who have physically strenuous jobs on the importance of exercise may likely encounter the position that they do enough exercise on their job, or perhaps that because they exert so much energy, a diet with higher fat content is of little relevance.

Before proceeding with the presentation of specific health psychology issues and their implications within the Latino population, we encourage the reader to consider the following key points before generalizing conclusions. First, it is important to note that prior to the 1970 census, there were no relevant statistics kept for Latinos. In fact, the current Vital Statistics reports continue to lack adequate representation of all minority groups, including Latinos. Second, within the context of diversity, some of the health issues presented are more relevant to some Latino groups than others (e.g., incidence of low birth weight is considerably higher in Puerto Rican American than in Mexican American women). Third, the reality of acculturation clearly contributes to health issues within the Latino communities. For example, in areas such as coronary heart disease, Latinos tend to decrease in health status as they acculturate to the dominant culture. Also, women, specifically Mexican American women who adhere to their cultural beliefs, generally tend to have better health outcomes than do those who acculturate. Finally, it is clear that Latinos have critical health issues that, indeed, place them at higher risk than other ethnic groups. Examples of these critical issues include the incidence rate of diabetes and AIDS.

CORONARY HEART DISEASE

Despite efforts aimed at preventing heart disease, this remains the major killer in the United States. Because heart disease is influenced by numerous factors, it is important to consider these when making inferences as to its incidence rate. Some of the major risk factors for developing coronary heart disease include smoking, diabetes, overweight, sedentary lifestyle, and diet. Health statistics consistently demonstrate that people of lower socioeconomic status have a higher incidence rate for each of these risk factors when compared with people of higher socioeconomic status. Of the ethnic minority groups studied over the last 10 years, Latinos are the only group that continues to show decline in SES. Consequently, it would be logical to assume that Latinos are among those falling at risk for coronary heart disease, a fact that is, indeed, true.

A common misconception about diet can be found in perceptions about Mexican food. There is the assumption that Mexicans routinely eat the type of diet that we see in popular restaurants with Mexican motif. However, this would be the equivalent of taking a Thanksgiving dinner and generalizing that this represents a typical meal for the Anglo American family. The health problem for Latinos and their diet is that, as they acculturate, they generally tend to move away from a more healthy traditional diet and consume more fast food. With the in-

roduction of fast food comes the gradual reduction of fresh fruits and vegetables and homecooked legumes, which are often a staple of many Latino diets.

The acquisition of a more Anglo American lifestyle also plays a significant role in the health decline of the Latino populace. The concept of *siesta* is one that is not easily transferable to the fast pace of westernized societies. The fast pace of life has often taken women out of the home, thus making the time-saving consumption of fast food a necessity. There is also a more sedentary lifestyle, where walking is not as common, given the need for the Latino family to keep up with the fast pace of the dominant culture. Often, it is necessary for both parents to work in order to make ends meet. This further contributes to the decentralization of the family, a major source of support for Latinos.

Stress is also known to play a significant role in the development and expression of coronary heart disease. Acculturation does not come without experience of stress. These stressors are exacerbated by the gradual deterioration of the family, leaving the individual to make difficult choices. To choose the family may be honorable but could well result in problems assimilating into the new dominant culture. Conversely, moving toward assimilation could result in alienation from his family and, thus, a loss of support. Stress can also be experienced by having to balance many variables in a new culture that is more foreign and perhaps more complex than the individual anticipated.

For example, access to health care is often not available for Latinos, even if they are gainfully employed. The high cost of medical care makes it prohibitive to seek out preventative care, thus resulting in more acuity by the time a physician is consulted. In the home country where health care is not as advanced, there is a network of folk healers that often fill this need, or the family resorts to herbal and other folkloric remedies that have been passed down through generations. However, accessing this type of network may be difficult and there is also a scarcity of sources where these supplies could be found and purchased.

HIV/AIDS

Even though the AIDS virus does not discriminate in regard to victims, analysis of health data shows that Latinos are disproportionately overrepresented among AIDS cases. Recent census data suggest that Latinos account for approximately 12% of the population in the United States. However, they account for more than 17% of AIDS cases, a rate that is second only to African Americans.

Latinos account for over 11% of the male population in the United States. Latinas make up about 10.4% and Latino children about 9.7%. However, Latino males account for over 17% of AIDS cases, Latinas about 20.2%, and Latino children represent an astonishing 23.1%. This means that nearly one in every four pediatric AIDS cases involves a Latino child. Compared to their non-Hispanic White counterparts, Latino males are three times more likely to contract AIDS, while Latinas are about 6.5 times more likely to contract AIDS (Organizations, 1998).

Unfortunately the trend toward disproportionate representation of AIDS cases in Latinos has steadily increased since 1987. This trend, combined with the fact that Latinos are among the fastest growing group in the United States, points toward the critical need to address prevention and health education campaigns that are specific to the needs of this population. However, statistics suggest that regional considerations should be weighed in developing prevention and intervention programs.

For example, the most common forms of AIDS transmission for Latinos are men having sex with men and intravenous drug use. Consequently, if an AIDS prevention program were constructed based on these demographics, it would make sense to strongly address homosexual male relationships. However, a closer look at this data shows that Massachusetts, New Jersey, New York, and Puerto Rico have a reported incidence rate of AIDS transmission through intravenous drug use that is three times higher than male homosexual intercourse. Thus, it would seem necessary that prevention programs in these states should place a significant emphasis on educating Latinos on the dangers of intravenous drug use.

The question of how we can reach Latinos with lifesaving information on AIDS prevention is as diverse as the population itself. Not only are there regional considerations, but also cultural beliefs, practices, and customs that, if not addressed, could hinder rather than advance progress. For example, a recent survey conducted by the Kaiser Family Foundation (1998) shows that most Latinos (77%) are aware that there is no cure for AIDS. However, from another perspective, this also means that approximately 23% of Latinos surveyed believe that either there is a cure for AIDS or are not sure whether a cure for AIDS exists. In the general population, 1 in 20 people believe that there is a vaccine for AIDS. Antithetically, 1 of 5 Latinos expressed a belief that there was a vaccine for AIDS. This obvious discontinuity in knowledge points toward the need to examine the nature and extent of prevention and intervention programs to see why they are not having commensurate results with Latinos.

Television and radio appear to be the most popular and influential media from which Latinos obtain information about AIDS. Compared to the general population, Latinos are more likely to hear information about AIDS from TV news programs at a rate that is 25% higher; 68% higher from TV entertainment programs; 61.5% higher from radio, talk, or call-in shows; and 100% higher from other radio programming. Generally speaking, Latinos who are primarily Spanish-speaking are more likely to obtain their information through TV and radio compared to English-speaking Latinos, who appear to get more of their information from newspapers and magazines.

CANCER

There is some available data that suggests that risk for cervical and breast cancer is higher in low socioeconomic status population groups (Suarez & Siefert,

1998; Wagner & Schatzkin 1994). This presents a particularly critical problem when working with Latinas, given that they are among the poorest members of society. For both of these types of cancer, early detection and intervention is critical to improve outcome. However, given that Latinas generally have less access to health care services, the probability of their being included in screening programs is lower than other groups. Additionally, level of acculturation may also play a mediating role in access to health care. Hubbell, Chavez, Mishra, and Valdez (1996) suggest that Latinos who are not acculturated appear to be at higher risk for not using health care services in a preventative manner. Instead, they are more likely to access services when the condition is more grave. However, Laws and Mayo (1998) suggest that acculturation, ethnicity, or level of education fail to predict utilization of mammography.

Patient education plays a critical role in health prevention programs, which means that patients need to have access to their physician in order to obtain the necessary information. For example, self-administered breast examinations can be very helpful in early detection of breast cancer. However, without routine visits to health care, the likelihood of learning and applying these techniques is significantly reduced.

In the case of cervical cancer, the issue of cultural beliefs also becomes important. Martinez, Chavez, and Hubbell (1997) suggest that within the Latino culture, the concept of promiscuity overrepresents the risks associated with cervical cancer. That is, Latinas are more likely to believe that if they are not promiscuous, they are not at any higher risk for cervical cancer. This suggests the need to educate Latinas on the other factors that contribute to cervical cancer and the importance of getting routine medical checkups to increase the likelihood of early detection.

DIABETES

Previously, it was implied that Latinos with low levels of acculturation, as a whole, tend to have better health outcomes in specific areas. However, diabetes is clearly one of the areas where Latinos, especially those of Mexican descent, are considerably more at risk than other population groups. By some estimates, Latinos are nearly two times more likely to have diabetes when compared to non-Latino Whites.

Among the more significant trends of diabetes in the Latino culture is the fact that young Latinos are being diagnosed with Type II diabetes at an alarming rate. Typically, Type II diabetes is not diagnosed until the individual is an adult. However, Latino children are being diagnosed with this type of diabetes with increasing frequency.

It is estimated that nearly 6% of the population in the United States has diabetes. However, of the nearly 16 million people estimated to have diabetes, approximately one-third have yet to be diagnosed. The highest prevalence for diabetes is found in persons over 65 years of age. In this age group, it is estimated that over 18% have this disorder. Those over 20 years of age have a prevalence

rate of just over 8%. Those under the age of 20 have the lowest incidence rate, at well under 1%.

Diabetes can be classified into four different types. Type I or insulin-dependent diabetes mellitus (IDDM) accounts for 5 to 10% of persons with diabetes. As the name implies, persons with Type I diabetes require insulin injections to manage their blood-sugar levels. Persons with insulin-dependent diabetes mellitus are more likely to develop the disease early in life. In fact, this type of diabetes used to be referred to as juvenile-onset diabetes.

Type II or noninsulin-dependent diabetes mellitus (NIDDM) accounts for 90 to 95% of persons diagnosed with diabetes. Persons with noninsulin-dependent diabetes mellitus are not dependent on insulin and are more likely to develop this condition later in life. However, it should be noted that both types of diabetes can occur in the very young or the very old (Miller-Keane, 1992).

Gestational and other specific types of diabetes account for a significantly smaller percentage of diabetes cases. Gestational diabetes occurs in 2 to 5% of all pregnancies and generally subsides after the termination of pregnancy. Hispanic women are among those at higher risk for developing gestational diabetes. Obesity also increases the risk for this type of diabetes. There is also an increased risk of developing Type II diabetes later in life for women with a history of gestational diabetes. Other specific types of diabetes account for less than 2% of all diagnosed cases of diabetes (National Diabetes Data Group, 1995).

PAIN: A LIFESPAN APPROACH

Management of pain is complicated, given the propensity of diversity in its etiology. This factor is confounded by how the individual experiences and expresses his experience of pain. From the perspective of professionals, pain rarely presents itself in a manner that is subject to direct measurement. Consequently, the degree of pain an individual should experience is largely based on inferences made from the type of injury sustained, determined by range of motion, biofeedback readings, grip strength, responses to questionnaires, and a plethora of other techniques, approaches and/or instruments. Furthermore, culture can also influence how pain is expressed and managed within the context of the identified patient's family.

Chronic pain presents challenges to the individual and family alike. Given the important role of family in the Latino cultures, the biopsychosocial model provides a functional paradigm from which to address pain management. The biological origins of pain are diverse and have significant variance. Back pain, joint pain, muscle pain, and other experiences of pain often have biological antecedents which are readily diagnosed. Magnetic resonance imaging and other technological advances have afforded ample opportunity to observe where pain may be present. However, there are numerous situations where this determination cannot be substantiated biologically. There are other circumstances where the degree of pain expressed by an individual is not consistent with bioanatomical evidence.

As is the case with other cultures, education on the medical or biological nature of the pain disorder is an important part of the healing mechanism for Latinos. At times, language can become a significant barrier in communicating with the Latino family. A common way around that has been for medical doctors to use a family member to translate the information to the patient or other members of the family. However, there may be times when young children are relied on for translation since they are more familiar with the English language. Unless these children are adults, professionals are likely to better serve the needs of their Spanish-speaking patients by requesting that the family bring with them an adult to provide the translation.

Psychological factors are strong moderating variables to the experience of pain. Prior research has informed that stress can be manifested physically through muscle tension and other biological markers. From a cognitive behavioral perspective, stress can be ameliorated by changing the cognitions of how the individual interprets and responds to stressful events. Prolonged experience of stress has a higher probability of decreasing healthy psychological adjustment which, in turn, could result in feelings of depression, anxiety, and other psychological problems. The prolonged experience of stress could be a consequence of unemployment, physical stress directly related to the pain disorder, familial stress resulting from change in roles, and acculturative stress that results from the process of acculturating into a new dominant society.

Even though Latinos are the fastest growing group in the United States, their demographics suggest that, as a whole, their economic and educational status has decreased in the past few years. Combined with the fact that Latinos tend to be underrepresented in regard to having medical insurance, a long-term pain disorder presents significant psychological challenges.

Because demographics show that Latinos are less likely to complete high school or college compared to other minority groups, it is logical to assume that they are more likely to be employed in jobs that require physical labor. Such jobs provide little opportunity for the body to heal. For those who have an employer that pays for disability or worker's compensation insurance, there is some source of income while they are incapable of working. However, even while gainfully employed, many Latino families have difficulty meeting their basic needs. The inability to provide for the family may subject the Latino male to an additional source of stress.

DISEASE PREVENTION AND HEALTH PROMOTION

Disease prevention and health promotion are important components of health psychology. However, health promotion is promulgated within the context of culture and family. The structure for Latino families is centripetal in that the tendency is to draw its members in rather than push them toward independence. Consequently, health promotion may be more successful with Latinos if more

emphasis were placed on family involvement (Fitzgibbon, Stolley, Avellone, & Sugerman, 1996). In fact, across many cultures, the family serves as the central medium by which values, beliefs, and customs are passed on (Bagley, Angel, Dilworth-Anderson, Liu, & Schinke, 1996), a dynamic from which Latinos are not exempt. Understanding the needs of the Latino cultures is important, especially when considering that this group could very well make up one-fourth of the entire United States population within the first half of the 21st century.

However, even though the Latino community continues to grow, it is failing to make gains in its socioeconomic demographics. The Latino community is relatively young but continues to be overrepresented in poverty and low levels of education, both of these being variables that have been linked to health outcomes. It is estimated that as many as one-third of Latinos do not have health insurance and, thus, have limited access to health care. Given this lack of quality health care, it is more likely that this subgroup of Latinos will seek out medical care only when their condition is more advanced, or only when they are experiencing a medical emergency. This level of access to health care is likely to result in poor access to preventative programs that can help decrease the acuity of their health needs, not to mention that the cost of care is much higher for the individual and for the society at large.

SUMMARY

The first part of this chapter deals with some of the general aspects of the study of culture in mainstream psychology that are relevant to the study and practice of health psychology with nondominant ethnic groups in a multicultural society. Then, issues such as the intragroup diversity of Latino Americans and other nondominant groups in the U.S. are discussed. Health data and statistics on some of the relevant health concerns of this population are used to illustrate the fact that some of the health issues presented are relevant to some, but not to other, Latino groups. In addition, general issues, such as patterns of immigration and acculturation, are considered in relation to health issues, such as coronary heart disease. Also, misconceptions about the health of Latino groups are contrasted with actual data. For example, data showing that, in many cases, the health of Latino groups deteriorates with acculturation are used to illustrate some of the complex effects of acculturation. Specifically, as Latino groups acculturate, they move away from healthier traditional diets and adopt aspects of the Anglo American lifestyle that contribute to their health decline.

The final part of the chapter focuses on specific health psychology issues of particular interest in dealing with the various Latino groups. Coronary heart disease, HIV/AIDS, cervical cancer, diabetes, and chronic pain management are among the topics considered in order to illustrate the kinds of health psychology issues that concern Latinos. Such issues are seen as important for a cultural approach to health psychology research and practice with this population.

CASE STUDY

Marcos, a 5-year-old Latino boy, was admitted to a rehabilitation unit in a major teaching hospital in Southern California. He had sustained a closed head injury as a result of an automobile accident. The nature of his injuries required him to undergo surgery and intensive rehabilitation services to help him return to a more normal level of functioning.

Marcos's family was involved throughout the course of his treatment and was present at all therapies. A member of the family, either immediate or extended, was present in his room at all times. His parents and the majority of the family spoke only Spanish. Since no official translator was provided, explanation of forms and procedures were translated only when a Spanish-speaking staff member was available. Occasionally, a cleaning person who happened to be at hand did this. Sometimes, when it came to making decisions about Marcos's care, the physician would talk to the mother and ask questions, all in English. According to his report, she was very agreeable to everything and never asked questions of him.

After several weeks of treatments, the team began to express concern that the family was hindering the process of therapy more than they were helping. For example, one of the tasks addressed in his therapy was dressing skills. However, whenever Marcos's mother was with him, she would proceed to assist Marcos in dressing, something he was capable of doing.

Not understanding what was happening and what was the boy's fate, the family turned to a Latino staff member in another unit, who was not involved in Marcos's care but was bilingual. In asking her colleagues to assist her in providing information to the family, she noticed that the presence of family members at all times appeared to bother some of the staff. Also, some of the therapists appeared to be unhappy with the "interference" of the mother with "unnecessary" assistance to the boy. However, after talking with the family, she realized that they did not know what was being done, why, and what the outcome would be. They felt that Marcos was not welcome in the hospital and were afraid that nobody cared enough to do the best that could be done to help him. They indicated that the doctor appeared not to care whether or not they understood him and whether or not they had any concerns. They were also concerned that what they saw as the therapists' hostility toward the family could put Marcos at risk for neglect or not getting the best treatment possible for his condition. This was a powerful deterrent for them to ask questions.

When Marcos's therapies extended beyond four weeks, the father became more assertive and reluctant to agree to additional therapies. He insisted more and more on outpatient services. Despite the persistence on the part of the medical team in informing the father on the importance and necessity of the treatments, the father remained insistent on discharge. Even though all members of the family expressed agreement with the recommendations of the medical team, none was observed to challenge the position of the father.

A bilingual/bicultural staff member from another unit was asked to trans-

late and mediate in meetings with the family. A full explanation of Marcos's condition and treatment needs was given to the family by the physician and translated into Spanish by the mediator. With the assistance of the bilingual mediator, the family could ask questions and express their concerns in Spanish. The negative attitude of the therapists toward the mother's assisting Marcos was explained to the family and the mother explained to the staff her understanding of motherhood and family. It became apparent that she understood perfectly that he was capable of dressing himself and that her behavior had nothing to do with objecting to the therapy or antagonizing the therapists. It had more to do with her perceived responsibility to satisfy the needs of the boy, comforting him and making him feel protected, particularly under conditions of high uncertainty and perceived hostility.

1. How do familism and related cultural value orientations, such as collectivism/individualism, serve to explain some of the behavioral phenomena observed in this case? Identify some aspects of the case (e.g., the attitude and behavior of the mother, the reaction of the therapists, the attitude and behavior of the physician, the father, the extended family) that could be explained on the basis of these or other cultural characteristics of Latinos and other Mediterranean cultures.

2. Based on the cultural factors involved in this case, identify aspects of the Anglo-dominated health care system, institutions, and personnel which could be changed in order to better serve the needs of the emerging majority population represented by Latinos and the other nondominant ethnic groups in states like California.

3. From a health psychology perspective, if you were a member of the staff, what culturally sensitive suggestions would you make to the physician, the other members of the staff, and the hospital?

SUGGESTED READINGS

- Betancourt H., & Lopez, S. (1993). The study of culture, ethnicity and race in American psychology. *American Psychologist, 48*, 629-637.
- Furino, A. (Ed.). (1992). *Health policy and the Hispanic*. Boulder, CO: Westview Press.
- Geisinger, K. (Ed.). (1992). *Psychological testing of Hispanics*. Washington, DC: American Psychological Association.
- Goldberger, N., & Veroff, J. (Eds.). (1995). *The culture and psychology reader*. New York: New York University Press.
- Padilla, A. (Ed.). (1995). *Hispanic psychology: Critical issues in theory and research*. Thousand Oaks, CA: Sage.
- Zambrana, R. E. (Ed.). (1995). *Understanding Latino families: Scholarship, policy, and practice*. (Vol. 2). Thousand Oaks, CA: Sage.

REFERENCES

- Bagley, S. P., Angel, R., Dilworth-Anderson, P., Liu, W., & Schinke, S. (1996). Panel V: Adaptive health behaviors among ethnic minorities. *Health Psychology, 14*, 632-640.

- Berry, J. W. (1990). Psychology of acculturation: Understanding individuals moving between cultures. In R. W. Brislin (Ed.), *Applied cross cultural psychology* (pp. 232–253). Newbury Park, CA: Sage.
- Berry, J. W., Kim, U., Minde, T., & Mok, D. (1987). Comparative studies of acculturative stress. *International Migration Review*, 21, 491–511.
- Berry, J. W., Poortinga, Y. H., Segall, M. H., & Dasen, P. R. (1992). *Cross-cultural psychology: Research and applications*. New York: Cambridge University Press.
- Betancourt, H. M., & Lopez, S. R. (1993). The study of culture, ethnicity, and race in American psychology. *American Psychologist*, 48, 629–637.
- Fitzgibbon, M. L., Stolley, M. R., Avellone, M. E., & Sugerman, S. (1996). Involving parents in cancer risk reduction: A program for Hispanic American families. *Health Psychology*, 15, 413–422.
- Goldberger, N. R., & Veroff, J. B. (Eds.). (1995). *The culture of psychology reader*. New York: New York University Press.
- Hayes-Bautista, D. E. (1992). Latino health indicators and the underclass model: From paradox to new policy models. In A. Furino (Ed.), *Health policy and the Hispanic* (pp. 32–47). Boulder, CO: Westview Press.
- Hubbell, F. A., Chavez, L. R., Mishra, S. I., & Valdez, R. B. (1996). Differing beliefs about breast cancer among Latinas and Anglo women. *Western Journal of Medicine*, 164, 405–409.
- Johnson, K. W., Anderson, N. B., Bastida, E., Kramer, B. J., Willimas, D., & Wong, M. (1996). Panel II: Macrosocial and environmental influences on minority health. *Health Psychology*, 14, 601–612.
- Kaiser Family Foundation (May, 1998). Kaiser Family Foundation national survey of Latinos on HIV/AIDS. Menlo Park, CA: Atlantic Information Services.
- Laws, M. B., & Mayo, S. J. (1998). The Latina breast cancer control study, year one: Factors predicting screening mammography utilization by urban Latina women in Massachusetts. *Journal of Community Health*, 23, 251–267.
- Martinez, R. G., Chavez, L. R., & Hubell, F. A. (1997). Purity and passion: Risk and morality in Latina immigrants' and physicians' beliefs about cervical cancer. *Medical Anthropology*, 17, 337–362.
- O'Toole, M. (Ed.). (1992). *Miller-Keane: Encyclopedia and dictionary of medicine, nursing and allied health* (5th Ed.). Philadelphia, PA: Saunders.
- National Diabetes Data Group. (1995). *Diabetes in America*. Bethesda, MD, National Institutes of Health.
- Organizations, N.C.O.H.H.A.H.S. (1998). HIV/AIDS: The impact on Hispanics [on-line]. Available <http://www.cossmho.org>.
- Peplau, L. A., & Taylor, S. E. (Eds.). (1997). *Sociocultural perspectives in social psychology: Current readings*. Upper Saddle River, NJ: Prentice Hall.
- Sorlie, P. D., Rogot, E., & Johnson, N. J. (1992). Validity of demographic characteristics on the death certificate. *Epidemiology*, 3, 181–184.
- Suarez, Z. E., & Siefert, K. (1998). Latinas and sexually transmitted diseases: Implications of recent research for prevention. *Social Work Health Care*, 28, 1–19.
- Wagner, D. K., & Schatzkin, A. (1994). Temporal trends in the socioeconomic gradient for breast cancer mortality among U.S. women. *American Journal of Public Health*, 84, 1003–1006.
- Williams, D. R., & Collins, C. (1995). U.S. economic and racial differences in health: Patterns and explanations. *Annual Review of Sociology*, 21, 349–386.
- Zambrana, R. E. (Ed.). (1995). *Understanding Latino families: Scholarship, policy, and practice*. Thousand Oaks, CA: Sage.