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ABSTRACT

This paper indicates the necessity for clinicians, especially Anglo-American clinicians, who provide services to individuals from the Puerto Rican population, to be conscious of their possible prejudice toward them; they should also be aware of the negative attitude which frequently occurs on the part of the patient. It is crucial that clinicians be sensitized to the culturally-based attitudes and beliefs prevalent among Puerto Ricans and to their healthy, as well as pathological, dispositions. Finally, when it is necessary to interview the patient in English, the clinician must be aware of the effects of the language on the content of the verbal productions of the patient and should evaluate any cues carefully before deeming them indicators of psychopathology. (Author)

ON THE ASSESSMENT OF PSYCHOPATHOLOGY IN THE PUERTO RICAN PATIENT**

by

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As clinicians, we must agree that a frame of reference applicable to the Anglo-American patient cannot be equally appropriate for the evaluation of the behavior of patients who are substantially affected by cross-cultural as well as cross-language factors. Empirical research seems to confirm this fact. In a recent study it was demonstrated that when Puerto Rican patients are interviewed in English, they are judged by experienced English-speaking clinicians as showing significantly more pathology than when they are interviewed in their mother tongue by Spanish-speaking psychiatrists.[1] The study indicates that although the clinicians' frame of reference may account for the discrepancy to a significant degree, there is also evidence suggesting relevant clinical changes in the patients attributable to their having to interact with an "alien doctor" in an "alien language."

It would be optimal if there were enough psychiatric clinicians who spoke Spanish and were familiar with the Spanish culture; short of the optimal, it is imperative that psychiatric professionals be sensitized to the effects of language and culture barriers upon the expression of health and disease in the Hispanic minority. My purpose in this paper is to outline fundamental factors which, I believe,

should be considered by any clinician when confronted with the psychiatric evaluation of a Puerto Rican patient.

The Prejudice Factor

By "prejudice" I mean any feeling, thinking or judgement, favorable or unfavorable, not based on real experience, directed toward an individual or group. In this factor I include two sources of prejudice.

Clinician's prejudice. Whether positive or negative, its adverse effects may be easily imagined and have been thoroughly described in the literature.

Patient's prejudice. In my experience, an *a priori* negative attitude toward the "Anglo clinician" is oftentimes present in the Puerto Rican patient. This factor seems to apply to other Spanish-American patients as well. As a brief illustration, I shall refer to the work of Simmons. This author found that Spanish-surnamed persons expected the "Anglo-American" to be cold, unkind, exploitive, distant, insincere, etc.[2] To consider this a phenomenon of prejudice without any basis on actual experience may be frequently incorrect since it is a fact that the Puerto Rican constantly suffers discrimination and social deprivation. This has been documented even in the psychiatric literature. In light of this, I should stress the likelihood of the presence of an attitudinal factor on the part of the patient. The results of the previously mentioned research study[3] corroborate this point. The Puerto Rican patients disclosed more

uncooperativeness, emotional withdrawal and hostility in the English interview than when they were evaluated in Spanish. The clinician, therefore, ought to be aware of this attitudinal factor in the Puerto Rican patient, as well as its socio-cultural roots, and assess it and deal with it as such.

The Cultural Factor

The cultural characteristics of the Puerto Rican population are vividly expressed through health and disease, as they are in any society. This gives rise to two possible misevaluations of the culture.

Cultural misunderstanding. This applies to those culturally bound attitudes and beliefs accepted by the Puerto Ricans but often defined as "unhealthy trends" or even psychiatric symptoms by non-Hispanic clinicians. I shall include in this chapter cultural values such as "spiritualism," "santeria," "respeto," "dignidad," "machismo," a certain disposition towards authority, a different notion of time, and other family and social values including the mother-son relationship, male dominance, and the idealized female role.

Cultural misdiagnosing. In this case, the deficient assessment of cultural factors is responsible for the incorrect diagnosis of culturally inspired, psychiatric syndromes. To my knowledge, the most frequent instances of cultural misdiagnosis are those in which dissociative reactions are diagnosed as schizophrenia and are treated as such. The so-called "Puerto Rican syndrome" provides a good example.

This "ataque" is a specific form of hysteria. It consists of hyperkinetic seizures of a bizarre nature at a time of acute tension and anxiety. Unfortunately, it is commonly misdiagnosed as schizophrenia. Somatization and other conversion symptoms, which not infrequently are attributed by this population to the workings of "black magic," are mistakenly considered to be somatic delusions or indicators of severe depression. As a final example, I shall refer to the commonly occurring case of "visions." This culturally accepted phenomenon typically involves ancestors, recently deceased family members and religious images; it is frequently shared by several members of the family and is considered a privilege rather than a disgrace. To the unfamiliar clinician, it often seems to constitute perceptual disorders symptomatic of schizophrenia.

The Language Factor

It is a readily apparent truth that patients whose mother tongue is not English are evaluated by professionals who speak only English. The effects of the language barrier upon Puerto Rican patients' ability to communicate was empirically studied in a recent research project.[4] In this study, the responses of each patient to the same questions in English and Spanish were compared. For each patient, clear and consistent differences were found between the English- and Spanish-language interviews. Schematically, the English-speaking clinician should attempt to keep in

mind the following effects of language.

In the English-language interviews, responses showed a striking tendency to be short-sentenced: "no," "no sir," and "I don't know" were frequent answers in the English interview. Sometimes the answer consisted of mute unresponsiveness. This behavioral pattern seems to be the consequence of both a language barrier and a negative attitude prior to the interview situation.

As might be expected, there are difficulties in translation when the patient is required to speak a language other than his native tongue. Language mixing is one such difficulty, wherein patients utilize Spanish words during their English interviews. This language intrusion makes their flow of thought sound more confused and disorganized. In addition, Puerto Rican patients who are not too fluent in English show a surprising amount of difficulty in using the past tense when having to speak in that language. They spoke in the present when interviewed in English, while the Spanish response to the same question made it clear that the past was intended. An interviewer who is unaware of this effect of translation may easily err in judgement.

Finally there are issues related to the infra-content of the language. The English interview evokes longer and more frequent silent pauses than the Spanish interview. It appears that this low activation effect, which may be caused by having to speak in a second language, is a characteristic

associated with depression in the native English-speaking person. Similarly, Puerto Rican patients interviewed in English demonstrated a significantly higher frequency of a number of speech disturbances (incoherent sound, sentence correction, repetition, sentence incompletion, etc.) which Mahl and others have suggested to be indicators of anxiety in the English-speaking patient. Unless the clinician is aware of these characteristic problems of second-language communication, he may interpret them as manifestations of psychopathology.

In conclusion, it is imperative that clinicians who provide psychiatric services to individuals from the Puerto Rican population be conscious of their own disposition and possible prejudice toward them; they should also be aware of the commonly occurring negative attitude on the part of the patient. Secondly, it is crucial that clinicians be sensitized to the culturally bound attitudes and beliefs of this Spanish-American population and to their healthy as well as pathological representations. Finally, when it is necessary to interview the patient in English, the clinician must be aware of the effects of the language on the content and infra-content of the verbal productions of the patient and should evaluate any cues carefully before deeming them indicators of psychopathology.

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