

Virtual Mentor

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Clinical Case

Susto: Acknowledging Patients' Beliefs about Illness

Commentary by Lindia Willies-Jacobo, MD

Junior Valez is admitted for treatment for presumed Guillain-Barre syndrome. On discussing the history of the 15-year-old boy's illness with the doctor, his mother volunteers her opinion that the illness resulted from a "susto"—a common folkloric concept among some Latino communities, where illness is thought to be provoked by psychological trauma. When asked what the inciting episode may have been, Junior's mother replies, "We don't want to talk about it."

"Is that right, Junior?" asks the physician.

"Yeah, it's fine."

The physician, Dr. Bernard, has to finish rounds but makes a note to herself to revisit the issue with Junior.

Dr. Bernard finds Junior alone the next day during her afternoon rounds and talks to him some more. They establish rapport, and he tells her that he is interested in science and wants to be a physician himself one day. Dr. Bernard decides now is a good time to ask the patient once more what might have caused the "susto."

"It was just something my father said."

"What did he say?"

"I don't want to talk about it."

Dr. Bernard, trained to search for underlying problems, is concerned that the boy may have been a victim of emotional abuse. At the same time, she has witnessed the interaction between the boy and his father, and also between both parents, and does not otherwise have any other reason to suspect abuse. Junior then asks, "Do you think he could have made me sick like my mom says?"

Commentary

As the racial, ethnic, and cultural portrait of the United States continues to change, it is increasingly important for health care professionals to become culturally competent. According to the 2000 U.S. Census Bureau Report, more than 47 million people speak a language other than English at home, and nearly 45 percent of these

have difficulty speaking English [1]. One in every 10 persons in the U.S. is foreign-born, and by the year 2020, an estimated 40 percent of school-age children will be members of minority groups. In California, Latinos are the fastest-growing minority group in that state, and one-third of these are children.

Cultural competence and sensitivity play an integral part in the effective delivery of patient care. Their importance has been acknowledged by several oversight bodies of medical education, including the Liaison Committee on Medical Education and the Residency Review Committee for Pediatrics. These groups have called for inclusion of the multicultural dimensions of health care in the curriculum and structured educational experiences that will prepare trainees for the role of health advocate within the community [2].

The American Academy of Pediatrics, in its December 2004 Policy Statement, recognized the need for culturally effective pediatric care. This policy states that

the needs of the pediatric population are influenced by factors relating to culture and ethnicity. Pediatricians must acquire the knowledge and practice skills that will allow them to recognize and address culture and ethnicity, make valid assessments of clinical findings, and provide effective patient management [3].

Awareness Assessment

This particular case presents several challenges. There are clearly cultural forces at play, with the added conflicts of adolescence and possible emotional abuse by the child's father. When interacting with patients and families from different cultural backgrounds, we must first understand and acknowledge that culture has a tremendous impact on a patient's health beliefs, practices, and behavior, regardless of the specific patient's cultural background. Then we should incorporate this knowledge into our treatment of the patient. Developing a systematic approach to interacting with patients and families from different backgrounds is essential.

Lee Pachter proposed a model for cultural competency known as "awareness-assessment-negotiation" [4] that can be applied to clinical encounters with patients from any background and is especially helpful when a family's beliefs about health and illness do not fit a standard Western biomedical model.

The first part of the model calls for awareness. The clinician must learn about the commonly held beliefs, practices, and values specific to the patient population that is being served. In this particular vignette, knowing about some of the normative cultural values of Latinos would have been helpful. Normative cultural values are beliefs, behaviors, and ideas shared by a group of people that are expected to be observed in interpersonal relations. Five normative cultural values of Latinos that can influence their expectations of the patient-physician encounter are *simpatia* (kindness), *personalismo* (formal friendliness), *respeto* (respect), *familismo* (collective loyalty to the extended family) and *fatalismo* (fatalism) [5].

Many Latino families prefer a warm, friendly style of communication and may value a more personal relationship with the physician. This can be in stark contrast to the manner in which many Western health professionals communicate. We often place significant value on “directness” and “getting to the point,” especially when there are distinct time constraints with each visit. The Latino culture may view this approach as offensive. In this particular vignette, depending on how the information about Guillain-Barre syndrome was discussed, the mother may have felt somewhat alienated from the beginning of the encounter. The danger here is that the person who feels alienated may withhold information.

Assessment of Family Beliefs

The second part of the model—assessment—asks whether the family with whom we are interacting embraces a particular belief system and, if so, under what circumstances. The risk of stereotyping is always present when we are dealing with people from other cultures, and this part of the model attempts to eliminate that element. Once you have become aware of some of the commonly held beliefs and practices of a particular culture, you should share that knowledge with the family and to find out whether the family subscribes to those beliefs and under what circumstances. Inquiring about the patient and family’s level of acculturation is important. There are many ways to do this, however. Using the Kleinman Cultural History [6], a physician asks open-ended questions to explore health-related belief systems.

Knowing about some of the folk illnesses in the Latino community would be useful in approaching this particular family. The mother mentions *susto* as a concern. *Susto*, also known as “fright,” is one of the common folk illnesses seen in the Latino population. Illnesses from *susto* are believed to result from a shocking, unpleasant, or frightening experience that is believed to cause the soul to leave the body. Common symptoms of *susto* are restlessness during sleep and listlessness and weakness when awake. Traditionally, *susto* is cured by *curanderos* (folk healers) through the use of herbal teas and prayer ceremonies, during which the patient and family are present. Other Latino folk illnesses that we should be aware of are *mal de ojo* (evil eye), *empacho* (blocked intestine), and *mollera caida* (sunken fontanel) [7]. Knowing about folk illnesses and their treatments is critical because some of the therapies may not be benign. For example, giving lead oxide-containing substances is the treatment of choice for *empacho*, and there are many reports of lead toxicity in the literature as a result of this practice.

Negotiating Cultural Conflicts

The third part of the model calls for negotiation. While the physician is under no particular obligation to agree with a patient’s or family’s particular belief system, he or she should find ways of compromising with families if there is an area of cultural conflict that has significant consequences for the child. In this case, in addition to asking about the inciting event, it may be helpful to explore some of the treatments that the mother had in mind for the child. This may promote better dialogue and

improve the clinical encounter. Because Junior is an adolescent, it is imperative that the physician have the opportunity to talk to him alone to gain a better understanding of his relationship with his parents and, more specifically, with his father. It is only after this relationship is understood that issues of possible emotional abuse can be better explored. Based on his comments to Dr. Bernard, Junior may be significantly more acculturated than his parents, which may also be a source of conflict. The issue of possible abuse should be raised with the boy and his family, but only if there continues to be suspicion after all of the cultural issues are addressed.

Delivering effective care to our patients demands that we acknowledge the role that culture plays in people's lives. A person's culturally based health beliefs and practices determine what problems are recognized as needing traditional Western medical care and also whether the patient and his or her family will follow through with the prescribed treatment.

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