Application of Cognitive Behavioral Techniques in the Treatment of Hispanic Patients

APPLICATION OF COGNITIVE BEHAVIORAL TECHNIQUES IN THE TREATMENT OF HISPANIC PATIENTS

A. Anthony Arce, M.D.
Christine Torres-Matrullo, Ph.D.

This article desribes certain aspects of the cultural dynamics of lower socioeconomic Hispanic populations. Specifically, there is discussion of a particular view of the world among Hispanics that emphasizes a concrete orientation and discourages the outward expression of anger or agression. The Cognitive Behavior model, which is structured and goal-oriented, and which addresses attitudes surrounding the expression of anger/aggression, is briefly described, and recommended as a particularly effective approach with Hispanic clients in individual and group therapy and in outpatient and partial hospitalizatoin settings.

It has been the clinical experience of the present authors and others that Hispanic patients who are relatively unacculturated, of poor socioeconomic background and psychologically unsophisticated do not respond to traditional psychodynamic, insight-oriented psychotherapeutic approaches. There is general agreement among Hispanic clinicians concerning the applicability and effectiveness of more structured, goal-oriented, problem-solving, behavioral approaches when working with such patient. The purpose of this article is to explore the application of cognitive behavioral techniques that may be utilized in a variety of treatment settings aimed at serving Hispanic patients.

CULTURAL CONSIDERATIONS

In discussing the effectiveness of therapeutic interventions across cultures, Torrey[1] identified four essential elements. In order of decreasing importance, they are:

Dr. Arce is Deputy Chairman, Department of Mental Health Sciences, Hahnemann Medical College & Hospital, Philadelphia and Executive Director, J. F. Kennedy Community Mental Health/Mental Retardation Center, Philadelphia. Dr. Torres-Matrullo is Director, Mental Health Associate Degree Program, and Assistant Professor, Department of Mental Health Sciences, Hahnemann Medical College & Hospital, Philadelphia. Requests for reprints may be addressed to Dr. Arce at 112 North Broad Street, Philadelphia, PA 19102.

PSYCHIATRIC QUARTERLY, 54(4) Winter, 1982
0033-2720/82/1600-0230$02.75©1982 Human Sciences Press

1. Patient and therapist must share a common view of the world.
2. The therapist must be able to project a warm, empathic, caring image.
3. The patient's expectations of being helped must be met.
4. Technique utilized must be congruent with patient background and expectations.

The relevance of these elements to the treatment of Hispanics merits further elaboration.

A person's view of the world is reflected in relational, motivational, learning, and coping styles, all of which are products of the culture in which the individual is raised. In the area of interpersonal relations, for instance, Hispanics have a very strong conviction on the self-value of human beings apart from the social class, educational level, or material wealth of the person. This sense of dignity and respect demands proper attention to a set of culturally prescribed rituals (posture, words of deference, handshakes, etc.) that must be observed in any encounter. Its corollary is an emphasis on the personal aspects of a relationship as a precondition for professional or business transactions. Thus, attention to these rituals is essential if the therapist is to communicate empathy and foster a working therapeutic alliance.

Hispanics place greater value on the spirit of cooperation than on that of competition from which stems the intricate interpersonal support systems encompassing distant relatives, friends and neighbors. In Minuchin's[2] classification, the Hispanic extended family structure is characterized as enmeshed rather than disengaged. Disengaged transactional patterns emphasize autonomy and independence. Enmeshed patterns are characterized by overinvolvement, dependence, and discouragement of self-differentiation. Familial relationships are based on the premise that the behavior of one member of the family affects all other members. For example, self-control is a highly valued behavior for the sake of "*las apariencias*", i.e., for the sake of appearances, so as not to bring shame on oneself and one's family. Hispanics may also exhibit a greater degree of motivation when seeking to succeed for others, such as family or ethnic group, rather than for self.[3]

In terms of motivational styles, Hispanics tend to experience a more external locus of control than Anglos. This is expressed in a fatalistic view of the world in which man's behavior is controlled by external natural and supernatural forces. The perception of external control provides the substrate for a more utilitarian view of religion, the adherence to a folk belief system, and the conceptualization of mental illness as an externally induced phenomenon. Thus, Hispanics tend to conceptualize mental illness as a physical disease of the nervous system ("*enfermedad de los nervios*") rather than as a result of psychological conflict. Affective responses such as anxiety, depression, and anger are seldom identified as such but are reported in terms of their psychophysiological concomitants—dizziness, fatique, parethesias of the limbs, headaches, and various gastrointestinal disturbances.

In the area of learning and coping styles, i.e., methods utilized in approaching and solving problems, Hispanics tend to exhibit more self-control subassertiveness than Anglos. This may be related to the cultural prohibition

against the overt expression of anger and aggression.[4] The need for self-control combined with feelings of powerlessness in dealing with the system, poor command of the English language, and the prevailing experience of being the object of overt discrimination and prejudice, results in coping styles that tend to be "subassertive."[5]

Assertive behaviors refer to any appropriate behavior needed to set limits in interpersonal relationships, to protect one's rights, and to express overtly strong feeling or emotion such as anger, irritation or love. Subassertive behaviors, such as passive endurance and pleading, are maladaptive responses that subject the individual to persistent, destructive interactions. They result in decreased skills in managing the system, reduced limit-setting ability, aggravation of the disadvantaged position, and increased suffering.

In our work with Hispanic women experiencing marital problems, we have observed that their tendency to acquiese passively to the husband's sometimes unrealistic demands is an obstacle in the learning of more assertive ways of dealing with the establishment.

CLIENT EXPECTATIONS

Hispanics tend to view their problems as based on social and interpersonal issues rather than on intrapsychic dynamics. Hence, in common with other low socioeconomic status persons, they approach therapy from a nonpsychological, nonintrospective, passive medical orientation. They typically expect responsiveness, reliability, and resourcefulness on the part of the therapist in helping them to find solutions. The therapist must not only communicate concern, interest, and caring, but also a firm belief in the patient's ability to learn and apply the needed skills. He/she merits "*respeto*" and acts from a position of power. His/her opinions and judgments carry weight and are viewed as prescriptions for action rather than as suggestions for consideration.

Ultimately, Hispanic patients expect that treatment be characterized by (1) immediate symptom relief, (2) guidance and advicegiving, (3) a concrete focus, and (4) a problem-centered approach.

Given the above considerations, a cognitive behavioral approach is particularly applicable to Hispanic patients since it is structured and goal oriented.

COGNITIVE BEHAVIORAL APPROACH

All behavioral approaches are based on learning theory models and focus on the interactions among three types of learned human response: affect, cognition, and physical actions. All involve the breaking down of the presenting clinical configuration into "target areas" or specific manageable units of behavior. These can include (1) learned patterns of helplessness, (3) maladaptive responses to an individual's behavior, or (5) idiosyncratic, negative, or distorted patterns of processing experience.

Once the specific target areas are identified, the goals and objectives of the therapy can be delineated in discrete units rather than global terms. The therapist can then determine what types of therapeutic interventions would be appropriate for the patient to achieve the desired goal. Numerous techiniques are available to the therapist: education, exploration of inhibiting factors, advice and guidance, assertiveness training, role playing, etc. Any of these techniques can be utilized alone or in conjunction with others (e.g., medication) simultaneously or sequentially, and can be applied in individual, group, or family therapy settings.

The cognitive behavioral approach emphasizes that the individual's responses to specific and nonspecific stresses are the result of how one *thinks* of oneself and one's experiences. These cognitive patterns develop from early childhood experiences, from feedback from others, and from identification with others. The cognitive set creates a reverberating circuit or feedback loop that reinforces and perpetuates response patterns. The aim of the therapy is to identify faulty or distorted cognitions and correct them so that a path for more adaptive behavioral responses is opened.

For example, many of the depressed Hispanic patients that we have treated presented numerous depression-generating cognitions revolving around the traditional Hispanic cultural prohibitions concerning (1) anger and aggression, and (2) sex-role behaviors. These cognitions affect interpersonal relations within the family as well as the larger social context. They often set up unrealistically high expectations of self as well as a tendency to compare oneself unfavorably with others, thus paving the way for poor self-esteem. The resulting maladaptive responses evoke negative environmental feedback which reinforces the low self-esteem and sets up the feedback loop. The therapeutic task involves:

1. a recognition that the way one characteristically processes experiences affects the way one feels and acts;
2. developing alternative ways of looking at and evaluating situations and people;
3. generating alternative solutions to problems;
4. understanding the means necessary to achieve desired goals;
5. grasping the possible consequences of alternative solutions; and
6. choosing goals and implementing necessary courses of action.

Throughout, the emphasis is on concretely dealing with situations as they come along, working with here-and-now events first and going on to more basic maladaptive assumptions as treatment progresses. The basic premise is that nothing succeeds like success, that mastery over a specific situation will begin to breakdown the negative feedback loop, and that a sequence of specific successes will ultimately be generalizable to other life situations. The process frees the patient to verbalize on-going needs and feelings in a socially appropriate manner and to deal with them on a cognitive level. An important goal of this approach is to make the patient more responsible for the direction, rate, and extent of therapeutic change. It minimizes the passive patient role and increases his/her ability to develop new skills in solving future problems as well.

CASE EXAMPLES

The following clinical vignettes illustrate the application of cognitive behavioral approaches with Hispanic patients in individual and group therapy.

Individual Therapy

A 24-year-old Puerto Rican mother of a five-year-old daughter came to the clinic complaining of multiple somatic complaints and feeling that her "brain wasn't working as it should." She was employed in a garment factory and had recently noticed that she had lost her confidence in her ability to operate her machine. While previously she had been able to do her work automatically, she found herself becoming distracted by many thoughts and needing to consciously focus on what she was doing to keep up. She had also become afraid of the possibility of personal injury if she didn't pay attention to what she was doing. This fear had now extended to other activities (cooking, shopping, etc). She had also developed increasing difficulty in making decisions and in expressing herself verbally, finding herself carefully weighing her words.

The client is the youngest of five children and has two brothers and two sisters. Her husband, from whom she had been separated for two years, is six years older. He is one of her older brother's friends and she met him when she was 15. She wasn't sure she was in love with him but married him three years later at the insistence of her brother and mother who held him in high regard.

Because of marital discord, she left her husband. In the ensuing two years, she lived with her mother and then her sister. She was constantly berated by her mother and her siblings for her decision to leave her husband and they reminded her that women stay married at all costs, that children should have a father, that a woman isn't worth anything without a husband. The husband, with encouragement from her mother and brother, alternately, pleaded for her return or threatened her with a violent end.

After her separation, she had also fallen in love with a co-worker and was terrified that her involvement with him would be discovered by her husband and family.

Initially, a direct educational approach was utilized to help the patient understand the relationship between her distressing symptoms and the destructive, degrading, frightening circumstances in her life. Identification of broad problem areas included, in order of priority, difficulties in coping with the demands of her family, husband, and boyfriend. Among the goals she set for herself within the above areas were: (1) decreasing her dependency on her family while encouraging greater family support and understanding, (2) getting her husband to consent to a divorce, and (3) moving to her own apartment.

By means of concrete examples she was helped to think in other dimensions, i.e., to identify other ways of looking at daily events, such as a specific interaction between herself and her mother. She began to realize that other people's behavior was aimed at keeping control over her and that her feeling of powerlessness was directly related to how much she permitted that to happen. She also began to understand that her acquiescence to such manipulation was based on the faulty assumptions about the role of women that she had come to accept, and that were now being constantly reinforced by her family as means of control. Factors inhibiting her taking more assertive action, e.g., setting limits to her family's interference, emerged as a set of fears. Realistic and unrealistic fears were examined and alternative ways of dealing with specific situations were rehearsed. (e.g., What is the worst possible scenario you can imagine? What could you do to deal with it?)

Such fantasized scenarios, more often than not, tended not to happen, and she emerged from each situation with a sense of mastery or control that reinforced her confidence in herself to handle interpersonal encounters. Much of the cognitive restructuring was oriented toward working through problems surrounding the expression of anger as an acceptable emotion and reworking maladaptive and unrealistic expectations around sex-role behaviors and child-parent interactions. At termination she had moved to her own apartment and had instituted divorce proceedings.

Group Therapy

As part of a partial hospitalization program within a community mental health center based in inner-city Philadelphia, several Hispanic patient groups were formed for newly migrated Puerto Rican families. These newly arrived patients were totally lacking in extended family supports and in need of more extensive treatment short of hospitalization. The primary presenting problems were depression and family conflicts.

This program was designed within a culturally syntonic framework and staffed entirely with bilingual, bicultural staff. All therapy was conducted in Spanish and in the context of a variety of activities, such as planning and preparing Puerto Rican dishes for the noon-day meal, getting oriented to the city and its agencies, and learning to identify sources of emotional stress.

The primary therapeutic modality utilized within this program was cognitive behaviorally oriented groups. Male-female co-therapy teams were chosen to colead the groups, which were same-sexed groups. It became necessary to have separate male and female groups for our Puerto Rican patients, not only because culturally the sexes are often segregated, but also because the newly arrived male and female Puerto Rican patients presented different problems and degrees of severity. The newly arrived Puerto Rican women appeared to be less severely depressed, and their presenting problems seemed to revolve around marital, sex-role, and childrearing issues. Many of the newly migrated male patients appeared to be more severely depressed. Some had serious drinking disorders or criminal records and were referred to the mental health clinic by probation and the courts.

Both male and female groups involved training in interpersonal problem solving, assertiveness training, and cognitive restructuring. For the male group, the focus was to minimize impulsivity and drinking behavior, which were characteristic methods of conflict resolution, through training in a number of more socially acceptable and adaptive behaviors for the expression of anger short of outright physical confrontation. For the female groups, the focus centered around child-rearing and child management as well as adaptive problem-solving strategies for marital conflicts.

These groups became extended systems of support for these newly migrated families. In most cases, the depression lifted as these patients learned more adaptive methods of conflict resolution and expression of anger and assertiveness, all of which are valuable adaptive skills for survival in this country.

At a different service site, an outpatient group was formed for women who were long-time residents of the city and were experiencing marital problems with their spouses and intergenerational conflicts with their children. It was labeled as a "*study* group for personal growth" and not as a group therapy. The techniques utilized were the same as in the above groups but much reliance was placed on members of the group providing to each other consensual validation, direct suggestions, and advice around individual issues and needs and mutual support in times of stress. Alternative ways of dealing with alcoholic

husbands, pregnant teenaged children, and other intrafamilial situations were examined with the goal of enhancing the members' coping strategies. Both individual successes and failures were discussed to reinforce the learning experience. The group also served as a social support system through the celebration of birthdays and special holidays. At termination, the members decided to hold a graduation ceremony and each participant was given two certificates (Spanish and English) attesting to their respective completion of the course on personal growth.

SUMMARY AND CONCLUSIONS

We have presented an overview of the cultural dynamics of lower socioeconomic, urban Hispanic populations—specifically, their particular view of the world that emphasizes mutual respect and cooperation, their learning and coping styles that include a concrete orientation and an emphasis on the present, and commonly held attitudes concerning the expression of anger and assertiveness—all of which render this particular patient population especially responsive to cognitive behavioral approaches.

The cognitive behavioral model, which is time limited, goal oriented, and problem centered has been applied with this population as a means of working through traditional cultural assumptions that are perhaps maladaptive in North American society. For example, the cultural prohibition of the expression of anger and what is generally considered to be stereotypical desirable male and female sex role behavior are found frequently to be operating with Hispanic patients, in particular Hispanic women who are depressed.

Both individual and group applications in outpatient and partial hospitalization settings have been discussed. Male and female Hispanic patients with such diverse presenting problems as excessive drinking and impulsivity (among males) as well as other marital, interpersonal, and child management issues have benefited from this approach particulary if adapted and applied by culturally sensitive clinicians.

REFERENCES

1. Torrey F: *The Mind Game: Witchdoctors and Psychiatrists.* New York, Emerson Hall, 1972.
2. Minuchin S: *Families and Family Therapy.* Cambridge, Mass, Harvard University Press, 1974.
3. Ramirez M, Castaneda A: *Cultural Democracy. Bicognitive Development, and Education.* New York, Academic Press, 1974.
4. Rothberg A: Puerto Ricans and aggression. Am J Psychiat 20: 962-970, 1964.
5. Ramirez Boulette T: Assertive training with low income Mexican American women. *Psychotherapy with the Spanish-Speaking: Issues in Research and Service Delivery,* Monograph, No. 3. SSMHRC, UCLA, 1976.