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What you will learn in this lesson:

- how to utilize interpreter services in a medical setting
- cultural courtesies and formalities in Spanish related to greetings, foods, time, space, privacy issues, family, and circular v. linear thought processes
- the near nonexistent concept of preventive medicine v. a doctor/dental visit only when feeling extremely ill or when toothache or throbbing is intolerable
- the concept of walk-in clinic v. doctor appointments
- prescriptions v. OTC meds v. consulting at the **farmacia** in Latin America (and subsequently purchasing medication without a prescription or without a previous doctor visit)
- to distinguish some "culture-bound syndromes"
- vocabulary related to medications
- vocabulary related to illnesses and symptoms
- medically related "layman" and slang terms

The first goal of this lesson is to be introduced to and understand some Latino cultural values and belief systems, as well as to be aware of the differences between "Anglo" and Latino behavioral patterns and subsequently to be able to apply this knowledge successfully during a Latino patient interview and exam.

The second goal is to use and recognize medically related terminology in order to express yourself, understand, and make yourself understood by all your Latino Spanish-speaking patients, no matter what their background may be.

This lesson is divided into two principal parts. The first is "Cultural competency/Cross-cultural communication" and discusses interpreter techniques, as well as many cultural factors including some religious beliefs and culture-bound syndromes to provide insight into your Latino patients' varied belief systems and needs. It is hoped that this, in turn, will aid in creating a better rapport between the healthcare professional and patients.

The second part consists of vocabulary related to herbal remedies and medicines, which are listed in alphabetical order. Following this is a list of illnesses and symptoms, grouped by body systems and ordered alphabetically.

15.1 Cultural competency/cross-cultural communication

THE INTERPRETER

There are three basic forms of interpreting: simultaneous, consecutive, and paraphrasing. Let's examine the strengths and weaknesses of each method.

Simultaneous interpretation. This method consists of speaking concurrently in one language while listening in the other. The interpreter tracks approximately one or two words behind the speaker and renders the most precise translation possible.

Simultaneous translation is helpful when conserving time is a predominant factor. It does not necessarily provide for establishing close physician–patient contact or personal communication, however. The best use of this technique is for interpreting conferences, where a large number of persons can listen to the translation using headsets. In a medical setting, some find this method too distracting because it is difficult to listen to two people speaking simultaneously in different languages.

Consecutive interpretation. This technique consists of interpreting several phrases as precisely as possible, *after* the speaker has paused. This method, depending upon the interpreter's ability to retain and recall information, may foster a better physician–patient rapport because the doctor and patient can establish eye contact more easily while "speaking" to one another. They can "listen" to each other, first comprehending what they can, and then resort to the interpreter's "rendition" for confirmation. The drawback is that consecutive interpretation is more time-consuming.

Paraphrasing. This method allows the doctor and patient to express several sentences or paragraphs, which the interpreter then summarizes. It is quicker than the consecutive method, but slower than the simultaneous method. Paraphrasing is not always as accurate as the other two techniques, but it does allow for the interpreter to

"soften" the language or to take into account cultural differences in expressions, courtesy, etc. The use of this method, however, can lead to a great deal of inaccuracy because salient factors may be lost by the interpreter's potential inability to recognize the important points and thus fail to convey crucial information.

Often a combination of all the techniques is used. Skilled interpreters usually defer to the doctor and patient regarding their preferences first, whenever possible.

Using an interpreter. When employing the services of an interpreter, the medical professional should first brief the interpreter on the upcoming procedure and examination and then request that the interpreter meet with the patient beforehand in order to explain what to expect during the procedure or exam, as well as what to expect in terms of the doctor, nurse, or technician. In this way, the interpreter can explain that a U.S.-trained doctor may seem more curt, brusque, dryer, and colder than a Hispanic doctor and that the patient should please not be offended. It also seems to be more effective, more comfortable, and less embarrassing for the patient when the interpreter is of the same sex.

In a hospital setting, the medical interpreter delicately balances the following four roles:

Direct translator	Must find a term with the exact equivalent.
Cultural broker	Must grasp two, often opposing backgrounds and take them into account within a split second while interpreting the concepts and content.
Biomedical interpreter	Must be a facilitator by linking healthcare knowledge, procedures, and analogies that properly convey the idea.
Patient advocate	Must help patients deal with red tape, and make their needs known in general. Often the interpreter must assist in finding locations, filling out forms, and guiding the patient.

Interpreters must be aware of various Spanish dialects, regionalisms, educational backgrounds, and untranslatable terms. Therefore, it is not necessarily true that being bilingual is equivalent to being a capable, competent interpreter. Interpreting is a highly developed academic skill and a discipline. It should be noted, as well, that a good medical interpreter is an integral part of the professional medical team when treating a non–English-speaking patient. He or she should not, however, offer personal opinions and impressions or give advice if the patient asks what the interpreter thinks. Nor should an interpreter release any information concerning the patient's condition unless it is given by the health care professional to be translated. The interpreter is the conduit from one culture and language to another.

The Medical Interpreters' and Translators' Code of Ethics states: "A medical interpreter/translator is a specially trained professional who has proficient knowledge and skills in a primary language or languages and employs that training in a medical or health-related setting in order to make possible communication among parties using different languages."

The skills of a medical interpreter/translator include cultural sensitivity and awareness with respect to all parties involved, as well as mastery of medical and colloquial terminology, which make possible conditions of mutual trust and accurate communication leading to effective provision of medical-health services.

GENERAL INFORMATION CONCERNING INTERPRETERS

The interpreter speaks in the first person ("I" form), as though he or she were the patient or healthcare provider. "He says," "She says," etc. are professionally improper.

The interpreter should maintain strictly confidential all information learned during an interpretation. If the content to be interpreted may be perceived as unwittingly or unintentionally offensive or insensitive to the dignity or well-being of the patient, the interpreter should tactfully inform the health professional. He or she should also make every effort to understand and communicate the social and cultural context in which the patient is operating because it may affect the patient's medical needs. It is the interpreter's responsibility to be aware of the cultural and social realities of the patient and to educate or inform those who might misunderstand and avoid becoming involved in conflict with those realities due to a lack of social awareness.

The interpreter should not accept any assignment for which he or she is not adequately qualified due to lack of language skill or knowledge of the subject matter, unless these limitations are understood by both the patient and the healthcare provider.

Confidentiality and comfort zones: Socioeconomic class differences openly exist in many Spanish-speaking countries, and attitudes formed by this system often continue to be manifested in the new country. An interpreter from a higher class may not show the same dignity or respect for a patient from a lower class or economically

challenged background. The patient may feel embarrassed or uncomfortable. On the other hand, a patient from a higher class background may feel uneasy confiding to the healthcare professional through an interpreter who could have been her maid or laundry woman in her own country.

No matter what the socioeconomic situation, confidentiality is a real problem in a small town or community where the patient can encounter the interpreter in the supermarket or at a neighborhood gathering. There is no assurance that the interpreter hasn't announced the patient's problems to the entire **barrio**. (If the interpreter is professional and/or ethical, the aforementioned should not occur, but the patient won't necessarily know or believe it.)

RELIGIOUS BELIEFS AS THEY AFFECT CULTURAL BELIEFS AND COMPLIANCE

In Latin America, religion and religious beliefs play an important role in the culture and how Latinos approach and seek medical help.

The Spaniards and Portuguese brought the Catholic religion to the Americas during their conquest and colonization. The indigenous people already had their own religious beliefs, as well as their own "proven" therapeutic customs and methods for taking care of medical needs. When these cultures and belief systems clashed, something quite interesting occurred. The indigenous Americans blended both religions, and thereafter practiced them either simultaneously and/or in a parallel fashion, quite unbeknownst to the conquerors.

In the Caribbean islands and coastal regions of the mainland, the "conquistadores" brutally killed off the indigenous peoples and subsequently introduced African slaves, who brought their own beliefs, customs, and gods with them. Interestingly enough, the same thing came to pass. Both religions merged, and were then blended with the African beliefs, rituals, and traditions.

The "old" customs and approaches are still strongly practiced in almost all parts of Latin America. Latinos living in major cities have easier access to modern medicine and will, thus, turn to it more readily than those living in the countryside who have less accessibility. The city dwellers may well use both methods concurrently.

It is important that healthcare providers be aware of these tendencies and beliefs, since their patients may use herbal teas, infusions, roots, and/or various home remedies to address their complaints. As we all know, these herbs, roots, etc., contain ingredients that could potentially have reactions with medicines that healthcare providers

may prescribe. Your patients may not mention their use of any of these home remedies, due to fear of being ridiculed, thus creating a potentially dangerous situation. One of the approaches we suggest to resolve this issue is to include the following, while maintaining the same tone of voice, when asking if your patient is taking any medication. "Are you taking any medication, including OTC meds (**medicamentos que no requieren recetas**), herbs, teas, or home remedies?"

By simply inquiring in this fashion, it allows them to know that you are aware of these traditions and accept them as routine, everyday practices. In this way, your patient will most likely feel more comfortable speaking to you and be more sincere and forthcoming.

THE HISPANIC PATIENT

In this section, we will look at general aspects to take into account concerning the Latino or Hispanic patient as opposed to the Anglo patient. Naturally, the authors are well aware that each individual is different and wish to avoid over-generalization. However, cultural differences simply do exist and are a fact of life, and it is incumbent upon healthcare professionals to be aware of them in order to avoid unwittingly offending a patient.

Within the Latino culture the extended family plays an extremely important role. The Hispanic family tends to be more close-knit than the Anglo family. A patient may often be accompanied by other family members for moral support, due to *cariño* (affection), or merely out of habit. The "Anglo" healthcare professional may feel somewhat overwhelmed by this, perhaps even somewhat defensive or frustrated, but there is no need to feel so. It is fairly customary.

Latinos also tend to be more expressive with their feelings, hand gestures, and body movements, in general, often touching each other in an affectionate or soothing manner, mentioning one another's names frequently within a conversation (a lovely personal touch), and/or often standing together at a much closer proximity than, for example, Anglo speakers would without feeling awkward or uncomfortable.

The Spanish language, which is reflective of Hispanic culture and vice versa, also observes more formal courtesies than does the mainstream culture in the United States. When meeting, greeting, interviewing, and leave-taking within the Hispanic culture, it is *extremely important*, customary, and courteous to shake hands upon meeting, greeting, and leave taking. Formalities and courtesies are stressed, while political correctness is not a recognized concept. Although hand shaking (especially if there are several people in the room) appears to

be a time-consuming gesture, especially when time is limited, in the long run it will be faster and more efficient to do so. The consult will run more smoothly as some rapport will have been established.

Latino children are generally taught not to question others, especially people in authority, because this is considered impolite and disrespectful. This attitude may carry over into adulthood. In the medical setting, it is not typical to ask questions or clarify points, as it is for mainstream U.S. patients. Thus, a healthcare professional may want to explain or emphasize some points a bit more or make sure all the patient's questions are answered. Remember, great respect is shown for priests, healthcare professionals, and the elderly. Out of respect for the healthcare providers, many patients may tend to agree with everything they say, so as not to "challenge" their authority and/or to avoid wasting the doctors' or nurses' valuable time.

Another cultural point to be aware of is that some Latinos adhere to the "homeostasis concept" that ill health may be interpreted as a lack of balance in the body. For example, it may be believed that a loss of blood affects sexual performance. Thus, the statement "The doctor needs to take blood" may result in a negative reaction unless the speaker also explains that there will be no ill effects from taking the sample. The concept of balance may affect other health issues; for example, parents may feel that they need to restore fluids that their baby has lost because of diarrhea.

Clearly, sensitivity to and awareness of cultural dynamics can greatly improve the relationship between the healthcare provider and the patient.

Attitudes toward food and family

Partaking, offering, and sharing food in an extended family environment is an integral part of Hispanic life. Food is not merely nutrition; it can signify security, warmth, survival, love, and acceptance. Thus, if dietary instructions are given in the following sense: "You should eat A, B, and C, but must stay away from D, E, and F" (which is concise and to the point in English), it would be construed as being harsh and unfeeling in Spanish. A more "apologetic" attitude, while also alluding to the family who loves and needs the patient, would be appropriate: "I am very sorry that you will need to be more careful of what you eat, but it is very important that you do so. Unfortunately, for your own health as well as your family's well-being, . . ."

Since the sharing and eating of food is such an important aspect of Latino life, it is understandable that bringing food to a hospital patient

during a visit is considered a warm and caring gesture. By the same token, it is common for family members and friends to visit a patient in the hospital even when the "crisis" is over. It would be considered cruel, cold, and uncaring not to visit or to visit without arms laden with food. Generally speaking, even the patient expects this support, and would feel saddened and grieve (thus taking longer to recover) without it. Although these visits en masse may be extremely annoying to the medical staff (who may well be understaffed, overoccupied with completing interminable documents, and busy dealing with multiple services), as well as to the other patients who share the room, at least it may help to understand why this "behavior" takes place.

Doctor-patient relationship

In order to establish a stronger, trusting doctor-patient relationship, the Hispanic patient would experience less stress if the doctor would do the following:

- Shake hands and introduce him- or herself.
- Try to pronounce the patient's name (**nombre**) and surnames (**apellidos**) correctly.
- Attempt to speak some Spanish, even if only a few initial courtesy phrases.
- Sit down for a moment with the patient to inquire about the family, the children, and how the patient has been feeling in general lately, etc. Even though the doctor may be pressed for time, this initial conversation smooths the way for more open dialogue and a more relaxed patient, allowing the remainder of the interview to be conducted more easily.
- Not be judgmental of the patient's customs and beliefs
- Never say that "grandma's" advice is wrong, foolish, or unwise as that argument will be lost along with any possibility of compliance.

The Spanish language and Latino culture often result in circular or branching thought processes; conversely, the English language and U.S. culture often result in linear thought processes. Whereas in the United States it is considered efficient to be brief, concise, and to the point, in Latin American countries, such "efficiency" would be considered the result of poor upbringing and the height of rudeness and offensiveness. Any meeting of Hispanics is preceded by standard courtesies and polite small talk, and only after these preliminaries can the reason for meeting be addressed. In a U.S. medical setting, the healthcare professional may find the preliminaries to be exceedingly frustrat-

ing. However, knowledge of the reasons behind them and acquaintance with the language and cultures should help explain why the patient may not be answering questions succinctly or may appear to go off on tangents without necessarily returning to the point. (In such cases, a gentle reminder may be all that is needed.)

In Latin America, patients will often talk to a doctor in the same manner as they would to a priest or a therapist. It is not as common nor as accepted to attend counseling sessions or see psychiatrists as it is in the Anglo population. As a result, the role of the doctor expands to include general counseling duties.

In Latin America it is still sometimes routine for doctors to make house calls. It is also not uncommon for the doctor or nurse to phone the patient the following day in order to check on his or her progress. In other words, Hispanics are accustomed to a more personal touch in health care. Once again, if an interpreter has not had time to speak with the patient and brief him or her on procedures or on what to expect during the interview, it would be very helpful for someone who speaks Spanish to do so. If this is not possible, hopefully the doctor will take the time to explain what he or she is going to be doing and why, in order to reassure the patient as much as possible.

Typical cultural differences

The following attitudes, beliefs, practices, and behaviors are generalizations. However, they are based on the authors' experiences and observations while interpreting doctor–patient interviews and talking with Hispanic patients.

1. It is still somewhat more common for Hispanics to believe that the fatter a baby is, the healthier she or he is. This is changing somewhat, however.

2. More sugar, salt, oil, and spicy seasonings are utilized in the "typical" Mexican diet than in the "typical" Anglo diet. (The food of most other Latin American countries is not as highly seasoned as that of Mexico.)

3. The concept of regular checkups and preventive medicine does not exist in Spanish-speaking countries. For adults, a yearly physical or a six-month dental checkup and teeth cleaning is almost inconceivable. The general attitude is, "If I feel really sick or am in great pain, I may go to see the doctor." First, however, the ailing adult usually tries home remedies, leftover medications, medicine suggested by the pharmacist, or treatments by other healers such as **curanderos**, **yerberos**, or **santeros**. About the only preventive medicine practiced is taking vitamins, drinking teas, and using antibiotics as a prophylactic measure. When the decision is finally made to go to the doctor, appointments are usually on a first-come, first-served basis. As a result, Latin Americans in the United States are often dismayed and alarmed when they finally call the doctor's office and are given an appointment in three to four weeks. Their reaction is, "I'll either be dead or better by then!" (In the United States, economics may also play a part in the delay in seeking medical help early on.)

Children, however, are an exception to the rule. They are considered God's treasure and are often taken to see the doctor for the slightest change in bodily functions, a fever, the sniffles, or unusual behavior. Preventive medicine is still not usual, even for children. (Recall from Chapter 4 that well-baby visits are rare to nonexistent in Latin America.)

4. The Latin American patient is more likely to drink liquids at room temperature than with ice in order to avoid "catching a cold." If a medication (particularly in liquid form) requires refrigeration, you may suggest removing it from the refrigerator some 10–15 minutes beforehand. This will allow it to return to room temperature (**a tiempo**), thus satisfying the patient and improving the possibility of compliance.

5. Latin Americans will often go in for an antibiotic shot (frequently at the **farmacia** or other business location where **inyecciones** are administered) in order to clear up a cold. In Mexico, as well as in many parts of Latin America, the pharmacy clerks are, at times, consulted for small ailments and will then recommend medication. Most medications (except amphetamines, mind-altering medicines, narcotics, and some tranquilizers) can be purchased without a doctor's prescription. The pharmacists are not required to have any specialized training or university studies; however, a great many of them do. Those who do not have generally learned the trade through daily contact and experience and usually have a Mexican *PDR* at hand.

6. The Latin American patient also often feels that if the doctor has not prescribed any medication, he or she has not really "treated" the patient's illness.

7. The following is a saying in Mexico referring to mealtimes: **Hay que desayunar como rey, almorzar como príncipe y cenar como mendigo,** which means "One should have breakfast like a king, lunch like a prince, and dinner like a pauper/beggar." It is believed healthier not to eat late at night. The large meal is eaten between 2:00 P.M. and

4:00 P.M. The wisdom of this practice has only been recognized here in the United States somewhat recently.

8. For some reason Anglos seem to complain of suffering more from headaches and backaches, whereas Latin American patients seem to mention bladder and liver problems with more frequency. According to Harvard medical anthropologist Arthur Kleinman, ". . . in the United States when we get stressed, we often get headaches. . . ." He goes on to quote Dr. Spann, who states, "In the Southern cone of Latin America—Argentina, Uruguay, and Paraguay—people frequently somatize to the liver. If they have a headache, they say the liver is bothering them."[1]

9. For some Latinos it is considered a punishment to be sick, which may be linked to religious as well as cultural beliefs.

10. It is often quite difficult to become acculturated to a new society, especially for Latino parents. Their children may assimilate more easily due to friends made at school or at play who are from other ethnic backgrounds. This can, in turn, cause great stress within the family, which can be manifested in a medical setting. Thus, since it is difficult to determine the degree of assimilation or acculturation of a patient, the medical professional is faced with additional obstacles when assessing the situation. Please keep in mind that a patient's country of origin, socioeconomic background, and formal education may also come into play.

11. We have noted in our classes during the past several years that several healthcare professionals have mentioned more frequently instances of young pregnant girls with no family or social support system. In some cases, her family may be back in her native country. This presents difficulties, and one (albeit perhaps glib) solution is to put the young girl in contact with **promotoras** who serve as mediators and liaisons between the community and the health clinic or healthcare system. The **promotoras** often live in the community or barrio and are accepted as friends, relatives, or trusted members of that area. Another potential solution is to put the girl in contact with a church group in her neighborhood.

CULTURE-BOUND SYNDROMES

Another significant area to be aware of is the existence of several "culture-bound syndromes" that are mentioned with a fair amount of frequency among Hispanic patients. The following are four of the most common: **caída de mollera** (fallen or depressed anterior fontanelle), **susto** (reactive depression or posttraumatic stress disorder), **empacho** (a blockage of the intestines), **nervios/ataque de nervios**, and **mal de ojo**.

[1]Robert P. Carlson, "Talking with your Hispanic immigrant patients," *Texas Medicine*, Oct. 1996, 91 (1996) 10:90.

Caída de mollera

The medical diagnosis is dehydration, which is believed to be caused by pulling the baby from the breast or bottle too quickly, holding the baby incorrectly, or allowing the baby to fall. Some of the symptoms are diarrhea, loss of appetite, fever, irritability, or vomiting, among others. **No debes de agitar mucho a los hijos porque se les cae la mollera.** Perceived cure: Push the thumb up in palate to try to raise and reshape the fallen area, which could cause more serious repercussions; turn the baby upside down and shake him lightly, tap his feet, or pat salt over his head.

Susto or mal de susto

The medical diagnosis may be reactive depression, an anxiety reaction, or post-traumatic stress syndrome and is believed to be caused by a startling or frightening event. Some of the symptoms are irritability, diarrhea, depression, insomnia at night, daytime drowsiness, and lack of appetite or weight loss. **El susto** is considered by some to be a departure of the soul from the body, which may be held captive by supernatural beings. This is believed to bring on TB, diabetes, miscarriages, and other disorders. Perceived cure: In some cases ritual cleansings or herbal teas are suggested. A healer might give the following instructions: prepare an herbal potion, put the potion in a spray bottle or have someone take a mouthful of the liquid and spray it on the patient while someone else suddenly covers the patient with a towel so that he or she continues to breathe in the vapors. In this way, the **susto** is cured with another **susto**.

Empacho

The medical diagnosis may be gastroenteritis, appendicitis, intestinal parasites, or food poisoning. **Empacho** is thought to be caused by a bolus of food that sticks to the intestinal wall as a result of eating certain foods at incorrect times, swallowing gum, swallowing too much saliva during teething, or eating too many sweets, among other things.

The symptoms are diarrhea, constipation, vomiting, indigestion, and feeling bloated and/or lethargic. The word *empacho* derives from the Indo-European word *ped* ("foot") and *impedire* ("to prevent"). The undigested food sticking to the wall of the digestive tract is perceived to differ from "regular" indigestion, perhaps as a result of social and psychological forces. For example, **empacho** in a child may occur if the child is forced to stop playing in order to eat dinner or is made to eat a dish or a food that he or she strongly dislikes. Perceived cure: Treatment may consist of having the back massaged, rubbing a raw egg over the area, and/or drinking herbal teas.

Nervios

Nervios or an **ataque de nervios** can consist of trembling, shouting, crying, aggressiveness, seizures, or fainting incidents. This can occur as a result of an extremely stressful happening, somewhat similar to **susto**. Other symptoms may include headaches, dizziness, nausea, diarrhea, anxiety, back or stomachaches, difficulty sleeping, fatigue, chest pains, lack of appetite, irritability, anger, sadness, crying, or agitation. The perceived cure is to drink teas or infusions, use herbs or roots, exercise, drink a lot of fluids, rest, and receive massages (often administered by **sobadores**). Other names for **nervios** include **espanto, pasmo, tripa ida,** and **pérdida del alma**.

Mal de ojo

Admiring or covetous looks are to blame for **mal de ojo**, which historically has been translated as "evil eye." Perceived symptoms include irritability, crying, sleeplessness, and fever. Prevention and treatment differ widely among Latinos from different regions. In the southwestern United States and Mexico, for example, **mal de ojo** can be warded off or prevented by touching a baby after looking at him or her with admiration or affection. Another preventive measure used is an amulet called **ojo de venado**[2] (made from a nut from a tree, **azabache**,[3] and amber tied together with red string), which is hung around the baby's neck or wrist, or a red string is tied around the baby's waist. In contrast, in the Caribbean region, it is "harmful" to touch a child after he or she has received admiring or covetous looks because this action

[2]**ojo de venado** literally, "deer's eye"
[3]**azabache** jet lignite

will pass on the **mal de ojo**. In Cuba, a mother is supposed to say, **Bésale el culito** ("Kiss his little ass/anus") after someone admires her baby. Around the Caribbean, **azabache** is used as a prophylactic. In many regions or countries, treatment may consist of passing an unbroken egg (a pure unborn entity) over the child's body.

NEGATIVE FORCES

Mal de ojo is a good example of the underlying concept of positive versus negative forces that is manifested in many beliefs and/or religions throughout the world. The "negative forces" (called evil, bad, the devil, dark, bad energy, etc.) make you ill, and the "positive forces" (called good, light, angels, etc.) make you well. In order to become better, healthier, richer, happier, etc., one must drive the negative out and replace it with something positive. A common practice worldwide is the use of an egg to attract the negative force from the person by drawing it into the egg, which is then disposed of so that it can no longer cause harm. In the case of **mal de ojo**, it is believed that when someone comments about a child (a pure and vulnerable entity), that person may be feeling envy, jealousy, or other negative emotions. This negative feeling sends out bad energy or "vibes" that may enter the child and make him or her sick. There are many methods of driving out the negative forces. In addition to eggs, animals are often used to attract the negative forces. Other methods consist of introducing goodness such as perfumes, incense, prayers, fire, or penance that will overwhelm the "negative" force and compel it to leave.

According to Robert T. Trotter II, Ph.D., in his article "Folk medicine in the Southwest," the first three illnesses, **caída de mollera**, **susto**, and **empacho**, "can be linked to recognized biologic conditions and therefore cannot be analyzed solely on the basis of socio-cultural factors. Clearly, it would be a mistake to continue ignoring these syndromes in the Southwest on the assumption that they are 'all in the mind' of the Mexican-American patients."[4] It can be added that these three illnesses are not only known by the above names within the Southwest of the United States and Mexico, but in all of Latin America as well. It is very important for non-Latino doctors to recognize their existence and symptoms, among those of other illnesses, in order to have a better understanding of their Hispanic patients.

[4]Robert T. Trotter II, "Folk medicine in the Southwest," Interstate Postgraduate Medical Assembly, 78 (December, 1985) 8:169–170.

VARIABLES

Naturally, each Latino patient's background must be taken into consideration regarding social and economic class, country and region, etc. These are all variable factors in any culture. They are particularly relevant when dealing with Spanish-speaking populations, since there are 20 countries in the Americas with native Spanish speakers, and each of these countries has its own indigenous populations with different customs and languages. Please bear this in mind while reviewing the following, some of which are also considered to be "culture-bound syndromes" or characteristics.

Giving birth. Some Hispanic women in U.S. hospitals may choose to deliver their babies in a squatting or kneeling position on the floor rather than in a hospital bed. These women are not accustomed to having their newborn whisked away to another room, but laid in their arms immediately after birth. This preference is in line with the holistic approach that many U.S. hospitals are beginning to accept as an alternative.

Attitudes toward hospitals. Because illness is often perceived as a weakness of character or a punishment from God, it merits mention that the Latin American patient often believes, as stated by Antonio Zavaleta, ". . . that if you go into a hospital you will not come out alive, that you will die there. For many Latino immigrants, this fear is real!"[5]

Mal aire. Literally, this means "bad air." The medical diagnosis may be angina pectoris, pneumonia, or even a peptic ulcer. **Mal aire** is believed to be night air that can enter any body cavity and cause gas and distention. Perceived preventions are many and varied. For example, placing a raisin on the umbilical cord of a newborn, covering an infant's ears with a cap, and, for mothers, avoiding sexual activity for 40 days after giving birth are all perceived as measures to prevent contracting **mal aire**.

In addition to exposure to night air, **mal aire** also applies to extremes of temperature, especially going from the heat into the cold. Situations in which **mal aire** can be contracted include the following:

- Having a pain in the side, chest, or back and being exposed to the cold
- Becoming hot while cooking or making tortillas and either going out into the cold or cool air or touching or drinking cold water

[5]Quoted in "Talking with your Hispanic immigrant patients" by Robert P. Carlson, page 38.

- Going out into the cold air when an eye is red or having red eyes from watching television or a movie and being exposed to cold air[6]

People who believe they have **mal aire** often state, **Me dio un aire** ("I caught an air [bad air]").

Treatment often consists of using a lighted candle and a glass to create suction, called **ventosa** in Spanish and "cupping" in English. Cupping of one kind or another is practiced all over the world. You can tell if a patient has tried this treatment by the circular pattern of superficial "hickeylike" indentations. Recognizing the results of this treatment can avoid a misguided call to the authorities to report abuse since these are superficial and not painful!

Mal de orin. A urinary tract infection, called "urine sickness," is manifested by frequency of urination or pain upon urination. (In Nicaragua, the term **chistata**, which means "cystitis," is often used.) This is normally treated with teas.

Algodoncillo. This disease or infection, called "thrush" in English, is believed to be provoked by heat rising from the body to the mouth. Concerned parents will often describe it as little bits of cotton (**algodoncillos**) between the lip and the teeth. It is actually a fungal infection that occurs in newborns and suckling babies up to six months of age.[7] The perceived cure is to put cotton on a stick or to use a cotton swab to remove the infection.

Erisipela. "Erysipelas" is red spots on the hands and arms that have been overexposed to sun. **Erisipela**, which is also called **jiotes** or **ersipela**, is also believed to be caused by a lack of vitamins.[8]

Fogaso. It is believed that heat rising from the center of the body causes tiny red dots on the mouth and tongue, stressed feet, and rashes.

[6]Patients have explained this syndrome to the authors as follows: *"Cuando tienes un dolor en el costado, pecho o espalda o cuando sales de repente de la casa y hace frío afuera y tienes calor o si estás guisando y tienes calor. O si estás haciendo tortillas, no debes de agarrar el agua fría porque tienes calor y te puede dar un aire, o si el ojo se pone muy rojo, y sales con el frío, o si estás viendo la tele o un cine y sales al frío, quizás es conjuntivitis pero se dice, me dio un aire."*

[7]This syndrome has been described as follows: *"Es una cosita blanca que les forma a los bebés recién nacidos hasta los 6 meses. Es como algodoncillos entre el labio y el diente. Pones algodón en un palito y lo quitas. Es como lama en la boca. Esto nada más ocurre con los bebés o niños lactantes—entre recién nacidos hasta los seis meses de edad."*

[8]This syndrome has been described as follows: *"O puede ser falta de vitaminas que también se llama 'jiotes' o ersipela."*

Postemillas; fuegos. Toothaches or abscessed teeth are common ailments. **Fuegos** (literally, "fires") is used to describe chancre sores, fever blisters, or cold sores.[9]

Chípil. This disease that children have after weaning is believed to be caused by crawling on a cold floor and is connected with cold and rejection. As an adjective, **chipilo(-a)** is used to describe a younger child. It is believed that jealousy or envy of a younger sibling causes a child to become **chípil** and demonstrate behaviors of crying, whining, or throwing tantrums. A child can even become **chipilón** from jealousy during the mother's pregnancy with another child.[10]

Hot and Cold Syndrome. Many common problems and complaints are believed to come from either heat or cold. For example, cold is believed to lead to chest cramps, earaches, headaches, stiffness, paralysis, pain due to strains, teething pain, stomach cramps, and maladies resulting from cold air on certain parts of the body. Tuberculosis may be provoked by the "cold theory." The Hot and Cold Syndrome is more than likely based on the early Hippocratic theory of disease and the four body "humors." The theory may well have spread through Spain between the 700s and 1400s while the Moors (Arabic culture) invaded and settled Spain and then from Spain to the New World (Latin America).

The disrupted relationship between these humors is often considered to be the cause of disease. Thus when all four "humors" are balanced, the body is healthy.

Blood	hot and wet	**Yellow bile**	hot and dry
Phlegm	cold and wet	**Black bile**	cold and dry

For example, if an illness is classified as "hot," it must be treated with a cold substance. To maintain balance, "hot" foods should not be combined; they should be eaten with "cold" foods. It is also suggested, for example, that after delivering a baby, which is considered a "hot" experience, a woman should not eat pork, a "hot" food, but should eat something "cold" to restore her balance.

Some "cold" foods are avocados, bananas, white beans, lima beans, coconut, and sugar cane. Some "hot" foods are chocolate, coffee, alcohol, corn meal, garlic, kidney beans, onions, and peas. (There is no logic by which to determine the category of a food; the classifications are simply "known" and passed down.)

[9]This syndrome has been described as follows: *"Son los 'fuegos' de la boca o úlceras o ulceritas."*

[10]This syndrome has been described as follows: *"Si estás embarazada con otro bebé, el niño se pone chípil o chillón y hace berrinches y llora."*

Some illnesses and conditions that are considered "cold" are arthritis, colds, menstruation, and joint pains; while some "hot" illnesses are constipation, diarrhea, rashes, and ulcers.

It is believed that penicillin is a "hot" medication and cannot be used to treat a "hot" disease. Unfortunately, for healthcare providers, the concepts of hot and cold can vary from country to country and even from region to region. Nevertheless, an awareness of patients' perceptions of hot and cold diseases, foods, and remedies can result in understanding why a patient may react strongly or fearfully to a doctor's recommendation, treatment program, or even diagnosis. Even in the mainstream U.S. culture, cold is associated with threatening aspects of existence, and heat is associated with secure and comforting aspects of existence.

SUMMARY

As can be seen, many concepts that underlie folk culture medicine have a basis, and the cures have been handed down through the years, some being very effective. The point here, however, is to be aware of common complaints, beliefs, and treatments and to recognize them within the context of the culture.

Dr. Zavaleta also has issued the following caution: "There's an ill-informed belief that culturally based health-care delivery systems like folk healers are declining, and that is absolutely not true." He continues by stating, "What we find is these delivery systems are very often not right out there for you to see. When you ask people, they are not going to tell you about them. It's the kind of thing you have to spend almost a lifetime studying in order to really see it and have people tell you the truth."[11]

After a great deal of study, much discussion with many Latino friends, acquaintances, and family, as well as firsthand knowledge, the authors wholeheartedly agree with Dr. Zavaleta. If anyone suggests that **curanderos** are very rare nowadays, he or she either has not won the patient's **confianza** ("trust") or is a Latino embarrassed to admit his or her belief for fear of ridicule. You can be sure that where there is a concentration of Latinos living in any area, city or rural, there are **hierberos** (**yerberos**) as well as practicing **curanderos, santeros,** and "shamans."

[11]Quoted in "Talking with your Hispanic immigrant patients" by Robert P. Carlson, page 40.

As of this latest edition, we can now, happily and at last, add that **nervios** is mentioned in the DSM IV, indicating that it has, at least, finally been recognized more "officially" by some of the health care professionals.

Presentations and discussion of **ataques** have been provided in several health conferences, such as the 14th Annual Latino Behavioral Health Institute Conference, held from September 15–18, 2008, in Los Angeles. N. Salgado de Snyder, Ph.D., has written many articles concerning **ataque de nervios**, and one of her latest discusses it in an article she authored with Bojórquez and Casique in the *International Journal of Social Psychiatry*, July 2009.

And finally, we are pleased to conclude that **empacho, mal de ojo, nervios,** and **susto** are now listed in the DSM-IV-TR as culture-bound syndromes!

As we conclude this section on cross-cultural communication and understanding, it bears repeating that the Latino patients' concerns and complaints should not be ridiculed or dismissed as inconsequential social and cultural phenomena. Latino patients, like all patients, should be accorded compassion, understanding, and respect by members of the medical profession.

15.2 Herbal remedies

The following is a list of some herbal remedies with their English names, Spanish name equivalents, and cures as perceived by the patient. Most are taken in the form of teas or applied as topical lotions. Many are also used as food seasonings.

English	Spanish	Perceived use
aloe, aloe vera	**sábila**	burns, cancer, asthma, scars, swelling of the extremities
chamomile (tea)	**manzanilla**	upset stomach, cramps, diarrhea, colic
camphor (tea, lotion)	**alcanfor**	laxative
coriander (tea)	**cilantro**	laxative, purgative, cramps
corn silk (tea)	**pelos, cabellos de elote**	urinary infection, kidney stones
garlic (garlic water)	**ajo**	blood pressure, asthma, TB, worms
gordolobo	**gordolobo, mullein, mullen**	cough, bronchitis, hemorrhoids, varicose veins
linden	**tila**	nervousness, sleeplessness
mint (tea)	**yerba, hierba buena**	stomachaches, colic, nerves
olive oil (oil)	**aceite de olivo**	burns, fever, constipation
onion (food)	**cebolla**	burns, coughs, tumors, warts
orange blossom (tea)	**flor de azahar**	nerves, tranquilizer, insomnia
rue (tea)	**ruda**	nerves, hysteria, headache, menstrual cramps, abortion during the first to second month
sage (tea)	**salvia**	high cholesterol, dysentery, headache, stomachache, phlegm
worm seed (tea, lotion)	**epazote**	fungus, as a diuretic, stomachache

15.3 Medicines
Medicinas

adrenaline	**la adrenalina**
analgesics	**los analgésicos**
antacids	**los antiácidos**
antibiotics	**los antibióticos**
antidote	**el antídoto**
antihistamines	**los antihistamínicos**
aspirin	**la aspirina**
atropine	**la atropina**
barbiturates	**los barbitúricos**
belladonna	**la belladona**
bicarbonate	**el bicarbonato**
bromide	**el bromuro**
liniment	**el linimento**
lozenges	**los trocitos, las pastillas para chupar**
ointment	**el ungüento**
paregoric	**el paregórico**
penicillin	**la penicilina**
pills	**las píldoras, las pastillas**
plasters/patches	**los parches**
pomade	**la pomada**
purgative	**el purgante**
sedative	**el sedante**