Somatization and Psychological Distress in Mexican American Immigrant Women: Literature Review and Qualitative Analysis

by

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B.A. (Yale University) 1991

A thesis submitted in partial satisfaction of the requirements for the degree of

Masters of Science
in
Health and Medical Sciences

in the

GRADUATE DIVISION

of the

UNIVERSITY OF CALIFORNIA, BERKELEY

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Spring 1998
Approval Page

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University of California, Berkeley
Spring 1998
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## Table of Contents

**Introduction**

1

**Literature Review**

3

**References**

22

**Somatization and Psychological Distress in Mexican American Immigrant Women**

**Introduction**

25

**Methods**

31

**Results**

37

**Discussion**

53

**References**

60

**Appendix**

63

**Conclusion**

64
Introduction

This project is a culmination of my experiences and interests in the areas of mind-body medicine and medical care for Latinos. I worked for several years (1992-1994) as a Patient Advocate at Mayfield Community Clinic in Palo Alto, CA, a publicly funded primary care clinic whose principal clients were immigrant Latinas and their young children. My job involved Spanish translation between patients and providers, health education, and medical assisting tasks such as taking vital signs and giving injections. I loved my job, and it was the inspiration for me to attend medical school.

I felt as if the services the clinic provided, such as prenatal care, family planning, and well-child care, were desired and accepted by the patients. In many cases these services were truly helpful to them. But as I watched and participated in these medical interactions, I also became aware that the providers were sometimes only obliquely addressing the patients' needs. I was continually surprised that, despite the friendly rapport I enjoyed with them, the patients rarely volunteered information about their personal lives and problems unless I asked them directly, and in a sympathetic tone. Yet my intuition told me that at least some of the patients looked to the medical encounter for emotional support. This need for emotional support was unspoken by the patients, and thus was not usually addressed directly by the medical providers. Instead, providers and patients carried out their roles according to a strictly medical script.

This sort of circumscribed interaction may have been frustrating for the patients; it was also disturbing and confusing for me. My questions have remained with me during my medical training: I wondered what the proper boundaries and limits of a medical interaction should be. How much should a
provider follow her intuition and pursue psychosocial issues with a patient who raises only medical concerns? How does a provider cope on a personal level with the depth of the emotional needs of her patients? How does she sort out the psychological elements of a physical problem, and how should she address these issues therapeutically? When should a physical symptom be treated as more than a physical problem? These were subtle and difficult issues, and it seemed to me that dealing with them cross-culturally demanded great skill and sensitivity. This research on somatization in Mexican American women moves towards a response to these questions, but it starts at the beginning: with an investigation of the women's own perspectives on their physical and emotional distress and well-being. It is my goal to illuminate some of the beliefs, emotions, and personal experiences that Mexican American women bring to the medical setting, but which remain largely unarticulated.
Literature Review

Somatization has been studied by various groups of professionals with unique perspectives on the relationship between the body and the mind, among them psychologists, psychiatrists, anthropologists, and physicians. This literature review draws on these perspectives to illuminate the current construct of somatization, as well as the issues surrounding somatization in Latinos. A description of the traditional psychoanalytic portrayal of somatization is followed by current formal definitions of somatoform disorders. The review then seeks to elaborate an understanding of somatization which takes into account recent research demonstrating the co-occurrence of physical and psychological distress. Research pertaining to discussions of somatization in the health care system and the links between somatization and depression is also reviewed.

The relationship between the mind and body is culturally specific, and somatic symptoms take on subjective meanings based on their cultural contexts. Somatization may function as an “idiom of distress” in Latino cultures, an indirect way of expressing discontent with relationships and life circumstances. Somatization thus functions as a complex, culturally based form of communication, as well as a way of experiencing distress. Given these complex, subjective meanings, the review concludes with an examination of the beliefs of Latinos themselves concerning the causal links between psychosocial factors and somatic symptoms. Considerations for medical providers working with Latino patients are also offered.

The Psychoanalytic View of Somatization

The traditional psychoanalytic understanding of somatization is derived from Freud’s notion of hysterical conversion. Somatization is conceptualized as
a way of defending against difficult emotional experience (Lipowski, 1988), "a process of converting, transferring, or diverting emotional distress into somatic symptoms" (Kirmayer, 1996, p. 132). Although the psychoanalytic perspective is by no means monolithic (Bucci, 1997), several important assumptions underlie the dominant viewpoint. First of all, the psychological is privileged over the physical as being a more advanced, sophisticated or true way to experience distress. Second, the experience and expression of emotional distress in physical versus psychological terms is seen as a dichotomous phenomenon, emphasizing a modern paradigm of mind-body dualism; distress is experienced and expressed in physical terms because psychological pathways are blocked. Finally, somatization is often seen to be a pathological or abnormal process rather than a potentially adaptive or culturally normative one.

**DSM-IV and Somatization**

The issues of psychopathology and the experience of distress are reflected in current formal diagnoses of somatoform disorders. There are several psychiatric disorders associated with somatization described in the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM-IV) (APA, 1994); the conceptualization of these disorders reflects an evolving understanding of the nature and significance of somatization. The DSM-IV describes several Axis I somatoform disorders: Somatization Disorder, Undifferentiated Somatoform Disorder, Pain Disorder, and Hypochondriasis. This cluster of conditions involves "the presence of physical symptoms that suggest a general medical condition...and are not fully explained by a general medical condition, by the direct effects of a substance, or by another mental disorder" (APA, 1994, p. 445).
**Somatization Disorder.** Somatization Disorder (SD) is a serious, chronic condition involving multiple somatic complaints in multiple organ systems (APA, 1994). Revised and simplified diagnostic criteria for SD in the DSM-IV include: four pain symptoms, two gastrointestinal symptoms, one sexual symptom, and one pseudoneurological symptom such as conversion or dissociation. The alternative diagnosis of Undifferentiated Somatoform Disorder is applied when a person suffers chronic, unexplained physical symptoms that do not meet the full criteria for SD. Patients with SD tend to seek and receive medical services, and may suffer significant iatrogenic morbidity due to invasive testing, unnecessary surgeries, and addiction to pain medication and tranquillizers. The diagnostic criteria for SD focus attention on somatic symptom counts at the expense of attention to behaviors surrounding the symptoms. This approach has been criticized because somatizing patients are known to be suggestible and to present different symptoms in different clinical settings (Fink, 1996). The cut-off for diagnosis of SD in terms of number of symptoms has been questioned as well. One study of high utilizers of primary care found no significant clinical or behavioral differences between patients suffering four to twelve unexplained symptoms as opposed to those with full-blown SD (Katon, Lin, VonKorff, Russo, Lipscomb et al., 1991).

Depression and anxiety disorders can involve extensive somatic symptomatology, rendering a differential diagnosis with SD difficult. Thus a diagnosis of SD requires showing that physical symptoms recur throughout life irrespective of affective state and that the symptoms are a major focus of any anxiety and worry which the person experiences (APA, 1994). Full-blown SD is quite rare, with a prevalence of 0.2-2% among women and 0.2% among men.
(APA, 1994). Although rates for Undifferentiated Somatoform Disorder are not reported in the DSM-IV, it may be the most common somatoform disorder (Kirmayer and Robbins, 1991a). Escobar, Rubio-Stipec, Canino, and Kano (1989) have proposed an abridged construct of SD (the Somatic Symptom Index, or SSI) which would fall under the rubric of DSM-IV Undifferentiated Somatoform Disorder. The SSI involves only six somatic symptoms for women and four for men. Based on the SSI construct, Escobar et al. found a prevalence of 9% to 20% in population-based samples interviewed as part of the landmark Epidemiologic Catchment Area (ECA) study done during the 1980s to assess psychopathology in the United States.

**Pain disorders.** There are three subtypes of pain disorder enumerated in the DSM-IV: Pain Disorder Associated with Psychological Factors, Pain Disorder Associated with Both Psychological Factors and a General Medical Condition, and Pain Disorder Associated with a General Medical Condition. The third disorder is not a somatoform disorder nor a mental disorder, and is coded on Axis III as a general medical condition. The juxtaposition of the three disorders in the DSM-IV is meant to emphasize that the experience of pain does not differ with differing etiologies (Hales, 1994). For diagnosis of the two pain disorders associated with psychological factors, these factors must have a causal relationship to the pain symptoms. Possible psychological factors to be specified include mental or personality disorders, as well as psychological reactions to life stressors (APA, 1994).

The experience of pain is generally understood to be extensively mediated by psychological factors (King and Strain, 1994). Specifically, pain disorders tend to be associated with depression and anxiety. Although the prevalence of pain disorders has not yet been studied, they are probably fairly
common conditions. (APA, 1994) Conspicuously absent from the DSM-IV discussion of pain disorder are clinical guidelines for judging to what extent or in what fashion psychological factors impact a particular patient’s pain experience. For example, must the psychological factor precede the pain for causality to be established? Must a patient be free of psychopathology and life stress for pain to be judged to be due to a medical condition only? What is an appropriate pain experience for a given medical condition? Nor are there guidelines presented which would aid a clinician in distinguishing between Undifferentiated Somatoform Disorder and the pain disorders. Because the mechanisms linking emotional and physical distress are poorly understood, clinicians are given little guidance in this area.

Hypochondriasis. Hypochondriasis involves misinterpretation of physical symptoms as disease, with distress and impairment resulting from preoccupation and fear that one has a disease. Such concerns often lead to medical help-seeking, and they do not subside upon reassurance by medical personnel (APA, 1994). If unassociated with an existing general medical condition, the symptoms in question may consist of mild abnormalities, normal bodily functions, or signs of autonomic arousal (Kirmayer and Robbins, 1991b). The team preparing the DSM-IV Sourcebook chapter on hypochondriasis (Cote, O’Leary, Barlow et al., 1994) notes that the disorder is difficult to distinguish from anxiety disorders, especially Phobia and Generalized Anxiety Disorder. However they do conclude that a tendency to amplify somatic sensations and to respond to them with fear and anxiety creates the vicious cycle specific to hypochondriasis. The status of hypochondriasis as a singular disorder has been questioned; it may alternatively be viewed as a dimension of other mental disorders, including the other somatoform disorders (Lipowski,
1988).

The Comorbidity of Physical and Psychological Distress

Somatization may be less clinically important as a phenomenon in and of itself than as a marker for other conditions. Somatization is strongly associated with non-somatof orm mental disorders and with psychological distress in general. Researchers have found significant correlations between the number of somatic symptoms and the incidence of psychiatric morbidity, especially anxiety and depression. For example, using survey data from the ECA study, Simon and Von Korff (1991) found that people experiencing one or two unexplained somatic symptoms are four times as likely to be depressed as those experiencing no symptoms, while those experiencing five or more symptoms are seventeen times more likely to be depressed. Similarly, respondents experiencing one or two somatic symptoms are eleven times more likely to suffer from panic disorder than those experiencing no symptoms, while those experiencing five or more symptoms are over two hundred times more likely to suffer from panic disorder. This marked association between physical and emotional distress contradicts the psychoanalytic schema in which physical distress substitutes for emotional distress. Instead it suggests that a process of heightened, parallel experience of both forms of distress might be operative for somatizing individuals.

The parallel experience of physical and emotional distress has been documented by Escobar et al. (1989) and Canino, Rubio-Stipec, Canino and Escobar (1992) with respect to Latinos. In Escobar et al.'s study, differences emerged between depressed Latinas and white women over forty with respect to patterns of somatization, although all groups experienced significant somatic symptomatology. Using the SSI, the researchers found Somatization Disorder
in 58% of depressed and dysthymic Puerto Rican women over forty, 48% of depressed or dysthymic Mexican-American women, but only 19% of depressed or dysthymic white women in the same age group (Escobar et al., 1989). Mexican-American women over forty also suffered significantly more phobias, panic, and dysthymia than white women or younger Mexican-American women, with lifetime prevalence rates as high as 9% for dysthymia and 21% for phobia (Karno, Hough, Burnam, Escobar, Timbers, et al., 1987). Both physical and emotional distress for Latinas may be impacted by social factors such as immigration and acculturation stress, social isolation, and a lack of marital support. For example, Canino et al. (1992) found that somatic symptoms were more common among Mexican-born women who were separated, widowed, or divorced than among married Mexican-born women.

**Unexplained Physical Symptoms and a Revisionist Definition of Somatization**

A common theme in both traditional and revisionist views of somatization is that of unexplained physical symptoms. The notion of unexplained physical symptoms has evolved from an earlier characterization of medical problems as either functional or organic. Organic problems are those for which a flaw in anatomy or physiology (anywhere from the macroscopic to the molecular level) can be ascertained by means of physical examination or diagnostic testing. For example, coronary angiography might demonstrate reduced blood flow to heart muscle due to atherosclerosis, accounting for a patient's symptoms of chest pain. Functional problems are those for which no flaw or lesion can be detected, and are currently referred to as “unexplained.” Functional problems are assumed to result from conditional or temporarily disordered functioning of a particular organ or system. An example of a functional problem is diarrhea
associated with hypermotility of the colon, otherwise known as irritable bowel syndrome. Other physical problems thought to be functional in nature include chronic pain syndromes, atypical chest pain, chronic fatigue syndrome (Simon and VonKorff, 1991) and tension headaches (Kirmayer and Robbins, 1991c). (The term “syndrome” in this context refers to a cluster of symptoms which occur together but for which a pathophysiological explanation has not been conclusively established.) Not surprisingly, functional problems have often been associated with psychological factors. Such an association can carry with it the morally charged implication that the individual with this problem is in some way responsible for his or her illness; this assumption that the body should be under voluntary control by the mind stems from the paradigm of mind-body dualism (Kirmayer, 1988; Kirmayer and Robbins, 1991d).

In recent years, the organic-functional distinction, as well as the paradigm of mind-body dualism, have been called into question. It has become clear that psychological factors can have a meaningful influence on the course of conditions once thought to be purely organic in nature (Kirmayer and Robbins, 1991a). On the other hand, as detection of disease processes, including the biochemistry of mental disorders, becomes more sophisticated, the possibility of finding “organic” mechanisms to account for many unexplained physical and psychological processes is becoming a reality. Thus there is an arbitrary quality to the distinction between functional and organic or explained and unexplained symptoms, reflected in changing lists of so-called somatic symptoms over time.

Given this emerging ambiguity, to call a symptom unexplained says more about the current state of medical knowledge than it does about the psychological origin of the symptom (Kirmayer and Robbins, 1991c). Several
authors have noted the frequent failure of a medical workup to identify the cause of an unexplained symptom; a symptom may not be fully investigated due to lack of training, resources (King and Strain, 1994; Kellner, 1991), or access to medical care, or perhaps because the physician and the patient agree not to pursue the matter (Kirmayer and Robbins, 1991c). Physicians may then resort to labeling a symptom as functional or psychogenic in order to allay their uneasiness concerning the limitations of their work.

Physicians have had little in the way of definitive research to draw on as they confront somatization, a common but daunting issue in general medical practice. Indeed, the causal mechanisms relating psychological factors to unexplained physical symptoms remain to be elucidated. Thus prominent researchers in the field of somatization (Kirmayer and Robbins, 1991a; Escobar et al., 1991) advocate for the use of the definition of somatization proposed by Lipowski (1988): “the tendency to experience and communicate somatic distress and symptoms unaccounted for by pathological findings, to attribute them to physical illness, and to seek medical help for them” (p. 1359). This definition contains experiential, cognitive, and behavioral elements without suggesting a mechanism of causation.

**Somatization in Medical Settings**

Somatization is clearly a broad descriptive category that encompasses phenomena of diverse origins and consequences (Lipowski, 1988). Because somatization involves medical help-seeking, it is important to explore the relationship of somatizing individuals to the health care system. Several researchers have attempted to distinguish among various forms of somatization as they are likely to be encountered in medical settings (Bridges and Goldberg,
1985; Lipowski, 1988). Kirmayer and Robbins (1991c) propose that somatization be divided into three distinct operational categories, based on their study of Canadian patients seeking primary care services: (a) high levels of functional somatic distress; (b) hypochondriasis measured by high scores on a measure of illness worry in the absence of evidence for serious illness; and (c) exclusively somatic clinical presentations among patients with current major depression or anxiety (p. 647). Depending on the exact criteria used, between 11.5% and 26.3% of the primary care patient population Kirmayer and Robbins studied were judged to be somatizers. Although all types of somatization were found to be common, there was significant non-overlap of the types among patients seeking primary care. About fifty percent of the somatizing patients displayed only one type of somatization, with functional somatization being the most common, while the rest displayed more than one type (Kirmayer and Robbins, 1991b). Distinguishing among these forms of somatization is important, because both research and treatment approaches are likely to vary among the three.

**Somatic Presentation of Depression and Anxiety in Primary Care**

The third category of somatization described above deserves special attention given the prominence, severity and undertreatment of major depression and anxiety. Recent National Comorbidity Survey (NCS) data show that professional treatment, including by a general physician, was received by only 36% of subjects with major depression and only 25% of those with anxiety disorders (Kessler, Nelson, McGonagle, Edlund, Frank, et al., 1996). Low utilization rates for mental health services are especially prominent among Latinos. Hough, Landsverk, Karno, Burnham, Timbers, et al. (1987) found that depressed Mexican-Americans in Los Angeles were half as likely as depressed
whites (4.5% vs 9%) to have had a mental health visit to a general physician or mental health professional within the past six months. Mexican-Americans were as likely as whites to have consulted a general physician for a mental health problem, but were only about one third as likely to have consulted a mental health professional (Hough et al., 1987).

Thus depression and anxiety are likely to come first to the attention of primary care providers as opposed to other professionals (Acosta, 1974), perhaps especially among Latino patients. But somatic presentation of the disorders by patients, coupled with lack of awareness and motivation on the part of many physicians, presents a formidable obstacle to effective detection and treatment of depression and anxiety in primary care. Bridges and Goldberg (1985) found that primary care physicians detected only half of all psychiatric disorders which presented somatically, while Perez-Stable, Miranda, Munoz, and Ying (1990) found that physicians had correctly diagnosed only 35% of depressed primary care patients; this low detection rate may be compounded by cultural and linguistic barriers between physicians and patients. Unfortunately, somatic presentation of depression and anxiety is the norm; one study showed that only 16% of patients with major depression or anxiety initially presented to their primary care physicians with psychosocial complaints (Kirmayer, Young, and Robbins, 1994).

Although many depressed and anxious patients present somatically, most will to cite psychosocial distress as a possible cause of their symptoms when asked directly. However, they may expect that physicians are interested in physical rather than psychological distress, and so may selectively report somatic symptoms (Kirmayer and Robbins, 1996). Only 12% of the somatically presenting depressed patients studied by Kirmayer et al. (1994), referred to as
the "true somatizers," failed to state even upon questioning that their physical symptoms could have a psychosocial component. True somatizers may experience a qualitatively different form of depression; they reported less sadness associated with their depressive episodes when they were followed over time (Kirmayer and Robbins, 1996).

**Somatization in Cross-Cultural Perspective**

Many patients may indeed selectively attend to the somatic aspects of their distress due to cognitive, developmental or cultural influences (Katon, Lin, VonKorff, Russo, Lipscomb et al., 1982). Although reports of somatic symptoms are high in all cultures, members of U.S. minority groups and members of non-Western cultures have generally been thought to report more somatic symptoms than members of the majority U.S. culture (Kirmayer, 1996). Similarly, individuals with lower socioeconomic status have been thought to report more somatic symptoms. Little quantitative evidence for these differences had existed before population-based studies such as the ECA were conducted in the 1980s (Canino et al., 1992; Escobar et al., 1989). The striking differences in rates of somatic symptomatology found among depressed Latina and white women over forty were discussed above. When Latinos were aggregated by national origin, variations in symptom reporting were less dramatic, but still significant. According to an analysis of ECA data, Latino groups had higher rates of the SSI than whites, even when demographic factors were controlled. Odds ratios for having the SSI were 1.1 for Mexican-born Mexican-Americans, 1.2 for U.S.-born Mexican-Americans, and 2.3 for Puerto Ricans (Escobar et al, 1989) as compared with whites.

These discrepancies in somatic symptom reporting may be due in part to
the well-known correlation of socioeconomic status with physical and mental health (Angel and Guarnaccia, 1989). Perhaps more importantly, while Western culture emphasizes distinguishing between physical and psychosocial distress, non-Western cultures may not. This unspoken unity of mind and body may lead to a "somatized" presentation for distress which would typically be understood in Western culture as psychosocial in origin (Kirmayer, 1996; Kleinman, 1986). Koss (1990) terms this way of experiencing distress "psychophysical" (p. 14) in the sense that neither the psychological nor the physical awareness dominates.

The existing research gives a mixed picture with respect to the cultural versus demographic factors influencing symptom reporting among Latinos. Data from the Hispanic Health and Nutrition Examination Survey (H-HANES) show that less-acculturated Latino subjects had more health complaints than their acculturated counterparts, as well as more depressive affect (Angel and Guarnaccia, 1989). (The H-HANES was a large survey of U.S. Latinos that included 3555 Mexican American, 1343 Puerto Rican, and 962 Cuban American adults.) Kolody, Vega, Meinhardt and Benussen (1986) studied the association between depression and physical complaints for Mexican-Americans as compared to non-Latino whites. While the researchers concluded that this association varied little among groups, the researchers did find that the association between severe health complaints and depression was stronger for Mexican-Americans. Further demographic variables, including age, sex, and marital status, were found to impact the basic rates of depression and physical complaints, but not the association between them. Canino et al. (1992) note that the differences between Latinos and non-Latino whites with respect to somatization are not fully explained by demographic factors such as
educational level and socioeconomic status. Furthermore, although Puerto Ricans have markedly higher rates of somatization than Mexican-Americans, the groups are more similar to one another with respect to the configuration of symptoms than they are to non-Latino whites.

**Somatization and Depression In Latinos**

Cultural influences have been studied extensively with respect to somatization and depression. Depression, as recognized in the dominant culture of the United States, may not be recognized as a legitimate illness in other cultures (Finkler, 1985). Individuals suffering from depression may have to be physically ill in order to receive care and treatment for their distress. In addition, mental illness may be strongly stigmatized while physical illness is not, leading to help-seeking for physical rather than emotional problems (Canino et al., 1992; Katon et al., 1982). The concept “somatized depression” implies a non-normative state; however the somatic experience of depression is the norm cross-culturally. Depression in contemporary Western culture may be actually be anomalous in that it often more prominently features cognitive elements such as guilt and low self-esteem and affective elements such as sadness (Katon et al., 1982). Interestingly, this focus on non-somatic symptoms may stem from a tendency to "psychologize" what is in fact both a psychosocial and a physical process.

There is some argument about whether distinct syndromes of depressive symptoms are cross-culturally valid (Angel and Guarnaccia, 1989), but many researchers do agree on a relatively universal, core set of depressive symptoms. These symptoms tend to be somatic and vegetative in nature, for example psychomotor retardation and fatigue; perhaps the cognitive and affective aspects of depression are more prone to cultural influences (Katon et
al., 1982). Data from the H-HANES suggest that Latinos exhibit a different pattern of depressive symptoms than do whites. Guarnaccia, Angel, and Lowe Worobey (1989) analyzed the H-HANES data using the statistical method of factor analysis. They found that affective and somatic depressive symptoms tended to occur together in Latinos, as opposed to the separate affective and somatic factors found in non-Latino whites. They wrote:

The combined factor structure indicates that Hispanics have both affective and somatic idioms for expressing depressive feelings, but that they are conceptually unified. It is likely that the somatic presentation of their depressive feelings and other psychosocial distress in clinical settings is more strategic, related to previous experience with the medical profession and the stigma that mental illness carries (p. 87).

Somatization does not occur at the expense of emotional experience for Latinos, but Latinos may selectively express somatic distress depending on the social context in which they find themselves. Demonstrating the complex impact of culture on the experience of depression, the same study showed that more acculturated Mexican-American women (as defined by being interviewed in English rather than Spanish) continued to unite somatic and affective aspects of depression, while acculturated Puerto-Rican women had a pattern of depression more similar to that of whites (Guarnaccia et al., 1989).

**Somatization as a “Culturally Sanctioned Idiom of Distress:” the Examples of Nervios and Ataques de Nervios in Latinos**

Complementing the three operational definitions of somatization proposed by Kirmayer and Robbins, an additional definition has been proposed and investigated by other authors (Kirmayer, 1996; Hulme, 1996; Koss, 1990; Kleinman, 1986; Kirmayer, 1985), many of whom share an anthropological perspective. According to this paradigm, somatization is characterized as “a
culturally sanctioned idiom of psychosocial distress to indirectly implicate family, school, work, financial, and other social problems” (Hulme, 1996). A prominent example of research using the idiom of distress model is Kleinman’s (1986) work on neurasthenia and depression in China, in which he found that neurasthenic patients used their disease and illness role as a mechanism to cope with painful and disempowering social circumstances such as forced geographical separation from family or dehumanizing work conditions. Such circumstances parallel those of many Latino immigrants in the United States.

The body is in a sense used metaphorically in this type of somatization (Kleinman, 1986; Lipowski, 1988). Such a metaphorical role for the suffering body should not imply that physical symptoms are any less real. The symptom exists simultaneously as a physical reality and as a metaphorical construct. Kirmayer (1985) notes that bodily metaphors are a sophisticated and subtle means of communication. Unfortunately, the heightened significance of the somatic symptoms may not be appreciated by members of cultures other than that of the patient’s. This misunderstanding may be particularly damaging in the medical setting, because it may lead to only physical aspects of somatic symptoms being addressed, and thus an ineffectual medical interaction.

Nervios [nerves] and ataques de nervios [nervous breakdown], identified as culture-bound syndromes in the DSM-IV (APA, 1994), may represent culturally sanctioned idioms of distress for some groups of Latinos (Hulme, 1996; Guarnaccia, DeLaCancela, and Carrillo, 1989). Nervios refers to a chronic sense of worry and uneasiness (Guarnaccia, DeLaCancela, and Carrillo, 1989) and has been studied in several Latino groups, especially Mexican Americans. Ataques de nervios are acute events that invoke a variety of symptoms including agitation and fainting, and have been most researched
in Puerto Ricans. *Ataques* often take place in situations of interpersonal crisis (Guarnaccia, DeLaCancela, and Carrillo, 1989). When an individual experiences an *ataque*, he or she typically elicits care and support from his or her social network (DeLaCancela, Guarnaccia, and Carrillo, 1986). The social meanings of the *ataque* exist independent of its particular physical symptoms. Such meanings include the communication of strong emotions such as anger and grief (Guarnaccia, DeLaCancela, and Carrillo, 1989). If a medical provider focuses on the somatic symptoms of the attack without ascertaining the circumstances that precipitated it, its central meaning is lost (DeLaCancela et al., 1986).

Koss (1990) has noted that the syndromes of *nervios* and *ataques de nervios* may confound the associations between somatic symptoms and anxiety and depression among Latinos in population studies. These syndromes may raise psychiatric symptom counts for the individuals who have them while remaining distinct from anxiety and depressive disorders. Duran (1997) has suggested that confounding of somatization and mental disorders is also a problem for researchers studying less-acculturated Latinas specifically. Using factor analysis, she found that depression and somatization were phenomenologically distinct for this group, with stressful life experiences leading directly to somatization and only secondarily to depression.

**Causal attributions and symptom meanings**

The anthropologists Finkler (1985) and Koss (1990) have proposed meanings for somatic symptoms within Latino cultures. Finkler (1985) studied illness among men and women in a rural region of the Mexican state of Guerrero. She concluded that women's inferior social status led to a higher rate of illness among women overall, but that for particular male and female patients
bereavement, family conflict, and other emotionally difficult events precipitated the presentation of physical symptoms in a clinical setting. This causal attribution was made by the patients; however, they did not generally recognize emotional distress as an illness in and of itself. Koss (1990) has hypothesized that, when considering the causes of illness, Latinos preferentially consider the effects of external factors, especially interpersonal relations, on both physical and emotional well-being. Thus somatic symptoms can sometimes function within Latino cultures as signals that one is experiencing distress due to interpersonal or other environmental problems.

A recent qualitative study by the author builds on these findings. Ten Mexican American immigrant women outpatients with somatic complaints were interviewed concerning their symptoms. The interviews focused on the life stressors associated with somatic symptoms, the coping mechanisms used when symptoms were experienced, and the causal links the women drew between psychosocial factors and physical distress. It was found that all of the interviewees believed that at least some of their symptoms were related to psychosocial factors. The most significant of these factors were acculturation stress, a lack of social and marital support, the difficulties of motherhood, and strained marital relationships. Somatization functioned as an "idiom of distress" for the interviewees, who had few alternative channels for emotional expression. When they experienced somatic symptoms, the interviewees temporarily obtained practical help and relief from their domestic duties, as well as emotional support from their partners. For this group of Latinas, the meanings and consequences of somatic symptoms extended into the social realm. Unfortunately, a review of their medical charts revealed that the medical care they received almost never addressed their psychosocial concerns.
Conclusion

This literature review documents the co-occurrence of somatic and psychological distress, as well as the underdetection of psychological distress and mental disorders such as depression in medical settings. This underdetection is due to somatic presentation in primary care by distressed patients; it is also due to a paradigm of mind-body dualism within the medical profession, leading physicians to treat physical conditions without also attending to psychosocial issues. Latinos may be particularly vulnerable to this gap of communication and understanding between providers and patients. They are perhaps even more likely than non-Latino whites to selectively express somatic distress in a context-dependent fashion. They also tend to seek help for somatic symptoms in medical settings despite the fact that they often believe their symptoms to be psychosocially mediated. Given the fact that these powerful mind-body connections remain largely unspoken, physicians would benefit from an enhanced awareness of the psychological comorbidities of somatic symptoms. Physicians serving Latinos would further benefit from an awareness of the significance of somatic symptoms in Latino cultures. The result of this enhanced awareness concerning somatization would be an increased emphasis on psychosocial issues in the medical setting, including appropriate referrals to mental health and social services. Such an adjustment in emphasis would potentially benefit all patients, not simply those suffering from unexplained physical symptoms.
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Somatization and Psychological Distress in Mexican American Immigrant Women: A Qualitative Analysis

Introduction

Somatization can be characterized as the tendency to experience and express distress which has an emotional component in the form of bodily symptoms. Somatization is of concern for health professionals in part because somatizing individuals often seek medical services for their problems, making up to 50% more primary care visits than their non-somatizing counterparts (deGruy, Columbia, and Dickinson, 1987). Somatization is common and occurs along a continuum of severity and prevalence (Fink, 1996). At the severe end of the continuum, the multi-symptom, multi-organ system Somatization Disorder described in Diagnostic and Statistical Manual-IV (DSM-IV) (APA, 1994) has a prevalence of only 0.2-2% in the general population, while an abridged version of Somatization Disorder (the Somatic Symptom Index or SSI), involving six somatic symptoms for women and four for men, revealed a prevalence of 9-20% in community samples which included several Latino groups (Escobar, Rubio-Stipec, Canino, and Kano, 1989).

Somatization has traditionally been understood as a defense mechanism, a substitution of physical distress for emotional distress or conflict along the lines of the hysterical conversions described by Freud. However, recent research has shown that somatization is most often associated with high levels of psychological distress and mental disorders, especially depression and anxiety. For example, data from the Epidemiologic Catchment Area (ECA) study showed that individuals experiencing one or two unexplained somatic symptoms were four times as likely to be depressed and eleven times more
likely to suffer from panic disorder, while individuals experiencing five or more unexplained somatic symptoms were seventeen times more likely to be depressed and over two hundred times more likely to suffer from panic disorder (Simon and VonKorff, 1991). These data suggest that a heightened, simultaneous experience of both physical and psychological distress may be operating for somatizing individuals. In fact, the two forms of distress may be intertwined and inseparable in the individuals’ subjective awareness. In support of this construction of somatization in Latino populations, an analysis of Hispanic Health and Nutrition Examination Survey (H-HANES) data revealed a strong correlation between self-assessment of health and affective symptomatology for both Mexican-Americans and Puerto Ricans (Angel and Guarnaccia, 1989).

Associations have also been found between somatization and negative life experiences such as childhood sexual abuse (Briere and Runtz, 1988; Morrison, 1989) and domestic violence. One study of Latinas with somatic symptoms revealed that 57% had experienced domestic violence, and 33% had been sexually abused as children (Duran, 1997). Somatization is also linked with Post Traumatic Stress Disorder and the refugee experience (Castillo, Waltzkin, and Escobar, 1994). Given these connections, it is reasonable to hypothesize that somatization results directly from distressing interpersonal or social circumstances (Castillo et al., 1994) for some individuals.

Somatization is thus a powerful marker of psychiatric morbidity and traumatic life experiences. Unfortunately, somatization often contributes to the well-documented underdetection of such problems in the primary health care setting (Kessler, Nelson, McGonagle, Edlund, Frank et al, 1996; Perez-Stable, Miranda, Munoz, Ying et al, 1990). The vast majority of depressed and anxious
patients present to their primary care physicians with somatic rather than psychosocial complaints, but physicians diagnose only fifty percent of psychiatric disorders which present somatically (Bridges and Goldberg, 1985). Most patients are willing to cite psychosocial distress as a possible source of their symptoms when asked directly (Kirmayer, Young, and Robbins, 1994), but physicians rarely inquire. The mutual reluctance of physicians and patients to broach psychosocial issues is an omission with profound consequences.

**Somatization and Ethnicity.**

The epidemiology of somatization remains an area of active inquiry. Historically, there has been much interest in variation in rates of somatization among various ethnic and social groups. Non-whites (including Latinos), women of all ethnicities, and groups with low socioeconomic status have often been characterized as reporting more somatic symptoms. These differences can be relatively subtle, as in the finding that Mexican-born respondents were 10% more likely to have Somatization Disorder (SD) based on the SSI construct described above as compared to non-Latino whites (Escobar et al, 1989). On the other hand, differences in the prevalence of somatic symptoms may be quite marked for certain subgroups of Latinos, especially women over 40. Escobar et al. (1989) found that half of all depressed Mexican American women over 40 met SSI criteria for SD, while only 19% of their white counterparts did. Equally striking are results of a recent study in the Denver area, showing that 83% of a sample of 465 Latina primary care patients met the criteria for SD based on the SSI (Duran, 1997).

For clinicians, simple awareness of the epidemiology of somatization is minimally useful; somatization is so universally prevalent that a high index of suspicion is appropriate in most situations. Unfortunately, stereotyping of
certain individual groups, such as Latinas, as "somatizers" may lead to their not receiving medical workups for physical illness. Such stereotyping may also limit recognition of comorbid conditions such as depression and domestic violence. More clinically useful would be an understanding of the specific implications of somatization within various social and cultural contexts.

**Somatization as an “Idiom of distress.”** One explanation of the link between somatization and distress is that somatization represents a way of communicating distress, as well as a way of experiencing distress. This explanation has been advanced by medical anthropologists studying meanings given to somatic symptoms in various cultures. Somatization is characterized as an "idiom of distress," an expression of dissatisfaction with personal and social conditions using the “language” of physical symptoms (Kleinman, 1982; Finkler, 1985). The principal culture-specific syndromes which have been studied as idioms of distress among Latinos are nervios and ataques de nervios, (Angel and Guarnaccia, 1989; Guarnaccia, DeLaCancela, and Carrillo, 1989). These syndromes involve extensive somatic symptomatology, but carry culture-based meanings that include the expression of grief, anger, and anxiety. When the somatic symptoms are brought to medical attention, they are often decontextualized; the culture-based meanings are then lost in the medical interaction (DeLaCancela, Guarnaccia, and Carrillo, 1986).

**Risk factors for distress in Latinas.** Because somatization is linked to distress, it is important to consider what specific factors might contribute to distress for Latinas. Extensive research has been done on psychosocial risk factors for Latinas, often with a focus on depressive symptomatology as the manifestation of distress. Several authors have focused on problems associated with immigration and acculturation. Espin (1987), along with
Vargas-Willis and Cervantes (1987), reports that Latina mental health patients experience conflicts due to differing gender role expectations in the United States relative to their countries of origin. They also feel grief and loss with respect to the home country and the culture and relationships they left behind. Melville (1978), in a qualitative study of Mexican American immigrant women, found that loneliness and loss of social support were important sources of stress associated with immigration, along with undocumented residency status. Financial problems and not knowing English were also important stressors for Mexican and Central American immigrants surveyed by Padilla, Cervantes, Maldonado and Garcia (1988). Salgado de Snyder (1987) found that acculturative stress predicted a full 16% of the variance in depressive symptoms in her sample of married Mexican American women. Poor health status, low income, low educational attainment, low English ability, recent arrival in the United States, having a disrupted marital relationship or recent traumatic event, and being unemployed are further risk factors for depression among Latinas (Vargas-Willis and Cervantes, 1987; Vega, Kolody, Valle, and Hough, 1986a; Guarnaccia, Angel, and Lowe Worobey, 1991).

**Protective factors.** Protective factors and coping strategies for distressed Latinas have also been identified. Family networks, although often limited in the United States, serve an important role in helping women who recently immigrated from Mexico cope with their new environment. Generally husbands who migrate before their wives provide the most assistance (Melville, 1978). Another important protective factor is confidant support, whether from a friend or family member or from within the marital relationship. A survey of Mexican American immigrant women showed that lack of confidant support was the most significant single predictor of the variance in depression (Vega,
Kolody, and Valle, 1986b). Confidant support was defined as having someone "with whom you can share your innermost thoughts and feelings" (Vega et al., 1986b, p. 599). This finding is particularly powerful when we consider the isolation and loss of social connections often precipitated by immigration.

The Current Study

This study advances a culturally specific understanding of somatization among Mexican American immigrant women. The research questions that informed the data collection were exploratory in focus, given the scarcity of research directly addressing this area:

1) What contextual and individual factors, including depressive symptomatology, are associated with somatic symptoms?

2) When Mexican American immigrant women contemplate their somatic symptoms, what causal role is accorded to psychosocial factors?

3) What coping mechanisms are used to deal with somatic symptoms, including use of the health care system?

Implications of this study include the use of somatization as a marker for depression and other life difficulties, as well as the use of dialogue concerning somatic symptoms as a means of initiating a discussion about these problems. This study links the general theoretical conceptions of somatization with risk factors and subjective meanings particular to Mexican American immigrant women. Factors specific to Latina immigrant experiences are highlighted as they pertain to psychological and somatic distress. With increased awareness of the issues underlying somatization in Latina immigrants, physicians may be better able to offer this population comprehensive and culturally appropriate health care.
Methods

Subjects

The subjects of this study were a convenience sample of 10 Mexican American immigrant women over the age of 18 who were recruited from the waiting rooms of the Mayfield Community Clinic in Palo Alto, CA, and the nearby Mountain View Community Health Center. Mayfield Community Clinic and Mountain View Community Health Center have both been providing services to low-income Santa Clara county residents for over twenty years. Although both clinics serve many Latino patients, Mayfield Community Clinic especially has a history of providing a largely monolingual Spanish Latino clientele with prenatal, well-child, women’s health, and general medical services. The patient population is largely made up of immigrants from Mexico, although other Latin American countries of origin are also represented. The clinics recently merged administratively in order to better serve their patients in the context of Medi-Cal managed care.

Subjects were not screened on the basis of medical problems or emotional distress. The only screening criteria were that potential subjects be patients at the clinics from which they were recruited, and that they have one or more ongoing symptoms of pain or discomfort such as headaches or abdominal pain. The ages of the interviewees ranged from 21 to 46, with a median age of 26.5. They were overall a young group, and had few chronic conditions or major health problems that would be detected on a physical exam. All interviewees were immigrants from central or northern Mexico. Their length of residence in this country ranged from 2 to 23 years, with a median stay of 8.5 years. Six of the ten women interviewed came to the United States to join a husband or parent who had already obtained employment and had
"established themselves." Three others migrated with husbands and children as a family unit, and one migrated as a teenager to care for her sister's young children. All but one of the women interviewed were married or living with a male partner, and all had children, six with children under five years of age. Two had children with serious congenital abnormalities, autism and mental retardation. Four of the interviewees had paid jobs, while the others worked exclusively in the home.

The median education level of the interviewees was 8 years. All were low-income, with a mean family income of $1170 per month. Two of the interviewees had private health insurance, and one had emergency Medi-Cal coverage because she was pregnant. None of the other women were covered by Medi-Cal, probably due to undocumented status; however, legal residency status was not assessed in this interview. Almost all the interviewees lived in crowded conditions, with relatives or other adults aside from the nuclear family living in a single apartment. For example, one interviewee reported that she lived in a one-bedroom apartment with four other people, while another reported that seven people were living in a two-bedroom apartment.

Procedures

Qualitative data collection. Permission to recruit subjects from clinics was obtained from the clinics' Executive and Medical Directors. The researcher then made periodic visits to the clinic waiting rooms and spoke to every woman there about the study, assessing her eligibility for the study and her desire to participate. A recruitment flier was shown and read to every potential participant as part of this process. (See Appendix). The study was described to the participants as "a study of physical symptoms and emotions." About 25% of the women with whom the study was discussed decided to
participate. Those who did not participate stated either that they did not have somatic symptoms or that they had somatic symptoms but were unwilling or unable to be interviewed.

Approval for this project was granted by the University of California, Berkeley Committee for the Protection of Human Subjects. Informed consent was sought from the participants at the outset of the interview using a written form describing the study. Each subject signed two copies of the form, and kept one copy for future reference. As part of the informed consent process, permission was sought to examine the patient's medical chart and manually record information from it.

Individual in-depth, semi-structured interviews lasting about one hour were conducted in English or Spanish by the researcher in clinic offices, at participants' homes, or at a nearby community mental health agency according to subjects' individual preferences. Nine of the ten interviews were conducted in Spanish. The interviews involved a set of open-ended questions to explore the experience, subjective meaning, and management of somatic symptoms, as well as more general health-related practices and beliefs. The interviews were tape-recorded and transcribed in their entirety by the researcher. At the outset, interviewees were asked to describe their symptoms, and then asked to describe how the symptom affected their lives, what made symptom pain better or worse, and what actions they took when they experienced the symptom. If the interviewee did not bring up a possible psychosocial cause for a particular symptom, she was asked directly whether she thought her problem might have something to do with emotional concerns. In the course of the interview, several specific questions were also asked concerning experiences of depression, use of mental health services, domestic violence, and childhood abuse. A $20
honorarium was paid to each interviewee as an incentive to participate.

**Quantitative data collection.** At the time of the interview, demographic information was collected, and standard measures of depression and acculturation were administered. Subjects' medical charts were also reviewed.

**Measures**

**Depression.** Symptoms of depression during the past week were assessed by the Beck Depression Inventory (BDI; Beck, Ward, Mendelson, Mock, and Erbaugh, 1961). The BDI was administered by the researcher to each participant at the close of the interview. This classic measure of depression has high internal reliability and validity, including high correlations with clinician ratings of depression (Beck et al., 1961). It is one of the most frequently used measures of depressive symptoms in research settings. In clinical settings, the BDI is generally used as a screening measure or to evaluate response to treatment, rather than as a means of making a definitive diagnosis of depression.

**Acculturation.** Acculturation was measured using the 5-item version of the Short Acculturation Scale (SAS) for Hispanics (Marin, Sabogal, Marin, Otero-Sabogal, and Perez-Stable, 1987), again administered by the researcher at the close of the interview. These five items belong to the scale's "language use" factor. Examples of language items include "What language(s) do you read and speak?" or "What were the language(s) you used as a child?" Subjects answer these questions on five point Likert scales ranging from "only Spanish" to "only English" with "both equally" as a midpoint. Marin et al. (1987) found that the language use factor accounted for 55% of the total variance in SAS scores, and had an alpha coefficient of .90 on a sample of 363 Latinos and
228 non-Latino whites, indicating high internal consistency and reliability. High correlations were also found between the language factor and respondents' generation (.69) and length of residence in the United States (.76).

**Data Analysis**

**Qualitative analysis.** The qualitative analysis undertaken here was informed by Grounded Theory methodology (Glaser and Strauss, 1967; Strauss and Corbin, 1994). One guiding principle of Grounded Theory is the use of data to develop new conceptual frameworks or to extend and modify existing conceptual frameworks (Strauss and Corbin, 1994). This analytic approach contrasts with quantitative methodology, which tends to use data to prove or disprove hypotheses (Glaser and Strauss, 1967). Rather, Grounded Theory analysis is developed inductively and builds on the researcher's perceptions concerning the phenomenon under study. This project presents an opportunity to develop theory pertaining to somatic symptoms among Latinas. A Grounded Theory perspective is particularly appropriate for this topic area because it balances the processes of scholarly interpretation and analysis with a loyalty to the "perspectives and voices" of research participants (Strauss and Corbin, 1994) (i.e., Latinas in this study).

The qualitative data analysis was accomplished using the NUD*IST (Non-numerical Unstructured Data Indexing Searching and Theorizing) computer program from Qualitative Solutions and Research (1997). This program facilitated line-by-line coding of interview transcripts. Coding is the process of assigning multiple descriptive and conceptual labels to sections of text, and is integral to a systematic analysis of qualitative data (Miles and Huberman, 1994). The interviews as a group were searched and indexed by code, allowing the researcher to elicit themes and patterns common to several
of the ten interviews. Codes were organized into categories such as "coping mechanisms" and "causal explanations," and relationships among categories were described. The NUD*IST program stored all searches and indexing operations, and allowed for memo-writing pertaining to specific codes and categories. The goal of this process was immersion in the data so that the theory that emerged was grounded in the experiences of the interviewees as they had articulated them. Although individual quotations have been translated into English for this paper, the interviews themselves were not translated from Spanish for the purposes of the analysis.

**Quantitative analysis.** Basic, descriptive statistics (e.g. means, standard deviations) were calculated for the BDI and SAS.
Results

Quantitative Results and Chart Review

The mean score on the BDI was 14, indicating moderate depression. Scores ranged from 5, indicating no depression, to 24, indicating potentially serious depression (Lewinsohn, Munoz, Youngren, and Zeiss, 1978), with a standard deviation of 5.8. The mean score on the SAS for Hispanics was 1.2, with a standard deviation of 0.55, indicating monolingual Spanish abilities and thus very low acculturation.

On chart review, it was found that the interviewees made an average of 5.9 medical visits during the year before the study, not including prenatal care appointments. Half of the medical visits were for women’s health matters such as annual exams, birth control refills, breast exams, and vaginal infections. The remaining half of the medical visits reflected a wide range of concerns such as urinary tract infections, isoniazid prophylaxis for tuberculosis, and respiratory problems. One interviewee had newly diagnosed Non-Insulin Dependent Diabetes Mellitus, and one had hyperthyroidism. Only four of the interviewees had made medical visits in which their presenting complaints were the somatic symptoms mentioned in their interviews. Only two charts made mention of psychosocial issues in chart notes or problem lists.

Overview of Qualitative Results

Qualitative results are organized thematically in this section. This organization is based on the thematic coding process described above. Themes are presented using illustrative quotes from the interviews. The first set of themes addressed is “distressing factors associated with somatic symptoms.” A substantial portion of the interview material related to these factors. In many cases these factors were discussed because of the causal relationships the
interviewees perceived between their life problems and their somatic symptoms. Distressing factors common to a number of the interviewees were: lack of social and marital support, difficulties of motherhood, experiences of childhood abuse and current domestic violence, financial problems, and immigration issues. Next, the interviewees' perceptions of the physiological and psychosocial causes of their symptoms are explored, followed by a discussion of the coping mechanisms used when symptoms are experienced. The Results section concludes with a description of interviewees' positive and negative experiences with medical care for their somatic symptoms.

Two culture-based themes ran through the interviews. The first is the tradiational ideal of marianismo. Marianismo is the female counterpart of machismo in Latino cultures. It is an ideal for female behavior that upholds women's primary identity as wives and mothers. A woman is expected to wholeheartedly dedicate herself to her family; this dedication may be a source of considerable satisfaction, but may also necessitate excessive self-sacrifice in relation to one's children and husband (Organista and Munoz, 1994). In fact, with its basis in Catholicism and the idealization of the Virgin Mary, marianismo carries a connotation of both suffering and moral purity (Comas-Diaz, 1988).

The second culture-based theme which is relevant to the following discussion is the ideal of controlarse [to control oneself]. Controlarse refers to the process of holding in and mastering negative emotions such as anger or sadness, rather than expressing them. Controlarse has a connotation of self-discipline that usually takes the form of resignation to an external problem, but may sometimes involve actively trying to prevail over it (Cohen, 1985; Organista and Munoz, 1985).

The recruitment flier read to each potential subject (see Appendix) listed
back pain, abdominal pain, and headache as examples of pain symptoms. These symptoms are among the more common somatic symptoms reported by Latinos (Finkler, 1985; Escobar, Burnham, Karno, Forsythe, and Golding, 1987). All of the women who agreed to participate in the study had at least one of the three symptoms. Because these three symptoms were each reported by more than one interviewee, the qualitative analysis focuses on these symptoms. All ten interviewees had chronic headaches. About half of them described their headaches as an important problem for them, causing significant impairment in their day-to-day functioning. For the others, the headaches were less severe, or seemed less important in comparison with their other symptoms. Eight of the ten interviewees had chronic back pain. Again, about half reported expensive impairment or distress as a result. Three of the interviewees had abdominal pain. Although chronic, it varied markedly in severity over time. For all three women, abdominal pain had on occasion been severe enough to lead them to seek emergency medical care.

**Distressing Factors Associated with Somatic Symptoms**

**Lack of social support.** Lack of social support was evident among many of the interviewees, and this lack was influenced by a number of personal and social factors. Two women described difficulty making friends due to shyness or lack of self-confidence. An interviewee named Carmen¹ lamented "I'm not social. I'd like to be able to talk, to greet people, but I can't." She felt that this reticence stemmed in part from her rural background; she had grown up on a farm in a remote area of the state of Michoacan, and had had contact with few people who were not relatives. Recently immigrated to the United States to join her husband, Carmen had left her entire family of origin behind. No longer able

¹ All interviewees names used here are pseudonyms.
to rely on her relatives, she wanted to make friends in order to form a social network but she was unable to. She spent her days at home without company, caring for her infant son. Four interviewees, including Carmen, stated that their pain symptoms often caused them to stay at home and not participate in their usual activities. This behavior also decreased the amount of social interaction and support which was available to them.

Loneliness was described by several other women who cared for small children at home while their husbands worked. For example the interviewee Magdalena, who had also recently joined her husband in the United States, said: "I don't have any friends because I just spend my life at home taking care of the kids. My friends live in Mexico, or Los Angeles. I feel lonely sometimes. You know how it is. In this country you just have to work all the time, so my husband can't spend time with me. He has to work two shifts so we can make ends meet with the children." Among the interviewees' important unmet needs were day-to-day company and assistance with child care. Keeping in mind the importance of confidant support for psychological well-being, it is also interesting to note that a full half of the women interviewed specifically stated that they did not discuss their pain symptoms with their friends. When asked with whom they discuss their pain symptoms, most interviewees replied "Nada mas con mi esposo" [Only with my husband].

**Lack of marital and family support.** Despite depending heavily on their husbands because of having few other close relationships, almost all of the women interviewed described a lack of marital support and intimacy. This lack of marital support may have been due simply to the demands of the

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2 The interviewees who lived with a male partner but were not married referred to their partners as "husband" throughout the interview. This cultural convention is preserved in the following discussion.
husband's job(s), as described by Magdalena above. More often, it was
ascribed to deeper factors in the relationship. Several interviewees reported
frequent overt conflict with their husbands, exacerbated by the strain of difficult
circumstances such as unemployment or other financial hardship. Thwarted
communication was also a major theme. One interviewee stated "He doesn't
make himself available to talk with me. We don't communicate. Then the
problems get even bigger," while another said bluntly "We don't have
communication." Several interviewees described their husbands' discomfort
with their expressions of distress. Elsa recounted how her husband minimized
her pain symptoms rather than sympathizing with her: "He tells me 'I went to
work today, and I'm not complaining.' " Ana described waiting until she is alone
in the house to make phone calls to her friends and relatives, because her
husband objects to her discussing family problems with others.

For Ana and Elsa, expressions of distress run counter to expectations for
their behavior which include the ideal of controlarse. Ana, who cares for a
retarded teenage daughter, poignantly lamented the lack of support from her
adult sons: "Men, I feel as if they don't have the same kinds of feelings
sometimes as women do. I have a daughter, but it's not the same because
she's not okay. And my sons, when they see I am going through some kind of
crisis, they go to me and say 'Mama, don't get like that. Control yourself
[Controlate ].' And they give me advice or try to help me. But it's just for an
instant, and afterwards they go back to their routine." Ana's sons were close
even enough to her to be involved in her crisis; however, their priority was helping
Ana control her behavior, rather than allowing her an opportunity for emotional
expression.

"I'm a very communicative person," said Ana, while the interviewee
Candelaria stated “The best cure for health [i.e., disorder, illness] is conversation.” Yet despite their beliefs about the importance of communication, the women interviewed generally had little opportunity to express their emotions or tell stories about their experiences, either in the context of friendships, or family and marital relationships. Demonstrating the depth of this unmet need, fully half of the interviewees spontaneously mentioned that the interview was a positive experience for them; they enjoyed it because it gave them the opportunity to talk about their problems. Several commented that it made them feel relaxed or diminished their pain symptoms.

The interviewees were very caring and committed mothers. The act of putting their own material needs aside in favor of their children’s was commonplace. For example, Socorro stated: “Because of our economic situation I don’t go to the doctor very much. I take my children when they’re sick, but the truth is that for myself I’d rather wait. I just pray to God that I don’t die.” Socorro’s words exemplify the ideal of marianismo, and they also hint at the toll this ideal may sometimes take on a mother’s well-being. Indeed, although motherhood was a stressful experience for many of the interviewees, this stress was rarely acknowledged directly, perhaps because to do so would not be culturally acceptable. It did, however, seem to be acceptable to discuss the stress of motherhood in the context of pain symptoms. Several interviewees described the difficulty of paying adequate attention to their children when in pain. Others described behaving in an irritable and even rejecting manner when their pain was particularly severe.

**Childhood abuse and domestic violence.** Because the majority of the interviews were conducted in the home, privacy was not always complete. Thus it was not possible to raise the issues of domestic violence and childhood
abuse with all of the interviewees. However, several of the women interviewed did report significant abuse histories. Childhood emotional abuse such as constant insults or neglect was as common as physical abuse, and seen as equally damaging. Witnessing conflict and violence between parents or other relatives during childhood was also described. Current domestic violence was reported by two interviewees, who also happened to have histories of childhood abuse. It is a near certainty that the rate of abuse found would have been much higher if all women had been questioned about it, especially considering the extent of marital dissatisfaction expressed in the interviews. Unfortunately, none of the abused interviewees had been questioned about abuse in a medical setting, and none had brought the subject up themselves. None had sought or been offered formal support services, although one survivor of longstanding domestic violence who was a Jehovah’s Witness had received extensive counseling from the elders of her church.

**Economic stress.** Economic hardship was a significant factor in the lives of the women interviewed, and was intertwined with the experience of immigration. Most interviewees described economic hardship in Mexico as a motivating factor for immigration to the United States: not having enough money for food, for shoes, or for medical care for a sick child. Most felt that their situations were somewhat improved in the United States, but financial problems continued. Several interviewees described the disappointment and guilt they felt because they were unable to afford send money to parents or other relatives in Mexico; for one woman interviewed, it was the principal source of distress in her life. Most of the interviewees reported that their husbands were the families’ principal wage earners. The women who stayed at home rather than working were ambivalent about their choices; they felt it was important to raise their
children themselves, but the family had to "sacrifice" as a result. Marisol was frustrated with the employment options available to her, so she had decided to stay at home with her two children: "Right now, why should I be in a hurry to get a job? I want to get some training, so I can earn better money. If I go to a work in a restaurant now, they'll pay me minimum wage, five dollars an hour, and I won't be with my sons. If I'm going to leave them, it should be worth it."

**Acculturation stress.** All nine of the women interviewed in Spanish were rated as monolingual Spanish speakers, indicating low acculturation. Stressful experiences associated with acculturation were described by a number of interviewees, such as being treated with disrespect because of not knowing English, and having to negotiate an unfamiliar health care system alone when a child was sick. For Araceli and her family, discrimination faced as undocumented immigrants, combined with financial strain, had led them to consider returning to Mexico: "It would be really great if we could stay here. But it's difficult. The problem is that you go looking for an apartment and they ask you for valid identification, social security number, residency papers. And they want a pay stub from a permanent job in a certain amount. It's really hard. We thought that we came here for our well-being, but we also came to suffer. You think that you can have the things that matter to you, that you won't suffer. And it's a lie. It's really a lie." This statement brings to light the anger and disappointment engendered by unmet expectations and the experience of social inequality. Araceli's nightly back pain began shortly after her arrival in the United States. She felt that immigration had been a turning point for her emotionally as well. Araceli scored 19 on the BDI, indicating that she was possibly seriously depressed (Lewinsohn et al., 1978). While responding to the BDI items, she noted that she was no longer able to cry: "Before, I was able
to. With every little thing. I was very sensitive, very sentimental. I was also very relaxed, very calm. I feel that it has been different in the time I've been here." Araceli had become more tense and less expressive in the two years she had lived in the United States.

**Depression.** In a group experiencing the above life stressors, as well as significant somatic symptoms, we might indeed expect rates of depression to be high. All of the women interviewed recalled feeling depressed at some time in their lives, or in some situations. Several of the interviewees described feeling depressed all the time, yet only one had informed a primary care physician. Thus the presentation in primary care was overwhelmingly somatic and, not surprisingly, none of the interviewees had received significant treatment for depression.

Depression was generally described as having a strong bodily component: "I've noticed that if I have a problem, later I get depressed, low blood pressure, without the motivation to do anything,"; "I feel depressed now. I even have a headache. I feel sad,"; "If you're depressed, everything hurts. If you have a problem, and your head or back is hurting, it feels like it hurts even more. You're just thinking, and you lose your optimism. You lose your energy and get sick." For these interviewees, depression involved simultaneous experiences of mental and physical distress. It was also understood as a transient phenomenon related to external problems, rather than as an endogenous disorder. Although the interviewees used the word "depression" (*depresión*) to describe their experiences, consistent with their scores on the BDI, their understanding of depression was distinct from conventional clinical definitions. While depression is conventionally defined as a mental disorder, the interviewees instead experienced it as an emotion like sadness or anger.
As an emotion, depression was accompanied by distinct physical sensations such as pain and fatigue.

**Perceptions of Causation of Somatic Symptoms**

All of the interviewees perceived significant causal links between their life experiences and emotions and their physical symptoms, although they may not have endorsed this connection for every symptom. For example, a common pattern involved believing that headaches and abdominal pain were at least in part psychologically based, while back pain was not. For four interviewees, anger or frustration at one's husband (*coraje*) sometimes provoked their pain. Two women with chronic abdominal pain experienced the pain during or following arguments with their husbands, while another woman interviewed described the onset of back pain when she asked her husband to turn down the stereo and he refused. Candelaria, whose alcoholic husband was sometimes physically abusive to her, stated: "The relationships at home sometimes provoke my stomachache. Like with my husband. Our relationship isn't good, so I'm always worrying, and that leads to nervousness. I think I have a nervous ulcer. So if I'm nervous, if I get angry, I get pain." For the interviewee Rosa, migraine headaches were interpreted as a product of her relationship with her husband: "I told my husband, 'My headaches, I think it's caused by you.' He laughed. But you know, in a way...not him, but maybe his attitude sometimes, the way he is. I always get hurt when we argue, but I don't talk back to him. I guess I just think too much about the problems, and then I start getting a headache."

For a number of the interviewees, specific emotional patterns related to stressful factors provoked pain. Interestingly, three women besides Rosa recounted a pattern in which thinking and worrying about one's problems could
in itself provoke a headache. These thoughts ranged from concern about one’s husband driving in inclement weather to a longing to see one’s family in Mexico. Other women remarked that their headaches were provoked by a feeling of pressure and tension in the home due to the strain of responsibilities for housework and children. This connection was most definitively articulated by Ana, who believed her headaches were caused by the difficulties of caring for her mentally retarded daughter. Ana felt she had to keep up with her household tasks even when she felt frustrated and upset, and that the resulting pressure provoked her symptoms. A causal link to the strain of being the sole caretaker for young children may be reflected in many interviewees’ descriptions of the onset of their somatic symptoms. Four described back pain dating from the birth of a child, while three described headaches which began or got significantly worse after the birth of a child.

Central to the causal explanations of a number of the women interviewed was the experience of holding in emotions rather than articulating them. The interviewee Carmen had drawn unique connections between her headaches and her inability to speak about the central difficult experiences of her life. She described the origin of her pain in the moments when she had witnessed her father’s physical abuse of her mother and had been unable to intervene: “My head hurt, and I also felt as if I was choking. Because I felt so bad, and I knew I couldn’t say anything.” This pattern of pain continued in relation to subsequent life experiences. As a newlywed and recent immigrant to the United States, Carmen missed her relatives, and she continued to remember a former boyfriend. “I can’t tell anyone how I feel, and it does me harm. When I first got married, there were times when I was crying because I missed my family, but I was also crying for that other guy. And my head would start hurting really badly.
because I was crying so much and I couldn't talk about what I was going through."

Although most interviewees offered psychosocial explanations for their symptoms, most also conceptualized their symptoms physiologically. Headaches were attributed to birth control pills or to sunlight. Abdominal pain was attributed to diet and to parasites. Back pain, the least emotionally connected symptom for the interviewees, was linked to falls, housework, temperature extremes, being overweight, and potential kidney problems. Two or more explanations were often offered for a given symptom, generally without any indication that the psychosocial and physiological explanations conflicted. An example is Candelaria's description of how she avoids abdominal pain. "Chile, soda, coffee, milk all affect me, so I try not to eat them. I also try not to get angry, and that helps me too." Similarly, psychosocial factors were mentioned along with strategies such as diet and exercise as important for a person's overall health, demonstrating that many interviewees had a concept of health that integrated the body and the mind. "Health depends on your state of mind," said one interviewee. Others recounted their wishes to "have a positive mind," "be distracted in some activity so I don't feel bad," "get along well at home," and simply "be happy" in order to be healthy.

**Coping Mechanisms for Somatic Symptoms**

The interviewees used a number of coping mechanisms when they had somatic symptoms. The principal coping mechanisms were the use of over-the-counter medications such as Advil, BenGay and Pepto Bismol and lying down and resting in a quiet place. Some of the women interviewed also sought health care for their symptoms, which will be addressed below. Despite the frequent belief of the interviewees that their symptoms were psychosocially
based, these coping mechanisms do not at first glance seem to address psychosocial factors. However, the simple act of lying down and resting can be understood to have potentially significant implications for family dynamics.

Eight out of ten interviewees reported lying down and resting when they were having pain. When they rested, they gained a brief respite from their duties of child care and housework, often because their husbands would take the children outside or otherwise occupy them. Rosa, who had complained that her husband caused her headaches, recounted his response to them: “He tells me to lay down. He knows my headaches are bad when I have them. So he takes the kids away, with my mom or something. And he leaves me in the house, by myself, and he doesn’t even bother me.” The pain was also an opportunity for the interviewees to be cared for by their husbands, or to care for themselves. Several women described their husbands comforting them, giving them massages, putting washcloths on their foreheads, or bringing them medicine. The only single mother in the sample would put on a video for her young daughters and try to relax while they were distracted. Thus the coping mechanism of lying down and resting altered the situations which had originally been stressful for the interviewees, by allowing them to obtain help for child care and receive more support and relaxation in the home.

**Medical Care for Somatic Symptoms**

Seeking medical care for their symptoms was not a given for the interviewees. Some did not think their symptoms were serious enough to warrant medical attention, while others stayed away because of the cost. Others discussed their symptoms with a health care provider in the course of visits for family planning or prenatal care, or when accompanying a child on a pediatric visit. These circumstances made it less likely that symptoms would
receive a provider's undivided attention; the interviewees may not have understood that making by an appointment specifically to address their pain symptom, they might have received more thorough care. Seven of the women interviewed recounted specific experiences in which they felt their complaints had not been taken seriously by a provider, or in which they were dissatisfied with the care they had received. These problems were often attributed to providers' being rushed in the patient encounter, or to their failure to listen respectfully.

The medical attention received by the interviewees tended to fall into a few unsatisfactory patterns, depending on the symptom in question. The women with abdominal pain had generally had extensive contact with the health care system, but they had not received satisfactory diagnoses or explanations for their pain. Their workups had been haphazard, because they had largely been the result of emergency room visits. The women who experienced back pain were generally given advice about sleeping on a harder surface or not overtaxing their back, and they did not find this advice particularly helpful. The women who had headaches were reassured that the headaches were not a sign of a serious problem, and were told that they might be due to taking birth control pills or to stress. However the discussion of the headaches did not generally extend to a discussion of the potential sources of stress in the interviewees' lives.

Candelaria, who suffered from back pain, abdominal pain, and headaches, described medical interactions which highlight the problems faced by Latina patients with somatic symptoms. A physician she had seen for her back pain had told her “You must like to give away your money, because there’s nothing wrong with you.” She had replied, “I wouldn’t be here if there was
nothing wrong." A visit to the emergency department for a bout of severe abdominal pain led to this series of interchanges:

One doctor came and asked me what I had, and then he went away again. Then the next one came and asked me what I had. I told him my problem, where it hurt and what I felt. And he said 'Okay. I'll be right back.' He left, and the third one came in. When the third one asked me what I had, I told him the same symptoms. He asked me 'What do you think you have?' I told him 'I didn't come here to tell you what I think, I came here so you could tell me what was wrong with me.' And he left, and I was there just waiting for a long time. And then the other one came back. He told me 'We don't know what's wrong with you.' I asked him why. He said 'But you, what do you think you have?' I got so angry that I wouldn't answer.

In all likelihood, Candelaria had been stereotyped as a "somatizer" by the emergency department physicians, and so did not receive a medical workup for her pain. Unfortunately, the physicians who thought she was somatizing also refrained from engaging her in a dialogue about the circumstances of her life (such as domestic violence) which could have been linked to her physical distress. Candelaria was denied both a medical and a psychosocial approach to her pain, but she remained deeply convinced that she was, in fact, suffering from something.

Several of the interviewees had had more satisfying experiences with medical care. Medical problems such as cholecystectomy and tonsillectomy had been dealt with effectively, perhaps because they involved a definitive diagnosis and treatment. In interactions which centered on the somatic symptoms, the key to a good interaction was physician-patient communication. Only two interviewees reported such positive interactions. Rosa described how much she liked talking to her neurologist about her migraines, because he was interested in her opinions about what exacerbated them. Yadira, who suffered
from intractable abdominal pain, said she had recently found a doctor who
would take the time to listen to her: “It’s really good to talk, because somehow it
makes you feel relaxed. It hurts less. Sometimes you go to the doctor and they
just say ‘Take this pill. It will make you better. Now get out of here.’ But if they
listen to you, it’s as if it takes away a part of the pain.” Despite years of
emergency department and outpatient visits, Yadira had not received a
meaningful diagnosis or treatment for her pain. Communication may have
finally been the best treatment her physician had to offer.
Discussion

This study elaborates connections between somatic symptoms and psychosocial factors for Latinas using a qualitative analysis of ten interviews with Mexican American immigrant women currently using outpatient medical services. The findings of this study can be cautiously generalized to other Latina immigrants with somatic symptoms. The interviewees articulated their experiences of psychological distress in the course of discussing their somatic symptoms. Inadequate social and marital support, motherhood, experiences of domestic violence and childhood abuse, economic hardship, and acculturation difficulties were psychosocial stressors described by the interviewees. The connection between somatic symptoms and depression was reflected in a mean score of 14 on the BDI, indicating moderate depression.

For the interviewees, somatization did not substitute for emotion, but rather was intimately and consciously linked to painful emotional awareness. The interviewees described direct causal relationships between their psychosocial problems and their physical symptoms, reflecting a conceptualization of health which does not separate body and mind. Among the most important factors causally linked to somatic symptoms were strain in the marital relationship, the stress of motherhood, and a lack of opportunity to communicate about one’s problems. The interviewees’ perspectives on their symptoms transcend the biomedical model of health and disease. Their commentaries demonstrate that an individual’s physical symptoms may function on two levels simultaneously: as manifestations of physiological disorder, and as powerful metaphors for emotional experience.

Furthermore, for the women interviewed, somatization functioned as an “idiom of distress” (Kleinman, 1982). Two principal themes support this
conclusion. First of all, an unmet need for emotional expression was strikingly evident throughout the accounts of most interviewees. Inadequate social and marital support contributed to this problem. In many cases, friends and relatives were not available because the interviewees had recently migrated from Mexico. Women leaned heavily on their husbands for support, but strained marital relationships meant that husbands often were unable or unwilling to play the confidant role.

The culturally specific ideals of marianismo and controlarse described above represented further obstacles to emotional expression. The expectation of selfless motherhood influenced the interviewees against expressions of frustration with respect to caring for their children; only in the interactions surrounding somatic symptoms were there suggestions of conflict between the mother’s needs and the child’s. Intriguingly, the ideal of controlarse did not generally extend to control of expressions of physical distress. On the contrary, interviewees tended to act on their symptoms in a relatively open way, significantly changing their daily routines to accommodate and mitigate their pain.

The second finding which supports the notion of somatization as an idiom of distress is that the interviewees’ somatic symptoms had the power to at least symbolically alter some of the distressing conditions of their lives. When they experienced pain, the women interviewed tended to receive emotional and practical support which was unavailable to them otherwise. Somatic symptoms could even be viewed as a form of protest against distressing circumstances. Because the protest was implicit rather than explicit, it could only be partially effective; broader changes such as sharing childrearing more equitably between parents were not discussed or implemented by the women interviewed and their mates. The skills to negotiate such changes could be of value to
immigrant families adjusting from an extended family situation in the country of origin to a nuclear family situation in the United States. The nuclear family may offer less in the way of practical and emotional support for women, and so necessitate more egalitarian values and practices in the home.

Given the recruitment strategy for this study, we can expect certain characteristics to be prominent among the interviewees as opposed to among Mexican American immigrant women overall. First of all, because clinic visits are often made for children's health care, a number of young mothers of young children were recruited for this study. Second, because recruitment was done during the day on weekdays, women without jobs or regular work hours were perhaps more likely to be interviewed. Depression might have created two opposing effects on participation in this study, the impact of which are difficult to assess. Depressed women might have been less likely to leave their homes, and thus less likely to be recruited. On the other hand, depression is often a predisposing factor for health care use (Perez-Stable et al., 1990), so depressed women might have been more likely to be recruited. Similarly, a desire to talk about one's personal problems was a salient characteristic of many of these interviewees, and they may have differed in this characteristic from the 75% of women approached who chose not to participate. This desire to discuss symptoms and problems may have reflected a high level of distress and unmet emotional needs on the part of the interviewees; it may also have reflected a high level of functioning in terms of the ability to reach out to a previously unknown individual and participate in an unfamiliar interaction.

The lack of alternative channels for the expression of psychological distress contributes to an emphasis on physical symptoms for Latinas. Latinas are likely to seek medical services for their symptoms at least some of the time;
an increased awareness of the culturally specific significance of somatic symptoms on the part of providers would be beneficial in these situations. Somatic symptoms often carry elaborate psychosocial meanings for Latinas, but these meanings generally remain implicit and unspoken in social interactions, including the medical encounter. Thus the most important change providers can make with respect to their Latina patients is to broach psychosocial issues in the course of the medical encounter. This subject area could be introduced with a simple question like “How are things going at home?” or “Do family problems make your pain worse?” Unless physicians actively initiate such a discussion, patients are likely to assume that they are not interested in their emotional state or life experiences (Kirmayer and Robbins, 1996).

Given the scarce opportunities for self-expression reported by the women interviewed for this study, the medical encounter represents a potentially significant forum for communication and support. It also represents an opportunity for physicians to detect mental disorders such as anxiety and depression, as well as serious life problems such as domestic violence, and to refer patients to appropriate mental health services and community resources. The diagnosis and treatment of affective disorders could dramatically improve somatic symptoms for some Latinas. For others, referrals to support groups and community services may be more effective because of the potential to enhance social support and expression of psychosocial concerns. Latinas may be less likely to embrace a treatment which focuses on individual well-being apart from the family; thus a physician’s recommendations for treatment might focus on the benefits to the family if a patient’s symptoms were to improve. Physicians could suggest simple stress-reduction techniques to their Latina patients (Duran, 1997), as well as emphasizing the need to obtain periodic relief from child care
and housework in order to better care for one's family in the long run.
Incorporating partners and other family members into such discussions may
enhance the success of these strategies.

These interviews did not address specific somatic syndromes such as
nervios among the interviewees. However, it is interesting to note that
headaches and abdominal pain were significantly more likely to be perceived
as psychologically linked than was back pain. This pattern needs to be
confirmed with further research, but it is reasonable to suggest that a Latina
patient complaining of headaches or abdominal pain may warrant a
psychosocial assessment as well as a medical workup.

Two "mistakes" made by the researcher in the course of interviewing will
be instructive to medical providers. The first mistake was that interviewees were
in some cases asked to choose between a physiological and a psychosocial
cause for their symptoms. Dual causation for a particular symptom was the rule
rather than the exception, and the request to choose was experienced as a
negation of this experiential truth. Thus if a provider were to attribute a symptom
to psychosocial factors and proceed to ignore potential physiological causes
(for example, by failing to do a physical exam), Latina patients are likely to feel
dissatisfied with the medical interaction. The second, related mistake was that
interviewees were on occasion asked directly "What do you think is causing
your symptom?" This question tended to elicit a negative or evasive response,
perhaps because it has a slightly confrontational or blaming quality. More
effective questions which elicited the same information were "What makes your
symptom better or worse?" and "What situations tend to bring on your
symptom?" These more indirect questions are recommended for use by
medical providers.
Given the sometimes negative experiences of Latinas in the health care system, it is crucial to understand medical providers' perspectives on Latinas and somatization. Somatization is an emotionally charged issue for medical providers; most providers are not adequately trained to confront psychosocial issues or to adopt a mind-body perspective, and so may feel inadequate and helpless when confronted with unexplained physical symptoms. This feeling of inadequacy may be intensified for providers working cross-culturally, and may lead to stereotyping. A qualitative study of medical providers working with somatizing Latina patients could address these complex issues; such a study could illuminate the causes of medical interactions in which neither physical nor psychological aspects of a symptom are properly addressed.

The most crucial gap in the literature concerning Latinas and somatization exists in the area of appropriate treatment. Reports to date have principally involved cognitive-behavioral techniques. A descriptive report by Bertagnolli, Harris, and Arean (1996) indicated the promise of a cognitive-behavior group for a multi-ethnic sample of mostly female medical outpatients. On a related note, Organista and Munoz (1996) describe the strategy of conducting Spanish language cognitive-behavioral depression groups in a hospital-based division of psychosocial medicine. Front-line medical staff are trained to refer patients to the groups who present with excessive somatic, anxiety, or depressive symptoms. Preliminary analyses showed significant decreases in depressive symptoms with treatment (Organista, Munoz, and Gonzalez, 1994).

Further trials of various treatment modalities for somatization should be conducted to ascertain which are most effective for Latinas, and for specific groups within the Latina patient population. The potential contribution of the
primary care physician to the treatment process should be considered. An
effective treatment for somatization among Latinas is likely to integrate attention
to physical symptoms with attention to distressing emotional and social factors;
thus a team approach may be particularly effective. Latinas are likely to be
quite receptive to treatment if it is offered in a respectful and sensitive way, and
if they feel that their somatic complaints are being taken seriously.
References


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Conclusion

Doing these interviews was an emotionally moving experience for me. The most poignant aspect of the research was the loneliness expressed by many of the women I interviewed, and their gratitude to me for listening to them speak of their problems and their lives. I had not expected that the interview itself would be so humanly meaningful, especially considering the complicated and circumscribed nature of the interaction. The interviewees were able to reach beyond the consent forms, tape recorder, and written questionnaires because their needs were so great.

Another eye-opening and poignant aspect of the research were the conversations with clinic staff members during my visits to the clinics for recruitment and chart review. Because of financial and administrative difficulties brought on Medi-Cal managed care, the clinics were struggling to stay open on a week-to-week basis. Perhaps fifty percent of the clinic staff moved on to other jobs during the course of my project, and they had not been replaced. In this chaotic atmosphere, a core of dedicated and even heroic providers and support staff kept seeing patients, doing lab work, and filing charts. I had the sense of medicine being practiced on the margins: the patients were members of socially marginalized groups, and the commitment had not been made by the larger society to provide these groups with appropriate health services.

The recommendations for clinical practice which follow the report of my research do not directly address this issue of medicine on the margins. Unfortunately, this marginalization adds another set of obstacles to meeting the psychosocial needs of patients. Providers are overworked and overwhelmed with meeting patients' medical needs in this atmosphere of scarcity, let alone
their emotional needs. Patients may need referrals to mental health services, but there are few culturally-sensitive, Spanish language programs available. Thus at first glance it might seem that my recommendations are less than appropriate for the realities of practice in many clinics serving Mexican American immigrant women. But I believe the opposite to be true. The medicine practiced in these settings is bare-bones, "low-tech" medicine, and as such provides an opportunity for the provider/patient interaction to come to the fore. Since there are so few resources, why not direct them to patients’ most pressing needs? Doing so requires ascertaining what those needs are, and that can only be accomplished by explicitly discussing the physical and psychological aspects of problems with patients themselves. It is my belief that once such dialogues begin, the extent of the unmet needs for culturally-appropriate mental health services will become known, and changes may be made in the health care system to begin meeting those needs.