Section I: Background Information

In this chapter, we present cultural profiles for two of the largest demographics in Mexico (i.e., dominant-culture Mexican or Mestizo and Indigenous or Amerindian). However, before proceeding, it is imperative that we pause to recognize that Mexico is ethnically and linguistically diverse. Several complex historical factors such as census shortcomings, including the fact that prior to 2015, Mexico did not collect data on ethnicity perpetuate inaccurate views of the population. Thus, despite misconceptions about Mexican homogeneity, it is important that the reader appreciate Mexico’s diversity.

Briefly, dominant-culture Mexicans or Mestizos (mixed Spanish/indigenous ancestry) comprise the largest demographic followed by Amerindians/Indigenous people. It is worth noting that, within the Americas, Mexico houses the largest indigenous population with 78 distinct ethnic groups and 68 distinct languages from 11 language families including 364 recognized dialects. Other ethnic groups, to name a few, include African Mexicans and Mexicans of Arab descent, both brought to Mexico as slaves, and Mexicans of Arab descent who immigrated to Mexico as early as the 19th century.

Thus, considering the aforementioned, what does it mean to be Mexican, dominant-culture Mexican, Amerindian, Mexican American, Hispanic, Chicano, Latinos, or of Mexican descent? Where does this terminology come from, why do we use it, and, perhaps more importantly, does it matter? Without a doubt! A delicate exploration of our patient’s cultural background has profound implications for our work as psychologists/neuropsychologists. In this chapter, we utilize select terminology (see Glossary), cultural characteristics, and a case illustration to weave this complex discussion. However, we caution the reader against the human tendency to view others in terms of broad ethnic/cultural categories. We rely on cultural profiles as the backdrop for a deeper discussion concerning the importance of understanding our patient’s unique experiences and perspectives.

Terminology

Language is not only a unique human ability but a powerful mechanism of cultural transmission relying on symbols, categories, and labels, including specialized terminology. Thus, language is “intrinsic to the expression of culture,” including our sense of self. As such, rather than reviewing a menu of terminology ascribed to individuals from Mexico or of Mexican ancestry, it is vastly more important to discuss the origins of said terminology as well as the function and limitations of its use.

Two constructs borrowed from linguists are particularly relevant to our discussion: etic—an outsider’s perspective/worldview; emic—perspective/worldview stemming from within the culture or context of interest. There is an array of terms available to describe individuals from...
Mexican Origin Communities

Mexico or those of Mexican ancestry (e.g., Hispanic, Latino/a/x, Mexican American). What we must recognize is that the vast majority of our terminology reflects the US culture and its institutions. In fact, many are US census labels or the result of US-based sociopolitical movements. If we delve in deeper, what we are, in fact doing is relying on these etic terms to extrapolate information about the other’s presumed worldview—identity, behavior, values, beliefs, etc. When we preoccupy ourselves exclusively with such US-based terminology/perspective, we risk failing to incorporate our patient’s unique experience and perspective.

With respect to Mexicans, the emic perspective must consider complex Mexican historical and sociopolitical factors that shape(d) their unique worldview. One such factor is the Mestizo ideology, which should not to be confused with Mestizo the ethnic self-identification denoting mixed Spanish/indigenous ancestry. Briefly, the Mestizo ideology can be summarized as a concerted effort in Mexico to eliminate racial/ethnic distinctions in favor of a national identity. Consequently, to many Mexicans, “ethnic identity” is an unfamiliar concept and, as such, an imposed etic from Euro-American cultures. Thus, when we ask patients from other cultures to self-identify, many are perplexed by this concept (i.e., unsure how to respond). Thus, in Mexico (all through Latin America, in fact), with respect to identity, people coalesce around a national rather than an ethnic/racial identity.

So, what bearing does this have on the clinical encounter? Though we juxtapose both perspectives here (etic vs. emic), our intention is not merely to simplify these into a false dichotomy and/or suggest that one takes precedence over the other. Our point is that, when working with individuals whose cultural background is different than ourselves, the shared experience requires awareness and integration of both cultural perspectives. Psychologists/neuropsychologists must be aware of the unique cultural/subcultural perspective they bring into the encounter and, simultaneously, explore and integrate the patients’ internalized characteristics on health/illness. Through this process, a unique working alliance is created with opportunities for optimal assessment/treatment.

**Author Perspective**

I (AMS) consider myself a Mexican American female, highlighting my status as a first-generation American with deep-rooted Mexican traditions/lifestyle practices. My upbringing in a predominant Mexican neighborhood in Southern California depicted primarily Spanish-speaking, working-class families who valued Mexican culture and had minimal interaction with the English-speaking community. A neighborhood composed of small bungalows and apartment complexes, my boundaries consisted of landmarks: a small park to the west, my English-based-majority White religious school to the east, the panadería (bakery) to the south, and the north was off limits as that is where the chulos (gangsters) lived. After leaving this neighborhood as a pre-adolescent, I learned about the “questionable safety” of the area, a stark contrast to my fond childhood memories. I can picture our small apartment and my neighborhood friends (with cute Spanish nicknames like Albondiga (Meatball). I did not suffer materialistic needs; I was not even aware of what I did not have until later in life. I had everyone I needed and truly enjoyed life on 56th street, a place where cultural practices were valued and respected, where weekends were filled with music and the small materialistic gains that each family accomplished were acknowledged. This neighborhood also introduced me to White, English-based school structures, where as the only Latina, many of my core values were not the norm. I remember what it was like to be different: unfamiliar with Westernized practices, limited English mastery, and lower socio-economic standing. It is these childhood experiences that molded me into the clinician I am today and that remind me of the importance of culturally informed, patient-centered care.

I (ALDS) identify as a Puerto Rican female, born and raised in the mountains of the island surrounded by family and friends, speaking only Spanish until I attended graduate school on the
mainland. Picking fruits and vegetables from the garden and feeding the chickens, rabbits, and horses were my primary chores after school. We enjoyed family gatherings to celebrate everything! Everyone coming to abuela’s (grandmother’s) house for dinner was a serious tradition. We shared a close relationship among family members, always available to help one another. After my immediate family immigrated to Florida following better employment opportunities, my process of acculturation to the mainstream American culture began. It was not a shock as I was surrounded by Latinos from the Caribbean and South America. Throughout my training, I have been taught the importance of being human first. The compilation of my upbringing, my “immigration” experience, acquisition of English and my training have shaped the clinician I am today. That is, aware of the need to provide individualized, quality care to all.

Born and raised in Mexico City, I (AP) have engaged and enjoyed the different traditions of my parents’ families. My father was from Durango (north of Mexico) and my mother is from Mexico City. This interplay of traditions and my exposure to American culture sparked my interest in learning about and appreciating different cultural lifestyle practices.

My perspective (OS) is that of a Ñuu Savi (Mixteco) immigrant neuropsychologist born in southern Mexico with professional and research interests in multicultural education and training, “cultural competency,” and health disparities.

Geography
Knowing your patient’s exact origin (specific city/town) prior to the clinical encounter may help generate hypotheses about their potentially distinctive characteristics (e.g., Amerindian vs. dominant-culture Mexican, bilingualism, socio-economic status, and implications for dietary deficiencies known to impact cognition). The uniqueness of each community will vary according to the specific geographical location. Of note, individuals from Mexico may often indicate that they are from “un rancholanchito” (ranch, little ranch), which generally implies that the individual is from a rural area and/or an indigenous village.

History
As articulated in Mexico’s Constitution (1917, Article 2), at the heart of the Mexican nation, lies its Amerindian roots. It is estimated that, upon the first encounter with Europeans, between 50 and 100 million people already inhabited the Americas. In the centuries that followed, these numbers declined considerably as a function of disease and wars provoked and/or exacerbated by Europeans. The conquest (1521) also brought new social structures, including a racial caste system that favored White European descent. To this day, White European features continue to be associated with positive attributes while indigenous or African features are viewed negatively.

The Mexican War of Independence from Spain (1810–1821) was followed by the Mexican Revolution (1910–1920), which largely disenfranchised indigenous people. Following the Mexican Revolution, there was an official government endorsement of “mestizaje” (i.e., mixed Spanish/indigenous ancestry) as the national identity whereby delegitimizing all other identities and cultures. As a result, the government did not recognize racial/ethnic self-identification until 2015. At this juncture; it is important to clarify that “mestizaje” is a socially constructed reality with complex historical-sociopolitical implications. Suffice it to say that, among other things, “mestizaje” (the ideology) obfuscated the indigenous and Afro-Mexican identity in Mexico and, in many ways, facilitated unchecked racism, discrimination, and oppression that persists to this day.

While the Mexican Revolution sought to address social inequality, the wealth gap in the 21st century remains a major problem in Mexico, with many citizens living in deep poverty (44% of
dominant-culture Mexicans and 78% of Amerindians). Overall, Mexico remains crippled by “poor governance in critical domains of public policy, high impunity and corruption rates, weak rule of law and protection of civil liberties and rights, entrenched marginalization, ... growing inequality, and low public confidence in political officials and institutions.” In the absence of healthy governance, over the past three decades, drug cartel-related crime and flagrant violence have engulfed Mexico. Thus, it is no wonder that Mexicans eagerly risk everything for a opportunity at the “American dream.”

**Immigration and Relocation**

Since 1980, Mexicans have represented the largest immigrant group within the United States. However, after four decades of burgeoning Mexican immigration, this surge plateaued in 2014 and has steadily declined since. Nevertheless, despite this decline, Mexicans remain the largest foreign-born group in the nation, accounting for 25% of all immigrants. Though the aforementioned statistics largely pertain to dominant-culture Mexicans, it is important to highlight that, since at least the 1960s, Amerindians have likewise been immigrating to the United States in large numbers with rapid population growth since the 1980s. The Amerindian presence in the United States has grown large enough that, as of 2010, the US census has endeavored to capture the racial/ethnic heterogeneity reflective of Mexico as well as the broader Native American population. According to recent data, Amerindians from Mexico comprise the fourth largest indigenous population within the United States (Cherokee, Navajo, and Choctaw are largest, respectively).

**Language**

Considering the heterogeneity of the Mexican population, including its large presence in the United States, clinicians should be mindful of their Mexican patient’s language proficiency and fluency, particularly with respect to Spanish, Amerindian language(s), and/or English. Bilingualism will be an important factor to consider as Mexican individuals may speak said languages at various levels of proficiency, fluency, and literacy. Consequently, it is important that the reader not assume that Amerindian patients are fluent in Spanish. Ignoring these elements may greatly impact the evaluation, with potentially significant negative consequences for the patient.

**Communication**

Mexican culture, as it pertains to Mestizo individuals, is considered a “high-context culture.” Accordingly, communication is less direct and points are made in a more diplomatic, subtle, and less confrontational manner. American linguist Robert Kaplan described the Romance languages’ communication style as “an arrow that makes sharp turns before getting to its destination.” As such, communication often “digresses” or moves away from the main point. However, following the flow of the conversation is considered integral to the point. In contrast, European Americans might find this style to be “disorganized or intellectually weak” as it deviates from the Eurocentric “direct or linear” form of communication. Meaning is conveyed via non-verbal cues and less direct verbal messages. For instance, a “no” would be conveyed with a “maybe” or a “we’ll see” in order to avoid causing disappointment or offense to the inquiring party. Given such practices, dominant-culture Mexicans may find the English-speaker to be aggressive/intimidating. Conversely, the English-speaker may perceive the dominant-culture Spanish-speaker as timid or taciturn.

Interpersonally, the focus is placed on relationship building; thus, the timing allotted to this aspect of the professional relationship is imperative. In clinical practice, it is important to establish
rapport, providing the patient with an explanation of standardized practices (including the expectation of minimal interpersonal conversations during testing) to aid the examiner in respectfully engaging/disengaging the patient. Timing is considered flexible, relaxed, and circular within the dominant Mexican culture. The concept of ahorita (right now) or mañana (tomorrow) is utilized within the dominant Mexican culture to denote later (in some cases due to perceived lack of urgency). The lex concept of time and the stress on relationship building must be considered when managing clinical procedures. In regard to personal space, dominant-culture Mexicans normalize less spacing between people in a group. The typical “2–3” feet European/American social standard may be considered distant/indifferent to dominant-culture Mexican patients. Tying in with the relationship-building aspect, dominant Mexican culture focuses on collectivism. Direct eye contact with individuals in authority may be viewed as disrespectful for some. Hence, the European American norm of maintaining eye contact while communicating might not be reciprocated. Lastly, both the initial and closing greeting toward the professional from the patient/family may include a hug and/or kiss on the cheek. This might not occur on the first session but can be part of the relationship that develops over time. The provider should be aware of this cultural interaction which should not be considered a boundary violation.

While Amerindians may also exhibit aspects of the aforementioned communication and interpersonal style, by virtue of their distinctive history, language, and culture, their characteristics are different from that of dominant-culture Mexicans. Broadly speaking, the characteristics detailed above can be observed within Amerindians but to greater degrees (e.g., more “disorganized” in communication; time as more flexible). Given shared commonalities with US Native Americans, Mexican indigenous people exhibit aspects resembling that of indigenous people of the United States. For example, given their semi-autonomous governments and history with chronic racism/discrimination, Amerindians are highly interdependent and may be more distrusting of others and reluctant to identify as indigenous to non-indigenous individuals. Clinicians should be aware of the cultural tendency to prefer politeness and less direct modes of communication, as this might result in a patient ostensibly abiding by the clinical recommendations provided without adherence.

Education

Mexico’s education system (see Table 33.1), established in 1917, is not only enormous but incredibly complex, marked by pervasive social inequality, corruption, and poor educational outcomes. Succinctly, this system was initially overseen by the federal government under the Secretariat of Public Education. However, in pursuit of quality and equity in education, in 1992, the federal government decentralized this system to Mexico’s 32 federal states, including the National Teachers Union (SNTE). Unfortunately, while the system slowly evolved over several decades with the SNTE increasingly accumulating power, the goal for quality and equity was lost.

Today, with respect to quality, national and international data consistently reveal disappointing results. For example, according to the National Plan for the Evaluation of Learning (PLANEA), more than 30% of all students in 2017 scored at the lowest level in Spanish. In other words, these students experienced difficulty comprehending or interpreting texts considered to be of medium complexity. Similarly, only approximately 8% of students could analyze complex arguments. By international standards, Mexico consistently ranks poorly in literacy, math, and science. Overall, 1 in 2 Mexican students lack the necessary knowledge required to obtain higher education, to confront the challenges of modern life, and/or to solve complex social/environmental problems.

With respect to equity, poverty is a major factor impacting the education system in Mexico, with Amerindian communities, the poorest of the poor, being disproportionately impacted. Amerindians face unique challenges including poverty and racism/discrimination that contribute to disproportionate access to education and have the highest dropout rates along with the highest
rates of illiteracy in Mexico. At the opposite end of the spectrum, private institutions are available for the select elite with such programs offering multilingual curriculums, some teaching in English and a second foreign language with no Spanish components.

Overall, careful exploration of the quantity and quality of education is of paramount importance in an evaluation. Simply inquiring about the highest level of education completed does not begin to capture the complexity described above. Furthermore, it is important to explore the age the individual initiated schooling, consistency of attendance and available academic resources. Other factors worth exploring include grade failure/retention and reading skill, specifically in terms of reading comprehension.

It is also worth cautioning the reader with respect to the possible assumption that premorbid functioning can be estimated as easily as with a native English speaker (i.e., reading test). Unlike English (opaque language with many irregular words), Spanish is considered a transparent language where simple, rudimentary phonetic skills are enough to decode college-level words.

**Table 33.1 Structure of the Mexican education system**

Mexico’s education law defines three main levels of education. Each level of education is further subdivided as follows:

- **Educación Basica (Basic Education)**
  1. Educación Preescolar (early childhood education): Ages 3–6
  2. Educación Primaria (elementary education): Grades 1–6
  3. Educación Secundaria (lower-secondary education): Grades 7–9

- **Educación Média Superior (Upper Secondary Education):** Typically grades 10–12
  1. Bachillerato General (general academic)
  2. Bachillerato Tecnológico (technological education)
  3. Profesional Técnico (vocational and technical education)

- **Educación Superior (Higher Education)**
  1. Técnico Superior (post-secondary/associate/diploma)
  2. Licenciatura (undergraduate and first professional degrees)
  3. Postgrado (graduate/postgraduate education)

**Socio-Economic Status**

As previously discussed, poverty and wealth inequality in Mexico are major challenges for Mexican citizens. While some improve their situation by immigrating to the United States, others continue to face challenges even within their host country. Within the United States, these individuals live in poor conditions (~20% live at or below the poverty line), lack health insurance, and face disproportionate rates of chronic health conditions including obesity, diabetes, and heart disease. Many factors contribute to the aforementioned situation including English language proficiency, discrimination, low education, and limited employment opportunities.

**Values and Customs**

Knowledge about commonly held values and customs (i.e., religious, spiritual, patriotic, and rite of passage customs or celebrations) in Mexican communities can support rapport building and help provide thoughtful/culturally informed services. Nonetheless, as emphasized throughout,
clinicians should also recognize the heterogeneity inherent in the Mexican population and consider possible variability in individual values and customs.

**Health Status/Health Providers**

In addition to marked social inequality, Mexico's complex history and cultural diversity characterize its formal/informal health care system. Perspective on health and illness, including etiology of diseases, diagnosis, and approach to treatment reflect an amalgamation of Amerindian, Greek, and modern Euro-American medical practices. Mexican's medical system is primarily composed of Amerindian traditional healing practices that exist parallel to, but separate from, modern medical practices (e.g., *Curanderos/Medicos Brujos*). Overall, traditional Amerindian practices are poorly understood and, as such, devalued by formal/modern medical institutions and providers. Consequently, efforts to integrate both models have consistently failed. While these may not be formally integrated to the average dominant-culture *Mestizo*; both medical perspectives are complementary. However, for economic reasons, *Mestizos* regularly access traditional healers. Consequently, in some respects, traditional practices such as herbology may be preferred over modern pharmacotherapy. Perceived etiology of ailments includes spiritual/supernatural, physical/natural, or both. Thus, treatment must match the perceived etiology for optimal results. Examples of traditional diseases include *empacho, mal de ojo, caida de mollera*, and *susto/espanto*.

**Gender and Sexuality**

Gender inequality and violence is a major problem in Mexico. Sources indicate that violence against women is experienced across age, social, economic, and cultural spheres. Data suggests that more than 65% of Mexican women will experience at least one incident of emotional, physical, or sexual violence in their lifetime. Unfortunately, sociocultural attitudes and government/legal enforcement apathy contribute to this epidemic. While laws exist, these are rarely honored and most women are reluctant to press charges. Given systemic apathy, acculturation factors are likely to influence outcomes in such situations, particularly among young Mexican women growing up in the United States who are caught between a home culture that potentially values *marianismo* (virgin moral purity) and a host culture that is perceived as more “liberal”, leading to high acculturation stress (*acculturation gap*). Additionally, research has revealed how immigration and context challenges gendered and culturally bound depictions of marriage. Gender inequality is also observed across social domains, such as education; for example, females are more likely to drop out of school by age 12 due to domestic demands. Consequently, they are less likely to graduate high school and attend higher education, whereby limiting economic opportunities as well as upward social mobility. In addition, Mexican women are likely to marry young and, as a result, terminate their education. Overall, Amerindian women have the highest rates of illiteracy, school dropout, domestic violence, health complications, and considerably less job opportunities.

**Spirituality and Religion**

Currently, more than 80% of individuals living in Mexico identify as Catholic. However, unlike Catholicism elsewhere, Mexican practices incorporate pre-colonial perspectives. Approximately half of Mexicans (44%) endorse a “medium” to “high” level of engagement with Amerindian beliefs and practices, such that 45% believe in “evil eye,” 39% believe in witchcraft, sorcery, and magic, and 31% believe that one can communicate with spirits. With respect to Mexicans living...
in the United States, 61% identify as Catholic, 39% believe in “evil eye,” 44% believe in witchcraft, sorcery, and magic, and 57% believe in spiritual possessions.80

The Virgin Mary, the most revered religious icon in Mexico, is a good example of how Catholicism incorporated indigenous people without integrating their worldview. In this example, inclusion of the indigenous community is only via the Virgin’s origin story, appearing to Juan Diego, an indigenous figure who served as her envoy. Mainstream Catholicism does not incorporate the indigenous cosmology and/or spirituality. Thus, if the aforementioned is conceptualized as “syncretism” it is on the light end. Mexican Catholicism is unique from other forms of Catholicism practiced outside of Mexico and religion or “Catholicism” practiced by indigenous people is marked with differences, depending on the particular indigenous group, geographic location, and level of community acculturation.

Acculturation and Systemic Barriers

Within the United States, Mexican immigrants, on average, have better health compared to US-born Mexicans and non-Hispanic Whites despite significant risk factors such as low81–83 socio-economic status. However, the health of Mexican immigrants declines the longer they remain within the United States.82,84,85 Though it is hypothesized that unique aspects of acculturation contribute to sharp declines in health, specific pathways have yet to be identified; nevertheless, hypotheses include discrimination and the erosion of cultural protective factors such as familismo. This phenomenon is most commonly referred to as the Hispanic/Latino immigrant paradox.86

Overall, compared to other foreign-born immigrants in the United States, Mexican immigrants, on average—are more likely to be Limited English Proficient (LEP), report lower levels of education, face poverty, and have inadequate health insurance.84 This is particularly true of Amerindians who, additionally, encounter racism/discrimination from both dominant-culture Mexicans as well as US nationals. Although second-generation immigrants may have higher rates of assimilation, acculturative stressors encumbered should be examined. Models of acculturation are particularly relevant here as they allow us to understand the unique acculturation strategies of Mexicans, as not all espouse the same strategy.87–90 Some employ a separation strategy of acculturation and retain a strong Mexican national identity aiming to preserve their home culture and language, while others espouse an assimilation strategy, striving to fully incorporate themselves into mainstream US society and, consequently, may take offense to any assumptions about their presumed cultural identity, including assumptions about their use, ability, and/or willingness to speak Spanish. These are the emic factors that clinicians must carefully explore as they not only influence the working alliance but inform the assessment process.

Mental Health Views

Overall, mental health services in Mexico are largely non-existent and significantly underdeveloped. According to national studies, few Mexicans access psychiatric care, and half of those who access care receive only minimally adequate services.81 In addition, three decades of drug cartel-related violence have increased the need for psychological/psychiatric care. Though not as disheartening as the situation in Mexico, Mexicans living in the United States also face challenges with access to psychiatric care due to multiple barriers including language, poverty and lack of health insurance, legal status, acculturation, stigma, and lack of culturally competent providers.92 Given how underdeveloped psychological and neuropsychological services are in Mexico, the reader should anticipate that Mexican individuals may likely be unfamiliar with the “rules of engagement” with respect to mental health care. Thus, at the outset (after exchanging pleasantries,
building rapport, and displaying personalismo, it is wise to offer education with respect to the clinical enterprise—what a psychologist/neuropsychologist is, nature of and reason for the evaluation/referral, mode of interaction, boundaries/confidentiality, expectations, testing, etc.

Approach to Neuropsychological Evaluations

Neuropsychological services in Mexico are fairly new. Nevertheless, current efforts in improving and formalizing specialized training in clinical neuropsychology are being prioritized. Current services are similar to those offered in the United States including assessment, diagnosis, and cognitive rehabilitation. However, it is important to note that historically, neuropsychological services in Mexico have been rendered primarily to children with neurodevelopmental disorders and it was not until the recent decades that services extended to adults.

Research has shown that Latinos may view cognitive changes, specifically memory loss and even a diagnosis of dementia as an unavoidable part of the natural aging process. Should patient/family share such perspective; providers should utilize this opportunity to reduce health outcome disparities by focusing on modifiable host factors that would otherwise prevent patients/families from seeking disease-modifying therapies. Health literacy regarding the process of normal aging and the impact of mental and physical health on brain health should be shared in a respectful and holistic manner, embracing the patient’s worldview.

Psychological and neuropsychological services are practically non-existent for Amerindians (both in Mexico as well as the United States). Nevertheless, a handful of studies suggest that Amerindians have unique cognitive profiles as a function of their unique sociocultural environments. Available data suggests that Amerindians have lower performances on working and verbal memory tasks but higher performances on visuospatial tasks compared to non-indigenous individuals. Overall, two factors have surfaced as particularly relevant, education (quantity/quality) and cultural relevance (test naiveté); some tasks are simply meaningless to indigenous people, therefore, impossible to comprehend and/or perform.

Section II: Case Study — “No Estoy Demente Sólo Vieja/I am Not Demented Just Old”

Our approach to neuropsychological services with Latino patients is one that takes into account the sociocultural/economic context of the individual. Patients are always welcomed in Spanish with respeto and personalismo, as the initial step toward the successful establishment of rapport. Patients are asked about their understanding of what will take place during their visit followed by psychoeducation regarding the expected process.

Presenting Concerns

Ms. Reynosa is a 76-year-old right handed, married female referred for declines in short-term memory as well as an increase in depression and anxiety. Family assists with finances and medication management.

Social History

Ms. Reynosa, of Meztizo dominant culture, was born and raised in a remote town in Mexico where she had to walk long distances to attend school. She completed eight years of education and denied academic difficulties. She described terminating her education due to safety concerns; her family felt she was at risk for violence due to her lengthy commute to and from school, and
they also needed her assistance with the family farm and household obligations. She immigrated to the United States in 1984 following her husband, who had immigrated seeking employment. She lived with her husband and worked in housekeeping until 2018, when she became his full-time caregiver.

Cultural History

Ms. Reynosa identified as bilingual (Spanish/English) and reported English as her dominant language. She resides in a “Mexican community” in the greater Houston area, and social interactions and media use are mainly conducted in Spanish. She identified as catholic and described stressors as tests of faith from God. Although she follows up with her doctor annually, she reported increased trust in community healers, given her past results. Ms. Reynosa described being inclined to take herbal supplements over prescription drugs and described distrust in medications. When inquired further, she described remembering how her mother used to care for her and her siblings with natural remedies without the need for doctors. Her current insurance plan covered neuropsychological assessment but did not approve neuroimaging studies requested by her referring doctor.

Medical History

Diagnosed conditions include diabetes, polyneuropathy, kidney disease, hyperlipidemia, hyperkalemia, hypertension, and GERD. She denied a history of seizures, head injury, or TIA/stroke. Medical records reveal poor diet compliance (coffee with peanut cookies for breakfast, a glycemic-control shake for lunch, and a shake with peanut cookies for dinner). Familial medical history is significant for Alzheimer’s disease, although she stated that memory problems are part of aging given her experience of memory problems in older family members.

Psychiatric history is significant for depression and anxiety, initially attributed to “un nido vacío” (empty nest) and recently exacerbated by her husband’s health status. She was started on an antidepressant one month ago but discontinued due to side effects and her report of lack of benefit. Familial psychiatric history is noncontributory. She denied a remote history and current use of alcohol, tobacco, or illicit drugs.

Behavioral Observations

Ms. Reynosa was tested in Spanish by a bilingual examiner. She was fully oriented. General appearance was neat and clean. Motor behavior was normal. Her mood was pleasant, albeit apprehensive at the beginning. Affect was mood-congruent. After a short conversation regarding the purpose of the evaluation and the process of testing, Ms. Reynosa was visibly more comfortable. She smiled and engaged actively. Conversational speech was coherent and goal-directed. She occasionally needed repetition of directions and lost place intermittently during complex set-tasks. She exhibited cooperative test-taking behavior. Attitude was appropriate and friendly. She expressed feeling comfortable with the examiner, as if with one of her granddaughters. The following results were considered a valid estimate of her current functioning.

Ms. Reynosa had identified English as her primary language (reporting a higher level of English mastery can be common among first-generation Mexican immigrants given experiences of discrimination). However, during the clinical interview, it was apparent that English was not her dominant language. Thus, acculturation and language99 were examined and results were interpreted immediately for Ms. Reynosa with the goal of highlighting the impact of language and culture on standardized neuropsychological testing and encouraging her to accept a Spanish (bilingual where needed) testing session.
Examiners working with Mexican monolingual and bilingual patients should be aware that inquiring about language dominance/mastery can be a difficult process, depending on the life experiences of the examinee. The use of standardized measures in determining language dominance is suggested (i.e., acculturation measure and Language Dominance Index, as this objective data can help the patient understand the examiner’s reason for encouraging testing be conducted in one language over the other. We have experienced a variety of reactions in our initial patient/family interaction with our monolingual and bilingual patients/families. While some have been appreciative of receiving clinical services in Spanish, others have been offended at the time of the initial Spanish greeting or when inquiry has been made regarding their dominant language. Moreover, hesitancy in receiving services in Spanish has been evident and discussed by patients/families as individuals can feel a sense of guilt/shame when provided with the option of receiving services in Spanish (especially if they have resided in the United States for many years), while others have questioned whether Spanish evaluations reflect a lower quality of care or a “less than” attribution in reference to the examiner’s skill set.

**Test and Norm Selection**

Measures and normative data that generalized to her sociodemographics were selected (see Table 33.2 in the Appendix).

**Test Results and Impressions**

Ms. Reynosa’s profile exhibited global impairments. With regard to memory, she displayed a pattern of rapid forgetting. Findings met the criteria for a diagnosis of Major Neurocognitive Disorder secondary to probable Alzheimer’s disease. Impacting social and environmental factors included acculturation difficulties (Z60.3) and exclusion and isolation (Z60.4). The impact of her poor mood was also considered.

**Feedback Session and Follow-Up**

Presenting complaints and testing procedures were reviewed. This practice highlights personal attention and psychoeducation assists the patient in understanding the process, which can be perceived as sterile/distant. Presentation of cognitive profile and diagnosis was the focus versus detailed findings by domain given global impairments. Examples of functional declines secondary to cognitive skills were helpful in highlighting a neurodegenerative process versus healthy aging. Psychoeducation (i.e., medication adherence) was provided.

**Recommendations for Patient/Family**

1. Dietary changes (i.e. MIND: Mediterranean-DASH Intervention for Neurodegenerative Delay Diet)
2. Psychiatric care to monitor and treat psychological symptoms and possible neurobehavioral changes
3. Psychological counseling for patient/family to discuss current and future care needs
4. Compensatory strategies (i.e., “memory station” where she would consistently place personal items; external memory aids such as shopping lists, calendars, pill reminders)
5. Intellectual stimulation: reading, jigsaw puzzles, familiar games (e.g., loteria)
6. Daily/weekly activities for physical and cognitive stimulation. Nostalgia-oriented materials for recreational purposes (e.g., old movies and music) are recommended over new materials.
Section III: Lessons Learned

• Each Mexican immigrant brings unique experiences in terms of language and cultural preference. Formal language assessment should be conducted to identify the dominant language for testing purposes and level of acculturation should be considered.
• Findings need to be interpreted in context with the individual’s sociocultural/economic circumstances to appropriately interpret data and tailor recommendations.
• Services with ethnically diverse individuals may include a higher level of advocacy on behalf of the patient given language mastery and other sociodemographic variables, particularly if the provider speaks the same language as the patient. When available, recommendations should include providers who can speak the patient’s language or provide interpreter services.
• The use of a certified medical interpreter is highly encouraged. It is typical for older patients to be “excluded” from their care as family (proficient in English with varying levels of education, acculturation and Spanish language mastery) may take the lead and communicate with the medical provider. Thus, speaking directly to the patient is imperative.
• Mexican immigrants have vast disparities in educational backgrounds and levels of literacy. Understanding their educational experience is critical given the known impact of education on neuropsychological outcomes. Feedback sessions are vital. Information should be provided at the patient’s level. General brain health psychoeducation (importance of optimal management of comorbidities, impact of diet, sleep, and psychiatric factors, etc.) and promotion of treatment adherence should be included.
• Little is available in terms of measures, normative data, and cognitive profiles of the Indigenous/Amerindian population. Materials available for the dominant Mexican culture may not be appropriate, depending on Spanish language mastery, cultural/lifestyle practices, education, and life experiences.

Acknowledgments

We would like to thank our Latino/a patients who trust us with their care as we work toward improving the cultural competence and humility of our specialty field.

Glossary

Chicano. More popular in the west coast area of the U.S., refers primarily to those of Mexican origin. Initially derogatory, but later adopted by civil rights activists to demonstrate solidarity. May be used by those who grew up in the civil rights era and can also be used in terms of gang affiliations.

Curanderos/Medicos Brujos. Healers who use traditional curing procedures, rituals, and medicinal plants to treat disease/illness, physical and psychological symptoms.

Educado. A cultural value in reference to appropriate social and moral behaviors and not academic standing (educated is literal translation). Variations of this socio-emotional construct may vary across socio-economic classes.
Espiritistas. Spiritualists who consider themselves religious practitioners first and alternative health providers second.

Familismo. A central Latin cultural value involves dedication, commitment, and loyalty to family. Regularly spending time with one's immediate and extended family is part of familismo. It also involves seeking the family’s advice and involvement in important decisions.

Fatalismo. Fatalism, belief that the course of fate cannot be changed and that life events are beyond one's control. In the health literature, fatalism usually is conceptualized as a set of pessimistic and negative beliefs and attitudes regarding health-seeking behaviors, screening practices, and illness. Some will use a religious perspective, leaving their burdens in the hands of God.

Hispanic. Refers to people who share an ethnic background in a Latin American or Spanish-speaking country. The term implies an association with Spain, which might produce negative reactions as Spain decimated the indigenous populations of Central/South America during colonization.

Latinos/as. Used to describe people with origins in Latin America including Brazil or whose native language is Spanish. The term signifies solidarity between ethnically and culturally diverse individuals who might not necessarily share the same country of origin within the Americas or Europe (e.g., Spain).

Latinx. A gender-neutral or non-binary term referring to people of Latin American origin or descent residing in the United States.

Machismo. Social behaviors which evidence a sense of masculine pride. From the negative connotation of an untouchable/unwavering position of authority as the head of household (strong or overbearing attitude as anyone perceived as inferior; demanding of complete subservience), highlighting aggressiveness, physical strength, emotional insensitivity, and womanizing to positive traits of valor, a caring/involved, responsible, decisive, strong temperament/character, family protector.

Marianismo. An idealized traditional feminine gender role characterized by submissiveness, selflessness, chastity, hyperfemininity, and acceptance of machismo in males. Although clearly derived from the traditional ideal of the Virgin Mary, marianismo is not to be confused with a specific religious practice of the Roman Catholic Church.

Mexican American. Refers to those whose families emigrated from Mexico to the United States sans implication concerning generational status. The term could be considered politically divisive since it is not inclusive of other Latin countries.

Mexican descent. Denotes individuals whose parents or grandparents emigrated from Mexico. It is preferred by some who wish to eliminate the ambiguity of Mexican-American.

Parteras. Provider who specializes in childbirth. Historically, these individuals did not offer prenatal care; however, current practices are evolving.

Personalismo. Often defined as “formal friendliness,” refers to the tendency to place great emphasis on personal relationships by Latinos. Latin culture is both people-oriented and collectivist, meaning that Latinos generally value personal relationships (“charisma”) over status, material gain, and institutional relationships.

Respeto. Considered a cultural value including deference to authority, setting clear boundaries, and knowing the level of courtesy required in a given situation in relation to the other person or a particular age, gender, or social status.

Sobadores. Practitioners who use sobada (massage) to care for pulled muscles and injured joints, as well as to stimulate internal organs.

Yerbero. Herbalists, experts in plants/herbs/natural ingredients used to treat symptoms/ailments.
References