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Article

Causal attribution for mental illness in Cuba: A thematic analysis

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Abstract
Explanatory models (EMs) for illness are highly relevant for patients, and they are also important for clinical diagnoses and treatment. EMs serve to capture patients' personal illness narratives and can help reveal how culture influences these narratives. While much research has aimed to understand EMs in the Western hemisphere, less research has been done on other cultures. Therefore, we investigated local causal attributions for mental illness in Cuba because of its particular history and political system. Although Cuban culture shares many values with Latin American cultures because of Spanish colonization, it is unique because of its socialist political and economic context, which might influence causal attributions. Thus, we developed a qualitative interview outline based on the *Clinical Ethnographic Interview* and administered interviews to 14 psychiatric patients in Havana. We conducted a thematic analysis to identify repeated patterns of meaning. Six patterns of causal attribution for mental illness were identified: *(1) Personal shortcomings, (2) Family influences, (3) Excessive demands, (4) Cultural, economic, and political environment in Cuba, (5) Physical causes*, and *(6) Symptom-related explanations*. In our sample, we found general and Cuba-specific patterns of causal attributions, whereby the Cuba-specific themes mainly locate the causes of mental

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illness outside the individual. These findings might be related to Cubans' socio-centric personal orientation, the cultural value of *familismo* and common daily experiences within socialist Cuban society. We discuss how the findings may be related to social stigma and help-seeking behavior.

Keywords
explanatory model, causal attribution, mental illness, Cuba, qualitative study, thematic analysis

Introduction

Mental illness[1] is an important public concern, but to treat it effectively, health care providers must consider patients' cultural diversity. One approach to help health care providers better understand how culture influences patients' mental illness is to use explanatory models (EMs) (Kleinman, 1988; 1991). EMs allow patients to describe how they perceive their illness' symptoms, time course, and aetiology; thus, EMs point to patients' inherent understanding and conceptualization of mental distress (Carpenter-Song, Chu, Drake, Ritsema, Smith, & Alverson, 2010; Leventhal, Leventhal, & Contrada, 1998). Importantly, EMs help patients make sense of their personal experiences and give health professionals insight into the individual lay concept (Rüdell, Bhui, & Priebe, 2009). Furthermore, EMs offer insight into how cultural influences affect patients' perceptions of their illnesses. Overall, EMs are based on patients' personal experiences and public knowledge about the disease (Broadbent, Petrie, Main, & Weinman, 2006; Kleinman, 1988; Leventhal et al., 1998), and, because public knowledge is rooted within culture, culture also shapes individual EMs.

Causal attribution

As part of creating an EM, patients try to explain what caused their mental illness (causal attribution). Understanding causal attribution is important because it guides patients' help-seeking behavior and influences their adherence to treatment (Arnoult & Shimabukuro, 2012; Okello & Neema, 2007). Thus, within EMs, causal attributions of mental illness have been heavily studied (e.g. Bhui, Rüdell, & Priebe, 2006; Carpenter-Song et al., 2010; McCabe & Priebe, 2004; Rosso & Bäärnhielm, 2012; Rüdell et al., 2009), but mostly within Western societies. From such studies, causal attributions of mental illness have been classified into six categories of causes: psychosocial, supernatural, behavioral, natural, physical, and economic (Rüdell et al., 2009).

In comparison, fewer studies have explored non-Western societies (Okello & Neeman, 2007; Patel, 1995). One study in Latin America identified biological, social, psychological, and magical-religious causal attributions among Mexican participants (Natera, Casco, González, & Newell, 1985), but this study captured

these causal attributions using a quantitative approach with predefined categories. While this approach can quantify and compare the frequency of certain causal attributions in distinct populations, it simultaneously obscures the individual, culturally influenced causal attributions that participants might divulge. Because many studies have used methods employing predefined categories of causal attribution (e.g. Bhui et al., 2006; Fortune, Barrowclough, & Lobban, 2004; Ward & Heidrich, 2009), little is known about EMs and causal attribution of mental illness in Latin America. To get a first impression of culturally influenced patterns of causal attribution for mental illness in this region, we investigated the perspective of Cuban psychiatric patients.

Cuba

The Caribbean island of Cuba is an interesting setting for such a study because of the unique history that shaped its current political, economic, and health care system—factors that may affect how Cubans perceive mental illness. Cuba has experienced little immigration in the last decades (Moya, 2013; Zeuske, 2012). For a long time the main type of international exchange was tourism and exchange of workers and students with other socialist or Latin-American countries organised by the government. In the 1990's, during the so-called "special period" (an economy crisis that followed the collapse of the Soviet Union; Zeuske, 2012) Cuba was opened for international tourism. However, there was limited access to the internet and other sources of international influences. Thus, Cuban culture has been less shaped by globalization than others. It is still strongly rooted in its own unique traditions, political system, and its distinctive pattern of economic development.

Cuba's culture was strongly influenced by Spanish colonization, and Cubans today identify as Latino (Zeuske, 2007; 2012). The Cuban population (11.2 million citizens) is divided between 64% who identify as white Cubans, 27% who report mixed origin, and 9% who identify as black Cubans (Oficina Nacional de Estadísticas e Información (ONEI), 2014). Since colonialization ended, Cuba has been governed by the *Communist Party* (Zeuske, 2012), and it is one of the world's last socialist economies. For decades, the Cuban economy has been limited by the US embargo, which has affected Cubans' overall standard of living that is rather low. However, Cuba has a high score on the Human Development Index (HDI): while it scores "low" on the HDI's *standard of living* factor (Gross National Income per capita), Cuba scores "very high" and "high", respectively, on the other two factors - *health* (life expectancy at birth) and *education* (mean years and expected years of education) (Human Development Report, 2015).

Cuban mental health care system

In comparison with other Latin American countries, Cuba's health care system is outstanding: health care is free for every citizen (Campion & Morrissey, 2013; Cooper, Kennelly, & Orduñez-Garcia, 2006; Keck & Reed, 2012; Zeuske, 2012).

Within mental health care, multi-professional teams work together to offer three categories of care. First, primary psychiatric care is administered by ''Community Centers of Mental Health'' that offer prevention programs, psychosocial rehabilitation, and general mental health support. Second, in psychiatric hospitals, mental health care professionals offer short-term crisis intervention, short-term hospital treatment, and treatment in day hospitals. Third, Cuba also offers more specialised mental health care services, such as forensic psychiatry.

Overall, psychiatric care in Cuba is guided by the ''Mental Health Action Plan 2013-2020'' of the World Health Organization (WHO, 2013). Specifically, mental health care is based on a scientific integrative treatment model, which is rooted in traditional, Cuba-specific approaches shaped by historical and cultural factors, as well as by cognitive-behavioral, and humanistic approaches. The most common form of intervention is a combination of short-term group psychotherapy, psychopharmacological treatment and the involvement of patients' social resources (family and community).

Taken together, Cuba's outstanding health care system and its political and cultural circumstances make it an interesting setting for studying EMs. The objective of this study was to assess the emic perspective on causal attribution for mental illness in Cuba. Since no previous research on this topic was available, we aimed to get a first impression of locally existing types of causal attributions and the influence Cuban culture might exert on them.

Methods

Approach and study design

Cuban psychiatric patients underwent qualitative in-depth interviews to determine their perspective on the causes of their mental illness. A semi-structured topic guide was developed based on the Clinical Ethnographic Interview (CEI; Saint Arnault & Shimabukuro, 2012), which is used to investigate the influence of culture on patients' mental distress and help-seeking behavior. The CEI includes the topics of (1) *Cultural models and symptom experience*, (2) *Meaning interpretation and social evaluation*, and (3) *Propriety, reciprocity, and help seeking*[2]. Additionally, as proposed by Saint Arnault and Shimabukuro (2012), we supplemented the CEI with questions from a paper on guidelines for cultural formulation interviewing (Mezzich, Caracci, Fabrega, & Kirmayer, 2009) and the McGill Illness Narrative Interview (Groleau, Young, & Kirmayer, 2006). Ultimately, our interviews followed an ethnographic outline in the form of a ''guided conversation'' where participants could express their experience in their own way (Groleau et al., 2006, p. 674). In addition to the qualitative interview, we applied the Mini International Neuropsychiatric Interview (MINI; Sheehan et al., 1998), which is a short structured interview to diagnose psychiatric disorders as defined by the DSM-IV (American Psychiatric Association, 1994) and ICD-10 (World Health Organization, 1992).

Interview guidelines were translated into Spanish by bilingual Cubans and adjusted to the Cuban common language. All interviews were conducted in Spanish by alternating dyads composed of five trained Cuban research assistants and the first author (LN). Eventually, Cuban research assistants were chosen as interviewers to reduce the possible influence of LN as a non-Cuban investigator, but LN closely supervised interviews. Interviews ranged in length from 55 to 134 minutes.

Setting and sampling

The data presented below are part of a research project conducted in the public university hospital General Calixto García Iñiguez in Havana. This hospital allowed for a heterogeneous sampling of Cuban patients because it is available to Cubans only and it admits patients from all over the country. The psychiatric department consists of three sections from which participants were recruited: (1) The ''Psychiatric emergency service and Unit of crisis intervention'' is where all psychiatric patients are seen first. It contains ten beds where patients can undergo intensive care for up to ten days. Patients at this site mainly suffer from acute anxiety episodes, psychomotor excitations, suicidal crises, or intoxication. (2) The second section of the psychiatric department (16 beds for men; 16 for women) offers short-term hospitalization for all psychotic patients for up to 30 days. (3) Finally, the Outpatient Mental Health Care Service offers separate psychotherapeutic group interventions for patients with addictions and neurotic and stress disorders. On average, psychotherapeutic group interventions take place one or two times a week and last for seven weeks. Further, the day hospital, as part of the Outpatient Mental Health Care Service, offers psychiatric care for psychotic patients with schizophrenia, bipolar, and depressive disorders. The program provides individual and group treatment for 20 patients and lasts for three to six months.

Our investigation took place in all three psychiatric departments from May to July, 2014. Whenever patients were available and stable, interviews were conducted in detached spaces. Besides voluntary participation, no explicit inclusion criteria were applied. Exclusion criteria were suicidal tendencies and acute psychosis.

Participants were selected according to theoretical sampling principles (Draucker, Martsolf, Ross, & Rusk, 2007; Glaser, 1978; Glaser & Strauss, 1998) with the help of health care professionals in each department. Data collection was guided by the evolving theoretical construct of causal attribution until theoretical saturation was reached (Glaser, 1978; Schwandt, 2007). We used diversity categories (age, sex, ethnicity, years of education, marital status, referral diagnosis; Van Keuk, Ghaderi, Joksimovic, & David, 2011) to select participants. These categories allowed us to realise principles of minimization and maximization of differences[3] (Glaser & Strauss, 1998). The use of diversity categories helped ensure inclusion of mentally ill participants with heterogeneous profiles (maximization). We aimed to capture a wide array of patient perspectives for causal attributions of mental illness

to get an unrestricted first impression. Sample size was determined by theoretical saturation. In total, 14 interviews were performed (see Table 1).

Ethical considerations

A committee at the hospital General Calixto García Iñiguez approved the study. Informed consent was obtained after each participant was verbally informed about the purpose and course of the study. Patients agreed to the audio recording of interviews.

Data analysis

Audio recordings were transcribed verbatim in Spanish and anonymised by replacing identifying information (e.g. names) with codes. All data processing was conducted completely in Spanish; only reported quotes were translated into English by LN and UvL and back-translated by a Cuban English teacher living in Cuba. Bilingual Cubans living in the USA reviewed the final quotes. We conducted an inductive thematic analysis (Braun & Clarke, 2006). During the analysis, each narrative was interpreted as the participant's lived experience. To facilitate an interpretation of the interview data, unstructured field notes were integrated into the analysis.

Table 1. Cuban sample (N = 14) of psychiatric patients.

Code	Sex	Age	Race/Ethnicity	Years of education	Marital status	Referral diagnosis*
P01	m	45	White Cuban	9	Married	Alcohol dependence
P02	m	31	White Cuban	12	Married	Alcohol dependence
P03	f	44	White Cuban	17	Divorced	Major depressive disorder
P04	m	38	Mixed origin	12	Single	Alcohol dependence
P05	f	26	White Cuban	12	Divorced	Anxiety disorder
P06	f	25	White Cuban	16	Single	Obsessive compulsive disorder
P07	m	63	White Cuban	17	Married	Major depression disorder
P08	m	24	White Cuban	16	Single	Anxiety disorder
P09	f	51	White Cuban	12	Single	Major depressive disorder
P10	m	50	Mixed origin	12	Single	Schizoaffective disorder
P11	f	69	Mixed origin	9	Divorced	Bipolar disorder
P12	f	48	White Cuban	9	Married	Major depressive disorder
P13	f	48	Mixed origin	12	Married	Bipolar disorder
P14	f	43	Black Cuban	6	Single	Mixed anxiety-depressive disorder

*Made by the Cuban health professionals of the local psychiatry and confirmed by the results of the MINI (Sheehan et al., 1998) and the observations of LN within the clinical routine.

We first organised the data on a general semantic level and generated tentative codes using MaxQDA (Version 11; VERBI Software, 1989-2015). As proposed by Stern and Kirmayer (2004), in addition to EMs, we also coded other knowledge structures, including prototypes or (generalised) chain complexes (Stern & Kirmayer, 2004). Most often, participants elaborated on their EMs during interviews, supplementing their initial causal attributions without retracting their first statements. If participants mentioned several (also potentially contradictory) causes of mental illness, each cause was coded independently to capture the variety of causal attributions offered by participants without discriminating among different forms of knowledge structures (Young, 1981; 1982). Further, we coded all causal attributions mentioned, both those that arose spontaneously and those given in response to a specific question. Initial codes were grouped into broader categories and then into overarching themes. To determine the overall patterns that best fit the data, we ensured that each theme met the criteria of internal homogeneity and external heterogeneity (Patton, 1990).

To improve reliability and validity, the research team performed context validation, multiple coding, and triangulation (Barbour & Barbour, 2003; Whitley & Crawford, 2005). First, Cuban research assistants revised the results to substantiate them. Second, a German research assistant familiar with the Cuban context coded several interviews independently to ensure accordance of categories. Multiple coding, to assess interrater reliability, indicated a high degree of correspondence. Third, methodological triangulation was applied, combining data from structured (MINI), semi-structured (CEI), and unstructured (field notes) methods, to countercheck the findings.

Findings

This study asked Cuban psychiatric patients about their assumptions regarding the causes of their mental illness. We identified six themes in the analysis (Table 2), which are described separately below.

Personal shortcomings

In this theme, participants attributed their illness to internal causes. All quotes assigned to this theme included attributions that were interpreted as personal shortcomings. For example, participants described stressful life events, but emphasised their own contribution to the development of their illness, as illustrated in this quote:

> *Because in the end somebody who doesn't have a drinking problem and is confronted with something like this [difficulty] doesn't drink. I did it because I was hiding behind it [the alcohol].* (l. 413; P02)

This participant explained that negative life events influenced his drinking behavior, but that it had always been his own decision to drink.

Table 2. Organization of categories and themes of causal attribution within the Cuban sample.

Categories	Themes
Internal attribution – Dysfunctional coping skills – Personal vulnerability due to personality traits	Personal shortcomings
Family context – Role modeling/ imitation – Familial vulnerability Childhood experience	Family influences
Daily hassles Chronic stressors Stressful life events	Excessive demands
Supply problems with adequate medication Hard living conditions and basic housing conditions Alcohol as part of Cuban culture and everyday life	Cultural, economic, and political environment in Cuba
Somatic symptoms	Physical causes
Circular arguments	Symptom related explanations

Another participant more explicitly stressed his own contribution to his current situation:

> *. . . I think that was about it, I could have shared it with another person or something like that, right? Instead, I started worrying about it and got deeper into it until I fell into this depressive crisis*. (l. 320; P08)

This participant mentioned how he had failed to resolve personal difficulties in the past and how it resulted in a psychiatric disorder. He explicitly attributed his symptoms to dysfunctional coping strategies.

In contrast, other participants explained their psychological distress by attributing them to individual characteristics or personality traits:

> *That affected me, anything did . . . some people are strong in tough situations but I am not*. (l. 552; P11)

Family influences

This theme includes external causal attributions that locate the cause of mental illness primarily in the participants' close family environment, specifically as related to aspects of family involvement. One participant mentioned role modeling or imitation to explain the cause of his alcohol dependence. He described his alcohol

abuse as a learned behavior:

> *Let's say, if you are raised in a place where everybody picks flowers; where your mother picks flowers, where your father, brother, uncle, and cousin are picking flowers. What do you do? You pick flowers*. (l. 793; P04)

Interestingly, one participant explicitly excluded heredity as an underlying mechanism:

> *So we have a nervous disposition. I think that's the point. [. . .] But I don't think it has anything to do with the things that stress me. I think it's not hereditary*. (l. 461 + l. 463; P05)

Other participants reported that they felt affected by childhood experiences and claimed that these were the cause of their current health situation. For example, one participant attributed his mental illness to the problematic relationship with his father and described his childhood as *a boxing ring* (l. 520; P10).

Excessive demands

An important topic in interviews was the role of daily hassles, critical life events, and chronic stressors in the evolution of mental illness. In this theme, participants mentioned "stress" as referring to different spheres, but especially in the family context:

> *It happened when my mother was sick and I stopped working. [. . .] Later I took care of her. It was like that. . .like that. But one can say that it changed me until I came to the Clinic of Stress[4] because of depression*. (l. 363; P09)

Consequently, she felt *trapped in always the same [routine]* (l. 443, P09) and complained about the uniformity and exhausting routine of everyday life.

Other participants reported that mental distress was induced by chronic stressors. One participant described her role within the family and how she felt overwhelmed by related daily hassles:

> *Sometimes, it's because of those things that I feel bad. Because they all depend on me. I mean, I don't get the money, the material thing, but the house, my child, the concern for the food...* (l. 547; P05)

Other causes of mental illness mentioned by participants were single life events such as the death of a loved one or a specific conflict:

> *When he [my father] died, I started drinking more and more often. This was the moment when I felt like an alcoholic for the first time*. (l. 671; P04)

Socio-cultural, economic, and political environment in Cuba

The causal attributions within this theme describe aspects of life and living situations that are typical in Cuba. Participants mentioned living conditions and critical life events (and resulting consequences) that are not unique, but instead are characteristic of life in Cuba.

For example, one participant had to switch medications unexpectedly because her original medication was no longer available in Cuba:

> *Then, the S was missing for a long while in this country; it used to enter through a donation, but it just stopped. [. . .] I fell into crisis again.* (l. 292; P06)

She thus related her problems to the conditions of the local health care system.

Another prevalent issue mentioned by patient was the poor living conditions in Cuba. Unmet everyday needs were described as prominent causes of mental distress. As, one participant stated:

> *Living in the countryside is really hard. Do you know what I mean? Too hard. And you turn to it [the alcohol] to find a way out.* (l. 789; P04)

Similarly, participants described the housing situation in Cuba as *rather bad* (l. 335; P13) and assumed it to be a cause of their mental distress:

> *I live together with my husband, my daughter, her two children, and her husband. We live with six persons in a single room in a size of 4x4 m. With a bathroom, a kitchen and a living room. [. . .] You see, this is something which lacerated me. See, to get this house I live in now I broke the lock on the door and just moved in. And the Cuban government. . .gave me the house. They were consistent and gave me the house because in the constitution of this country it is written that if you have nowhere to go. . .so they gave me the house. [. . .] What happens is that my family expanded [more family members].* (l. 366; P13)

Cubans often live with many people from different generations in a small space. Participants in this situation reported experience a lack of privacy and related everyday challenges, which they in turn related to their mental illness.

Further, participants reported that houses often collapse in Havana. Homeowners usually do not have the right resources or materials needed to fix their homes, which creates a feeling of powerlessness. Thus, one participant described this situation and its long-lasting negative consequences as the origin of her mental illness:

> *My house fell down, it's falling into pieces. [. . .] Well, I started getting depressed when the problem with the house began. I had to get the money to fix it. There wasn't enough money for the concrete, the food, the fixing.* (l. 268 + l. 310; P12)

A further prominent theme was the role of social norms in alcohol consumption in Cuban society. Participants attributed their own problematic drinking behavior to the drinking behavior of their peers, social norms, or Cuban culture as a whole. One participant described consuming alcohol excessively during his teenage years, which he identified as the origin of his current alcohol dependence. He experienced commonplace pressure to drink in order to fulfill others' expectations and social norms:

> *I started drinking when I was 15. I was encouraged by 3rd and 4th year students when I was at a boarding school. You want to be like them and you think drinking alcohol makes you a man.* (l. 495; P02)

Generally, participants considered alcohol consumption to be normal because *almost everybody drinks there in the countryside* (l. 783; P04). In that context, alcohol consumption was not conceptualised as a consequence of difficult living situations or family transmission (as described in earlier themes) but was instead considered part of Cuban *tradition* or *culture* (l. 783 + l. 889; P04).

> *And yes, alcoholism here in Cuba is. . .let's say. . .it's like planting rice in China. Here everybody drinks, from the child to the old man.* (l. 887 + l. 893; P04)

Physical causes

When asked to explain how their mental illness developed, participants also reported physical causes. One participant explained that her disorder emerged

> *. . .as a consequence of an epileptic seizure. I developed an obsessive-compulsive disorder and also a preliminary schizophrenia.* (l. 153; P06)

This participant based the cause of her illness on neurological distortions that directly resulted in psychiatric symptoms. Further, she also explained her epilepsy in an explicitly somatic way:

> *I'm not crazy, I have a disorder that unfortunately was provoked by the delay of my birth. It provoked an epileptic seizure and the epileptic seizure provoked this disorder but I'm not crazy.* (l. 385; P06)

This participant thus referred to many physical causes to explain her neurological and psychological symptoms.

Another participant mentioned physical symptoms as well, but had a more psychological interpretation:

> *When I was in 2nd year, they detected this problem at my mitral valve. And it was then when those crises started, when I had symptoms of depression, panic, fear of death...* (l. 316; P08)

Although the psychiatric symptoms might have evolved as a consequence of how he dealt with the somatic diagnosis, the participant nevertheless identified this diagnosis as the origin of his mental problems.[5]

Symptom-related explanations

The last theme includes statements in which participants named psychiatric symptoms as causes of their mental illness. When asked for the cause of their illness, they repeatedly referred to their experienced symptoms or behavior:

> *I1: It was always the same cause?*
> *P10: Yes. The voices, the dejection, the depression.*
> *[. . .]*
> *I1: What were the causes?*
> *P10: ⟨Depression⟩, ⟨sadness⟩ . . . I heard voices, I talked a lot by myself. I didn't take a shower at all. Nothing. I didn't relate with other persons. I lived trapped in my house, in my room.* (l. 284–285 + l. 503–504; P10)

> *I had another one [crisis] because of – like I'm obsessive-compulsive – I had to check everything at home before leaving the house.* (l. 270; P06)

For explanations in this theme, participants located the cause of their illness within the symptoms of the illness itself.

Discussion

This exploratory study aimed to get a first impression of how Cubans tend to explain the causes of their mental illnesses. Qualitative in-depth interviews were conducted with a diverse Cuban sample from a local psychiatry department in Havana to understand how Cuban culture influences EMs, irrespective of specific mental disorders. From the obtained narratives, we performed a thematic analysis and found that our current findings partly overlap with previous findings from the literature, but also offer new culture-specific insights. We discuss the implications of Cuba-specific themes in more detail.

Internal causal attribution

Rüdell et al. (2009) emphasise that most lay people think their mental illness is *"at least partly due to themselves"* (p. 341). In the Cuban sample, internal causal attribution is also prevalent, appearing in the theme *Personal shortcomings*. Cuban participants specifically mentioned personal vulnerability to mental illness and substances like alcohol due to inadequate coping skills and personal traits. Interestingly, some participants internally attributed their mental illness to

dysfunctional coping with stressful life events instead of attributing it externally to the life event itself (McCabe & Priebe, 2004; Rosso & Bäärnhielm, 2012; Rüdell et al., 2009).

The theme *Physical causes* summarises somatic causal attributions, also representing a type of internal attribution. Participants invoking physical causal attributions generally held a stringent biologised EM, hardly mentioning any other causal attributions. Further, these participants mentioned discussing the illness with a health professional or reading related scientific literature. This is unusual because Cuban health professionals tend not to speak with patients about their mental illness (preferring to speak with family members instead; Campion & Morrissey, 2013), and biomedical models are not usually described to patients. Furthermore, other studies have shown that in lay populations, somatic and biological causal attributions are not given as often as psychosocial causes (Bhui et al., 2006; McCabe & Priebe, 2004; Rüdell et al., 2009). One reason why participants reported physical causal attributions might be the intense stigmatization of mental illness in Latino cultures (Guarnaccia, Martinez, & Acosta, 2005; Suarez Kuneman, 2010). People with mental illness are described as *loco*/*loca* (crazy), and mental illnesses are called *locura* (madness). Thus, in our study, physical causal attributions might be used to separate participants' own mental distress from other mental illnesses and *locos* (madmen), to protect themselves from social stigma (P06, l.385; Guarnaccia et al., 2005; Suarez Kuneman, 2010).

In general, participants only mentioned a few causes of mental illness that might be considered internal. This corresponds well with results from a former study on emotional reactions, where a Cuban sample reported mostly external causes of positive and negative emotions (Galati et al., 2004). This might be partly explained by Cubans' collectivist or socio-centric personal orientation (Galati et al., 2004; 2006; Suarez Kuneman, 2010), whereby individuals experience themselves in relation to the social environment; this may, in turn, influence people's cognitive, emotional, and behavioral states (Kirmayer, 2007). This personal orientation might also influence people's assumptions about the causes of mental illness (Choi, Nisbett, & Norenzayan, 1999; Morris, & Peng, 1994), such that individuals with a socio-centric personal orientation may focus more on external causes of mental illness.

Circular reasoning

Regarding the standard themes used to describe causal attributions for mental illness, one of our themes, *Symptom-related explanations*, is rather unconventional. However, some participants in our study were convinced that their experienced symptoms of mental illness (sadness, hearing voices) were the cause of the mental illness itself. In these cases, participants used temporal contiguity between mental distress and psychiatric treatment to infer that their symptoms were the cause of their illness. Further, they described prototypical symptoms of different crises and identified them as causal for their mental illness. This resembles the knowledge structures of *Generalized Chain Complexes* and *Prototypes* described by Stern and

Kirmayer (2004), with the exception that Cuban participants used prototypes based on their own experiences and rarely refer to other persons. Further, they organised the prototypes in the form of causal explanations. Although clinicians would likely view this type of explanation as a categorical diagnosis, an idiom of distress, or a symptom, participants identified these symptoms as the cause of their mental illness. Since we aimed to represent the view of Cuban participants, we included these statements as causal attributions.

While our analysis of Cuban participants revealed some unconventional causal attribution for mental illness, it failed to reveal some issues prominent in the literature, such as self-vulnerability due to personal characteristics of age, gender, religion, and race (Rüdell et al., 2009). Similarly, emotions, sensations, and various behavioral causes were largely absent; natural causal attributions such as climatic or astrological causes did not come up, nor did supernatural causes (e.g. witchcraft or being possessed by evil spirits, dominant within Asian or African populations (de Toledo Piza Peluso & Blay, 2004)). The absence of supernatural causal attribution might be surprising, given that the Afro-Cuban syncretic tradition *Santería* is socially important in Cuba. However, the current sample showed a general absence of religious beliefs, indicating that supernatural causal attributions may have been absent because *Santería* followers were not represented. This likely occurred because followers of *Santería*, which has its own system of healing and ritualistic practices (Lefever, 1996), likely seek such help from *Santeros* (spiritual guides) and *Orishas* (deities) instead of seeking professional mental health care. To clarify this assumption, future research might investigate help-seeking behaviors and causal attribution for mental illness in the general Cuban population.

Familismo

Within the Cuba-specific themes, causal attributions for mental illness were predominantly external. This prominence was previously found in other studies (Bhui et al., 2006; Rosso & Bäärnhielm, 2012) and therefore might not be specific to Cubans. What seems culture-specific in our data is that most of these causes were anchored in the family context. In Cuba and other Latino cultures *familismo* (familism) is a strong cultural value (Castillo, Perez, Castillo, & Ghosheh, 2010; Suarez Kuneman, 2010). It encompasses not only specific hierarchical family structures and roles, but also strong family ties, unity, loyalty, and family traditions (Suarez Kuneman, 2010). Within *familismo*, there is high interdependence between family members, where (certain) individuals are expected to support all (extended) family members (Marin & Marin, 1991 as cited by Suarez Kuneman, 2010). Additionally, Cubans generally spend considerable time at home and describe their homes as being open and typical places for emotional experiences (Galati et al., 2004). Thus, the familial environment fundamentally influences Cuban life.

Because family heavily influences Cuban life and culture, it seems reasonable to initially attribute mental illness to aspects of the family context. Although no participant explicitly named *familismo* as the cause of their mental illness, many of

their causal attributions related to the family context (*Family influences; excessive demands; Cultural, economic, and political environment in Cuba*). While the theme *Family influences* describes mechanisms of familial transmission of mental illness that seem applicable to diverse cultural contexts (learned behavior, familial disposition, adverse childhood), most of the stressors described in the theme *Excessive demands* relate to Cuba-specific family structures. For example, participants mentioned familial responsibilities that overwhelm them and highlighted the burdens and difficulties that come with being highly involved with family. Furthermore, within the theme *Socio-cultural, economic, and political environment in Cuba* participants revealed a lack of privacy and strong interfamilial dependency due to the living conditions that are also believed to have contributed to their mental distress.

Although *familismo* is generally considered highly beneficial and protective (e.g. Ayón, Marsiglia, & Bermudez-Parsai, 2010; Dillon, De La Rosa, Sastre, & Ibañez, 2013; Piña-Watson, Ojeda, Castellon, & Dornhecker, 2013), participants in our study suggest that *familismo* might also have a dark side; this dark side has also been hinted at in other qualitative studies (e.g. Calzada, Tamis-LeMonda, & Yoshikawa, 2012; Davila, Reifsnider, & Pecina, 2011). Specifically, the study by Calzada et al. (2012) argues that behavioral *familismo* has both positive and negative consequences, and the dominance of one type of consequence depends on the specific familial circumstances; for example, they found that extensive financial obligations and crowded living conditions might cause *familismo* to impact individuals negatively. Importantly, these are the same themes that Cuban participants in our study indicated as burdensome. Because recent studies hint at a more holistic view of *familismo*, more qualitative and quantitative research is needed to understand the determinants, costs, and benefits of *familismo*.

Likewise, little is known about costs and benefits of the gender-specific *familismo*, which describes the female Latina role as *marianismo* and refers to an idealization of Latina gender role expectations (Castillo et al., 2010). Within *marianismo*, women are expected to fulfill a wide range of expectations reflecting the prioritization of familial responsibilities, including to focus on caring for and nurturing their family and to offer physical and emotional support to nuclear and extended family members (Castillo et al., 2010; D'Alonzo, 2012). Although *marianismo* is differently interpreted in distinct contexts and societies, it has been discussed as one factor associated with self-sacrifice that may impair self-care and health promotion behavior among woman with strong *marianismo* beliefs (D'Alonzo, 2012). This demanding role of women within the family was described by Cuban female participants. Cuban women have to raise the children and are responsible for doing housework and providing the family's emotional support, even when they work full-time, which is common in Cuba. Hence, the cultural value of *marianismo* might be a vulnerability factor for Cuban women, since female participants identified various demands related to high expectations of womanhood and motherhood as causes of their mental distress.

Daily hassles of life in Cuba

Everyday burdens were not only mentioned as causes of mental illness when related to *familismo*. In addition to *Excessive demands*, participants mentioned several instances of daily hassles contributing to their mental illnesses that were associated with living conditions and social standards in Cuba. We aggregated these causal attributions into the theme *Socio-cultural, economic, and political environment in Cuba* which represents the most Cuba-specific theme within the data set. Within this theme, individual causal attributions offered an explanatory framework to describe how aspects of the Cuban system or social standards can contribute to mental distress. For example, chronic stressors that were explained as making everyday life in Cuba burdensome ranged from the public transportation system that often cannot serve every customer, to the lack of constant water or power in many households, or the shortage of "essential" products for everyday life. Furthermore, although every Cuban citizen has a right to residential property, the living space citizens are given often serves the whole (extended) family. Hence, many generations usually cohabit. Unsurprisingly, Cuban participants described their living conditions as modest, cramped, and tiring. Daily hassles, chronic stressors, and critical life events have previously been identified as important within the aetiology of mental illness (Thoits, 1995), but some hassles seem to be very common within Cuban everyday life.

Dealing with difficulties

Although everyday needs and financial worries are frequently experienced by most of the Cuban population, such difficulties have been mentioned as causal attributions in other populations and are not Cuba-specific (Rüdell et al., 2009). However, this type of causal attribution might have distinct consequences in different cultural contexts. Attributing mental illness to the external factor of general living conditions might reduce patients' perceived sense of control, which again might affect their recovery. In Cuba it is a common expectation for patients to *poner de su parte* ("do one's part", Suarez Kuneman, 2010) within recovery. This means, in this cultural context, that patients are expected to contribute actively to the treatment (e.g. follow physicians' orders, take prescribed medications), even when unpleasant. However, this expectation might be contradictory when patients attribute their mental distress to social factors that they cannot change. Related to this, many Cubans express some helplessness and acceptance.

This accepting attitude seems to be common within Cuban society, as it is implied in several Cuban proverbs: One proverb which expresses acceptance of unchangeable conditions is *Es lo que hay* (This is what is available). It is generally used when a person is not pleased with her/his current situation. The same attitude arises in other Cuban proverbs like *Es lo que me toca* (This is what I have to deal with), which indicates an acceptance of personal destiny. Further, Cubans

encourage each other to accept whatever happens, using the proverb *¡No cojas lucha!* (Don't catch a fight!). This acceptance is not always related to a bad state of mind but with a special type of humor. Thereby, Cubans express a basic satisfaction and the feeling of solidarity because they all live in similar conditions.

These Cuban sayings might represent a culture-specific factor of resilience that has developed within Cuba, as they encourage Cubans to deal with circumstances they cannot change. Generally, this resilience towards burdensome living conditions seems to be supported by the government. Further, many shortcomings are attributed to the US embargo. This political attribution of burdensome living conditions to an external factor might promote the willingness of Cuban population to keep on fighting (*seguir luchando*) and to resist the political pressure by the USA. At the same time, this externalization might instill a feeling of individual powerlessness. Whether this general attitude and coping strategy is actually correlated with the observed tendency to attribute mental illness externally to unchangeable circumstances is an important topic for future studies.

Comparably, alcohol consumption was mentioned as a Cuba-specific cause of mental illness and at the same time conceptualised as a common coping strategy. Participants at times conceptualised alcohol consumption as an outcome of Cubans' hard living conditions and thus as a dysfunctional coping strategy that leads to mental illness. Still, participants described alcohol consumption and rum as part of Cuban culture and everyday life. This might be at least partly due to low rum prices and the major importance of rum production for the Cuban economy.

Cuban (psychiatric) health care system

The theme *Socio-cultural, economic, and political environment in Cuba* also includes participant-described causes of mental illness that are inherent to the Cuban health care system. Although the Cuban health care system has a good international reputation, a frequent problem is that medical supplies can be (temporarily) unavailable. Therefore, patients often depend on donations for some medical supplies, but they are out of luck and can experience relapse if their medication is unavailable.

Another characteristic specific to Cuban psychiatric treatment is that patients are generally not offered psycho-educational programs, and this lack of education seemed to influence several types of causal attribution. For example, in their individual EMs, several participants identified well-known risk factors (daily hassles, chronic stressors, and critical life events) as causes of their mental illness. Simultaneously, other participants identified their symptoms as causes of their illness (as described by the theme *Symptom related explanations*). Overall, these participants did not seem to have a holistic concept of their mental illness and could not connect the symptoms they were experiencing with the diagnosis they received. Particularly, as some patients with a long clinical history repeated this causal attribution during the interviews, it seems likely that no mental health

professional has offered these patients a scientific explanatory model of their disorder, as would be common during cognitive behavioral therapy in Western countries.

No structured psychoeducation about explanatory models for patients was observed during the research stay. This might also explain why no participants mentioned genetic causes of their mental illness, even though several participants gave reasons that included some kind of familial vulnerability. Further, health education in Cuba is frequently offered to family members and is generally prevention- and treatment-focused (compare Compain & Morrissey, 2013). Thus, health education might focalise factors that can be directly influenced by treatment or family and disregard unchangeable factors such as genetic vulnerability.

Conclusion

The patterns of causal attribution for mental illness found within the narratives of Cuban psychiatric patients overlap with previous findings from other countries and populations, but they also show Cuba-specific causal explanations. We identified different social patterns, cultural values and system-inherent factors that might influence the Cuban sample's causal attributions. Specifically, the important cultural value of *familismo*, the daily hassles of Cuban life, typical ways of dealing with such hassles, and the apparent lack of psycho-education seem to influence how Cubans think about the causes of their mental distress.

The ways that Cubans try to make the best out of their situation fit with a socio-centric personal orientation. Within this worldview, things are accepted as they are and self-control is conceptualised as the capacity to successfully adapt to the conditions, requirements, and limits of the situation (Kirmayer, 2007). While a socio-centric personal orientation dominates in most Latin American cultures (Suarez Kuneman, 2010), the unique political system in Cuba may strengthen this attitude. Most facets of Cuban daily life are shaped by rigid hierarchical structures. Decisions made by higher powers are accepted without further argument, even though they might affect personal matters. Hence, an accepting attitude is part of the daily routine and might function as a psychological adaption to Cuban living conditions. Thus, an accepting attitude might be a feature of psychologically healthy individuals and an important factor of resilience within Cuban society. Generally, the identified causal attributions of the Cuban sample and their link to Cuban cultural factors might give us an initial understanding of specific factors that influence vulnerability and resilience within the Cuban population. As a next step, it would be interesting to study these factors systematically and to describe their influence on the prevalence of mental illness, help-seeking behavior, and the treatment process.

Culture-specific causal attributions seem to mainly link mental illness to external factors (*Family influences, Excessive demands, Cultural, economic, and political environment*). Externalizing the causes of mental illness might help protect affected individuals from stigma and its negative consequences (Weiner, Perry, & Magnusson,

1988). This could be important in Latino cultures, which heavily stigmatise mental illness (Guarnaccia et al., 2005; Suarez Kuneman, 2010). Individuals labeled as *loco*/*loca* (crazy) are perceived as severely mentally ill, potentially aggressive, and not curable (Guarnaccia et al., 2005). Further, as *familismo* plays an important role, this desire to offload responsibility might protect not only the affected individual, but also her/his family. As described by Suarez Kuneman (2010), families in Latino cultures might feel ashamed by a mentally ill family member. Thus, family members often try to reduce stigma by labeling the individual as suffering from *nervios* (nerves; Guarnaccia et al., 2005). This is especially true when mental distress is interpreted as personal weakness. Hence, there might be an important relationship between the type of causal attribution and the experienced stigma.

While attributing the causes of mental illness externally might prevent affected individuals from strong stigmatization, it might simultaneously reduce perceived control over the origin of mental illness. This might have further implications regarding the recovery process; specifically, this perceived lack of control may be worsened by the expectation that Cubans must *poner de su parte* during the treatment. It would be of great interest to analyze whether the type of causal attribution and the accepting cultural attitude influence the treatment progress and help-seeking behavior.

To date, most knowledge about Latino mental health stigma comes from research with immigrant Latino populations. There is little currently known about the stigmatization of mental illness and its consequences in Latin American countries. In the Cuban context, one could also hypothesise that the mental health care system helps fight stigma by promoting the reintegration of mentally ill Cubans into society: Generally, patients are not hospitalised for long periods and families are highly involved in patients' treatment and recovery. Further, day hospitals and "Community Centers of Mental Health" support patients' participation in everyday life. Moreover, Cubans with chronic mental illness are supposed to work; the Cuban government offers employment that is compatible with their impairment, and thus offers people with mental illness the chance to contribute to society. These efforts align with current literature that discusses the mechanisms of psychiatric deinstitutionalization and frequent contact between the public and mentally ill persons as potential ways to reduce the stigma of mental illness (e.g. Schomerus, Matschinger, Kenzin, Breier, & Angermeyer, 2006). Hence, the Cuban mental health care system might be combating the high stigma around mental illness in Latino communities and thus facilitating the use of the health care system. Yet, existing evidence does not allow for further conclusions. To determine how causal attribution, stigma, and help-seeking behavior in Cuba are related, more research is necessary.

Limitations and future research

The current study was conducted by a German researcher (LN) in Cuba. The perception of the researcher as an outsider might have influenced the interviews, although interviews were mainly conducted by Cuban research assistants, and LN

spent several months in the psychiatry department to increase familiarity with participants.

Given the qualitative nature of our study, the current sample was small, not representative, and heterogeneous with respect to patients' general characteristics and referral diagnoses. Our findings offer some initial insights into systematic patterns of causal attribution, but cannot identify patterns that may be linked to specific diagnoses, or affected by sociodemographic characteristics including gender, ethnicity, and education. Future studies with larger sample sizes, could examine the impact of individual factors and sociocultural influences on causal attribution patterns. Moreover, future research should examine whether different types of causal attributions are related to attitudes about treatment (Arnoult & Shimabukuro, 2012; Okello & Neema, 2007), which may offer important implications for therapy (McCabe & Priebe, 2004).

Finally, the current study was carried out before the recent political changes in Cuba. Thus, these studies on causal attribution could be repeated longitudinally to explore their change in response to new social, cultural, and political contexts. Despite limitations, the current study represents the first qualitative study of EMs from Cuba and provides a foundation for future qualitative and quantitative research in this field and for developing therapeutic interventions in this cultural context.

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Notes

1. In this report, we use the term *mental illness* as conceptualised by Kleinman (1991) thus it *"refers to the patient's perception, experience, expression, and pattern of coping with symptoms"* (p. 7).
2. The CEI also contains three open-ended techniques (*Body map, Life line, Social network*) that were applied as described by Saint Arnault and Shimabukuro (2012). They facilitate

participants' disclosure and enabled them to structure their narratives. Currently, data from these techniques were not analyzed explicitly and will be reported in another publication.
3. Minimization and maximization of differences between participants are used with the end of reaching theoretical saturation. Minimization allows one to approve emerging themes and to verify the basic concept of causal attribution; maximization raises the probability of finding different causal attributions and to identify basic, stable features of themes (Glaser & Strauss, 1998). Sampling is finished when theoretical saturation is reached; that is, when further interviews do not add new information.
4. The *Clinic of Stress* is one of the local outpatient group therapies offered to neurotic patients.
5. The participant mentioned the diagnosis of his mitral valve prolapse in childhood as one cause of his current mental illness; he did not mentioned whether this connection was explicitly suggested to him by a physician (see: Santos Filho, Maciel, Martín-Santos, Romano, & Crippa, 2008). Since it was one central aspect of his personal EM we decided to include this statement.

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